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RECENT MODIFICATIONS TO THE PREEMPTION DOCTRINE & THEIR IMPACT ON STATE HMO LIABILITY LAWS

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INTRODUCTION

For years, significant attention has been devoted to problems arising from medical necessity determinations made by managed care organizations (“MCOs”) such as health maintenance organizations (“HMOs”). That is, decisions by an HMO that medical services or treatments recommended by subscribers’ treating physicians are “not medically necessary,” and thus not covered by the HMO plan. When an HMO subscriber subsequently suffers injury or death as a consequence of a denial of coverage, legal barriers have precluded the subscriber from holding the HMO accountable for the negligent medical necessity determination. Most predominantly, for many years the preemption provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”)¹ presented a formidable barrier to redress for such injuries for most subscribers who obtained their health coverage through employer provided benefit plans (“ERISA plans”).² Since 1995, however, the courts have painstakingly worked through the common law developments of the law of ERISA preemption, and some lower courts have finally allowed lawsuits to proceed against HMOs for negligent denials of coverage.³ For example, in

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1. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832 (codified as amended at 29 U.S.C. §§ 1001-1461 (2003)). ERISA’s general preemption provision broadly preempts “any and all State laws insofar as they . . . relate to any employee benefit plan.” 29 U.S.C. § 1144(a) (2003).

2. *Id.* § 1002(1). ERISA defines employee benefit plans to include both pension and welfare benefit plans; welfare benefit plans include plans established or maintained by employers for the purpose of providing medical, surgical, or hospital care benefits. *Id.* § 1003(b)(1)-(5). ERISA does not extend to certain plans, however. These plans include governmental plans, church plans, excess benefit plans, plans maintained solely for the purpose of complying with applicable workmen’s compensation, unemployment compensation or disability insurance laws, and plans maintained outside of the United States primarily for the benefit of persons who are non-resident aliens. *Id.* See generally Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing the Federal Legislative Solution*, 65 MO. L. REV. 405 (2000). Courts have historically found that ERISA preemption extends to state law civil actions against HMOs or other managed care entities if the claim asserted therein arises from a coverage determination even if the determination at issue was based on a finding that recommended treatment is not medically necessary. *Id.*

3. See *Cicio v. Does*, 321 F.3d 83 (2d Cir. 2003) (holding that a negligence claim against an HMO challenging a medical decision by the HMO about appropriate treatment is not preempted by ERISA § 514). See also *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001). Other courts have answered only part of the preemption issue. See, e.g., *Land v. CIGNA Healthcare*

Cicio v. Does,⁴ the Second Circuit Court of Appeals held that ERISA did not preempt an ERISA plan beneficiary's medical malpractice claim against an HMO which made an allegedly negligent medical decision to deny medical care recommended by the claimant's treating physician.⁵ The Second Circuit acknowledged that other courts addressing similar facts had concluded that "malpractice claims based on utilization review" are preempted because a medical necessity determination is "part and parcel" of a coverage determination.⁶ However, the court explained that those decisions had been rendered before the Supreme Court's "retrenchment of ERISA preemption's margins;"⁷ and, in particular, before *Pegram v. Herdrich*,⁸ in which a unanimous Court explained that a "mixed eligibility and treatment decision"—a utilization review determination based on medical necessity—"cannot be untangled from physicians' judgments about reasonable medical treatment."⁹ The Second Circuit, in *Cicio*, construed *Pegram* as "demonstrat[ing] that the mere presence

of Fla., 339 F.3d 1286 (11th Cir. 2003) (using the same analysis as in *Cicio*, but holding only that a medical malpractice claim against an HMO was not completely preempted, reserving the issue of § 514 preemption to the state court); *Lazorko v. Pa. Hosp.*, 237 F.3d 242 (3d Cir. 2000).

4. *Cicio*, 321 F.3d at 83.

5. In *Cicio*, the plaintiff decedent's physician, on January 28, 1998, had recommended "high dose chemotherapy supported with peripheral blood stem cell transplantation, in a tandem double transplant, for [Mr. Cicio's] diagnosis of multiple myeloma." *Id.* at 87. The HMO's medical director, Dr. Spears, on February 23, 1998, denied the request for preauthorization of Cicio's physician, Dr. Samuel. *Id.* at 88. Dr. Spears noted that the procedure was not covered because Cicio's health benefit plan stated that experimental or investigational procedures were not covered. *Id.* On March 4, 1998, after unsuccessful attempts to contact Dr. Spears by telephone, Dr. Samuel wrote an appeal for reconsideration, noting that the recommended treatment was a well-established and effective treatment. *Id.* On March 25, 1998, Dr. Spears approved a single stem cell transplant, but again denied the original request for tandem stem cell transplant. *Id.* By March 25, 2003, Cicio was no longer a candidate for the transplant. *Cicio*, 321 F.3d at 88. Mr. Cicio died on May 11, 1998. *Id.*

On appeal, the remaining claims challenged the timeliness of Dr. Spears' decisions, the allegedly misleading nature of the HMO's representations about Cicio's health benefit plan, and the quality of the medical decision made by the HMO and the physician medical director, both of whom were named as defendants. *Id.* at 90.

Interestingly, the Court of Appeals noted that the HMO's abstract determination that a double stem cell transplant to treat the condition was experimental might lack the "significant application of medical judgment" and thus represent a decision simply about the scope of benefits. *Id.* at 91. However, the Court of Appeals read certain allegations in the complaint as more clearly challenging the appropriateness of a medical decision by the HMO because Dr. Spears reviewed a thorough case history of Mr. Cicio's illness and the decision thus, could have rested on an analysis of the appropriate treatment for Mr. Cicio's specific condition. *Id.* The court noted that, "[b]y denying one treatment and authorizing another that Dr. Samuel had not specifically requested, Dr. Spears at least seems to have been engaged in a patient-specific prescription of an appropriate treatment . . ." *Id.*

6. *Cicio*, 321 F.3d at 100 (citing *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995)).

7. *Cicio*, 321 F.3d at 100.

8. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

9. *Cicio*, 321 F.3d at 100 (quoting *Pegram*, 530 U.S. at 229).

of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component."¹⁰ Accordingly, the court held that § 514(a) of ERISA did not preempt the claimant's medical malpractice claim because the claim simply did not "relate to" ERISA plans.¹¹

The question of the day, however, is whether the Supreme Court will ultimately agree with this emerging perspective of the scope of ERISA preemption, including both the outcome and the analysis leading to the outcome. Two recent cases shed some light on the answer to the question, but predictably, also raise new questions. Continuing along the path begun in 1995,¹² the Supreme Court in *Rush Prudential HMO, Inc. v. Moran*¹³ ("*Rush*") and *Kentucky Association of Health Plans, Inc. v. Miller*¹⁴ ("*KAHP*"), drew additional lines marking the boundaries of the preemption of state law by ERISA. More specifically, in both decisions the Court broadened the scope of ERISA's "savings clause."¹⁵ Further, the Court in *KAHP* streamlined the basic savings clause standards¹⁶ and the Court in *Rush* provided an intricate analysis, which ultimately limited or narrowed the scope of the conflict preemption exception to the savings clause.¹⁷

Both opinions can readily be construed as drawing lines that are consistent with the path taken by the Court in recent years, and consistent with the view held by many, that ERISA should not be construed as preempting state law claims against managed care organizations for negligent medical necessity determinations. However, the cases suggest an analysis that differs from that used in *Cicio* and different from that advocated by some ERISA scholars.

10. *Id.* at 103.

11. *Id.* at 104 ("[W]e conclude that § 514 preemption does not obtain with regard to those claims predicated on the violation of a state tort law by a failure to meet a state-law defined standard of care in diagnosing or recommending treatment of a plaintiff patient's constellation of symptoms.").

12. In 1995, the Supreme Court issued an ERISA preemption decision that, for the first time, began detailing the limitations on the scope of ERISA preemption. See *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645 (1995). See generally Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 *YALE J. ON REG.* 255 (1996) (analyzing the *Travelers Insurance* decision and applying the more restrained view to emerging preemption issues).

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

14. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

15. Through ERISA's savings clause, Congress expressly exempted from the reach of ERISA preemption state laws that regulate insurance. ERISA's savings clause prescribes that ERISA shall not "be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." 29 U.S.C. § 1144(b)(2)(A) (2003). The Supreme Court traditionally has declared that ERISA's savings clause should be broadly construed, but in reality has kept the scope of the exemption relatively narrow. See *supra* notes 74-88 and accompanying text for a discussion on broadening.

16. See *infra* notes 89-123 and accompanying text.

17. See *infra* notes 151-96 and accompanying text.

Rather than avoiding preemption by a finding that state HMO liability laws do not impermissibly “relate to” ERISA plans, *Rush* and *KAHP* suggest that the resolution of the issue ultimately may hinge on application of the conflict preemption exception. Justice Souter’s opinion in *Rush*, which was joined by a majority of the Justices, seemed to clear the way for state HMO liability laws by carefully describing the holdings in key precedential cases in an effort to delimit the preemptive force of § 502(a).¹⁸ Unfortunately, despite Justice Souter’s care, some language in the majority opinion could be construed as supporting the exact opposite view: that *Rush* supports ERISA preemption of state legislative attempts to impose liability on managed care plans for violation of a duty of ordinary care in arranging for medically necessary services.¹⁹ Indeed, that opposite view was highlighted in the December 2002 publication of the American Bar Association’s Health Law Section.²⁰

Accordingly, this Article analyzes the *KAHP* and *Rush* refinements to the law of ERISA preemption, highlights the key doctrinal and policy implications, and then applies the refinements to the question whether ERISA preempts civil actions that are essentially “medical malpractice” lawsuits against MCOs for negligent denials of claims based on “medical necessity determinations.” As noted, the crux of the analysis may well hinge on application of conflict preemption principles and, specifically, on the Court’s view of the preemptive force of ERISA’s civil enforcement provisions. This Article concludes, using Justice Souter’s analysis, that state HMO liability laws fall outside the scope of the preemptive force of § 502(a).

I. SIDE BAR: CERTIORARI GRANTED ON THE NARROWER “COMPLETION PREEMPTION” ISSUE

Notably, as this Article was going to print, the Supreme Court granted certiorari in two consolidated cases in which Aetna and CIGNA policyholders (Calad and Davila) sued their HMOs for their alleged negligence or failure to use ordinary care in denying coverage for the medical care recommended by the claimants’ physicians (hereafter the “*Davila* case”).²¹ In the cases,

18. See *infra* notes 275-93 and accompanying text.

19. See David M. Humiston et al., *Navigating the Shoals of ERISA: The Effect of ERISA Preemption on New State Laws Creating Tort Liability Against Managed Care Entities*, 14 HEALTH LAW 1, 8 (2002) (opining that, even in light of *Pegram* and *Rush*, ERISA preempts state statutory liability for delays and denials of requested benefits; although state laws holding HMOs liable for negligent acts of agents or employees while *providing* direct medical services to plan participants will survive preemption).

20. Gregory Pimstone & Michele Johnson, *Rush Prudential: Savior of Pilot Life?*, HEALTH LAW., Dec. 2002, at 7. See *infra* notes 276-79 and accompanying text (describing the views set forth in this Article).

21. See *Aetna Health, Inc. v. Davila*, 124 S. Ct. 462 (2003); *CIGNA Healthcare of Tex., Inc. v. Calad*, 124 S. Ct. 463 (2003). *Davila* and *Calad* filed complaints which expressly set forth claims based on state law—the law of negligence generally and the more specific HMO

however, the issue addressed in this Article, § 514 preemption, is not squarely before the Court. Nonetheless, § 514 considerations may play a key role in the *Davila* decision.

In the *Davila* case, the Fifth Circuit Court of Appeals held that the removal to federal court by Aetna and CIGNA of the negligence-based actions filed by Davila and Calad was not proper.²² More specifically, the Fifth Circuit held that the claims of Davila and Calad did not fall within the scope of the “complete preemption” doctrine, a doctrine that allows the removal of actions involving state law claims due to the special preemptive force of certain federal laws.²³ The doctrine applies and allows removal if the state law cause of action falls “within the scope of § 502(a)(1)(B).”²⁴ Mere preemption (a § 514(a) defense) is insufficient to confer removal jurisdiction. Importantly, although the § 514 issue is not squarely before the Court, the § 514 preemption analysis may be implicated in two ways.

First, if the Court *disagrees* with the Fifth Circuit and finds that the cases were properly removed, the Court necessarily also resolves the broader § 514 preemption question: a claim that is completely preempted is preempted and must be pursued, if at all, as a § 502(a) claim. Indeed, this has been the trend in the lower courts for years. For example, in *Corcoran v. United Healthcare, Inc.*,²⁵ the Fifth Circuit held that ERISA preempted a state law negligence claim against an HMO arising out of a medical necessity determination. The *Corcoran* holding was primarily guided by the Supreme Court’s statement in *Pilot Life Insurance Co. v. Dedeaux*,²⁶ in which the Court first emphasized § 502(a)’s role in the preemption analysis. In *Pilot Life*, the Court stated that § 502(a)(1)(B) provides the exclusive vehicle for claims alleging improper

liability law enacted by the legislature of Texas. *Davila*, 124 S. Ct. at 462; *Calad*, 124 S. Ct. at 463.

22. See *Roark v. Humana, Inc.*, 307 F.3d 298, 306-08 (5th Cir. 2002), *cert. granted sub. nom.*, *Aetna Health, Inc. v. Davila*, 124 S. Ct. 462 (2003); *CIGNA Healthcare of Tex., Inc. v. Calad*, 124 S. Ct. 463 (2003).

23. Thus, although Calad and Davila chose to bring claims created by or based on state law, their actions would nonetheless be removable if they fell within the scope of the complete preemption exception. Under the general rules, an action is removable only if the action is one that could have been filed in federal court. 28 U.S.C. § 1441 (2003). Generally, then, an action between non-diverse parties would not be removable unless the action involved a claim falling within “federal question” jurisdiction. *Id.* Under the long-established “well-pleaded complaint” rule, whether a claim falls within federal question jurisdiction depends on whether the plaintiff’s stated claim or cause of action is created by or based on federal law. See *Louisville & Nashville R.R. v. Motley*, 211 U.S. 149, 152 (1908). A federal issue raised by the defendant as a defense, or a defense anticipated by the plaintiff and expressly raised in the complaint, is insufficient to support an exercise of federal question jurisdiction. *Id.* The complete preemption doctrine is an exception to the general removal rules. *Id.*

24. See *Metropolitan Life v. Taylor*, 481 U.S. 58 (1987). See also *Beneficial Nat’l Bank v. Anderson*, 539 U.S. 1 (2003) (involving preemption by the National Bank Act); *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1 (1983) (involving ERISA preemption).

25. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1331 (5th Cir. 1992).

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

processing of a claim for benefits.²⁷ The court in *Corcoran* held that, although a denial based on “no medical necessity” is different from a pure coverage decision of the type in *Pilot Life*, the medical decision is still made as “part and parcel” of a benefit determination; thus, the Concorans’ claim fell within the scope of § 502(a)(1)(B)’s preemptive sweep.²⁸

Under that rationale, courts have found actions such as those in *Davila* as being removable via complete preemption and preempted. Similarly, although the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*²⁹ refined the test for complete preemption to carve out removal of claims challenging the “quality” of care provided, the court adhered to the view in *Corcoran* that § 502(a)(1)(B) of ERISA preempts and thus completely preempts a claim arising from a denial of benefits.³⁰ So, if the Court finds that the claims in *Davila* are within the complete preemption doctrine and thus properly removed, the Court will also resolve the § 514 preemption issue.

Second, § 514 preemption may also be implicated if the Court agrees with the Fifth Circuit’s approach in *Davila* and finds that the cases were *not* properly removed. The implication is not necessary or absolute, however, given that the Court could simply affirm the appropriateness of remand—which would leave the issue of § 514(a) preemption to the state court. The issue of § 514(a) preemption remains because the scope of state law causes of action completely preempted due to § 502(a) is not necessarily co-extensive with the scope of state law causes of action preempted by § 514(a) or preempted due to a mere conflict with § 502(a). Rather, courts have repeatedly recognized, even beyond the context of ERISA, that state claims that are not completely preempted may nonetheless be preempted. For example, the Third Circuit in *Dukes* explained that, although not removable under the complete preemption doctrine, state negligence claims challenging the quality of care provided by an HMO to an ERISA plan participant might nonetheless be preempted by ERISA.³¹

Nonetheless, § 514 preemption may well play a key role in the Court’s complete preemption analysis given the existence of an important corollary. State claims that are not preempted are also not completely preempted. This corollary is important because of one aspect of the recent Supreme Court cases highlighted in this Article—the majority’s narrowing of the preemptive force of § 502(a) in *Rush Prudential* as is explained in Part III(A)(1) of this Article. The narrower view of § 502(a) adopted by the majority in *Rush* suggests that at least some of the Justices lean towards the position that Congress did not intend for ERISA to preempt claims against HMOs challenging allegedly negligent medical necessity determinations, even when the claims are brought

27. *Id.* at 56-57.

28. *Corcoran*, 965 F.2d at 1332.

29. *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995).

30. *Id.* at 357.

31. *Id.*

by ERISA plan participants and beneficiaries and are asserted against entities such as HMOs which serve as administrators of ERISA health benefit plans. If that view prevails in the *Davila* case, § 514(a) preemption considerations may drive the decision of the complete preemption issue. That is, although not squarely before the Court, the *Davila* opinion may reflect the position (fleshed out later in this Article) that § 514(a) does not preempt the claims of Calad and Davila—and thus, a fortiori, the claims also are not completely preempted and remand was proper.³²

32. Although it is beyond the scope of this Article to thoroughly address the complete preemption issue, the author believes the case law favors Davila and Calad. Notably, the Supreme Court cases do not expressly discuss how to determine whether a state claim is within the scope of § 502(a). Nonetheless, the Supreme Court cases addressing complete preemption have impliedly answered the question. For example, in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), the Court held that, although ERISA may support complete preemption, it was not available in that case because the claim by the state was not within the scope of § 502(a). *Franchise Tax Board* involved an action by a state tax enforcement agency brought in state court against a multi-employer trust that had been established to administer a collective bargaining agreement. *Id.* The claim was not within the scope of § 502(a) because § 502(a) does not create a cause of action in favor of state governments to enforce tax levies. Rather, § 502(a) creates various causes of action for plan participants or beneficiaries, plan administrators or fiduciaries, or the Secretary of the Department of Labor, to be brought against plan administrators or fiduciaries to enforce rights under the terms of the plan or rights under ERISA. *See* 29 U.S.C. § 1132(a) (2003). In *Franchise Tax Board*, the claimant's cause of action did not even come reasonably close to duplicating or looking like a cause of action authorized by § 502(a). *Franchise Tax Bd.*, 463 U.S. at 1.

In other Supreme Court cases addressing complete preemption, the claimants stated causes of action, which clearly *did* fall within the scope of the relevant federal statute. For example, in *Metropolitan Life v. Taylor*, 481 U.S. 58 (1987), the case in which the Court expressly held that the preemptive force of ERISA also supports complete preemption removal, the plaintiff sought re-implementation of disability benefits and insurance coverage, as well as damages for "money contractually owed." *Id.* at 61. As such, the plaintiff's claim clearly duplicated the cause of action explicitly authorized by ERISA—§ 502(a)(1)(B) provides a vehicle to protect a plan participant's contractual rights to benefits. Although the plaintiff also sought additional remedies beyond those allowed by ERISA, the claim was still within the scope of § 502(a)(1)(B).

The same was true in *Beneficial National Bank v. Anderson*, 123 S. Ct. 2058 (2003), the Court's most recent complete preemption case in which the Court extended the doctrine to the claims within the scope of the National Bank Act. In that case, the plaintiff sought, through a claim based on a state usury law, damages from a national bank for allegedly charging excessive interest. Yet, the National Bank Act governs the rate of interest that a national bank may lawfully charge and provides a private right of action for certain remedies against national banks that charge an excessive rate. *See id.* at 2061 (citing the National Bank Act, 12 U.S.C. §§ 85-86 (2003)). Thus, the federal statute protects the right to a "non-excessive" interest rate and the plaintiff's state law claim in *Beneficial National Bank* clearly duplicated the cause of action provided by the federal statute to protect that right. As in *Taylor*, although the plaintiff also sought remedies not allowed by the federal statute, removal was deemed proper.

The Davila and Calad claims fall somewhere between the claims in the Supreme Court cases. That is, on the one hand they are not so clearly *not within* the scope of § 502(a) as the claim in *Franchise Tax Board*. Rather, several aspects of the claims make them resemble a § 502(a)(1)(B) claim. State negligence-type claims of the sort in *Davila* are claims brought by ERISA plan participants and beneficiaries against HMOs that serve as administrators or fiduciaries of the ERISA plan through which the plaintiffs' health coverage is provided.

II. INTRODUCTION TO *KAHP* AND *RUSH* AND THE PREEMPTION ISSUES

Both *Rush* and *KAHP* involved ERISA preemption challenges to state laws enacted in response to managed care strategies used by health insurers or other health coverage providers. In both cases, the Court resolved the preemption issue through analysis involving only ERISA's savings clause.³³ This part of the Article first explains the state laws challenged in the cases and then provides a general sketch of the basic principles of ERISA's preemption and savings clause doctrines.

A. *The Rush Case*

The state law at issue in *Rush* was a provision in the Illinois Health Maintenance Organization Act ("the HMO Act") requiring HMOs to provide independent and external review ("IER") of the question whether a covered service is medically necessary when a dispute arises between the primary care

Further, the claims arise, at least in part, from a denial of benefits. Thus, according to many lower courts, such claims fall within the scope of § 502(a)(1)(B), which provides a cause of action to plan participants and beneficiaries to recover benefits due.

However, the claims also are not so clearly *within* the scope of the federal statute as in *Taylor* and *Beneficial National Bank*. Claimants such as Davila and Calad are seeking compensatory damages as a remedy for harm caused by a negligent decision, recommending that services or treatments are not medically necessary; they are not seeking benefits due under the plan, however, they are challenging medical decisions and not merely a denial of coverage. Moreover, the state cause of action protects a right that is not protected by ERISA. A § 502(a)(1)(B) action protects primarily a contractual right to benefits promised under the plan; whereas, the state claim protects the right to have a medical necessity decision made in accord with a standard of reasonable care.

The issue, then, is whether a claim by plan participants, such as Calad and Davila, against HMOs which administer their benefits should be characterized as "within the scope of § 502(a)(1)(B)" whenever the factual allegations involve a denial of coverage and the claim arises from that denial of coverage, even though the state law claim is regulating conduct that ERISA does not regulate (the exercise of medical discretion) and is protecting rights not addressed by ERISA.

In the author's view, the Supreme Court complete preemption cases suggest that the proper inquiry does not focus on the factual circumstances giving rise to the claim. The inquiry, rather, focuses on the *claim* asserted: whether the purported state claim duplicates a cause of action explicitly authorized by the federal statute by regulating conduct that is regulated by the federal statute and protecting a right protected by the federal statute. Additionally, the focus in the Supreme Court cases was not on the remedy sought; although, an obvious consequence of asserting a claim within the scope of a federal cause of action is that the plaintiff is thereby limited to the remedies allowed by the federal statute. Under this view, the state claims in *Davila* are not within the scope of the complete preemption doctrine.

33. Through ERISA's savings clause, Congress expressly exempted from the reach of ERISA preemption state laws that regulate insurance. ERISA's savings clause prescribes that ERISA shall not "be construed to exempt or relieve any person from any law of any State which regulates insurance . . ." 29 U.S.C. § 1144(b)(2)(A). The Supreme Court traditionally has declared that ERISA's savings clause should be broadly construed, but in reality has kept the scope of the exemption relatively narrow.

provider of a plan subscriber and the HMO and to cover services deemed medically necessary by the independent reviewer.³⁴ The plaintiff, Debra Moran, was a beneficiary of an ERISA health benefit plan. Moran's ERISA plan contracted with Rush Prudential HMO, Inc. ("Rush HMO"), to provide medical services for plan participants and beneficiaries.³⁵ Moran's primary care physician recommended that Rush HMO approve of a particular treatment for Moran's condition; however, Rush HMO denied the request on the ground that the procedure was not medically necessary, and Moran invoked the IER provision.³⁶ After being compelled by a state court, Rush HMO submitted Moran's claim for IER. The independent reviewer decided that the recommended treatment was medically necessary, but Rush HMO continued to deny Moran's claim.³⁷ Moran, who had proceeded with her treatment pending the process, sought reimbursement for the cost of the treatment by filing a civil action in state court. Rush HMO removed Moran's claim to federal court, under the Illinois IER provision, and the district court properly treated the claim as a suit under ERISA for benefits due.³⁸ The district court denied the claim on the ground that ERISA preempted the Illinois IER law; no other basis for the claim for benefits was at issue.³⁹ The Seventh Circuit reversed.⁴⁰

A majority of the Supreme Court affirmed the Seventh Circuit's decision and held that ERISA did not preempt the IER law.⁴¹ The Court first summarily concluded that it was "beyond serious dispute" that the law relates

34. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359-61 (2002). The IER law provides:

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 . . . , 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.

See Illinois HMO Act, 215 ILL. COMP. STAT. 125/4-10 (2000).

The Act defines a health maintenance organization as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Id.* 125/1-2.

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

36. Moran's primary care physician "recommended that Rush approve surgery by an unaffiliated specialist . . . who had developed an unconventional treatment for Moran's condition." *Id.* at 360.

37. *Id.* at 361-62.

38. *Id.* at 362.

39. *Id.* at 363.

40. *Id.*

41. *Rush*, 536 U.S. at 387 ("The savings clause is entitled to prevail here, and we affirm the judgment.").

to employee benefit plans.⁴² The Court noted that the law “bears ‘indirectly but substantially on all insured benefit plans’ . . . by requiring them to submit to an extra layer of review for certain benefit denials if they purchase medical coverage from any of the common types of [HMOs] covered by the state law’s definition of HMO.”⁴³ The Court thus viewed the preemption analysis as hinging on the ERISA savings clause analysis.

B. *The KAHF Case*

Two any-willing-provider laws (“AWP statutes”) were at issue in *KAHP*, one regulating benefit plan relationships with health care providers generally⁴⁴ and one regulating their relationships with chiropractic providers.⁴⁵ Both statutory provisions prohibited discrimination by health care benefit plans against health care providers willing to meet the terms and conditions and other standards established by the plans for participation in the plans.⁴⁶

The laws thus interfered with the managed care strategy of contracting with networks of selected health care providers in order to control costs and quality. The Court noted that, pursuant to a contract between the HMO and providers, the providers “agree[d] to render health-care services to the HMOs’ subscribers at discounted rates and to comply with other . . . requirements. In return, they receive the benefit of patient volume higher than that achieved by

42. *Id.* at 365.

43. *Id.* (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)). While the relation to ERISA plans was fairly obvious, the opinion would have been clearer if the Court had explained the law’s impermissible connection with ERISA plans. The law acts directly on HMOs. Many of the regulated HMOs contract with ERISA plans. Accordingly, the requirement of IER adds a step in the process of claims administration for those ERISA plans that contract with HMOs. The process of administering claims for benefits for ERISA plan participants and beneficiaries is at the heart of administration of an ERISA benefit plan. Accordingly, the IER law can readily be characterized as a law that mandates or binds administration of the ERISA benefit plans and therefore constitutes an impermissible connection with ERISA plans. As explained more fully *infra*, for precisely this reason, however, many students of the ERISA preemption doctrine believed that the Court would find the law preempted, notwithstanding the savings clause analysis. The dissenting Justices also noted this point. *Id.* at 387-89.

44. KY. REV. STAT. ANN. § 304.17A-110(3) (Banks-Baldwin 1994) (repealed 1999) (“Health care benefit plans shall not discriminate against *any provider* who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan.”) (emphasis added). See *Id.* § 304.17A-100(4)(a). Health benefit plan is defined to mean any “hospital or medical expense policy or certificate; non-profit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and [certain] standard and supplemental health benefit plan(s).” *Id.*

45. *Id.* § 304.17A-171(2) (“[A] health care benefit plan that includes chiropractic benefits shall . . . [p]ermit *any licensed chiropractor* who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.”) (emphasis added).

46. See *supra* notes 44-45 and accompanying text.

nonnetwork providers who lack access to [the HMOs'] subscribers."⁴⁷ HMOs are often opposed to AWP statutes because they interfere with an HMO's ability to limit the number of providers in a network and thus impair the "ability to use the assurance of high patient volume as the *quid pro quo* for discounted rates;" thereby frustrating an HMO's cost and quality control.⁴⁸

Accordingly, HMOs licensed under the laws of Kentucky and a Kentucky-based association of HMOs sought an injunction against enforcement of the AWP statutes, arguing that they were preempted by ERISA.⁴⁹ The district court and Sixth Circuit Court of Appeals concluded that the laws relate to ERISA plans within the meaning of ERISA's preemption clause, but the laws were saved from preemption because they regulate insurance.⁵⁰ The Supreme Court addressed only whether the AWP statutes constitute laws that regulate insurance.

C. The Preemption Issues

In both *Rush* and *KAHP*, the state laws at issue were challenged as being preempted by ERISA. Preemption of state laws by ERISA involves consideration of both § 514 of ERISA, the basic preemption clause, and § 514(b)(2)(A), ERISA's savings clause. Section 514(a) of ERISA provides that ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"⁵¹ The Supreme Court has always explained that ERISA's preemption provision reflects broad congressional intent to preempt state laws that have a connection with or reference to ERISA plans.⁵² However, in more recent years, the Court has also more clearly refined limitations on the broad scope of ERISA preemption. The Court has determined that the analysis should be guided by the objectives of ERISA and should involve consideration of the nature and purpose, as well as the effect, of the state law at issue.⁵³ Rather than any mere reference to an ERISA plan, the Court has stated that a reference will warrant preemption if the state law "acts immediately or exclusively upon ERISA plans, . . . or where the

47. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1474 (2003).

48. *Id.*

49. *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 355 (6th Cir. 2000).

50. *Id.* at 355, 357-63 (preemption analysis), 363-72 (savings clause analysis).

51. 29 U.S.C. § 1144(a) (2003).

52. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (related to ERISA plans because a mandated benefit requirement bears indirectly but substantially on all insured plans); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (preempted because the statute referenced ERISA plans and was specifically designed to affect such plans); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (anti-subrogation law contained a reference to benefit plans and had a connection with such plans because it posed the risk of subjecting plan administrators to conflicting state regulations).

53. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655-57 (1995).

existence of ERISA plans is essential to the law's operation"⁵⁴ Rather than any mere connection with an ERISA plan, the Court has stated that preemption is warranted if the law "mandates employee benefit structures or their administration or provides alternative enforcement mechanisms [to ERISA]."⁵⁵ Further, the Court has emphasized the presumption against preemption of state laws regulating the health and welfare of a state's citizens, an area traditionally within a state's police powers.⁵⁶

Through ERISA's savings clause, Congress expressly exempted state laws that regulate insurance from the reach of ERISA preemption. ERISA's savings clause prescribes that ERISA shall not "be construed to exempt or relieve any person from any law of any State which regulates insurance"⁵⁷ The Supreme Court traditionally has declared that ERISA's savings clause should be broadly construed, but in reality has kept the scope of the exemption relatively narrow. Before *KAHP*, the scope of the clause was circumscribed by grafting into the analysis the complex tripartite standard originally established under the McCarran-Ferguson Act for determining whether a practice constitutes the "business of insurance" for purposes of that Act's antitrust exemption.⁵⁸ The savings clause analysis therefore included the following basic legal standards: (1) whether the law regulates insurance from a common sense perspective; and (2) whether the law satisfies the McCarran-Ferguson factors—namely, does it target a practice that (a) has the effect of transferring or spreading a policyholder's risk, (b) is an integral part of the policy relationship between the insurer and the insured, and (c) is limited to entities within the insurance industry.⁵⁹ In addition, the Court has further narrowed the scope of ERISA's savings clause by injecting into the analysis a moderating factor or exception to saving a law regulating insurance; the conflict preemption exception allows consideration of whether saving the state law would further the objectives of ERISA. For example, in *Pilot Life Insurance Co. v. Dedeaux*, the Court bolstered its decision that a state law was not saved by explaining that preemption was warranted in order to avoid frustration of congressional objectives underlying ERISA's complex civil enforcement provisions.⁶⁰

54. *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 325 (1997) (citing *Makey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992)).

55. *Travelers*, 514 U.S. at 658.

56. *Id.*

57. 29 U.S.C. § 1144(b)(2)(A) (2003).

58. *See, e.g., Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). The factors developed in the McCarran-Ferguson Act cases require an assessment of whether the law targets a practice that has the effect of transferring or spreading a policyholder's risk, is an integral part of the policy relationship between the insurer and the insured, and is limited to entities within the insurance industry. *See id.*

59. *Id.*

60. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-57 (1987). This Article will refer to the consideration of conflict preemption principles as the conflict preemption exception.

The Supreme Court in *Rush* and *KAHP* addressed only whether the laws at issue were saved from preemption. Because neither case explained in any detail why the laws had a sufficient connection with ERISA plans to warrant preemption and thus trigger the savings clause, the cases add little to our understanding of the application of ERISA's preemption clause. As noted, however, the cases significantly add to our understanding of the application of the savings clause. *KAHP* streamlined the basic legal standards of the savings clause analysis and *Rush* limited the scope of the conflict preemption exception; both cases reflect a broader view of laws saved from ERISA preemption. The following part of the Article details the doctrinal modifications of the saving clause analysis and the key policy implications thereof.

III. THE REFINEMENTS TO THE BASIC SAVINGS CLAUSE ANALYSIS

Prior to *KAHP*, the basic savings clause standards included the common sense test and a consideration of the McCarran-Ferguson Act factors. These basic standards had been applied in countless lower court cases over the years. As noted, the standards have generally been applied in a fairly narrow manner, especially the McCarran-Ferguson factors. As explained in more detail later in the Article, the McCarran-Ferguson factors were developed in cases involving the McCarran-Ferguson Act's antitrust exemption for the "business of insurance."⁶¹ In those cases, the Supreme Court appropriately took a narrow view of what constitutes the business of insurance. Lower courts have tended to follow this narrow approach in the ERISA context.⁶²

Additionally, over the years, the savings clause inquiry had become somewhat truncated. In addressing whether a state law satisfies the common sense test, the Supreme Court has traditionally asked whether the law is "specifically directed" towards the insurance industry. For example, in *Pilot Life*,⁶³ the Court found that a common law cause of action arising from the insurer's allegedly bad faith refusal to pay a claim for benefits did not further a "common sense" understanding of ERISA's saving clause because the action evolved from general principles of tort and contract law which, obviously, were not applicable solely to insurers.⁶⁴ In recent years, however, lower courts have also asked, in the common sense prong of the analysis, whether the law focuses on the primary elements of insurance—the spreading and underwriting of a policyholder's risk—or whether the law deals with the relationship

61. See *infra* notes 98-105 and accompanying text.

62. See, e.g., *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144 (2d Cir. 1995); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir. 1994); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105 (5th Cir. 1993); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426 (6th Cir. 1989). See generally Karen A. Jordan, *ERISA Pre-emption: Integrating Fabe into the Savings Clause Analysis*, 27 RUTGERS L.J. 273 (1996).

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

64. *Id.* at 50 ("Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.").

between the insurer and insured. In doing so, the courts have thereby tended to truncate the analysis by blending the common sense and McCarran-Ferguson Act factor considerations. Courts have also tended to truncate the analysis by stating that an affirmative answer to the question whether a law is specifically directed towards the insurance industry also shows that the law satisfies the third McCarran-Ferguson factor; that is, if the law is specifically directed towards the insurance industry, the law also is limited to entities within the insurance industry.

The Sixth Circuit's opinion in the *KAHP* case provides a good example of the truncated analysis.⁶⁵ In addressing the common sense prong of the test, the Sixth Circuit found that the AWP laws target insurance because the laws regulate entities such as insurers and HMOs which engage in the spreading and underwriting of policyholders' risk, and because the laws deal directly with the relationship between insureds and insurers.⁶⁶ Both of these considerations are part of the McCarran-Ferguson Act analysis. Indeed, when engaging in the McCarran-Ferguson Act analysis, the Sixth Circuit repeated its view that the laws affect risk spreading (since the type of coverage is a component of risk) and regulate the relationship between the insured and insurer; the Court further noted that the third McCarran-Ferguson factor was satisfied for the reasons previously stated in the common sense part of the analysis.⁶⁷

The savings clause analysis has also been somewhat relaxed in recent years in light of the Supreme Court's clarification in *UNUM Life Insurance v. Ward*⁶⁸ that the McCarran-Ferguson Act factors serve as guideposts or checking points and do not constitute separate essential requirements.⁶⁹ Before *UNUM*, some lower courts rigidly required an affirmative answer to all three of the McCarran-Ferguson Act factors before finding a law saved from preemption.⁷⁰ The Court in *UNUM* explained that the factors were "considerations [to be] weighed"⁷¹ "and that [n]one of these criteria is necessarily determinative in itself."⁷² Nonetheless, the Court in *UNUM*, and later in *Rush*, continued to address the three McCarran-Ferguson Act factors as part of the basic savings clause analysis.⁷³

65. See *Ky. Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000).

66. *Id.* at 364-68.

67. *Id.* at 368-71.

68. *UNUM Life Ins. v. Ward*, 526 U.S. 358 (1999).

69. *Id.* at 373-74.

70. See, e.g., *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 110 (5th Cir. 1993) (deciding that because the state law did "not spread the [policyholder's] risk," it was unnecessary to address the other factors set forth in *Metropolitan Life*). See also *Coots v. United Employers Fed'n*, 865 F. Supp. 596 (E.D. Mo. 1994) (following *Tingle*).

71. *UNUM*, 526 U.S. at 373 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 49 (1987)).

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

73. See *infra* notes 83-85 and accompanying text.

The Court in *Rush* had little difficulty applying the basic legal standards of the savings clause analysis; yet, the decision significantly aids in understanding the Court's application of the standards to state laws regulating HMOs. The Court's decision in *KAHP* is similarly important, as it streamlined the basic standards by rephrasing the three McCarran-Ferguson factors as one factor. Moreover, both decisions reflect a broader view of laws saved from preemption.

A. *Rush*: Broadening the "Who" and the "What" of Laws Saved

The Court in *Rush* had little difficulty applying the basic standards to the IER provision to determine whether the provision was saved from preemption. Two important principles nonetheless emerged, both relevant to the common sense prong of the savings clause analysis.

First, in first applying the common sense inquiry, the Court in *Rush* focused on *who* the law regulates and resoundingly rejected *Rush* HMO's argument that because the law regulates HMOs, it does not regulate insurance.⁷⁴ The Court noted that the common sense inquiry focuses on "'primary elements of an insurance contract [which] are the spreading and underwriting of a policyholder's risk.'" ⁷⁵ The Court then readily found that an HMO, although in part a health care provider, also provides insurance: "[I]t would ignore the whole purpose of the HMO-style of organization to conceive of HMOs . . . without their insurance element."⁷⁶ The Court exhaustively recounted authority for the proposition that HMOs assume financial risk and underwrite and spread risk among their participants.⁷⁷ Indeed, the Court noted that "virtually all commentators on the American health care system describe HMOs as a combination of insurer and provider, and observe that in recent years, traditional 'indemnity' insurance has fallen out of favor."⁷⁸ According

74. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 359-61 (2002). The Court noted, "Rush contends that seeing an HMO as an insurer distorts the nature of an HMO, which is, after all, a health care provider, too. This, Rush argues, should determine its characterization, with the consequence that regulation of an HMO is not insurance regulation within the meaning of ERISA." *Id.*

75. *Id.* (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979)).

76. *Id.* at 367.

77. *Id.* at 367-68. The Court cited *Pegram v. Herdrich*, 530 U.S. 211, 218-19 (2000), "The HMO thus assumes the financial risk of providing the benefits promised . . ." *Id.* Congressional understanding when the HMO Act of 1973 was enacted included requirements that the HMOs would bear and manage risk. *Id.* at 233-34. Congress was aware that states regulated HMOs as insurers and compared HMOs to indemnity or service benefits insurance plans; and the continued regulation of HMOs by states through their respective insurance departments. *Rush*, 536 U.S. at 368-69. See also RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 104 (4th ed. 1992). HMOs underwrite and spread risk among their participants. *Id.*

78. *Rush*, 536 U.S. at 370 (citing Weiner & De Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. HEALTH POL., POL'Y & L. 75, 77 (1993)); Marsha R. Gold, *Understanding the Roots: Health Maintenance Organizations in*

to the Court, "Nothing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the savings clause may apply."⁷⁹

Second, the Court also rejected Rush HMO's argument that the Illinois IER provision was drafted too broadly to constitute a law specifically directed at the insurance industry. Rush HMO argued that the law's definition of HMO⁸⁰ would result in application to an entity that contracted with a self-funded ERISA plan to provide only administrative services and, which in fact, did not assume any financial risk.⁸¹ The Court held that Congress likely did not intend that such minimal application to noninsurers would preclude a law from being characterized as insurance regulation saved from preemption.⁸² Thus, *Rush* reflects a broader application of the common sense prong of the savings clause analysis than in earlier cases.

The Court also easily disposed of the McCarran-Ferguson prong of the analysis. The Court in *Rush* readily found that the second and third McCarran-Ferguson factors were satisfied, expressly avoiding the need to answer whether the IER law regulates a practice that "spread[s] a policyholder's risk."⁸³ Illustrating the truncated nature of the analysis, the Court found that the law is aimed at a practice limited to entities within the insurance industry for virtually the same reasons that the law passed the common sense test: HMO contracts are contracts for insurance.⁸⁴

Additionally, the Court concluded that the law is integral to the policy relationship between the insured and the insurer. The Court held that the extra layer of review of a claims dispute created by the law affects the policy relationship between the HMO and covered person "by translating the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty."⁸⁵ The Court thus viewed the law, in essence, as targeting

Historical Context, in CONTEMPORARY MANAGED CARE 7, 8, 13 (M. Gold ed., 1998); ASPEN HEALTH LAW & COMPLIANCE CTR., MANAGED CARE LAW MANUAL 1 (Supp. 6, Nov. 1997); R. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 552 (1997); R. SHOULDRICE, INTRODUCTION TO MANAGED CARE 13, 20 (1991)).

79. *Rush*, 536 U.S. at 367.

80. The Illinois Act, chapter 125 sections 1 and 2, defines an HMO as "any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers." *Id.* at 370-71.

81. *Id.* *Rush* argued that the law would apply to an HMO that merely brought together self-funded ERISA plans and medical care providers, even if the providers bore all the risk. *Id.*

82. *Id.* at 372.

83. *Id.* at 373 (quoting UNUM Life Ins. v. Ward, 526 U.S. 358, 373 (1999)). Foregoing analysis of the first McCarran-Ferguson factor because the second and third factors were clearly satisfied by the IER law. *Rush*, 536 U.S. at 373.

84. *Id.* at 374.

85. *Id.* at 373. The Court noted that the law provides "a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMO's medical obligations." *Id.* at 374.

the interpretation of the insurance agreement between the HMO and covered persons when applied to the question whether a submitted claim is medically necessary.

The analysis of the McCarran-Ferguson factors in *Rush* also arguably reflects a broader view of the savings clause. In an analogous earlier case, *Union Labor Life Insurance Co. v. Pireno*,⁸⁶ the Supreme Court held that the use of peer review by an insurer as a check on medical necessity determinations was not integral to the policy relationship between the insured and the insurer. The particular type of review at issue in the prior case was distinguishable primarily because it was advisory; whereas in *Rush*, the IER law specified that the finding of the independent external reviewer is binding.⁸⁷ This difference is significant. However, the Court in *Rush* noted, "It was not too much of an exaggeration to conclude [in *Pireno*] that the practice was 'a matter of indifference to the policyholder.'"⁸⁸ The Court in *Rush* thus acknowledged that its conclusion in *Pireno* was borderline; thereby suggesting that, at least in the ERISA context, the practice likely would satisfy the McCarran-Ferguson factors. As noted, this reflects a broader application of the savings clause. However, as the next section of the Article explains, the *KAHP* decision goes much further in modifying the McCarran-Ferguson prong of the savings clause analysis, and thereby in broadening the scope of laws exempt from preemption under ERISA's savings clause.

B. *KAHP*: Streamlining the Analysis

KAHP similarly represents important refinements to the basic savings clause standards. First, the Court's application reflects a broader view of laws saved from preemption. Second, the Court recognized the truncated nature of the analysis and streamlined it. The Court concluded that for a state law to be deemed a law which regulates insurance, the law must satisfy only two requirements; the law "must be specifically directed toward entities engaged in insurance" and "must substantially affect the risk pooling arrangement between the insurer and the insured."⁸⁹

The streamlining was thus twofold. First, the Court dropped the common sense language and focused instead on its judicial gloss—whether a state law is specifically directed at the insurance industry. Second, the Court made a "clean break from the McCarran-Ferguson factors."⁹⁰ The break from the McCarran-Ferguson factors was surprising in the sense that the Court in *Rush* did not expressly suggest an eminent shift and, in fact, applied the factors to the IER law. However, Justice Scalia, in *KAHP*, highlighted the following

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

87. See *supra* note 34 and accompanying text.

88. *Rush*, 536 U.S. at 374.

89. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1479 (2003).

90. *Id.*

language from *Rush* which impliedly foreshadowed the break. In its initial explanation of the savings clause analysis, the Court in *Rush* noted that it is “generally fair to think of the combined ‘common-sense’ and McCarran-Ferguson factors as parsing the ‘who’ and the ‘what.’ when insurers are regulated with respect to their insurance practices, the state law survives ERISA.”⁹¹ Arguably, this statement suggests that, in reality, there are but two key considerations in addressing whether a law is saved from preemption.

Little consequence is likely to result from the first refinement. As noted, the Supreme Court had historically explained that the common sense test is satisfied when a state law is specifically directed at the insurance industry. Thus, presumably, the existing case law benchmarks for when that test is satisfied, including the relaxing of the test in *Rush*, remain good benchmarks. The Court in *KAHP* followed the analysis in *Rush* and similarly focused on *who* the law regulates; thus, the Court ultimately rejected the HMOs’ contention that Kentucky’s AWP laws failed the test because the laws regulate “not only the insurance industry, but also doctors who seek to form and maintain limited provider networks with HMOs.”⁹² The Court noted that neither statute “by its terms” imposes prohibitions or requirements on providers; but, rather, the statutes impose them on “health insurer[s]” and “health benefit plans.”⁹³ The Court noted that the unavoidable effect on providers—the inability to enter into certain agreements with Kentucky insurers—was insufficient to preclude characterizing the law as one specifically directed towards the insurance industry.⁹⁴

The *KAHP* Court also rejected the HMOs’ arguments that the AWP statutes failed the specifically directed test because the laws applied to self-insured ERISA plans and HMOs that provided only administrative services to self-insured plans. According to the Court, the entities, in both situations, sufficiently engage in the activity of insurance such that the laws are still appropriately directed at the insurance industry.⁹⁵ The Court also expressly affirmed the view espoused in *Rush* that Congress likely did not intend for “minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved.”⁹⁶ Thus, *KAHP* affirmed the broader

91. *Rush*, 536 U.S. at 366; *Ky. Ass’n of Health Plans*, 123 S. Ct. at 1475. In *KAHP*, Justice Scalia stated: “As we explained in *Rush Prudential*, insurers must be regulated ‘with respect to their insurance practices.’” *Ky. Ass’n of Health Plans*, 123 S. Ct. at 1475.

92. *Id.*

93. *Id.*

94. *Id.* at 1475-76 (“Regulations ‘directed toward’ certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such regulation outside the scope of ERISA’s savings clause.”).

95. *Id.* at 1476 n.1 (“Self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance;” and that “administering self-insured plans . . . suffices to bring . . . [HMOs] within the activity of insurance for purposes of [the savings clause].”).

96. *Id.*

view that “some over breadth” in state laws regulating insurers will not interfere with application of the savings clause.

The second refinement, the “clean break from the McCarran-Ferguson factors,” may have greater consequences. The Supreme Court has historically explained that state laws saved from ERISA preemption are those that not only are specifically directed at the insurance industry, but that also regulate insurers as to the business of insurance. For example, the Court in *Rush* explained that a law regulates insurance within the scope of ERISA’s savings clause when the law regulates the insurance industry “with respect to their insurance practices.”⁹⁷

The Supreme Court originally looked to the McCarran-Ferguson factors as a way to help assess whether a law regulates insurers with respect to their insurance practices. In *Metropolitan Life Insurance Co. v. Massachusetts*,⁹⁸ the Court first referred, in the ERISA savings clause analysis, to two McCarran-Ferguson Act cases, *Group Life & Health Insurance Co. v. Royal Drug*⁹⁹ and *Union Labor Life Insurance Co. v. Pireno*.¹⁰⁰ The Court looked to the factors used in those cases because they had been developed for a similar purpose: to identify whether certain activities of insurers constitute the business of insurance.

The McCarran-Ferguson cases involved the antitrust exemption from the McCarran-Ferguson directive preserving to states, generally, primary authority over the regulation of insurers and the business of insurance.¹⁰¹ The McCarran-Ferguson Act also allows federal regulation of insurance if the federal law specifically relates to the business of insurance and allows application of the federal antitrust laws to insurers.¹⁰² However, the Act creates an exception to application of the federal antitrust laws: the antitrust laws will not apply to a practice that constitutes the business of insurance if the

97. *Ky. Ass’n of Health Plans*, 123 S. Ct. at 1475 (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366 (2002)).

98. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).

99. *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979).

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

101. 15 U.S.C. §§ 1011-1015 (2003). The McCarran-Ferguson Act, section 2(b), provides: “No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance” *See id.* § 1012(b). *See also* *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944). The McCarran-Ferguson Act was enacted in response to the Supreme Court’s holding in *United States v. South-Eastern Underwriters Ass’n* that an insurance company conducting a substantial part of its business across state lines was engaged in interstate commerce and thereby subject to the antitrust laws. Fearing Commerce Clause challenges, Congress enacted, within two years of the *South-Eastern Underwriters Ass’n* decision, the McCarran-Ferguson Act and restored to the states the ability to continue taxing and regulating the insurance industry without fear of Commerce Clause challenges. *See* RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 143 (1997).

102. 15 U.S.C. § 1012(b). The Act provides that federal law shall not supersede state laws regulating insurance “unless such [federal] Act specifically relates to the business of insurance: *Provided*, that . . . [the federal antitrust laws] shall be applicable to the business of insurance” *Id.* (emphasis added).

state regulates that practice.¹⁰³ Because *Royal Drug* and *Pireno* involved anti-trust challenges to certain insurance practices and the McCarran-Ferguson factors were thus developed in the context of an exemption to the antitrust laws, the case law suggested a narrow view of what constitutes the business of insurance. Some scholars, however, have noted an incongruity.¹⁰⁴ Using the narrow approach to the business of insurance, developed in *Royal Drug* and *Pireno*, is inconsistent with the broad intent of Congress to save state laws that regulate insurance from ERISA preemption.¹⁰⁵ Nonetheless, the Supreme Court continued to use the McCarran-Ferguson factors although it had not expressly explored, in its ERISA preemption opinions, the appropriateness of applying the factors in light of the broad scope of ERISA preemption.

Accordingly, in *KAHP*, the HMOs relied on *Royal Drug* in arguing that the AWP statutes were not saved from preemption.¹⁰⁶ In *Royal Drug*, independent pharmacies mounted an antitrust challenge against Blue Shield's practice of entering into preferred provider agreements with certain pharmacies, which tended to result in policyholders using the preferred pharmacies rather than nonparticipating pharmacies.¹⁰⁷ The case thus provided a seemingly perfect analogy for analyzing the AWP statutes. In *Royal Drug*, the issue was whether the practice by an insurer of contracting with some but not all providers constituted the business of insurance. In *KAHP*, the issue was whether a state law regulating or prohibiting the practice of contracting with some but not all providers constituted a law regulating the insurance industry as to insurance practices.

Because *Royal Drug* involved an antitrust challenge and did not involve ERISA preemption, the Court focused predominantly on the McCarran-Ferguson factors to determine whether the preferred contracting arrangement constituted the business of insurance. The Court in *Royal Drug* noted that underwriting and the spreading of risk of loss as widely as possible were indispensable characteristics of insurance.¹⁰⁸ The Court held that the practice of contracting with pharmacies did not involve either characteristic; rather, the practice was merely a cost-savings strategy and "indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low."¹⁰⁹ This reasoning was sound because the

103. *Id.* More specifically, the Act provides that the federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." *Id.*

104. *See, e.g.,* Jordan, *supra* note 62, at 273.

105. *See, e.g.,* Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). In *Shaw*, the Court noted, "The breadth of § 514(a)'s 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." *Id.* at 96-97 (citing Black's Law Dictionary).

106. Ky. Ass'n of Health Plans, Inc. v. Miller, 123 S. Ct. 1471, 1476-77 (2003).

107. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

108. *Id.* at 212 (citing SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 79 (1959)).

109. *Id.* at 213-15.

pharmacies did not assume any risk under the particular provider agreement at issue. Participating pharmacies agreed to charge Blue Shield policyholders two dollars per prescription and to accept discounted reimbursement from Blue Shield in an amount that would cover the cost to pharmacies of acquiring the drug.¹¹⁰ The arrangement encouraged policyholders to go to preferred pharmacies and thereby lowered Blue Shield's cost in prescription drug coverage.

Additionally, the Court in *Royal Drug* found that the preferred contracting arrangement did not affect the contract between the insurer and the insured. The Court noted that, in preserving insurance regulation for the states and in limiting application of the federal antitrust laws to the business of insurance, Congress' concern was with "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement."¹¹¹ The Court concluded that, because the agreements were merely cost-saving arrangements, they did not affect the reliability, interpretation, or enforcement of the insurance contract.¹¹² Further, the Court concluded that "[t]here is not the slightest suggestion in the legislative history that Congress in any way contemplated that arrangements . . . which involve the mass purchase of goods and services from entities outside the insurance industry, are the 'business of insurance.'"¹¹³

By analogy, then, *KAHP* certainly had a meritorious argument that a state law regulating the practice by insurers of entering into preferred provider agreements is not a state law regulating insurers as to an insurance practice. Nonetheless, Justice Scalia and the Court concluded, "It does not follow from *Royal Drug* that a law mandating certain insurer-provider relationships fails to 'regulate insurance.'"¹¹⁴ The Court then reached a conclusion inconsistent with *Royal Drug* by holding that the Kentucky AWP statutes were saved from ERISA preemption. The Court accomplished this outcome by taking a broader approach to the issue and by making "the clean break" from the McCarran-Ferguson factors.

The Court in *KAHP* distinguished *Royal Drug* by noting that "ERISA's savings clause . . . is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they 'regulate.'"¹¹⁵ Then, to help illustrate what type of state law could legitimately be characterized as "regulating insurance," the Court described a state law requiring licensed attorneys to participate in ten hours of continuing legal education ("CLE") each year, noting that "[t]his statute 'regulates' the practice of law—even though sitting through [ten] 10 hours of CLE classes does not constitute the

110. *Id.*

111. *Id.* at 215-16 (citing *Variable Annuity Life Ins. Co.*, 359 U.S. at 65).

112. *Id.* at 216-17.

113. *See Group Life*, 440 U.S. at 224.

114. *Ky. Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471, 1477 (2003).

115. *Id.* at 1476-77.

practice of law—because the state has *conditioned* the right to practice law on certain requirements, which substantially affect the product delivered by lawyers to their clients.”¹¹⁶ According to the Court, Kentucky’s AWP statutes similarly impose conditions on the right to engage in insurance: “Those who wish to provide health insurance in Kentucky . . . may not discriminate against any willing provider.”¹¹⁷

The Court’s new approach, however, is not quite as broad as the foregoing statement implies. Justice Scalia explained that to remain true to the idea that a law is saved only if it regulates the insurance industry with respect to insurance practices, a law conditioning the right to engage in the business of insurance must “substantially affect the risk pooling arrangement between the insurer and the insured.”¹¹⁸ The Court found that Kentucky’s AWP laws satisfied that requirement:

By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds No longer may Kentucky insureds seek insurance from a closed network . . . in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.¹¹⁹

Thus, under *KAHP*, a state law can constitute a state law regulating insurance within ERISA’s savings clause regardless of whether the practice or conduct regulated constitutes the business of insurance, as long as the law has the requisite substantial affect on the risk pooling arrangement between the insurer and the insured.

Although the new perimeters of the savings clause in light of Justice Scalia’s new terminology is uncertain, it is clear that the Court has broadened the scope of the laws exempt from preemption due to the savings clause. If a state law is saved when it affects the product offered to subscribers by an HMO (the health coverage policy), then many recent managed care reform laws passed by states will satisfy the standard.¹²⁰

Moreover, the Court in *KAHP* ensured a broader approach to the savings clause analysis in future cases by making the “clean break” from the McCarran-Ferguson factors. The Court noted, “We believe that our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case

116. *Id.* at 1477.

117. *Id.*

118. *Id.*

119. *Id.* at 1477-78.

120. See *infra* notes 137-38 and accompanying text.

demonstrates, added little to the relevant analysis.”¹²¹ The Court then explained that it had never held that the McCarran-Ferguson factors were an essential component of the savings clause analysis, that the Court had referred to them as mere “considerations [to be] weighed,” and that they were only “‘checking points’ [or guideposts] to be used after determining whether the state law regulates insurance from a ‘common-sense’ understanding.”¹²² Accordingly, the Court proclaimed to make a clean break and repeated that a state law need satisfy only two requirements to be deemed a law which regulates insurance and therefore, is saved from ERISA preemption: “First, the law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured.”¹²³

C. *Doctrinal and Policy Implications of the Changes to the Basic Savings Clause Analysis*

The Supreme Court in *Rush* and *KAHP* added significant refinements to the basic savings clause analysis. Overall, it is fair to say that the cases relaxed, broadened, and streamlined the analysis. Yet, the cases have also raised questions about the proper application of the savings clause to state managed care reform laws; it is still not clear whether the savings clause would encompass state laws allowing civil actions that are essentially medical malpractice lawsuits against managed care organizations for negligent denials of claims based on medical necessity determinations.

The cases have streamlined the analysis to a more straightforward assessment of the *who* and the *what* of the state law at issue. Prior to the cases, the courts used multiple factors to assess whether the law looked, from a common sense perspective, like a regulation of insurance. In applying the common sense test, courts considered both *who* and *what* was being regulated; courts also considered the McCarran-Ferguson factors to help ensure that a law was properly characterized as a law regulating insurance. After *Rush* and *KAHP*, parsing the *who* and *what* of the law remains the crux of the analysis.

To assess the *who* aspect of a law, the Court focused on identifying whether the law imposes duties, obligations, or rights primarily on entities which engage in insurance-type activities. Neither an effect on other entities nor minimal over-breadth in the law will suffice to negate the law as a regulation of insurance. This aspect of the cases suggests that many state managed care reform laws, which typically target HMOs and other MCO arrangements, will satisfy the specifically directed prong of the analysis.

121. *Ky. Ass'n of Health Plans*, 123 S. Ct. at 1478.

122. *Id.* at 1479.

123. *Id.*

However, the cases did not address the Supreme Court's reasoning articulated in *Pilot Life* for its holding that a state common law bad faith breach of contract action was not specifically directed at the insurance industry.¹²⁴ In *Pilot Life*, the specific cause of action at issue was applicable only to those in the insurance industry, but the state law cause of action evolved from general principles of tort and contract law, which obviously, were not applicable only to insurers.¹²⁵ This consideration was not relevant in *Rush* and *KAHP* because the cases involved state laws enacted by legislatures that did not simply evolve from pre-existing general principles. Because the Court in *Rush* and *KAHP* did not expressly or impliedly overrule this aspect of *Pilot Life*, it is reasonable to conclude that this reasoning is still relevant to the inquiry.¹²⁶

To parse out the *what* aspect of the state law, the Court in *KAHP* pronounced that the analysis should focus simply on whether the state law has a substantial effect on the risk pooling arrangement between the insurer and the insured. As noted, this language and the break from the McCarran-Ferguson factors should result in a broader application of the savings clause. Laws may be saved even if they fail to meet the more stringent concept of the business of insurance.

The emerging questions, however, are twofold. First, what does Justice Scalia's new terminology mean? Second, will the new terminology prove to be a workable and sufficient test for deciding whether a state law should be characterized as a law regulating insurance, and thus saved from ERISA preemption? Entities which provide health coverage arrangements engage in numerous functions and strategies in the course of providing their risk pooling arrangements. State laws regulate many of those strategies.¹²⁷ Will those laws, many of which are viewed as traditional laws regulating insurance, be exempt from ERISA preemption under the new terminology?

First, what does the new language mean? What is the "risk pooling arrangement between the insurer and the insured?" Generally, private health coverage products pool individuals' risk of high health care costs across a large number of people, permitting them to pay a premium based on the

124. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987).

125. *Id.* at 50.

Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law.

Id.

126. As explained *infra*, this factor complicates application of the recent cases to state HMO liability laws. See *infra* notes 268-70 and accompanying text.

127. See *infra* notes 129-38 and accompanying text.

average cost of medical care for the group of people.¹²⁸ Thus, any health coverage product constitutes a risk pooling arrangement. Justice Scalia's terminology, then, would encompass any state law with a substantial effect on any health coverage product.

What does that mean? Entities that sell or provide health insurance products engage in numerous strategies in order to make the risk pooling arrangement viable and profitable. For example, risk pooling should result in expected costs that are predictable. Accordingly, coverage providers strive to maintain risk pools of people whose health on average is the same as that of the general population, thus avoiding adverse selection; that is, attracting a disproportionate share of people in poor health.¹²⁹ Underwriting is the primary strategy used to maintain predictable and stable levels of risk within various risk pools. Underwriting is the process used to determine whether to accept an applicant for coverage and to determine the terms of coverage.¹³⁰ One of the most efficient underwriting strategies to avoid adverse selection is to provide coverage to large groups of people already in existence, such as employees of large employers.¹³¹

Underwriting is also used to determine the appropriate premium.¹³² For large groups, the premium is based on considerations such as claims history of the group, age distribution, industry, and geographic location.¹³³ Adverse selection is also controlled through the use of limited open enrollment periods for persons in the large group and through the use of preexisting condition exclusions.¹³⁴ Additionally, providers of health coverage typically have multiple risk pooling arrangements, such as separate arrangements for different markets (small business versus trade association) or plans with different deductibles.¹³⁵ This type of product differentiation protects the insurer because problems in one risk pooling arrangement will not have a direct effect on people participating in another pooling arrangement.¹³⁶

Would Justice Scalia's new terminology encompass state laws regulating the basic strategies used by insurers to help ensure a viable and profitable product? That is, will the new terminology prove to be a workable and a sufficient test for deciding whether a state law should be characterized as a law

128. See generally GARY CLAXTON, HENRY J. KAISER FAMILY FOUND., HOW PRIVATE INSURANCE WORKS: A PRIMER (Apr. 2002), available at <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14053> [hereinafter KAISER PRIMER ON INSURANCE].

129. *Id.* at 4. "Said another way, health coverage providers take steps to avoid attracting a disproportionate share of people in poor health into their risk pools, which often is referred to as adverse selection." *Id.*

130. *Id.* at 5.

131. *Id.* at 6.

132. *Id.* at 5.

133. KAISER PRIMER ON INSURANCE, *supra* note 128, at 6.

134. *Id.*

135. *Id.* at 4.

136. *Id.*

regulating insurance and thus saved from ERISA preemption? The preliminary answer would seem to be yes. State laws regulating the underwriting process would seem to have a substantial effect on the product offered by an insurer to an insured. For example, states have typically enacted laws relating to insurance and the underwriting process, such as laws regulating:

- Licensing of entities providing health coverage;
- Financial standards (minimum capital, investment practices, claims & other reserves);
- Management;
- Market conduct/business practices (advertising, marketing standards);
- Policy forms;
- Access to coverage (guaranteed issue & guaranteed renewability);
- Mandated benefits laws;
- Restrictions on preexisting condition exclusions;
- Premiums (loss ratios, rate bands, community rating);
- Breach of contract/bad faith breach; and
- Unfair claims practices.¹³⁷

Further, state laws enacted pertaining more specifically to HMOs and MCOs practices include laws regulating:

- Utilization review (“UR”) standards;
- Quality assurance/quality improvement programs;
- Grievance processes;
- Health care provider agreements;
- Network adequacy;
- Credentialing of health care providers;
- Independent external review;
- Malpractice for failure to use care in delivery of care; and
- Negligent determination that recommended treatment is not medically necessary.¹³⁸

All of the aforementioned types of state regulation arguably have an important effect on the product offered to policyholders. For example, a law regulating marketing standards may help ensure that consumers receive what is promised in terms of the quality of the health coverage product; laws regulating premiums affect the level of risk that a coverage provider will provide in its products. Additionally, policyholders care about standards for UR and the type of grievance process that is available. Thus, state laws

137. *Id.* at 7-12 (describing typical state laws regulating insurance practices).

138. *Id.* (describing typical state laws regulating insurance practices).

regulating these and other aspects of health coverage affect, in an important way, the product offered to consumers or policyholders.

Admittedly, it is not clear that an “important effect” satisfies Justice Scalia’s requirement of a “substantial effect.” However, given the Supreme Court’s overall implication that a broader view of what constitutes a law regulating insurance is appropriate, it is reasonable to conclude that the effect of managed care reform laws on the product offered to policyholders is sufficiently substantial to satisfy the test. Thus, such state laws would seem to have the requisite effect on the risk pooling arrangement between the insurer and the insured.

Accordingly, most insurance and managed care reform laws would be saved and exempt from ERISA preemption (1) as long as the laws also can be characterized as being specifically directed towards the insurance industry and (2) unless the conflict preemption exception to the savings clause suggests that preemption is appropriate, even though the law may be characterized as regulating insurance. As the next part of this Article explains, after *Rush*, this possibility is considerably circumscribed.

IV. RUSH’S INTRICATE REFINEMENTS TO THE CONFLICT PREEMPTION EXCEPTION

Whether a state law is saved from preemption hinges predominantly on application of the basic standards discussed in the previous part of this Article. But not exclusively. Rather, the Supreme Court has narrowed the scope of laws exempt from preemption by the savings clause by injecting into the analysis a moderating factor or exception to saving a state law that regulates insurance. In *Rush*, the majority opinion carefully drew new lines relating to the conflict preemption exception; lines which strengthened the power of the savings clause to exempt laws from preemption. One line constitutes a general limit on the role of conflict preemption as an exception to the operation of the savings clause. A second line more narrowly construes any exception to the savings clause for state laws that arguably conflict with § 502(a), ERISA’s civil enforcement provision.

A. Pre-Rush Application of Conflict Preemption Principles

In contrast to the basic savings clause standards, the moderating factor or conflict preemption exception has only rarely been central to the savings clause analysis. Yet, the Supreme Court has clearly indicated that it is important to consider whether application of the savings clause to a particular state law comports with the role of the “savings clause . . . as a whole,” thereby

allowing consideration of whether saving the state law will further the objectives of ERISA.¹³⁹

Most notably, this consideration was a central aspect of the Court's savings clause analysis in *Pilot Life*, which involved state common law causes of action grounded in allegations of improper processing of the plaintiff's claims for benefits.¹⁴⁰ In *Pilot Life*, the Court stated, "In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy."¹⁴¹ The Court explained that saving the common law causes of action would be inconsistent with § 502(a), ERISA's civil enforcement section that, according to the Court, Congress intended as the exclusive vehicle for redressing assertions of improper processing of a claim for benefits. The Court described § 502(a) as "represent[ing] 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."¹⁴²

As used in *Pilot Life*, the conflict preemption consideration arguably is best characterized as an additional assessment in the savings clause analysis; a factor to consider before ultimately concluding that a law regulating insurance should be saved. However, the conflict preemption consideration has been broadened by the Court in later cases, such that it could also fairly be characterized as an additional assessment in the basic § 514(a) preemption clause analysis. For example, in *Ingersoll-Rand Co. v. McClendon*,¹⁴³ the Court examined a state common law action for wrongful discharge. The Texas courts had created an exception to the doctrine of at-will employment where an employee was unlawfully discharged primarily because of the employer's desire to avoid contributing to, or paying benefits under, the employee's pension fund.¹⁴⁴ In holding that the state cause of action was preempted under § 514 of ERISA due to its relation to ERISA plans, the Court was influenced by the fact that ERISA itself prohibits discrimination for the purpose of interfering with the attainment of any right under a pension plan and, therefore, by the fact that the Texas cause of action would have provided a legal remedy beyond the equitable remedy expressly allowed by ERISA § 502(a).¹⁴⁵

139. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51-52 (1987).

140. *Id.*

141. *Id.* at 51 (quoting *Kelly v. Robinson*, 479 U.S. 36, 43 (1986)).

142. *Id.* at 54.

143. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).

144. *Id.* at 136.

145. *Id.* at 142-45. The Court in *Ingersoll-Rand* also was influenced by the fact that the Texas causes of action were premised on the existence of a pension plan. *Id.* at 139-40. That is, if no pension plan exists, there can be no cause of action; thus, the duty imposed on employers arises only if an ERISA plan exists. *Id.*

Additionally, in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*,¹⁴⁶ the Court recounted its prior preemption cases in which state laws had been found to relate to ERISA plans and concluded that preempted state laws either (1) mandated employee benefit structures or administrative practices of plans or (2) provided "alternative enforcement mechanisms" within the scope of ERISA's civil enforcement provisions.¹⁴⁷ Whether viewed as an exception to the savings clause or as part of the "relates to" preemption analysis, the Court in *Pilot Life* and *Ingersoll-Rand* readily sent a signal that conflict preemption is an important aspect of an ERISA preemption analysis.

That importance was emphasized in other ERISA preemption cases as well. For example, in *John Hancock Mutual Life Insurance Co. v. Harris Trust & Savings Bank*, the Supreme Court held that a state law regulating insurers' conduct in relation to management of general assets of the insurer was preempted due to the conflicting directive in ERISA that insurers manage certain funds in their general assets for the exclusive benefit of ERISA plan participants and beneficiaries.¹⁴⁸ The insurer had argued that ERISA must yield to a state law regulating insurance. The Court stated, however:

[W]e discern no solid basis for believing that Congress when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs.¹⁴⁹

Similarly, in *Boggs v. Boggs*, which addressed ERISA preemption of a state community property law, the Court stated that "[c]onventional conflict preemption principles require pre-emption . . . 'where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'"¹⁵⁰ Thus, although not as firmly a part of the savings clause analysis as the basic savings clause standards, consideration of conflict preemption principles seemed to be well established prior to *Rush*. Yet, the

146. *N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

147. *Id.* at 658 (citing *Ingersoll-Rand*, 498 U.S. at 133).

148. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993).

149. *Id.* at 99 (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). The Court also stated, "ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized . . ." *Id.* at 98. In a footnote, the Court stated, "No decision of this Court has applied the savings clause to supersede a provision of ERISA itself." *Id.* at 99 n.9.

150. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992)).

majority in *Rush* significantly limited the role of conflict preemption in the ERISA preemption context.

B. Rush's Application of Conflict Preemption Principles

Rush HMO presented several arguments grounded in the Supreme Court's recognition of a role for conflict preemption in the ERISA preemption context. These arguments emphasized that exempting the Illinois IER law from preemption was inconsistent with Congress' intention to provide through ERISA a uniform federal regime of rights and obligations for employers, ERISA plans, and ERISA plan participants and beneficiaries. Importantly, the Court was unable to dispose of Rush HMO's conflict preemption arguments as readily as those pertaining to the basic savings clause standards. Indeed, the Court split five to four on the issue of whether the state law frustrated congressional intent and thus should be preempted notwithstanding its characterization as a law regulating insurance.

Rush HMO's overarching contention was that the IER law interfered with Congress' vision of a uniform enforcement scheme by creating an alternative remedy; that is, a process that supplements or supplants the federal scheme by allowing ERISA Plan participants and beneficiaries to obtain remedies under state law that Congress rejected in ERISA. More specifically, Rush HMO argued that the IER law created a "form of binding arbitration that allows an ERISA beneficiary to submit claims to a new decision-maker to examine Rush's determination de novo, supplanting judicial review under the 'arbitrary and capricious' standard ordinarily applied when discretionary plan interpretations are challenged."¹⁵¹ The dissent agreed. The IER law "cannot be characterized as anything other than an alternative state-law remedy or vehicle for seeking benefits [I]t is in fact a binding determination of whether benefits are due [I]t is thus most precisely characterized as an arbitration-like mechanism to settle benefits disputes."¹⁵² Moreover, the dissent noted that, because the judicial review pursuant to a § 502(a)(1)(B) action would be limited, the IER law "establishes a system of appellate review of benefits decisions that is distinct from" that provided for in ERISA.¹⁵³ According to the dissent, the exclusivity and uniformity of ERISA's enforcement scheme must remain supreme, and the IER law was therefore preempted under ordinary principles of conflict preemption.¹⁵⁴

The majority disagreed, however; as noted, it did so by intricately drawing new lines marking the boundaries of ERISA preemption. One line constitutes a general limit on the role of conflict preemption as an exception to the

151. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-12 (1989)).

152. *Id.* at 394-95 (Thomas, J., dissenting).

153. *Id.* (Thomas, J., dissenting) (quoting Judge Posner's statement in his dissent from the denial of rehearing en banc. *Moran v. Rush Prudential HMO, Inc.*, 230 F.2d 959, 973 (2000)).

154. *Id.* at 401 (Thomas, J., dissenting).

operation of the savings clause.¹⁵⁵ A second line more narrowly construes any exception to the saving clause for state laws that arguably conflict with § 502(a), ERISA's civil enforcement provision.¹⁵⁶ As with the Court's holding relating to the basic standards, the lines relating to the conflict preemption exception strengthen the power of the savings clause to exempt laws from preemption.

1. *Narrowing Congressional Objectives Relating to § 502(a)*

In addressing the exception to the savings clause for state laws arguably in conflict with ERISA § 502(a),¹⁵⁷ the majority in *Rush*, using a common law analysis approach, narrowed the exception to the precise contours of key precedent. More specifically, Justice Souter, writing for the majority, traced the case law origins of the exception and carefully explained the issues and holdings of the relevant cases and construed the key precedents as limiting any exception to the savings clause to state laws constituting only certain types of alternative causes of action, which would give rise to alternative remedies.

The key precedent included *Russell, Taylor, Ingersoll-Rand*, and *Pilot Life*. Justice Souter emphasized that *Massachusetts Mutual Life Insurance Co. v. Russell*¹⁵⁸ involved a claimant pursuing types of damages other than those specified in ERISA via an ERISA § 502 claim for benefits, and that the Court in *Russell* rejected the concept of "causes of action under ERISA itself" beyond those specified in § 502(a).¹⁵⁹ Regarding *Metropolitan Life Insurance Co. v. Taylor*,¹⁶⁰ which involved complete preemption of a claim for benefits pled as a state law cause of action, Justice Souter placed emphasis on the Court's holding that Congress had so completely preempted the field of benefits law that an "ostensibly state cause of action for benefits was necessarily a 'creature of federal law' removable to federal court."¹⁶¹ Similarly, Justice Souter explained that in *Ingersoll-Rand*,¹⁶² the Court rejected a state tort claim for wrongful discharge which duplicated the elements of a claim available under ERISA, but which would have converted the equitable remedy available under ERISA into a legal remedy for money damages.¹⁶³

Justice Souter then addressed *Pilot Life*, which involved an ERISA plan participant who had been denied disability benefits.¹⁶⁴ The claimant sued in state court on state tort and contract claims and sought damages for breach of contract, damages for emotional distress, and punitive damages. Justice Souter

155. See *infra* notes 178-96 and accompanying text.

156. See *infra* notes 157-77 and accompanying text.

157. See *Rush*, 536 U.S. at 377-80 (noting section III(A) of Justice Souter's opinion).

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

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

160. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

161. *Rush*, 536 U.S. at 378 (emphasis added).

162. *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133 (1990).

163. *Rush*, 536 U.S. at 379.

164. *Pilot life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

placed emphasis on the Court's holding in *Pilot Life* that, in a case where a claimant was pursuing payment of benefit amounts under an ERISA plan, ERISA "would not tolerate a diversity action seeking monetary damages for breach generally and for consequential emotional distress," when neither damages for breach nor for emotional distress were explicitly authorized in § 502(a).¹⁶⁵ That is, ERISA § 502(a)(1)(B) authorizes a suit for benefits due, and if the action is really about benefits due, additional damages beyond those authorized by § 502(a) are impermissible.

Thus, Justice Souter stressed that, in each earlier case, the state law at issue provided a vehicle for a claimant to pursue, in essence, a claim that was actually available under ERISA—that is, claims for breach of the duty to pay benefits due and a claim for discrimination prohibited by ERISA. And, at the same time, the state law would have resulted in a remedy other than those specified in ERISA. Moreover, Justice Souter stressed that the monetary awards at issue in the cases were pursued as remedies, which would be "provided at the *ultimate* step of plan enforcement,"¹⁶⁶ that is, the laws "provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA."¹⁶⁷ The desire to keep the scope of any exception to the savings clause narrowly confined to the contours of the noted cases was emphasized in other statements made by Justice Souter in distinguishing the Illinois IER law. Justice Souter stated that the IER law "does not involve *the sort of* additional claim or remedy exemplified in *Pilot Life*, *Russell*, and *Ingersoll-Rand*"¹⁶⁸ and "imposes no new obligation or remedy *like the causes of action* considered in *Russell*, *Pilot Life* and *Ingersoll-Rand*."¹⁶⁹ A majority of the Court joined in Justice Souter's opinion, thereby agreeing with this narrow, common law analysis approach to the key conflict preemption precedent.

The dissent, however, did not agree with the majority's narrow view of impermissible "alternative enforcement mechanisms," noting that the Court had previously focused on ERISA's "overall enforcement mechanism and remedial scheme."¹⁷⁰ Moreover, the dissenting Justices thought that the Illinois IER law represented the type of remedy precluded by ERISA and the Court's prior cases: "[The IER law] cannot be characterized as anything other than an alternative state-law remedy or vehicle for seeking benefits. . . . [The law] comes into play only if the HMO and the claimant dispute the claimant's

165. *Rush*, 536 U.S. at 378-79.

166. *Id.* at 378 (emphasis added) (describing the laws at issue in *Metropolitan Life*, *Russell*, and *Pilot Life*).

167. *Id.* at 379 (describing the state wrongful termination action at issue in *Ingersoll-Rand*).

168. *Id.* at 380 (emphasis added).

169. *Id.* at 386 (emphasis added).

170. *Id.* at 397 (Thomas, J., dissenting). "[T]he Court until today had consistently held that state laws that seek to supplant or add to the exclusive remedies in § 502(a) of ERISA . . . are pre-empted because they conflict with Congress' objective that rights under ERISA are to be enforced under a uniform national system. *Rush*, 536 U.S. at 393.

entitlement to benefits; [and] the purpose of the review is to determine whether a claimant is entitled to benefits.”¹⁷¹ The dissent viewed the IER law as creating “an arbitration-like mechanism to settle benefit disputes”¹⁷² “outside of, or in addition to, ERISA’s remedial scheme.”¹⁷³

The majority, however, concluded that the IER law “does not involve the sort of additional claim or remedy exemplified in *Pilot Life, Russell, and Ingersoll-Rand*”¹⁷⁴ The law does not supplement or supplant the enforcement scheme of § 502(a) because “the relief ultimately available would still be what ERISA authorizes in a suit for benefits under section [502(a)]”¹⁷⁵—namely the promised benefit and only the promised benefit.¹⁷⁶ The majority acknowledged some resemblance to arbitration but held that the state law simply did not constitute an alternate vehicle to obtain, at the ultimate step of plan enforcement, a remedy different than that allowed by ERISA.¹⁷⁷ Because the law did not represent the sort of claim or the sort of remedy at issue in *Pilot Life, Russell, and Ingersoll-Rand*, the law was not an impermissible alternative enforcement mechanism. Moreover, as explained in the following subsection, the majority was unwilling to recognize any other type of conflict with ERISA as justifying preemption of a state law otherwise found to be exempt under the savings clause analysis.

2. *Limiting the Role of Conflict Preemption in the ERISA Preemption Analysis*

Rush HMO also argued that the Court should apply conflict preemption principles beyond conflicts with ERISA’s civil enforcement provision and find that ERISA supersedes state laws that frustrate the more general congressional objectives underlying ERISA. The majority acknowledged that sometimes conflict preemption principles may impact the ERISA preemption analysis; namely, when congressional intent is so clear that it overrides the otherwise applicable savings clause provision.¹⁷⁸ The majority in *Rush*, however, suggested that it had previously recognized only one such overpowering federal policy in ERISA: the policy underlying ERISA’s civil enforcement provisions, which the majority found protected by the narrow approach just explained.¹⁷⁹ Notably, the Court did not attempt to distinguish, in any way, prior cases in which the Court had more broadly suggested that laws frustrating congressional objectives in ERISA should be found preempted by ERISA.

171. *Id.* at 394 (Thomas, J., dissenting).

172. *Id.* at 395 (Thomas, J., dissenting).

173. *Id.* at 398 (Thomas, J., dissenting).

174. *Id.* at 380.

175. *Id.*

176. *Rush*, 536 U.S. at 380. Notably, Moran was pursuing simply a remedy of “benefits due” via a § 502(a)(1)(b) claim. *Id.*

177. *Id.* at 382-84.

178. *Id.* at 375-76, 381.

179. *Id.*

In *Rush*, after narrowing the scope of conflict preemption due to ERISA's civil enforcement provisions, the majority expressly opined that "further limits on insurance regulation preserved by ERISA are unlikely to deserve recognition."¹⁸⁰ This statement purports to limit the role of conflict preemption in the ERISA context. That is, the majority rejected the idea that a state law regulating insurance could ever be preempted due to its frustration of, for example, congressional intent to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."¹⁸¹ The majority provided no reason for expressing such a limitation. Furthermore, the Court did not attempt to distinguish *John Hancock* or *Boggs*, both of which involved a conflict with provisions of ERISA other than ERISA's civil enforcement provisions. *John Hancock* involved a state law regulating insurance, which was nonetheless found to be preempted because of its conflict with the fiduciary duties imposed by ERISA.¹⁸² *Boggs* involved a state law which the Court found to be preempted due to a conflict with two other ERISA provisions; one mandating the form of annuity benefits payable upon retirement,¹⁸³ and one creating an exception to the general prohibition on alienation of ERISA benefits.¹⁸⁴

In contrast, the dissent construed the role of conflict preemption in the ERISA context as much more substantial.¹⁸⁵ Thus, due to the law's mandate that HMOs provide coverage for services deemed medically necessary by the independent reviewer, the dissent viewed the law as being in conflict with ERISA due to an impermissible effect on the system of judicial review of benefit decisions via § 502(a) actions.¹⁸⁶ Traditional judicial review of a denial of benefits involves interpreting the plan terms or analyzing whether the plan

180. *Id.* at 381.

181. N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645, 657 (1995). The quoted language is from *Travelers*, wherein the Court articulated the "basic thrust of the preemption clause" for purposes of applying what, in essence, has become an implied preemption analysis when ascertaining whether a state law "relates to" an ERISA plan. *Id.*

182. See *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 97-101 (1993).

183. See *Boggs v. Boggs*, 520 U.S. 833, 841 (1997).

184. See *id.* at 843-45.

185. *Rush*, 536 U.S. at 389 n.1 (citing *Boggs*, the dissent noted that "[w]e can begin and end the pre-emption analysis by asking if [the IER law] conflicts with the provisions of ERISA." *Id.* The dissent also noted that:

[W]hile the preeminent federal interest in the uniform administration of employee benefit plans yields in some instances to varying state regulation of the business of insurance, the exclusivity and uniformity of ERISA's enforcement scheme remains paramount. . . . In accordance with ordinary principles of conflict pre-emption, therefore, even a state law 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

Id. at 393-94 (Thomas, J., dissenting). (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

186. *Id.* at 394-95 (Thomas, J., dissenting).

provided the full and fair review required by ERISA—often using a deferential level of scrutiny. In contrast, the IER law would render judicial review a matter of “rubberstamping” or enforcing the reviewer’s judgment.¹⁸⁷ Similarly, the dissent believed that, because many other states have enacted similar laws but with varying “applicability, procedures, standards, deadlines, and consequences,” saving the laws from preemption “is wholly destructive of Congress’ expressly stated goal of uniformity in this area . . . [and] inimical to a scheme for furthering and protecting ‘the careful balancing of the need for prompt and fair claims settlements procedures against the public interest in encouraging the formation of employee benefit plans.’”¹⁸⁸

The majority, however, was unconcerned about the impact of the process on the scope of judicial review because nothing in ERISA itself mandates the “standard of review” in § 502(a)(1)(B) actions.¹⁸⁹ The majority further explained:

Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards . . . we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan’s benefit determinations were matters of high or unfettered discretion. Nothing in ERISA, however, requires that these kinds of decisions be so ‘discretionary’ in the first place; whether they are is simply a matter of plan design or drafting of an HMO contract. In this respect, then, [the IER law] prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contracts terms. As such it does not implicate ERISA’s enforcement scheme at all, and is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption, such as mandated-benefit statutes and statutes prohibiting the denial of claims solely on the ground of untimeliness.¹⁹⁰

Additionally, the majority was equally unconcerned about varying state laws mandating IER. “Such disuniformities . . . are the inevitable result of the con-

187. *Id.*

188. *Id.* at 400 (Thomas, J., dissenting).

189. *Rush*, 536 U.S. at 385. “[W]e have read [the statute] to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations.” *Id.* (citing *Pilot Life*, 481 U.S. at 56).

190. *Id.* at 385-86.

gressional decision to 'save' local insurance regulations."¹⁹¹ Furthermore, in a footnote, the majority noted that the varying IER laws would not impermissibly burden ERISA plans: "[I]t is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations This means there will be no special burden of compliance upon an ERISA plan"¹⁹²

However, it is perhaps important that, in another footnote, the majority noted that it simply did not perceive any conflict between the IER provision and any specific ERISA directive.¹⁹³ More particularly, the Court noted that it did not see a conflict with the ERISA provision that directs ERISA plans to have an internal claims review process in accordance with regulations promulgated by the Secretary.¹⁹⁴ The Court noted that ERISA merely requires that plans provide "internal appeals of benefit denials;" and the IER law "plays no role in this process, instead providing for extra review once the internal process is complete."¹⁹⁵ Although somewhat disingenuous since the Court did not expressly explain why the ERISA directive did not impliedly indicate that Congress intended the Secretary's regulations regarding the internal appeals process to constitute the sole regulation of an appeals process, this arguably leaves the door open for a case where a state insurance law more clearly is in direct conflict with an ERISA provision other than § 502(a).¹⁹⁶

C. Doctrinal and Policy Implications

As with the Court's recent holdings relating to the basic savings clause standards, the holdings of the majority opinion in *Rush* relating to the conflict preemption exception strengthened the power of the savings clause to exempt laws from preemption. However, the holdings strengthened and broadened the savings clause in different ways. The holdings related to the basic savings clause standards make it more likely that managed care reform laws will be found exempt from ERISA preemption because they constitute laws regulating insurance. The *Rush* majority's holdings related to the conflict preemption exception will come into play primarily when a state law has been found to be

191. *Id.* at 381 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985)).

192. *Id.* at 381 n.11. The majority added that the costs of compliance passed on to the ERISA plan likely would not rise to the impermissible level triggering preemption. *Id.* The dissent noted that "isolat[ing] the 'plan' from the HMO" was a "novel" view; especially where the HMO is a plan administrator. *Rush*, 536 U.S. at 401 n.9 (Thomas, J., dissenting).

193. *Id.* at 385 n.16.

194. *Id.*

195. *Id.* (citing ERISA § 503(2), 29 U.S.C. § 1132(2) (2003)).

196. *Id.* at 386 n.17. The Court also arguably left the door open for further expansion of the conflict preemption exception by noting that the decision rested in part on the recognition that "the disuniformity that the Congress hoped to avoid is not implicated by decisions that are so heavily imbued with expert medical judgments." *Id.* This statement arguably suggests that, again, the Court in this case was somewhat influenced by the fact that the IER provisions looked like state regulation of medical decision-making. *Rush*, 536 U.S. at 366 n.17.

a law regulating insurance, but seems inconsistent in some way with ERISA itself: despite inconsistency, the narrowing of the conflict preemption exception will make it more likely that the law is nonetheless exempt from ERISA preemption.¹⁹⁷

The majority in *Rush* significantly limited the effectiveness of arguments that a state law regulating insurance should nonetheless be preempted due to a conflict with ERISA itself. Foremost, the majority limited the exception to state insurance laws that conflict with the congressional objectives underlying only § 502(a) and specifically rejected the idea that a state law regulating insurance could ever be preempted due to its frustration of, for example, congressional intent to “avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”¹⁹⁸ This limitation would seem to leave the states free to regulate a multitude of insurer and HMO practices relating to administration of the health benefits offered by employers, notwithstanding any resulting disuniformity.¹⁹⁹

This result is arguably sound given the typical way in which employers set up insured ERISA plans.²⁰⁰ With insured plans, the employer contracts with a provider of health coverage to provide the health insurance and, in most cases, to administer the plan. State laws regulating providers of health coverage relating to administration of that health coverage will, as the majority noted, burden the insurer or HMO and will not impermissibly burden ERISA plans: “[I]t is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations This means there will be no special burden of compliance upon an ERISA plan”²⁰¹ Further, this is true even

197. Notably, it probably remains proper to view the conflict preemption principles as also providing a basis for a finding that a law “relates to” ERISA plans and is therefore preempted.

198. *Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995). The quoted language is from *Travelers*, wherein the Court articulated the “basic thrust of the preemption clause” for purposes of applying what, in essence, has become an implied preemption analysis when ascertaining whether a state law relates to an ERISA plan. *Id.*

199. *Rush*, 536 U.S. at 381. According to the majority, “disuniformities . . . are the inevitable result of the congressional decision to ‘save’ local insurance regulations.” *Id.*

200. *But see* E. Haavi Morreim, *ERISA Takes a Drubbing: Rush Prudential and Its Implications for Health Care*, 38 TORT TRIAL & INS. PRAC. L.J. 933 (2003). The author emphasized the negative implications arguably flowing from *Rush*:

[T]he Court has endorsed a procedural remedy that quite clearly adds to ERISA’s exclusively federal remedies. It has also permitted independent reviewers essentially to replace the role of ERISA’s fiduciaries in ways that appear to ignore if not outright contradict the statute. Moreover, by permitting “medical necessity” to be interpreted in ways that need not even refer to the plan’s own terms, the Court may well have substantially reduced employers’ ability to predict and control the cost of employee benefits, a need that the Court itself has acknowledged is integral to the goals of ERISA.

Id. at 934.

201. *Rush*, 536 U.S. at 381 n.11. The majority added that the costs of compliance passed on to the ERISA plan likely would not rise to the impermissible level triggering preemption. *Id.* The dissent noted that “isolat[ing] the ‘plan’ from the HMO” was a “novel” view; especially where the HMO is a plan administrator. *Id.* at 401 n.9 (Thomas, J., dissenting).

as to insurers or HMOs that provide only administrative services to employers who self-insure.

However, from a doctrinal perspective the majority's analysis is less satisfactory. As noted, the majority failed to explain the departure from the broader view of conflict preemption reflected in earlier cases. As explained, the Court in *John Hancock* stated:

[W]e discern no solid basis for believing that Congress, when it designed ERISA, intended fundamentally to alter traditional preemption analysis. State law governing insurance generally is not displaced, but 'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress,' federal preemption occurs.²⁰²

The Court in *Boggs* stated that "[c]onventional conflict pre-emption principles require pre-emption . . . 'where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'"²⁰³ Both cases involved state laws found to frustrate congressional objectives other than those underlying ERISA's civil enforcement provisions.²⁰⁴ From a doctrinal perspective, therefore, it is difficult to understand the Court's strong rejection of the role of conflict preemption in the savings clause analysis. The difficulty is compounded by the fact that the Court was not required to make the categorical rejection, given that the Court noted that it did not view the IER law as actually conflicting with any provision of ERISA.²⁰⁵

The majority in *Rush* also significantly limited the exception even as to state laws that arguably conflict with the objectives underlying § 502(a). According to the dissenting Justices, the majority has, in essence, created a new test, which warrants preemption of a state law regulating insurance only if the state law "'provides [a] new cause of action' or authorizes a 'new form

202. *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993) (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). The Court also stated, "ERISA leaves room for complementary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized . . ." *Id.* at 98. In a footnote, the Court stated, "No decision of this Court has applied the savings clause to supersede a provision of ERISA itself." *Id.* at 99 n.9.

203. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992)).

204. *John Hancock*, 510 U.S. at 97-101. *John Hancock* involved a state law regulating insurance which was nonetheless found to be preempted because of its conflict with the fiduciary duties imposed by ERISA. *Id.* See also *Boggs*, 520 U.S. at 844. *Boggs* involved a state law which the Court found to be preempted due to a conflict with two other ERISA provisions; one mandating the form of annuity benefits payable upon retirement and one creating an exception to the general prohibition on alienation of ERISA benefits. *Id.*

205. See *Rush*, 536 U.S. at 385 n.15 (noting no conflict because ERISA does not specify a standard of review for § 502(a)(1)(B) actions); *id.* at 385 n.16. (noting that ERISA § 1133 merely requires Plans to provide an internal appeal, and thus that the external review required by the IER law does not create a conflict).

of ultimate relief.”²⁰⁶ While more abbreviated, the dissent’s characterization is compatible with this Article’s explanation that the majority opinion suggests a desire to limit the exception to state laws which provide a vehicle for an ERISA claimant to pursue, via a civil action, a claim or cause of action that is, in essence, available under ERISA, and which would allow a remedy not available in the ERISA action.²⁰⁷ This aspect of *Rush* arguably would leave states free to allow medical malpractice claims against HMOs arising from allegedly negligent denials on the basis of medical necessity. This assessment is arguable, however, because as explored in the next part of this Article, important unanswered questions remain.

V. APPLICATION TO STATE “HMO LIABILITY” LAWS

As noted, the question of the day is whether the Supreme Court ultimately will agree with the emerging judicial perspective that ERISA does not preempt an ERISA plan beneficiary’s medical malpractice claim against an HMO which served as the plan administrator; that is, a claim arising from the HMO’s determination that medical services or treatments recommended by the treating physician are not medically necessary. As noted in the introduction, some have construed *Rush* as affirming the idea that ERISA preempts state common law and legislative attempts to impose liability on managed care plans for violation of a duty of ordinary care in arranging for medically necessary services. Indeed, that view was highlighted in a December 2002 article in *The Health Lawyer*.²⁰⁸ That view of *Rush*, however, is inconsistent with the majority’s careful narrowing of the conflict preemption exception to the savings clause.

A. State HMO Liability Laws

The problems arising from HMO determinations that medical services or treatments recommended by treating physicians are not medically necessary have been addressed by states through laws in addition to laws requiring IER. One of the most controversial means is through a state law imposing liability

206. *Id.* at 397 (Thomas, J., dissenting).

207. *See supra* notes 158-69 and accompanying text.

The majority thus stressed that, in each earlier case, the state law at issue provided a vehicle for a claimant to pursue, in essence, a claim that was actually available under ERISA (claims for breach of the duty to pay benefits due and a claim for discrimination prohibited by ERISA); and yet would have resulted in a remedy other than those specified in ERISA. Moreover, the majority stressed that the monetary awards at issue in the cases were pursued as remedies which would be ‘provided at the *ultimate* step of plan enforcement.’

Id. (emphasis added).

208. *See Pimstone & Johnson, supra* note 20, at 7-9. *See also infra* notes 276-79 and accompanying text (describing the views set forth in this article).

on HMOs for a failure to exercise appropriate care in making such a determination. That state law can either be common law, that is, judicial recognition that HMOs owe a duty of reasonable care to their subscribers in making medical necessity-based utilization review determinations or, more commonly, a legislatively enacted law.

Because of the historical barrier posed by ERISA preemption, state courts have had limited opportunities to develop common law liability claims against HMOs. Over the years, plaintiffs in many cases have included allegations to the effect that the defendant HMO negligently determined that medical care or services recommended by their treating physician were not medically necessary.²⁰⁹ Because the claims arose out of the process of determining whether a claim for benefits should be paid, defendants argued and lower courts agreed that the claims were preempted by ERISA, thereby cutting off the opportunity to consider whether judicial recognition of the cause of action was proper.²¹⁰ In the recent cases, such as *Cicio*, in which the courts have held that various negligence claims against HMOs are not preempted, courts have carefully noted that the finding of no preemption did not mean that the cause of action was viable as a matter of state law.²¹¹ However, as cases have escaped preemption, state courts have begun recognizing a variety of common law negligence claims against HMOs.²¹² While medical malpractice claims are likely to emerge as a viable tool to hold HMOs accountable for activity comparable to practicing medicine, it may be years before a body of case law develops.²¹³

209. See, e.g., *Moscovitch v. Danbury Hosp.*, 25 F. Supp. 2d 74 (D. Conn. 1998).

210. See, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992). See also *Jordan*, *supra* note 2, at 410 n.15 (citing a multitude of cases following *Corcoran* over the years).

211. See, e.g., *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003).

[W]e reiterate that we do not decide under what circumstances, if any, the decisions made by [the HMO or its medical director], or utilization review decisions generally, may when negligently made be actionable under New York law. Perhaps they never are. . . . [T]hat will be a question for the New York courts to decide upon remand.

Id.

212. See, e.g., *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000) (holding that the doctrine of institutional negligence may be applied to HMOs); *Shannon v. McNulty*, 718 A.2d 828, 836 (Pa. Super. Ct. 1998) (deciding that duties applicable to hospitals should also be applicable to HMOs, when the HMO is performing similar functions). See also Gail B. Agrawal & Mark A. Hall, *What if You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235, 279 (2003) (noting that insurance contracts give insurers discretion to determine uncertain issues requiring individual clinical assessments and that if an insurer's judgment was arbitrary, unreasonable or incorrect, "the liability that results from any misfeasance raises issues [that] cannot be resolved without resort to concepts from the domain of tort law").

213. See *Wickline v. State*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986); *Wilson v. Blue Cross of S. Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990). Interestingly, the framework for analyzing HMO negligence may have its roots in cases decided before ERISA preemption became the notorious shield against managed care liability.

In contrast, legislative HMO liability laws have been adopted in several states. The laws vary from state to state, but the objective of all is to provide a mechanism for holding HMOs accountable when their utilization review decisions constitute, in essence, the exercise of medical judgment. In 1997, Texas became the first state to enact legislation establishing a standard of care, and a cause of action for breaches thereof, for HMO benefit determinations which cause injury.²¹⁴ To date, at least ten states have codified laws opening the door to managed care liability for inappropriate medical necessity determinations.²¹⁵ Most impose a duty to exercise ordinary or reasonable care in making such determinations and allow injured plan participants to recover damages beyond the benefit itself.

California's statute provides a good example of a state legislative HMO liability law. California's Civil Code Section 3428 provides that managed care entities such as HMOs

shall have a duty of ordinary care to arrange for the provision of medically necessary health care service[s] to its subscribers and enrollees, where the health care service is a benefit provided under the plan, and shall be liable for any and all harm legally caused by its failure to exercise that ordinary care when both of the following apply:

(1) The failure to exercise ordinary care resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee[; and]

(2) The subscriber or enrollee suffered substantial harm.²¹⁶

California, therefore, has legislatively imposed a tort duty on HMOs to use ordinary care when the HMO is wearing its "provider hat." That is, the duty is imposed as to activities involved "in arranging for the provision of medically necessary health care."²¹⁷ Through use of this language, the duty extends to actions including denials of, or delays in approving, coverage for recommended medical services. Indeed, the California statute specifically imposes liability on HMOs for a denial of coverage resulting from a failure to

214. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002 (Vernon 2003) (codifying the Health Care Liability Act).

215. See generally PATRICIA BUTLER, HENRY J. KAISER FAMILY FOUND., KEY CHARACTERISTICS OF STATE MANAGED CARE ORGANIZATION LIABILITY LAWS: CURRENT STATUS AND EXPERIENCE (Aug. 2001) (including Arizona, California, Georgia, Maine, Oklahoma, Texas, Washington, and West Virginia), available at <http://www.kff.org/insurance/3155-index.cfm>.

216. CAL. CIV. CODE § 3428 (West 2003).

217. *Id.*

satisfy the tort duty, when the denial legally causes substantial harm to an HMO subscriber or enrollee.²¹⁸

The December 2002 article in *The Health Lawyer* specifically cited this California HMO liability law as an example of the type of state law that would be preempted under the author's view of *Rush*.²¹⁹ Accordingly, this Article will use California's HMO liability law as the basis for its exploration of the proper application of *Rush* and *KAHP* to the preemption analysis.

Whether state HMO liability laws are preempted depends on the following: (1) whether the laws relate to ERISA plans and thus fall within the scope of § 514(a); (2) if so, whether they are laws regulating insurance within the scope of § 514(b)(2)(A) and, thus, generally are exempt from preemption; and (3) if so, whether the laws should nonetheless be preempted pursuant to conflict preemption considerations. The analysis of ERISA preemption of state HMO liability laws is largely the same regardless of whether the laws are state common law or legislative enactments. Accordingly, the following subsections explore the preemption analysis for both types of state HMO liability laws.

B. State HMO Liability Laws "Relate To" ERISA Plans

Section 514(a) of ERISA preempts state laws that relate to ERISA plans.²²⁰ Although the Supreme Court has acknowledged the breadth of this express preemption language, the Court has clarified that the analysis should be guided by the objectives of ERISA and should involve consideration of the nature and purpose, as well as the effect, of the state law at issue.²²¹ Rather than any mere reference to an ERISA plan, the Court has stated that a reference will warrant preemption if the state law "acts immediately or exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation."²²² Moreover, rather than any mere connection with an ERISA plan, the Court has stated that preemption is warranted if the law "mandate[s] employee benefit structures or their administration [or provides] alternative enforcement mechanisms [to ERISA]."²²³ Further, the Court has emphasized the presumption against preemption of state laws in areas traditionally regulated pursuant to a state's domain over the health and welfare of its citizens.²²⁴

218. *Id.*

219. See Pimstone & Johnson, *supra* note 20, at 8 (citing CAL. CIV. CODE § 3428 (West 2003)).

220. See *supra* note 49 and accompanying text.

221. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

222. See, e.g., *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 325 (1997).

223. See *Travelers*, 514 U.S. at 658.

224. See *id.* at 663.

1. Impermissible "Reference To" Is Unlikely

Preemption on the basis of an impermissible reference to ERISA plans will, of course, always depend upon the precise language or terminology of the state of HMO liability law. A review of several state HMO liability laws shows that it is unlikely that such laws will impermissibly reference ERISA plans. The laws typically impose the duty of care on health carriers²²⁵ or health insurance carriers,²²⁶ managed care entities,²²⁷ HMOs,²²⁸ or organized delivery systems.²²⁹ These terms typically are defined to reach entities with which an employer may contract to provide health coverage for its employees or to provide administrative services for employers that self-insure. As defined, the terms typically do not encompass the ERISA plan itself.²³⁰

The assertion that the laws do not reference ERISA Plans is confirmed by the *Rush* majority's view of an ERISA plan. In *Rush*, Justice Souter rejected Rush HMO's argument that differences in state independent review laws would impose impermissible burdens on ERISA Plan administration.²³¹ Writing for the majority, Justice Souter noted that "it is the HMO contracting with a plan, and not the plan itself, that will be subject to these regulations, and every HMO will have to establish procedures for conforming with the local laws, regardless of what this Court may think ERISA forbids."²³² The dissenting opinion reiterated the majority's narrow view of what constitutes the ERISA Plan by noting that the "[majority] isolates the 'plan' from the HMO and then concludes that the independent review provision does not 'threaten

225. See WASH. REV. CODE § 48.43.545(1)(a) (2003); ME. REV. STAT. tit. 22, § 4313 (1)(A) (West 2003); N.J. REV. STAT. § 2A:53A-33(a) (2003).

226. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003).

227. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003); N.C. GEN. STAT. § 90-21.51(a) (2003).

228. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003).

229. See N.J. REV. STAT. § 2A:53A-33(a) (2003).

230. See WASH. REV. CODE § 48.43.005(18) (2003). For example, Washington's HMO liability law imposes the duty on health carriers and defines that term to include a "disability insurer, . . . a health care service contractor, . . . or a health maintenance organization." *Id.* See TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (Vernon 2003). The Texas HMO liability law imposes the duty on, inter alia, "managed care entities" and defines that term to include:

[A]ny entity which delivers, administers, or assumes the risk for health care services, with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services, to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees

Id.

231. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 381 n.11 (2002).

232. *Id.*

the object of [ERISA]' because it does not affect the plan, but only the HMO."²³³

Moreover, even if the law did use terminology that could arguably be construed as encompassing the ERISA plan itself, it would be unlikely that the law would reach only ERISA plans, as the laws will primarily target insurers, HMOs, and other entities performing an insurance function. Thus, it is unlikely that any state HMO liability law would be drafted such that it would act "immediately and exclusively upon ERISA plans, . . . or [create a situation] where the existence of ERISA plans is essential to the law's operation" ²³⁴ Rather, preemption due to a relation to ERISA plans is likely to result from an impermissible connection with ERISA plans.

2. *Rush Suggests an Impermissible "Connection With"*

The generally articulated principle is that preemption due to a connection with an ERISA plan is warranted if the law "mandate[s] employee benefit structures or their administration [or provides] alternative enforcement mechanisms [to ERISA]."²³⁵ Applying this test focuses primarily on the effect of the state law on ERISA plans. However, the nature and purpose of the law are also relevant, and the Court has emphasized the presumption against preemption of state laws in areas traditionally regulated pursuant to a state's domain over the health and welfare of its citizens.²³⁶ Interestingly, prior to *Rush* and *KAHP*, scholars of ERISA preemption and some lower courts believed that the Supreme Court was signaling that state laws regulating health care, and especially the quality of health care, should not be preempted because such laws did not relate to ERISA plans.²³⁷ *Rush* and *KAHP* suggest the same ultimate conclusion, but suggest a different approach to the analysis.

For exploration of the "connection with" analysis, the Second Circuit's decision in *Cicio* provides a useful starting point. Recall that, in *Cicio*, the

233. *Id.* at 401 n.9 (Thomas, J., dissenting). The dissent went on to note, "To my knowledge such a distinction is novel. . . . Its application is particularly novel here, where the Court appears to view the HMO as the plan administrator, leaving one to wonder how the myriad state independent review procedures can help but have an impact on plan administration." *Id.* However, the majority's view is not as illogical as Justice Thomas implicates. *Id.* It has long been recognized that the HMO or insurer with whom an employer contracts in order to provide health coverage through an ERISA plan, although often serving as the plan administrator, also functions in other roles, such as administering the HMO's business—distinct from administrative functions that may constitute "administration of an ERISA plan." *Id.* See, e.g., Jordan, *supra* note 12, at 299-304 (exploring the concept of administration of ERISA plans).

234. See, e.g., Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., 519 U.S. 316, 325 (1997).

235. See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995).

236. See *id.*

237. See, e.g., Jordan, *supra* note 2, at 442-49 and *infra* notes 238-52 and accompanying text.

Second Circuit held that ERISA did not preempt an ERISA plan beneficiary's common law medical malpractice claim against an HMO, which served as the plan administrator, for an allegedly negligent medical decision to deny medical care recommended by the claimant's treating physician.²³⁸ The issue of preemption of the state common law HMO liability claim was one of first impression for the Second Circuit,²³⁹ and the court therefore was influenced only by the recent Supreme Court ERISA preemption cases. The court began and ended its analysis with the strong presumption against preemption of state law in the field of health care. In the court's view, based on recent Supreme Court cases, the state common law civil action being pursued by the plaintiff constituted a state law regulating health care and, for that reason alone, was not preempted under § 514(a) of ERISA. That is, as a law regulating health care, the law simply did not impermissibly relate to ERISA benefit plans.

More specifically, the Second Circuit in *Cicio* viewed the Supreme Court's decision in *Pegram v. Herdrich*²⁴⁰ as bearing significantly on the preemption issue.²⁴¹ In *Pegram*, the claimant argued that the HMO breached the fiduciary duties imposed by ERISA. Thus, the Court addressed only whether the challenged conduct, making UR decisions while influenced by financial incentives, constituted administrative acts triggering imposition of the ERISA fiduciary duties.²⁴² The Court explained that UR decisions made by HMOs (or

238. *Cicio v. Dees*, 321 F.3d 83, 87-88 (2d Cir. 2003). In *Cicio*, the plaintiff's physician recommended on January 28, 1998, "high dose chemotherapy supported by peripheral blood stem cell transplantation, in a tandem double transplant, for [Mr. Cicio's] diagnosis of multiple myeloma." *Id.* The HMO's medical director, Dr. Spears, on February 23, 1998, denied the request of Cicio's physician (Dr. Samuel) for preauthorization. *Id.* Dr. Spears noted that the procedure was not covered because Cicio's health benefit plan stated that experimental/investigational procedures were not covered. *Id.* On March 4, 1998, after unsuccessful attempts to contact Dr. Spears by telephone, Dr. Samuel wrote an appeal for reconsideration, noting that the recommended treatment was a well-established and effective treatment. *Id.* On March 25, 1998, Dr. Spears approved a single stem cell transplant, but again denied the original request for tandem stem cell transplant. *Id.* By March 25th, Cicio was no longer a candidate for the transplant. *Cicio*, 321 F.3d at 88. Cicio died on May 11, 1998. *Id.* On appeal, the claims remaining challenged the timeliness of Dr. Spears's decisions; the allegedly misleading nature of the HMO's representations about Cicio's health benefit plan; and the quality of the medical decision made by the defendants. *Id.* at 90.

239. *Id.* at 98.

240. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

241. *Cicio*, 321 F.3d at 100-03 (noting that other cases finding medical practice claims preempted were decided before the Court's decision in *Pegram*, and that *Pegram* alters the framework used in prior cases by demonstrating that the presence of a medical component to a coverage decision is determinative).

242. In *Pegram*, the plaintiff Herdrich suffered injury when her physician, Dr. Pegram, discovered an inflamed mass in Herdrich's abdomen, but delayed the allegedly necessary ultrasound diagnostic procedure. Dr. Pegram decided that Herdrich could wait eight days in order to have the ultrasound performed at a facility staffed by Carle Care HMO, the HMO of which Dr. Pegram was both an owner and participating provider. *Pegram*, 530 U.S. at 215.

Carle Care HMO had contracted with Herdrich's employer to provide health coverage and administrative services for the employer's health benefit plan. Accordingly, Carle Care HMO was subject to certain duties imposed by ERISA. Herdrich alleged that Carle Care HMO

by physician owners of the HMO who also serve as the treating physician) fall into distinct categories: pure eligibility decisions, which turn on the plan's coverage of a particular condition or treatment,²⁴³ treatment decisions, which turn on issues of "how to go about diagnosing and treating a . . . condition;"²⁴⁴ and "mixed eligibility and treatment decisions," which involve eligibility decisions that "cannot be untangled from physicians' judgments about reasonable medical treatment."²⁴⁵ The conduct challenged in *Pegram* constituted mixed eligibility and treatment UR decisions,²⁴⁶ and the Court held that UR decisions which constitute mixed decisions do *not* constitute "administration of the plan," thereby defeating the plaintiff's claim for breach of ERISA's fiduciary duty.²⁴⁷

In supporting its decision, the Court in *Pegram* also noted that no breach of fiduciary duty action could be brought under ERISA because, in part, such an action would be a mere replication of state malpractice actions with HMO defendants.²⁴⁸ The Court in *Pegram* also noted that allowing the ERISA claim would raise a "puzzling issue of preemption;" the Court pointed out that allowing the claim would raise a problematic "prescription for preemption," given that *Travelers* "throws some cold water" on the theory that ERISA preempts medical malpractice claims.²⁴⁹ The court in *Cicio* therefore noted that the "availability of some state law malpractice actions based on at least some varieties of utilization review decisions was a predicate of the Court's holding [in *Pegram*]."²⁵⁰

Although not a preemption case, the Second Circuit in *Cicio* viewed the rationale used by the Court in *Pegram* as dictating that a mixed eligibility and treatment decision, that is, a UR determination made by a payor denying

had breached ERISA's fiduciary duty by devising a system of financial incentives which influenced treatment decisions made by its physician owners. *Id.* at 215-16, 216 n.3.

243. *Id.* at 228-29. For example, "whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis) . . ." *Id.*

244. *Id.* For example, "given the patient's constellation of symptoms, what is the appropriate medical response?" *Id.*

245. *Pegram*, 530 U.S. at 228-29.

246. In *Pegram*, physician owners of Carle Care HMO also served as treating physicians. Rather than having a process of UR distinct and separate from the treating physicians' decisions (as in a more typical managed care organization), the Carle Care HMO physicians made treatment decisions and the UR or coverage decision simultaneously. In *Pegram*, the decision was whether Herdrich required an immediate ultrasound performed at the local hospital or whether it was reasonable to have Herdrich wait eight days for an ultrasound that could be performed at a Carle Care facility. The Court found that this decision and the others mentioned in Herdrich's complaint constituted mixed eligibility and treatment decisions. *Id.* at 229-30.

247. *Id.*

248. *Id.* at 235 (noting that allowing a breach of fiduciary action arising from actions constituting the exercise of medical judgment would "simply apply the law already available in state courts and federal diversity actions today . . ."). See also *Cicio v. Dees*, 321 F.3d 83, 101 (2d Cir. 2003) (quoting *Pegram*, 530 U.S. at 236).

249. *Pegram*, 530 U.S. at 236-37. The Court in *Pegram* of course did not expressly address the preemption issue being explored in *Cicio* and in this Article.

250. *Cicio*, 321 F.3d at 101.

recommended care based on a finding regarding medical necessity or the experimental nature of the treatment for a particular HMO subscriber, constitutes an exercise of medical judgment.²⁵¹ Accordingly, the court held that the claimant's medical malpractice action "regulating" that conduct constitutes a state law regulating health care, and thus, is not preempted absent clear and manifest indication of congressional intent.²⁵²

As noted, scholars have similarly viewed the recent Supreme Court cases involving the "connection with" analysis as supporting a finding that a state HMO liability law, as a law regulating health care does not sufficiently relate to ERISA plans to warrant preemption.²⁵³ Interestingly, the more recent Supreme Court cases, while supporting a holding that state HMO liability laws are not preempted, may not support *Cicio's* approach to the preemption analysis.

More specifically, it is not clear that *Rush* supports *Cicio's* resolution of the issue through a finding that the medical malpractice cause of action, as a regulation of health care, does not sufficiently relate to ERISA benefits plans. In *Rush*, the IER law at issue could also be characterized as a law regulating health care. Yet, the Court in *Rush* summarily concluded that the law relates to an ERISA plan and therefore was preempted, unless saved.²⁵⁴

Indeed, the majority in *Rush* referred to the IER law as a law regulating health care. The majority noted that the law set in motion a process resembling the practice of obtaining another medical opinion.²⁵⁵ Additionally, the Court explained that states often regulate insurance in order to safeguard the welfare of their citizens. For example, "Illinois has chosen to regulate insurance as one way to regulate the practice of medicine, which we have previously held to be permissible under ERISA."²⁵⁶ The Court noted,

[A]ny lingering doubt about the reasonableness of [the IER law] . . . may be put to rest by recalling that regulating insurance tied to what is medically necessary is probably insepar-

251. *Id.* at 102. The Court noted that decisions regularly made by payers, such as "whether one treatment option is so superior to another under the circumstances, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement" in a health benefits contract, "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* (quoting *Pegram*, 530 U.S. at 229).

252. *Id.* at 102 ("We conclude that a state law malpractice action, if based on a 'mixed eligibility and treatment decision,' is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms.").

253. *See, e.g.*, Jordan, *supra* note 2, at 442-49.

254. *See* Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 365 (2002). "It is beyond serious dispute . . . that the [IER law] 'relates to' employee benefit plans . . ." *Id.*

255. *Id.* at 383. "The reference to an independent reviewer is similar to the submission to a second physician, which many health insurers are required by law to provide before denying coverage." *Id.*

256. *Id.* at 387 (quoting *Pegram*, 530 U.S. at 237).

able from enforcing the quintessentially state-law standards of reasonable medical care. “[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.”²⁵⁷

However, as noted, the Court in *Rush* found that the IER law related to ERISA plans and viewed the determinative issue as whether the law regulated insurance and thus was saved from preemption.²⁵⁸ Perhaps this was because the Illinois IER law represented a direct regulation of HMOs and MCOs,²⁵⁹ as would a state HMO liability law. Accordingly, although the most recent Supreme Court cases support the emerging view that state HMO liability laws are not preempted, they suggest that the outcome lies in the savings clause analysis.

C. State HMO Liability Laws Satisfy the Broader View of Laws Regulating Insurance

Based on the foregoing discussion, it could be argued that a full-blown savings clause analysis of state HMO liability laws is unnecessary because the Supreme Court’s recent precedent at least arguably still suggests simply that, if the law is a law regulating health care, it is not preempted. It is possible that such an argument is correct. However, in this author’s view, it is far from certain how the Supreme Court will approach the issue of preemption of state HMO liability laws. The Court’s discussion in *Rush*, relating to the inappropriateness of preemption of laws regulating health care, could be viewed simply as dicta provided as further support for the majority’s conclusion—which became more important given the view of four dissenting Justices that the IER law was impermissibly in conflict with ERISA’s exclusive enforcement scheme. The more prudent course in any ERISA preemption action in which the validity of a state HMO law is at issue would be to formulate and articulate the full gamut of savings clause arguments.

After *Rush* and *KAHP*, a law is saved from ERISA preemption if it (1) constitutes a law specifically directed at the insurance industry and (2) substantially affects the risk pooling arrangement between the insurer and the insured. The crux of the analysis is a parsing of the *who* and the *what* of the regulation. Laws are saved from preemption if they regulate entities in the insurance industry with respect to their insurance practices.

257. *Id.*

258. See *supra* notes 41-43 and accompanying text.

259. 215 ILL. COMP. STAT. ANN. 125/1-2 (West 2003). The Illinois IER law defines a Health Maintenance Organization as “any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.” *Id.*

1. *Are State HMO Liability Laws “Specifically Directed” at the Insurance Industry?*

As noted, legislatively enacted state HMO liability laws typically impose the duty of care on health carriers²⁶⁰ or health insurance carriers,²⁶¹ managed care entities,²⁶² HMOs,²⁶³ or organized delivery systems.²⁶⁴ These terms are defined to reach entities with which an employer may contract to provide health coverage for its employees or to provide administrative services for employers that self-insure.²⁶⁵ Both *Rush* and *KAHP* took a broad view of the *who* prong of the analysis and found it was satisfied if the laws primarily target entities which sufficiently engage in insurance activities. Nonetheless, as explored in the following paragraphs, it is not clear whether state HMO liability laws will always pass the test.

The Court in *Rush* specifically held that HMOs sufficiently engage in insurance activities for the IER law to be specifically directed at the insurance industry, despite also engaging in non-insurance activities. According to the Court, HMOs engage in insurance activities because they assume financial risk and underwrite and spread risk among their participants.²⁶⁶ Further, the Court in *KAHP* specifically noted that HMOs that provide solely administrative services for self-insured plans sufficiently engage in insurance activities to satisfy the test. Similarly, the other entities often targeted by state HMO liability laws—for example, “managed care entities” or “organized delivery systems”—can readily be characterized as sufficiently engaging in insurance activities. Although their structures may vary considerably, most MCOs oper-

260. See WASH. REV. CODE ANN. § 48.43.545(1)(a) (West 2003); ME. REV. STAT. ANN. tit. 24-A, § 4313 (1)(A) (West 2003); N.J. STAT. ANN. § 2A:53A-33(a) (West 2003).

261. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003).

262. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003); N.C. GEN. STAT. § 90-21.51(a) (2001).

263. See TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2003); OKLA. STAT. tit. 36, § 6593(A) (2003).

264. See N.J. STAT. ANN. § 2A:53A-33(a) (West 2003).

265. WASH. REV. CODE ANN. § 48.43.005(18) (West 2003). For example, Washington’s HMO liability laws imposes the duty on health carriers and defines that term to include a “disability insurer, . . . a health care service contractor, . . . or a health maintenance organization.” *Id.* See also TEX. CIV. PRAC. & REM. CODE ANN. § 88.001(8) (Vernon 2003). The Texas HMO liability law imposes the duty on, inter alia, “managed care entities” and defines that term to include:

[A]ny entity which delivers, administers, or assumes the risk for health care services, with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services, to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees

Id.

266. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 365-66 (2002). See also *supra* notes 74-79 and accompanying text.

ate comparably to HMOs: they assume financial risk and underwrite and spread risk among their participants or provide administrative services for self-insured plans.²⁶⁷ Thus, if *Rush* and *KAHP* provide the only precedent, state HMO liability laws can readily be viewed as being specifically directed towards the insurance industry.

However, as noted, *Rush* and *KAHP* did not address the reasoning articulated in *Pilot Life* for its determination that a common law bad faith breach of contract action was not specifically directed at the insurance industry. In *Pilot Life*, the specific cause of action at issue was applicable only to those in the insurance industry; the state law cause action had evolved from general principles of tort and contract law, which, obviously, were not applicable only to insurers.²⁶⁸ This consideration was not relevant in *Rush* and *KAHP* because the cases involved state laws enacted by legislatures that did not simply evolve from pre-existing general principles. Because the Court in *Rush* and *KAHP* did not expressly or impliedly overrule this aspect of *Pilot Life*, it is logical to conclude that this reasoning still may be relevant to the inquiry.

If so, this aspect of *Pilot Life* raises one of the harder savings clause issues related to state HMO liability laws. As to a common law, judicially recognized medical malpractice liability claim against an HMO, the better argument may be that *Pilot Life* precludes a finding that the law is specifically directed at the insurance industry. Such a cause of action represents an evolution of basic tort law to newly emerging conduct that constitutes an exercise of medical judgment. The analysis is less clear as to legislatively enacted state HMO liability laws. For example, at least one lower court has recently held that a state statute authorizing a civil action for bad faith breach of an insurance contract, which expressly limits the action to the insurance context, is distinguishable from the law in *Pilot Life* and is fairly characterized as being specifically directed towards the insurance industry.²⁶⁹ This court, however, still found the statute preempted based on other savings clause standards.²⁷⁰ Thus, although it is unclear whether the emphasis in *Rush* and *KAHP* on the *who* of regulation diminishes *Pilot Life's* specifically directed rationale, this factor nonetheless may be satisfied as to a legislatively enacted HMO liability law.

267. See, e.g., Vickie Yates Brown & Barbara Reid Harting, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 27-29 (1998) (describing various forms of managed care organizations).

268. See *supra* notes 124-26 and accompanying text.

269. See, e.g., *Bell v. UNUM Provident Corp.*, 222 F. Supp. 2d 692, 696-97 (E.D. Pa. 2002) (discussing recent cases and concluding that, under the common sense test Pennsylvania's bad faith statute "regulates insurance" because it is applicable only to insurers in actions arising under an insurance policy and is never applied outside the insurance industry).

270. *Id.*

2. *The Laws Substantially Affect the Risk Pooling Arrangement*

In *KAHP*, Justice Scalia wrote that to be saved from preemption, a state law must also substantially affect the risk pooling arrangement between the insurer and the insured.²⁷¹ Although the meaning of Justice Scalia's terminology is not entirely clear, it is arguable that the test broadly encompasses any state law which has a substantial (or important) effect on any health coverage product offered by a health coverage provider.²⁷² A state law which allows injured subscribers to bring a civil action for damages arising from an HMO's negligent medical necessity determination would seem to satisfy this test.

State HMO liability laws do not directly affect the product offered by health coverage providers—that is, the policy or health coverage itself. However, they arguably produce an indirect effect. If HMOs can be held accountable for coverage decisions that constitute medical decisions and held liable for monetary damages for a breach of a tort duty of care, it is reasonable to conclude that HMOs will use some greater care in the UR process; thereby resulting in an improved health coverage product. Additionally, since most insurers strive to make a profit by maintaining predictable and stable levels of risk and by setting premiums at a level tailored to ensure a reasonable profit,²⁷³ it is reasonable to conclude that a law allowing liability for negligent UR decisions will impact the underwriting and premium setting process. Thus, state HMO liability laws arguably have an important effect on the product offered by health coverage providers.

The unknown is whether the above described effects are sufficiently substantial to satisfy Justice Scalia's new test. Language in other relevant Supreme Court precedent perhaps sheds light on this question. In *Royal Drug*, the Court noted that Congress wanted to preserve state law regulation of insurance because it was concerned with "[t]he relationship between insurer and insured, the type of policy which could be issued, [and] its reliability, interpretation, and enforcement."²⁷⁴ Although the Court in *KAHP* made a clean break from the McCarran-Ferguson factors developed in *Royal Drug*, *KAHP* does not suggest that the Court's general statements in *Royal Drug* about laws regulating insurance law are no longer relevant. Rather, because the Court in both *Rush* and *KAHP* broadened the scope of the savings clause, it is reasonable to conclude that the Court's general language regarding laws regulating insurance (even if made in the context of the narrow antitrust exemption) is still relevant. Thus, if the effect of a state law is to enhance the reliability of coverage decisions or the interpretive process used by a health coverage provider or to strengthen a subscriber's ability to enforce promises

271. See *supra* notes 118-19 and accompanying text.

272. See *supra* notes 128-38 and accompanying text.

273. See *supra* notes 129-36 and accompanying text.

274. See *supra* notes 107-13 and accompanying text.

made in the health coverage policy, the effect readily seems sufficiently substantial to fall within the scope of Justice Scalia's test.

A state HMO liability law has two important effects. Such a law may well make it more likely that an HMO or MCO will promptly approve coverage of recommended medical services that are arguably medically necessary. Similarly, a state HMO liability law may enhance the ability of subscribers to deter negligent UR activity. Thus, it is reasonable to argue that the law thereby enhances the reliability of coverage decisions and the interpretive process used by the health coverage provider and moreover, strengthens subscribers' ability to enforce the policy. The effect therefore readily seems sufficiently substantial to warrant exemption from preemption as a law regulating insurance, unless, of course, the law still falls within the conflict preemption exception to the savings clause.

*D. State HMO Liability Laws Likely Fall Outside Justice Souter's
Carefully Drawn Conflict Preemption Exception*

As discussed in the foregoing sections, *Rush* and *KAHP* suggest that the Court may determine that state HMO liability laws relate to ERISA plans, but also constitute laws regulating insurance. As such, the conflict preemption principles may present the crux of the preemption analysis of state HMO liability laws—which is perhaps why Justice Souter took such care in narrowing the role of conflict preemption in the ERISA context. HMOs will strongly urge the Court to find that state HMO liability laws conflict with ERISA's exclusive civil enforcement provisions by impermissibly providing an alternative cause of action with alternative remedies, thereby warranting preemption despite being characterized as a law regulating insurance. Whether HMOs are successful in this argument depends on whether five Justices again agree with Justice Souter's more narrow view of the preemptive force of ERISA § 502(a).

As noted, some have construed *Rush* as affirming the idea that ERISA preempts state common law and legislative HMO liability laws.²⁷⁵ In the December 2002 article published in the American Bar Association's ("ABA") publication, *The Health Lawyer*, the authors concluded that *Rush* "would appear also to invalidate state [common law] and legislative attempts to create additional judicial rights and remedies for ERISA participants under the rubric of 'insurance regulation.'"²⁷⁶ The authors then expressly opined that *Rush* confirms the broad view of the preemptive force of ERISA's civil enforcement provisions, and that the preemptive force of *Pilot Life* would preclude state

275. See Pimstone & Johnson, *supra* note 20, at 7-9; see also Humiston et al., *supra* note 19, at 7-8 (viewing *Rush* as being consistent with the quality-quantity distinction that evolved from the *Concoran* and *Dukes* line of cases).

276. Pimstone & Johnson, *supra* note 20, at 8.

laws such as California's HMO liability law.²⁷⁷ That view of *Rush*, however, is inconsistent with the majority's careful narrowing of the conflict preemption exception to the savings clause. The authors of the ABA article seemed to focus only on Justice Souter's statements regarding state laws affording remedies, in a judicial forum, other than those specified in ERISA,²⁷⁸ they failed to notice the integral accompanying statements clarifying cases, such as *Pilot Life*, involving plaintiffs using state laws to enforce claims that were actually available under ERISA.²⁷⁹ Yet, Justice Souter's careful description of the key precedent, including *Pilot Life*, must be read as a whole.

Recall that the majority opinion in *Rush* carefully confined the scope of the conflict preemption exception in accordance with the contours of the key Supreme Court precedent.²⁸⁰ Read as a whole, Justice Souter's discussion stressed that, in each earlier case, the state law at issue provided a vehicle for a claimant to pursue, in a judicial forum, a claim that was, in essence, actually available under ERISA (claims for breach of the duty to pay benefits due and a claim for discrimination prohibited by ERISA) and yet would have resulted in a remedy other than those specified in ERISA.²⁸¹ Thus, in determining whether the conflict preemption exception is available, Justice Souter clarified that the focus is not just on the remedy afforded by the state law but also depends on the claim, as well as the timing and forum of the relief provided by the state law.

State HMO liability laws without question allow a remedy other than those specified by ERISA § 502(a). For example, California Civil Code Section 3428 provides that HMOs shall be liable for "any and all harm" caused by the HMO's violation of the duty imposed, and that damages recoverable for violation of the law include "the amount which will compensate for all detri-

277. *Id.* (noting that, inter alia, "*Rush* affirms the continuing vitality and relevance of *Pilot Life*;" and "[t]he Supreme Court in *Rush* underscored the 'overpowering federal policy of exclusivity in ERISA's civil enforcement provisions.'").

278. *Id.* For example, the authors noted that the Court in *Rush* declared that, in considering whether the preemptive force of § 502(a) warrants preemption, "a state provision regulating insurance will lose if it allows plan participants 'to obtain remedies . . . that Congress rejected in ERISA.'" *Id.* Similarly, the authors noted: "A state law 'that provided a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA, declared the *Rush* Court, would 'patently violate[]' ERISA's policies and is preempted." *Id.*

279. *Id.* This oversight may be attributable to the fact that the authors' focus throughout most of the article was on continued preemption of state bad faith claims. Pimstone & Johnson, *supra* note 20, at 8. Because bad faith claims are grounded in a duty imposed by contract law (and ERISA imposes comparable duties to conform to the terms of the insurance policy governing the ERISA plan), the argument that ERISA preempts such state laws remains viable after *Rush*. *Id.* However, the authors' conclusions went beyond state bad faith claims. *Id.*

280. See *supra* notes 158-69 and accompanying text.

281. *Id.*

ment proximately caused thereby²⁸² Several Supreme Court cases have expressly held that ERISA does not authorize compensatory damages.²⁸³

State HMO liability laws also provide a vehicle for a claimant to pursue that form of “ultimate relief” in a judicial forum. In *Rush*, the majority recognized that any remedy available as a result of the IER law would be attainable only by way of a § 502(a)(1)(B) action for benefits due.²⁸⁴ That is, the IER law created a process through which an HMO subscriber attained a right to coverage of a claim for benefits but did not create a private right of action or a vehicle for accessing the ultimate remedy for violation of that right. Unlike the IER law at issue in *Rush*, state HMO liability laws create both a right to the remedy and a vehicle for accessing the remedy for violation of that right. As with the California law, the right created by state HMO liability laws is the right to have HMOs use ordinary care in making medical necessity determinations.²⁸⁵ Also, the vehicle for accessing the remedy of compensatory damages is a cause of action or a civil action in a judicial forum. Moreover, many state HMO liability laws specifically provide that, subject to certain exceptions, the cause of action cannot be maintained until the claimant has exhausted all required internal and external review of the medical necessity determination,²⁸⁶ thereby further indicating that the remedy is a form of ultimate relief. However, state HMO liability laws do not satisfy one key requirement stressed by Justice Souter for application of the conflict preemption exception. The claim created by state HMO liability laws is *not* a claim that is, in essence, available under ERISA. In *Rush*, Justice Souter carefully pointed out that the key Supreme Court precedent involved claims that were grounded in duties imposed by ERISA.²⁸⁷ In *Russell and Pilot Life*, the plaintiffs sought benefits due under the insurance policies at issue; the plaintiffs’ claims therefore predominantly were grounded in breach of ERISA’s directive to pay claims due under the terms of an ERISA plan.²⁸⁸ In *Ingersoll-Rand*, the plaintiff’s claim was grounded in conduct that constituted

282. See CAL. CIV. CODE § 3428(a), (j) (West 2003); see also *id.* § 3333.

283. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 378 (2002) (describing the Court’s holdings in *Metropolitan Life, Russell, and Pilot Life*).

284. *Id.* at 379-80.

285. See *supra* note 216 and accompanying text.

286. See, e.g., CAL. CIV. CODE § 3428(k)(1).

A person may not maintain a cause of action pursuant to this section against any entity required to comply with any independent medical review system or independent review system required by law unless the person or his or her representative has exhausted the procedures provided by the applicable independent review system.

Id. Exceptions exist for cases where substantial harm has or will occur prior to completion of the review. See *id.* § 3428(k)(2)(A)-(B).

287. See *supra* notes 158-69 and accompanying text.

288. See *Rush*, 536 U.S. at 378-80.

a violation of ERISA's directive prohibiting discrimination in relation to employment benefits.²⁸⁹

In contrast, the state HMO liability laws do not create a claim that is grounded in a duty imposed by ERISA. State HMO liability laws impose on HMOs a tort duty to use reasonable (or ordinary) care when making medical necessity determinations.²⁹⁰ To conclude that the HMO liability tort duty is not, in essence, imposed by ERISA, the Supreme Court's determination in *Pegram* becomes relevant. As explained, the Court in *Pegram* held that, even if made by an HMO serving as an ERISA plan administrator, UR decisions based on medical necessity determinations constitute mixed eligibility and treatment decisions and thus are not "administration of the plan" as that phrase is used in ERISA.²⁹¹ Rather, such decisions constitute the exercise of medical judgment. Moreover, the Court explained that state law, not ERISA, regulates the exercise of medical judgment.²⁹² Thus, because ERISA imposes no duty or directive comparable to the duty imposed by state HMO liability laws, the claim or cause of action created by state HMO liability laws is *not* grounded in duties imposed by ERISA and thus is not a claim that is, in essence, available under ERISA.

In sum, although state HMO liability laws create a vehicle for accessing, in a judicial forum, a form of ultimate remedy that is not available under ERISA, saving the law from preemption does not impermissibly conflict with ERISA's civil enforcement provisions. Because ERISA imposes no duty or directive comparable to the duty imposed by state HMO liability laws, the claim or cause of action created by state HMO liability laws is *not* a claim that is, in essence, available under ERISA. Therefore, according to the carefully drawn lines in the majority opinion in *Rush*, state HMO liability laws are outside the scope of the conflict preemption exception, thereby allowing the laws to be saved from preemption as laws regulating insurance.

VI. CONCLUSION

Continuing the trend begun in 1995 in *Travelers*, the Supreme Court in *Rush* and *KAHP* has added significantly to the doctrinal aspects of ERISA preemption and, more specifically, to the doctrinal aspects of ERISA's savings clause. As detailed in this Article, the reworked basic savings clause standards should result in lower courts more readily finding state managed care reform laws to be within the scope of ERISA's savings clause, thereby strengthening the role of states in regulating activities and strategies of HMOs and other managed care entities. Indeed, because of the Court's rejection of the conflict

289. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-43 (1990).

290. *See supra* note 216 and accompanying text.

291. *Pegram v. Herdrich*, 530 U.S. 211, 229-30 (2000). *See supra* notes 240-49 and accompanying text.

292. *Pegram*, 530 U.S. at 248-29.

preemption principles beyond the preemptive force of ERISA's civil enforcement provisions, and because the burden of such regulations was found to rest on the HMO or MCO, not on the ERISA plan itself, the cases suggest that states have a role in regulating HMOs and MCOs even as to activities and strategies that constitute administration of ERISA plans. The Court was unconcerned about the "disuniformity" affecting insured ERISA plans operating in multiple states because that is simply the inevitable consequence of Congress' decision to exempt from preemption state laws regulating insurance.

Some issues remain uncertain, of course. Most notably, it is not absolutely clear how the Court would resolve the question whether ERISA preempts emerging state HMO liability laws. Overall, *Rush* and *KAHP* seem to support the emerging perspective that ERISA does not preempt state HMO liability laws. However, the crux of the analysis may well hinge on application of conflict preemption principles and, specifically, on the Court's view of the preemptive force of ERISA's civil enforcement provisions.

Justice Souter's opinion in *Rush*, which was joined by a majority of the Justices, seems to clear the way for state HMO liability laws by carefully describing the holdings in key cases in an effort to delimit the preemptive force of § 502(a). This Article has attempted to explain and emphasize the limitations detailed by Justice Souter. Using Justice Souter's analysis, state HMO liability laws fall outside the scope of the preemptive force of § 502(a). Ultimately, then, the key question is whether a majority of the Court will again join in a narrow view of the preemptive force of ERISA's civil enforcement provisions.