

SUPREME COURT HOLDS ILLINOIS INDEPENDENT REVIEW LAW IS NOT PREEMPTED BY ERISA

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In June, the U.S. Supreme Court ruled that an Illinois law requiring HMOs to abide by independent reviewers' decisions on medical necessity is not preempted by the federal law that governs employee benefit plans. The case, *Rush Prudential HMO, Inc. v. Moran*,² clarified the factors that must be considered in determining whether a state independent review law may be applied to an insured employee health plan.

Background

Debra Moran was covered by her husband's group health plan which was provided through his employer. Rush Prudential HMO was the service provider to the plan, and the plan was governed by the Employee Retirement Income Security Act ("ERISA").³ Moran experienced numbness and pain in her shoulder that was diagnosed as thoracic outlet syndrome, and after conservative treatment was not effective, her HMO primary care physician recommended surgery by a specialist who had developed an unconventional treatment for Moran's condition. The surgeon recommended was not affiliated with the HMO. (The treatment consisted of the standard surgery for the condition, plus microneurolysis of the brachial plexus.)

The HMO contract specifically provided that only medically necessary treatment was covered and, in general, only if provided by a physician affiliated with the HMO. Treatment by an unaffiliated physician would be covered only if the services were authorized by both the primary care physician and the HMO's medical director. The HMO repeatedly refused to authorize the treatment, and finally Ms. Moran had the surgery without authorization from the HMO.

The Illinois HMO Act provides that if a primary care physician and an HMO disagree regarding the medical necessity of a covered service proposed by the primary care physician, the HMO must submit the dispute to review by an unaffiliated physician selected jointly by the patient, the primary care physician, and the HMO. The HMO is bound by the decision of the external reviewer.⁴ At Moran's request, a state court ordered the HMO to submit the dispute to an independent reviewer. The reviewer determined that the treatment was medically necessary, based on the definition of medical necessity in the HMO contract and on his own judgment. However, the HMO's medical director again determined that the surgery was not medically necessary, and the HMO refused to pay for the surgery.

The Supreme Court's Analysis

Under ERISA, any state law that "relates to" an employee benefit plan is preempted.⁵ However, the preemption provision also includes an exception (referred to as the "saving clause") for state laws that regulate insurance.⁶

The Supreme Court had no difficulty finding that the Illinois HMO Act "relates to" ERISA plans: "The state 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[.]"⁷ The Court also found that the state law regulated insurance because HMOs assume and spread risk,⁸ the independent review requirement regulates an integral part of the policy relationship between the insurer and the insured,⁹ and the state law is limited to entities within the insurance industry.¹⁰ (In a footnote, the Court stated that the saving clause would not protect the Illinois law from preemption to the extent the law applied to self-funded plans.¹¹)

The Supreme Court then tackled the issue that had led lower courts to conflicting decisions¹² about state independent review laws: whether such laws create a cause of action or a remedy that goes beyond those provided by ERISA. This issue arises because ERISA includes very specific provisions setting forth a plan participant's rights against the plan, and the remedies available to enforce those rights. For example, ERISA does not provide a right to recover damages for emotional distress or punitive damages because of a plan's refusal to provide a benefit, and state laws that attempt to give plan participants such rights are preempted.¹³ In dicta, the Supreme Court has stated that if

forced to choose between the Congressional policy of limiting the remedies under ERISA to those provided by the statute, and a state law that regulates insurance and is saved by the saving clause, the state law would lose.¹⁴

Therefore, even if a state law is protected from preemption by the saving clause, it will not be enforceable against an employee benefit plan if it offers a remedy that ERISA would not otherwise provide.

The Court examined the remedies provided by the Illinois HMO Act, and found that the law did not create any cause of action or any form of relief other than what is provided by ERISA. The Court said: “While independent review under [the state law] may well settle the fate of a benefit claim under a particular [insurance] contract, the state statute does not enlarge the claim beyond the benefits available in any action brought under [ERISA].”¹⁵ In particular, the Court drew a distinction between a state law that requires disputes between an insurer and an insured to be submitted to arbitration, and the provision in the Illinois HMO Act. According to the Court, although the procedure required by the Illinois law has some resemblance to arbitration, “the proceeding [has] a different character . . . not at all at odds with the policy behind [the ERISA provisions]. The [Illinois law] does not give the independent reviewer a free-ranging power to construe contract terms, but instead, confines review to a single term: the phrase ‘medical necessity’[.]”¹⁶ The Court determined that the independent review required by the Illinois HMO Act “does not resemble either contract interpretation or evidentiary litigation before a neutral arbiter, as much as it looks like a practice (having nothing to do with arbitration) of obtaining another medical opinion.”¹⁷

The Court was also careful to emphasize that under the Illinois law, the independent reviewer was limited to consideration of what is medically necessary, a decision that it characterized as “heavily imbued with expert medical judgments.”¹⁸ The Court noted that its decision did not imply that states could require independent review of other terms of insurance contracts.¹⁹

Finally, the Court rejected the HMO’s argument that requiring it to submit medical necessity disputes to independent reviewers would impermissibly encroach on the discretion granted to the employee benefit plan administrator. An earlier Supreme Court case, *Firestone Tire & Rubber Co. v. Bruch*, held that if an employee benefit plan grants discretion to the plan administrator, the administrator’s decisions are subject to review only for abuse of that discretion.²⁰ In general, a court will overturn a plan administrator’s decision for abuse of discretion only if the decision is unreasonable, even if the court itself would have reached a different decision. *Rush Prudential* argued that by inserting an independent reviewer between the plan administrator and the participant, the grant of discretion to the plan administrator was ignored, and the abuse of discretion standard of review would no longer apply.²¹ The Court pointed out that ERISA does not require that administrators’ decisions be reviewed only for abuse of discretion, and characterized the Illinois law as merely prohibiting insurance contracts from giving plan administrators unfettered discretion as to decisions relating to medical necessity.²²

To summarize, the Court upheld the Illinois law because the independent review procedure it mandates is more like obtaining a second opinion than like arbitration; because after the independent review procedure is completed, the patient may only obtain the remedies provided by ERISA (i.e., the benefit under the plan); and because the independent reviewer’s scope is limited to medical necessity, which requires expert medical judgment.


Implications

Many states have laws requiring health insurers to submit disputes to external reviewers. Before the decision in *Rush Prudential HMO, Inc. v. Moran*, the enforceability of those statutes in relation to employee benefit plans was an open question. Now, there is some guidance that can be used to determine whether a particular external review statute is enforceable or is preempted by ERISA:

- What is the nature of the external review? Is it more like obtaining a second opinion (which is permitted) or more like arbitration (which is not permitted)?
- Does the state law create new rights or remedies for the insured that are not provided by ERISA? (If it creates new rights or remedies, it is probably preempted.)
- Does the state law apply only to insurers (so that it is permitted under the savings clause), or does it also apply to self-funded employee benefit plans (which may not be deemed to be in the business of insurance)?
- What is the subject matter of the external review? Is it a determination of what is medically necessary, or some other issue that requires the application of expert medical judgment (which is permitted), or is it something else (which is still an open question)?

On a practical level, the decision may result in higher costs for insurers and employee benefit plans that provide benefits through insurance products, as determinations of medical necessity may be taken out of the hands of the insurers. The decision may also result in primary care physicians having greater control over patient care decisions, if the outside reviewer agrees with the primary care physician.

Endnotes

1. D. Robert Enten and Christine Williams are members of the law firm of Gordon, Feinblatt, Rothman, Hoffberger and Hollander, LLC, located in Baltimore, Maryland.
 2. ___ U.S. ___, 122 S. Ct. 2151, 153 L. Ed. 2d 375, 2002 U.S. LEXIS 4644 (6/20/2002).
 3. 29 U.S.C. § 1001 *et seq.*
 4. Illinois Health Maintenance Organization Act, 215 Ill. Comp. Stat., ch. 125, § 4-10 (2000).
 5. 29 U.S.C. § 1144(a).
 6. 29 U.S.C. § 1144(b)(2)(A).
 7. 122 S. Ct. at 2159, 153 L. Ed. 2d at 389, 2002 U.S. LEXIS 4644 at *19, *quoting Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).
 8. 122 S. Ct. at 2160, 153 L. Ed. 2d at 390, 2002 U.S. LEXIS 4644 at *22.
 9. 122 S. Ct. at 2163, 153 L. Ed. 2d at 394, 2002 U.S. LEXIS 4644 at *33.
 10. 122 S. Ct. at 2164, 153 L. Ed. 2d at 394-95, 2002 U.S. LEXIS 4644 at *35.
 11. 122 S. Ct. at 2162 n.6, 153 L. Ed. 2d at 393 n.6, 2002 U.S. LEXIS 4644 at *30 n.6.
 12. Cf. *Rush Prudential HMO, Inc. v. Moran*, 230 F.3d 959 (7th Cir. 2000) (holding Illinois law not preempted) and *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F.3d 526 (5th Cir. 2000) (holding Texas law preempted).
 13. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987), *quoted by* 122 S. Ct. at 2165, 153 L. Ed. 2d at 396, 2002 U.S. LEXIS at 4644 *38.
 14. *Id.*
 15. 122 S. Ct. at 2167, 153 L. Ed. 2d at 398, 2002 U.S. LEXIS 4644 at *43.
 16. 122 S. Ct. at 2168, 153 L. Ed. 2d at 400, 2002 U.S. LEXIS 4644 at *47.
 17. 122 S. Ct. at 2169, 153 L. Ed. 2d at 400, 2002 U.S. LEXIS 4644 at *49.
 18. 122 S. Ct. at 2170 n.17, 153 L. Ed. 2d at 402 n.17, 2002 U.S. LEXIS 4644 at *54 n.17
 19. *Id.*
 20. 489 U.S. 101, 115 (1989).
 21. 122 S. Ct. at 2169, 153 L. Ed. 2d at 400-01, 2002 U.S. LEXIS 4644 at *50.
 22. 122 S. Ct. at 2170, 153 L. Ed. 2d at 402, 2002 U.S. LEXIS 4644 at *52. 
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