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Analysis & Perspective

The Effect of Rush Prudential v. Moran: A Review of Three State External Review Laws

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In June of this year, the Supreme Court issued *Rush Prudential HMO, Inc. v. Moran*[1] the latest in a recent string of ERISA [Employee Retirement Income Security Act] preemption decisions, this time addressing whether ERISA preempts state "external review laws." These laws, currently adopted in over 40 states,[2] are state-imposed procedures for resolving disputes between health plans and their enrollees over adverse benefit determinations. Health insurers and HMOs were keenly interested in the outcome of *Rush Prudential* because the rate that health plan denials are overturned by the external review process is nearly fifty percent.[3] Health plans, many of which operate throughout the country, were also concerned with the prospect of complying with a patchwork of different laws.

Rush Prudential did not resolve the preemption issue as cleanly as some may believe. Although the Court held that the particular Illinois external review law at issue was not preempted, the majority decision did not create a bright-line test for preemption. Instead, the decision is fact-bound, thereby creating the prospect of numerous new lawsuits to challenge various states' external review laws. This article discusses the external review laws of Maryland, Virginia, and the District of Columbia, and analyzes the extent to which, in light of *Rush Prudential*, those laws might be preempted by ERISA.

Overview of Rush Prudential Decision

The issue in *Rush Prudential* was whether ERISA preempts the Illinois external review law. The Illinois statute requires HMOs, for each denial based on the lack of medical necessity, to "provide a mechanism" for review by a physician "unaffiliated" with the HMO and "jointly selected" by the HMO and the patient.[4] If the external reviewer determines the service to be medically necessary, then the HMO is required to pay for the service.

The specific facts in the case were that Debra Moran, an enrollee in a Rush Prudential HMO, wished to have a special surgery on her shoulder. Rush Prudential denied her request, stating that the surgery was not medically necessary. Ms. Moran's request for external review under the Illinois law was denied by Rush Prudential. She sued in state court to compel Rush Prudential to provide the external review. Rush Prudential removed the action to federal court, but the action was remanded. While her lawsuit was pending, Ms. Moran underwent the surgery. The state court ultimately ordered Rush Prudential to permit the external review, and the physician conducting the review determined that the surgery was medically necessary. When Rush Prudential nonetheless refused to pay, Ms. Moran amended her complaint to seek reimbursement for the surgery. Rush Prudential again removed the action to federal court, which this time assumed jurisdiction. The district court ruled that ERISA preempts the Illinois external review law. The Seventh Circuit reversed and held that the law was "saved" from preemption as an insurance

regulation, under ERISA §514(b)(2)(A). In a five-to-four decision written by Justice Souter, the Supreme Court affirmed the Seventh Circuit. The Court applied a three-step analysis, essentially answering the following questions:

(1) Was the Illinois law preempted by ERISA as a law that "relates to" employee benefits plans?

(2) Was the law "saved" from preemption under ERISA as a law regulating insurance?

(3) If it was saved, was it nevertheless preempted under the principles articulated in *Pilot Life* as a law that supplements or supplants ERISA's remedial scheme?

Step 1: "Relates to" analysis. As an initial matter, the Court noted in a brief paragraph that it was beyond "serious dispute" that the Illinois law "relates to" employee benefits plans under ERISA's preemption provision, §514(a).[5]

Step 2: A law "regulating insurance." The Court then addressed whether the law was saved from preemption under ERISA §514(b)(2)(A) as one regulating insurance. It held that under the "common sense" test of *Metropolitan Life Insurance Co. v. Massachusetts*,[6] and utilizing the McCarran-Ferguson Act factors, the Illinois law did regulate insurance and therefore was "saved."[7] In applying these tests, the Court essentially looked first at whether the statute was aimed at the insurance industry and then at whether the law was an integral part of the insurance relationship with the enrollee.

The Court concluded that the law was aimed at the insurance industry. It disagreed with Rush Prudential's argument that a law regulating HMOs is not an insurance regulation within the meaning of ERISA because HMOs also provide health care. Although the Court agreed that HMOs are both providers and insurers, it was not persuaded that this meant the savings clause could not apply.

The Court also concluded that the law related to an integral part of the insurance relationship with the participant, primarily because the Court interpreted the Illinois law as requiring the independent reviewer to construe the terms in the insurance policy. It emphasized that the Illinois law added an extra layer of review when there is disagreement about an HMO's denial of coverage, and that the reviewer "applies both a standard of medical care ... and characteristically, as in this case, construes policy terms."[8] This review, according to the Court, affects the relationship between the insurer and insured because "the interpretation of insurance contracts is at the 'core' of the business of insurance."[9]

Although, based on this analysis, the Court concluded that the Illinois law regulated insurance and was saved under ERISA §514(b)(2)(A), it also noted that the Illinois law did not actually require the reviewer to refer to definitions of medical necessity contained in the contract. However, because the reviewer had done so, the Court assumed that "some degree of contract interpretation is required" by the law.[10]

It emphasized that "[w]ere no interpretation required, there would be a real question" as to whether the law would be saved under ERISA §514(b)(2)(A).[11]

Step 3: Pilot Life analysis. Finally, the Court reviewed whether the Illinois law, although "saved" from preemption, should nonetheless be preempted since it created an alternative remedy to those set forth in ERISA. In *Pilot Life Insurance Co. v. Dedeaux*,[12] the Supreme Court said that, even if state law claims brought against a plan could be characterized as laws that "regulated insurance" and thus be saved, they still might be preempted due to a conflict with the Congressional purpose that "the federal remedies provided by [ERISA] displace state causes of action."[13]

The Court held that because the Illinois law did not create a new cause of action under state law and did not authorize a new form of ultimate relief, it was consistent with ERISA's existing remedies.[14] The fact that an HMO may ultimately have to cover procedures previously determined to be deemed not medically

necessary was not a supplemental remedy; instead, "the relief ultimately available would still be what ERISA authorizes in a suit for benefits" - that is, the benefits themselves.[15]

The Court also carefully reviewed the Illinois law to ensure that it did not resemble an adjudication, such as an arbitration, which might fall within the realm of *Pilot Life* preemption. The Court was confident, however, that the Illinois external review law did not require a form of arbitration. Instead of an arbitration-like process, the Court viewed the Illinois law as simply requiring a physician to come to an independent professional judgment. This, the Court said, is closer to a state-mandated second opinion or a state-mandated benefit than to an arbitration.[16]

Framework for Analyzing State External Review Laws

Based on the *Rush Prudential* decision, there are several bases on which to challenge a state external review law.

First, does the state law provide remedies in addition to those provided in ERISA? If so, then even if it is saved, it will be preempted under the *Pilot Life* principles. Damages and penalties are an obvious remedy subject to such a challenge. In addition, mandatory fee shifting provisions might also be a problem, either because they are disguised penalties or because ERISA does not mandate (although it permits) the payment of attorney fees in litigation.

Second, does the review mechanism established by the state law resemble an adjudication (such as an arbitration) rather than something more akin to a "second opinion?" When the decision maker is an independent medical professional who brings his or her professional judgment to the matter, the process looks like a second opinion. If the decision maker instead is a state official who decides based on the evidence presented or generated, then the process looks less like a second opinion and more like an adjudication. Also, the process, as described in the state statute and regulations, may be more like an adjudication, for instance, with allocated burdens of proof.

Third, does the law require review and interpretation of the terms in the insurance contract? The Court suggested that if an external review law does not require such an interpretation, then the state law might not be one "regulating insurance," and therefore might not be saved.[17] Asserting this basis may be difficult, given that the Illinois law at issue in *Rush Prudential* did not require contract interpretation; yet, because the reviewer in that case *had* done so, the Court assumed that "some degree of contract interpretation" was required by the law.[18] Insurers will need to determine if this hinders their chances of succeeding in facial challenges to the law, as opposed to case-by-case lawsuits.

With this framework in mind, we now survey the external review laws in Maryland, the District of Columbia, and Virginia.

Maryland

Maryland's external review law is, of the three states, most susceptible to an ERISA preemption challenge.[19] It also has resulted in a relatively high rate of ruling against the insurer and ordering payment of previously denied benefits. For 2000, the external review process resulted in a sixty-seven percent overturn rate, and an additional six percent of benefits denials were modified.[20]

There are several potential issues with Maryland's law. One issue is that the law permits the state regulators to impose a penalty or fine.[21] The commissioner is given authority to impose penalties or fines when an insurer fails to provide coverage as specified in its insurance contracts. Such fines are in addition to the remedies otherwise available under ERISA. Under the *Pilot Life* step in the *Rush*

Prudential analysis, the prospect of the imposition of fines may make the Maryland law vulnerable to a preemption challenge.

In addition, and perhaps more important, the Maryland external review process looks less like the Illinois law's "second opinion" and more like an adjudication. The decision maker is not a medical professional exercising his or her professional judgment. The state insurance commissioner is the decision maker required by law to issue written final decisions on all appeals seeking external review.[22] While the commissioner "may seek" the advice of an independent review organization or a medical expert, the final decision, in the end, is issued by the commissioner.[23] In addition, the proceeding itself is described as an adjudication, with the insurer bearing the "burden of proof."[24] These factors could be sufficiently "adjudicatory" to distinguish the Maryland law from the Illinois law.

Finally, the Maryland law does not, on its face, require the insurance commissioner or any external review entity to interpret or review the relevant terms of the insurance contract. At the same time, the law does not prohibit such a review. Instead, the commissioner or external reviewer can "consider all of the facts of the case and any other evidence ... consider[ed] appropriate."[25] As discussed above, the Supreme Court assumed contract review was required by the Illinois law since, in the case before it, the external physician engaged in such a review. The lack of any contract interpretation occurring in a particular case may, under *Rush Prudential*, open the external review decision to preemption attack, given that insurance contract interpretation is, according to the Supreme Court, integral to the insurance relationship and thus integral to the determination of whether a law is an insurance regulation saved under ERISA.

Given these issues, it is not surprising that Maryland's law has already been subject to several challenges. Recently the Maryland federal district court dismissed two consolidated challenges to the state external review law by invoking the doctrine of abstention.[26] The federal court abstained because there are several cases pending in Maryland state courts involving the same parties raising similar preemption claims. Unless a different insurer or HMO brings a federal challenge, it is likely that in Maryland the state courts will determine the preemption issue in the first instance.[27]

District of Columbia

The District of Columbia's external review law is part of its "Health Benefits Plan Members Bill of Rights,"[28] but few people have invoked this right. In 2000, only three reviews were completed, and the insurer's determination was overturned in two of them.[29]

Insured persons in the District of Columbia may appeal an adverse coverage decision to the D.C. Department of Health.[30] The Department of Health then assigns the appeal to an independent review organization, which is required by law to consider medical records, practice guidelines issued by the federal government, national professional medical societies, boards, or associations, as well as "any applicable clinical protocols or practice guidelines developed by the insurer."[31] The Department of Health then forwards the independent reviewer's findings to the insurer and participant. The decision is non-binding on the parties and has no affect on any other legal cause of action.[32]

D.C.'s external review creates fewer preemption issues than does the Maryland law. The process looks more like the "second opinion" involved with the Illinois law than an adjudication (the reviewer is an independent professional, and the process is not particularly adjudicatory). There also are no fines or penalties that can be levied on the insurer, making the law less susceptible to challenge on a *Pilot Life* theory.

Perhaps one potential issue is that the law, on its face, does not require interpretation of the contract terms. It does, however, state that the reviewer must consider the insurer's clinical protocols or practice guidelines. Although this is not a requirement that the reviewer interpret the actual contract, it may come close, particularly if the independent reviewer actually does consider the contract terms when making a determination.

Virginia

At sixty percent, Virginia, like Maryland, has an above-average rate of overturned insurer benefits determinations.[33] Also like Maryland, Virginia's external review law is vulnerable to an ERISA preemption challenge.[34] The Virginia law provides that the decision maker is the commissioner of insurance - who is not bound by any independent review organization's opinion.[35] Again, this makes the law look less like a second opinion requirement and more like a supplementary - and thus preempted - adjudicatory or remedial process. Unlike Maryland, Virginia does not regulate which party has the "burden of proof" in the external review.

Although Virginia's external review law does not provide for penalties or fines, it does have a fee-shifting provision: if the commissioner overturns the insurer's benefits denial, then the insurer must pay fees that, in the commissioner's "sole discretion," cover the costs of the review.[36] This cost assessment could be preempted under a *Pilot Life* analysis. ERISA permits fee shifting, but unlike the Virginia law, does not mandate it. This could be a preempted "supplemental" remedy.

Finally, there is no issue with regard to the requirement that the reviewer interpret the contract. The Virginia statute specifically states that the reviewer should determine if the adverse benefits decision is, among other factors, "appropriate under the terms of the contract."

More to Come

While many may have thought that *Rush Prudential* paves the way for the operation of all state external review laws, that is not the case. *Rush Prudential* establishes standards that some states' laws, unlike Illinois's law, might not satisfy. Those that delegate decision-making authority to state officials, impose additional monetary penalties, and avoid contract interpretation create serious preemption issues. Insurers and HMOs in every state will need to consider how their state laws measure up to the *Rush Prudential* standards.

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[1] 122 S. Ct. 2151, 2002 U.S. LEXIS 4644 (2002).

[2] A state-by-state survey of external medical review laws, prepared by BNA's Health Law & Business Series editors, will be included in the December supplement to the Series.

[3] *See* K. Pollitz, *et al.*, "Assessing State External Review Programs and Effects of Pending Federal Patients' Rights Legislation," The Henry J. Kaiser Family Foundation, Rev. May 2002, p. v-vi, available at www.kff.org/content/2002/3221/externalreviewpart2rev.pdf [*hereinafter* "Kaiser Family Foundation Report"].

[4] 215 Ill. Comp. Stat., ch. 125, §4-10.

[5] 122 S. Ct. at 2159.

[6] 471 U.S. 724, 740 (1985).

[7] *Id.*

[8] 122 S. Ct. at 2163.

[9] *Id.*

[10] *Id.* at 2169 n.12.

[11] *Id.*

[12] 481 U.S. 41 (1987).

[13] *Id.* at 57.

[14] 122 S. Ct. at 2167.

[15] *Id.*

[16] *Id.* at 2169.

[17] *Id.* at n.12.

[18] *Id.*

[19] *See* Md. Code Ann. Ins. §15-10A-01 *et seq.*; Md. Regs. Code tit. 31, subtit. 10, chs. 18, 19.

[20] Kaiser Family Foundation Report, p. vi, Exh. A.

[21] Md. Code Ann. Ins. §15-10A-04(c).

[22] *Id.* §15-10A-04(a)(2).

[23] *Id.* §15-10A-03(d).

[24] *Id.* §15-10A-03(e)(1).

[25] *Id.* §15-10A-03(e)(2).

[26] *Larsen v. CIGNA Healthcare Mid-Atlantic, Inc.*, Civil Action Nos. WMN-02-155 & -280, 2002 U.S. Dist. LEXIS 16158 (D. Md. Aug. 2, 2002).

[27] *See Conn. Gen. Life Ins. Co. v. Md. Ins. Admin.*, No. 98 (Md., filed Nov. 7, 2001), *appealing Conn. Gen. Life Ins. Co. v. Md. Ins. Admin.,* No. 24-C-01-002387 AA (Cir. Ct. Baltimore City, filed May 11, 2001); *Conn. Gen. Life Ins. Co. v. Md. Ins. Admin.*, No. 24-C-02-000070 AA (Cir. Ct. Baltimore City, filed Jan. 8, 2002); *Conn. Gen. Life Ins. Co. v. Md. Ins. Admin.*, No. 24-C-02-000925 AA (Cir. Ct. Baltimore City, filed Feb. 21, 2002).

[28] *See* D.C. Code Ann. §44-301.01 *et seq.*; D.C. Mun. Regs. tit. 22, §22-600 *et seq.*

[29] Kaiser Family Foundation Report, p. vi, Exh. A.

[30] D.C. Code Ann. §44-301.07.

[31] *Id.* §44-301.07(d), (j).

[32] *Id.* §44-301.07(p).

[33] Kaiser Family Foundation Report, p. vi, Exh. A.

[34] *See* Va. Code Ann. §38.2-5900 *et seq.*; 14 Va. Admin. Code §5-215-10 *et seq.*

[35] *Id.* §38.2-5902(A).

[36] *Id.* §38.2-5902(D).