Tactical Self-Funded ERISA Employers Unnecessarily Threaten Employees' Right to an Independent Review of an HMO's Medical Necessity Determination with Preemption

L. Darnell Weeden

Follow this and additional works at: https://scholarship.law.stjohns.edu/lawreview

Recommended Citation

This Symposium is brought to you for free and open access by the Journals at St. John's Law Scholarship Repository. It has been accepted for inclusion in St. John's Law Review by an authorized editor of St. John's Law Scholarship Repository. For more information, please contact lasalar@stjohns.edu.
TACTICAL SELF-FUNDED ERISA EMPLOYERS UNNECESSARILY THREATEN EMPLOYEES’ RIGHT TO AN INDEPENDENT REVIEW OF AN HMO’S MEDICAL NECESSITY DETERMINATION WITH PREEMPTION

L. DARNELL WEEDEN†

INTRODUCTION

The issue presented is whether the recent Supreme Court decision in *Rush Prudential HMO, Inc. v. Moran*¹ allows states to grant a patient the right of external review on the issue of medical necessity under ERISA without the fear of preemption.² Prior to the Supreme Court’s decision in *Rush Prudential HMO, Inc.*, the Court of Appeals for the Fifth Circuit³ asserted that a state law granting a patient the right to external review of a denial of health benefits in an employer-sponsored plan was preempted by ERISA.⁴ The Supreme Court rejected the position

† Professor, Thurgood Marshall School of Law, Texas Southern University; B.A., J.D., University of Mississippi. I would like to thank Professor Tanya Kateri Hernandez of Rutgers Law School-Newark; Marva O. Coward, Public Services Coordinator Thurgood Marshall School of Law Library; and Julie Congress, Research Assistant at Thurgood Marshall School of Law, Class of 2004, for their valuable comments concerning earlier drafts of this Article.


² *Id.* at 2156.

³ *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526, 536 (5th Cir. 2000) (describing the Texas statute as “squarely within the ambit of ERISA’s preemptive reach”), *motion for panel rehearing and petition for rehearing en banc denied*, 220 F.3d 641, 645 (5th Cir. 2000), *vacated and remanded by Montemayor v. Corporate Health Ins.*, 122 S. Ct. 2617 (2002).

⁴ 29 U.S.C. § 1144(a) (2000). The statute provides in relevant part:
Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee.
taken by the Fifth Circuit. In this important decision, the Court adopted the assertion of the Court of Appeals for the Seventh Circuit by holding that section 4-10 of the Illinois Health Maintenance Organization Act providing an independent medical review of specific HMO's medical necessity decisions in an employer-sponsored health plan is not preempted under ERISA.

The basic legal right to have an independent third-party review a determination by an HMO that a claim is being denied because of the lack of medical necessity is a significant issue because at least forty states provide this right. The right to external review is a substantial federal issue for those patients who seek medical care under employer-sponsored ERISA employee benefit plans because of the implications of federal preemption. In *Rush Prudential HMO, Inc.*, the Supreme Court has taken a major step in giving states the right to expand a patient's right to independent external review on the question of medical necessity without fear of preemption by ERISA.

As a general rule, ERISA's deemer clause prohibits a state from applying its insurance regulations to self-funded plans. Part I of this Article presents the facts and procedural setting for the legal disputes addressed by the Supreme Court in *Rush Prudential HMO, Inc.* with a brief analysis of the Court's rationale for refusing to apply ERISA's preemptive arm. Part II of this Article presents an analysis of the Supreme Court's rationale for its decision in *Rush Prudential HMO, Inc.* Part III discusses why a state's medical necessity review insurance regulations must be protected from illusory ERISA self-funded

---

5 *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2158.
7 *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2156.
8 See *id.* at 2161.
10 See *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2156.
benefit plans. Part III examines whether the rationale of *Kentucky Ass'n of Health Plans v. Miller*\(^\text{1}\) allows a state to use medical necessity review insurance regulations to impose conditions on the right to insure ERISA self-funded benefit plans without violating the deemer clause.

**I. FACTUAL AND PROCEDURAL SETTING FOR THE LEGAL DISPUTES IN RUSH PRUDENTIAL HMO, INC. V. MORAN**

**A. Facts**

Rush Prudential HMO is a health maintenance organization (HMO)\(^\text{13}\) that enters into agreements offering medical services to employee benefit plans under ERISA.\(^\text{14}\) Debra Moran was an insured under Rush Prudential HMO's plan through her husband's employer.\(^\text{15}\) In 1996, Mrs. Moran underwent conservative treatments from her primary care physician, Dr. Arthur LaMarre. Moran's conservative treatment included physiotherapy for the pain and numbness existing in her right shoulder.\(^\text{16}\) In October of 1997, Rush Prudential was requested to approve Dr. LaMarre's proposal that another doctor not affiliated with Prudential, Dr. Julia Terzis, perform surgery on her shoulder.\(^\text{17}\) This procedure was considered an unconventional course of treatment. Rush Prudential

\(^{12}\) 123 S. Ct. 1471, 1476 (2003).

\(^{13}\) The definition of an HMO has been forced to evolve as quickly as the number of emerging applications. Traditionally, an HMO was defined as an entity that financed and delivered complete health care services to enrollees for a prepaid fee per enrollee. No longer, however, can an HMO be defined by prepaid financing. A contemporary definition acknowledges that an HMO is also a health plan that possesses primary care physicians as gatekeepers and shifts varying degrees of financial risk for medical expenses to providers. Subscribers who enroll in an HMO are generally restricted to utilizing the participating providers in order to receive full plan coverage. Jay M. Howard, *The Aftermath of HMO Insolvency: Considerations for Providers*, 4 ANNALS HEALTH L. 87, 89–90 (citing 42 U.S.C. § 300e (1988) and Peter R. Kongstvedt, *Glossary of Terms, Jargon, and Common Acronyms*, in THE MANAGED HEALTH CARE HANDBOOK 504 (Peter R. Kongstvedt ed., 2d ed. 1993)). The Illinois law describes 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.” 215 ILL. COMP. STAT. ANN. 125/1-2 (9) (West 2000).

\(^{14}\) *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2156.

\(^{15}\) Id.

\(^{16}\) Id.

\(^{17}\) See id.
determined that it was not a medical necessity and denied Mrs. Moran's request to pay for the surgery,\textsuperscript{18} despite her primary care physician's conclusion that the unconventional treatment by Dr. Terzis was in her best medical interest. Rush's denial of Moran's claim for payment for the unconventional surgery was not consistent with her primary care physician's recommendation that she have the surgery. Rush offered an alternative course of treatment that was considered the standard surgery for her condition.\textsuperscript{19} In January of 1998, Mrs. Moran requested in writing an independent medical review of her claim as provided for under section 4-10(a) of the Illinois HMO Act.\textsuperscript{20}

B. Procedural History

Rush refused to provide Mrs. Moran the requested independent review, and Mrs. Moran sued Rush Prudential HMO in state court under the Illinois HMO Act for its failure to grant her the requested independent review under the Act.\textsuperscript{21} Rush Prudential successfully removed Mrs. Moran's suit to federal district court on the ground that Illinois's HMO Act was preempted by ERISA.\textsuperscript{22} As she was awaiting the outcome of the litigation, Mrs. Moran had the surgery performed by Dr. Terzis, which she paid for herself, and presented a $94,841.27

\textsuperscript{18} See id.

\textsuperscript{19} See id.

\textsuperscript{20} See id.; see also 215 ILL. COMP. STAT. ANN. 125/4-10(a) (West 2000). The statute provides in relevant part:

\begin{quote}
Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure.
\end{quote}

\textit{Id.}

\textsuperscript{21} Rush Prudential HMO, Inc., 122 S. Ct. at 2156–57; see also 215 ILL. COMP. STAT. ANN. 125/4-10(a).

\textsuperscript{22} See Rush Prudential HMO, Inc., 122 S. Ct. at 2157.
repayment claim to Rush.  Rush handled the repayment claim as a converted request for benefits and started a new investigation to decide the coverage issue presented by Mrs. Moran’s repayment request. Three doctors with whom Rush conferred concluded that Mrs. Moran’s surgery was not medically necessary. In the meantime, Mrs. Moran persuaded the federal district court to send the case back to state court on the ground that her demand for independent review under section 4-10 did not involve an interpretation of the provisions of an ERISA plan.

Mrs. Moran’s claim was not so “completely preempted” as to authorize removal under 28 U.S.C. § 1441 because her request for a review was not considered by the federal court as a

23 Id.
24 Id.
25 Id.
27 See id. Specifically, the Moran court stated that

Debra C. Moran (“Moran”) filed a complaint for specific performance in the Circuit Court of Cook County against Rush Prudential HMO, Inc. (“Rush”). On January 26, 1998, Rush removed the case to federal court on the grounds that Moran’s state law claim was completely preempted by the Employee Retirement Income Security Act of 1974 (“ERISA”). Moran moves to remand this case to the Circuit Court of Cook County

The parties dispute whether section 4-10 of the HMO Act falls outside the scope of complete preemption through application of ERISA’s “savings clause.”

“...If a state law claim has been ‘displaced’ and therefore completely preempted by § 502(a), then a plaintiff’s state law claim is properly ‘recharacterized’ as one arising under federal law.”

Rush argues that Moran’s state-law claim cannot be resolved without interpreting plan language—specifically, the meaning of the plan exclusion for “Services or Supplies Not Medically Necessary.”

... Because Moran’s state-law claim can be resolved without interpreting a contract governed by federal law, her claim is not properly recharacterized as an ERISA claim.

... “[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law” because the federal law serves only as a defense to the state law claims.

Id. at *1–4 (quoting Rice v. Panchal, 65 F.3d 637, 640 (7th Cir. 1995)) (internal citations omitted) (alteration in original).
clarification of the conditions of the ERISA plan. The state court implemented the Illinois independent review law by requiring Rush to present Moran's claim to an independent doctor for review.

Dr. A. Lee Dellon, a reconstructive surgeon at Johns Hopkins Medical Center, was chosen to conduct the independent review. Dr. Dellon determined that Dr. Terzis's treatment and surgery were medically necessary under the definition of medical necessity contained in Rush's Certificate of Group Coverage and his own medical conclusion. Rush's medical director rejected Dellon's medical judgment that Mrs. Moran's surgery was medically necessary and disallowed her claim for a refund in January of 1999. Mrs. Moran amended her complaint in state court to ask for repayment for the surgery as "medically necessary" as provided in Illinois's HMO law, and Rush again removed to federal court, contending that Moran's revised complaint actually presented a claim for benefits provided under ERISA that were preempted by ERISA's civil enforcement terms. The federal district court considered Moran's claim as presenting a cause of action under ERISA and rejected her claim because the federal district court believed ERISA preempted the independent review provisions contained in the Illinois HMO Act. On appeal, the Seventh Circuit rejected the analysis of the

29 Id.
30 Id.
31 Id.
32 Id.
33 Id. at 2157-58.
34 Id. at 2158. The district court held that
Moran's summary judgment response first addresses this court's lack of jurisdiction over her claims because they are state law claims not preempted by ERISA.

...On March 22, 1999, this court denied Moran's motion to remand, finding her claim for reimbursement preempted by ERISA's civil enforcement policy in § 502(a). Section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Complete preemption under § 502(a) occurs when three factors are present: (1) the plaintiff is eligible to bring a claim under that section; (2) the plaintiff's state law cause of action falls within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the plaintiff's state law claim cannot be resolved without an interpretation of a contract
federal district court and reversed the decision.\textsuperscript{35} Although the
Seventh Circuit concluded that Moran's state law refund claim
was preempted by ERISA for the limited purpose of allowing the
case to remain in the federal district court, the Seventh Circuit
also rejected the district court's position that the substantive
prerequisites of Illinois's HMO Act were preempted under
ERISA.\textsuperscript{36} The Seventh Circuit stated that although ERISA
generally "preempts any state laws that 'relate to' employee
benefit plans" under the provisions contained in 29 U.S.C. §
1144(a), "state laws that regulat[e] insurance" are exempted
from preemption under 29 U.S.C. § 1144(b)(2)(A).\textsuperscript{37} Because the
Illinois HMO Act's independent review requirement was an
insurance regulation, it was exempted from ERISA preemption.\textsuperscript{38}
The Seventh Circuit did not accept the argument that Illinois's
independent review obligation represented a prohibited
"alternative remedy" under the Supreme Court's holding in \textit{Pilot
Life Insurance Co. v. Dedeaux}\textsuperscript{39} and highlighted the fact that
section 4-10 does not authorize any specific type of relief in state
courts as it relates to any ERISA health plan.\textsuperscript{40} According to the
Seventh Circuit, the decision of the independent reviewer under
the Illinois HMO Act is properly implemented in a cause of
action filed under ERISA's civil enforcement system.\textsuperscript{41} Because

\textsuperscript{35} See Rush Prudential HMO, Inc., 122 S. Ct. at 2158 (citing Moran v. Rush
Prudential HMO, Inc., 230 F.3d 959 (7th Cir. 2000)). The Seventh Circuit stated:
Illinois laws automatically are incorporated into all contracts of insurance
in that state. Thus, the provisions of § 4-10 of the HMO Act have been
incorporated into Ms. Moran's insurance contract. Therefore, the extent
and the enforceability of Ms. Moran's right to an independent review
necessarily requires an examination of the contract. Thus, Ms. Moran's
claims properly are recharacterized as claims for benefits under ERISA's
civil enforcement provision, § 502(a)(1)(B), and removal was proper.

\textsuperscript{36} See Rush Prudential HMO, Inc., 230 F.3d 959, 967 (7th Cir. 2000).

\textsuperscript{37} Id. (alteration in original).

\textsuperscript{38} Id. (citing Moran, 230 F.3d at 972 and UNUM Life Ins. Co. of America v.
Ward, 526 U.S. 358, 375–76 (1999)).


\textsuperscript{40} Rush Prudential HMO, Inc., 122 S. Ct. at 2158.

\textsuperscript{41} Id. (citing 29 U.S.C. § 1132(a) (2000) and Moran, 230 F.3d at 971).
the opinion was in disagreement with the Fifth Circuit's handling of a comparable provision of Texas law in Corporate Health Insurance, Inc. v. Texas Dep't of Insurance, the Supreme Court granted certiorari and affirmed the decision of the Seventh Circuit.

C. Analysis of the Supreme Court's Rationale in Rush Prudential HMO, Inc. v. Moran

Justice Souter, writing for the Court in Rush Prudential HMO, Inc., appeared to acknowledge that ERISA's statutory language is internally contrary because the "relate to" phrase can easily be interpreted to preempt all things related to an employee benefit plan. On the other hand, ERISA's saving clause appears to exempt from preemption any employee benefit plan that is related to an insurance plan regulated by the state. When ERISA's "relate to" language allows for an expansive use of preemption insurance companies, HMOs are able to reject an employee's claim for health benefits under ERISA plans without facing any litigation accountability as defendants under state insurance law because of an unintended use of the preemption rationale.

---

42 Corp. Health Ins., Inc. v. Texas Dep't of Ins., 215 F.3d 526 (5th Cir. 2000).
44 Id. at 2156.
45 Id. at 2158 (citing 29 U.S.C. § 1144(a)). 29 U.S.C. § 1144(a) states that [e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
46 Corporate Health Ins., Inc., 215 F.3d at 539; Weeden, supra note 9, at 231-33. The Fifth Circuit rejected the position that the mandatory provision of the Texas independent review law was saved from ERISA preemption under the savings clause. One major federal goal of the savings clause is to allow the states to continue to regulate the insurance industry under the McCarran-Ferguson Act. Under the Fifth Circuit's analysis, the Texas law providing for independent review of an HMO's medical necessity decision is an exception to ERISA's savings clause because otherwise saved provisions are preempted if they "conflict with a substantive provision of ERISA." Although the Fifth Circuit appears to concede that the Texas independent review law does not create a substantive cause of action for patients, it unfortunately applies Pilot Life's expansive "relate to" ERISA preemptive rationale to the procedural review issue presented in Corporate Health Ins. The Court in Pilot Life stated "that state laws related to ERISA may also fall under the saving
I agree with the observation made by one commentator that the Supreme Court historically refused to use ERISA's saving clause in an expansive manner to save a patient tort claim for denial of health benefits against an HMO from being preempted.\textsuperscript{47} The Supreme Court in \textit{Rush Prudential HMO, Inc.} \textsuperscript{48} used ERISA's saving clause for state insurance regulations\textsuperscript{49} to exclude the internal review of medical necessity disputes between a patient's primary care physician and the patient's HMO provider from ERISA's very destructive "relate to" preemptive clause. ERISA's "relate to" preemptive clause was very destructive to employee health care insurance benefits because it simply denied an ERISA claimant an effective state clause—was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law.\textsuperscript{47} The Fifth Circuit's reliance on \textit{Pilot Life} to support an ERISA "relate to" conflict-based preemption is misplaced because the Court in \textit{Pilot Life} refused to apply ERISA's savings clause to an employee's common law tort and contract claims because those claims simply did not regulate insurance under Mississippi law. \textit{Id.} (quoting Corp. Health Ins., Inc., 215 F.3d at 538 and Pilot Life v. Dedeaux, 481 U.S. 41, 57 (1987)).

\textsuperscript{47} Commentators have similarly remarked:

Notwithstanding the savings clause, the Supreme Court has interpreted the scope of ERISA's preemption to be quite broad. Thus, a person whose health insurance is provided as an employee benefit, and who seeks compensation for an improper denial of benefits, can only sue under ERISA's civil-enforcement provision. This provision only permits a claimant "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." A plaintiff forced to sue under ERISA cannot recover for consequential damages including pain, suffering, or even death. ERISA also bars the award of punitive damages.


\textsuperscript{49} See 29 U.S.C. \textsection 1144(b)(2)(A)–(B), (b)(4). Section 1144(b)(2)(A) states that: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." Section 1144(b)(2)(B) states in relevant part:

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. \textsection 1144(b)(2)(B). Section 1144(b)(4) states that "[s]ubsection (a) of this section shall not apply to any generally applicable criminal law of a State."
law method to hold the HMO accountable under state insurance law.\textsuperscript{50} I believe the "relate to" preemptive clause has been used unfairly by HMOs to deny patients their health care insurance benefits because their health coverage was provided by their employer as an employee insurance benefit under ERISA. I agree with those commentators who characterized the Supreme Court's opinion in \textit{Rush Prudential HMO, Inc.} as "the most important ERISA preemption case to ever" be decided by the Court.\textsuperscript{51} I consider the Supreme Court's decision in \textit{Rush Prudential HMO, Inc.}\textsuperscript{52} as a step in the right direction because the Court allows states to regulate HMOs under their insurance laws when the HMO has contracted to insure that patients filing a claim under an ERISA plan will receive needed medical treatment. The Court in \textit{Rush Prudential HMO, Inc.} was shrewd enough to tame, for now, the negative impact ERISA's preemptive "relate[s] to" rationale has on the ability of state insurance regulators to hold HMOs accountable for providing covered employee patients with quality health care treatments.\textsuperscript{53}

\textsuperscript{50} Silver, supra note 47, at 854. This commentator states: ERISA's preemption clause harms those patients who cannot hold their MCOs fully liable for negligent actions. The harm wrought by the statute, however, extends beyond those patients who seek tort recovery. ERISA's preemption provision reduces MCOs' financial incentives to provide quality care, thereby harming all MCO subscribers. Since the clause shields MCOs from complete accountability for their actions, MCOs are left with a relatively small financial incentive to maintain the quality of care at the optimal level. Yet MCOs have very strong financial incentive to cut costs at the expense of quality. This Note argues that in order to induce MCOs to provide the optimal level of care, they need to be made subject to tort liability to offset their incentives to eliminate costs.

\textit{Id.} (citations omitted).

\textsuperscript{51} Allen D. Allred & Don L. Daniel, \textit{Upon Further Review: Rush Prudential HMO, Inc. v. Moran and a New Era of Managed Care Organization Liability}, 47 ST. LOUIS U. L.J. 309, 319 (2003) ("The Rush case 'highlights the continuing struggle courts have in defining concise and predictable boundaries as to the scope of [ERISA] preemption of state laws,' and 'will encourage more state regulation and ... trigger lawsuits on how far states can go to protect patients from [adverse MCO benefit decisions].'")) (alterations in original) (citations omitted).

\textsuperscript{52} \textit{Rush Prudential HMO, Inc.}, 122 S. Ct. at 2151.

\textsuperscript{53} \textit{Id.} at 2159. The Eastern District of Pennsylvania stated: District courts in the Eastern District of Pennsylvania have consistently held that Pennsylvania's bad faith statute is preempted by ERISA. However, in a very recent Eastern District opinion, the Honorable Judge Newcomer re-examined this issue in light of a "new trend in the federal law" established by two recent United States Supreme Court decisions, \textit{Rush Prudential HMO, Inc. v Moran}, 122 S. Ct. 2151 (2002) and \textit{UNUM Life Ins. Co. of Am. v Ward}, 526 U.S. 358 (1999). Judge Newcomer held
The *Rush Prudential HMO, Inc.* Court conceded, without meaningful debate, that section 4-10 of the Illinois HMO law related to an employee benefit plan under 29 U.S.C. § 1144(a) because the state law obliged every insured benefit plan to provide for review of specific benefit rejections if benefit plans buy medical coverage from HMOs covered by the Illinois law. The Supreme Court simply stated that not every state law that relates to an employee benefit plan is preempted by ERISA because Congress has exempted from ERISA's preemptive grasp employer-sponsored benefit plans that are insurance contracts.

---

that Pennsylvania's bad faith statute is not preempted by ERISA as it falls under ERISA's savings clause.


In order for a state law to regulate insurance from a common-sense view of the matter, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." The plain language of Pennsylvania's bad faith statute suggests that the state law 'regulates insurance' because § 8371 is applicable only to insurers in actions arising under an insurance policy. In addition, this statute is never applied outside the insurance industry. Therefore, Pennsylvania's bad faith statute appears to satisfy the common-sense view of a state law that regulates insurance.


That statute provides:

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.


See *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2159; see also 15 U.S.C. § 1012(b). That statute states:

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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b)

See *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2159–60; see also 29 U.S.C. § 1144(b)(2)(A) "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which
In a pragmatic analysis of the dispute presented in Rush Prudential HMO, Inc., the Supreme Court rejected Rush’s one-dimensional contention that it was not an insurer under the Illinois HMO law because its predominant role was to serve as a health care provider. The Court appropriately rejected Rush’s contention that it was not an insurer under the Illinois HMO law by applying a common sense understanding of insurance law to key aspects of its McCarran-Ferguson test. Under a multidimensional common sense examination of the typical agreement between an HMO and its policyholder, the agreement contains “elements of an insurance contract” because the HMO is “‘spreading and underwriting... a policyholder’s risk.” The Supreme Court correctly approves of the Illinois HMO law as regulating insurance because the law describes an HMO as an organization that “provide[s] or arrange[s] for... health care plans” in a scheme where the organization assumes the risk of delivering health care to covered policyholders. Rush argued before the Supreme Court that it could not be acting as an insurer under the ERISA saving clause because of its role as a health care provider. In response, the Supreme Court gave

regulates insurance, banking, or securities.”).

57 Rush Prudential HMO, Inc., 122 S. Ct. at 2160.
58 See id. at 2159 (“In Metropolitan Life, we said that in deciding whether a law ‘regulates insurance’ under ERISA’s saving clause, we start with a ‘common-sense view of the matter,’ under which ‘a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.’” (quoting Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985) and Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 50 (1987))).
59 See id. (“[I]t 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 insurances practices, the state law survives ERISA.”).
60 Id. (quoting Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979)).
61 Id. (quoting Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979)).
62 Id. (alterations in original) (citation omitted).
63 See id.
64 Id. at 2160. The Supreme Court responded:
The answer to Rush is, of course, that an HMO is both: it provides health care, and it does so as an insurer. 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 saving clause may apply. There is no serious question about that here, for it would ignore the whole purpose of the HMO-style of organization to conceive of HMOs (even in the traditional
Rush and the HMO industry a reality check by advising them of the obvious fact that they assumed the risk of losing money and that historically Congress has viewed the HMO health care delivery method as a structure for insurers.65

I believe the Supreme Court's rationale in *Rush Prudential HMO, Inc.* that an HMO cannot avoid common sense by totally denying its insurance obligation to its policyholders/employees66 is helpful to state insurance regulators67 who want to protect their working class employees68 from HMOs that deny

---

65 *Rush Prudential HMO, Inc.*, 122 S. Ct. at 2161. Here, the Court found: [O]ne year before it passed ERISA, Congress itself defined HMOs in part by reference to risk, set minimum standards for managing the risk, showed awareness that States regulated HMOs as insurers, and compared HMOs to “indemnity or service benefits insurance plans.”

This conception has not changed in the intervening years. Since passage of the federal Act, States have been adopting their own HMO enabling Acts, and today, at least 40 of them, including Illinois, regulate HMOs primarily through the States’ insurance departments ... although they may be treated differently from traditional insurers, owing to their additional role as health care providers ... . Finally, this view shared by Congress and the States has passed into common understanding.

66 *Id.* at 2162 (“Rush cannot checkmate common sense by trying to submerge HMOs’ insurance features beneath an exclusive characterization of HMOs as providers of health care.”).

67 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, 1 (2002). The authors discussed:

Several states have recently enacted health care liability laws establishing statutory causes of action against health care service plans and managed care entities. These statutes employ various approaches and utilize differing language in an effort to avoid Employee Retirement Income Security Act of 1974 (“ERISA”) preemption of state laws relating to employee benefit plans.

68 See L. Darnell Weeden, An HMO Does Not Owe an ERISA Fiduciary Duty to Its Employee Beneficiaries: After Pegram v. Herdrich, Who Will Speak for the
policyholders a meaningful opportunity to challenge a broad range of issues related to the quality of healthcare provided.\(^6\) Although *Rush Prudential HMO, Inc.* is accommodating to state insurance regulators wanting to provide additional rights to patients seeking healthcare from an HMO under an ERISA plan, the decision raises new issues about whether a state as an insurance regulator may provide traditional judicial remedies to patients who have received negligent or inadequate medical care from the HMO where the HMO's profit motive as an insurer is the proximate cause of the HMO's negligent behavior as a health care provider.\(^7\) Some commentators argue that the holding of *Rush Prudential HMO, Inc.* generally prohibits states from expanding patients' judicial rights in the name of insurance regulations because to do so would defy ERISA's preemptive rationale by providing a patient with an independent alternative

\(^{69}\) Cf. Humiston et al., supra note 67, at 6–7. The authors found: The Supreme Court's ruling in *Rush Prudential* did not address the quality/quantity distinction because this issue was not central to the review law conflict that resulted in the court considering this case. Nevertheless, the Supreme Court's reasoning in *Rush Prudential* is consistent with the quality/quantity distinction because the court determined that the plaintiff's claims amounted to a basic coverage dispute and that the state independent physician review law was subsumed into the ERISA plan by operation of law. Therefore, in the wake of *Rush Prudential*, the quality/quantity distinction continues to remain a viable tool for the evaluation of state laws that attempt to encroach on the exclusivity of ERISA's civil enforcement scheme for the foreseeable future.

\(^{70}\) See Gregory Pimstone & Michele Johnson, *Rush Prudential: Savior of Pilot Life?*, 15 HEALTH LAW. 7, 8 (2002). Pimstone and Johnson discussed the Supreme Court's finding in *Rush Prudential HMO, Inc.*:

While the primary focus in *Rush Prudential* was the Court's controversial finding that the state-law provision at issue—a provision of the Illinois HMO Act mandating an independent medical review that is binding on the HMO—did not constitute a state law enforcement mechanism alternative to ERISA, the Court quietly dispensed with the notion that Pilot Life was dead. Even while it upheld the state provision at issue, the Court confirmed that state bad-faith law, as well as other state laws that seek to create judicial remedies outside those provided under ERISA, remain preempted under Pilot Life—even when they are aimed directly at HMOs or insurers.

\(^{Id.}\) at 8.
remedy in violation of the exclusive remedy requirements of *Pilot Life*.\(^7\) Miles J. Zaremski correctly suggests that the *Rush Prudential HMO, Inc.* and *Pegram v. Herdrich* rationales allow a state to expand a patient's rights against an HMO because states traditionally regulate insurance and the quality of treatment patients receive from healthcare providers.\(^7\)

\(^7\) See id. The authors, Pimstone and Johnson, argued: The Court repeatedly cited to the bad-faith claim in *Pilot Life* as an example of state law that impermissibly invaded ERISA's civil enforcement scheme and, as if to underscore its point, observed that even if the state-law claims in *Pilot Life* "could have been characterized as the products of 'insurance regulation', they nonetheless would have significantly expanded the potential scope of ultimate liability imposed on employers by the ERISA scheme." 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. The Supreme Court in *Rush* underscored the "overpowering federal policy of exclusivity in ERISA's civil enforcement provisions."

*Id.* (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 41–42 (1987)).


"Two final comments here. First, some observers would say the Supreme Court, in *Rush Prudential*, has announced that damages, in whatever context they are raised, are limited to the cost of the benefit denied when a beneficiary disputes a decision of a plan based upon denial of care, in turn based upon whether that care is medically necessary. After all, we now know, these observers would further say that this type damage, once only enforceable in an action brought under ERISA's civil enforcement scheme, still can be pursued only in federal court under ERISA with the same damage cap. This is making pronouncements with blinders affixed.

The *Rush Prudential* decision is a benefits case; it is that simple. When a beneficiary of a plan wants his or her treatment covered, without claiming any further damages, then the relief now could arguably be found under state law in a state court providing for independent reviews of health plan decisions premised on medical necessity. That is, what the Court arguably does, in a practical sense, is perhaps suggest a shifting of forums for resolution of a benefits claim involving an independent reviewer's determination from federal court under ERISA to state court for violation of an independent reviewer statute (again, should the reviewer decide against the HMO and the HMO does not wish to follow the decision of the independent reviewer). Others, perhaps, would differ here, opining that, where federal courts have, at a minimum, concurrent jurisdiction with state courts, the ultimate arbiter for benefits even based upon a state statute that has been violated remains federal court under ERISA. Nonetheless, a beneficiary knows that, regardless of the forum used, an independent review provided by state statute cannot be preempted by ERISA, and that deference will not be given to how plan documents define
In *Rush Prudential HMO, Inc.* the Supreme Court stated that under ERISA law, the civil enforcement provisions of 29 U.S.C. § 1132(a)\(^7\) may demonstrate a congressional intent that supersedes a federal law aimed at preventing state insurance law from being preempted.\(^7\) According to the Supreme Court, a state law necessarily conflicts with the enforcement provisions of 29 U.S.C. § 1132(a) by making available a forbidden "form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA."\(^7\) In *Rush Prudential HMO, Inc.*, the state regulatory system did not violate the enforcement provisions because it did not create a "new cause of action under state law," and thus section 4-10 did not allow a new type of eventual remedy.\(^7\) Although independent review under section 4-10 could resolve the status of a benefit claim involving a specific insurance contract, the Illinois law does not expand the claim outside of the benefits presented in a lawsuit filed under section 1132(a).\(^7\) Even if the reviewer's judgment is substituted for the HMO's concerning what is "medically necessary" under the insurance contract, the remedy ultimately available is permitted by ERISA in a federal court case claiming benefits under section 1132(a).\(^7\) The Illinois HMO law section 4-10 is "medical necessity." In possibly allowing for this, the Court affirms the precept that the area of health law is traditionally venued within the states.\(^7\)

\(^7\) See *Rush Prudential HMO, Inc.* v. Moran, 122 S. Ct. 2151, 2164 n.7 (2002) ("Title 29 U.S.C. § 1132(a) provides in relevant part: A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section . . . or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .")

\(^7\) The Supreme Court has held that "the civil enforcement provisions are of such extraordinarily preemptive power that they override even the 'well-pleaded complaint' rule for establishing the conditions under which a cause of action may be removed to a federal forum." Id. at 2165 (citing *Metro. Life Ins. Co.* v. *Taylor*, 481 U.S. 59, 63–64 (1987)). The Court noted in *Metropolitan Life* "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." Id. at 2166 (citations omitted).

\(^7\) Id. at 2166.

\(^7\) Id. at 2167.

\(^7\) Id.

\(^7\) Id. The Court wrote:

This case therefore does not involve the sort of additional claim or remedy exemplified in *Pilot Life*, *Russell*, and *Ingersoll-Rand*, but instead bears a resemblance to the claims-procedure rule that we sustained in *UNUM Life*
reasonably accommodated by the federal civil enforcement provisions contained in § 1132(a) because reviewing insurance decisions about what is "medically necessary" is likely inseparable from enforcing indispensable state-law regulations which ensure reasonable medical care.79 In affirming the lower court's judgment, the Supreme Court held that because Illinois law provides the right to review medical necessity disputes between the claimant and the HMO, the civil enforcement goals of section 1132(a), ERISA's saving clause, were not undercut. The Court further stated that because section 1132(a) was applicable, it followed that section 4-10 of the Illinois HMO law was valid.80

II. A STATE'S "MEDICAL NECESSITY" REVIEW INSURANCE REGULATION MUST BE PROTECTED FROM ILLUSORY ERISA SELF-FUNDED BENEFIT PLANS

One reviewer of leading cases states that the Court's opinion in Rush Prudential HMO, Inc. will clearly encourage states to expand their regulation of HMOs, thereby increasing regulation costs.81 This view is contrasted by the argument that Rush Prudential HMO, Inc. was a mixed blessing for state insurance regulators wanting to invoke more costly regulations to protect a

Ins. Co. of America v. Ward, 526 U.S. 358 (1999), holding that a state law barring enforcement of a policy's time limitation on submitting claims did not conflict with § 1132(a), even though the state "rule of decision," could mean the difference between success and failure for a beneficiary. The procedure provided by § 4-10 does not fall within Pilot Life's categorical preemption.

Id. (citations omitted). 79 See id. at 2171.
80 See id.

This expanded definition of insurance regulation has an important, concrete result: substantive regulation of the contractual relationship between HMOs and their providers—the mechanism HMOs use to control costs—now likely qualifies as insurance regulation under ERISA's savings clause. For instance, "any willing provider" (AWP) state statutes, which require an HMO to contract with any provider that agrees to comply with the HMO's terms, are probably insurance regulations not preempted by ERISA—an issue that had split the circuits before Moran and on which the Supreme Court has granted certiorari for argument this Term.

Id. at 417–18. In Kentucky Ass'n of Health Plans v. Miller, 123 S. Ct. 1471, 1479 (2003), the Supreme Court held that Kentucky's AWP statutes were valid insurance regulations and were not preempted by ERISA.
patient's right to adequate medical treatment without any undue interference from the HMO. 82 Nevertheless, if the Rush Prudential HMO, Inc. decision's regulatory power increases costs to employers, this may lead some employers to change to unfunded employee benefit plans to avoid ERISA's insurance saving clause. 83 An employer may be motivated to change "because the insurance savings clause applies only to 'funded,' or 'insured,' employee welfare benefit plans." 84 The Court observed in Rush Prudential HMO, Inc. that "ERISA's 'deemer' clause provides an exception to its saving clause that forbids States from regulating self-funded plans as insurers." 85

In my opinion an allegedly self-funded ERISA employer who purchases any amount of reinsurance to mitigate its healthcare losses runs the risk of being converted into an insurer under the ERISA saving clause. I believe an ERISA employer should not be allowed to take advantage of ERISA's deemer clause for self-funded healthcare plans when there is objective evidence that the employer is self-funded in name only because the employer has actually purchased reinsurance to cover its healthcare liabilities.

Funded benefit plans pay for promised health care benefits by contracting with a health insurer—for example, a fee-for-service provider such as Blue-Cross/Blue-Shield, or a managed care organization, such as an HMO . . . to pay the benefits. In a self-funded plan, the employer itself pays the promised benefits. 86

When an ERISA self-funded plan 87 breaches its promise to pay an employee from its own funds by seeking reinsurance to

82 See Leading Cases, supra note 81, at 421.
83 Id.
84 Id. This commentator remarked:
Thus, the Court's decision may actually decrease the number of employee benefit plans subject to state health regulation. Unfunded plans are only lightly regulated because of ERISA's broad preemptive reach and corresponding lack of substantive health plan regulation. And employers can mitigate the financial risks of offering unfunded employee benefit plans by either purchasing reinsurance and contracting with insurance companies to perform the administrative tasks or, for large employers, by spreading risk among their own employees.

Id. (citations omitted)
86 Leading Cases, supra note 81, at 421.
87 See id. at 421 n.59. "These labels are imprecise because self-funded/insured
mitigate against any losses incurred by a self-funded promise to pay, that breach should disqualify the pretextual self-funded employer from ERISA's deemer clause. I think when an allegedly self-funded insurance plan under ERISA functions as a well-designed, de facto stop loss insurance plan, ERISA's savings clause and not its deemer clause should apply. The *Rush Prudential HMO, Inc.* Court found that "primary insurers . . . usually purchase insurance to cover a portion of the risk they assume from the consumer." When a pretextual self-funded ERISA employer functions like a primary insurer in covering its employees' healthcare benefits by purchasing insurance to cover its ERISA plan's risk of loss, it should no longer be deemed a self-funded ERISA employer under ERISA's deemer clause.

Congress intended that HMOs be risk-bearing organizations controlled by state insurance law. Therefore, a state law that "defines HMOs by reference to risk-bearing . . . is a law 'directed toward' the insurance industry . . . under a 'commonsense' view" and the McCarran-Ferguson factors. In *Pilot Life v. Dedeaux* the Court identified three factors to consider in deciding whether the ERISA savings clause applies to a specific practice in the "'business of insurance' for purposes of the McCarran-Ferguson Act." Under the first factor, a court must determine "whether the practice has the effect of transferring or spreading a

---


89 See id. at 2162 n.6.

90 *Id.* at 2163. The Supreme Court has stated:

[I]n deciding whether a law "regulates insurance" under ERISA's saving clause, we start with a "commonsense view of the matter," under which "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." We then test the results of the commonsense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act. Although this is not the place to plot the exact perimeter of the saving clause, it is generally fair to think of the combined "commonsense" 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.


policyholder’s risk.” The second factor requires a court to decide “whether the practice is an integral part of the policy relationship between the insurer and the insured.” Lastly, the third factor explores “whether the practice is limited to entities within the insurance industry.” Writing for the Court, Justice Souter stated that application of the second and third McCarran-Ferguson factors supported the Court’s application of the savings clause because the independent review obligation under the Illinois HMO law “regulates an integral part of the policy relationship between the insured” and because the Illinois law “regulates [the] application of HMO contracts” by granting the insured a review of a rejected claim.

The Supreme Court in Rush Prudential HMO, Inc. correctly rejected Rush’s contention that an HMO ceases to be an insurer when it puts together a strategy to limit or eliminate the level of its exposure to potential risk by contracting with third-party insurers. I take the position that an ERISA employer who alleges that it operates a self-funded plan but designs a scheme to contract with a third-party insurer to limit or eliminate the exposure of its self-funded plan has only created an illusory self-funded plan. I define illusory ERISA self-funded plans as those plans where the alleged self-funded ERISA plans have actually

---

92 Id.
93 Id. at 48–49.
94 Id. at 49.
95 Rush Prudential HMO, Inc., 122 S. Ct. at 2163. Here, the court stated: Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption and so we follow our precedent and leave open whether the review mandated here may be described as going to a practice that “spread[s] a policyholder’s risk.” For in any event, the second and third factors are clearly satisfied by § 4-10.

Id. (citations omitted).
96 Id.
97 Id. at 2164.
98 Id.
99 Id. at 2162. The Court further explained: These arguments, however, are built on unsound assumptions. Rush’s first contention assumes that an HMO is no longer an insurer when it arranges to limit its exposure, as when an HMO arranges for capitated contracts to compensate its affiliated physicians with a set fee for each HMO patient regardless of the treatment provided. Under such an arrangement, Rush claims, the risk is not borne by the HMO at all. In a similar vein, Rush points out that HMOs may contract with third-party insurers to protect themselves against large claims.

Id.
assigned either all or some of the risk of providing an employee healthcare benefit to a third party. In my opinion, under the Court's rationale in Rush Prudential HMO, Inc., nothing prohibits "applying the saving clause" to an illusory self-funded ERISA plan where the employer has actually prearranged for any part of the risk of providing the healthcare benefit to its employees to a third party.\textsuperscript{100} The Court suggested that the saving clause may apply to a state law description of an HMO that includes a contractor that only provided administrative services for a self-funded plan.\textsuperscript{101} The Court's suggestion lends support to my theory that an insurer or HMO that provides any risk of loss to an illusory self-funded plan establishes that the risk spreading self-funded plan is not entitled to be exempted from insurance regulations under ERISA's deemer clause.\textsuperscript{102} The mere possibility of some overbreadth in the application of ERISA's deemer clause to an illusory self-insured fund that has actually purchased insurance to cover its risks of health benefits to its employees fails to demonstrate that Congress intended such an incidental "application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption."\textsuperscript{103}

The federal statutory deemer clause was intended to focus directly upon the specific practice of excluding a self-funded plan from being regulated as insurance by state law because under a true self-funded plan there is no "relation of insured to insurer"\textsuperscript{104} to impact, as the uninsured self-funded plan assumes, all the risks of providing ERISA benefits.\textsuperscript{105} When the illusory self-funded plan attains insurance coverage to protect itself against potential losses, it "also affects the relation of insured to insurer and the spreading of risk—matters that [the] Court, in other contexts, has placed at the core of the McCarran-Ferguson Act's"\textsuperscript{106} anti-preemption savings clause rationale. One

\begin{footnotes}
\item[100] Id.
\item[101] See id. ("Nor do we see anything standing in the way of applying the saving clause if we assume that the general state definition of HMO would include a contractor that provides only administrative services for a self-funded plan.").
\item[102] Id.
\item[103] See id. at 2163.
\item[105] Id.
\item[106] Id.
\end{footnotes}
commentator has accurately described alleged self-funded plans as “functional insurers.”\textsuperscript{107} I believe that when illusory self-funded plans actually function as insurers, they lose the right to assert deemer clause preemption because Congress did not intend for an illusory self-funded plan to take advantage of a deemer clause designed to protect the true self-funded plan from state insurance regulation.\textsuperscript{108} In \textit{FMC Corporation v. Holliday}, the Court decided that ERISA preempted a Pennsylvania law prohibiting employee welfare benefit plans from implementing subrogation rights involving a tort claim.\textsuperscript{109} Justice O'Connor, speaking for the Court, stated that “[t]he Plan is self-funded; it does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.”\textsuperscript{110} I believe the logical deduction from Justice O'Connor's statement is that an illusory self-funded plan that purchases an insurance policy to cover its obligations to plan participants ceases to be a self-funded plan under ERISA's deemer clause and is not entitled to preemption.\textsuperscript{111} An employer who claims that his plan is a self-funded plan but actually purchases insurance to cover his potential ERISA plan benefit losses should be “subject to indirect state insurance regulation”\textsuperscript{112} that normally applies to insured plans. The real issue is whether Congress intended to allow a pretextual self-funded plan that actually purchases insurance to mitigate against ERISA's healthcare benefit claims to invoke preemption under a deemer clause intended for de facto self-funded plans.\textsuperscript{113} I think Congress did not intend to

\textsuperscript{107} See \text{Leading Cases}, \textsuperscript{supra} note 81, at 421 n.59.


\textsuperscript{110} \textit{Id.} at 54.

\textsuperscript{111} \textit{Id.} at 54.

\textsuperscript{112} \textit{Id.} The Court stated:

An insurance company that insures a plan remains an insurer for purposes of state laws “purporting to regulate insurance” after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.\textit{Id.} at 61.

\textsuperscript{113} \textit{Id.}

\textsuperscript{114} \textit{Id.} Justice O'Connor reasoned:

We read the deemer clause to exempt self-funded ERISA plans from state laws that “regulat[e] insurance” within the meaning of the saving clause... [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation “relate[s] to” the plans. State laws directed
permit self-funded ERISA benefit plans that fail the self-funded duck test because the employer actually purchased insurance to cover its ERISA benefit losses to invoke preemption under ERISA's deemer clause.\textsuperscript{114} I take the position that once the employer of an historically self-funded plan purchases stop-loss insurance to cover its ERISA benefits for employees, it should be considered as an insured plan because the state may engage in the “regulation of the substantive terms of insurance contracts”\textsuperscript{115} under the rationale of ERISA's saving clause.

In a dissenting opinion in \textit{FMC Corporation}, Justice Stevens properly asserted that “[f]rom the standpoint of the beneficiaries of ERISA plans—who after all are the primary beneficiaries of the entire statutory program—there is no apparent reason for treating self-insured plans differently from insured plans.”\textsuperscript{116} There is no perceivable basis for a court to believe that Congress rationally intended that an illusory self-insurance plan where the employer actually buys insurance to diminish future ERISA health benefit losses could escape the reach of the saving clause.\textsuperscript{117} I agree with Justice Stevens's inference that a narrow

\textsuperscript{115} \textit{See} \textit{FMC Corp.}, 498 U.S. at 62 (citing \textit{Metro. Life Ins. Co. v. Massachusetts}, 471 U.S. 724, 742–44 (1985)).
\textsuperscript{116} \textit{Id.} at 66 (Stevens, J., dissenting).
\textsuperscript{117} \textit{Id.} (Stevens, J., dissenting).

Why should a self-insured plan have a right to enforce a subrogation clause against an injured employee while an insured plan may not? The notion that this disparate treatment of similarly situated beneficiaries is somehow supported by an interest in uniformity is singularly unpersuasive. If Congress had intended such an irrational result, surely it would have expressed it in straightforward English. At least one would expect that the reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation.

The Court's anomalous result would be avoided by a correct and narrower reading of either the basic pre-emption clause or the deemer clause.

The Court has endorsed an unnecessarily broad reading of the words “relate to any employee benefit plan” as they are used in the basic pre-emption clause of § 514(a).
and plain reading of the deemer clause leads to the unremarkable conclusion that the clause prohibits a state from regulating contracts by deeming a self-funded uninsured ERISA plan without the benefit of stop-loss coverage to be an insurance entity.\textsuperscript{118} It is true that a self-funded uninsured ERISA plan is not deemed to be subject to state insurance regulations.\textsuperscript{119} It is also equally true that the deemer clause does not address a situation of whether the employer sponsor of an illusory self-funded plan that actually secures an insurance contract to cover its potential ERISA plan benefits liability must comply with an insurance law granting a patient a right to review certain medical necessity decisions.\textsuperscript{120} In Rush Prudential HMO, Inc., I believe the Court narrowed the reach of ERISA’s “relate to” phrase while saving a state law granting a patient’s right of external review on the issue of medical necessity from preemption.\textsuperscript{121} Even under a generous construction of the “relate to” phrase in ERISA’s central pre-emption clause, the response to the query of whether an illusory self-funded plan covered against ERISA benefit losses by an employer’s insurance policy “must comply with state laws regulating” insurance contracts “depends on the scope of the saving clause.”\textsuperscript{122} According to Justice Stevens, the class of state laws depicted in the saving clause is more expansive than the type of laws explained within the deemer clause.\textsuperscript{123} Justice Stevens also stated:

While the saving clause thus exempts from the pre-emption clause all state laws that have the broad effect of regulating insurance, the deemer clause simply allows pre-emption of those state laws that expressly regulate insurance and that would therefore be applicable to ERISA plans only if States were allowed to deem such plans to be insurance companies.\textsuperscript{124}

\textit{Id.} (Stevens, J., dissenting).
\textsuperscript{118} \textit{See id. at} 70 (Stevens, J., dissenting).
\textsuperscript{119} \textit{See id.} (Stevens, J., dissenting).
\textsuperscript{120} \textit{See id.} (Stevens, J., dissenting).
\textsuperscript{122} \textit{FMC Corp.}, 498 U.S. at 71 (Stevens, J., dissenting) (citing 29 U.S.C. § 1144(b)(2)(A) (2000)). Section 1144(b)(2)(A) provides: “Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”
\textsuperscript{123} \textit{FMC Corp.}, 498 U.S. at 71 (Stevens, J., dissenting).
\textsuperscript{124} \textit{Id.} (Stevens, J., dissenting).
In my opinion, a state law mandating HMOs to grant an independent review of medical necessity disputes under an ERISA plan "fits into the broader category of state laws that fall within the saving clause"125 if an employer for an alleged self-funded plan actually purchases an insurance contract to cover any self-funded plan welfare benefit losses.126

III. THE RATIONALE OF KENTUCKY ASS'N OF HEALTH PLANS V. MILLER ALLOWS A STATE TO USE MEDICAL NecessITY REVIEW INSURANCE REGULATIONS TO IMPOSE CONDITIONS ON THE RIGHT TO INSURE ERISA SELF-FUNDED BENEFIT PLANS WITH STOP-LOSS COVERAGE

Unlike some commentators,127 I believe ERISA's anti-preemption saving clause should apply whenever an employer buys a stop-loss128 insurance policy to limit the employer's

125 Id. at 72 (Stevens, J., dissenting).
126 See id. (Stevens, J., dissenting). On this point, Justice Stevens stated: Pennsylvania's Motor Vehicle Financial Responsibility Law fits into the broader category of state laws that fall within the saving clause only. The Act regulates persons in addition to insurance companies and affects subrogation and indemnity agreements that are not necessarily insurance contracts. Yet because it most assuredly is not a law "purporting" to regulate any of the entities described in the deemer clause—"insurance companies, insurance contracts, banks, trust companies, or investment companies," the deemer clause does not by its plain language apply to this state law. Thus, although the Pennsylvania law is exempted from ERISA's pre-emption provision by the broad saving clause because it "regulates insurance," it is not brought back within the scope of ERISA pre-emption by operation of the narrower deemer clause. I therefore would conclude that petitioner is subject to Pennsylvania's Motor Vehicle Financial Responsibility Law.

Id. (Stevens, J., dissenting).
127 See, e.g., Diane Kutzko et al., HIPAA in Real Time: Practical Implications of the Federal Privacy Rule, 51 DRAKE L. REV. 403, 445 (2003) (asserting that as long as stop loss coverage is a part of a plan obligation, it is preempted by ERISA).
128 See id. at 445-46 (describing how stop loss coverage may invoke ERISA preemption).

Typically, employers that sponsor self-insured plans will obtain insurance from an insurance company so as to provide coverage to the employer in the event claims under such a self-insured plan exceed a certain dollar amount during the course of the plan year. Stop loss insurance is usually designed to pay if claims reach a specific (claims over a certain dollar amount per participant per plan year) and an aggregate (a total amount of plan claims per plan year). Stop loss coverage is designed to protect the employer—and the plan—from catastrophic claims in any given plan year.

Id. at 445 n.255 (citing CCH Benefits Law Analysts, CCH, Inc., Employee Benefits Management ¶ 10,355 (2002)).
financial liability to claims in a plan year. I maintain that it is an illogical verbal contradiction to allow an employer to buy stop loss insurance "to cover the risks associated with its self-funding of the plan" while simultaneously claiming to be a self-funded employer sponsor of an ERISA benefit plan. Commentators recognize that self-funded employers travel on a slippery slope by purchasing stop-loss insurance to cover the risks of an alleged self-funded plan. In order to avoid both ERISA's saving clause and the burden of state insurance regulations and to preserve preemption, a self-funded employer, who purchases insurance to cover plan risks, should carefully create the legal fiction that stop-loss coverage is not a responsibility of the plan "because this insurance is typically obtained by the employer to cover the risks associated with its self-funding of the plan, and not regular claims."

Recently, in *Kentucky Ass'n of Health Plans v. Miller*, the Supreme Court clearly expanded the regulatory reach of state insurance laws and narrowed ERISA's preemptive reach by applying the savings clause to a state law regulating self-insured, non-ERISA plans and "entities outside the insurance industry, such as health-care providers." In *Kentucky Ass'n of Health Plans*, Kentucky's "Any Willing Provider" (AWP) law was challenged in a suit by a number of HMOs as preempted by ERISA. Kentucky's AWP laws harmed the HMOs' capacity to control the quantity of providers with the right to use to their networks, and consequently their capacity to utilize the assertion of a large number of patients as a *quid pro quo* for the

129 *Id.* at 445.
130 See *id.* at 445–46 (warning that extra care should be given in setting up stop-loss coverage to avoid preemption issues).
131 *Id.* at 445.
133 *Id.* at 1475.
134 *Id.* at 1474. The Kentucky law declares that "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships." KY. REV. STAT. ANN. § 304.17A-270 (Michie 2001). Moreover, any "health 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." *Id.* § 304.17A-171(2).
lower prices charged by members of the network.\textsuperscript{135} The HMOs assumed that the AWP laws would negatively impact their attempts to have power over cost and quality and would eventually prohibit consumers from receiving the benefit of HMOs' cost-saving measures with network providers.\textsuperscript{136} The federal district court held that although Kentucky's AWP laws "relate to" an employee benefit plan within the meaning of 29 U.S.C § 1144(a), each law "regulates insurance" and is saved from preemption under section 1144(b)(2)(A).\textsuperscript{137} The Court of Appeals for the Sixth Circuit affirmed the federal district court's decision.\textsuperscript{138} The Sixth Circuit held that Kentucky's AWP laws "regulate insurance 'as a matter of common sense,' because they are 'specifically directed toward insurers and the insurance industry.'"\textsuperscript{139} After concluding that Kentucky's AWP laws regulate insurance both under the common sense assessment and the three McCarran-Ferguson factors,\textsuperscript{140} the Sixth Circuit agreed with the district court's conclusion that the AWP laws were not preempted.

The Supreme Court specifically rejected the appellant HMO's contention that the state's AWP laws failed the "not specifically directed toward" insurance requirement for regulating insurance because the AWP law applied to self-insurer arrangement not saved from preemption by ERISA's savings clause.\textsuperscript{141} "We do not think § 304.17A-270's application to self-insured non-ERISA plans forfeits its status as a 'law... which regulates insurance' under 29 U.S.C. § 1144(b)(2)(A)."\textsuperscript{142}

\textsuperscript{135} \textit{Kentucky Ass'n of Health Plans}, 123 S. Ct. at 1474.
\textsuperscript{136} \textit{Id.}
\textsuperscript{137} \textit{Id.}
\textsuperscript{138} \textit{Id.} (citing Kentucky Ass'n of Health Plans v. Nichols, 227 F.3d 352, 363–72 (6th Cir. 2000)).
\textsuperscript{139} \textit{Id.} (citations omitted). The Sixth Circuit relied on \textit{UNUM Life Ins. Co. of America v. Ward}, 526 U.S. 358 (1999), for its common sense analysis of whether Kentucky's AWP law regulates insurance. \textit{Kentucky Ass'n of Health Plans}, 123 S. Ct. at 1474.
\textsuperscript{140} \textit{Kentucky Ass'n of Health Plans}, 123 S. Ct. at 1474–75.
These factors are: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." The Sixth Circuit found all three factors satisfied. \textit{Id.} at 1474 (citations omitted).
\textsuperscript{141} \textit{Id.} at 1476 n.1.
\textsuperscript{142} \textit{Id.}
In my opinion the Court’s rationale in *Kentucky Ass’n of Health Plans* lends itself to the strong argument that ERISA’s savings clause for insurance regulations should apply to the ERISA self-insured plans as well as non-ERISA “self-insured plans [that] engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan.”\(^{143}\)

The Court stated that ERISA’s savings clause should characterize state insurance laws by what they actually regulate.\(^{144}\) A state law regulates insurance if it requires certain conditions to be met in order to engage in the business of insurance when those conditions substantially affect the method of assigning risks.\(^{145}\) Under the rationale of *Kentucky Ass’n of Health Plans*\(^{146}\) and *Rush Prudential HMO, Inc.*,\(^{147}\) a state may require those attempting to provide insurance, or its functional equivalent, to cover any of the risks of an illusory self-funded ERISA employee benefit health plan to provide the illusory self-funded plan with a reinsurance contract that allows for independent review in a dispute involving the question of medical necessity.\(^{148}\) A state law requiring an insurer to provide medical necessity reviews in its insurance contracts with self-funded employers seeking to cover its risks of loss under an ERISA employee benefit plan clearly “affect[s] the risk pooling arrangement” between the insurer and the illusory self-funded plan that actually purchases the insurance.\(^{149}\)

---

\(^{143}\) *Id.*

\(^{144}\) *Id.* at 1476–77.

\(^{145}\) *Id.* at 1477. The Court stated:

We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA’s savings clause. Otherwise, any state law aimed at insurance companies could be deemed a law that “regulates insurance,” contrary to our interpretation of § 1144(b)(2)(A) in *Rush Prudential*. A state law requiring all insurance companies to pay their janitors twice the minimum wage would not “regulate insurance,” even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangement undertaken by insurer and insured.

*Id.*

\(^{146}\) See *supra* notes 134–44 and accompanying text.

\(^{147}\) See *supra* Part I.C.

\(^{148}\) See *Kentucky Ass’n of Health Plans*, 123 S. Ct. at 1477 (holding that state laws which “substantially affect to risk pool arrangement between insurer and insured” may be considered regulating insurance).

\(^{149}\) *Id.*
By shifting its potential ERISA health plan benefits losses from itself to an insurer, the operator of a self-funded employee plan has unilaterally affected risk pooling arrangements between the insured employer risk and the self-funded ERISA plan.\textsuperscript{150} I believe the self-funded plan ceases to be a functional self-funded ERISA plan once an employer purchases insurance to cover the risk of a self-funded ERISA plan’s employee benefits losses. It is my position that once an employer purchases stop-loss insurance to cover the risk of a self-funded ERISA plan, a state may require an insurer to include “the independent-review provisions [the Court] approved in \textit{Rush Prudential}.”\textsuperscript{151} In \textit{Kentucky Ass’n of Health Plans}, the Court made it clear that ERISA’s savings clause requires “that the state law substantially affect the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk.”\textsuperscript{152} A state law requiring an insurer that provides risk coverage to an employer operating a self-funded plan to grant review in a medical necessity dispute governs whether an insurance company must grant review in medical necessity disputes, “which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed”\textsuperscript{153} in providing coverage for an employer operating a self-funded plan. In my opinion a state law granting medical necessity review under the circumstances of a stop-loss purchase “qualifies as a substantial effect on the risk of pooling arrangement between the insurer”\textsuperscript{154} and the stop-loss insured employer sponsor of a self-funded ERISA plan.

In \textit{Kentucky Ass’n of Health Plans}, the Supreme Court stated that its historical use of the three factor McCarran-Ferguson test in the specific context of the ERISA saving clause analysis had been “misdirected” while contributing very little to a relevant legal analysis.\textsuperscript{155} The Court announced it would “make a clean break from the McCarran-Ferguson factors” in deciding whether a state law regulates insurance under ERISA’s savings clause.\textsuperscript{156} For purposes of ERISA’s saving clause, a state

\textsuperscript{150} Id. at 1477–78.
\textsuperscript{151} Id.
\textsuperscript{152} Id. at 1477 n.3.
\textsuperscript{153} Id.
\textsuperscript{154} Id.
\textsuperscript{155} Id. at 1478.
\textsuperscript{156} Id. at 1479 (citing 29 U.S.C. § 1144(b)(2)(A) (2000)). 29 U.S.C.
law regulates insurance if it is "specifically directed toward entities engaged in insurance" and the law "must substantially affect the risk pooling arrangement between the insurer and the insured." I believe a state law directing entities providing stop-loss insurance to employers to cover the health benefit risks of the employers' self-funded ERISA plan, like the Kentucky law in *Kentucky Ass'n of Health Plans*, satisfies each of these requirements.

In *Bill Gray Enterprises v. Gourley*, the Court of Appeals for the Third Circuit addressed the issue of whether a self-funded employee benefit plan that buys stop-loss insurance from a third-party insurer is subject to Pennsylvania laws regulating anti-subrogation clauses in insurance contracts. The court held that a self-funded employee benefit plan containing a stop-loss insurance provision is not deemed an insurance provider under ERISA. According to the Third Circuit, the plan was not subject to state laws regulating insurance contracts because the self-funded plan does not provide insurance. Under the rationale of the Supreme Court in *Kentucky Ass'n of Health Plans*, if a state insurance regulation requires that an insurer selling stop-loss insurance covering health benefit claims to contain a provision allowing for independent review in medical necessity claim disputes, the law should be treated as valid under ERISA's savings clause because it is directed at the risk pooling arrangement between the insured plan and the insurer. In my opinion, the holding of *Bill Gray Enterprises* should not apply to those situations where the state insurance regulation is aimed at the risk pooling arrangement between the stop-loss insured and the insurer providing the stop-gap

---

§ 1144(b)(2)(A) states that "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

157 *Kentucky Ass'n of Health Plans*, 123 S. Ct. at 1479.
158 See id. at 1479.
159 248 F.3d 206 (3d Cir. 2001).
160 Id. at 209.
161 Id.
162 Id. at 214.
163 *Kentucky Ass'n of Health Plans*, 123 S. Ct. at 1478–79 ("It is obvious enough that the independent review requirement regulates an integral part of the policy relationship between the insurer and insured." (quoting *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2163 (2002))).
insurance because the law only incidentally impacts\textsuperscript{164} a self-funded plan electing to purchase stop-gap insurance for its otherwise self-funded plan.\textsuperscript{165} Prior to the Supreme Court adopting a new test for what constitutes insurance regulation for ERISA's saving clause analysis in \textit{Kentucky Ass'n of Health Plans}, the Third Circuit reasoned that "[b]ecause stop-loss insurance is designed to protect self-funded employee benefit plans, rather than individual participants, plans purchasing stop-loss insurance are not deemed 'insured' under ERISA."\textsuperscript{166}

Unlike the court in \textit{Bill Gray Enterprises}, I believe that it challenges our common sense understanding of the English language to pretend that an ERISA plan with stop-gap insurance is to be deemed an uninsured plan for purposes of ERISA's deemer clause. Under 15 U.S.C. § 1012(a), the Supreme Court has "identified laws governing the ‘business of insurance’ in the Act to include not only direct regulation of the insurer but also

\textsuperscript{164} See Lincoln Mut. Cas. Co. v. Lectron Prod., Inc., 970 F.2d 206, 210 (6th Cir. 1992) ("In other words, the deemer clause relieves ERISA benefit plans—both uninsured and insured plans—from direct state regulation, but, because the clause does not relieve a plan's insurer, state regulation may have an incidental, or 'indirect,' effect on ERISA plans.").

\textsuperscript{165} See \textit{Bill Gray Enterprises}, 248 F.3d at 215, for a counter viewpoint. The Third Circuit, however, prior to the Supreme Court's decision in \textit{Kentucky Ass'n of Health Plans}, expressed the view that

[m]erely by purchasing stop-loss insurance and at the same time retaining financial responsibility for plan participants' coverage, self-funded plans may not rely on the assets of an insurance company in the event of insolvency. It follows that reimbursement and subrogation rights are vital to ensuring the financial stability of self-funded plans. Consistent with other courts of appeals, therefore, we hold that when an ERISA plan purchases stop-loss insurance but does not otherwise delegate its financial responsibilities to another third party insurer, it remains an uninsured self-funded welfare plan for ERISA preemption purposes. Because stop-loss insurance is designed to protect self-funded employee benefit plans, rather than individual participants, plans purchasing stop-loss insurance are not deemed “insured” under ERISA.

Because the Bill Gray Plan purchased stop-loss insurance to insure the Plan from losses in the event its members suffered catastrophic injury requiring substantial medical payments, it is not an insurance provider under ERISA. Accordingly the Bill Gray Plan, as an uninsured self-funded employee benefit plan is exempt from § 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law.

\textit{Id.} (citations omitted).

\textsuperscript{166} \textit{Id.} (citing Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 358 (4th Cir. 1997) and United Food & Commercial Workers & Employers Ariz. Health & Welfare Trust v. Pacyga, 801 F.2d 1157, 1162 (9th Cir. 1986)).
regulation of the substantive terms of insurance contracts." In my opinion when a historically ERISA self-funded plan purchases a stop-gap insurance contract from an insurer to cover any of the plan's potential risks, it is functionally no longer a self-funded plan and the contracts of those stop-loss insurers "are subject to direct state regulation." 

I think the purchase of stop-gap insurance alters the plan's status from an entity without a contract with an insurer to an entity with a contract with an insurer. When the stop-gap insurance contract with the insurer provides very limited risk to either the plan or the employer, the plan should be considered as substantially insured and saved from preemption by ERISA's savings clause. While comparing the deemer and saving clause, the Supreme Court said, "[T]he saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans." Once an historically self-funded plan has substantially altered its risk of loss by purchasing a stop-gap insurance policy, a state law that specifically directs insurers selling health insurance to provide an independent medical necessity review is a law that regulates insurance under Kentucky Ass'n of Health Plans because such law significantly impacts the risk pooling arrangement between the selling insurer and the stop-loss insured plan by requiring all insurance contracts to provide a claimant with the right to review. After Kentucky Ass'n of Health Plans the issue presented when an employer purchases large amounts of stop-loss insurance is not whether the purchase allows a self-funded ERISA plan to be regulated as an insurance company under an ERISA preemption analysis but whether

---


168 Id. at 63.

169 See id. at 62–63.

170 Id. at 64.


172 But see Bill Gray Enters. v. Gourley, 248 F.3d 206, 215 (3d Cir. 2001). The court in Bill Gray Enterprises stated:

But we recognize that a self-funded ERISA plan may purchase such a large amount of stop-loss insurance that it appears as if the plan is no longer operating as a self-funded employee benefit plan but rather effectively operating as an insurance company... Because there is no evidence that the Bill Gray Plan purchased an excessive amount of stop-loss insurance,
such purchase from a common sense view, allows the state to place a condition\textsuperscript{173} of medical necessity review on the right of an insurance company to sell stop-loss insurance. A state must be allowed to prohibit entities engaged in selling stop-loss insurance contracts from shielding illusory self-funded employers from ERISA's anti-preemptive savings clause by the simple expedient of purchasing stop-loss insurance.\textsuperscript{174}

CONCLUSION

I agree with Justice Stevens' dissenting comment about congressional intent and ERISA self-funded plans made prior to the Supreme Court's holding Kentucky Ass'n of Health Plans.\textsuperscript{175} According to Justice Stevens, the real issue for Congress is not "whether uninsured plans are to be regulated under state insurance laws" as insurance companies "but whether they [should] be permitted" at all.\textsuperscript{176} If there is uncertainty about whether a federal law preempts a state law, courts must apply the strong presumption against the cancellation of established state law.\textsuperscript{177} "Application of that presumption leads me to the conclusion that the pre-emption clause should apply only to those state laws that purport to regulate subjects regulated by ERISA or [subjects] that are inconsistent with ERISA's central purposes."\textsuperscript{178}

Congress could not have rationally intended to bar a state from implementing the medical necessity provisions of its state health insurance law "against ERISA plans—most certainly, it did not intend to pre-empt enforcement"\textsuperscript{179} of state medical necessity review laws "against self-insured plans" that actually

we do not reach the issue whether the purchase of large amounts of stop-loss insurance effectively makes a self-funded ERISA plan an insurance company for ERISA preemption purposes.

\textit{Id.}

\textsuperscript{173} See Kentucky Ass'n of Health Plans, 123 S. Ct. at 1477.

\textsuperscript{174} See Bill Gray Enters., 248 F.3d at 215 ("In this instance the purchase of large amounts of stop-loss insurance may be evidence that the plan is attempting to retain the financial security provided by insurance coverage while at the same time reap the benefits of ERISA preemption, including the avoidance of state laws regulating reimbursement.").

\textsuperscript{175} FMC Corp., 498 U.S. at 69 (Stevens, J., dissenting).

\textsuperscript{176} Id. (Stevens, J., dissenting).

\textsuperscript{177} Id. at 67 (Stevens, J., dissenting).

\textsuperscript{178} Id. (Stevens, J., dissenting).

\textsuperscript{179} Id. (Stevens, J., dissenting).
purchase stop loss insurance while preserving implementation of medical review laws “against insured plans.”

Professor Zelinsky supports amending ERISA section 514 to allow the states to control employers self-funded health benefits.

According to Professor Zelinsky:

Congress should, in the interests of parity, amend section 514 to permit states to extend their regulation of insurance (including HMOs) to include employers' self-funded financed health care plans. Without such amendment of section 514, the regulatory gap persists in regard to employers' self-financed plans administered without the participation of an insurance carrier.

While I support Professor Zelinsky's proposed amendment to section 514, I think the Court should conclude that Congress could not have reasonably intended that self-funded plans, administered with the purchase of stop loss insurance from an insurance carrier should be excluded from state insurance regulations “tied to what is medically necessary” under the pre-emption rationale.

Since health care is an area of traditional state regulation, ERISA pre-emption does not apply unless a clear manifestation of congressional intent is present.

---

180 See id. (Stevens, J., dissenting).
182 Id.
184 See FMC Corp., 498 U.S. at 69 (Stevens, J., dissenting).