



STATE COVERAGE
INITIATIVES

ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICY MAKERS

by Patricia Butler



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for STATE HEALTH POLICY

ERISA Preemption Manual for State Health Policymakers

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January 2000

January 28, 2000

Dear Colleague:

As you are well aware, the Employee Retirement Income Security Act (ERISA) has had a tremendous impact on state health policy since its enactment in 1974. State efforts to expand health care coverage and regulate insurance markets over the past two and a half decades have repeatedly been effected by ERISA's national standards for employee benefit plans. Though recent court decisions have narrowed the scope of ERISA (as you will find detailed here), the reach of this federal law remains extensive.

This manual has been produced jointly by the Alpha Center and the National Academy for State Health Policy with the generous support of The Robert Wood Johnson Foundation through its *State Coverage Initiatives* program. Authored by Patricia Butler, the manual provides state officials with a tool for examining how their health policy objectives intersect with the provisions of the ERISA law. Both the Alpha Center and the National Academy for State Health Policy have long-standing relationships with Pat, and she has advised us on ERISA for many years. We are delighted to have collaborated with each other and with her on this project.

We at the Alpha Center and at the National Academy for State Health Policy have learned first hand over a number of years that ERISA is a centrally important issue for states, and so we know that a receptive audience awaits the release of this product. We sincerely hope that this manual will assist you as you continue to move ahead in meeting your health care policy and reform objectives.



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Acknowledgments

The author is grateful to the following reviewers of an earlier draft of this Manual whose corrections, comments, and suggestions have immeasurably improved the final product. Opinions and errors in this version are the sole responsibility of the author.

Barbara Morales-Burke (North Carolina Department of Insurance); Jane Beyer (staff, Washington State House of Representatives); John Colmers (Maryland Health Care Cost Control and Access Commission); Jennifer Cook and Mary Beth Senkewicz (National Association of Insurance Commissioners); Stephanie Lewis and Nicole Tapay (Georgetown University Health Policy Center); Fred Nepple (Wisconsin Department of Insurance); Karl Polzer (George Washington University National Health Policy Forum); Trish Riley (National Academy for State Health Policy); Bob Wake (Maine Department of Insurance); and Ben Wheatley (Alpha Center).

Thanks also to Amanda Lewis, University of Colorado School of Law, for legal research, citation checking, and abstracting law review articles.

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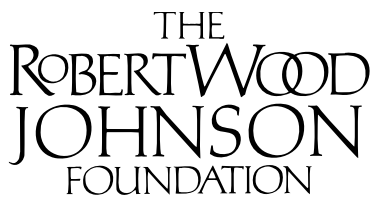
for STATE HEALTH POLICY

The National Academy for State Health Policy is a non-profit, multidisciplinary organization that provides a forum for leading state policy officials to exchange insights, information and experience in formulating health policy and to develop practical, innovative solutions to complex health policy issues confronting states. The Academy accomplishes its mission through policy analysis, demonstrations of innovation, forums and workshops including the annual state health policy conference, training and technical assistance to states, and through its publications and website (www.nashp.org).

About the SCI Program



This technical assistance manual was produced for The Robert Wood Johnson Foundation's *State Coverage Initiatives* program. The *State Coverage Initiatives* program helps states improve the availability and affordability of health insurance coverage, particularly for working families. Through providing states with grants, technical assistance, workshops, and information on best practices, the program is designed to build the policy making and technical capacity of states to address their own unique health care coverage issues.



The Robert Wood Johnson Foundation (www.rwjf.org), based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to reduce the personal, social, and economic harm caused by substance abuse tobacco, alcohol, and illicit drugs.



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Alpha Center (www.ac.org) is a non-profit health policy center dedicated to improving access to affordable, quality health care. With more than 23 years experience, Alpha supports the development of research and its translation into the policy process by providing policy and technical assistance to those making health policy and those administering health programs and benefits. The ultimate goal of these efforts is to develop programs and analytical information that serve the broad public interest. Alpha Center serves as the national program office for *State Coverage Initiatives*.

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Chapter I: Introduction

A. Purpose of this Manual

The purpose of this Manual is to assist state health policymakers in understanding the implications of ERISA (the Employee Retirement Income Security Act) for initiatives to achieve health policy goals, such as expanding access to affordable, high quality health care, maintaining a stable and fair health insurance market, and monitoring the fast-changing health care delivery system. ERISA, the 1974 federal employee benefits reform law, is relevant to state health policy because its preemption provisions may prohibit states from implementing laws that affect private-sector employee health plans or that are inconsistent with federal law. Furthermore, even though ERISA does not preempt state laws regulating insurance (other than those conflicting with recently enacted federal insurance laws), some courts have held that certain state managed care standards do not meet ERISA's test of insurance regulation.

ERISA poses several challenges to state health policymakers. Its preemption clause was originally interpreted very broadly by the courts, though these interpretations have narrowed somewhat in recent years. And because courts have decided relatively few cases involving state health care laws, ERISA's impact on many laws that might theoretically raise ERISA preemption issues remains uncertain. Furthermore, recently enacted federal insurance rules are charting new territory in federal-state jurisdiction, which is likely to evolve as Congress considers adopting other standards for managed health care plans.

Recent Supreme Court opinions narrowing ERISA preemption should reassure states that they can regulate in traditional areas of interest, such as taxing and overseeing insurers and health care providers and regulating managed care plans. In the many areas of uncertainty, state officials should not be discouraged from crafting desirable health policy. Understanding ERISA can sometimes help legislators draft laws to avoid preemption problems. And the current judicial climate suggests that states may win many ERISA preemption challenges.

This Manual provides background on the purpose of ERISA preemption provisions and the general approach the courts take in interpreting them. It outlines the implications of ERISA preemption for four broad categories of state health policy initiatives that have been or are being considered in legislatures and executive branch agencies:

- expanding access to health care coverage;
- regulating managed care and other health insurance products;
- resolving disputes between plans and their enrollees; and
- monitoring access, cost, and quality in the state's health care delivery system.

Because the Manual focuses on ERISA preemption of state law, it is not a comprehensive resource on ERISA. For example, its discussion of federal employee benefit plan standards is

limited to provisions relevant to state policy. Nor is the Manual a general treatise on the policy advantages and disadvantages of ERISA preemption. And because it is designed to help state health policymakers craft or defend their laws based on current court interpretations, it does not propose new legal theory, a task more appropriate for law review or health policy journal articles. Readers interested in a broader view of ERISA's requirements for employee benefits plans, discussion of the policy wisdom of preemption, or more detailed legal analysis and proposals for ERISA reform may find helpful the references listed in Appendices B and D.

B. Organization of the Manual

Chapter 2 provides a basic primer on ERISA preemption that, we hope, is useful to state health policymakers who have limited ERISA knowledge. Chapter 3 provides background necessary to consider ERISA implications for specific state health policy initiatives. It describes the statute, its purpose, and its legislative history along with amendments over the last 25 years relevant to state health policy. Because the courts are the primary interpreters of ERISA preemption, this chapter also summarizes the key preemption decisions of the U.S. Supreme Court and lower federal courts and the framework for analysis they have created. This chapter would be useful reading for state health policymakers who lack a detailed background in ERISA's legal interpretation. In order to be accessible to non-lawyers, the text summarizes the case law while the end notes provide more detailed case citations and descriptions that may be helpful for legal advisors to state health policy-makers.

Chapter 4 describes the responsibilities of the U.S. Department of Labor (DOL), which administers and enforces ERISA, and the relationship between the DOL and the states. It outlines areas where the both levels of government have collaborated and suggests other areas where they could work together in the future.

Chapters 5 through 8 examine ERISA implications for a variety of strategies that states have undertaken or considered to advance state policy objectives regarding coverage expansion, managed care and other insurance regulation, health plan-enrollee dispute resolution, and delivery system oversight. Each of these chapters begins with an outline of the legal framework necessary to analyze the initiatives included therein. The notes at the end of each chapter provide more detailed legal analysis.

Finally, appendices at the end of the Manual include the text of the preemption provisions (Appendix A); a list of books, monographs, and articles that could be useful both to expand on the analysis outlined in the Manual and enhance general background on ERISA subjects not covered in the Manual (Appendix B); a glossary of ERISA and other health care terms (Appendix C); as well as abstracts of selected law review and health policy journal articles on ERISA preemption topics that might be of interest to state health policymakers, regulators, and Attorney General staffs in designing policy and defending state laws against preemption challenges (Appendix D).

C. Disclaimer

This Manual does not provide legal advice, and state policymakers are encouraged to consult with their own legal counsel in developing, interpreting, enforcing, and defending state health policy initiatives against ERISA challenges.

D. Conclusion

Despite the existence of some serious limitations on state authority due to both federal law and court interpretations, state policymakers should not view ERISA as a barrier to innovative state health policy. An objective of this Manual is to assist policymakers in understanding ERISA's preemption provisions in order to draft legislation to avoid ERISA problems, when possible, and to defend state laws if they are challenged under ERISA.

Chapter II: ERISA Preemption Primer

It is helpful for state health policymakers to know about ERISA because of its potential negative impact on state health care legislation, including health insurance regulation. Courts have held that ERISA (the federal Employee Retirement Income Security Act of 1974) supercedes some state health care initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have a substantial impact on employer-sponsored health plans. Several recent U.S. Supreme Court opinions limit ERISA's impact on state authority, but many uncertain areas remain. State policymakers face ERISA issues as they consider proposals to expand access to health care, regulate managed care and other health insurers, prescribe appeal rights of health plan enrollees, and monitor health care costs and quality. This Primer provides a basic outline of ERISA's implications for state health care initiatives. More detailed analysis is provided in Chapters 5 through 8 of this Manual.

What is ERISA and why was it enacted?

Congress enacted ERISA primarily to establish uniform federal standards to protect private employee pension plans from fraud and mismanagement. But the federal statute also covers most other types of employee benefits plans, including health plans. ERISA is codified in Volume 29 of the U.S. Code, starting with section 1001. Regulations of the Department of Labor are published in Volume 29 of the Code of Federal Regulations, starting at section 2509.

What kinds of plans does ERISA regulate?

ERISA applies to all employee pension, health, and other benefits plans established by private-sector employers (other than churches) or by employee organizations such as unions. If they meet certain requirements, employee plans are "ERISA plans" even if they offer benefits through state-licensed insurers. ERISA does not apply to plans administered by federal, state, or local governments. It does not apply to plans established solely to meet state workers' compensation, unemployment compensation, or disability insurance laws.

What does ERISA require?

For pension plans, ERISA provides detailed standards for vesting; funding; solvency insurance; disclosure and reporting to plan participants and beneficiaries and the U.S. Department of Labor; nondiscrimination; and administrator fiduciary requirements. For health plans, federal law prescribes fewer substantive standards: administrators' fiduciary standards (to administer the plan in the best interests of beneficiaries) and requirements for plan descriptions to be given to enrollees, reporting to the federal government, and certain minimum standards ("continuation"

The U.S. Department of Labor is responsible for administering and enforcing the ERISA law and setting policy for the conduct of employee benefit plans. The federal courts are the primary source of interpretation of ERISA's preemption provisions.

health coverage; group plan guaranteed issue and renewability; pre-existing condition exclusion requirements; nondiscrimination in premiums and eligibility; maternity hospital length-of-stay standards; post-mastectomy reconstructive surgery; and limited mental health “parity”). States impose some of these types of standards on HMOs and other insurers, but these laws cannot directly regulate private-sector employer-sponsored plans.

How does ERISA's original preemption clause affect state health policy?

Several of ERISA's provisions preempt state law. ERISA's “preemption clause,” Section 514, makes void all state laws to the extent that they “relate to” employer-sponsored health plans. (This clause states that “the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...”.) The Supreme Court has interpreted the preemption clause very broadly to carry out the congressional objective of national uniformity in rules for employee benefits programs. The Court has held that ERISA preempts state laws that either refer explicitly to ERISA plans (i.e., all plans offered by private-sector employers) or have a substantial financial or administrative impact on them. Consequently, courts have held that ERISA prohibits both state laws that *directly* regulate employer-sponsored health plans, such as mandating that employers offer health insurance, and some laws that only *indirectly* affect plans, such as regulating the provider networks ERISA plans may use.

How do recent ERISA amendments affect state health policy?

Congress has begun to exercise more control over insurance and managed care, creating new models of federal-state jurisdiction. For example, a 1996 ERISA amendment prescribes minimum maternity hospital length of stay, but allows certain specific types of state maternity stay laws. Sections enacted in 1996 and 1998 require insurers to provide both mental health parity (preempting state law that prevents application of federal law) and breast reconstruction for post-mastectomy patients (permitting existing state laws that require at least the same coverage as federal law). Finally, provisions added by HIPAA in 1996 mandate insurance market reforms, prescribing several specific areas where state laws may differ from federal law. The 106th Congress also is debating additional types of managed care regulation, some of which might apply to insurers that traditionally have been subject to state law. Proposals for increasing access to and quality of health coverage would use this approach to shared federal-state authority over health insurance.

Who interprets and enforces ERISA?

The U.S. Department of Labor is responsible for administering and enforcing the ERISA law and setting policy for the conduct of employee benefit plans. The federal courts are the primary source of interpretation of ERISA's preemption provisions. Much of the uncertainty about whether ERISA affects a proposed state health care initiative or policy results from differing court interpretations of the preemption provisions across the country. While the Supreme Court is ultimately responsible to interpret federal law, it has decided relatively few ERISA cases, only four of which explicitly involve state health policy. This has left lower courts to decide ERISA cases with only limited Supreme Court guidance on many current state health policy issues.

Are there exceptions to ERISA preemption?

ERISA's preemption provisions contain an exception important to state health policy; it allows states to continue to regulate "the business of insurance" (authority that Congress gave to the states in the McCarran-Ferguson Act of 1945). Courts have interpreted ERISA's insurance regulation "savings clause" to allow states to regulate traditional insurance carriers conducting traditional insurance business. This includes, for example, mandating the benefits that insurers must offer. Some courts have held, however, that states cannot regulate all activities of insurers. For instance, when insurers act only in an administrative capacity, such as administering a health plan but not bearing any risk, some courts have held that states cannot impose insurance requirements, such as health benefits mandates.

What does ERISA's insurance "savings clause" permit?

Under the insurance regulation savings clause, states can regulate the terms and conditions of health insurance, for example, the benefits in an insurance policy or the rules under which the health insurance market must operate. But through its so-called "deemer clause," the statute prohibits states from regulating plans that "self-insure," by bearing the primary insurance risk, even though by bearing risk, they appear to be acting like insurance companies. The Supreme Court recognized that this distinction creates two classes of employer-sponsored health plans. Plans funding coverage through insurance are subject to state insurance regulation, while those that self-insure are completely beyond state jurisdiction. This creates an important distinction between insured and self-insured employer-sponsored health plans. *Both types of plans are still ERISA plans*, but only the former are subject to some types of state oversight.

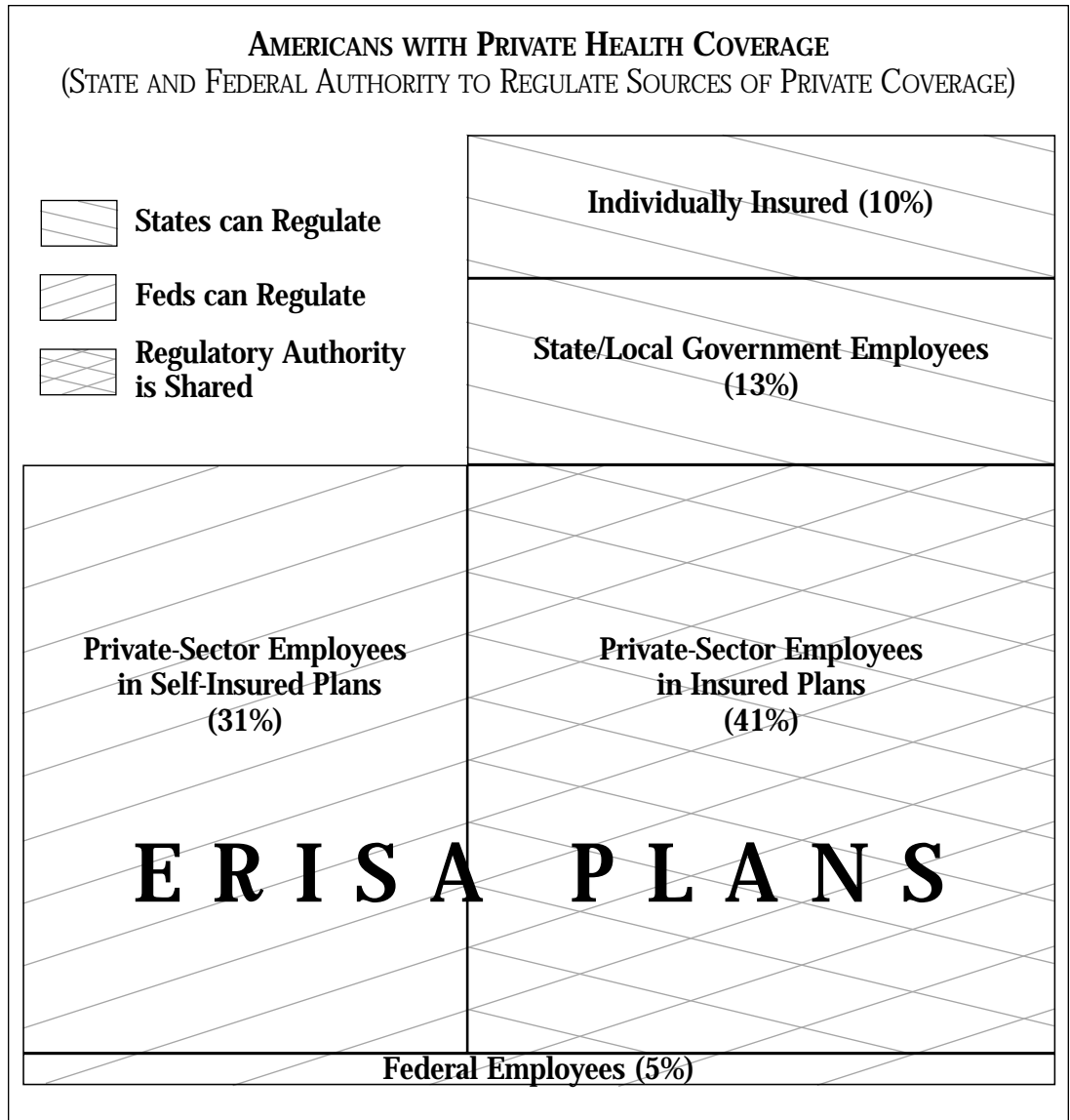
How many people are enrolled in insured health plans compared to self-insured health plans?

The number of employer-sponsored health plans that self-insure has grown over the last 20 years. While no detailed data are currently available, it is estimated that between 33 and 50 percent of employees throughout the country are in self-insured plans, though the number varies among states. An intermediate estimate of 43 percent means that about 53 million of the 123 million Americans receiving coverage through the workplace in 1997 were not covered by state regulation. State insurance laws could regulate health plans covering about 70 million Americans in insured, private-sector employer-sponsored plans plus 23 million insured employees of state and local governments and 18 million people in individual health insurance plans.

What authority do the federal and state governments have over health plans?

As shown in the diagram on page 8, states have authority over insurance covering a majority of people in the private insurance market. But states have no authority over self-funded ERISA plans and they share regulatory authority with DOL over a significant share of people insured through workplace health plans.

States have no authority over self-funded ERISA plans and they share regulatory authority with DOL over a significant share of people insured through workplace health plans.



Have Supreme Court interpretations of ERISA preemption changed in recent years?

While not overruling earlier preemption opinions, Supreme Court decisions in 1995, 1997, and 1999 narrowed the scope of the preemption provisions and broadened the scope of the insurance savings clause. For example, in the 1995 *Travelers* decision, the Supreme Court held that ERISA did not preempt a state's hospital surcharges that employer-sponsored health plans had to pay, which provides support for other types of state health care taxes that might affect ERISA plans. Consequently, the Supreme Court recently appears more favorably disposed to the exercise of state authority.

In general, what can states do and not do under ERISA?

Based on ERISA case law, including Supreme Court decisions, states generally **can**:

- tax and regulate traditional insurers performing traditional insurance functions;
- regulate multiple employer welfare arrangements (where two or more employers jointly sponsor health coverage);
- regulate hospital rates charged to insurers and others who pay health care bills, and by extension, probably tax health care providers; and
- provide remedies for injuries when a health plan controls medical care delivery (traditional medical malpractice cases).

Court decisions have also made clear that states generally **cannot**:

- directly regulate private employer-sponsored health plans;
- mandate that private employers offer or pay for insurance;
- tax private employer-sponsored health plans themselves;
- regulate self-insured private employee plan benefits or financial solvency; or
- indirectly affect employer-sponsored health plans by imposing substantial costs on plans.

The impact of ERISA on many types of health policy initiatives that states have enacted or are considering is unclear, because either lower federal courts have reached inconsistent conclusions, the Supreme Court has not explicitly resolved the issue, or the question has not been litigated. The implications of ERISA's preemption provisions will always depend on the precise language of the state law in question. This long and growing list of uncertain state authority includes:

- many types of managed care regulation, such as any-willing-provider laws;
- independent ("external review") appeals programs;
- regulation of stop-loss insurance (purchased by employer-sponsored health plans to share the risk of high-cost cases);
- employer pay-or-play health care programs;
- employer health coverage tax credits;
- regulation of third-party administrators (TPAs) that administer self-insured health plans;
- requirements that public health care access programs coordinate closely with employment-based coverage;
- requirements that employee plans pay health care provider assessments directly to state agencies; and
- regulation of non-traditional insurers, such as provider-sponsored organizations, accepting risk from ERISA plans.

States have considered several approaches to make health care coverage broadly available, such as employer mandates, individual mandates, and government-operated programs, most of which raise ERISA preemption issues.

How might ERISA affect state health care access programs?

States have considered several approaches to make health care coverage broadly available, such as employer mandates, individual mandates, and government-operated programs, most of which raise ERISA preemption issues. Only Hawaii's employer health coverage mandate has been explicitly litigated, and Congress authorized this employer mandate in a 1983 ERISA amendment.

- ERISA prohibits an *employer* mandate, as enacted in 1992 in Washington state and Oregon, because it directly “relates to” employer-sponsored health plans.
- An *individual* mandate that requires each state resident to obtain insurance coverage (as many states do for auto insurance) might avoid an ERISA challenge if it in no way referred to employer-sponsored health plans. If a state wanted to discourage employers from dropping current employee coverage, ERISA would pose a problem because a state individual mandate law that explicitly imposes obligations on employer or employer-sponsored health plans (for example, to continue covering insured workers) is likely to be preempted.
- Publicly funded programs would raise preemption concerns if they attempt to tax ERISA plans or if they impose duties on ERISA plans, for example, through a transition to a more universal program.
- Even a tax preference (for example, a credit or deduction for employers offering coverage or establishing medical savings accounts) can raise an ERISA preemption problem if the state law conditions the tax advantage on certain design features.

ERISA also can impede state approaches to finance health care for uninsured people with low incomes or medical conditions that make them “uninsurable.” For example, about half the states operate risk pools for uninsurable people, most of which are funded by taxes or assessments on health insurance companies. As more employer-sponsored health plans have become self-insured, the financing source of traditional insurance companies has declined. ERISA prohibits states from imposing such assessments on employer-sponsored health plans. Following the analysis of the Supreme Court's 1995 *Travelers* decision, some lower courts have held that ERISA does not preempt state hospital charity care assessments or other provider taxes. Consequently, programs for low income or uninsurable people could be financed by taxing providers, even though the providers are likely to pass these taxes on to employer-sponsored health plans.

How does ERISA affect state health insurance regulation?

While there have been few cases interpreting ERISA's insurance savings provisions, it is likely that ERISA does not invalidate traditional state standards governing insurer solvency, market conduct, advertising, and fair practices requirements unless Congress were to enact federal law in these areas. Court decisions suggest that ERISA permits states to adopt standards to make the health insurance market function more fairly, as most states had done before HIPAA. In enacting HIPAA, Congress imposed several standards on both insured and self-insured employee health plans, creating a federal floor that states may supplement (in ways specified in the federal law) in regulating health insurers.

States have begun to regulate managed care plans, for example, by adopting standards for provider network structure, enrollee choice of provider, and definitions of services such as emergency care. Relatively few of these standards have been challenged in court, although the courts are split on whether ERISA preempts any-willing-provider laws (requiring health plans to contract with all providers willing to accept their contract terms) as applied to insured as well as self-insured ERISA plans. Requirements that regulate the relationship between plans and providers (such as provider selection and termination standards) face a more difficult challenge under ERISA because they do not resemble traditional insurance regulation.

An important ERISA implication for state health insurance regulation is that it establishes a largely unregulated sector: self-insured ERISA plans. Because employers can choose to self-insure if they feel state regulation is too costly or intrusive, states must carefully balance the policy wisdom of enacting health insurance standards against the potential that they will drive more employer plans to self-insure.

How does ERISA affect state standards for resolving disputes between health plans and enrollees?

Enrollees in traditional indemnity health insurance plans can resolve disputes over payment after they receive services. But managed care coverage disputes may be more urgent, because managed care plans typically decide whether to cover expensive services before they are provided, and a decision not to cover can mean the enrollee will not obtain an arguably needed service. State laws may provide several avenues of dispute resolution, from appealing to state insurance regulators, to requiring managed care plans to provide an internal grievance process, to increasingly popular programs using reviewers independent of the health plan. Health plan enrollees injured by coverage denials also sometimes sue health plans for allegedly inappropriate denials of care, and a few states have enacted laws attempting to make it easier for enrollees to bring these suits.

These dispute resolution initiatives raise ERISA preemption issues. For example, while states have long required HMOs to provide grievance procedures, some state standards would conflict with rules proposed by the U.S. Department of Labor in September 1998. States can probably supplement such federal rules as long as there is no direct conflict with them. A Texas district court held that ERISA preempts the state's external review law as applied to insured and self-insured ERISA plans. And many federal courts, relying on Supreme Court precedent, have held that ERISA preempts lawsuits for damages from injuries due to health plan coverage denials or delays (although the courts generally allow medical malpractice lawsuits against plans that directly control or influence clinicians' medical practice). Because ERISA plans include all private-sector employer plans (not just those that self-insure), ERISA preempts state court damages suits against managed care plans and other insurers — not just against self-insured employee plans — challenging benefit denials.

An important ERISA implication for state health insurance regulation is that it establishes a largely unregulated sector: self-insured ERISA plans.

Only Congress can grant states an exemption from ERISA's preemption provisions. The U.S. Department of Labor does not have the authority to grant ERISA waivers.

How does ERISA affect states' ability to monitor their health care systems?

State health policymakers need information in order to monitor health care access, costs, and quality. States can collect this information only from providers, such as hospitals, or traditional insurers and managed care plans. It remains unclear whether states can collect such data from insurers of third-party administrators (TPAs) administering employers' self-insured plans. But states cannot require employer-sponsored health plans to report this information directly.

How can states obtain relief from ERISA's preemption provisions?

Only Congress can grant states an exemption from ERISA's preemption provisions. The U.S. Department of Labor does not have the authority to grant ERISA waivers. Congress has exempted only one state health program from preemption; in 1983 it amended ERISA to permit Hawaii to operate its employer health insurance mandate that was adopted in 1974, just before ERISA was passed. Congress has considered enacting other ERISA preemption exceptions. For example, in 1992 the Senate held hearings on an amendment that would have allowed the Department of Labor to grant waivers to states wanting to experiment with various health care access and cost-containment programs. OBRA (the Omnibus Budget Reconciliation Act) of 1993 would have authorized four specific state programs: rate-setting systems in Maryland and New York, the Minnesota health care provider tax, and changes to Hawaii's employer mandate. In 1994, congressional representatives from Oregon and Washington state introduced bills to permit those states to implement their health care reform laws (for instance, by taxing health care providers, limiting spending, and requiring employers to offer insurance). None of these federal laws was enacted, however.

What is Congress' current approach to health care legislation?

Since 1996, Congress has become more involved in regulating employee health benefits, enacting HIPAA, the hospital maternity length-of-stay law, the mental health parity law in 1996, and the post-mastectomy care law in 1998. These laws extend federal protections to the 53 million Americans in self-insured ERISA plans. They also create a new relationship between the state and federal governments by setting a federal floor for insured employee plans, while generally permitting states to enact stronger laws. This federal floor can protect consumers in states that have not enacted related laws. Some of these federal laws prescribes the types of laws states can enact, while others permit state laws that do not directly conflict with federal law.

What are prospects for congressional revision to ERISA?

As the current congressional debate on expanding federal standards over ERISA plans has shown, powerful forces have aligned to resist amending ERISA. For several reasons, businesses, unions, and others that administer multi-state employer-sponsored health plans oppose narrowing ERISA's preemption provisions. In fact, some congressional proposals would expand pre-

emption of state law, for example, eliminating state authority to regulate MEWAs and other multiple employer arrangements. Opponents of repealing ERISA's preemption provisions argue that by prohibiting potentially conflicting state laws that regulate employer-sponsored health plans, ERISA preemption has saved multi-state plans from costly administrative requirements. Businesses also assert that they have saved money because ERISA allows them to develop innovative benefits design, such as managed care. They point to any-willing-provider laws in the majority of states that permit all health care providers of a specific type, like pharmacies, to participate in managed care organizations as examples of state laws that inhibit cost control. On the other hand, advocates of greater state flexibility under ERISA first point out that states, with their historic (sometimes even state constitutional) obligation to care for low-income and disadvantaged people, are ultimately accountable for health care access within their borders. Even though most large businesses insure many workers and their dependents, they also fail to insure many workers, who may become a state responsibility. Proponents of ERISA change also note that while not every state would seek to address access and managed care standards in the same way, those that achieve locally acceptable policy and are willing to devote local resources to enforce it should be given the tools to implement their laws and not be held hostage by national interest groups. Finally, they note that employers are subject to many interstate differences, such as taxes and employee workplace protections, as well as differing court interpretations of ERISA, belying the notion of uniform national standards.

How can states navigate ERISA preemption to achieve their health policy goals?

ERISA has limited states' ability to implement some types of health care initiatives, although the courts have recently narrowed the wide reach of ERISA's preemption provisions. Without congressional relief from ERISA preemption, states are limited in using the foundation of employer health insurance to adopt universal coverage programs. Nor can states fund coverage by taxing employers or their plans. Nevertheless, recent Supreme Court opinions narrowing ERISA preemption should reassure states that they can regulate in traditional areas of interest, such as taxing and overseeing insurers and health care providers and regulating many activities of managed care plans. In the areas of uncertainty, state officials should not be discouraged from crafting desirable health policy. Understanding ERISA can sometimes help legislators draft laws to avoid preemption problems. The current judicial climate suggests that states may win many ERISA preemption challenges.

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Chapter III: ERISA and its Preemption Provisions

A. The ERISA Statute

ERISA was enacted by Congress in 1974 to remedy pension fraud and mismanagement. The law¹ prescribes a comprehensive scheme to regulate employee pension programs, including requirements for holding in trust plan assets used to provide benefits; disclosure of plan information to employees; reporting of plan operations to the federal government; employee plan eligibility and participation; pension vesting; pension funding; plan fiduciary and management standards; and a federal insurance system to fund insolvent pension plans. The law applies to employee benefit plans, including both pension plans and “welfare benefit plans,” a term that includes arrangements to provide benefits such as vacation, day care, and prepaid legal services, as well as medical care “through the purchase of insurance or otherwise.”² ERISA governs such plans when established by employers³ or employee organizations such as labor unions.⁴ *The term “ERISA plan” means all such private-sector employee plans, whether they are insured or “self-insured.”* All private-sector employee plans are subject to ERISA except those operated by churches⁵ and their affiliates. Plans not covered by ERISA include those offered by governments and those maintained solely to comply with state workers’ compensation,⁶ unemployment compensation, or disability insurance laws.⁷ ERISA is administered and enforced by the U.S. Department of Labor (DOL).

In contrast to its detailed provisions regarding pension programs, ERISA originally imposed few standards on welfare benefit plans like health plans. It required only that they disclose information to covered individuals,⁸ meet fiduciary duty standards,⁹ and provide a procedure to resolve disputes with the plan (including a limited financial remedy and recovery of costs of denied services¹⁰). As described below, Congress has amended ERISA several times. There remain, however, no federal standards for health plan solvency, participation, or vesting. Federal standards for information disclosure, mandated benefits, and remedies for injuries due to health plan coverage disputes fall far short of the insurance standards and common law that exist in virtually all states.¹¹

Under the federal supremacy doctrine of the U.S. Constitution, when a state law directly conflicts with federal law, federal law prevails.¹² But while Congress typically allows states to regulate in areas where federal law is silent, ERISA traditionally supercedes such state legislation through its preemption provisions. ERISA’s so-called preemption clause, section 514(a) of the Act, states:

Except as provided in subsection (b)... the provisions of this [law] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...¹³ [Appendix A sets out ERISA’s preemption provisions.]

For purposes of ERISA, the term “state” includes states and political subdivisions as well as the District of Columbia and the territories. “State law” includes laws, decisions, rules, regulations or other actions having the effect of law.¹⁴

Chapter Highlights:

- ERISA’s preemption provisions invalidate state laws that have a connection with private-sector employee health plans, save from preemption state laws regulating insurance, and set federal standards for certain health benefits offered through group health plans.
- Initially broad court interpretations of the preemption clause have been narrowed in recent years.
- States can tax and regulate health care providers and insurers but are prohibited from enacting laws that impose administrative burdens or significant costs on employee plans.

ERISA's so-called "savings clause," section 514(b), exempts from preemption several types of state law: those regulating insurance, banking, and securities; criminal law; the Hawaii Prepaid Health Care Act; certain laws regulating multiple employer welfare arrangements; Medicaid secondary payer laws; and qualified domestic relations orders.¹⁵ Congress left state insurance regulation — a federal responsibility when it occurs in interstate commerce¹⁶ — to states in the 1945 McCarran-Ferguson Act.¹⁷ While state laws regulating health insurers are thus saved from preemption, in its "deemer clause" ERISA forbids a state to consider an employee benefit plan to be an insurer in order to bring it under state jurisdiction.¹⁸ A final section of ERISA's original preemption provisions notes that ERISA is not intended to invalidate or supercede other federal law.¹⁹

B. Prevalence of Employee Plan Self-Insurance

In 1997 about 123 million Americans had health coverage through ERISA plans operated by private-sector employers.²⁰ Another 32 million people receive coverage through federal, state, or local governments whose plans are not governed by ERISA. A substantial proportion of people with private employer-sponsored health coverage are in plans designated as self-insured.

State policymakers could use information on the extent to which employee health plans self-insure to determine the potential impacts of policy changes and to monitor health coverage over time. For a number of reasons, however, data on the prevalence of self-insurance are inconsistent at the national level and only rarely available at the state level. First, there is no commonly accepted definition of the term "self-insurance."²¹ Neither ERISA nor DOL regulations attempt to define this term, and courts have held that ERISA preempts state attempts to do so.²²

Because the DOL is not a complete source of national or state-specific data on the prevalence of self-insurance among ERISA plans,²³ this information must be collected through employer surveys, which can produce inconsistent estimates. For example, researchers at the RAND Corporation recently estimated that the prevalence of private employer self-insurance declined from 40 percent of the people insured through the workplace in 1993 to 33 percent in 1997.²⁴ In contrast, other researchers have estimated that the proportion of workplace-covered employees in self-insured plans increased from 46 percent in 1995 to 50 percent in 1998.²⁵ The DOL estimates that about 43 percent of Americans with private-sector health coverage are in self-insured plans. The variations in these estimates probably result from differences in sampling frames, different survey instruments, and normal statistical error.²⁶ A Robert Wood Johnson Foundation survey produced estimates of self-insurance in 10 states, but this survey has not been routinely updated nor is it available for all states.²⁷ An intermediate estimate drawn from these studies is that about 53 million Americans (43 percent of those in ERISA plans) are covered by self-insured plans.

The differences in estimates of the number of self-insured employee health plans makes it particularly difficult to observe trends. It is very likely that the proportion of employees covered by self-insured plans grew substantially from the 1970s until the 1980s when employee plans began to purchase health coverage from HMOs and other insured managed care plans. The prevalence of self-insurance could increase in the future if employer-sponsored plans become dissatisfied with HMO premium increases and begin to contract directly with unlicensed provider networks or "rent" managed care plan networks and care management services while

still claiming to bear the insurance risk.²⁸ More small firms may also be claiming to self-insure by buying very generous stop-loss coverage in order to avoid regulation.²⁹

C. Legislative History of ERISA's Preemption Provisions

The preemption provisions in the version of ERISA that originally passed the House and Senate were narrow, prohibiting states from legislating only matters specifically covered by the federal statute.³⁰ The broad preemption language finally enacted was added in the Conference Committee and described briefly in subsequent floor debates.³¹ The provision was thus not subjected to discussion or analysis in hearings preceding ERISA's enactment. What little legislative history exists to explain it comes from the conference report (which is not detailed),³² the post-conference statements on the floor of Congress, and recollections of congressional staff and lobbyists involved in the debate.

Rather than merely avoiding direct conflicts between levels of government, Congress enacted ERISA's preemption provisions to prohibit states from regulating even in areas where federal law was silent and where there would be no direct inconsistency. This was apparently done to eliminate regulatory variation across states. Representative John Dent called the preemption provisions the "crowning achievement" of the bill that would eliminate "the threat of conflicting and inconsistent state and local regulation",³³ a sentiment shared by Senate sponsor Harrison Williams.³⁴ Senator Jacob Javits supported broad preemption to avert "the possibility of endless litigation over the validity of state action that might impinge on federal regulation, as well as opening the door to multiple and potentially conflicting state laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the federal regulatory scheme."³⁵ Senator Javits did recommend, however, that the effects of preemption later be evaluated and that the preemption provisions be modified if it "has the effect of precluding essential legislation at either the state or federal level."³⁶

Recollections of advocates and congressional leaders involved in drafting ERISA suggest that Congress was aware of contemporary state proposals to tax and regulate private-sector employee health plans. Business and labor leaders sought broad preemption to thwart such proposals under discussion in Hawaii, California, and other states in the 1970s that might interfere with multi-state benefits contracts.³⁷ For example, since 1967, Hawaii had been developing a health care reform proposal that resulted in the Hawaii Prepaid Health Plan Act of 1974, mandating that all employers offer and partially finance employee health insurance.³⁸ In 1975, California enacted the Knox-Keene Act, regulating HMOs and other prepaid health care programs, arguably including those directly offered by employers.

Furthermore, the majority of states were beginning to require that health insurers cover specific providers, services, or beneficiaries. For example, by 1974, 31 states had required health insurers to reimburse such providers as chiropractors, dentists, optometrists, podiatrists, and psychologists, or cover newborns or disabled dependents.³⁹ Before ERISA was enacted, there were about 70 such mandates, and another 32 were passed in 1974. Although this is a small fraction of the more than 1,250 state health insurance mandates in effect in 1998, a trend to expand health insurance regulation may have been sufficiently evident in 1974 to raise the con-

Rather than merely avoiding direct conflicts between levels of government, Congress enacted ERISA's preemption provisions to prohibit states from regulating even in areas where federal law was silent and where there would be no direct inconsistency.

cerns of multi-state employers and union health plans that they might be taxed or subject to varying state standards.

There were apparently few self-insured plans in the early 1970s. The Health Insurance Association of America has estimated that only 4 percent of health benefits were paid under insurance administrative services (self-insured) plans in 1976,⁴⁰ in contrast to between 33 and 50 percent in recent years. But the self-funded plans that did exist would have been large, multi-state employers like Hewlett-Packard and Standard Oil, which would have desired interstate uniformity, been aware of state insurance regulation, and backed ERISA preemption. Labor representatives also supported broad preemption based on their belief that state mandates would interfere not only with national contracts but also with union bargaining power. Fearing the loss of business and labor support for broader pension reform, congressional conferees drafted the preemption provisions that were finally adopted. As one historical analysis concludes, a handful of congressional staff and lobbyists for labor and industry “made a major decision about employee benefits policy as if it were a technical issue.”⁴¹

While some preemption opponents have subsequently argued that the breadth of congressional preemption was “inadvertent”,⁴² others argue persuasively that while the provision was not “deeply considered” and there was no independent analysis of its long-term implications, Congress intended broad preemption in 1974.⁴³ Despite several recent ERISA amendments, the reluctance to modify ERISA’s preemption provisions suggests that Congress has generally been satisfied with their court interpretations over the years. The absence of more fundamental ERISA changes also underscores the political power of business and organized labor, who oppose repealing or substantially amending ERISA.⁴⁴

D. Recent ERISA Amendments

Congress has amended ERISA several times in the 25 years since its enactment. Two 1983 amendments have affected state health policy: the authorization of Hawaii’s mandate that employers provide and pay for employee health coverage, and the expanded state authority to regulate MEWAs (discussed more fully in chapters 4 and 6). In the 1985 budget bill (“COBRA”), Congress imposed its first broad mandate on ERISA plans, requiring employee plans to permit former employees and their dependents to remain in the group plan up to 36 months under certain circumstances upon payment of up to 102 percent of group premium.⁴⁵ Through the HIPAA and related laws, in 1996 Congress added several types of substantive standards to ERISA health plans: that they provide a limited form of mental health parity;⁴⁶ cover a minimum number of hours of post-delivery maternity and newborn hospitalization;⁴⁷ and include a series of access and portability standards for group health coverage (limits on pre-existing condition exclusion (pre-ex) periods, guaranteed issue for small groups and renewability regardless of health status of employees, and credit for pre-ex periods when changing insurers or employer plans).⁴⁸ In 1998 Congress required ERISA plans that cover mastectomy also to cover reconstructive surgery and related benefits.⁴⁹ These laws create a federal floor of consumer protections standards that apply to all ERISA plans but permit states to adopt more generous requirements for insurers. These provisions create several different types of state law preemption, resulting in new models of shared responsibility for employee health plan regula-

tion between state and federal governments.⁵⁰ Debates in the 106th Congress about regulating managed care plans continue this controversy over the proper balance of national versus state jurisdiction and highlight the complexity of crafting health coverage preemption language.

E. Supreme Court Interpretations of ERISA's Original Preemption Provisions

As the final arbiters of the meaning of both the U.S. Constitution and federal statutes, the federal courts are responsible for interpreting federal law. ERISA's preemption provisions are not particularly clear on their face; the U.S. Supreme Court has observed, for example, that section 514(a) is "not a model of legislative drafting",⁵¹ and its legislative history is sparse. So ERISA raises many unanswered questions, giving rise to thousands of preemption cases. This section summarizes the key federal court opinions that interpret the original preemption clause⁵² in cases relevant to state health policy initiatives. After determining that an employee benefits program is a "plan," the courts examine the affect of ERISA's preemption clause by asking two questions:

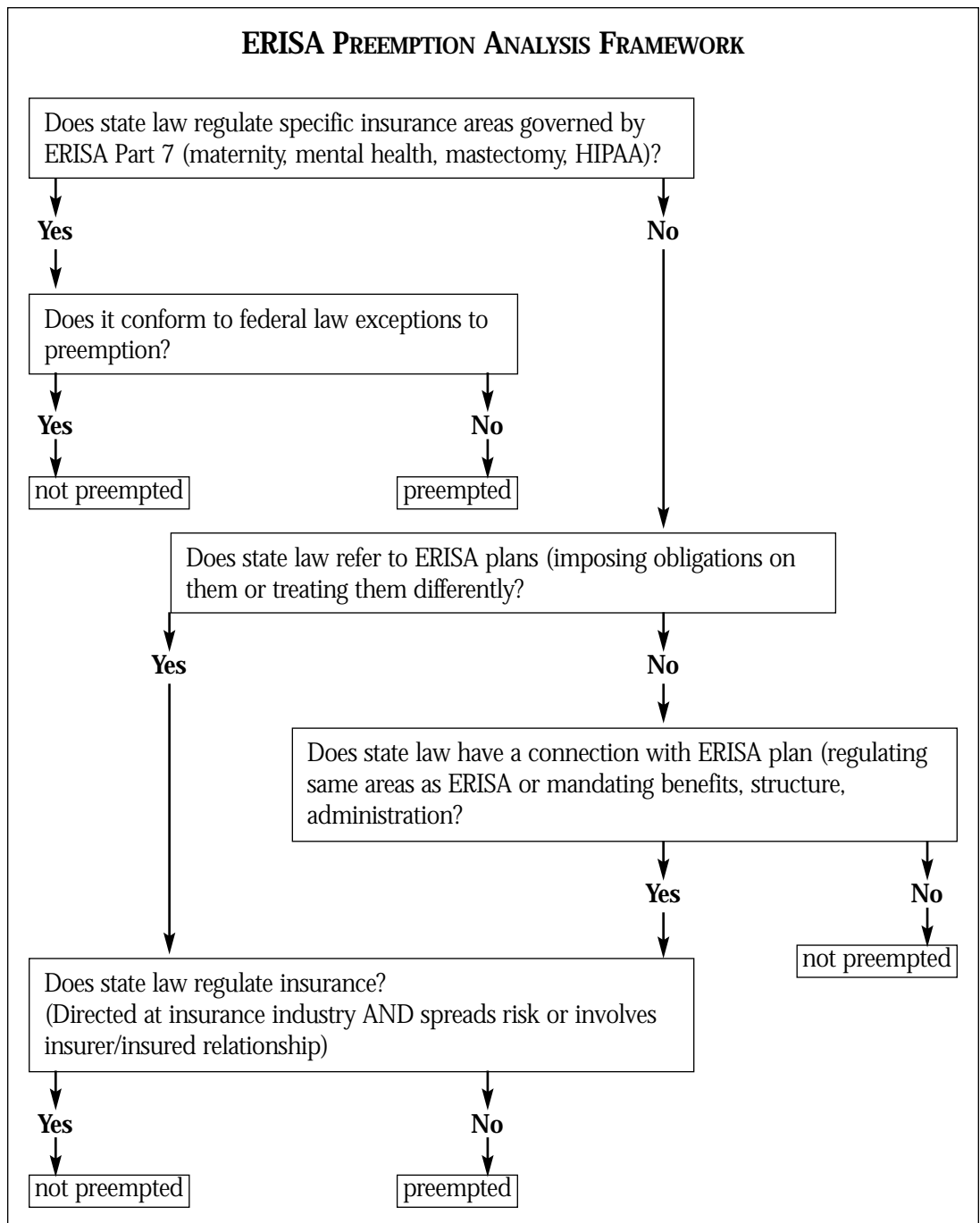
1. Does the state law in question "relate to" an ERISA plan? and
2. If it does, is it "saved" from preemption under ERISA's savings clause because it regulates the business of insurance?

It is important to understand the meaning of this framework and its application. To survive an ERISA preemption challenge, every state law must be determined either not "relate to" an ERISA plan (within the meaning of the preemption provisions) or to regulate the business of insurance (as the courts have defined this construct under ERISA).

1. What is an employee benefit plan under ERISA?

The courts have determined that most employee benefits programs constitute "plans" for purposes of ERISA.⁵³ The few exceptions include an employee severance program offered when the business closed⁵⁴ and vacation pay when an employee was discharged⁵⁵ because in both instances the employer did not have ongoing administrative responsibilities.

One of the many sources of confusion under ERISA is the meaning of the term "health plan." An ERISA (i.e., private-sector employer-sponsored) health plan is one that meets ERISA's technical definition as a program established by an employer or employee organization to provide health benefits.⁵⁶ In contrast, an employer's agreement to deduct from an employee's wages voluntary employee contributions to an insurance policy with no employer participation in selecting, paying for, or administering the health program does not constitute an ERISA plan.⁵⁷ Health coverage programs offered by managed care companies and other insurers are commonly referred to as health plans.⁵⁸ Even when sold to ERISA plans, however, these health coverage products are not of themselves ERISA plans.⁵⁹ Because the term "health plan" is ambiguous, courts sometimes appear to confuse the notions of the health benefits plan established by an employer, which is governed by ERISA, and the products sold to an employee health plan by insurers, which are a vehicle through which an ERISA plan offers benefits but are not themselves ERISA plans.



2. When does a state law “relate to” an employee benefit plan?

Determining whether a state law “relates to” an ERISA plan requires asking the following questions:

- Does it refer to ERISA plans specifically or is it a law of general applicability?
- If the law does not refer to ERISA plans, might it be argued to have a connection with ERISA plans so as to be preempted? For example:
 - Does it regulate areas already addressed by ERISA such as reporting, disclosure, remedies, or fiduciary obligations?

- Does it mandate an ERISA plan's benefits, structure, or administration, or merely limit the plan administrator's choices?
- Does it impose a substantial cost on ERISA plans?
- Does the state law involve an area of traditional state regulatory authority, such as public health, which makes it easier to argue that Congress did not intend ERISA to preempt it?

Two of the earliest ERISA preemption cases concerned health plan regulation under California's Knox-Keene Act⁶⁰ and the Hawaii Prepaid Health Plan Act.⁶¹ In cases challenging these laws, a federal court held that the California statute (requiring health plans to cover certain services) and the Hawaii employer mandate (defining required benefits and employer contributions) "related" to health plans because they affected them directly. Citing congressional intent to permit employee benefit plan uniformity across states, federal courts invalidated both state laws.

In 1981 the U.S. Supreme Court affirmed the decision in the Hawaii case without opinion in light of its first preemption case involving a New Jersey workers' compensation law that affected calculation of pension benefits.⁶² Unlike the California and Hawaii laws explicitly directed at employee benefit plans, the New Jersey state statute affected pension benefits only indirectly, yet the Supreme Court held it was preempted by ERISA.

In subsequent cases, the Court has reiterated the sweeping nature of section 514, stating that "relates to" means "having a connection with or referring to" an employee benefit plan⁶³ and that the clause is "conspicuous in its breadth."⁶⁴ These cases make clear that ERISA preempts state laws that either directly refer to employee plans⁶⁵ or dictate or restrict choices regarding a plan's structure,⁶⁶ benefits,⁶⁷ or administration.⁶⁸ It is important to note, however, that the Court has suggested there might be some state law impacts on a plan that are "too tenuous, remote, or peripheral" to be preempted,⁶⁹ though it has never decided such a case explicitly.⁷⁰

In its 1995 *Travelers Insurance*⁷¹ decision the Supreme Court narrowed the reach of ERISA's preemption provisions by limiting the types of state law impacts that "relate to" ERISA plans. The Supreme Court held that ERISA did not preempt a state law imposing surcharges on certain insurers' hospital bills because the state law was not directed specifically at health plans but rather was a law of general application within states' traditional area of authority (hospital rate-setting). In analyzing ERISA's preemption provisions, the Court observed that, taken literally, the words "relate to" have no logical limitation. The Court determined that despite the breadth of the preemption provisions, federal preemption is disfavored and should be construed only as broadly as appropriate to effect congressional intent. In the case of ERISA's preemption provisions, the Court determined that Congress intended to subject employee plans to a uniform body of benefits law and minimize administrative and financial burdens of complying with conflicting state and local requirements. Even though the Court concluded that the surcharges might have an indirect economic effect on plan choices, it determined they would not compel plan administrators to structure benefits in any particular way or limit a plan's ability to have uniform benefits packages or uniform administrative practices across state boundaries. Explicitly acknowledging state authority to regulate health care,⁷² the Court noted that the fact that hospital or other health care costs vary across states does not create an ERISA problem and that Congress could not have intended to preempt the many types of state health care regulation, such as quality standards or workplace regulations, that indirectly impose costs on ERISA health plans.⁷³ As a result of *Travelers*, states

Travelers and its successors stand for the proposition that ERISA preemption does not condemn all types of state health care regulation, as long as the state law is not directed at ERISA health plans, even if it has some effect on plan costs, benefit design, or administrative responsibilities.

can regulate hospital rates and, arguably, can tax health care providers. The Supreme Court reaffirmed this narrower interpretation of ERISA preemption in two 1997 cases.⁷⁴

Travelers and its successors stand for the proposition that ERISA preemption does not condemn all types of state health care regulation, as long as the state law is not directed at ERISA health plans, even if it has some effect on plan costs, benefit design, or administrative responsibilities. It specifically sanctions state health care rate-setting programs⁷⁵ and strongly suggests that states can use their authority to regulate health care providers⁷⁶ — for example, setting standards for provider networks — to achieve policy objectives that might previously have been challenged on ERISA grounds. These arguments will be explored in Chapters 5 through 8.

3. The insurance “savings clause”

ERISA’s major exception to preemption relevant to state health care legislation is state authority to regulate insurance. Determining whether a state law regulates insurance under the savings clause involves answering the following questions:

- Does the law meet the “common sense” view of insurance regulation by being directed specifically at the insurance industry and applicable only to insurance arrangements?
- If so, is the regulated activity one that:
 - spreads risk across a broad population?
 - integrally involves the relationship between the insurer and the insured (for example, the type of policy that can be issued and its reliability, interpretation, and enforcement)? and/or
 - is limited to entities within the insurance industry?

The Supreme Court has decided three cases interpreting the savings clause. In its 1985 *Metropolitan Life* decision,⁷⁷ the Court first concluded that a Massachusetts mental health insurance benefit mandate related to employee plans because it affected the benefits they must cover (if they chose to buy insured products). The Court then held that the state law was nevertheless not preempted because it was insurance regulation under the savings clause. The Court acknowledged that this exception to preemption establishes two classes of health benefits: those covered by traditional insurers, over which states have some influence by regulating insurers, and those covered by self-funded plans, whose benefits and administration states cannot control. The Court found that Congress was aware of this difference in treatment and was obligated to uphold congressional intent.⁷⁸ In deciding what state laws constitute “insurance regulation,” the Court first determined that the state law in question must meet the “common sense” test of insurance regulation by being directed specifically at insurers. It then applied three criteria from its cases interpreting the 1945 McCarran-Ferguson Act, which granted states authority to regulate insurance. The benefits mandate would be considered insurance regulation if the regulated activity: 1) spread risk; 2) involved the relationship between insured and insurer; and 3) was conducted by traditional insurers. In the 1987 *Pilot Life* case, the Court applied this framework and held that state common law remedies for fraud and breach of contract not specifically directed at the insurance industry failed this test.⁷⁹

Several lower courts have held that all three McCarran-Ferguson Act criteria must be met and that several state laws, such as any-willing-provider laws, did not satisfy all three. But in its

1999 *UNUM* decision, the Supreme Court reiterated earlier decisions to hold that these criteria are merely “considerations to be weighed” in deciding whether a state law is insurance regulation and that none alone is determinative.⁸⁰ The Court did not decide which, if any, of these criteria must be met (rendering no opinion on the lower court’s conclusion that the state law did not spread risk), but it found that the law in question mandates a policy term and consequently involves the policy relationship between the insurer and insured person. As discussed in Chapter 6, this opinion should help states defend many types of managed care standards on which ERISA might previously have cast doubt.

As is true for the first step in ERISA analysis (whether a state law relates to an ERISA plan), there is no simple template for deciding when a state law regulates insurance (whether satisfying any one of the three factors but not the others is sufficient, for example). But the *UNUM* decision, like that in *Travelers*, provides somewhat greater flexibility for states to defend insurance regulation against ERISA preemption challenges.

F. Lower Court ERISA Preemption Cases Involving Health Coverage

Many federal courts have attempted to apply these Supreme Court principles to employee health plan cases, such as those involving provider taxes, any-willing-provider laws, damages remedies for health plan coverage disputes, and health plan mandates. This section summarizes the key lower federal court opinions involving ERISA health plans. Other cases will be cited in the analysis of state health policy initiatives in Chapters 5 through 8.

1. Health care provider taxes

Following the Supreme Court’s *Travelers* decision, two federal Courts of Appeals upheld state laws imposing taxes on health care providers against ERISA challenges. The Eighth Circuit Court of Appeals upheld Minnesota’s tax on hospitals, physicians, and other providers whose revenues are used to fund programs for uninsured Minnesotans.⁸¹ The Second Circuit upheld two Connecticut hospital taxes that funded the state’s charity care pool.⁸² These cases extended the *Travelers* holding beyond state hospital rate regulation to provider taxes, citing *Travelers* for the proposition that ERISA does not preempt health care taxes and assessments that are not directed specifically at ERISA health plans, but do impose costs on them. Financing health care access initiatives is discussed in Chapter 5.

2. State provider mandate laws

Along with requiring managed care and other health insurance plans to cover specific services in their policies, most states have long mandated that insurers pay certain categories of providers — such as chiropractors and optometrists — if they render covered services.⁸³ Since the Supreme Court’s decision in *Metropolitan Life*, state policymakers have assumed that ERISA would not preempt these “provider mandates” because they resemble the mental health benefit mandate upheld in that case. The first case to raise this issue involved a state law prohibiting managed care and other health plans from excluding categories of providers that are licensed to provide services that the law requires plans to cover, such as acupuncture, massage therapy, and chiropractic care.⁸⁴ The Ninth Circuit Court of Appeals held that the provider mandate law did not relate to ERISA plans⁸⁵ and also that it was exempt under the savings clause, including an explicit holding that HMOs, to which the law applies, are insurers.

The UNUM decision, like that in *Travelers*, provides somewhat greater flexibility for states to defend insurance regulation against ERISA preemption challenges.

3. Any-willing-provider (AWP) laws

Courts have reached inconsistent conclusions regarding state laws requiring managed care plans to contract with any provider that agrees to comply with the plan's payment and other terms (typically pharmacies, but in some cases physicians and other providers). A 1993 decision by the Fourth Circuit Court of Appeals upheld Virginia's AWP law that applied only to insurance carriers.⁸⁶ But more recent decisions by the Fifth and Eighth Circuits hold that ERISA preempts such laws in Arkansas, Louisiana, and Texas because they directly referred to ERISA plans by attempting to either include or exempt them from the AWP requirement.⁸⁷ These courts also held that the AWP laws are not saved from preemption because they did not meet all of the McCarran-Ferguson criteria: they were not limited in their application to insurers (because they applied either to self-insured plans or to HMOs, which some courts have held are not insurers⁸⁸); their purpose was to benefit health care providers, not health plan enrollees; and they did not spread risk (because they expanded networks, not covered services). Although under the Supreme Court's decision in *UNUM* an AWP law need not involve risk-spreading, the *UNUM* decision does not explicitly overcome these Court of Appeals' conclusions that because HMOs are not insurers, the AWP law does not even meet the "common sense" test of insurance regulation.

Finally, a federal district court in Massachusetts held that ERISA does not preempt the state's any-willing-pharmacy law.⁸⁹ Relying on *Travelers* and its successors, the district court held that the law does not relate to ERISA plans because these plans could self-insure if they did not want to use an expanded provider network⁹⁰ and because health plan administration is not the type of core plan administrative function whose non-uniformity concerned Congress in enacting ERISA's preemption provisions. The court also held that even if the AWP law related to ERISA plans, it was saved from preemption because it satisfied all three McCarran-Ferguson criteria to regulate the business of insurance.⁹¹ ERISA implications for health insurance regulation are discussed in Chapter 6.

4. Health plan damages remedies

In its 1987 *Pilot Life* decision, the Supreme Court held that ERISA preempts a state court suit seeking punitive damages against a disability insurer for wrongfully failing to pay a claim. This case has been applied to bar state court damages suits against private-sector employee health plans for injuries due to a plan's coverage denial or delay. *Pilot Life* is based on two types of federal law preemption. First, the Court applied the traditional constitutional doctrine that federal law prevails over a directly conflicting state law.⁹² It noted that ERISA provides remedies for an employee plan's denial of coverage — a federal lawsuit to recover benefits due or enforce plan terms. But the Court held that because ERISA does not provide for other damages remedies, such as lost wages, pain and suffering, or punitive damages, Congress implicitly intended to prohibit them. Second, the Court held that state common law damages remedies relate to ERISA plans by affecting the manner in which benefits disputes are addressed, a significant plan administration responsibility. Furthermore, the Court held that because the common law damages could be sought from organizations other than insurers, the law was not saved from preemption because it was not directed at the insurance industry. This reasoning has been applied by many federal courts to prohibit damages suits by health plan enrollees injured by health plan coverage denials and delays.⁹³

In an apparent effort to provide relief to some injured people, however, the majority of federal courts in recent years have drawn a distinction between disputes where enrollees challenge

health plan coverage decisions (where ERISA remedies are exclusive and state court lawsuits are preempted) and more traditional medical malpractice cases where a health plan controls a clinician's practice so as to be held responsible under traditional legal doctrines of an employer's liability for employee misconduct.⁹⁴ Most courts hold that these so-called "quality" or malpractice cases seeking lost wages, compensation for pain and suffering, or punitive damages can be brought in state court. Drawing this distinction can be difficult because health plans may design payment and coverage policies to influence provider practice.⁹⁵ For example, health plan policies typically limit coverage to medically necessary services, which requires their staff to determine the medical appropriateness of a service for an enrollee's condition. Despite the control over medical practice that such analysis suggests, the courts generally have considered such decisions to involve the interpretation of ERISA plan coverage terms and hold that state court disputes over them are preempted.⁹⁶ ERISA implications for state policy to resolve disputes between health plans and their enrollees are discussed in Chapter 7.

G. Conclusion

ERISA permits states to regulate the business of insurance but does not inhibit state regulation of the individual insurance market or employee plans offered by state or local governments or religious institutions. But the federal law prohibits states from directly regulating self-insured ERISA plans, which cover 33 to 50 percent of Americans with health care coverage. Because some courts disagree on the proper interpretation of ERISA's preemption and savings clauses, and because so many state laws that might arguably affect ERISA plans or involve insurance regulation have not been challenged, there remains much uncertainty about how the courts might treat a particular state law. The language of ERISA's preemption provisions certainly prohibits states from enforcing laws, other than those regulating traditional insurance carriers, with intended or direct impact on employee health plans.

Until the Supreme Court decides a case (and even then its decision technically applies only to the facts of the case before it), the scope of ERISA preemption is unclear. Based on the terms of the federal law and fairly unambiguous Supreme Court precedent, however, a few general conclusions about ERISA preemption can still be drawn.

■ State laws generally **cannot**:

- mandate that employers offer or pay for insurance;
- directly tax such private employee health plans (whether insured or self-insured);
- regulate private employee health plan benefits or solvency;
- require private employee health plans to report data to the state; or
- provide damages remedies for insurers' failure to pay covered benefits.

■ State laws generally **can**:

- tax and regulate health insurers (e.g., mandating benefits to be included in health insurance products and other insurance policy terms);
- tax and regulate health care providers;

Until the Supreme Court decides a case (and even then its decision technically applies only to the facts of the case before it), the scope of ERISA preemption is unclear.

- regulate Multiple Employee Welfare Arrangements (MEWAs); and
- provide enrollees the right to sue their health plans for controlling or influencing clinician's health services (traditional medical malpractice cases).

Because few courts have addressed ERISA preemption of state health policy and court interpretations have been inconsistent, *ERISA implications for many state initiatives to expand coverage, regulate health insurers and insurance markets, and monitor health care delivery systems remain uncertain, including state authority to:*

- assure that publicly funded health care access programs coordinate closely with employment-based coverage;
- provide employer tax credits or deductions that are conditioned on meeting specific standards for health benefits;
- require employee plans to pay health care provider assessments directly to state agencies;
- impose various types of managed care standards, especially those governing plan- provider conduct, such as AWP laws;
- regulate non-traditional insurers, such as provider-sponsored organizations, accepting risk from ERISA plans;
- regulate stop-loss insurance policies;
- regulate third-party administrators of employee health coverage programs;
- obtain information on health care coverage, use, and costs from organizations other than licensed HMOs and other insurers; and
- prescribe external appeals systems.

ERISA preemption implications for these and related state health policy initiatives are the subject of Chapters 5 through 8.

Notes

1. 29 U.S.C. sections 1001 *et seq.*
2. 29 U.S.C sections 1002 (1), (3).
3. The statute defines “employer” as a person “acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan, and includes a group or association of employers acting for an employer in such capacity,” 29 U.S.C. section 1002(5).
4. The statute defines “employee organization” as a “labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, or dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose in whole or in part, or establishing such a plan,” 29 U.S.C. section 1002(4).
5. ERISA allows churches to voluntarily bring their pension programs (but not other employee benefit plans such as health plans) under ERISA jurisdiction.
6. States can, and do, regulate self-funded workers’ compensation plans. But the Supreme Court held in *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), that states cannot regulate employee benefits plans that combine health benefits with workers’ compensation, unemployment, or state-mandated disability benefits. This raises some specialized ERISA preemption issues for states experimenting with integrated “24-hour coverage programs” (which are beyond the scope of this manual). The *Delta Air Lines* decision does not allow employers to avoid state regulation of workers’ compensation, unemployment, or disability plans, however, because the states can require the employer to provide the state’s required benefits through a separate state-regulated program. The Supreme Court has also held that the workers’ compensation clause does not authorize states to require employers to keep workers’ compensation claimants on their health plans, because such laws relate to the employer’s ERISA health plan, *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992).
7. 29 U.S.C. section 1003(b).
8. Plans must provide a “summary plan description” that includes the name and address of the plan administrator, requirements of eligibility to receive benefits, circumstances that may result in ineligibility or denial of benefits, a general description of benefits, whether an insurer is involved in funding or administering the plan, methods of presenting claims, and grievance processes. 29 U.S.C. sections 1021-1022. The U.S. DOL has opined that plans must also provide upon request information on provider payment schedules, DOL Op. 96-14A (7/31/96).
9. Plan administrator(s) must operate the plan prudently and in the best interests of plan participants. 29 U.S.C. section 1104(a)(1). This obligation has been interpreted to permit suits for damages where, for example, a plan administrator failed to disclose financial incentives imposed on health care providers that could influence a provider’s willingness to refer patients to diagnostic services (*Shea v. Eisensten*, 107 F.3d 625 (8th Cir. 1997), *cert. denied*, 66 U.S. 3137 (1997)).

and *Drolet v. Healthsource, Inc.*, 968 F. Supp. 757 (D. N.H. 1997)) or where an employer encouraged employees to move to another business without disclosing its instability that jeopardized their pension rights (*Varity Corp. v. Howe*, 516 U.S. 489 (1996)). The Seventh Circuit Court of Appeals recently held that a plan may have breached its fiduciary duty by incentive payments that discouraged physicians from providing necessary care, *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1999), *cert. granted*, 67 U.S.L.W. 3758 (1999). A district court held, however, that a managed care plan did not breach its fiduciary duty by changing the way it paid physicians, which caused the plaintiff's primary care physician to leave the plan. *Maltz v. Aetna Health Plans of New York*, 114 F.3d 9 (2d Cir. 1997). And another held that financial incentives that allegedly prevented physicians from advising patients of their treatment options or imposing financial risk on physicians did not necessarily violate the plan's fiduciary duty (*Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (S.D. N.Y. 1997)).

10. 29 U.S.C. section 1051.

11. Butler, P.A. and K. Polzer. 1996. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: George Washington University Health Policy Forum; U.S. GAO. 1995. *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*. GAO/HEHS-85-167, U.S. Government Printing Office; U.S. GAO. 1998. *Indemnity Health Plans: Key Features of Consumer Complaint and Appeal Systems*. GAO/HEHS-98-189. Washington, D.C: U.S. Government Printing Office.

12. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997). The conflict can result when compliance with both state and federal law is a "physical impossibility," *Florida Avocado Growers v. Paul*, 373 U.S. 132, 142-143 (1962) or when the "scheme of federal regulation is 'so pervasive as to make reasonable the inference that Congress left no room for the states to supplement it,'" *Gade v. National Solid Wastes Management Assoc.*, 505 U.S. 88, 98 (1992).

13. 29 U.S.C. section 1144(a).

14. 29 U.S.C. section 1144(c).

15. 29 U.S.C. section 1144(b)(2)(A).

16. *U.S. v. Southeastern Underwriters' Assoc.*, 322 U.S. 533 (1944).

17 (17) 15 U.S.C. section 1101 *et seq.*

18 (18) 29 U.S.C. section 1144(b)(2)(B).

19. 29 U.S.C. section 1144(d). This so-called "equal dignity" clause has been interpreted to preserve other federal law, such as bankruptcy law, and state laws conforming to it, insofar as it is consistent with ERISA, *Heitkamp v. Dyke*, 943 F.2d 1435 (5th Cir. 1991).

20. These data, deriving from the 1998 Current Population Survey, were provided by Len Nichols of the Urban Institute.

21. The terms “self-insurance” and “self-funding” are often used interchangeably. Both terms present problems of accuracy. Self-funding suggests that there is a separate fund or trust from which benefits are paid (rarely true for non-insured employee health plans). Self-insured implies the pooling of insurance risk. For simplicity, this Manual will use the term “self-insured” to mean ERISA plans whose “insurance” risk is not covered, at least in part, by an insurer such as an indemnity carrier, HMO, or other insuring entity.

22. *American Medical Sec. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997), *cert. denied*, 118 S. Ct. 2340 (1998); *Associated Indus. of Missouri v. Missouri Dept. of Ins.*, Cole County Circuit Court, CV195-1326CC, December 27, 1995.

23. The DOL has access to information that ERISA plan sponsors provide on IRS Form 5500, including whether a welfare benefit plan is offered through an insurance contract. But firms with fewer than 100 employees do not need to file this form, so data on source of coverage are not available for smaller plans. Furthermore, the accuracy of the unaudited Form 5500 data is uncertain. Although the DOL has no source of state-level data about ERISA plans, a contractor for the DOL recently developed state-specific estimates of the numbers and proportions of ERISA health plan participants in insured and self-insured plans. These estimates, derived from existing national databases and prior studies, are available from Joseph Piacetini, DOL/PWBA, 202-219-7222 ext. 2402.

24. Marquis, S. and S. Long. 1999. “Recent Trends in Self-Insured Employer Health Plans.” *Health Affairs* 18(2):161-166.

25. Jensen, G. A. and M.A. Morrissey. December 1999. “Employer-Sponsored Health Insurance and Mandated Benefit Laws.” *Milbank Quarterly*, citing studies by Gabel and Jensen.

26. Analysis by Long and Marquis (“Recent Trends in Self-Insured Employer Health Plans”), for example, used a Robert Wood Johnson Foundation survey of 22,000 employers in 10 states in 1993 and a survey of 21,000 employers in 60 large communities in 1997. The wording of the questionnaire was revised between the two surveys. The Gabel and Jensen study used KPMG Peat Marwick and Wayne State University studies of 2,000 firms nationwide. In a personal communication with the author, Gail Jensen reported that the prevalence of self-insured plans increased from 1995 to 1996 and decreased from 1996 to 1998 but still increased overall from 1995 to 1998. She said she suspects the decrease may be due to HIPAA, which reduced the advantages for small firms to self-insure.

27. Acs, G., S.H. Long, S. Marquis and P. F. Short. 1996. “Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums.” *Health Affairs* 15(2):266-278.

28. Recent analysis by Marquis and Long (“Recent Trends in Self-Insured Employer Health Plans”) suggest that this phenomenon was not prevalent in 1997 and its coverage of employees increased only slightly between 1993 and 1997.

29. Stop-loss insurance (often purchased by insurers) protects the plan from individual high-cost cases or high aggregate group claims. Some employers buy stop-loss that pays for claims above low thresholds of \$500 to \$1000; this type of coverage resembles regular health insurance

and has been the subject of state regulation and ERISA preemption challenges, discussed in Chapter 6.

30. H. R. Rep. No. 93-533 and 93-807, 93rd Cong., 2d Sess. (1974); S. Rep. 93-127 and 93-383, 93rd Cong., 2d Sess. (1974).

31. 120 Cong Rec. 29,197, 29,933, 29,942 (1974).

32. H.R. Rep. No. 93-1280, 93rd Cong., 2d Sess. 383 (1974), U.S.C.C.A.N. 93d Cong. 2d Sess. at 5162.

33. 120 Cong. Rec. 29,197, August 20, 1974.

34. 120 Cong. Rec. 29,933, August 22, 1974.

35. 120 Cong. Rec. 29,942, August 22, 1974.

36. Id. The Congressional Pension Task Force established under the law was charged with studying the effects of preemption. In 1977 the U.S. House of Representatives Labor and Education Committee held ERISA oversight hearings and reported that the “federal interest and need for national uniformity are so great that enforcement of state regulation should be precluded” (H. Rep. 94-1785 at 47) and it was “convinced of the propriety and necessity for the very broad preemption policy contained in section 514” (Id at 48).

37. Martin, N. 1993. “ERISA: The Law that Ate Health Care Reform.” *California Lawyer* (May): 40-44, 86-87; Gordon, M. 1992. “The History of ERISA’s preemption provision and its bearing on the current debate over health system reforms.” Presentation to the George Washington University Health Policy Forum, Washington, D.C. (November 18); Fox, D. M and D. C. Schaffer. 1989. “Health Policy and ERISA: Interest Groups and Semipreemption.” *Journal of Health Politics, Policy, and Law* 14 (2): 239-260.

38. Neubauer, D. 1993. “State Model: Hawaii.” *Health Affairs* 12(2): 31-39.

39. Laudicina, S. S., J.Y. Yerby, and K. Pardo. 1998. *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans*. Washington, D.C.: BlueCross BlueShield Association.

40. Author’s personal communication with Thomas Musco, HIAA, December 14, 1993.

41. Fox and Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption* at 244.

42. This was Senator Inouye’s characterization (at hearings on Hawaii’s bid for an exception) of the Standard Oil District Court’s reference to the fact that Congress had not discussed preemption explicitly in legislative history (Fox and Schaffer, *Health Policy and ERISA: Interest Grops and Semipreemption* at 248).

43. Fox and Schaffer, *Health Policy and ERISA: Interest Groups and Semipreemption*.

44. Atkins, G. L. Atkins and K. Bass. 1995. *ERISA Preemption: The Key to Market Innovation in Health Care*. Washington, D.C.: Corporate Health Care Coalition.
45. 29 U.S.C. sections 1161-1168 were enacted by COBRA.
46. 29 U.S.C. section 1185a was enacted by the Mental Health Parity Act of 1996. State laws regarding mental health parity for health insurance issuers apply except to the extent that they “prevent the application” of the federal law, 29 U.S.C. section 1191(a)(1).
47. 29 U.S.C. section 1185 was enacted through the Newborns and Mothers Health Protection Act of 1996. The federal law does not apply to newborn coverage of a health insurance issuer if state law requires either: at least 48-hour stay for a vaginal delivery (and 96 for caesarean section); maternity and pediatric care under guidelines of established professional medical societies; or maternity hospitalization is left to the decision of the attending provider and mother.
48. 29 U.S.C. sections 1181-1183 were enacted by HIPAA. This federal law prescribes the only areas where state group insurance market reforms may differ from federal law to be: shortening the 6-month period prior to enrollment date during which a pre-existing condition can be determined; shortening the 12- and 18-month pre-existing condition exclusion periods; increasing the 63-day break-in-coverage period beyond which the pre-ex credit need not apply; increasing the 30-day period for newborns and adopted children to enroll without a pre-ex period; expanding beyond those in federal law the prohibitions on conditions and people to whom a pre-ex period may be applied; requiring additional special enrollment periods; and reducing the maximum HMO affiliation period to less than two months, 42 U.S.C. section 300gg-23(b).
49. 29 U.S.C. section 1185b was enacted by the Women’s Health and Cancer Rights Act of 1998. This federal law does not preempt state law in effect before October 21, 1998 if it requires at least the coverage in federal law.
50. As discussed in end notes 46-49, some differing state laws are permitted in only specific circumstances while others are permitted as long as they do not prevent the operation of the relevant federal law.
51. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 at 740 (1985).
52. If courts are confronted with challenges to state laws involving the same subject areas as recent changes to Part 7 of ERISA (maternity hospitalization, mental health parity, post-mastectomy coverage and HIPAA), they will use a different analytical framework from the one involving section 514 cases. A court would ask whether the state law complies with the exceptions to preemption set out in the federal statute (outlined in endnotes 46-49). No such cases have been reported.
53. *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982). The Pension and Welfare Benefits Administration of the DOL has issued many advisory opinions addressing what constitutes a plan for purposes of ERISA.

54. *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987).
55. *Massachusetts v. Morash*, 490 U.S. 107 (1989).
56. 29 U.S.C. section 1002 (1).
57. See DOL regulation 29 C.F.R. section 2510.3-1(j) (1998), *Johnson v. Watts*, 63 F.3d 1129 (1st Cir. 1995); *Levett v. American Heritage Life Ins. Co.*, 971 F. Supp. 1399 (M.D. Ala. 1997); *Cooley v. Protective Life Ins. Co.*, 815 F. Supp. 189 (S.D. Miss. 1993).
58. HIPAA introduced a new definition of “group health plan”: “an employee welfare benefit plan to the extent that the plan provides medical care...to employees or their dependents... Directly or through insurance reimbursement, or otherwise.” 29 U.S.C. section 119b (a)(1).
59. The health insurer becomes an ERISA fiduciary with certain duties to plan participants if it exercises discretion in administering benefits under an employer plan, but this does not turn the health insurance product itself into an ERISA plan.
60. *Hewlett-Packard v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978).
61. *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).
62. In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court held that ERISA preempted a state law prohibiting workers’ compensation awards from being offset against pension benefits even though the effect on pension benefits was indirect. The Court noted that “every action bearing on private pensions may encroach on areas of exclusive federal concern.” 441 U.S. at 525.
63. In *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983), the Supreme Court held that ERISA preempted two state statutes requiring pregnancy leave because they have an impact on employee benefits.
64. In *FMC Corp. v. Holliday Corp.*, 498 U.S. 52 (1990), the Supreme Court held that ERISA preempted a state law prohibiting ERISA health plans from recovering money a plan participant received from a negligent automobile driver for accident-related medical costs because the state’s “anti-subrogation” law related to an employee benefits plan.
65. In *Mackey v. Lanier Collection Agency*, 486 U.S. 834 (1988), the Court held that ERISA preempted a Georgia statute that *exempted* ERISA plans from state garnishment laws because the law referred directly to ERISA plans and treated them differently (albeit preferentially) than other plans. In *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992), the Court reiterated that reference to an employee plan compels preemption in a case involving a D.C. ordinance requiring an employer’s workers’ compensation benefits to cover the same health benefit as those offered under an employee health plan, *if the employer provided one*.

66. *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) held that ERISA preempted a state law prohibiting employee health plans from discriminating on the basis of pregnancy and requiring employers to provide sick leave for pregnancy.

67. *Metropolitan Life In. Co. v. Massachusetts*, 471 U.S. 724 (1985) held that mental health benefits mandates would be preempted if they applied directly to self-insured plans. In that case, they applied only to insured products and were saved from preemption under ERISA's savings clause.

68. *Alessi v. Raybestos-Manhattan, Inc.* 451 U.S. 504 (1981) held that ERISA preempted a state law prohibiting workers' compensation awards from being offset against pension benefits, even though the impact on pension benefits was indirect.

69. *Shaw v. Delta Air Lines*, 463 U.S. at 100 (1983).

70. In *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992), the Court reiterated such an exception, citing as an example *Mackey v. Lanier Collection Agency*, 486 U.S. 825 (1987), upholding application of a state's general garnishment statute to an ERISA welfare plan despite alleged costs and burdens on the plan (and was criticized by the dissent for so doing).

71. In *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), insurers challenged New York's requirement that hospitals add surcharges to their rates to be collected from all third-party payors other than the state's Medicaid program and Blue Cross and Blue Shield plans. The purpose of the surcharges was to reduce the competitive disadvantage to the Blues plans that occurred because of their higher premiums, resulting from serving as "insurers of last resort" for less healthy individuals. The lower federal courts had held that ERISA preempted this surcharge because the law related to ERISA health plans by imposing costs on those that used other insurers, forcing them to either use Blue Cross or reduce benefits.

72. A law that is in a state's traditional area of authority, such as health care regulation, is not automatically exempt from preemption, but the Court suggested that it is less likely that Congress intended ERISA to preempt such laws. Consequently, it should be somewhat easier to defend laws within state's traditional sphere of authority against ERISA challenges.

73. The Court did say that state laws imposing "exorbitant" costs on ERISA plans might have a sufficient impact to relate to them, 514 U.S. at 664, but the 13 percent and 24 percent surcharges at issue in *Travelers* were not so great as to compel preemption.

74. *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997), presented the unique situation of a union-operated ERISA health plan that owned clinics. The union ERISA plan challenged New York's tax on the gross receipts of licensed health care facilities such as hospitals and clinics. In an apparent inconsistency with the *Travelers* decision, the Second Circuit Court of Appeals (the same court whose *Travelers* decision was reversed by the Supreme Court) agreed with the health plan that ERISA preempts the law because (unlike the insurance surcharge in *Travelers*) the tax directly applied to the employee health plan's assets. The Supreme Court, however, reversed the Court of Appeals' decision, reiterating its conclusion in

Travelers that ERISA was not intended to preempt states' "historic police powers" in regulating matters of health and safety. Earlier this same term, the Court also relied on *Travelers* in upholding, against an ERISA preemption challenge, a California law permitting lower wages to be paid in state-approved employee apprenticeship programs (a type of ERISA plan) that participate in public works programs. In *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997), the Court characterized a state law setting standards for voluntary use of approved apprentice programs as analogous to the New York hospital rate law, both of which exerted indirect economic influence but did not mandate employee benefit plan structure or administration. The Court noted that states traditionally regulate wages in public works projects and this law altered incentives but did not require use of an apprentice program.

75. Ironically, state interest in hospital rate-setting was waning by the time of the *Travelers* decision. New York repealed its hospital rate-setting law in 1996. Currently only Maryland maintains a program of setting hospital rates. For a historical analysis of the politics of rate-setting programs in Massachusetts, Maryland, New Jersey and New York, see, McDonough, J. 1997. *Interests, Ideas, and Deregulation: The Fate of Hospital Rate Setting*. Ann Arbor: University of Michigan Press.

76. For example, states should easily be able to defend both general health care provider quality and other standards imposed under state licensing laws as well as regulation of provider networks that contract with managed care plans and other payors (discussed more fully in end note 11, Chapter 6).

77. *Metropolitan Life Ins. Co.*, 471 U.S. 724 (1985).

78. 471 U.S. at 747, n. 25.

79. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), involved a suit for actual and punitive damages against an employee disability plan insurer for failure to pay a claim. The Court held that the state law remedy relates to the employee disability plan, was not saved as insurance regulation, and also directly conflicted with ERISA's limited court remedies (to recover the cost of the benefit in dispute or enforce plan terms).

80. *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999), involved an employer's disability plan that refused to pay benefits because the employee submitted his application beyond the plan's time limit. Under California's common law (court-made) "notice-prejudice rule," a penalty for the insured's failing to file timely is waived unless the insurer has been prejudiced by the delay. The disability insurer asserted that ERISA preempts this state law, but the Supreme Court held that it is a law regulating the business of insurance and therefore is saved from preemption. Because the parties agreed that the notice-prejudice rule relates to employee benefit plans by affecting their administration, the opinion involved only ERISA's savings clause.

81. *Boyle v. Anderson*, 68 F3d 1093 (8th Cir. 1995), *cert. denied*, 516 U.S. 1173 (1996).

82. *New England Health Care Employees Union v. Mount Sinai Hospital*, 65 F3d 1024 (2d Cir. 1995); *Connecticut Hosp. Assoc. v. Weltman*, 66 F3d 413 (2d Cir. 1995).

83. Laudicina, et al. *State Legislative Health Care and Insurance Issues: 1996 Survey of Plans*.
84. *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999).
85. The Court of Appeals held that the law does not refer to ERISA plans although it does exempt them from the law's application (which the Supreme Court in *Mackey* and the Eighth Circuit Court in *Prudential Ins. Co. v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998), held to compel preemption). The Court then held that the state law does not relate to ERISA plans because it does not force employers to offer any type of plan. And it held that the law regulates the business of insurance as satisfying all the Supreme Court's insurance regulation factors (although it held that all the criteria need not be met), including an opinion that HMOs are insurers.
86. *Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993).
87. In *CIGNA Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996) *cert. denied*, 519 U.S. 964 (1996) and *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) *cert. denied*, 118 S. Ct. 75 (1997), the state laws attempted to impose the AWP requirements on employee (i.e., ERISA) plans. In *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998), the law attempted to exempt "self-funded or other health benefits plans that are exempt by virtue of" ERISA, citing the Supreme Court's decision in *Mackey*.
88. A few old state court cases held that HMOs and Blue Cross plans were not insurers subject to state insurance law because they did not indemnify enrollees but provided services directly. These cases may be one reason that most states have drafted separate enabling legislation to license HMOs. See, e.g., *Jordan v. Group Health Association*, 107 F.2d 239 (D. D.C. 1939); *California Physicians' Service v. Garrison*, 172 P. 2d 4 (Cal. 1946); *Michigan Hosp. Serv. v. Sharpe*, 63 N.W. 2d 638 (Mich. 1954). But see, *Klamath-Lake Pharmaceutical Assoc. v. Klamath Medical Services Bureau*, 701 F.2d 1276 (9th Cir. 1983), *cert. denied*, 464 U.S. 822 (1983). *O'Reilly v. Cueleers*, 912 F.2d 1383 (11th Cir. 1990) involved a bankrupt HMO employee's claim for severance pay based on an alleged breach of the HMO's fiduciary duty, a cause of action available only if the HMO were an insurer under state insurance receivership law. The Court of Appeals held that it was not an insurer and denied the cause of action. *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993) was a malpractice-type claim under the state's hospital emergency treatment ("anti-dumping") law that the court held that ERISA preempted because the HMO was not an insurer, citing *O'Reilly*.

See also, *Prudential Insurance Co. v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998); *Cigna Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996) *cert. denied*, 117 S. Ct. 387 (1996) and *Texas Pharmacy Association v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) *cert. denied*, 118 S. Ct. 75 (1997); *Ryan v. Fallon Community Health Plan*, 921 F. Supp. 34 (D. Mass. 1996) (state cause of action for unfair and deceptive insurance practices preempted); *Dees v. Primehealth*, 894 F. Supp. 1549 (S.D. Ala. 1995) (state subrogation law preempted); *New York State Health Maintenance Organization Conference v. Curiale*, S.D.N.Y., 93 Civ. 1298, February 25, 1994, *rev'd on other grounds*, 64 F.3d 794 (2d Cir. 1995) (demographic pooling arrangement to

share costs of high-risk cases across HMOs preempted); *OraCare DPO v. Merin*, 13 Employee Benefits Cases 2720 (D. N.J. 1991) (law requiring a state license for a prepaid dental plan preempted); *McManus v. Travelers Health Network of Texas*, 742 F. Supp. 377 (W.D. Tex. 1990) (HMO Act's unfair practices act provisions would be preempted).

In contrast, however, the Ninth Circuit Court of Appeals has held that HMOs are insurers in Washington state, *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999). See also, *Physicians Health Plan v. Citizens Ins. Co.*, 673 F. Supp. 903 (W.D. Mich. 1987) (state's coordination of benefits law was not preempted because it regulated the business of insurance and HMOs were insurers; *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996) (state law requiring continuation of coverage through an employee's HMO for a divorced spouse was not preempted because it regulated the business of insurance and HMOs are insurers, disagreeing with the holding in *Ryan v. Fallon Community Health Plan*); *Anderson v. Humana*, 24 F.3d 899 (7th Cir. 1994). In *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the federal district court agreed with *Cellilli* and disagreed with *Ryan*.

89. *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997).

90. This argument presents a dilemma for states because they do not necessarily want to encourage self-insurance to escape state regulation.

91. The court held that the law spreads risk by expanding networks and transferring to insurers the costs an enrollee would pay to a non-network pharmacy; was a policy term because it expands the range of providers; and was a law regulating insurance entities (explicitly recognizing HMOs as insurers).

92. See cases cited in note 12.

93. *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999); *Danca v. Private Healthcare Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Insurance Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994); *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1992), *cert. denied*, 510 U.S. 1045 (1994), *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D. N. Y. 1994); *Dearmas v. Av-Med, Inc.* See *Oullette v. Christ Hospital*, No. C-1-96-370 (S. D. Ohio Oct. 10, 1996).

94. In *U.S. Healthcare, Inc. v. Bauman*, 3rd Cir. Sept. 16, 1999, the Court of Appeals held a health plan's policy that newborns should be discharged within 24 hours involved a dispute over the plan's medical treatment policy, not plan coverage policy. In *Dukes v. U.S. Healthcare System of Pa.*, 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995), the Court of Appeals held that where a provider failed to provide appropriate tests (not because they were not covered by the plan) the state law case is not so obviously preempted that a state court could not decide that issue after a factual hearing (this involves the issue of whether there is

“complete” preemption so as to require moving the case to federal court). See also, *Rice v. Panchal*, 65 F3d 637 (7th Cir. 1995), *Pacificare of Oklahoma v. Burrage*, 59 F3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Intn’l, Inc.*, 28 F3d 269 (2d Cir. 1994); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Haas v. Group Health Plan, Inc.*, 875 F Supp. 544 (S.D. Ill. 1994); *Burke v. Smithkline Bio-Science Labs*, 858 F Supp. 1181 (M.D. Fla. 1994), *Paterno v. Albuerne*, 855 F Supp. 1263 (S.D. Fla. 1994), *Smith v. HMO Great Lakes*, 852 F Supp. 669 (N.D. Ill. 1994); *Elsesser v. Hospital of Philadelphia College*, 802 F Supp. 1286 (E.D. Pa. 1992); *Independence HMO, Inc. v. Smith*, 733 F Supp. 983 (E.D. Pa. 1990); *Newton v. Tavani*, 962 F Supp. 45 (D. N.J. 1997); *Lancaster v. Kaiser Foundation Health Plan*, 958 F Supp. 1137 (E.D. Va. 1997); *Schwartz v. FHP Int’l*, 947 F Supp. 1354 (D. Ariz 1996); *Kampmeir v. Sacred Heart Hosp.*, (E.D. Pa., May 1, 1996); *Roessert v. Health Net*, 926 F Supp. 343 (N.D. Cal. 1996).

95. Wendy K. Mariner. 1996. “Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field.” *American Journal of Public Health* 86(6):863-869.

96. *Corcoran v. United Health Care*, cited in note 88; *Spain v. Aetna Life Ins. Co.*, cited in note 88; *Tolton v. American Biodyne, Inc.*, cited in note 88; *Andrews-Clarke v. Travelers Ins. Co.*, cited in note 88.

Chapter IV: The Role of the U.S. Department of Labor in ERISA Preemption

This chapter briefly outlines the responsibilities of the DOL in administering ERISA, particularly its interpretation of ERISA's preemption and savings clauses and its relationships and activities with state insurance regulators and other state health policymakers.

A. The DOL's ERISA Responsibilities

In its responsibility to administer ERISA, the Pension and Welfare Benefits Administration (PWBA) of the DOL:

- interprets the statute by issuing regulations,¹ opinion letters, and other policy statements;
- collects information from ERISA pension and welfare plan administrators;
- conducts and supports research on ERISA pension and welfare plan characteristics;
- enforces ERISA by bringing actions against:
 - ERISA plan administrators for violating ERISA's requirements, including breaching their fiduciary duties to plan beneficiaries (e.g., by fraud and mismanagement);
 - employers for failing to notify beneficiaries about their rights to COBRA continuation benefits in violation of federal law; and
- files *amicus curiae* briefs in selected ERISA court cases, including those brought by plan enrollees against plans and those asserting that state laws are preempted.

The DOL views its ERISA enforcement responsibility primarily to safeguard the collective rights of employee pension and welfare plan participants from misconduct by plan administrators. The central office in Washington, D.C. establishes policy and coordinates enforcement efforts through 10 regional offices and five additional district offices. About half of the inquiries and complaints DOL offices received in 1998 involved employer health plans, most dealing with rights under COBRA.² The number of the DOL staff available to respond to individual health coverage inquiries has increased from about a dozen in 1994 to five dozen in 1999. These "benefits advisors" can informally intercede with health plan sponsors to attempt to resolve disputes, but the DOL does not bring lawsuits on behalf of individuals in disputes between one participant and the plan. Rather, the Department advises dissatisfied participants about their legal rights and availability of private legal advice.³ If an individual's concern involves a problem that appears to be plan-wide and affects multiple participants, the matter may be referred to DOL enforcement staff for investigation. An example of an industry-wide health policy problem that the DOL has addressed through litigation is several cases filed against Blue Cross plans (e.g., in Hawaii, Illinois, Massachusetts, and Virginia) for failure to pass along the benefit of provider discounts to ERISA plan participants. The Department also files *amicus curiae* ("friend of the court") briefs in cases

Chapter Highlights:

- The U.S. Department of Labor (DOL) administers ERISA.
- DOL has become more active in recent years in working with states by (1) developing policy regarding state authority to regulate Multiple Employer Welfare Arrangements (MEWAs); (2) enforcing MEWA standards; and (3) filing *amicus curiae* briefs in court cases on behalf of state interests.
- In some areas, such as insurance dispute resolution, there may be conflicts between state and federal policy.

brought by other parties that concern important issues.⁴

1. Consumer education and outreach

The DOL has undertaken several initiatives to educate employers, insurers, and insurance plan participants and beneficiaries about new rights and responsibilities under HIPAA and the other ERISA Part 7 requirements. The agency has published a reference booklet on these amendments and provided public service announcements to the radio and print media.⁵

In the fall of 1998, the DOL began a health plan consumer education initiative (the “Health Benefits Education Campaign”) in partnership with several government agencies, unions, employers, insurers, health care providers, and consumer advocates. Three DOL publications, which also appear on its Web site, provide information to health coverage consumers about considerations in choosing plans, legal rights under COBRA and HIPAA, and consumer protections.⁶ These documents link to other resources and publications available by mail or on the Internet.

2. DOL guidance on ERISA preemption

Recent DOL regulations interpreting the 1996 HIPAA, maternity, and mental health parity amendments explain specific preemptive effects of those statutes.⁷ But earlier DOL regulations are not particularly helpful to state regulators seeking help interpreting ERISA’s general preemption provision, Section 514(a); they leave that responsibility to the courts. For example, federal regulations do not define what plans are self-insured or fully insured, although this would seem to be within the Department’s authority as part of its requirements that plans disclose their financial arrangements and any insurer functions to plan enrollees.⁸

B. DOL Relationships with State Health Insurance Regulators

1. Implementation and enforcement of HIPAA and related laws

The DOL (along with the Health Care Financing Administration (HCFA) and Internal Revenue Service) has worked closely with state regulators and other policymakers to implement HIPAA and insurance benefits standards enacted by Congress in 1996 and 1998. In these laws, Congress created a federal framework to regulate employment-based group health plans⁹ under the direction of three federal agencies but allowed states to impose stricter standards on insurers in several enumerated areas.¹⁰ If a state does not implement HIPAA’s small group and individual insurance standards, HCFA is required to do so.¹¹

Members of the DOL’s Health Care Task Force attend quarterly meetings of the National Association of Insurance Commissioners (NAIC) at which they discuss HIPAA implementation with state regulators. These DOL staff also have participated as interested parties in discussions of a variety of NAIC committees established to revise NAIC model laws to conform to HIPAA. Because of the need for consistent interpretation and enforcement of HIPAA standards, the DOL has collaborated with state officials in developing policy, providing education, and coordinating enforcement. For example, states and regional DOL and HCFA offices have designated HIPAA contact people in field offices and the NAIC has identified a health care contact person in each state insurance department. The DOL has conducted HIPAA training and assisted states in updating their state laws to conform to HIPAA. Along with NAIC staff, DOL Health Care Task

Force members have worked to educate state regulators about the DOL consumer complaints and inquiries process. DOL staff also have assisted state insurance regulators to develop consumer education materials on federal health coverage rights. In addition, the DOL has worked with state regulators in several dozen enforcement actions arising out of the new federal protections. Federal and state officials view these policy interpretation and enforcement efforts as a successful collaboration. DOL has established a link from PWBA's web page to state insurance department web pages¹² and coordinated with the NAIC to establish a similar link from the NAIC web page to PWBA's web page.¹³

2. Joint efforts to regulate MEWAs

As discussed more fully in Chapter 6, MEWAs are organizations through which employers can purchaser health coverage. Although MEWAs have helped small businesses buy affordable health coverage, some have experienced serious financial difficulties, including insolvency, due to both mismanagement and enrollment of less healthy people, leaving many people without coverage.¹⁴ Responding to the need to oversee multiple employer plans and the confusion about jurisdiction over them, in 1983 Congress amended ERISA to give states greater authority to regulate MEWAs.¹⁵ ERISA defines a MEWA as an employee welfare benefit plan or other arrangement established to provide benefits to the employees of two or more employers except those established or maintained under a collective bargaining agreement or by a rural electric or telephone cooperative.¹⁶

States can require “fully insured” MEWAs to meet insurance reserve and contribution levels. MEWAs that are not fully insured may be subject to any insurance law that does not conflict with ERISA.¹⁷ Some state regulators have expressed confusion about whether they need a formal DOL opinion on whether a group health coverage purchasing arrangement is a MEWA, for example, when a health program asserts it is collectively bargained. But at least one court decision has found that the DOL is not required to issue individualized determinations on this issue.¹⁸

The DOL and states have long recognized the problem of multiple employer arrangements claiming to be collectively bargained plans (sponsored by sham “unions”) entirely outside state jurisdiction. The DOL is in the process of developing proposed regulations setting out criteria defining when an employee benefit plan is established under a collectively bargained agreement¹⁹ so that states would have an easier time determining the types of organizations they can regulate and defending these decisions. This regulation is being drafted in a “negotiated” rule-making process that includes federal and state regulators and private employer and employee plan sponsors.

Because multiple-employer arrangements are often not ERISA plans,²⁰ DOL's authority over them is often limited to enforcing MEWA administrators' performance of fiduciary duties.²¹ Under this authority, the DOL has initiated several hundred civil and criminal actions against health coverage MEWAs for fraud (diversion of funds), abuse (excessive administrative fees and prohibited transactions), and mismanagement (failure to obtain actuarial advice, collect adequate premiums, or maintain reserves).²² The DOL can seek court-appointed receiverships to safeguard ERISA plan assets under the control of mismanaged MEWAs. Partly because fiduciary duty investigations are time-consuming and remedies for fiduciary duty breaches are limited, the DOL also shares information on these investigations with state regulators, who can generally act more quickly to enjoin the operation of unlicensed insurers. The DOL sometimes pursues joint enforcement actions with states and other times agrees to act separately. The DOL also coordin-

Because multiple-employer arrangements are often not ERISA plans, DOL's authority over them is often limited to enforcing MEWA administrators' performance of fiduciary duties.

The DOL depends on states and other parties to report on cases in which they would like the federal government to submit a brief.

ates enforcement activity with the NAIC and, for criminal matters, with the U.S. Department of Justice. State and federal officials report that these coordinated efforts have reduced the number and severity of MEWA problems.²³ The DOL and the NAIC share information on policy developments. For example, the NAIC reviewed a draft of the DOL's 1992 MEWAs Manual²⁴ and the DOL has reviewed the NAIC's ERISA Handbook.²⁵

3. DOL amicus curiae briefs in ERISA preemption cases

In recent years, the DOL has often supported state laws against preemption arguments by filing *amicus curiae* briefs in support of state law.²⁶ For example, on behalf of the DOL, the U.S. Solicitor General argued in *Travelers, DeBuono*, and *Dillingham* that the state laws in question did not relate to ERISA plans and in *UNUM* that the state law was saved as insurance regulation. Over the last several years, the DOL has filed such briefs in almost 50 federal and state court preemption cases, including those raising the issue of whether ERISA preempts: state law damages suits against health plans (asserting that cases involving plan responsibility for malpractice of their agents and employees are not preempted); state group-to-individual conversion laws (asserting that these policies and their disputes are governed by state law, not ERISA); and state laws requiring workers' compensation programs to be separate from ERISA plans.²⁷

4. Opportunities for federal-state collaboration

DOL officials are interested in collaborating with states within the constraints of ERISA that, for example, do not allow the DOL to waive ERISA preemption or delegate its ultimate enforcement authority.²⁸ DOL officials encourage states to alert them to potential problem MEWAs, because once they come to the attention of federal regulators they are often in deep financial trouble and jeopardize plan assets and health coverage for thousands of individuals. While state insurance regulators routinely are on the lookout for potentially problematic multiple employer arrangements, other state policymakers should share information they might gather about such unlicensed insurance arrangements.

The DOL's *amicus curiae* program also can benefit from more state involvement. The DOL depends on states and other parties to report on cases in which they would like the federal government to submit a brief. Because the DOL's *amicus* program has been helpful to states in preemption cases, it would be useful for state regulators, staff in Attorneys General offices, and other state health policy agencies to advise the DOL Office of the Solicitor about cases challenging state law in which federal *amicus* briefs could be helpful. Similarly, DOL officials have helped states draft legislation to overcome potential ERISA problems.²⁹ At the national level, the DOL works with the NAIC on issues affecting group health plans. For example, the DOL and the NAIC have discussed congressional proposals that would expand ERISA preemption and might undermine state insurance reforms.

C. Potential Conflicts between State and Federal Laws and Regulations

Only recently has the federal government become involved in insurance regulation. HIPAA and the provisions in Part 7 of ERISA are examples. Another is presented by some provisions of the proposed revisions to DOL "claims procedures" regulations that address plan-participant disputes about benefits coverage. As discussed more fully in Chapter 7, some of the proposed regulations

might conflict with state insurance law.³⁰ For example, some states impose a shorter timeframe for appeals to be decided and different standards for reviewers or require two internal appeal levels. While state laws that do not make it impossible to comply with federal law or any finally adopted federal regulations should survive an ERISA challenge,³¹ others could face a preemption problem. In written comments and testimony at a congressional hearing on the proposed regulations, the NAIC and several individual states have urged the Secretary of Labor not to issue regulations that purport to limit state insurance regulatory authority. DOL officials report that they are discussing ways to expeditiously determine if state laws conflict with regulations that are finally issued. Because of the large number of comments on these rules, it is not clear when they will be final, how they will ultimately be drafted, and how any potential conflict between the states and the federal government will be resolved.

Notes

1. 29 C.F.R. sections 2509 through 2590 (1998).
2. The DOL's Pension and Welfare Benefits Administration received 155,134 participant inquiries in FY 1998. Polzer, K. 1999. *Issue Brief No. 735: HIPAA as a Regulatory Model: Early Experiences and Future Prospects*. Washington, D.C.: George Washington University, National Health Policy Forum. About half of these health plan coverage inquiries involved how to retain group coverage under COBRA and HIPAA.
3. Polzer, *HIPAA as a Regulatory Model*; Butler, P.A. and K. Polzer. 1996. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: National Health Policy Forum, George Washington University.
4. The *amicus* program is designed to clarify and provide consistency to judicial interpretations of ERISA as well as to expand participant access to the federal courts under ERISA, assure that the full extent of ERISA remedies are available to them, and to interpret the scope of federal preemption of state law in the way DOL staff believe was intended by ERISA's drafters.
5. The booklet, titled "Questions and Answers: Recent Changes in Health Care Law" is currently in its 4th edition and is available from the PWBA publications hotline (1-800-998-7542) or on the PWBA Web site, www.dol.gov/dol/pwba.
6. The DOL Web site is located at www.dol.gov/dol/pwba. The Health Benefits Education Campaign brochures are "Life Changes Require Health Choices: Know Your Benefits Options"; "Top 10 Ways to Make Your Health Benefits Work for You"; and "Work Changes Require Health Choices: Protect Your Rights."
7. See, e.g., 1997 Federal Register 62 (67):16904.
8. 29 C.F.R. sections 2520.102-3(q) (1998). The IRS has defined "fully insured" ERISA plans for purposes of its enforcement of ERISA (through instructions to IRS Form 5500) as an ERISA plan whose benefits are provided exclusively through insurance contracts or policies (issued by state-authorized HMOs and other insurers) and whose premiums are paid directly by the employer or employee organization from general assets (in addition to any premium contributions from employees).
9. This includes all ERISA (e.g., private-sector employee plans) plus church plans exempt from ERISA but covered under the Internal Revenue Code and exempts employment groups with fewer than two participants.
10. See discussion of these HIPAA provisions and state authority to supplement them in Chapter 3 notes 45-48 and accompanying text.
11. Failure to enact conforming legislation has resulted in HCFA enforcing all or part of HIPAA requirements in California, Missouri, and Rhode Island. Polzer, *HIPAA as a Regulatory Model*.

12. At the PWBA Web site (www.dol.gov/dol/pwba), click on “Consumer Information on Health Benefits Plans” then “State Insurance Regulators.”

13. At the NAIC Web site (www.naic.org), click on “Insurance Regulators” and then “U.S. Department of Labor.”

14. U.S. GAO. 1992. *Employee Benefits: States Need Labor’s Help Regulating Multiple Employer Welfare Arrangements*. Washington, D.C.: U.S. Government Printing Office.

15. 29 U.S.C. section 1144(b)(6); the legislative history of this amendment is outlined in the court’s opinion in *Virginia Beach Policeman’s Benevolent Assoc. v. Reich*, 881 F Supp. 1059 (E.D. Va. 1995). States can fully regulate any organizations providing coverage to more than one employer if the organization does not meet the definition of a MEWA, *MD Physicians and Assoc. v. State Bd. of Ins.*, 957 F2d.178 (5th Cir. 1992), *cert. denied*, 506 U.S. 861 (1992).

16. 29 U.S.C. section 1002(40)(A).

17. *Atlantic Healthcare Benefits Trust v. Googins*, 2 F3d 1 (2d Cir. 1993), *cert. denied*, 510 U.S. 1043 (1994); *Fuller v. Norton*, 86 F3d 1016 (10th Cir. 1996). The *Googins* court held that the state can exercise existing insurance law and need not develop separate MEWA licensing rules.

18. *Virginia Beach Policeman’s Benevolent Assoc. v. Reich*, 881 F Supp. 1059 (E.D. Va. 1995).

19. The proposed regulation was published August 1, 1995, Federal Register 60: 39208.

20. They often do not meet the definition of a plan established by one or more employers or employer organizations to offer health benefits to employees because they are often not established by employers and often offer coverage for people who are not employees of any participating employers.

21. To the extent that MEWA administrators exercise discretion in their responsibilities to administer each employer’s ERISA plan, MEWA administrators are considered ERISA plan fiduciaries.

22. In 1998, for example, the DOL obtained a temporary restraining order freezing the assets of a large interstate multiple employer arrangement whose operators allegedly diverted more than \$1 million in health benefits assets (*Herman v. Hyde*, N.D. Cal. 8/5/98), “Court Freezes MEWA’s Assets on Allegation of Diversion of Benefits Assets,” *BNA Pension and Benefits Reporter* 25(34):1925 (August 24, 1998).

23. Polzer, K. 1997. *Issue Brief No. 707: Preempting State Authority to Regulate Association Plans: Where Might It Take Us?* Washington, D.C.: George Washington University, National Health Policy Forum.

24. U.S. Department of Labor. 1992. *MEWAs — Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation*. Washington, D.C.: U.S. DOL, Pension and Welfare Benefits Administration.

25. National Association of Insurance Commissioners. 1997. *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation*. Washington, D.C.:NAIC. This handbook is currently under revision.

26. The Department has had an amicus program since 1983 that has become more active in the last couple of years (about 20 briefs filed per year) (See, E.R. Demby, "Friend of the Court" *Plan Sponsor*; vol. 4, no. 1 (February 1996)). U.S. DOL has filed amicus briefs to: 1) oppose arguments that ERISA preempts state causes of action against attorneys, auditors, and brokers for fraud or bad advice; 2) support plaintiffs in *Varity Corp. v. Howe* (516 U.S. 489 (1996)) in the Supreme Court arguing plan participants have a separate cause of action for breach of fiduciary duties; 3) support the right of retirees to sue for breach of promise to maintain health benefits; 4) support state authority to regulate MEWAs; 5) support New York's HMO risk-pooling law as an exercise of state authority to regulate the business of insurance; and 6) oppose federal court removal and ERISA preemption in medical malpractice cases. The DOL also occasionally files briefs in cases of individual employees denied benefits when the case presents an issue of national importance. The DOL does not always support participants; in some cases it sides with the plan.

27. These cases are listed on the DOL Web site: <http://www.dol.gov/dol/pwba/public/pubs/ab>. Copies of the DOL amicus briefs are available on this site. The DOL position in these cases has been that where the claim involves a plan's responsibility for the malpractice of its employees or agents, failing properly to refer enrollees to specialists, or having financial incentives to discourage physicians from providing needed care, they are not "completely preempted" so as to be required to be removed from state to federal court.

28. A recent agreement between the DOL and one state insurance department under which the state could investigate complaints from participants in self-insured employee plans, but had no authority to enforce plan participants' rights, does not appear to have been particularly successful. States considering negotiating such arrangements should keep in mind both the DOL's inability to delegate ERISA enforcement authority and the need for increased state staff resources to investigate a larger volume of consumer complaints.

29. DOL officials worked with insurance regulators in Maryland to redraft the state's stop-loss law so that it will be more likely to withstand an ERISA challenge.

30. 63 Fed. Reg. 48390-48409, September 9, 1998.

31. In *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999), the Supreme Court noted that the state law at issue (extending the time to file an insurance claim) did not conflict with ERISA's general statutory claims procedures requirements or the DOL claims procedures regulation, stating, "By allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations." (119 S. Ct. at 1391).

Chapter V: Implications of ERISA Preemption for State Health Policy Initiatives: Expanding Access to Health Coverage

In keeping with their historic and constitutional responsibility to provide for the public health and welfare, states have taken the lead in developing programs to provide access to health services. These initiatives typically have supplemented Medicaid by covering low-income people, but in the early 1990s, several states considered programs designed to assure that all state residents would be insured.¹ A few states enacted such laws, relying on a combination of employer insurance and public programs or subsidies, but their universal coverage features were subsequently repealed. More recent state programs finance health care access for smaller population groups, such as lower-income children (funded through the federal Children's Health Insurance Program (CHIP)) and people leaving welfare for work.

State initiatives to expand access to health coverage may raise ERISA preemption problems if they involve private-sector employee (i.e., ERISA) health plans. For example, state health policymakers may wish to build on the workplace as the source of most private health coverage by subsidizing premiums for lower-income employees, providing tax incentives for employers to offer coverage, facilitating employer purchasing arrangements, and other means to encourage employment-based coverage. These strategies can raise ERISA preemption concerns to the extent that they affect, directly or indirectly, employer health coverage benefits or administration. Alternatively, states finance access to health care through public programs such as Medicaid, CHIP, and other individual coverage subsidies, and by regulating insurers and health care providers (for example, through pools for uninsurable individuals or hospital uncompensated care). Even when these initiatives are not directly connected with employment-based coverage, they may impose costs on employee health plans that could raise ERISA problems.

This chapter examines several types of state access initiatives whose interface with private employee health plans may raise ERISA preemption concerns. These initiatives fall into two broad categories:

- those designed to coordinate with or encourage employment-based coverage; and
- those that might impose costs on employee health plans by taxing or regulating insurers, providers, or other entities contracting with employee health plans.

As is true for all ERISA preemption analysis, there are three questions that state health care access initiatives must address. First, does the state law in question “relate to” ERISA (i.e., private employee) plans by either directly referring to them or by having a substantial impact on their benefits, structure, or administration? State health care access initiatives that impose costs or other burdens on employee health plans are likely to stand or fall on this first hurdle. Second, if the state law relates to ERISA plans, is it exempt from preemption because it regulates the

Chapter Highlights:

- ERISA prohibits state employer coverage mandates but should not impede other initiatives that could promote some types of employment-based coverage.
- ERISA does not impede state initiatives to finance health care access expansions by taxing health care providers, insurers, or administrators.
- HIPAA authorizes many state insurance market reforms, but ERISA's effect on state continuation and conversion laws is unclear.

Although no courts have examined ERISA implications of employer tax credits, they do raise potential ERISA issues.

business of insurance under ERISA's savings clause? Finally, does a state health care access initiative conflict with any of the benefits standards in part 7 of ERISA?

This chapter describes the few types of state health care access initiatives that have been challenged on ERISA grounds as well as potential ERISA preemption challenges to other health care access approaches. It should be noted that programs that are voluntary and uncontroversial, such as tax credits or employer purchasing pools, are less likely to be challenged than those that impose costs or other burdens on employers or employee health plans even if they raise theoretical preemption issues. Voluntary approaches are more easily defended because they do not interfere with the congressional goal identified by the Supreme Court in *Travelers* — to permit nationally uniform benefits and administrative practices.

A. Facilitating Employment-based Coverage

1. Employer coverage mandates

Courts have long held that ERISA preempts state requirements that employers offer health coverage or that they include particular benefits in an employment-based plan.² Shortly after ERISA was enacted, such employer mandates were invalidated in Hawaii and California.³ The Supreme Court has held more recently that ERISA also preempts state standards that apply only if an employer voluntarily offers coverage.⁴ This line of cases prohibits states from mandating employer coverage, as Washington and Oregon attempted to do in their health care reform laws of the early 1990s. It also prohibits state laws requiring that health insurance cover medical claims in automobile accidents,⁵ and interferes with state proposals to develop mandatory “24-hour coverage” that coordinates workplace health coverage and workers’ compensation.⁶

2. Employer pay-or-play initiatives

An alternative to a direct employer mandate is a pay-or-play approach such as the one enacted in Massachusetts in 1988 (though later repealed before implementation). The Massachusetts Health Security Act would have required employers to pay a tax to finance a public health coverage program while providing a credit for the costs of any employee health benefits the employer actually funded. The law did not refer to ERISA (i.e., private employee) plans,⁷ did not prefer whether employers would “pay” or “play,” and imposed no standards on the types of benefits offered, the amount the employer must pay, or any other plan features.⁸ Consequently, it had no direct impact on an employee *plan's* benefits, structure, or administration.

Although a court challenge to the Massachusetts law was abandoned when the law was repealed, opponents argued that ERISA preempted the law because it required employers to evaluate their plans and modify them to minimize tax burdens. But the Supreme Court's decision in *Travelers* should help a state overcome such an argument. A pay-or-play law may be able to withstand an ERISA challenge if it does not refer to employment-based plans or condition the tax credit on certain features of workplace coverage.⁹ A state could argue that the incentive such a law provides to a plan administrator to re-evaluate whether to *pay* the tax or *play* by offering coverage is comparable to the influence of New York's differential hospital surcharges on the decision about which type of insurance to buy.¹⁰ Because the Supreme Court held in *Travelers* that hospital surcharges did not *bind* plan administrators to any particular choice, a carefully drafted pay-or-play law also should not result in ERISA preemption.¹¹

While no states have recently discussed pay or play initiatives, a similar model was considered in Washington as part of an increase in the state's minimum wage law. The state restaurant association proposed authorizing a lower minimum wage if the employer financed an acceptable level of health coverage.¹² Had this proposal been adopted, it would have raised ERISA issues because it directly referred to employee health plans and conditioned the ability to pay a lower minimum wage on providing a certain set of benefits and paying a minimum share of the premium.¹³

3. Employer health coverage tax credits

In addition to state tax laws allowing employers to deduct the cost of employee health plan premiums from business income taxes, several states have enacted tax credits to encourage employers, particularly smaller firms, to offer employee health coverage. (Although no courts have examined ERISA implications of employer tax credits, they do raise potential ERISA issues.) The first is that the law would necessarily refer to employee health plans because it is for the costs of such a plan that the credit is offered, and such direct references have been held to cause ERISA preemption.¹⁴ States could argue that taxation is a traditional exercise of state authority¹⁵ and draw upon *Travelers* to assert that ERISA does not prohibit a tax credit because it operates like other business deductions that Congress could not have intended to preempt. This assertion might be undermined if the legislature explicitly recites that the purpose of the tax credit is to encourage employers to offer and pay for health coverage, an impermissible interference with employee plan administration. Furthermore, this argument would be much stronger if a state employer health plan tax credit law did not attempt to influence the plan's benefits, structure, or administration. For example, a business tax credit for the costs of *any* employee health coverage would seem easier to defend than one conditioned on an employer sharing a certain proportion of the premium or offering certain benefits, as some state small business tax credit laws stipulate.

4. MSA employer tax deductions

Half of the states have enacted laws providing tax incentives to employers and employees who establish Medical Savings Accounts (MSAs).¹⁶ These laws both provide tax deductibility for the costs of employer health coverage under an MSA (both the contributions to the savings account and the premiums for the high-deductible insurance policy) and exempt employer contributions to the MSA from employee income under state tax law. Several states had adopted such laws before 1996 to encourage MSA use. Other states enacted these laws more recently to create consistency between state and federal tax policy after Congress authorized a federal MSA pilot project in HIPAA.¹⁷

State MSA tax deduction laws can pose ERISA concerns for the same reasons that prescriptive state tax credit laws raise ERISA issues — they attempt to mandate the benefits, administration, or structure of private employee health plans.¹⁸ Such state laws raise at least theoretical ERISA problems if they condition favorable tax treatment on an employer's contribution levels, benefits for which accounts can be used, disclosure to plan participants (directly intruding on ERISA rules), and reporting to state agencies, because such qualifications begin to encroach upon private employee plan administration. The fact that these types of laws are purely voluntary is in itself no bar to ERISA preemption, although it renders a challenge unlikely; none has yet been challenged in court.

5. Coordinating public programs with employer coverage

Many states pay all or part of workplace insurance premiums for employed Medicaid benefi-

iaries, as allowed by OBRA 1990, if to do so is cost-effective.¹⁹ State interest in “buying into” employee coverage is likely to grow as states consider modifying their Medicaid programs to assist people leaving welfare for work, and as they implement CHIP, which permits state contributions to employer plans under certain circumstances.

State subsidies to assist individuals enrolled in employer-sponsored health plans can raise ERISA issues if they impose obligations on employers such as reporting information to states about coverage and contributions,²⁰ informing employees about buy-in opportunities, modifying payroll tax deductions, or remitting public funds to insurers. ERISA limits state authority to require employer plans to provide information or administer public programs,²¹ so states wishing to work with employers need to establish voluntary arrangements with them.²² Under a Medicaid Section 1115 waiver, for example, Massachusetts offers tax credits to small businesses in addition to employee premium subsidies.²³ While this strategy raises the ERISA concerns discussed above regarding tax laws, to the extent that the program is voluntary, it is less likely to be challenged and it creates incentives for employers to work with the state to administer the employee premium subsidy program.

6. Public works contracts

States might exert some influence on access to health coverage by requiring firms to offer it as a condition of public works contracts.²⁴ A few courts have held that ERISA does not preempt state or local laws requiring contractors on public works projects to provide employee benefits or meet other conditions. These cases are based on the so-called “marketplace exception” to preemption under federal laws like ERISA and the National Labor Relations Act (NLRA).²⁵ When a government agency acts like another purchaser of services in the market, its contracting requirements may be viewed not as a law (that is preempted when it affects employee benefits) but a “proprietary action.” Several courts have determined, however, that state or local laws do not fall within the marketplace exception.²⁶ Based on this fairly recent line of cases, a state public works contracting requirement related to health benefits appears most likely to survive an ERISA preemption challenge if: the government’s stated motivation is proprietary (i.e., to advance the project in a timely manner) rather than policy; the condition is not too remote to achieve the proprietary interest; the condition applies to a single project rather than all government contracts; private organizations would include a similar condition in their contracts; and the government is not acting as a monopoly purchaser (in which case even contractual conditions take on the nature of regulation).

State policymakers interested in requiring public works contracts to include health benefits should consider a proprietary rationale such as the importance to the job’s timely completion of access to adequate medical services (to avoid absenteeism, etc.) and determine whether similar conditions are imposed in private-sector contracts. States should avoid justifying such contract terms to achieve any broader policy goals such as a general interest in employment-based health coverage. They may also want to consider imposing this condition on a project-by-project basis.

7. Employer health coverage purchasing pools

Many states have adopted laws authorizing creation of purchasing pools through which employers, and sometimes individuals, can purchase health coverage.²⁷ These pools could serve several policy objectives, such as encouraging small firms to offer coverage by reducing premiums (by increased bargaining leverage with plans and providers) and administrative costs, as well as

permitting them to offer a choice of plans. A recent analysis revealed that employers participating in a variety of pooled arrangements were more likely to offer plan choice and information to covered employees but that the pools did not seem to lower premium costs.²⁸

ERISA raises few potential legal obstacles for state health care purchasing pools. It does not, for example, interfere with state standards for public- or private-sector pools. But a state cannot mandate that all employers wishing to buy coverage through a pool use only the state's designated pool. Instead, encouraging purchasing pool participation requires different regulatory strategies (such as mandating that insurers in the small group market sell coverage only through a pool) or incentives, such as reducing tax burdens on insurance purchased through a pool.²⁹

B. Financing Health Care Coverage Programs

States take many approaches to assist residents to obtain health care. For example, they subsidize hospitals and other providers of care to low-income people through publicly administered programs, such as Medicaid, or grants to defray the cost of uncompensated care. They subsidize the cost to purchase insurance through high-risk pools, the individual insurance market, or employers. States also have discussed publicly financed universal programs³⁰ and mandating that individuals be covered.³¹

State health care access initiatives can raise ERISA implications even when they do not directly attempt to involve employer-based coverage. Regulating or taxing health care providers or insurers to finance health care coverage programs may have an indirect effect on private employer plans that can raise ERISA concerns. Most of these initiatives, however, should overcome an ERISA challenge under the reasoning of *Travelers* and several lower federal court cases.

1. Taxing health care providers

A few states have imposed various types of taxes on health care providers to fund health care access programs. For example, Minnesota's provider tax revenue funds its MinnesotaCare program for lower-income uninsured people. New York originally used a hospital tax, collected by insurers other than Blue Cross and Blue Shield, to minimize the competitive disadvantage the Blues plans faced from higher premiums due to the poorer health status of their enrollees for whom they served as insurers of last resort. New York currently uses a provider tax to support uncompensated hospital care.

The Supreme Court's decision in *Travelers* and several lower court decisions make health care provider and insurer taxes relatively easy to defend. The Supreme Court held that despite making other health insurance products more costly to ERISA plans and other insurance purchasers, ERISA did not preempt this type of indirect subsidy, operated through the state's hospital rate-setting mechanism (that the Court acknowledged to be an exercise of traditional state authority³²). Following the *Travelers* reasoning, a more recent Supreme Court case and two federal appellate courts have upheld state provider taxes. The Supreme Court's 1997 *DeBuono* decision upheld a state health care provider revenue tax as applied to a clinic operated by a union ERISA health plan.³³ The Eighth Circuit Court of Appeals upheld Minnesota's tax on hospitals, physicians, and other providers, whose revenues are used to fund programs for uninsured Minnesotans.³⁴ And the Second Circuit upheld two Connecticut hospital taxes that funded the

State health care access initiatives can raise ERISA implications even when they do not directly attempt to involve employer-based coverage. Regulating or taxing health care providers or insurers to finance health care coverage programs may have an indirect effect on private employer plans that can raise ERISA concerns.

state's charity care pool.³⁵ Relying on *Travelers* for the proposition that ERISA does not preempt health care taxes and assessments not directed at ERISA health plans but that impose some costs on them, these cases extended the *Travelers* holding beyond state hospital rate regulation to health care provider taxes and provide sound authority for states to tax health care providers or insurers in order to explicitly or implicitly fund care for lower-income uninsured people.

Although state authority to impose costs on private-sector employee health plans by taxing providers is no longer in doubt, state requirements that health plans *collect* the tax may raise ERISA issues. Laws in New York and Massachusetts require that third-party payers remit to the state the hospital taxes to fund indigent care pools.³⁶ These laws have not been challenged but do raise potential ERISA issues because both impose administrative obligations on employee plans and other payers to collect the provider taxes. Were these laws to be challenged, they could best be defended by arguing first that the administrative burden is slight (no different, for example, than remitting other taxes imposed by the state) and its cost minimal, and second, that this type of administrative obligation does not involve essential operations of an employee benefit plan, such as plan design, eligibility, and funding.³⁷ The Massachusetts law includes a fail-safe provision requiring hospitals to pay the tax if a court invalidates the statute.

2. Taxing health insurers and administrators

Health insurance taxes represent a traditional exercise of state insurance regulation.³⁸ About half the states have high-risk pools for people unable to obtain insurance in the individual market due to their poor health status.³⁹ Originally enacted in the 1970s, these programs now serve as one way states can meet HIPAA's requirement to provide a means for people leaving the group insurance market to obtain coverage, so-called group-to-individual portability.⁴⁰ These laws typically cap premiums at some multiple (125 to 200 percent) of individual market rates. Because claims experience has always exceeded these capped premium revenues, excess costs were originally assessed against insurers doing business in the state and sometimes offset against state premium tax revenues. Insurer taxes have been challenged as imposing costs on private employee health plans. Courts have held that ERISA prohibits states from taxing self-insured firms directly to fund high-risk pools.⁴¹ But taxes on insurers, including stop-loss insurers,⁴² have been upheld against an ERISA challenge as acceptable insurance regulation.⁴³

On the other hand, courts have generally held that ERISA preempts state taxes on insurers functioning in an "administrative services only" (ASO) capacity and other health plan administrators operating as third-party administrators (TPAs).⁴⁴ Because these court decisions predate *Travelers*, however, states should have an easier time defending taxes on the gross receipts of TPAs or insurers acting as ASO arrangements. Even if they raise employee health plan costs somewhat, they do not dictate plans' benefits, structure or administration, and such taxes arguably resemble the provider gross receipts taxes upheld in *DeBuono*.⁴⁵

Because such an insurer tax may create an additional incentive for employee plans to self-insure, states have considered alternative ways to finance high-risk pools. As discussed above, under the reasoning in *Travelers* and the recent cases discussed above upholding provider taxes, states should be able to fund these pools with provider taxes, which would be paid by everyone using the provider's services. Because employees of self-insured employers may use high-risk pools,⁴⁶ this type of tax spreads costs over the larger community that benefits from these pools, and it also minimizes one of the incentives to self-insure.

C. Expanding Access to Coverage by Insurance Regulation

1. State guaranteed issue and renewal and pre-existing condition exclusion requirements

Many states have exercised their authority over insurers to expand access to health coverage. For example, as a condition of tax exemptions, some states have required Blue Cross and Blue Shield plans to accept enrollees regardless of health status. Although these policies were often very expensive, they could serve as an alternative to state high-risk pools for people who could afford to buy them and were one model for more recent insurance market reforms. Before Congress enacted HIPAA, most states had adopted insurance market reforms limiting the ability of insurers to refuse coverage to people with existing medical problems.⁴⁷ These laws required insurers to issue and renew policies in the small-group and, sometimes, individual market regardless of enrollee health status and also to credit pre-existing condition exclusion (pre-ex) periods if an enrollee changed insurers. These laws have never been challenged under ERISA and would not be preempted as long as they do not prevent application of federal law or conflict with federal law, which prescribes areas states can supplement (for example, by setting shorter pre-ex periods).⁴⁸

2. State continuation and conversion requirements

Before Congress enacted COBRA in 1985, many states had required insurers to permit people leaving an employer's group health plan to continue as part of the group — paying the full premium — for periods of one to 36 months and/or to convert to an individual policy without regard to health status. These laws could not be applied to self-insured plans, however.⁴⁹ Under COBRA, Congress amended ERISA to require group plans with 20 or more employees to permit employees leaving a job and their dependents to continue group coverage (if they pay up to 102 percent of the group premium).⁵⁰ State continuation and conversion laws could apply to insurers covering smaller businesses or could extend the continuation periods beyond those prescribed by COBRA. These state insurance laws might be held to relate to private employee plans by mandating continued group participation, which could affect the plan's overall claims experience and subsequent premiums, and by requiring employers to provide information about these options to departing employees. But at least the provisions of these laws that require insurers to extend group coverage should be saved from preemption because they regulate insurers' risk pools and regulate policy terms. Some courts have upheld state insurer continuation and conversion laws against ERISA preemption challenges.⁵¹ Others, however, have held that ERISA preempts state insurer conversion and continuation laws.⁵²

Notes

1. U.S. GAO. 1992. *Access to Health Care: States Respond to Growing Crisis*, GAO/HRD 92-70, Washington, D.C.: U.S. Government Printing Office.
2. *Simas v. Quaker Fabric Corp.*, 6 F 3d 849 (1st Cir. 1993).
3. In *Standard Oil v. Aghalud*, 633 F2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), the court invalidated Hawaii's employer mandate, later authorized by Congress. In *Hewlett-Packard v. Barnes*, 571 F2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978), the court invalidates California's benefits and administration standards for prepaid health plans as they would apply to self-insured employers. In *St. Paul Elec. Workers' Welfare Fund v. Markham*, 490 F. Supp. 931 (D. Minn. 1980), a federal district court held that ERISA preempted the state's mandated benefits as applied to self-insured firms and reporting requirements under the state's high-risk pool that would require firms to report to the Insurance Commissioner that they were self-insured.
4. In *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992), the Court held that ERISA preempts a District of Columbia ordinance requiring the health benefits of workers' compensation (which ERISA allows states to regulate) to be identical to those of employer health coverage, if any were offered. Even though this type of requirement does not burden an employee health plan, because it merely patterns workers' compensation on existing health insurance, the Court held that because the law directly referred to and was dependent on employee health coverage, it "related to" that coverage and was preempted.
5. *Thompson v. Talquin*, 928 F2d 649 (4th Cir. 1991), *Auto Club v. Health and Welfare Plans*, 961 F2d 588 (6th Cir. 1992); *Lincoln Mutual v. Lectron*, 970 F2d 206 (6th Cir. 1992). See also, *FMC v. Holliday*, 498 U.S. 51 (1990).
6. ERISA would preempt any state regulation compelling employers to integrate health insurance, workers' compensation, disability coverage, and other related health services coverage. In fact, courts have held that states can require employers to establish workers' compensation programs separate from other employee benefits, *Employer Staffing Services v. Aubry*, 20 F3d 1038 (9th Cir. 1994); *Combined Management, Inc. v. Superintendent of Ins.*, 22 F d 1 (1st Cir. 1994), *cert. denied*, 115 S. Ct. 350 (1994); *Contract Services Employee Trust v. Davis*, 55 F3d 533 (10th Cir. 1995). No courts have examined voluntary programs, such as a pilot project in Maine, where states permit employers to combine health-related benefits into 24-hour coverage. (Other provisions of the Maine workers' compensation law were at issue in *Combined Management*, but not the state's authority to offer such a pilot project.)
7. By referring generally to employee plans, including public-sector plans, the Massachusetts law did not technically refer to ERISA plans, nor did it impose any duties on the plan itself, only on the employer.
8. In this respect, a "pay-or-play law" enacted in Oregon (but also repealed before implementation) faced a more difficult ERISA preemption problem because it did set standards for employer contributions and benefits. Butler, P. A. 1994. *Roadblock to Reform: ERISA Implications for State Health Care Initiatives*. Washington, D.C.: National Governors' Association.

9. As a health policy matter, states may want to ensure that an employee plan is adequate, but ERISA would prohibit a state from regulating plans directly. The tax credit would need to be set at a level that would cover an adequate insurance package from an actuarial standpoint, but that would not guarantee that all workplace coverage was adequate.

10. A court might, however, distinguish the influence under *Travelers*, exercised through a provider tax, from the more direct influence a pay-or-play law would exert on health plan sponsors.

11. The tax credit in a pay or play law will necessarily refer to employment-based coverage but unlike the workers' compensation law at issue in *Greater Washington Board of Trade*, it is not "premised on the existence of" an employee health plan, though the amount of the tax varies depending on whether a plan exists. If ERISA preempts a tax credit for general health coverage, it would also seem to preempt traditional state business tax deductions for any employee benefit costs, which no court has held.

12. H.R. 3114, 55th Leg., Reg. Sess (Wash. 1998).

13. Two cases raising these problems are *Alessi v. Raybestos-Manhattan*, 451 U.S. 504 (1981), where the Supreme Court held that ERISA preempted a state law that prohibited offsetting workers' compensation benefits against pension benefits (which ERISA permits) and *Greater Washington Board of Trade*, cited in note 4, where the Court held that the D.C. workers' compensation law was premised on the existence of an ERISA plan. The Second Circuit Court of Appeals has held that a mere reference to ERISA plans should not compel preemption if state law does not require an interpretation of an ERISA plan or impose obligations on it. *NYS H.M.O. Conference v. Curiale*, 64 F3d 794 (2d Cir. 1995). *But see Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F3d 812 (8th Cir. 1998).

14. See, *Greater Washington Bd. of Trade*, cited in note 4, and *Mackey v. Lanier Collection Agency*, 486 U.S. 834 (1988), where the Court held that exempting ERISA plans from the state's garnishment law was preempted because the law referred to ERISA plans and treated them differently from other plans, even though the law did not impose burdens on the employee plans. See also, *Prudential Insurance Co. v. National Park Medical Center*; where the law advantaged ERISA plans by exempting them from the state's AWP law but was still preempted.

15. See, e.g., *Thiokol Corp. v. Roberts*, 76 F3d 751 (6th Cir. 1996), *cert. denied*, 520 U.S. 1271 (1997)

16. Laudicina, et al. *State Legislative Health Care and Insurance Issues: 1998 Survey of Plans*. Washington, D.C.: BlueCross/BlueShield Association.

17. 26 U.S.C. 220 (IRS code); Pub. L. No. 104-191 section 301.

18. As discussed in Chapter 6, ERISA's savings clause permits states to define the policies insurers offer to insured employee plans, which is a separate issue from the tax treatment of the plans themselves.

19. Tollen, L. 1999. *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States*. Washington, D.C.: Institute for Health Policy Solutions.

20. States need this information to determine whether premium subsidies are cost-effective under Medicaid and CHIP standards.

21. States could pay employees directly, avoiding these potential ERISA pitfalls, as do Massachusetts and Oregon. Tollen, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States*.

22. Although both the Medicaid and CHIP statutes authorize state buy-in programs, nothing in either law permits states to impose obligations on employer plans. Consequently, it would be difficult to argue under Section 514(d) that ERISA preemption impedes the enforcement of other federal law so as to exempt state laws from preemption.

23. Tollen, L. *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States*.

24. Alternatively, a state could require contractors to pay prevailing wages that include a combination of cash and benefits as long as the state law allowed the contractor to decide how to allocate the wage package between wages and fringe benefits. *Burgio and Campofelice, Inc. v. N.Y.S. Dep't of Labor*, 107 F.3d 1000 (2d Cir. 1997); *Associated Builders & Contractors v. Perry*, 115 F.3d 386 (6th Cir. 1997).

25. In *Associated General Contractors of America v. Metropolitan Water District of Southern California*, 159 F.3d 1178 (9th Cir. 1998), a federal Court of Appeals held that provisions of project labor agreements that a metropolitan water district had negotiated with unions requiring contractors to participate in employee benefit plans were not preempted by ERISA because the district was acting as a market participant. Based on the reasoning of a Supreme Court case involving the NLRA (*Building & Const. Trades Council v. Associated Builders*, 507 U.S. 218 (1993)), the Court of Appeals held that the market participant/regulator distinction applies to ERISA as well as NLRA because ERISA “carefully distinguishes between state action in general and state action which has the effect of law.” *Id.* at 1183. The court took as further evidence of lack of regulatory motivation by the district its stated intent “to ensure labor harmony and avoid disruption during the lengthy period of construction...and, generally, to increase the potential for on-time, effective, efficient construction.” *Id.* at 1184. A county requirement that all county public works project include “fringe benefits” was upheld against ERISA preemption in *Lott Constructors, Inc. v. Camden County Board of Chosen Freeholders*, 1994 WL 263851 at 18 (D.N.J. 1994). See also, *Minnesota Chapter of Associated Builders and Contractors, Inc. v. County of St. Louis*, 825 F.Supp. 238, 243 (D. Minn. 1993), where the court found that the policy’s application to a particular project rather than all contractors and its similarity to private-sector requirements were evidence that the action was not regulatory.

26. In *Air Transport v. City and County of San Francisco*, 992 F.Supp. 1149 (N.D. Cal. 1998), a district court held that ERISA preempted a city ordinance requiring city contractors to cover domestic partners in their benefits to the same extent they cover spouses because the city acted as a regulator rather than a marketplace participant. They found first that the city was motivated by policy concerns, not by proprietary interests based on its written anti-discrimination rationale. Furthermore, the court did not believe a proprietary interest existed: “[t]he connection between eliminating domestic partner discrimination in employee benefit plans and the quality of services provided by the contractor is too tenuous and remote.” *Id.* at 1179. Finally, in a similar line of

reasoning as used in the Alameda case, the court held that the market participant exception applies only when the city acts as an ordinary consumer, not at the airport where it exercises more than ordinary economic power. See also, cases holding that governments are not market-place participants for purposes of NLRA when the conditions were motivated by policy: *Van-Go Transport Co., Inc. v. New York City Board of Education*, 53 F Supp.2d 278 (E.D. N.Y. 1999) and *Wisconsin Dept. of Indus., Labor and Human Relations v. Gould*, 475 U.S. 282 (1986).in

27. Laudicina, S., J. Yerby and K. Pardo. 1998. *State Legislative Health Care and Insurance Issues: 1998 Survey of Plans*. Washington, D.C: Blue Cross Blue Shield Association.

28. Long, S.H. and M.S. Marquis. 1999. "Pooled Purchasing: Who are the Players?" *Health Affairs* 18(4):105-111.

29. The legal issues and policy advantages and disadvantages of these purchasing pool regulatory and incentive strategies are discussed in Butler, P. 1993. *ERISA Implications for Exclusive Health Insurance Purchasing Cooperatives*. Institute for Health Policy Solutions, Washington, D.C. Reprinted in App. C in Butler, *Roadblock to Reform: ERISA Implications for State Health Care Initiatives*.

30. By definition, a universal public "single payer" system would not bear any relationship to private employee health plans other than to make most of them obsolete. The fact that some employers might choose to offer employee plans to supplement a public program would not seem a sufficient connection under the reasoning in *Travelers*. Because of multi-year contracts between unions and employee health plans, however, a universal publicly financed program would face some transitional issues that might raise ERISA preemption problems.

31. Mandates that individuals obtain health coverage would not raise ERISA preemption issues if they did not attempt to regulate the interaction between individual and employer coverage, for example, by requiring employers currently covering workers to continue to do so in order to protect people from having workplace coverage terminated.

32. *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

33. *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

34. *Boyle v. Anderson*, 68 F3d 1093 (8th Cir. 1995), *cert. denied*, 516 U.S. 1173 (1996), allows providers to add the tax to their bills but does not explicitly refer to ERISA plans.

35. *New England Health Care Employees Union v. Mount Sinai Hosp.*, 65 F3d 1024 (2d Cir. 1995); *Connecticut Hospital Association v. Weltman*, 66 F3d 413 (2d Cir. 1995).

36. The New York law requires third-party payers to remit 8.18 percent of hospital, clinic, ambulatory surgery center, and laboratory bills by anyone (whether in or out of state) paying for use of a New York hospital (N.Y. Public Health Law 2807-j). The law does not explicitly refer to ERISA plans but does include in the definition of "payer" insurers, HMOs, and self-insured funds. Payers that do not elect to remit monthly to the state are charged 32.18 percent. The Massachusetts law requires private-sector third-party contributors to pay an amount determined annually

based on their pro rata share of private-sector billing, Mass. General Laws Ch. 118G, sections 18 and 18A. The law does not directly refer to ERISA plans but includes in the definition of “third-party contributor” individuals and entities purchasing health services other than government programs, workers’ compensation, and natural persons.

37. The Massachusetts federal district court used similar reasoning in upholding the state’s “any-willing-pharmacy” law in *American Drug Stores v. Harvard-Pilgrim Health Care*, 973 F. Supp. 60 (D. Mass. 1997).

38. *Prudential Ins. Co. of Am. v. Benjamin*, 328 U.S. 408 (1946).

39. Laudicina, et al. *State Legislative Health Care and Insurance Issues: 1998 Survey of Plans*.

40. States also can require insurers to guarantee certain types of coverage (without regard to health status) to people leaving the group for the individual market within certain time frames or use other approved mechanisms to provide access to individual coverage, Mitchell, E., C. Pernice and T. Riley. 1997. *The Health Insurance Portability and Accountability Act of 1996: A Guide for State Action*. Portland, ME: National Academy for State Health Policy.

41. *Bricklayers’ Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991); *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (D. Wis. 1981); see also *St. Paul Elec. Workers Welfare Fund v. Markham*, 490 F. Supp. 931 (D. Minn. 1980).

42. “Stop-loss” insurance is a policy purchased by both traditional health insurers and self-insured employer plans to protect themselves against very high claims. As discussed in Chapter 6, state attempts to regulate stop-loss carriers have met mixed success due to ERISA. But the courts have generally held that ERISA does not preempt state taxes on stop-loss insurers’ premiums.

43. In *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995), the federal Court of Appeals upheld against an ERISA preemption challenge Wisconsin’s assessment on stop-loss carriers covering allegedly self-insured private employee health plans. The Court of Appeals held that the insurer tax was comparable to that at issue in *Travelers* and imposed some costs or indirect influence on private employee plans, but that these indirect effects (with no explicit reference in the law to ERISA plans) were insufficient to hold that the tax “relates to” ERISA plans so as to compel preemption. In a pre-*Travelers* case, *General Motors Corp. v. California State Bd. of Equalization*, 815 F.2d 1305 (9th Cir. 1987), cert. denied, 485 U.S. 941 (1988), another federal Court of Appeals held that ERISA did not preempt California’s tax on stop-loss insurance premiums even though the self-funded plan was required by the stop-loss carrier to pay the state tax. (In Wisconsin the stop-loss insurer testified that it also passed these costs on to its insureds.)

44. *NGS Am. Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993); *E-Systems v. Pogue*, 929 F.2d 1100 (5th Cir. 1991); *Self-Insurance Institute v. Koriotoh*, 993 F.2d 479 (5th Cir. 1993); *Birdsong v. Olson*, 708 F. Supp. 792 (W.D. Tex. 1989).

45. If TPA taxes are held to relate to ERISA plans they probably would not be saved as insurance regulation, since by definition these administrators are not bearing risk and therefore do not meet a “common sense” definition of insurers, *Self-Insurance Institute of America v. Gallagher*, No. 86-

7308-WS, N.D. Fla. 1989, 11 E.B.C. 2162, *affirmed without opinion*, 909 F.2d 1491 (11th Cir. 1994); *see also*, *NGS American Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993); *E-Systems v. Pogue*, 929 F.2d 1100 (5th Cir. 1991); *Self-Insurance Institute v. Koriath*, 993 F.2d 479 (5th Cir. 1993); *Birdsong v. Olson*, 708 F.Supp. 792 (W.D. Tex. 1989).

46. Although there are no national data on the extent to which this occurs, some state policymakers have reported that self-insured employers have “dumped” high-risk employees into the state pools, Butler and Polzer, *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*.

47. Mitchell, E., C. Pernice and T. Riley. 1997. *The Health Insurance Portability and Accountability Act of 1996: A Guide for State Action*. Portland, ME: National Academy for State Health Policy.

48. 42 U.S.C. 300gg-23 and 29 U.S.C. 1191. These areas are: shortening the six month period prior to enrollment date during which a pre-existing condition can be determined; shortening the 12- and 18-month pre-existing condition exclusion periods; increasing the 63-day break-in-coverage period beyond which the pre-ex credit need not apply; increasing the 30-day period for newborns and adopted children to enroll without a pre-ex period; expanding beyond those in federal law the prohibitions on conditions and people to whom a pre-ex period may be applied; requiring additional special enrollment periods; and reducing the maximum HMO affiliation period to less than two months.

49. *General Split Corp. v. Mitchell*, 523 F.Supp. 427 (D. Wis. 1981); *Dawson v. Whaland*, 529 F.Supp. 626 (D. N.H. 1982).

50. Continuation periods are 18 months for an employee and/or dependent who is terminated or whose work hours are reduced; 36 months for dependents if the employee dies, divorces his/her spouse, or becomes eligible for Medicare; 18 months if an employee is found eligible for Social Security Disability Income when terminated from employment (which may be extended up to 29 months); 36 months for dependents who lose dependent child status under the terms of the group health plan; 36 months if a firm from which an employee retires declares bankruptcy; and an additional 18 months for dependents if the former employee dies or is divorced during the original 18-month continuation period.

51. *Demars v. Cigna Norp.*, 173 F.3d 443 (1st Cir. 1999); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991), *cert. denied*, 504 U.S. 973 (1992); *Henken v. Northrop Corp.* 921 F.2d 864 (9th Cir. 1990); *DePasquale v. Aetna Life Ins.*, 743 F.Supp. 364 (E.D. Pa. 1990), *Hall v. Pennwalt*, 746 F.Supp. 507 (E.D. Pa. 1988).

52. *Painter v. Golden Rule Ins. Co.*, 121 F.3d 436 (8th Cir. 1997), *cert denied*, 118 S. Ct 1516 (1998); *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990), *aff'g*, 716 F.Supp. 740 (W.D. N.Y. 1989); *Klosterman v. Western General Management, Inc.*, 80 F.Supp. 570 (N.D. Ill. 1992). *See also* *Tingey v. Pixley-Richards West*, 953 F.2d 1124 (9th Cir. 1992), which did not directly challenge the state continuation law but involved an employee seeking to sue in state court for failure to be notified of his state law continuation rights for unlawful termination in order to deny him benefits. The court held that his sole remedy lay under ERISA (since Congress had incorporated federal COBRA continuation policy for firms of 20 or more employees into ERISA in

1985). It is not clear from COBRA legislative history, however, that Congress intended to preempt the entire field of continuation and conversion (H. Rep. No. 99-24, *reprinted in* 1985 U.S.C.C.A.N. 622).

Chapter VI: Implications of ERISA Preemption for State Health Policy Initiatives: Regulating Health Insurance Plans

Acknowledging the states' traditional role in overseeing insurance, Congress exempted laws regulating insurance from preemption through ERISA's savings clause, while recently enacting several federal insurance market and benefit standards. Exactly which laws meet the test of "regulating insurance" is far from clear, however. The Supreme Court has held that a law regulates insurance under ERISA's savings clause if it looks like insurance regulation from a "common sense" viewpoint and also regulates an activity that either spreads risk, involves the insured-insurer relationship, or is conducted by insurers. Lower federal courts have not consistently applied the Supreme Court's principles to define the business of insurance under the savings clause. For example, some courts have held that all three McCarran-Ferguson criteria must be met,¹ although even before *UNUM*, the Supreme Court had stated otherwise.² Several courts have held that HMOs are not insurers so that managed care standards are not saved from preemption.³ Furthermore, courts have held that not all activities of insurance companies are the business of insurance that is saved from preemption.⁴

The distinction between insured and self-insured ERISA plans created by the interplay between the preemption, savings, and deemer clauses often creates challenges for state health policymakers. Congress created a largely unregulated sector, self-insured ERISA plans, which employers can choose to offer if they feel state insurance regulation is too costly or intrusive. Consequently, states must weigh the policy advantages of adopting new health insurance standards against the potential that they will encourage employers to leave the insurance market and self-insure.

This chapter examines ERISA implications for a variety of state initiatives to protect insurance consumers by regulating insurance companies. These state laws include not only traditional types of insurance regulation, such as the solvency of risk-bearing entities, accuracy of marketing and other information, fair market practices, and the benefits insurers must offer, but also standards governing the conduct of managed care plans, which both bear risk and agree to provide or arrange for care. Because many of these standards affect the benefits, structure, or administration of ERISA (private employee) health plans, they frequently will "relate to" ERISA plans. But if they meet the Supreme Court's criteria for regulating the business of insurance, these types of standards should be exempt from preemption under ERISA's savings clause. This area of ERISA preemption law remains dynamic as states continue to adopt a wide variety of managed care standards and as the federal courts begin to apply principles set out in the Supreme Court's 1999 *UNUM* decision interpreting ERISA's savings clause. Furthermore, the relationship between the state and federal governments regarding insurance regulation is changing as Congress reclaims some of this jurisdiction to enact a floor of federal standards that states can supplement in specified ways.

Chapter Highlights:

- States should be able to define what constitutes risk transfer so that its insurance initiatives come within ERISA's savings clause.
- The savings clause preserves jurisdiction over traditional state insurance regulation.
- A recent Supreme Court case provides greater latitude in defining the business of insurance under the savings clause.
- State authority to enact some laws, such as stop-loss policy requirements or certain managed care standards, remains unclear.
- States can regulate MEWAs.

A. Defining what Constitutes the Business of Insurance

Fundamental to applying ERISA's savings clause to shield state law from preemption is a definition of what activities constitute the business of insurance. Until recently, state insurance law applied to traditional indemnity health insurers and HMOs, but the evolution of managed care continues to raise questions about the extent to which new risk-sharing care delivery arrangements constitute the business of insurance. The advantages for employee plans to claim that they are self-insured while buying very low-deductible stop-loss coverage has raised the issue of how far states can regulate stop-loss insurance policies. States will be best able to defend regulation against ERISA preemption challenges if they explicitly define risk-assuming arrangements as the business of insurance.⁵ States under the jurisdiction of the federal courts that have held that HMOs are not insurers face a particular challenge.⁶ To the extent that these decisions are based on statutory drafting (e.g., New York's HMO licensure law that provides that HMOs are not insurers⁷), legislatures can remedy this problem. In states where the courts misconstrue the nature of HMOs, which perform both insurance and care delivery functions, policymakers need to re-educate the courts about how managed care plans assume risk like other insurers.⁸

1. Insurance risk

The essence of insurance is the spreading of risk. People typically buy insurance to transfer the risk of a rare but potentially costly event, such as the need for hospitalization or other expensive medical care.⁹ Insurers assume this risk and, by pooling a large enough group of risk-transferors, charge premiums whose revenue covers anticipated costs of the risk and insurance administration plus profit. A pooled transfer of a risk of loss whose magnitude is uncertain for any individual (but actuarially more predictable for a group) is called insurance risk¹⁰ — the risk that premium revenues will be insufficient to cover the costs of the promised payment or service.¹¹ Although any business whose costs perpetually exceed revenues will fail, regulators are concerned about insurance risks, rather than these normal business risks, because insurers promise to pay if certain risks, such as the need for hospitalization, occur, and failure to keep that promise can impose large financial burdens on insured individuals. State insurance solvency standards are designed to assure that risk-assuming entities maintain adequate reserves to meet their contractual promises.

2. Provider-sponsored organizations

Defining what constitutes health insurance risk has become a more challenging policy problem for states with the growth and evolution of managed care. Managed care combines the risk-bearing function of traditional insurance with the promise to provide or pay for health care services. New forms of managed care organizations have evolved as purchasers have embraced managed care and as physicians and hospitals have grown dissatisfied in their relationships with HMOs and other insurers. These organizations are variously known as provider-sponsored organizations (PSOs, for example, under Medicare), provider-sponsored networks (PSNs), physician-hospital organizations (PHOs), integrated service networks (ISNs), and integrated delivery systems (IDSs). The emergence of these new health care delivery arrangements, some of which bear risk like insurers, has caused states to re-examine their health insurance laws in order to protect consumers from insolvency, assure accurate marketing and information, and provide for fair dispute resolution, regardless of the entity's form or label. State authority to regulate provider networks that do not bear risk, such as preferred provider organizations (PPOs), should not raise a serious preemption ERISA issue.¹²

Some of these risk-bearing provider-sponsored organizations (which for simplicity will collectively be called PSOs in this Manual) have resisted licensure on the theory that they are bearing “service risk” rather than insurance risk because they theoretically would provide all services needed by their enrolled populations.¹³ But states generally take the position that if these organizations promise to provide or pay for health care services to a group of people paying a premium, they have assumed insurance risk and must comply with solvency and other insurance standards. Most states regulate the transfer of insurance risk to PSOs by defining them as either HMOs subject to existing licensure standards, limited-purpose HMOs offering a narrower set of benefits, or PSOs subject to special statutory or regulatory standards.¹⁴

PSOs may assume some level of insurance risk by various payment arrangement with insurers such as HMOs, for example, by accepting capitation payments to provide their own services and those of other providers, such as non-network medical specialists. State policies vary on the types of payment to providers that constitutes a risk transfer, generally determining that capitation for one’s own services (and certainly for those of other providers) constitutes risk transfer, while discounted fee-for-service payment does not. Between these clear cases, however, is a spectrum of payment arrangements, such as fee-for-service payments with a bonus for keeping costs below budget targets or risk corridors, under which providers accept some degree of risk.¹⁵

The vast majority of states and the NAIC have taken the position that providers bearing defined levels of risk are engaged in the business of insurance and must either be licensed or contract with licensed HMOs or other insurers.¹⁶ But the policy of several states is that ERISA prohibits state regulation of risk-bearing contracts between a PSO and an allegedly self-insured private employee health plan.¹⁷ There has never been a court challenge to state regulation of risk-bearing PSOs. As long as a state’s laws meet the Supreme Court’s criteria for regulating the business of insurance under ERISA’s savings clause, states should be able to justify defining risk transfer to a PSO (for example, by full or partial capitation) whether paid by an ERISA plan¹⁸ or other organization, as the business of insurance, so as to shield these standards from preemption.

Under the Supreme Court’s principles in *UNUM*, *Metropolitan Life*, and *Pilot Life*, state law regulates the business of insurance if it looks from a common sense viewpoint like insurance regulation and if the regulated activity spreads risk, prescribes insurance policy terms, and/or involves only entities within the insurance industry. Regulating risk-assuming PSOs appears to meet the “common sense” test and the first two criteria easily. As discussed in Chapter 3, the Supreme Court held in *UNUM* that not all three McCarran-Ferguson factors need be met (finding that at least the second criterion — being a policy term — was satisfied) but did not comment on the third criterion. Nevertheless, a court should uphold a reasonable and evenly applied¹⁹ state definition of what types of risk assumption constitutes the business of insurance even when it applies to organizations that had not previously assumed risk.²⁰

3. Regulating stop-loss policies

Stop-loss is insurance issued to protect an insurance plan, like an HMO, from very expensive cases. Some ERISA health plans call themselves “self-insured” but use stop-loss policies as a way to avoid state insurance regulation.²¹ Neither Congress, the courts, nor DOL has defined what constitutes self-insurance, and some courts have held that ERISA prohibits states from doing so. Like large firms, small employers are interested in self-insuring to avoid state benefits mandates, insurance taxes, and managed care regulation. Yet like large firms, most small businesses have

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hesitated to bear the full risk of health coverage because of their potential exposure to a high-cost case. Buying stop-loss insurance is one way to protect the self-insured plan against potentially catastrophic losses or customize risk-sharing arrangements.²² But in contrast to large firms that typically buy stop-loss to cover costs that exceed a high threshold, such as \$10,000 to \$25,000 per individual case, or \$100,000 or more for the entire group (called the stop-loss “attachment point”), some ERISA health plans claim to self-insure with very generous stop-loss coverage with a low attachment point (for example, a few hundred dollars).

It is consistent with ERISA to consider plans with such low attachment points to be “partially insured,” permitting the states to regulate the insured portion of the coverage by regulating substantive terms of the stop-loss policy. To address what appeared to some state regulators as a ploy to avoid state benefit mandates, insurance taxes, and other regulation, the NAIC developed a model stop-loss act, which defined an attachment point below which a health plan’s alleged use of stop-loss coverage would be considered health insurance subject to state regulation, and above which would be considered reinsurance of a self-insured plan. This \$20,000 attachment point in the NAIC model was determined by actuarial analysis as the level at which the plan and the stop-loss carrier each shared half the risk of loss. Several states adopted stop-loss rules patterned on the NAIC model with varying attachment points.

Two courts have invalidated state laws similar to the NAIC stop-loss model act, even though these state laws might appear to have been protected insurance regulation. A federal Court of Appeals determined that both Maryland’s stop-loss regulation and its underlying purpose (to prevent employee health plans from avoiding state benefit mandates) were impermissible under ERISA.²³ The Court held that the state’s stop-loss rule, which deemed a stop-loss policy with an attachment point below \$10,000 to be health insurance subject to state insurance laws, was preempted. The court first held that the rule related to ERISA plans by referring to them. It also held that although the regulation met the savings clause criteria for regulating the business of insurance, because it regulated the relationship between ERISA plans and their participants,²⁴ the rule was as an attempt to consider certain ERISA health plans as insurers in violation of ERISA’s “deemer” clause. For similar reasons, a state court in Missouri also invalidated that state’s stop-loss rule.²⁵

In an effort to address the Court of Appeals’ concerns, the Maryland legislature amended its stop-loss law in 1999 to make it more clear that the statute regulates stop-loss carriers and the policies they issue. The new law deletes references to employee health plans, defines stop-loss insurance as insuring individual people (not the plan), does not indicate an intention to consider stop-loss policies as health insurance or to deem employee plans to be insurance, and prohibits insurers from selling stop-loss policies with attachment points lower than those set out in the statute.²⁶ Maryland officials expect an ERISA challenge to this new law but hope the courts will uphold it, especially in light of the generally more flexible approach to state insurance regulation suggested in the Supreme Court’s recent *UNUM* decision.²⁷ The NAIC also revised its stop-loss insurance model act along lines similar to Maryland’s new law.²⁸

In contrast to the Maryland and Missouri cases, a state court in Kansas held that ERISA did not preempt the Insurance Commissioner’s state stop-loss rule (although it also held the rule was not authorized by state law).²⁹ Disagreeing explicitly with the federal Court of Appeals in the Maryland case, the Kansas court held that regulating stop-loss policies does not “relate to” ERISA

health plans because, by not requiring self-insured plans to take any action, it does not regulate ERISA health plan benefit design or structure. Relying on the Supreme Court's reasoning in *Travelers*, the Kansas court said that any influence on plan administration is indirect and insufficient to cause preemption.

Both the Maryland Court of Appeals and Kansas state court acknowledged that states can regulate some aspects of stop-loss insurance policies.³⁰ For example, they can be subject to taxes, risk pool assessments,³¹ reporting requirements, and other regulation that does not directly affect the structure or administration of the underlying ERISA health plan.

B. Traditional Insurance Regulation

ERISA would not appear to impose an obstacle to traditional types of state insurance regulation, such as standards for insurer solvency, market conduct, advertising, or benefits mandates, whose purposes are to assure that insurers are financially sound, information provided to prospective and current subscribers is accurate, coverage is adequate, and premiums are fair. The Supreme Court has long held that states can regulate the activities involved in insurance contracts such as “the type of policy which could be issued, its reliability, interpretation, and enforcement” and other activities constituting “the relationship between the insurance company and the policyholder.”³²

In *Metropolitan Life v. Massachusetts*,³³ its first ERISA savings clause case, the Court upheld a state mental health benefits mandate as insurance regulation, providing authority for state laws prescribing or defining covered services. The Court rebuffed an argument, still advanced by opponents of managed care laws, that the savings clause does not protect laws bearing on subjects also covered by ERISA.³⁴ Most recently, a federal Court of Appeals applied this precedent to uphold Washington state's requirement that all managed care plans reimburse an array of providers (such as acupuncturists and naturopaths) licensed to render covered services.³⁵

As discussed in Chapter 5, state insurance market “reforms,” such as credit for satisfying pre-existing condition exclusion periods, guaranteed issue and renewability, and arrangements for people leaving the group market to continue access to insurance, fall within traditional insurance regulatory authority and are explicitly sanctioned by HIPAA. States should not face an ERISA preemption challenge to laws regulating high-deductible policies offered in conjunction with medical savings accounts (MSA), despite any potential ERISA problems related to the tax credit for the MSA itself, as discussed in Chapter 5. For example, states should easily defend against a preemption challenge that laws mandate the benefits, cost sharing and other features those policies must offer, as well as information disclosure to potential insurance purchasers about the products.

Courts have, however, held that ERISA preempts some types of traditional state insurance standards. For example, a state law limiting the time to pay claims was held to be preempted,³⁶ raising questions about laws recently enacted in more than half the states³⁷ that prescribe time limits for managed care plans and other insurers to pay provider claims, which have resulted from well-publicized payment delays.³⁸ A state requirement that insurers notify group plan participants if their employer fails to pay premiums was preempted.³⁹ A state insurance law requiring written notice before terminating a policy was held not to provide a state cause of action

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against an employee ERISA health plan.⁴⁰ And a state law providing that errors in an insurance application must be intentional in order to void the contract was preempted.⁴¹ Courts might decide these cases differently under the principles established in the Supreme Court's 1999 *UNUM* decision. And laws that impose duties merely on insurers, without regard to an underlying employee plan, are less likely to be preempted.⁴²

C. Managed Care Plan Consumer Protection Standards

As managed care has become the predominant form of health care coverage and delivery, state legislatures have responded to provider and consumer complaints by adopting an array of managed care laws. These laws define the minimum scope of benefits that must be covered, prescribe access to providers, enhance enrollee appeals procedures, limit provider payment arrangements, and mandate provider contract terms and selection and termination procedures. While most of these laws should survive an ERISA preemption challenge, some may be easier to defend than others.

1. Benefits mandates

Because of the decisions in *Metropolitan Life*⁴³ and *Washington Physicians' Services*,⁴⁴ state laws seem best able to survive an ERISA challenge if they can be characterized as prescribing insurance policy terms by mandating or defining benefits that must be covered. Several types of state managed care laws appear to fit this favored category. For example, to overcome the financial incentives for managed care plans to skimp on coverage, most states have adopted laws prescribing lengths of stay for maternity and other types of hospitalization or mandating specific services.⁴⁵ Recent amendment to ERISA explicitly incorporate a few of these mandates into federal law, prescribing areas states may supplement. Many states require health plans that cover prescription drugs to include uses for which the drugs are not approved by the FDA. A few states require plans to cover experimental treatments, such as those offered only through clinical trials. These laws represent traditional benefits mandates such as mental health care, spreading the risk of needing a service to a broad population and including many people who will not need it. Similarly, requiring that emergency services be covered if the situation appears to a "prudent lay-person" to be an emergency spreads risk and becomes part of the insurance contract by operation of state law. While these laws would likely be held to relate to ERISA plans as mandating the plan's benefits, under the reasoning in *Metropolitan Life* and *UNUM*, if directed at only insuring entities, they should easily satisfy all the McCarran-Ferguson criteria.

2. Consumer access-to-provider laws

One of the most common concerns expressed by managed care plan enrollees is whether they will be able to see physicians, particularly specialists, when the need arises.⁴⁶ People with chronic illness can determine whether their physicians are in a plan's network before they enroll. Healthy enrollees may worry that if they become ill they will not have access to appropriate providers, yet before they enroll in a plan they cannot predict the types of physicians from whom they may need to seek care. Women whose only routine medical care is an annual gynecological exam may prefer a gynecologist as their primary care gatekeeper. People with chronic illness may be better served if a physician specialist, rather than a generalist, manages their care. Other plan enrollees may worry about the disruption of service if their provider leaves the plan's network. States have adopted a series of standards to address these consumer concerns.⁴⁷ Many states have enacted

laws requiring managed care plans to permit enrollees to obtain services from non-network providers at no greater cost than in-network providers if networks are not “adequate” to meet enrollee needs.⁴⁸ More than two-thirds of the states require plans to permit women to use a gynecologist as a primary care physician. Several states require plans to offer a point-of-service (POS) option (often with higher premiums or cost sharing) that allows enrollees to seek care outside the plan’s network. Some states require plans to permit chronically ill enrollees to use a specialist as a gatekeeper or to provide a “standing referral” to see a specialist without frequent authorization visits to the primary care physician. Several states require plans to pay providers for a specified number of months after they leave the network when an enrollee is undergoing a course of treatment for a chronic or life-threatening condition.

Even when these provider access laws are drafted to amend health insurance contracts, they may be somewhat harder to defend than more traditional benefits mandates if a court views them as similar to any-willing-provider (AWP) laws designed to benefit providers and follows the Fifth and Eighth Circuits’ reasoning in *Prudential*, *Cigna*, and *Texas Pharmacy Association*.⁴⁹ Yet laws specifying the types of providers health plan enrollees can use or requiring networks to be adequate can be distinguished from AWP laws. In the first place, by regulating the relationships of providers and their patients these laws arguably fall within the state’s traditional authority to regulate medical care, specifically sanctioned in *Travelers*, so they could be held not to relate to employee health plans. Furthermore, they are more like the alternate provider law upheld in *Washington Physicians’ Service* than AWP laws. Not only do they fail to dictate an ERISA plan’s choices (because it could self-insure to avoid the state laws), they also do not affect ERISA plan structure. Unlike AWP laws, provider mandates allow enrollees to seek care from a wider variety of physicians within the network but do not enlarge networks and undermine the often-cited value of a limited network in containing costs.⁵⁰ If provider access laws are held to relate to ERISA plans, they should be exempt from preemption under the savings clause because they are designed to benefit insured enrollees by amending the policy’s terms, the McCarran-Ferguson Act criterion applied by the Supreme Court in *UNUM*. Provider access standards are designed to ensure that enrollees receive needed care from appropriate providers, the service for which they have contracted. Laws requiring plans to pay providers after they leave a network for specified time periods during an enrollee’s continuing course of treatment involve provider relations (which, as discussed below, may be harder to defend from ERISA preemption), but they are designed primarily to benefit enrollees and should therefore also be saved as insurance regulation.

D. Provider-Plan Contract Standards

Although courts differ in their analysis of AWP laws, state statutes designed primarily to regulate relationships between health insurers and providers may face difficulty surviving an ERISA preemption challenge.⁵¹ Even when state legislatures justify these laws on consumer protection grounds, as was done with the Arkansas AWP law, they may not be saved as insurance regulation because they do not primarily involve the insurer-insured contract, which the Supreme Court found in *UNUM* to be sufficient to characterize a law as insurance regulation.

1. Any-willing-provider laws

More than half the states have adopted some form of AWP law (mostly applying to pharmacies but some to physicians and other clinicians).⁵² As discussed in Chapter 3, courts have reached

If provider access laws are held to relate to ERISA plans, they should be exempt from preemption under the savings clause because they are designed to benefit insured enrollees by amending the policy’s terms.

Provider contract standards should be held not to relate to ERISA plans because they do not mandate an employee plan's structure to the same extent as any-willing-provider laws.

inconsistent conclusions about whether ERISA preempts these laws. Although the current weight of authority favors preemption, the Fifth Circuit's secondary holding in the *Texas Pharmacy* case suggests that state laws directed only at insurers might survive an ERISA challenge.⁵³ Even if a court is not persuaded by the more creative arguments of *American Drug Stores*⁵⁴ that AWP laws do not relate to ERISA plans because an ERISA plan could self-insure to avoid the state law, a state AWP law could be saved from preemption by: 1) applying only to entities conducting the business of insurance (which should include HMOs, despite contrary court opinions); 2) making its terms a mandatory part of insurance policies (rather than a mandate on insurance companies); 3) not indicating a purpose to benefit providers by allowing them to participate in health plan networks; and 4) not referring to ERISA plans (even to exempt them from the law's reach). The *UNUM* decision is of little help in defending AWP laws in states where the courts hold that HMOs are not insurers because these laws cannot meet the initial "common sense" test of insurance regulation.

2. Provider contract terms

Concerned over allegations that managed care plans prohibit physicians from freely discussing with patients treatment options that the plan may not cover, many state legislatures have prohibited so-called "gag clauses" in plan-provider contracts despite some question as to whether they exist.⁵⁵ Some states also prohibit plans from requiring providers to indemnify them for plan errors. These types of laws have rarely been challenged, but a Texas district court held that ERISA preempts them because they directly affect ERISA plan administrators' discretion in structuring the plan and are not saved as insurance regulation because they apply to HMOs that are not insurers.⁵⁶ This reasoning raises the prospect that ERISA might be held to preempt not only these more recent plan-provider contract terms but also the requirement in most state HMO licensing laws that HMOs must prohibit providers from seeking remuneration from enrollees if the plan fails to pay. This "hold harmless" provision is designed to protect plan enrollees from being asked to pay for services if the plan becomes insolvent and is typically used in lieu of insurance "guaranty funds" that pay claims of insolvent indemnity insurers. States may want to require that these provider-enrollee, hold harmless guarantees be part of plan-enrollee contracts in order to better defend them as insurance regulation.

The Texas court's decision invalidating these provider contract terms appears inconsistent with current preemption principles. Provider contract review has been a core activity of HMO regulation in many states because of its impact on the delivery of services to enrollees. Provider contract standards should be held not to relate to ERISA plans because they do not mandate an employee plan's structure to the same extent as AWP laws. Under an AWP law, an ERISA plan arguably cannot achieve cost and quality goals available in an insurer's limited network plan. Provider-patient communications or provider-plan indemnity arrangements would have an insignificant impact on an ERISA plan administrator's ability to contract for cost-effective health coverage. Even if a court were to hold that they relate to ERISA plans, standards prohibiting gag clauses or holding *patients* harmless from providers' unpaid bills should be saved on the ground that they primarily benefit policyholders. Standards chiefly benefitting providers, like the plan indemnity provisions, might be harder to justify as insurance regulation.

3. Provider risk-sharing limits

Managed care companies often attempt to control service use and therefore plan costs by sharing risk with contracting providers. They may pay providers a fixed fee for agreeing to deliver cover-

ed services (capitation), withhold a proportion of the fee paid for each service and return all or part of these funds if cost-containment goals are met, or pay bonuses for achieving cost or quality objectives.⁵⁷ Because these financial incentives have the potential to encourage physicians to skimp on needed care, several states have enacted limits on their use.⁵⁸

Such financial incentive standards have not been directly challenged as preempted by ERISA, although one Court of Appeals has recently held that they may violate an ERISA plan administrator's fiduciary duties to ERISA plan participants.⁵⁹ If provider risk-sharing arrangements are viewed as important cost and use controls whose absence threatens health coverage affordability, they might, like AWP laws, affect ERISA plan structure so as to relate to ERISA plans. In contrast, if they are seen as provider-plan terms with little impact on ERISA plan administration, a court should be able to determine that they do not relate to employee health plans. If these risk-sharing limits are held to relate to ERISA plans, they are likely to be saved only if they affect policyholders, perhaps from a broad view that sharing risk with providers represents a non-traditional but increasingly important arrangement that itself becomes the business of insurance that states need to regulate to protect consumers.⁶⁰

4. Provider selection and termination standards

At the request of providers who seek to contract with managed care plans and have their applications treated fairly, several states require health plans to make provider contract requirements public, allow all interested providers to apply for network participation, give providers written reasons for denying or terminating participation, and provide an appeal process for providers whose applications are denied or contracts terminated.⁶¹ In contrast to provider contracting standards discussed above, these "provider due process" standards might be easier to defend under *Travelers* as not relating to ERISA health plans. The procedures that insurers use to credential, monitor, and contract with providers arguably have no impact on an ERISA plan. The Connecticut Supreme Court upheld a state law prohibiting PPOs from rejecting providers applying to their networks if the PPO had not filed with the state information on selection and termination criteria.⁶² This state law did not prescribe selection and termination standards but only required them to be public and to be followed as filed. But the court's reasoning that the standards did not affect employee eligibility or benefits under an ERISA plan or mandate substantive coverage could be useful in defending more prescriptive provider due process standards. If a court were to hold, however, that these types of standards do relate to ERISA plans, it may be difficult to define them as regulating the business of insurance, even under an expansive view of that activity, because they are not designed primarily to benefit policyholders, are not included in the insurance policy terms, and/or do not spread insurance risk.

E. Regulating MEWAs

Multiple Employer Welfare Arrangements (MEWAs),⁶³ sometimes previously known as Multiple Employer Trusts (METs), are entities through which employers can purchase health coverage. Although MEWAs have helped small businesses buy affordable health coverage, some have experienced serious financial difficulties, including insolvency, due to both mismanagement and enrollment of less healthy people, leaving many people without coverage.⁶⁴

As discussed in Chapter 4, the DOL can regulate MEWAs that are ERISA plans, which must

comply with fiduciary responsibility requirements and other applicable provisions of ERISA. In its 1983 ERISA amendments, Congress clarified the states' role in regulating MEWAs. States can regulate any entity providing coverage to more than one employer if the entity meets the definition of a MEWA — an employee welfare benefit plan established to provide benefits to the employees of two or more employers. Excepted from the definition of a MEWA are plans provided under a collective bargaining agreement or by a rural electric or telephone cooperative.⁶⁵

A MEWA itself may or may not be an ERISA plan. It is an ERISA plan if it is an organization established and operated by employers. But most MEWAs are not ERISA plans themselves because they merely assist employers in obtaining benefits or are associations offering benefits to both members and non-members.⁶⁶

States can require “fully insured” MEWAs⁶⁷ to meet insurance reserve and contribution levels. MEWAs that are not fully insured may be subject to any insurance law that does not conflict with ERISA.⁶⁸ States can fully regulate any organization providing coverage to more than one employer if the organization does not meet the definition of a MEWA.⁶⁹

A 1992 analysis by the RAND Corporation for the U.S. DOL found that about half the states require self-insured MEWAs to be licensed as insurers and a few states have enacted specific MEWA licensing statutes.⁷⁰ (The state need not have a MEWA law to regulate MEWAs as insurers.) The researchers noted that states had experienced mixed success in overseeing MEWAs and preventing their insolvency.

Among the complex jurisdictional issues raised by the federal MEWA definitions are whether a health benefits program may involve one or more employers. For example, DOL has found that “employee leasing” firms are MEWAs (rather than a single employer) if they provide benefits for their own employees and those of client firms. Similarly, DOL has indicated that an association of employers can offer benefits to the association's own employees as a single employer ERISA plan, but if it offers benefits to each member's employees, that arrangement is a MEWA.⁷¹

Furthermore, some MEWAs assert that they are operating under a collective bargaining agreement and are therefore exempt from state regulation even though they do not actually bargain with employers. In the absence of a finding by DOL that an entity is collectively bargained, states are free to regulate MEWAs. The confusion surrounding what is a legitimate collective bargaining agreement led DOL to publish a proposed rule that is now the subject of a negotiated rulemaking process.⁷² Some state regulators have expressed confusion about whether they need a formal DOL opinion on whether a group health coverage purchasing arrangement is a MEWA, but at least one lower court has indicated that DOL is not required to issue individualized determinations as to whether an entity is a MEWA or a collectively bargained plan.⁷³

Notes

1. Some courts have invalidated a state law only because the regulated activity did not spread risk, *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105 (5th Cir. 1993), *Kelly v. Sears, Roebuck & Co.*, 882 F.2d 453 (10th Cir. 1989). Others have held a law was not saved only because the activity did not involve the relationship between the insurer and insured, *Texas Life, Acc. Health & Hosp. Service Ins. Guar. Assoc. v. Gaylord Entertainment Co.*, 105 F.3d 210 (5th Cir. 1997), cert. dismissed, 521 U.S. 1113 (1997); *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988). Several courts have determined that the third factor (that the law be limited to entities in the insurance industry) was absent when state laws applied to HMOs as well as other insurers because HMOs are not insurers, *Prudential Ins. Co. v. National Park Medical Ctr.*, 154 F.3d 812 (8th Cir. 1998); *Texas Pharmacy Assoc. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997), cert. denied, 118 S. Ct. 75 (1997); *CIGNA Health Plan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996), cert. denied, 519 U.S. 964 (1996).

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

3. See, *Prudential Ins. Co. v. National Park Med. Ctr.*, cited in note 1; *Texas Pharmacy Assoc. Prudential Ins. Co.*, cited in note 1; *Cigna Health Plan v. State of Louisiana*, cited in note 1.

4. *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205, 217; *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987); *Powell v. Chesapeake & Potomac Telephone Co. of Va.*, 780 F.2d 419 (4th Cir. 1985), cert. denied, 476 U.S. 1170 (1986).

5. At least one court has held that the issue of what is the business of insurance under the McCarran-Ferguson Act's antitrust exemption for insurance activities is entirely a matter of federal law (*Manasen v. California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976), *rev'd on other grounds*, 638 F.2d 1152 (9th Cir. 1979)), and state law would need to satisfy the Supreme Court's McCarran-Ferguson criteria as interpreted in its ERISA savings clause cases. But it seems unlikely that a federal court would disturb a state's reasoned definition of the types and extent of risk transfer that constitutes insurance risk.

6. Some of these cases involved laws other than state insurance statutes. *O'Reilly v. Cueleers*, 912 F.2d 1383 (11th Cir. 1990) involved a bankrupt HMO employee's claim for severance pay based on an alleged breach of the HMO's fiduciary duty, a cause of action available only if the HMO were an insurer under state insurance receivership law. The Court of Appeals held it was not an insurer and denied the cause of action. *Dearmas v. Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993) was a malpractice-type claim under the state's hospital emergency treatment ("anti-dumping") law, which the court held that ERISA preempted because the HMO was not an insurer, citing *O'Reilly*. Others involved HMO licensing laws that explicitly provide that HMOs are not insurers. *Ryan v. Fallon Community Health Plan*, 921 F. Supp. 34 (D. Mass. 1996) (state cause of action for unfair and deceptive insurance practices preempted); *Dees v. Primehealth*, 894 F. Supp. 1549 (S.D. Ala. 1995) (state subrogation law preempted); *New York State Health Maintenance Org. Conference v. Curiale*, No. 93 Civ. 1298 (S.D. N.Y., Feb. 25, 1994); *rev'd on other grounds*, 64 F.3d 794 (2d Cir. 1995) (demographic pooling arrangement to share costs of high-risk cases across HMOs preempted); *OraCare DPO v. Merin*, 13 Employee Benefits Cases 2720 (D. N.J. 1991) (law requiring a state license for a prepaid dental plan preempted); *McManus v.*

Travelers Health Network of Texas, 742 F. Supp. 377 (W.D. Tex. 1990) (HMO Act's unfair practices act provisions would be preempted).

7. *New York State Health Maintenance Organization Conference v. Curiale*, cited in note 6.

8. States could, for example, point out that the HMO Act of 1973 authorizing new forms of health insurance and delivery had just been passed when ERISA was enacted and that HIPAA defines HMOs to be included as "health insurance issuers" that are subject to health insurance market reforms (29 U.S.C. section 1191(b)(2)). States can also cite the following ERISA cases holding that HMOs are insurers: *Physicians Health Plan, Inc. v. Citizens Ins. Co.*, 673 F. Supp. 903 (W.D. Mich. 1987); *Cellilli v. Cellilli*, 939 F. Supp. 72 (D. Mass. 1996); *Anderson v. Humana*, 24 F.3d 889 (7th Cir. 1994); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997).

9. NAIC 1997. *The Regulation of Health Risk-Bearing Entities*. Washington, D.C.: National Association of Insurance Commissioners.

10. This risk denotes uncertainty for both individuals and insurers. Through pooling and greater knowledge about the risks of large groups, insurers can reduce their risk more substantially than individuals could experience on their own.

11. NAIC 1997. *The Regulation of Health Risk-Bearing Entities*; Butler, P.A. and E. Mitchell. 1996. *Health Care Provider Networks: Regulatory Issues for State Policymakers*. Portland, ME: National Academy for State Health Policy.

12. At least half the states license PPOs and some states license other types of provider-sponsored networks, which contract with risk-bearing entities such as HMOs and other insurers as well as with self-insured plans. Even when provider-sponsored organizations do not bear risk, states may be interested in protecting consumers by ensuring that the networks are adequate to provide promised services, inform consumers about network providers, do not limit provider communications with consumers via gag clauses, provide appeal procedures for consumers and providers, and limit provider financial disincentives to render appropriate care (See, generally, Butler, P. 1996. *Public Oversight of Managed Care Entities: Issues for State Policymakers*. Washington, D.C.: National Governors' Association). Although a state probably could not enforce such a law upon a provider network established exclusively by and for the sole use of a private-sector employer, a law directed at networks that contract with HMOs and insurers as well as self-insured employee plans ought to withstand an ERISA preemption challenge under the language in *Travelers*. Not only do these types of laws have minimal effects on the costs and administration of an underlying employee health plan, they can be characterized as "general health care regulation," which the Supreme Court in *Travelers* noted Congress did not intend to preempt. State provider network laws might be easiest to defend if they do not refer to ERISA plans and if they are codified as part of other state health care provider quality standards.

In contrast to consumer protection standards such as information disclosure and network adequacy, "any willing provider" laws that apply to provider networks face a more difficult ERISA problem because several courts have held that they impermissibly interfere with employee health plan administration, as discussed later in this chapter.

13. See, e.g., Hirschfield, E. "Assuring the Solvency of Provider-Sponsored Organizations." 1996 *Health Affairs* 15(3):28-30. This argument appears to be based on older cases holding that certain types of HMOs were not insurers because they provided care directly. *Jordan v. Group Health Assoc.*, 107 F.2d 239 (App. D.C. 1939); *California Physicians' Services v. Garrison*, 172 P.2d 4 (Cal. 1946). The limitation of this argument, however, is that even if a physician would be willing to work without pay to meet an unexpectedly large demand for services, the physician cannot personally provide many types of health care, such as hospitalization, lab tests, or prescription drugs, that these patients may need; consequently, a promise to provide that broad range of services involves insurance risk.

14. Kudner, Kathrin E. 1997. "Risk Regulation: A 50-State Survey." *Health Law Digest* 25(1):3-14, 57-64. Washington, D.C.: National Health Lawyers' Association; Ward, S. O. 1997. *Provider-Sponsored Networks: State Oversight and Contracting Innovations*. Washington, D.C.: Alpha Center; Butler and Mitchell, *Health Care Provider Networks*.

15. Kudner, "Risk Regulation: A 50-State Survey;" NAIC, *The Regulation of Risk-Bearing Entities*."

16. Kudner, "Risk Regulation: A 50-State Survey;" NAIC, *The Regulation of Risk-Bearing Entities*." Many states do not regulate PSOs accepting downstream risk from licensed entities.

17. Kudner, "Risk Regulation: A 50-State Survey." While the deemer clause (interpreted by the stop-loss cases discussed below) makes it hard for states to define at what point an ERISA plan is self-insured (i.e., what amount of risk an employee plan must retain to be self-insured), states should be able to define at what point a risk-assuming entity becomes an *insurer* subject to state insurance law because defining what is the business of insurance is a prerequisite to regulating the business of insurance, which the Supreme Court has repeatedly upheld as within a state's jurisdiction (e.g., *Group Life Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, n. 18 (1979); *Union Labor Life Ins. Co. v. Pireno*, cited in end note 2; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999)). Consequently, if a PSO accepts the amount of risk defined as the business of insurance (e.g., via capitation contracts with an employee plan), it should be irrelevant that the employee plan claims to be self-insured; the state is regulating the insurer and not the employee plan.

18. Employers sometimes assert that they are self-insured even when passing full risk to a PSO by arguing that they are ultimately responsible to cover the cost of employee health services if a PSO goes out of business and that they therefore retain some level of risk. The flaws in this argument, however, are: 1) ERISA does not require employer-sponsored plans to guarantee coverage; and 2) even if an employer assumes such a responsibility, this is no different than the employer agreeing to back up an insolvent HMO (which would generally not be protected by state insurance guaranty funds). In other words, the fact that an employer may agree to bear some risk at a later time does not undermine the essential nature of the ongoing risk that the employer plan has transferred to the PSO, which makes the PSO a risk-bearing entity and eliminates the employer's claim to self-insure.

19. One danger of a state deciding not to regulate risk transfers by allegedly self-insured employee health plans to PSOs is that a state may be accused of not applying equally a definition of risk-transfer to similar organizations.

20. As discussed more fully later in this chapter, states where federal courts have held that HMOs are not insurers may face a somewhat greater challenge in defending PSO regulation against ERISA preemption. All types of risk transfer that state insurance regulators consider to be insurance regulation should be explicitly defined in statute to help in overcoming this type of argument. The Supreme Court held that the delegation of insurance regulation to the states included “existing and future state systems for regulating and taxing” this business. *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946).

21. Many small firms self-insure without stop-loss coverage, which can expose their employees to high costs if the employer becomes insolvent, Butler, P.A. and K. Polzer. 1996. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: National Health Policy Forum, George Washington University.

22. Most courts hold that the existence of stop-loss insurance does not turn the underlying employee plan into an insured plan. *Tri-State Machinists, Inc. v. Nationwide Life Ins. Co.*, 33 F3d 309 (4th Cir. 1994), *cert. denied*, 115 S. Ct. 1175; *Thompson v. Talquin Bldg. Products Co.*, 928 F2d 649 (4th Cir. 1991); *Brown v. Granatelli*, 897 F2d 1351 (5th Cir. 1990), *cert. denied*, 498 U.S. 848 (1990); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F2d 1157 (9th Cir. 1986). (Technically, these conclusions may only be dicta because the cases involved enrollee grievances against the plan (not the stop-loss insurer), and the courts focused on the fact that the state cannot regulate the underlying ERISA plan as an insurer, not how states might be able to regulate the stop-loss insurer itself.) ERISA generally does not govern disputes between a self-insured plan and its reinsurer, *Behavioral Sciences Inst. v. Great-West Life*, 930 F2d 933 (Wash. App. 1997).

23. *American Med. Sec. v. Bartlett*, 111 F3d 358 (4th Cir. 1997), *cert. denied*, 118 S. Ct. 2340 (1998).

24. Plan participants were not parties to the stop-loss insurance contract, which is designed to protect the plan, not individual enrollees. The court said, “In seeking to address this perceived loophole [a plan purporting to self-insure to avoid benefits mandates but actually bearing minimal risk itself through low-deductible stop-loss coverage] the state in fact ends up regulating self-funded employee benefit plans that are exclusively subject to ERISA.” 111 F 3d at 363.

25. In *Associated Ind. of Missouri v. Missouri Dep’t of Ins.* Cole County Circuit Court, CV195-1326CC, Dec. 27, 1995, the court held that the regulation was not authorized by state law and also was preempted by ERISA.

26. The TPA plaintiff in the original case has already sought an injunction from the federal judge, who held that plaintiffs must file a new suit challenging the new law. *American Med. Sec. Inc. v. Larsen*, No. H-95-1463 (D. Md. Sept. 1999).

27. By essentially outlawing the sale of stop-loss policies with attachment points below \$10,000, the state gives employee plans the choice of either not self-insuring or of assuming risk of losses for the first \$10,000, which could expose employees, especially those in very small firms, to potential insolvency. This choice could pose a dilemma for state consumer protection policy, although insurance regulators may argue that in these cases the employer plans should be fully insured.

28. The model act, expected to be approved in December 1999, is published on the NAIC web site (www.naic.org).
29. *American Trust Adm'rs, Inc. v. Kathleen Sebelius*, Case No. 96-CV-908, Shawnee County Kansas District Court, April 25, 1997.
30. 111 F.3d at 365.
31. *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647 (7th Cir. 1995) drew upon the reasoning in *Travelers* to hold that these assessments did not relate to ERISA plans even though they might make self-insured health coverage somewhat more costly. This assessment was based on the premium revenues collected by each insurer which, in the case of stop-loss insurers, was only the premium for their stop-loss policies, not payments by the underlying self-insured plans.
32. *Securities and Exchange Comm'n v. National Sec. Inc.*, 393 U.S. 453, 458-59 (1969).
33. 471 U.S. 724 (1985).
34. 71 U.S. 746-7. In *UNUM*, the Court reiterated this view, noting that only state laws that directly conflict with federal law would be preempted, 119 S. Ct. at 1391.
35. *Washington Physicians Serv. Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999).
36. *Chatelaine v. Southern Baptist Health System*, 907 F. Supp. 206 (E.D. La. 1995). This case might be decided differently in light of *UNUM*, although the district court found that none of the three McCarran-Ferguson criteria were satisfied and that the law did not meet the “common sense” test of regulating insurance (possibly because the state 30-day claims payment law may have been seen as merely a basis for a suit for benefits denied, which, as discussed in Chapter 7, courts always hold to be preempted by ERISA).
37. Health Policy Tracking Service. 1999. *Major Health Care Policies: 50 State Profiles, 1998*. Washington, D.C.: National Conference of State Legislatures.
38. To the extent that these laws regulate insurer-provider contracts, they arguably do not even “relate to” the underlying ERISA plan, although such state time limits on payment could not apply directly to self-insured ERISA plans.
39. *Presley v. Blue Cross-Blue Shield of Alabama*, 744 F. Supp. 1051 (N.D. Ala. 1990).
40. *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir. 1994), *cert. denied*, 513 U.S. 808 (1994). The court held that the law did not spread risk and was hard to characterize as a term of the insured-insurer contract, though the reasoning might be different in light of *UNUM*.
41. *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105 (5th Cir. 1993). Because the court held that this state law did not spread risk (comparable to the state law at issue in *UNUM*), this case might be decided differently today. *See also, Davies v. Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997).

42. For example, in *United of Omaha v. Business Men's Assurance Co.*, 104 F.2d 1034 (8th Cir. 1997), the Court of Appeals upheld a state "extension of benefits" law allocating responsibility for a disabled beneficiary between his previous and current insurer.

43. 471 U.S. 724 (1985).

44. 147 F.3d 1039 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999).

45. Health Policy Tracking Service. 1999. *Major Health Care Policies: 50 State Profiles*.

46. Blendon, R. J., et al. 1998. "Understanding the Managed Care Backlash." *Health Affairs* 17:80-94.

47. Health Policy Tracking Service. 1999. *Major Health Care Policies: 50 State Profiles*; Families USA Foundation. 1998. *Hit and Miss: State Managed Care Laws*. Washington, D.C.: Families USA.

48. About one-third of the states permit plan enrollees to obtain services from a non-network provider, and almost half the states have enacted "Freedom of Choice" ("FOC") laws, applying almost exclusively to pharmacies (an early variant of "any willing provider" laws, discussed later in this Chapter). But network adequacy and FOC laws should be somewhat easier to defend against an ERISA preemption challenge than AWP laws because, rather than automatically extending a plan's network, they allow the enrollee to leave the network selectively.

49. *Cited in note 1.*

50. Hellinger, F. J. 1995. "Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment." *Health Affairs* 14:297-302. "Network adequacy" laws generally do allow enrollees to go outside the network (at no greater out-of-pocket cost) if the type of care they need is not available within the network. Although this requirement does enlarge the network selectively, it is so inherently necessary to ensure that the benefits promised by the managed care plan — access to needed care — are actually available, that it seems more analogous to a benefits mandate designed to ensure the contract is reliable than to an AWP law.

51. This reasoning derives from a Supreme Court case, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), involving the business of insurance exception for prosecution of anti-competitive conduct under the antitrust laws. The Court there held that contracts between insurers and providers (pharmacies in that case) did not spread risk or involve insured-insurer policy terms and included entities (pharmacies) outside the insurance industry. Although the Supreme Court noted (in *U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491 (1993)) that the McCarran-Ferguson Act's delegation to the states of insurance regulatory authority need not necessarily be analyzed the same way as the Act's antitrust insurance exception, lower courts have relied on the antitrust analysis in *Royal Drug* to hold that ERISA preempts "any-willing-provider" laws.

52. Health Policy Tracking Service. *Major Health Care Policies: 50 State Profiles*.

53. The Court in *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1996), *cert. denied*, 118 S. Ct. 75 (1997), examined an earlier version of the law that applied only to insurers

and, relying on *Stuart Circle Hospital v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert denied*, 510 U.S. 1003 (1993), upheld that law and the policies that still operated under it on the ground that the statute dictated terms of insurance policies and consequently met the risk-spreading and insurer-policyholder tests.

54. 973 F. Supp. 60 (D. Mass. 1997).

55. U.S. GAO. 1997. *Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, but Physician Concerns Remain*. GAO/HEHS-97-175. Washington, D.C.: U.S. General Accounting Office. In a review of over 500 HMOs, the GAO found no limits on physician discussions with patients about treatment options but did find clauses prohibiting physicians from making disparaging remarks about the HMO, urging patients to enroll in another plan, or distributing proprietary information.

56. *Corporate Health Insurance, Inc., et al. v. Texas Department of Insurance*, 12 F. Supp.2d 597 (S.D. Tex.1998); the case is currently on appeal to the Fifth Circuit.

57. Hillman, A. L. 1987. "Financial Incentives for Physicians in HMOs: Is there a Conflict of Interest?" *New England Journal of Medicine* 317:1743-1748.

58. Health Policy Tracking Service. *Major Health Care Policies: 50 State Profiles*.

59. *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998)), *cert granted*, 67 U.S.L.W. 3758 (1999). Other courts have held to the contrary, however, *Maltz v. Aetna Health Plans of New York*, 114 F.3d 9 (2d Cir. 1997); *Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748 (S.D. N.Y. 1997).

60. This argument was advanced in Jordan, K.A. 1996. "ERISA Preemption: Integrating *Fabe* into the Savings Clause Analysis." *Rutgers Law Journal* 27:273-342 at 320.

61. Health Policy Tracking Service. *Major Health Care Policies: 50 State Profiles*.

62. *Napoletano v. CIGNA Healthcare of Connecticut*, 680 A.2d 127 (Conn. 1996), *cert. denied*, 816 U.S. 1003 (1997); Polzer, K. 1997. "Issue Brief (no. 707): Preempting State Authority to Regulate Association Plans: Where Might It Take Us?" Washington, D.C.: National Health Policy Forum.

63. Multiple employer welfare arrangements are to be distinguished from "multi-employer plans," defined under ERISA as plans operated by several employers through a collective bargaining agreement.

64. U.S. GAO. 1992. *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*. Washington, D.C.: U.S. General Accounting Office.

65. 29 U.S.C. section 1002(40)(A).

66. See, e.g., *Cooley v. Protective Life Ins. Co.*, 815 F. Supp. 189 (S.D. Miss. 1993); *Wisconsin Education Assoc. Ins. Trust v. Iowa State Bd.*, 804 F.2d 1059 (8th Cir. 1986)).

67. A stop-loss policy does not turn a self-insured MEWA into a “fully insured” one. *Bone v. Association Management Serv., Inc.*, 632 F Supp. 493 (D. Miss. 1986)
68. *Atlantic Healthcare Benefits Trust v. Googins*, 2 F.3d 1 (2d Cir. 1993), *cert. denied*, 510 U.S. 1043 (1994); *Fuller v. Norton*, 86 F.3d 1016 (10th Cir. 1996); *Atlantic Health Care Benefits Trust v. Foster*, 809 F Supp. 365 (M.D. Pa. 1992), *aff’d*, 6 F.3d 778 (3d Cir. 1993) and *cert. denied*, 510 U.S. 1043 (1994). The courts in *Googins* and *Foster* held that the state can exercise existing insurance law and need not develop separate MEWA licensing rules. The DOL MEWA Manual indicates that states can impose stricter standards than ERISA imposes, including reserve and contribution requirements, licensure, and reporting to the state.
69. *MD Physicians and Assoc., Inc. v. State Board of Ins.*, 957 F.2d. 178 (5th Cir. 1992), *cert. denied*, 506 U.S. 861 (1992).
70. Liebowitz, A., C. Damberg and K. Eyre. 1992. *Multiple Employer Welfare Arrangements*. Santa Monica, CA: Rand Corp.
71. In order for a group or association to constitute an employer there must be a bona fide group or association of employers acting in the interest of its employer-members to provide benefits to employees. The DOL has found that where several unrelated employers executed boilerplate trust agreements without a genuine organizational relationship between employers, no employer group or association exists. Pension and Welfare Benefits Administration. 1992. *MEWAs – Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation*. Washington, D.C.: U.S. Department of Labor, PWBA.
72. The proposed regulation was published August 1, 1995, Fed. Reg. 60: 39208.
73. *Virginia Beach Policeman’s Benevolent Assoc. v. Reich*, 881 F Supp. 1059 (E.D. Va. 1995).

Chapter VII: Implications of ERISA Preemption for State Health Policy Initiatives: Resolving Health Plan-Enrollee Disputes

Making sure that insured people have a process to resolve disputes with their insurance companies is an important objective of state insurance regulators. Because traditional indemnity insurance typically involves only a dispute over payment after a service has already been provided, there is less urgency to resolve claims quickly. But many disagreements over managed care coverage occur before the services are rendered because the managed care plan may decide it will not authorize payment for coverage on the ground that, for example, the care is not “medically necessary.”¹ Although individuals could pay for the service and argue later about who will pay, this is often not practical and providers may refuse to render services without a payment guarantee. Consequently, timeliness of managed care plan coverage decisions is usually important to plan enrollees.

All state HMO licensing laws require plans to establish enrollee grievance procedures. More recently, many states have amended these internal grievance system requirements and also created “external review” programs independent of health plans.² In 1997, the Texas legislature authorized lawsuits against managed care plans when an enrollee is injured by a plan’s treatment decisions. California, Georgia, and Louisiana enacted similar laws in 1999. State agencies often provide direct consumer assistance, and a few states have developed health plan “ombudsman” programs that offer information and can investigate and attempt to help enrollees resolve disputes with their plans. While few debate the value of at least the internal and external coverage dispute resolution systems, they may conflict with ERISA.

Dispute resolution standards regulate the insurance contract as a means to ensure its “reliability, interpretation, and enforcement.”³ Consequently, even though these types of standards might relate to ERISA health plans (for example, by directly affecting the plan’s administration⁴), they are insurance regulation that should fall easily within ERISA’s savings clause. ERISA presents an additional problem for state health plan grievance procedures, however, because ERISA explicitly includes dispute resolution provisions.⁵ In its *Pilot Life* decision, the Supreme Court held that ERISA preempts not only state laws that directly conflict with these ERISA provisions but also those that impinge upon the general field of private employee benefit plan coverage dispute resolution, which the Court held Congress intended ERISA to occupy. ERISA permits ERISA plan participants to sue in federal court to enforce plan terms or recover benefits due, but not for other types of damages such as lost wages, pain and suffering, or punitive damages. Consequently, state health plan-enrollee dispute provisions can raise both types of preemption; some state laws may directly conflict with federal law (such as recently proposed DOL claims procedures rules) while others, such as HMO liability laws, may attempt to legislate in an area that the courts have held Congress intended to be exclusively federal. These issues are likely to grow as Congress and DOL impose new substantive requirements on ERISA health plans.

Chapter Highlights:

- State regulators and consumer assistance programs can help health plan enrollees resolve disputes with their plans.
- States’ traditional standards for internal health plan grievance systems regulate the business of insurance, but a few conflict with recently proposed federal ERISA rules.
- One court has held ERISA preempts a state’s managed care external review program.
- Courts hold that ERISA preempts state court damages remedies against health plans over benefits coverage disputes but usually permit such suits involving health plans’ direct involvement in medical care treatment.

ERISA would preempt state laws authorizing ombudsman programs to intervene directly in a dispute between a self-insured ERISA health plan and its enrollees. But ERISA should not preempt a state law establishing a consumer assistance program that does not refer directly to ERISA plans or purport to extend authority over them.

A. State Agency Dispute Resolution

State insurance regulators and others who oversee health plan performance can protect health plan enrollees through informal negotiations, enforcement actions, and formal administrative hearings.⁶ Some states have established toll-free telephone numbers for consumer inquiries and complaints. States may require HMO enrollees to use their insurance plan's grievance process before appealing to the state agency.

ERISA presents two obstacles to states' ability to directly assist people in resolving health coverage disputes. First, although state insurance regulators receive complaints from participants in self-insured ERISA plans,⁷ ERISA prohibits states from taking enforcement action directly against these plans. For example, seeking an injunction against a self-insured ERISA plan for failure to pay for covered service would certainly "relate to" the ERISA plan and could not be saved as insurance regulation because the self-insured plan could not be deemed to be an insurer.⁸ Regulators in some states report that although they have no enforcement authority, they attempt to resolve disputes with self-insured plans informally, especially if the plan administrator is a licensed insurer (where the state has bargaining leverage due to its jurisdiction over insurers).⁹ Some courts have suggested that ERISA could impose an obstacle to state enforcement of insurance laws against insurers. In holding that ERISA prohibits health plan enrollees from suing plans under state "unfair claims procedures" laws,¹⁰ federal and state courts have hinted that ERISA might prevent state agencies from using those laws to prosecute insurer misconduct.¹¹ These cases were decided before the Supreme Court's 1999 *UNUM* decision, however, which should provide an easier argument that state unfair claims practices laws regulate insurance and are saved from preemption, as long as these laws are directed at insurers¹² and involve the terms of the contract between the insurer and insured. Even if these laws do not provide a basis for *individuals* to sue insurers (because of broader conflicts with ERISA's dispute resolution procedure, discussed below), they should be saved from preemption when used by state regulators against managed care plans and other licensed health insurers.

B. State Health Plan Ombudsman Programs

Several states have considered, and half a dozen have created, programs to supplement state insurance regulators' traditional authority to investigate and assist health plan enrollees to resolve disputes with their plans. These laws often are modeled on successful ombudsman programs operated for many years under federal sponsorship for Medicare beneficiaries and residents in long-term facilities.¹³ State health insurance ombudsman programs generally provide consumer education about health coverage, health plans, and existing appeals procedures, information about the terms of an individual's health coverage, and informal assistance to individuals in resolving plan-enrollee disputes.¹⁴ As discussed with respect to state insurance agency authority, ERISA would preempt state laws authorizing ombudsman programs to intervene directly in a dispute between a self-insured ERISA health plan and its enrollees. But ERISA should not preempt a state law establishing a consumer assistance program that does not refer directly to ERISA plans or purport to extend authority over them. Like state regulators, ombudsman programs can use persuasion to assist in resolving disputes with both insured and self-insured ERISA plans.

C. State Plan Internal Appeals System Requirements

The long-standing general state requirements that HMOs provide enrollee appeals systems has never been challenged under ERISA. These standards might arguably relate to ERISA plans because they address a subject — dispute resolution — specifically covered by ERISA, which requires employee benefit plans to provide a mechanism for “full and fair review” of a denied benefits claim, although as applied to HMOs and other insurers they also should be saved as a traditional type of insurance regulation necessary to assure the contract’s enforceability.¹⁵ Several states’ more recent requirements for the structure of managed care plan internal grievance systems that must be offered by managed care plans and utilization review organizations conflict with a few of the DOL’s proposed revisions to its claims processing regulations.¹⁶ The federal standards proposed to require, for example, that appeals be decided within 30 days or three days in emergency situations, that only persons not party to the original adverse determination may conduct the review, that no more than one level of review can be required, and that medical necessity determinations be made in consultation with a trained medical professional. Some states have imposed shorter time frames for appeals to be decided, require two levels of review,¹⁷ and prescribe more specifically than federal rules the qualifications of reviewers. Because federal law governs when it conflicts directly with state law,¹⁸ some of these proposed federal standards may raise ERISA issues if they are finally adopted. For example, state law such as shorter appeals time limits that arguably supplement federal standards should not be preempted under the reasoning in *UNUM*, which upheld a state insurance law on the grounds that it was the business of insurance and did not directly conflict with federal standards but rather supplemented them.¹⁹ On the other hand, a state law requiring two levels of review may be preempted because it directly conflicts with the proposed DOL rules prohibiting more than one review level.²⁰ Because the DOL received several hundred comments on the proposed regulations, their final form and likely publication date remain uncertain.

D. State External Review Programs

To address managed care plan enrollees’ concerns that their plan’s internal grievance process may be biased in favor of the plan, more than 30 states have enacted various laws permitting enrollees to appeal certain coverage disputes to a review organization independent of the plan.²¹ These laws vary in scope but most permit review of a plan’s decision to deny coverage because it was not medically necessary, and some also authorize an appeal of non-clinical disputes. An external reviewer’s decision is usually binding on the plan. External review programs are widely favored by consumer advocates because they provide an unbiased appeal forum, by regulators because they appear to modify plan behavior over time, and by plans and employers because they may reduce the likelihood of litigation and yet have not proven extremely costly or cumbersome. External review also can help restore consumer confidence in the integrity of health plan coverage decisions.

Despite broad support, however, these new appeals systems face a serious ERISA obstacle. As a coverage dispute process, external review requirements clearly relate to ERISA plans because they affect coverage determinations, a key plan administration responsibility. When directed only at insurers, they ought to fall under the savings clause, especially under the relaxed *UNUM* standard. But because external review creates an additional appeal step (albeit one far less costly than damages awards), ERISA may preempt external review programs, as a Texas district court held.²²

The long-standing general state requirements that HMOs provide enrollee appeals systems has never been challenged under ERISA.

That court reasoned that the program of independent review and the definition of “medical necessity” in the Texas statute improperly mandated an integral function of ERISA plan administration (determining when benefits are covered). Furthermore, the court held the law was not saved because it applied to HMOs, which the court held were not insurers based on precedent in the Fifth Circuit Court of Appeals.²³ Even in states where the courts do not hold that HMOs are not insurers, however, an external review law might be preempted because it adds an intermediate step to the two-stage appeal process set out in ERISA (internal plan review and judicial review). Under the Supreme Court’s reasoning in *Pilot Life*, state law cannot interfere with ERISA’s remedial process, which the Court found Congress intended to be exclusive of other supplemental remedies like punitive damages.

If external review is characterized as offering an additional remedy in the claims procedure process for private-sector employee health plans, it would face conflict preemption. On the other hand, external review could be characterized as merely an additional procedural step rather than an additional remedy (since these state programs do not permit relief beyond what the internal plan review or a court could provide).²⁴ Relying on the reasoning in *UNUM*, a court might conclude that state external review systems merely supplement rather than conflict with federal law.

E. Judicial Remedies

Some state policymakers are interested in providing a right for people injured by managed care plans or other insurers to sue their plans. Several types of plan conduct might lead to an enrollee’s injury, for example, employment or direct control of a clinician who makes an error in diagnosis or treatment, negligent selection of clinicians, provider financial incentives that lead to inappropriate care decisions, and coverage denials or delays. Proponents of expanded health plan liability argue that health-insuring entities should be accountable for their conduct like other businesses and that managed care plans facing no penalty other than the obligation to cover a disputed service have little incentive to settle disputes promptly and carefully. Opponents of health plan liability raise concerns that increased litigation costs will make health coverage unaffordable.²⁵ Although California, Georgia, Louisiana, and Texas are the only states yet to enact managed care liability laws, many other states have considered similar legislation. There are several reasons states may want to enact such laws: an explicit statutory basis for a lawsuit avoids the uncertainties of whether the common law provides such a claim; it can overcome existing barriers to litigation such as the “corporate practice of medicine” doctrine; and it can subject managed care plan liability suits to existing malpractice litigation limits.²⁶

ERISA raises two types of obstacles to state court suits against health insurers. The Supreme Court held in *Pilot Life* that ERISA preempts state common law damages claims against the insurer of an ERISA disability coverage plan because first, common law claims are not saved as insurance regulation,²⁷ and second, they conflict with ERISA’s more limited set of judicial remedies.²⁸ States may be able to bring their health plan liability laws within ERISA’s savings clause by drafting them to apply only to organizations conducting the business of insurance²⁹ and requiring them to be incorporated into the insurance policy’s terms.³⁰

But the second ERISA preemption hurdle is more difficult to overcome because *Pilot Life* stands for the proposition that state damages awards conflict with ERISA’s existing, albeit limited,

judicial remedies. Consequently, courts unanimously hold that ERISA preempts state common law damages suits against HMOs and other insurers administering ERISA plans for coverage denials and delays, because these cases involve interpreting the employee plan's terms.³¹ Court decisions are split on whether ERISA preempts state law damages suits involving negligent selection and supervision of physicians in a health plan's network³² and physician incentive payment approaches that might compromise high-quality care.³³

In recent years, courts have begun to distinguish between two types of suits against health plans for purposes of ERISA preemption analysis. Although ERISA preempts state court damages suits over coverage denials (sometimes called "quantity of care" cases),³⁴ most courts now hold that ERISA does not preempt state court lawsuits against health plans for their traditional legal responsibility for the medical errors in diagnosis or treatment of clinicians they employ or who act as their agents.³⁵ The courts hold that ERISA does not preempt these cases, sometimes referred to as "quality of care" cases, because under the reasoning in *Travelers* they do not relate to ERISA plans but rather represent a traditional area of state authority — tort suits involving the quality of medical care.³⁶

The distinction between medical malpractice-type cases and those involving health plan coverage decisions is not easy to draw, however. Health plan decisions about "medical necessity" imply a standard of medical care practice³⁷ and provider financial incentives are often designed to encourage physicians to provide "appropriate" care. Nevertheless, although it appears that courts are increasingly sympathetic to injured health plan enrollees,³⁸ at this point the courts hold that ERISA preempts any suits involving interpretation of a plan's coverage terms, including whether a service is covered because it is or is not medically necessary.³⁹

A federal district court upheld part of the Texas managed care plan liability law, which created a right to sue for both health plan "health care treatment decisions"⁴⁰ and coverage denials or delays. Consistent with the distinction drawn by other federal courts between coverage and care quality cases, the Texas court held that ERISA would not preempt cases brought under the state law alleging a health plan's direct involvement in medical treatment.⁴¹ The court noted, however, that ERISA would preempt cases brought under the law seeking damages for health plan coverage denial or delay and that a court must determine on a case-by-case basis how to characterize each lawsuit.

The Supreme Court has not decided a case involving a state health plan liability law. But consistent with the majority of federal appeals courts and the holding in the Texas managed care plan liability case, it appears likely that states can authorize managed care plan enrollees to sue plans for traditional medical negligence when the plan exercises control over the clinician's practice. Yet ERISA still preempts state court suits involving employee health plans, even state laws directed only at insurers. Proposals to expand federal ERISA remedies or authorize state damages lawsuits continue to be the major point of contention in managed care legislative proposals in the 106th Congress.

Although ERISA preempts state court damages suits over coverage denials, most courts now hold that ERISA does not preempt state court lawsuits against health plans for their traditional legal responsibility for the medical errors in diagnosis or treatment of clinicians they employ or who act as their agents.

Notes

1. Bergthold, L. 1995. "Medical Necessity: Do We Need It?" *Health Affairs* 14:180-190. For a critique of the application of "medical necessity" in health plan coverage decisions, see Rosenbaum, S., et al. 1999. "Sounding Board: Who Should Determine When Health Care is Medically Necessary?" *New England Journal of Medicine* 340(3):229-232.
2. Pollitz, K., et al. 1998. *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*. Menlo Park: Henry J. Kaiser Family Foundation.
Families USA Foundation. 1998. *Hit and Miss: State Managed Care Laws*. Washington, D.C.: Families USA.
3. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 458-459 (1969).
4. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
5. ERISA requires that employee plans provide an opportunity for "full and fair review" of claims disputes (29 U.S.C. 1133) and provides a right to go to court to recover benefits due under the plan, enforce rights under the plan, or clarify rights to future plan benefits (29 U.S.C. section 1132(a)(1)(B)).
6. Examples of the types of health plan enrollee complaints submitted to states and state responses to assist consumers are reported in Butler, P. and Polzer, K. 1996. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: National Health Policy Forum, George Washington University.
7. Health plan enrollees often do not understand how their employee coverage is financed and are particularly likely to believe it is insured if a licensed insurer, like Blue Cross or Prudential, administers the plan because these enrollees often have a card with this insurer's name. Butler and Polzer, *Private-Sector Health Coverage*. This confusion may be relieved by HIPAA's requirement that ERISA plans inform participants about whether an insurer finances or administers the plan, 29 U.S.C. section 1022(b).
8. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).
9. Butler and Polzer, *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*; NAIC 1999. *ERISA White Paper — ERISA: Barrier to Health Care Consumers' Rights*. Washington, D.C.: National Association of Insurance Commissioners.
10. For example, a claim under West Virginia's law (W.Va. Code 33-11-4(9)) was held preempted in *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993); Colorado's similar provision (C.R.S. 10-3-1101) was invalidated as applied to employee health plans in *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453 (10th Cir. 1989) and California Insurance Code section 790 *et seq.*, was invalidated as applied to employee health plans in *Commercial Life Ins. Co. v. Superior Court*, 764 P.2d 1059 (Cal. 1988), *cert. denied*, 490 U.S. 1075 (1989) and *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989). But ERISA did not preempt a suit under an unfair claims processing statute in *Graves v. Blue Cross of California*, 688 F. Supp. 1405 (N.D. Cal. 1988).

11. This issue was expressly reserved by courts in California. *Kanne v. Conn. Gen. Life Ins. Co.*, 867 F.2d at 493 n. 6, and *Commercial Life Ins. Co. v. Superior Court*, 764 P.2d at 1066 n. 7.
12. This argument is more difficult to assert in states where the federal 5th, 8th, and 11th Circuit Courts of Appeals hold that HMOs are not insurers, as discussed in Chapter 6, end notes 6-8 and accompanying text.
13. Some of these Medicare “Health Insurance Consumer Assistance Programs” (“HICAP”) are housed in state insurance agencies while others are independent. State long-term care ombudsman programs are typically separate from state government.
14. See, e.g., Utah’s 1999 Office of Consumer Health Assistance, amending Laws of Utah, 31A- 2-215 - 31A-2-216.
15. This is an example of the importance of distinguishing between ERISA plans and insurance products — states can regulate dispute resolution between insurers and their enrollees as long as the state law does not make it impossible to comply with ERISA’s dispute resolution procedures.
16. 63 Fed. Reg. 48390-48409, September 9, 1998.
17. The NAIC model law, on which many state managed care plan grievance standards are based, requires plans to offer two levels of review but does not require plan enrollees to exhaust both levels, so state laws based on this model may not directly conflict with the proposed federal rule.
18. When there is a direct conflict between state and federal law, federal law governs, *Boggs v. Boggs*, 520 U.S. 833, 844 (1997). The conflict can result when compliance with both state and federal law is a “physical impossibility,” *Florida Avocado Growers v. Paul*, 373 U.S. 132, 142-43 (1963) or when the “scheme of federal regulation is ‘so pervasive as to make reasonable the inference that Congress left no room for the states to supplement it,’” *Gade v. National Solid Wastes Management Assoc.*, 505 U.S. 88, 98 (1992).
19. The Court noted that the state law at issue (extending the time to file an insurance claim) did not conflict with ERISA’s general statutory claims procedures requirements or the DOL claims procedures regulation, stating “By allowing a longer period to file than the *minimum* filing terms mandated by federal law, the notice-prejudice rule complements rather than contradicts ERISA and the regulations.” (119 S. Ct. at 1391).
20. States could argue first that the savings clause preserves to the states all state insurance regulation and furthermore that a federal regulation cannot preempt state law, based on the McCarran-Ferguson Act, 15 U.S.C. 1012, which permits only federal law that “specifically relates to the business of insurance” to preempt state insurance regulation authority. That is, states could argue that state insurance regulation authority can be preempted only explicitly by Congress.
21. Pollitz, et al. *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare*.
22. *Corporate Health Ins. Inc., et al. v. Texas Dep’t of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998).

23. The district court holding was based on the Fifth Circuit's decision in *CIGNA Healthplan v. State of Louisiana*, 82 F3d 642 (5th Cir. 1996) *cert. denied*, 519 U.S. 964 (1996). Although not cited, another Fifth Circuit case *Texas Pharmacy Assoc. v. Prudential Ins. Co. of America*, 105 F3d 1035 (5th Cir. 1997), *cert. denied*, 118 S. Ct. 75 (1997), explicitly holds that by including HMOs in the state's AWP law, the law is not limited to entities in the insurance industry. Because the Fifth Circuit characterized these laws as failing to satisfy the third McCarran-Ferguson criterion, the more relaxed framework enunciated in *UNUM*, holding that all three tests need not be met, may encourage the Fifth Circuit to find that the external review law falls within the savings clause. The Court of Appeals also would have to agree that the external review law directed at HMOs, among other insurers, meets the "common sense" test of insurance regulation.

24. External review of decisions about medical necessity might also be characterized as laws governing medical practice, which under *Travelers* suggested is an area of traditional state authority. But it is difficult to argue that such laws do not therefore relate to ERISA plans when the medical necessity decision is a plan contract term on which payment is conditioned.

25. For analysis of possible reactions by employers to expanded health plan liability, see Studdert, D. M., W. M. Sage, C. R. Gresenz and D. R. Hensler. 1999. "Expanded Managed Care Liability: What Impact on Employer Coverage?" *Health Affairs* 18(6):7-27.

26. Butler, P.A. 1997. *Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation*. Menlo Park: Henry J. Kaiser Family Foundation.

27. They did not look like insurance regulation from a "common sense" viewpoint, were not directed at the insurance industry, and also failed to satisfy the three McCarran-Ferguson Act criteria.

28. ERISA permits a suit to recover benefits due under the plan, enforce rights under the plan, or clarify rights to future plan benefits, 29 U.S.C. section 1132(a)(1)(B).

29. This argument would, however, need to distinguish the cases where courts have held that ERISA preempts state court suits against insurers for failure to pay claims under state "unfair insurance practices" laws, even though these laws are generally directed at the insurance industry, *Kanne v. Connecticut Gen. Life Ins.*, cited in note 10 and *Anderson v. Humana, Inc.*, 820 F Supp. 368 (S.D. Miss. 1993), *aff'd*, 24 F3d 889 (7th Cir. 1994).

30. In Texas, which is subject to the Fifth Circuit Court of Appeals' view that HMOs are not insurers, the district court in *Corporate Health Ins., Inc., et al. v. Texas Department of Insurance*, did not fully analyze the savings clause argument.

31. Cases holding that ERISA preempts state court damages suits regarding coverage denials and delays include *Hull v. Fallon*, 188 F3d 939 (8th Cir. 1999); *Danca v. Private Healthcare Systems, Inc.*, 185 F3d 1 (1st Cir. 1999); *Bast v. Prudential Ins. Co.*, 150 F 3d 1003 (9th Cir. 1998), *cert denied*, 68 U.S.L.W. 3022 (1999); *Turner v. Fallon Community Health Plan*, 127 F3d 196 (1st Cir. 1997); *cert. denied*, 118 S. Ct. 1512 (1998); *Jass v. Prudential Health Care Plan, Inc.*, 88 F3d 1482 (7th Cir. 1996); *Rodriguez v. Pacificare of Texas*, 980 F2d 1014 (5th Cir. 1995), *cert. denied*, 508 U.S. 956 (1993); *Settles v. Golden Rule Ins. Co.*, 927 F2d 505 (10th Cir. 1991); *Tolton v. American*

Biodyne, Inc., 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994); *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *cert. denied*, 506 U.S. 1033 (1992); *Garrison v. Northeast Ga. Med. Center, Inc.*, No. Civ. 2:99-CV-8-WCO (N.D. Ga. Apr. 20, 1999); *Brandon v. Aetna Services, Inc.*, 46 F. Supp.2d 110 (D. Conn. 1999); *Thompson v. Gencare Health Systems, Inc.*, 49 F. Supp.2d 1145 (E.D. Mo. 1999); *Andrews-Clarke v. Travelers Ins. Co.*, D. Mass. 984 F. Supp.49 (D. Mass. 1997); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D. N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D. N.J. 1993); *Dearmas Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993).

32. Cases holding that state law damages suits alleging negligent physician selection and retention are preempted include: *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61 (D. Conn. 1990); *Stoker v. Rubin*, 94-5563, (E.D. Pa. Dec. 22, 1994); *Butler v. Wu*, 853 F. Supp. 125 (D. N.J. 1994). Cases holding such claims are not preempted include: *U.S. Healthcare, Inc. v. Bauman*, 3rd Cir. Sept. 16, 1999; *Dukes v. U.S. Healthcare System of Pa.*, 57 F.3d 350 (3rd Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995); *Kampmeir v. Sacred Heart Hospital*, No. Civ. A95-7816 (E.D. Pa. May 1, 1996); *Frappier v. Wishov*, 678 So.2d 884 (Fla. Dist. Ct. App. 1996); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *McClellan v. Health Maintenance Org. of Pa.*, 604 A.2d 1053 (Pa. Super. Ct. 1992.), *aff'd* 686 A.2d 801 (Pa. 1996).

3. One court has held that ERISA preempted state damages lawsuits based on allegations that an HMO's physician incentive payments led a physician to provide substandard care, *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States*, 958 F. Supp. 1137 (E.D. Va. 1997). But one court has held that ERISA does not preempt such claims, *Oullette v. Christ Hosp.*, 942 F. Supp. 1160 (S.D. Ohio 1996).

34. These cases are cited in note 31.

35. These cases are based on the tort principle of *respondet superior*, that is, the employer is responsible for the negligence of its employees and agents acting within the scope of their employment or agency. A health plan must exercise control over a clinician's practice in order to be held responsible for the clinician's professional errors, *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994). Because most managed care plans are loose network models, the plan may not exercise enough supervision or control over a physician's practice to be held responsible for medical treatment or diagnosis errors. *Chase v. Independent Practice Assoc., Inc.*, 583 N.E.2d 251 (Mass. App. Ct. 1991). An Illinois court recently held to the contrary, however. *Petrovich v. Share Health Plan of Illinois, Inc.* No. 85726 (Ill. Sept. 30, 1999). This is a factual matter to be determined at trial.

36. In *U.S. Healthcare, Inc. v. Bauman*, 3rd Cir. Sept. 16, 1999, the Court of Appeal held a health plan's policy that newborns should be discharged within 24 hours involved a dispute over the plan's medical treatment policy, not plan coverage policy. In *Dukes v. U.S. Healthcare System of Pa.*, 57 F.3d 350 (3rd Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995), the Court of Appeals held that where the Court of Appeals held that where a provider failed to provide appropriate tests (not because they were not covered by the plan) the state law case is not so obviously preempted that a state court could not decide that issue after a factual hearing (this involves the issue of whether

there is “complete” preemption so as to require moving the case to federal court). See also, *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995); *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2^d Cir. 1994); *Crum v. Health Alliance-Midweek, Inc.* 47 F. Supp. 1013 (C.D. Ill. 1999); *Moscovitch v. Danbury Hospital*, 25 F. Supp.2d 74 (D. Conn. 1998); *Prihoda v. Shpritz*, 914 F. Supp. 113 (D. Md. 1996); *Newton v. Tavani*, 962 F. Supp. 45 (D. N.J. 1997); *Schwartz v. FHP Int'l Corp.*, 947 F. Supp. 1354 (D. Ariz. 1996); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996); *Whelan v. Keystone Health Plan East*, No. Civ. A 94-5733 (E.D. Pa. June 29, 1995); *Chagervand v. CareFirst*, 909 F. Supp. 304 (D. Md. 1995); *Jackson v. Roseman*, 878 F. Supp. 820 (D. Md. 1995); *Kearney v. U.S. Healthcare, Inc.*, 859 F. Supp. 182 (E.D. Pa. 1994); *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S. D. Ill. 1994); *Burke v. Smithkline Bio-Science Labs*, 858 F. Supp. 1181 (M.D. Fla. 1994); *Paterno v. Albuerne*, 855 F. Supp. 1263 (S.D. Fla. 1994); *Smith v. HMO Great Lakes*, 852 F. Supp. 669 (N.D. Ill. 1994); *Elsesser v. Hospital of Philadelphia College*, 802 F. Supp. 1286 (E.D. Pa. 1992); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990); *Nealy v. U.S. Healthcare HMO*, N.Y. Ct. of App. 711 N.E.2d 621 (N.Y. 1999); *Pappas v. Asbel*, 675 A.2d 711 (Pa. Super. Ct. 1996).

37. This is one interpretation of the well-known case of *Corcoran v. United Health Care*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 506 U.S. 1033 (1992), where the court characterized a health plan's utilization review decision to deny hospitalization to a woman with a problem pregnancy while authorizing coverage of several hours of daily home nursing care as a coverage decision although it involved the plan's view about what was medically appropriate care. The fetus died while the nurse was not on duty and the court held that ERISA preempted the state court damages suit.

38. In a close case, courts may be more inclined to characterize a plan's actions as directly involving treatment rather than coverage. For example, in *Pappas v. Asbel*, 675 A.2d 711 (Pa. Sup. Ct. 1996), a state court held that a plan's delay in authorizing treatment was a medical treatment error causing injury for which damages could be pursued in state court. And in *Bauman v. U.S. Healthcare, Inc.* 1 F. Supp. 420 (D. N.J. 1998), *affirmed*, 3rd Cir. September 16, 1999, a federal court held that the plan's maternity length-of-stay policy (whose objective was to change physician practice) was a medical treatment decision, so that ERISA did not preempt a suit for injuries due to premature discharge.

39. *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life In. Co.*, 11 F.3d 129 (9th Cir. 1993), *cert. denied*, 511 U.S. 1052 (1994); *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997).

40. “Health care treatment decision” is defined as a “determination made when medical services are actually provided by a health plan” that “affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees” Texas Ins. Code Section 88.001(5).

41. Because the statute was challenged on its face, the court was able to uphold it based on a reading that ERISA would not preempt at least some types of lawsuits provided under the state law.

Chapter VIII: Implications of ERISA Preemption for State Health Policy Initiatives: Monitoring Health Care Access, Cost, and Quality

States need current information about health care coverage, health care use, and health care delivery arrangements to:

- assess the need for state initiatives to expand access, regulate health care delivery and insurance arrangements, and oversee health care cost and quality;
- develop programs to address identified needs; and
- evaluate the impacts of existing policy.

Among the types of information that states might find useful in policy development and evaluation are data on:

- the extent to which private-sector employees are covered by self-insured employee plans;
- types of plans (HMO, PPO, POS, indemnity, etc.) in which the state's residents (including those with private-sector coverage) are enrolled;
- health care expenditures;
- health care use patterns; and
- consumer experience with their health plans.

States can obtain some of this information from health care providers or through consumer or employer surveys. Consumers are not a particularly reliable source of information on issues such as types of plans under which they are covered or whether a plan is self-insured. Employer surveys are useful, but their expense makes it impractical to conduct them frequently. Third-party payers, such as insurers or self-insured plan administrators, are a more reliable source of information on numbers of people with health coverage, benefits, delivery arrangements, and spending for covered services.

ERISA would undoubtedly preempt any state attempt to obtain such information directly from private-sector employee (ERISA) plan sponsors.¹ Such a requirement would relate to employee health plans by imposing on them administrative burdens that duplicate the reporting already required to DOL. Employers and unions sponsoring health plans might be willing to share data through participation in purchasing cooperatives, report card initiatives, and similar voluntary activities,² but such voluntary efforts may not be adequate for state health policy development. To obtain more complete information on the experience of residents with third-party coverage, states must turn to more comprehensive sources of data on which they can impose reporting requirements

Chapter Highlights:

- ERISA impedes states' ability to obtain data on health care coverage, use, costs, and delivery arrangements for all state residents.
- States can require insurers, providers, and probably third-party administrators to report this information.
- States cannot require private employee health plans themselves to report.

A. Requiring Insurers to Report Health Care Information

The state's authority to regulate the business of insurance should include the right to obtain information from licensed managed care plans and other insurers (including stop-loss carriers³) about the numbers and characteristics of subscribers, premiums, product design features (including managed care financing and delivery arrangements), benefits, expenditures, and health care utilization for the insured products insurers sell. But some courts have held that ERISA preempts state laws regulating insurance carriers performing non-risk-bearing functions such as claims processing for self-insured plans (i.e., under "Administrative Services/ASO" arrangements).⁴ Consequently, an insurer acting as a third-party administrator ("TPA") might challenge a state reporting requirement regarding its ASO services.

A state should be able to defend insurer ASO reporting requirements against an ERISA preemption challenge as long as the statute does not refer to ERISA plans. First, such a requirement would seem not to relate to ERISA plans because it imposes on the plans themselves neither responsibilities (i.e., does not bind plan administrators to a particular choice of benefits design or administrative structure) nor any significant costs. The insurer's reporting costs are likely to be small and nothing like the 13 to 24 percent surcharges at issue in *Travelers*.⁵ In its first ERISA savings clause case, the Supreme Court noted that state laws regulating "only the insurer or the way in which it may sell insurance, do not 'relate to' benefit plans in the first instance."⁶ This observation would seem even more apt in light of the relaxed preemption clause analysis in *Travelers*, where the Court held that state laws face preemption if they interfere with the congressional goal of permitting uniform national employee benefits and administrative practices. Consequently, state managed care and other insurance company reporting laws would seem to overcome the first preemption hurdle. If held to relate to ERISA plans, however, reporting requirements regarding non-insured health benefits would be more difficult to defend as regulating the business of insurance.

B. Requiring Other Third-Party Health Plan Administrators to Report Health Care Information

Besides insurers, other organizations such as benefit consulting firms and claims administration companies act as TPAs to administer self-insured plans, including those operated by private-sector employers and unions. Several cases decided before *Travelers* held that ERISA preempts state laws imposing licensing and other obligations on TPAs working with self-insured ERISA plans. For example, a federal district court held that ERISA preempted Florida's comprehensive law requiring health plan contract administrators to obtain a license, post a bond, provide information to the state about its contracts and financial status, and operate under written agreements with self-insured plans that included provisions regarding claims, fiduciary duties, notices to employee participants, advertising, and compensation.⁷ The court held that the state law related to ERISA plans (under the Supreme Court's expansive pre-*Travelers* view of preemption) and would not be saved because these arrangements did not involve insurance. A federal Court of Appeals later held that ERISA preempted provisions of Texas laws imposing similar licensing, administrative obligations, fees, and taxes on TPAs.⁸ It held that the law related to ERISA plans because it authorized the state insurance commissioner to review contracts between

the TPA and ERISA plans and also imposed reporting, disclosure, and other “significant” burdens on TPAs. The appellate court distinguished Kentucky’s simple TPA licensure requirement, which had previously been upheld against an ERISA challenge,⁹ on the ground that the Texas law was “more intrusive” than the Kentucky licensing law. Finally, the court concluded that the law did not regulate insurance because it involved no-risk-bearing arrangements.

Some of the TPA regulations at issue in the Florida and Texas cases that directly affect contracts between TPAs and ERISA plans might still be difficult to defend, because they both refer to ERISA plans and attempt to regulate their administrative structures. But under the reasoning in *Travelers*, it should be far easier for states to argue that requiring TPAs to provide information about plans they administer does not relate to ERISA plans because these requirements, while possibly imposing some costs on plans using TPAs, have no impact on the ERISA plans’ structure or administration.¹⁰ States may want to develop data reporting standards consistent with information to which TPAs have ready access so that no burden is imposed directly on ERISA plans.

States should also be able to require TPAs to be licensed, certified, or registered with the state (which would facilitate the enforcement of data reporting requirements) as long as the licensure standards did not attempt to regulate TPA relationships with ERISA plans.¹¹ In the unlikely event that a TPA reporting law were held to relate to ERISA plans, it would be difficult to defend the law as insurance regulation under the savings clause because it involves no risk transfer.

Notes

1. HIPAA amended ERISA to require ERISA plans to disclose to plan participants whether a health insurer finances or administers the plan, 29 U.S.C. 1022(b).
2. The GAO has reported that states have had difficulty obtaining information about health coverage of employed Medicaid beneficiaries from their employers, U.S. GAO. 1997. *Medicaid: Three States' Experiences in Buying Employer-Based Health Insurance* (HEHS-97-159). Washington, D.C.: U.S. Government Printing Office.
3. Although no court has considered this issue, the Seventh Circuit Court of Appeals decision upholding assessment of high-risk pool assessments against stop-loss carriers (*Safeco Life Ins. Co. v. Musser*, 65 F3d 647 (7th Cir. 1995)) should be helpful in defending a state stop-loss carrier reporting law. Reporting information should have no impact on the self-insured plan and consequently not “relate to it.” Traditional stop-loss carriers that insure a self-insured plan will have limited information on utilization or spending below the stop-loss thresholds but should be able to report at least the existence of the self-funded plan, its stop-loss attachment point, benefits and other design features, and the numbers of enrollees. In states with laws like Maryland’s new statute defining stop-loss policies as insuring individuals, stop-loss carriers may have access to more information about the underlying plan, which states could require these carriers to report.
4. *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205, 217; *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F2d 408 (3d Cir. 1987); *Howard v. Parisian, Inc.*, 807 F2d 1560 (11th Cir. 1986); *Powell v. Chesapeake & Potomac Telephone Co. of Va.*, 780 F2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986).
5. For similar analysis regarding financial assessments imposed on stop-loss carriers of self-insured ERISA plans, see, *Safeco Life Ins. Co. v. Musser*, 65 F3d 648 (7th Cir. 1995).
6. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 at 741 (1985).
7. *Self-Insurance Institute of America v. Gallagher*, No. TCA 86-7308-WS, (N.D. Fla. June 2, 1989) *aff'd mem.* 909 F2d 1491 (11th Cir. 1994).
8. *NGS American, Inc. v. Barnes*, 998 F2d 296 (5th Cir. 1993); see also *Self-Insurance Institute v. Koriath*, 993 F2d 479 (5th Cir. 1993).
9. In *Benefax Corp. v. Wright*, 757 F Supp. 800 (W.D. Ky. 1990) the Kentucky law required TPAs who collect premiums or adjust or settle insurance claims under health insurance and other insurance arrangements to obtain a license under a law prohibiting the insurance commissioner in issuing a license to someone who cannot demonstrate competence, trustworthiness, reliability, an acceptable level of education, financial responsibility, and no previous license revocations. Noting that the statute did not single out or refer to ERISA plans, the court held that the law does not relate to ERISA plans “any more than licensing statutes for other individuals such as attorneys, physicians, chiropractors or accountants who may, in the course of their business, service ERISA plans...” 757 F Supp. at 804.

10. Drafting a data reporting requirement to apply generally to all health benefits plans that TPAs administer and not explicitly refer to ERISA plans should help a state overcome any ERISA preemption challenge.

11. Even without a reporting requirement, states ought to be able to justify a TPA licensure law imposing fewer obligations on TPAs than in Florida and Texas under the reasoning in *Benefax Corp. v. Wright*, 757 F Supp. 800 (W.D. Ky. 1990).

Appendix A: ERISA Preemption Clause

I. Section 514 [29 U.S.C. 1144] (general preemption clause)

(a) Except as provided in subsection (b) of this section, the provisions of this title [protection of employee benefit rights] and title IV [plan termination insurance] shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 U.S.C. 1003(a), defining employee benefit plans] and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b)(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

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

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (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.

(b)(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act [coordination of responsibilities].

(b)(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(b)(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health care Act (Haw. Rev. Stat. Sections 393-1 through 393-51).

(B) nothing in subparagraph (A) shall be construed to exempt from subsection (a) –
(i) any State tax law relating to employee benefit plans, or
(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supercede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph), but the Secretary may enter into cooperative

arrangements under this paragraph and section 506 with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superceded by such parts 1 and 4 and the preceding sections of this part.

(6)(A) Notwithstanding any other provisions of this section –

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides –

- (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
- (II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class or arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section (4) necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to do business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i).

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is

provided, or is eligible for, benefits or services pursuant to a plan under Title XIX of the Social Security Act, to the extent such law is necessary for the State to be eligible to receive reimbursement under Title XIX of that Act.

(c) For purposes of this section:

(1) The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term “State” includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b) [direct repeal of former pension law]) or any rule or regulation issued under any such law.

II. Section 711(f) (29 U.S.C. 1185(f)) [mothers and newborns coverage]

(f) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 1191(d)(1) of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a caesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 1191(a)(1) of this title shall not be construed as superseding a State law described in paragraph (1).

III. Section 713 (29 U.S.C. section 1185b) [post-mastectomy care]

(e) Preemption, relation to State laws –

(1) In general

Nothing in this section shall be construed to preempt any State law in effect on October 21, 1998 with respect to health insurance coverage that requires at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) ERISA

Nothing in this section shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

IV. Section 731 (29 U.S.C. section 1191) [HIPAA standards and mental health parity]

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b) of this section, this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(b) Special rules in case of portability requirements

(1) In general

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 1181 of this title which differs from the standards or requirements specified in such section.

(2) Exceptions

Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision -

(A) substitutes for the reference to "6-month period" in section 1181(a)(1) of this title a reference to any shorter period of time;

(B) substitutes for the reference to "12 months" and "18 months" in section 1181(a)(2) of this title a reference to any shorter period of time;

(C) substitutes for the references to "63 days" in sections 1181(c)(2)(A) and (d)(4)(A) of this title a reference to any greater number of days;

(D) substitutes for the reference to "30-day period" in sections 1181(b)(2) and (d)(1) of this title a reference to any greater period;

(E) prohibits the imposition of any preexisting condition exclusion in cases not described

in section 1181(d) of this title or expands the exceptions described in such section;
(F) requires special enrollment periods in addition to those required under section 1181(f) of this title; or
(G) reduces the maximum period permitted in an affiliation period under section 1181(g)(1)(B) of this title.

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Appendix C: Glossary¹

Any-willing-provider law – A law that requires managed care plans to contract with all health care providers that meet their terms and conditions.

Administrative services only (ASO) – An arrangement under which an insurer administers a health or other benefits plan acting not as a risk-bearing insurer but merely as a plan administrator to determine eligibility for services, pay claims, and perform similar functions.

Deemer clause – A provision of ERISA’s preemption clause that prohibits states from considering (“deeming”) ERISA health plans to be insurers: “Neither an employee benefit plan...nor any trust established under such a plan shall be deemed to be an insurance company or other insurer... For purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts...” 29 U.S.C. section 1144(b)(2)(B).

ERISA health plans – Employee health plans defined by ERISA to include most group health plans offered as an employee benefit (29 U.S.C. section 1102 (1) and (3)). ERISA plans do not include those offered by public employers, churches, and multiple employer welfare arrangements or employer programs under state workers’ compensation laws and disability laws, 29 U.S.C. section 1003(b).

Fiduciary – A relationship founded on trust or confidence and where the fiduciary is responsible to act in the best interest of another person or organization. ERISA designates as a fiduciary any person exercising discretion in administering pension or employee benefits plans and requires fiduciaries to act solely in the interests (i.e., loyally, fairly, and honestly) of ERISA plan participants.

Guaranteed issue – An insurance regulatory term that requires all health plans offer coverage to all groups or individuals during some period each year without regard to health status of the group members or individuals.

HIPAA – The Health Insurance Portability and Accountability Act of 1996, which requires ERISA plans and health insurance issuers to comply with certain “health insurance market” standards, including limits on pre-existing condition exclusion periods, credit for satisfying pre-ex periods, guaranteed issue and renewability, and arrangements for people leaving the group market to continue access to insurance.

Health maintenance organization (HMO) – An entity that uses an organized system providing health care in a geographic area and accepts the responsibility to provide or otherwise assure the delivery of an agreed-upon set of services to an enrolled group of people for which the entity is paid through a fixed, periodic prepayment made on behalf of each person or family unit enrolled without regard to the amount of services actually provided.

¹ Many of these definitions are drawn from “Glossary of Terms Commonly Used in Health Care” (1996), prepared by the Alpha Center for the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.

Hold harmless – With respect to a plan and its enrollees, a contractual requirement prohibiting a provider from seeking payment from an enrollee for services rendered prior to a health plan's insolvency; with respect to a plan and its contracting providers, a contractual requirement requiring a provider to indemnify a plan for the plan's errors.

Multiple Employer Welfare Arrangement (MEWA) – A term defined in ERISA to mean an arrangement (which may or may not be an employee welfare benefit plan) to provide employee benefits to the employees of two or more employers and which states are explicitly authorized to regulate as set forth in ERISA.

Point of service (POS) plan – A health insurance benefits program wherein subscribers can select between delivery systems such as an HMO, PPO, or fee-for-service, at the point they need a service rather than when initially enrolling in a health plan. Out-of-pocket costs to receive care from the HMO are generally lower than the costs to receive care from a PPO or from a non-network provider.

Preferred provider organization (PPO) – A formally organized entity generally consisting of hospital and physician providers that provides health care services to purchasers at discounted rates in return for expedited claims payment and a more predictable market share. Consumers generally have a choice of using PPO or non-PPO providers but face financial incentives to encourage use of the PPO network providers.

Preemption clause – The provision in ERISA that invalidates state laws that relate to ERISA plans: ERISA employee benefits rights “shall supercede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in [section defining employee benefits plans]... 29 U.S.C. section 1144(a). A state law has generally been interpreted by courts to relate to an ERISA plan if it specifically refers to ERISA plans or has a connection to ERISA plans, for example, by affecting their structure, benefits, or administration.

Risk-bearing entity – An organization that assumes financial responsibility for the provision of a defined set of benefits by accepting prepayment for some or all of the cost of care.

Savings clause – The provision in ERISA's preemption clause exempting (“saving”) certain state activities, including insurance regulation, from preemption: “Except as provided in [the deemer clause], nothing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.” 29 U.S.C. section 1144(b)(2)(B).

Self-insured plans – ERISA plans that bear insurance risk directly rather than contracting to transfer that risk to an insurer, such as an HMO, Blue Cross plan, or indemnity carrier or other insuring organization (sometimes called a “self-funded” plan, although few ERISA plans set aside a fund from which health benefits are paid). Self-insured plans may be administered by the employer or employee organization directly or by an “administrative services only:” (“ASO”) agreement with an insurer or by another third-party administrator (“TPA”). Federal law does not define what constitutes a self-insured plan, and some state attempts to do so have been challenged as preempted by ERISA.

Stop-loss policy – An insurance policy that protects an ERISA plan or an insurance company against catastrophic costs (sometimes called “reinsurance”). The point at which a stop-loss policy covers the costs for an insurer or large self-insured business (called the “attachment point”) has typically been \$10,000 to \$25,000 per individual insured person per year or \$50,000 to \$100,000 or more for the entire plan per year.

Third-party payer – A public or private organization that pays or insurers health or medical expenses on behalf of participants, enrollees, beneficiaries, or recipients, acting between the individual receiving the services (the first party) and the provider of services (the second party).

Third-party administrator (TPA) – A fiscal intermediary that processes claims, provides services, and issues payments on behalf of certain private or public health benefits programs, health insurers, or self-insured plans.

Appendix D: Abstracts of Selected Law Review and Health Policy Journal Articles

This appendix contains abstracts of law journal articles that discuss various facets of ERISA preemption and may be of interest to state health policymakers.

Covington, R. 1999. "Amending ERISA's Preemption Scheme." *Kansas Journal of Law & Public Policy* 8 (3):1-42.

Although recent Supreme Court decisions have begun to narrow the breadth of ERISA preemption, the wrongful denial cases are unlikely to be reversed, despite the limited remedies provided by ERISA itself for wrongful denials of treatment. The need for national uniformity that led to the broad language of section 514(a) is not enough to justify the unfairness of denying patients and their families a meaningful remedy. The author proposes that Congress enact a reforming statute to: 1) provide for prompt review of treatment denial decisions through arbitration-like mechanisms that are made available with a minimum of procedural obstacles, such as requirements that all requests be in writing; 2) extend the regulatory power saved to the states by section 514(b)(2)(A) of ERISA so that the states can apply the same regulations to managed care organizations that they apply to insurers; 3) restrict abuse of the "deemer" clause, section 514(b)(2)(B), by treating as truly self-funded only those health plans that do not use stop-loss insurance with low thresholds; and 4) appoint a commission to review on a comprehensive basis whether there should be increased federal regulation of the health care industry, rather than doing so on a piecemeal basis as in the past.

Cunningham, J. F. 1996. "ERISA: Some Thoughts on Unfulfilled Promises." *Arkansas Law Review* 49: 83-91.

Under ERISA, plan participants and beneficiaries may actually have less protection than what they received under common law. When federal courts interpret ERISA claims, federal presumption tends to be equated with a lack any remedies in any court. On numerous occasions, the U.S. Supreme Court and other federal courts have construed the ERISA statute narrowly with regard to available remedies. The law that has developed under ERISA ignores ERISA's intended objectives and legislative history. Some solutions to this ERISA problem include state jurisdiction over these cases, administrative reviews for claims denials, and correcting federal decisions through statutory modifications, but the best solution would be for federal courts not to presume that federal presumption under ERISA means no remedy.

Edwards, M. A. 1997. "Plan Protections for ERISA Self-Insured Employee Welfare Benefit Plan Participants: New Possibilities for State Action in the Event of Plan Failure." *Wisconsin Law Review* 351-73.

Although states may not regulate employee health benefits directly under ERISA, they may act indirectly through regulation of insurance companies and insurance contracts purchased under

the plan. However, if the plan is self-insured, where no outside insurance is purchased to cover the plan, the plan may be exempt from state regulations. States have been unable to provide protection for these employees through state insurance guaranty funds because ERISA's broad preemption clause prevents them from assessing ERISA self-insured plans for contribution to these funds. Thus, ERISA offers little protection to participants in self-insured employee health benefit plans in the event of a plan failure, causing plan participants to then pay for any of their unpaid health care bills. Attempts have been unsuccessful to address this issue at the federal level. States, however, may be in a position to act given the recent *Travelers*, *United Wire*, and *Safeco* cases. Surcharges and assessments were permitted in these cases provided that they only had an indirect impact on the plans and did not directly affect the substantive choices or administration of the plan. Given this analysis, states may be able to combine hospital use surcharges and taxes on the purchase of stop-loss insurance from ERISA self-insured plans and participants for state insurance guaranty funds.

Farrell, M. G. 1997. "ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism" *American Journal of Law and Medicine* 23 (2&3): 251-89.

The U.S. Supreme Court's approach to ERISA preemption has created unexpected and nonsensical results. The Court should look to basic constitutional principles of federalism to interpret the meaning of this ambiguous provision. The Court's literal, textual analysis effectively prevents state regulators from preventing abuses by MCOs through state regulatory initiatives. The author explores the possibility of leaving national health policy to the courts and finds them institutionally wanting. The author concludes that "managed federalism," which is shared federal and state legislative authority determined by functions that each is capable of performing shared health policy goals and federalism principles, may solve the current confusion. One possible model for managed federalism could be the regulatory federalism that controls the private market for health insurance supplementing Medicare-Medigap insurance, and which model coordinates state and federal, legislative and judicial, and private and public authorities based on their institutional competence to carry out necessary functions.

Fox, D. M. and D. C. Schaffer. 1989. "Health Policy and ERISA: Interest Groups and Semipreemption." *Journal of Health Politics, Policy and Law* 14(2):239-60.

The authors outline the history of the enactment of ERISA and its preemption and savings clauses. Because so little of the debates over the preemption clause was memorialized in congressional documents, the authors drew upon other published materials and interviewed many of the individuals involved in the discussions about preemption. The article describes how interest groups that rarely work together coalesced to create and sustain ERISA preemption. The authors concluded that this partial ERISA preemption resulted from the absence of interest groups who could jointly agree on policy issues raised by the nation's continued commitment to providing health insurance as a benefit of employment.

Grosso, S. M. 1998. "Rethinking Malpractice Liability and ERISA Preemption in the Age of Managed Care" *Stanford Law and Policy Review* 9 (2):433-61.

Broad ERISA preemption interpretation prevents victims of negligent managed care from receiving recovery of costs because the entity that imposes quality-threatening cost-containment measures remains free from liability. In order to prevent ERISA's preemption provision from

undermining progress in the delivery of health care, enterprise liability should be adopted either by a congressional amendment to ERISA or by the courts narrowing the interpretation of the preemption provision. Enterprise liability provides the best way to achieve optimal cost reduction in today's delivery system because incentives will encourage managed care organizations to contain costs, while still providing maximum quality health care. With respect to claims for negligent implementation of managed care, state governments tend to be in support of both reformation of health care delivery and the adoption of enterprise liability, but their support will not benefit patients covered by ERISA plans until either Congress or the courts act.

Jacobson, P.D. and S. D. Pomfret. 1998. "Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence" *Houston Law Review* 35(4):985-1078.

The article proposes that courts use a functional, rather than formalistic, analysis of ERISA preemption guided by the following rules: 1) play fair; 2) know what you're talking about; 3) think before you act; 4) take responsibility; and 5) no harm, no foul. The three goals of this functional analysis are: 1) to ensure that courts can hold managed care organizations accountable for the economic and medical choices they make; 2) to ensure that plan participants and beneficiaries can depend on plan promises; and 3) to achieve more doctrinal predictability. Because of ERISA's preemption clause and because it contains no substantive provisions, its effect, under the formalistic approach, has been to deregulate the health care industry. The authors argue that ERISA is an ambiguous statute and thus should not be subject to "plain language" analysis and that a functional analysis does not violate the principle of separation of powers since it furthers Congressional intent, rather than frustrating it. The authors recommend that courts first ask whether the state law governs a choice Congress could reasonably have intended to delegate exclusively to a plan sponsor or administrator, and second, ask whether the state law substantially restricts a plan administrator's choices such that failure to preempt the law would result in a lack of uniformity that would prevent an employer from offering a chosen plan nationwide.

Jordan, K. A. 1996. "ERISA Pre-emption: Integrating *Fabe* into the Savings Clause Analysis" *Rutgers Law Journal* 27(2):273-342.

Congress has broadly exempted state laws regulating insurance from ERISA preemption. ERISA's savings clause allows states to increase access to health care by reforming health insurance. ERISA's deemer clause, which qualifies the savings clause by prohibiting states to characterize employee benefit plans as insurance companies, precludes the application of state health insurance reform to self-insured plans. The 1993 Supreme Court case, *United States Department of the Treasury v. Fabe*, should place into question the current practice of deciding what constitutes the "business of insurance" according to the older Supreme Court decisions, *Group Life & Health Insurance Co. v. Royal Drug Co.* and *Union Labor Life Insurance Co. v. Pireno*. *Fabe* states that the McCarran-Ferguson Act preserves broad state authority to regulate the "business of insurance" and establishes a narrow exemption from antitrust laws for the "business of insurance." The author concludes that the broad view of what constitutes the "business of insurance" taken by *Fabe*, rather than the narrow view taken by *Royal Drug* and *Pireno*, is more appropriate for a savings clause analysis. The article also demonstrates how such an approach would work and argues that it will allow state health reform strategies to proceed.

Kilcullen, J. K. 1996. "Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability" *American Journal of Law and Medicine* 22(1)7-50.

ERISA was enacted to encourage employers to fund their own health care plans, which may be operated by a managed care organization, such as an insurance company. To encourage the establishment of such plans, ERISA preempts actions for injuries and wrongful death resulting from negligence by the plan's physicians or administrators, sacrificing patient protection by inadequately replacing traditional tort relief. The article argues that because physicians and HMOs, which determine the parameters of medical practice together, form part of a single enterprise affecting patient care, enterprise liability should be an essential part of managed care liability. Medical enterprise can handle the risk while distributing its costs in compensating injured patients from negligence. The article examines enterprise liability, the current movement for third-party liability under traditional negligence, and ERISA's vitiation of liability for payers when they operate under self-funded employer health care plans. The article concludes with a proposal to incorporate enterprise liability into ERISA.

Medill, C. E. 1998. "HIPAA and its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?" *Tennessee Law Review* 65 (2):485-510.

The enactment of HIPAA and related legislation may indicate an increasing willingness by Congress to use ERISA to establish and enforce minimum federal standards for private health care plan coverage and benefits. ERISA's possible new role has two implications for health care reform: 1) Congress will likely continue to establish substantive federal coverage and benefits requirements for private health care plans in targeted areas through Title I of ERISA, and 2) in areas where federal requirements have been established for private health care plans, ERISA's preemption requirements will act as a "floor," preempting lower state law requirements. The author asserts that ERISA must be part of the solution to the country's health care problems, since employment-based health care will likely remain part of the American health care system. The article explains the importance of ERISA's differentiation between "insured" and "self-insured" employee plans. One consequence of HIPAA and its related legislation is the need for a bright-line definition at the federal level of what constitutes an "insured" plan. Another consequence is that the new Title I rights created by HIPAA and its related legislation will greatly expand ERISA's civil enforcement scheme.

Overbay, A. and M. Hall. 1996. "Insurance Regulation of Providers that Bear Risk" *American Journal of Law & Medicine* 22(2&3):361-387.

This article discusses the regulation of "Risk-Bearing Provider Groups" (RBPGs), a term intended to encompass HMOs, IDSs, MCOs, EPOs, PHOs, IPAs, PSNs, and OWAs. The authors argue that RBPGs should be regulated according to a specifically tailored scheme, rather than as insurers or HMOs. The specifically tailored scheme favored by the authors is the approach being developed by the National Association of Insurance Commissioners (NAIC), which looks to function rather than form of the RBPG and attempts to base capital requirements on the individual characteristics of the health care organizations rather than on their declared organizational categories. Such regulations may protect consumers and encourage market reform. The authors also argue that ERISA should not preempt state regulation of RBPGs and that states should proceed to develop RBPG regulations.

Paredes, T. 1997. "Stop-loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption" *Harvard Journal on Legislation* 34:233-92.

ERISA preempts state laws relating to employee welfare benefit plans while preserving state authority to regulate insurance. Stop-loss insurance, by which an employer that self-funds its benefit plan insures against the risk of excessive financial obligations, does not fit neatly into ERISA's regulatory framework. As a result, the Circuit Courts of Appeals have split over how to treat stop-loss plans for preemption purposes. The author argues under ERISA's dual regulatory scheme, precedent, basic insurance principles, and the legislative history of the Act that ERISA should not be construed to preempt states from enforcing their insurance laws against a stop-loss plan's insurer.



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