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ERISA and State Health Care Reform: Roadblock or Scapegoat?

Jesselyn Alicia Brown†

Think back on any number of stories of health insurance atrocities: the Texas man whose employer was allowed to slash his AIDS coverage as he was dying of the disease; the retiree whose "lifetime" insurance was suddenly canceled; the woman with advanced breast cancer unfairly denied coverage for the only treatment that might save her life. All these cases have one unexpected thing in common: the monumentally boring, complex, far-reaching law called ERISA.¹

Before the failure of federal health care reform in Washington last year, many states were already exploring ways to address the health care crisis² on their own. Vermont, Florida, and Minnesota spent 1993 implementing new laws to widen access to their uninsured.³ New York implemented community rating in April 1993 for all health insurance sold in the state.⁴ The same year, California, Florida, and Texas introduced comprehensive, small-group market reform measures, forming numerous community health purchasing alliances within each respective state.⁵ Despite the demise of national health care reform, action continues at the state level.

But states have only gone so far in promulgating reforms. Many perceive a major obstacle in the preemption of state law by the Employee Retirement

† Honor Program Attorney, United States Department of Justice. A.B., Brown University, 1992; J.D., Yale Law School, 1995. The views expressed in this article are those of the author and do not necessarily represent the views of the United States, the Administration, or the U.S. Department of Justice. This Note was originally written as an Intensive Semester paper for Professor Michael Graetz and Professor Jerry Mashaw. The author wishes to thank Professors Graetz and Mashaw for acting as faculty supervisors and Jennifer Klein for acting as on-site supervisor during the author's six months with the White House Domestic Policy Council/Office of the First Lady. The author would also like to express her thanks to Dean Barbara Safriet, Professor Sara Rosenbaum, Keith Kessler, Dorann Bunkin, and Gil Menna. This Note is dedicated with love and admiration to Richard L. Brown.

2. "In 1991, the United States spent over $700 billion . . . to provide health care services [about 13% of GNP], while, by 1990, the number of uninsured people under the age of 65 had increased to over 33 million." UNITED STATES GENERAL ACCOUNTING OFFICE, GAO/HRD-92-70, ACCESS TO HEALTH CARE: STATES RESPOND TO GROWING CRISIS 12 (1992) [hereinafter STATES RESPOND].
5. Id.
Income Security Act of 1974 (ERISA). The primary purpose of ERISA is to regulate pension plans sponsored by private employers. While the word "retirement" appears prominently in its title, ERISA goes beyond regulating pension plans to cover a wide range of other benefit plans—including plans that provide employee health care, disability, and accident benefits. Most importantly, ERISA preempts many forms of state regulation affecting health benefit packages.

While ERISA allows states to regulate health insurance, it also shields self-funded plans from most state laws. Insured health plans are therefore subject to such requirements as consumer protection provisions, state-mandated benefit laws, premium taxes, "any willing provider" laws, and participation in community-rated or high-risk pools, while self-funded plans are not. The shield that ERISA preemption provides to self-funded plans causes state health care planners consternation for two reasons. First, clearly distinguishing between self-funded and fully insured plans is growing more difficult as the health market changes. Often self-funded plans simplify their administrative burden by contracting with an insurance company or other organization to perform administrative services. As a result employees themselves often do not know whether their employer-based health plan is self-funded or purchased through an insurer. Furthermore, employers are increasingly adopting arrangements that are neither fully insured nor fully self-funded. These arrangements include increased use of "stop-loss" insurance to moderate the employers' risk, as well as alternative arrangements with managed care

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7. For a more detailed discussion of how ERISA preserves states' authority to regulate insurance through the insurance savings clause, see infra text accompanying notes 77-83.

8. In a self-funded health plan an employer directly holds much of the financial risk associated with its employees' health care costs. See UNITED STATES GENERAL ACCOUNTING OFFICE, GAO/HEHS-95-167, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA (1995) [hereinafter ISSUES, TRENDS, AND CHALLENGES]. Although both the terms "self-insured" and "self-funded" are commonly used to describe employer health plans that are less than fully insured, neither is completely accurate. Insurance is a contractual agreement in which financial risk from one party (the "insured") is transferred to another party (the "insurer"). Following the lead of the General Accounting Office, this Note refers to firms that bear a large portion of the risk for employee health claims as self-funded rather than self-insured because no insurance arrangement covers this risk. Even the term "self-funded" may not be entirely accurate because, in most cases, employers do not set aside separate funds to finance their health plans but pay for incurred health costs through general assets. A more accurate but too awkward term may be "less than fully insured" because many employers with self-funded plans purchase stop-loss insurance to mitigate their potential losses or purchase prepaid health care contracts for some employees. See id. at 3 n.2.

9. Because self-funded plans are not deemed to be insurance, ERISA's preemption clause protects them from certain state regulatory programs and reforms. For a more detailed discussion of ERISA's deemer clause which draws this distinction, see infra text accompanying notes 84-90.

10. These are typically called "administrative services only" contracts and are performed by "third-party administrators."

11. For a more detailed discussion of stop-loss insurance and how it relates to ERISA preemption, see infra text accompanying note 233.
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organizations that share risk among the plan, providers, and the employer. The second cause of frustration for would-be state health care reformers is that self-funded plans constitute an increasingly large portion of the health care purchasing market. According to the General Accounting Office (GAO), few employers self-funded when ERISA became effective in 1974, meaning that most health benefit plans were subject to state regulation. Now, with ERISA health plans covering nearly half of all workers in the United States, nearly forty percent of ERISA plans are self-funded. The GAO hypothesizes that the growth in self-funding among firms of all sizes reflects employers' recognition that self-funding employee health benefits offers three main advantages:

Employers believe that self-funding allows them to directly gain from their cost-containment efforts by having plan design flexibility, control of premium assets, and reduced administrative costs. In addition, employers' self-funding allows them to avoid potentially costly state regulation, including premium taxes, reserved funding requirements, benefit mandates, any-willing-provider laws, and participation in community-rated or high-risk pools. Employers also indicate that the ability to maintain national uniformity in plan design and benefits through self-funding enhances employee relations.

This second "advantage" for self-funded firms clearly poses a problem for state health care planners. If reforms cannot reach self-funded plans, is meaningful reform possible at the state level? This Note argues that, although ERISA's preemption clause does place limits on state reform efforts, it does not block them altogether.

In 1994 several bills surfaced on Capitol Hill proposing to give ERISA

12. Currently available data sources do not provide sufficient detail to gauge such trends accurately, in part because ERISA preempts states from requiring health plans to report such data and federal data collection efforts have been limited. ISSUES, TRENDS, AND CHALLENGES, supra note 8, at 3.

13. ERISA requirements (reporting requirements, criteria for pension eligibility, fiduciary duty standards, causes of action, and an insurance mechanism to guarantee payment of certain pension benefits) apply to all private employer-based health plans, whether fully insured through a third-party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40% of these plans, covering about 44 million people, the employer chooses to self-fund and retain the risk for its health plan. ISSUES, TRENDS, AND CHALLENGES, supra note 8, at 2-3.

14. STATES RESPOND, supra note 2, at 2. A new GAO report estimates that roughly 114 million individuals (44% of the U.S. population) are covered by ERISA health plans. In most of these ERISA plans, the employer purchases health care coverage from a third-party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40% of these plans, covering about 44 million people, the employer chooses to self-fund and retain the risk for its health plan. ISSUES, TRENDS, AND CHALLENGES, supra note 8, at 2-3.

See also James R. Tallon, Jr., ERISA: A Thorn in States' Sides, NEWSWEEK, Nov. 3, 1994, at A38 ("In the 1970s, only 4% of health benefits in the United States were paid by self-insured plans. Thus, ERISA's ban on state regulation of such plans had far less bite than it does today, when 44 percent of benefits are paid by these plans."). See generally C.B. Sullivan & T. Rice, The Health Insurance Picture in 1990, 10 HEALTH AFF. 104-15 (1991).


15. ISSUES, TRENDS, AND CHALLENGES, supra note 8, at 14.
waivers to a handful of states taking the lead on reform. Because comprehensive federal action on health care seemed in the offing, they went nowhere. But with the death of comprehensive federal health care reform—and a broader national political movement favoring state flexibility—the day of reckoning may be at hand for state-level health care reform. As one commentator notes:

At a time when Medicare and Medicaid are being slashed by a Republican-controlled Congress, states are more desperate than ever to locate alternative health care dollars. As a result, they are seeking to amend ERISA and currently pending before Congress are three bills that, if adopted, would do just that.

ERISA-bashing reached a fever pitch last year when, at its annual summer conference in Washington, D.C., the National Governors’ Association made reform of the twenty-year-old law a priority:

ERISA’s reach is very broad, and it continues to expand into areas such as hospital rate setting, risk pooling, and provider taxes over which states long believed they had jurisdiction. Rather than encouraging state experimentation with new approaches to health care delivery, the act is likely to stifle innovation. . . . National health policy should be established by Congress, not the federal courts. . . . If Congress does not enact a comprehensive universal federal program, it is only through relief from ERISA that states can regulate insurance markets and delivery systems to achieve equity in coverage and financing.

Frowning on judicial policymaking, the Association’s report emphasized federal legislative options to increase state health care reform flexibility.

But 1995 brought huge shifts in states’ health care reform movements. The 1994 Republican revolution produced congressional leaders skeptical of Big Government and intent on handing the states responsibility for policy areas traditionally administered by Washington. “The philosophy behind this change, dubbed ‘devolution’ by policy wonks . . . holds that the states are inherently more efficient than the federal government [in areas such as health care reform] because they are closer to the people they serve.” This philosophical shift dovetails with a U.S. Supreme Court ruling on a challenge to the legality of state rate-setting in a critical case, New York State Conference of Blue Cross

16. Current law provides for states to request and be granted a Medicaid waiver, which essentially permits them to disregard selected Medicaid requirements that would otherwise apply. See 42 U.S.C. §1315. Some states would like ERISA amended to establish a similar mechanism for granting ERISA waivers.
19. BUTLER, supra note 18, at 22-32.
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& Blue Shield Plans v. Travelers Ins. Co.,21 that states have long and anxiously awaited. At stake were state powers to regulate hospital rates, tax providers, and set health care standards.

In a unanimous April 26 decision that sent shock waves through the commercial insurance, health maintenance organization (HMO), and risk management industries, the Supreme Court held that ERISA does not preempt a New York rate-setting law that imposes surcharges on hospital bills paid by commercial insurers and certain self-funders but not on those paid by Blue Cross & Blue Shield plans. The law was designed to help Blue Cross & Blue Shield, which insures a broader array of patients, compete more effectively with commercial insurers. About half the states in the country have similar provisions, according to New York officials.22

The decision surprised many benefit law experts by reversing a recent trend of broad federal court interpretation of ERISA's preemption clause. This decision alone, however, cannot overcome the long history of blaming ERISA for blocking virtually all health care reforms at the state level, typified by two commentators' charge that:

ERISA preemption has been used to eviscerate state attempts to regulate both health care financing and health care delivery. Preemption has undercut efforts to implement employer mandates and to cross-subsidize uncompensated care and high-risk pools. It is now being invoked to deny the states any meaningful role in regulating HMOs, PPOs, and insurer/provider relations. All of this is occurring despite the absence of any countervailing federal substantive regulation of such entities and their activities.23

Although Travelers may have provided states more flexibility in some areas, particularly rate-setting and provider taxes, ERISA opponents complain that it "hasn't really made the regulatory waters any less murky."24 Health policymakers still fear that

[given the pervasiveness of self-insurance . . . almost any scheme states devise to broaden insurance coverage and spread risk appears subject to challenge on ERISA grounds. That means everything, from risk pools and mandated benefits, already ruled inapplicable to self-insured plans by the courts, to the later generation of employer mandates, insurance reforms like guaranteed issue and community rating and even the seemingly innocuous task of data collection, is off the table.25

24. Rath, supra note 17, at 3.
In short, this preemption doctrine has led one commentator to bestow on ERISA the dubious distinction of being "the law that ate health care reform." 

In the wake of the Court's ruling in Travelers, there is still cause for concern about ERISA preemption, but also a new optimism suggesting greater flexibility for states. Prior to Travelers, courts interpreted ERISA's preemption power very broadly, and reformers were cowed. This broad construction of the preemption power may be waning, however, depending on how widely the Travelers decision is applied. Even if the Travelers limitation on ERISA preemption, which dealt only with provider surcharges, is not applied to other types of health care regulation in the states, much reform can still take place, contrary to the opinion of many analysts. Thus, Travelers may open new areas of reform that previously appeared closed, or it may simply give reformers more courage to pursue reform options that in fact were already open to them.

The Travelers case underscores the fact that ERISA preemption is not as stifling to reform as many state policymakers believe. Recent attacks on ERISA have lacked a comprehensive and evenhanded discussion of what health policy analysts and state policymakers clearly can and cannot do under the Act. Policymakers who seek to amend or even repeal ERISA must clearly understand the contours of this most complex and important law, lest in slaying one monster they inadvertently create another. This Note submits that ERISA does in fact allow states substantial flexibility to enact health reform initiatives. State policymakers merely need a good road map to guide them through ERISA's intimidating and seemingly incomprehensible byways.

This Note seeks to provide guidance to reform-minded state policymakers. Part I reviews the sparse legislative history and conflicting motivations behind the preemption clause and the Supreme Court's interpretation thereof. Part II describes ERISA's implications for various state health care financing, cost containment, and administrative strategies—explaining which initiatives ERISA clearly permits, clearly prohibits, and affects with uncertainty. Part III concludes that, in a variety of cases, states do not need explicit legislative relief from ERISA in order to implement health care reforms; rather, states need clarification about what they definitely can and cannot do under the law.

I. ERISA PREEMPTION

Three provisions form the basis for ERISA preemption doctrine. First is the

26. Martin, supra note 1, at 40. See also Selling an Idea, MED. & HEALTH, June 15, 1992, in "Perspectives" insert (Alicia Pelrine, a National Governors' Association lobbyist, explains: "We are caught between a rock and a hard place. . . . On the one hand Congress wants to support incremental reforms in the states, and on the other if business succeeds in killing any hopes we might have, we can't do anything but nibble around the edges.").
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very broad, sweeping language of the preemption clause. Preemption is presumed if the state law "relate[s] to" any employee benefit plan. Second is a savings clause that may "save" from preemption a state law that falls within the bounds of the preemption clause if the law regulates insurance, banking, or securities. Third is the requirement that the savings clause save state insurance regulation laws only to the extent that they regulate genuine insurance companies or insurance contracts. A state may not "deem" an employee benefit plan an "insurance plan" in an effort to avoid preemption if the benefit plan would not otherwise qualify as an insurance company or contract. The "deemer" clause thus limits the application of the "savings" clause to conventionally insured employee benefit plans. The net effect of this tripartite structure is to preempt states from regulating self-funded plans.

Policymakers share a strong consensus that the courts have adopted an expansive reading of the ambiguous ERISA preemption language in health care cases. The Supreme Court itself has from time to time emphasized the breadth of ERISA's preemption provision, requiring that the "relates to" language be given its broad common-sense meaning so as to displace state laws that concern themselves even indirectly with employee benefit plans. Pointing out that "the key to [ERISA's preemption clause] is found in the words 'relate to,'" the Court reiterated that a state law may be preempted even though it does not address "the specific subjects covered by ERISA." The Court has delineated the breadth of the preemption clause as follows: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." It is not surprising, therefore, that the Court has "virtually taken it for granted that state laws which are specifically designed to affect employee benefit plans are preempted."

In Travelers, however, its most recent ERISA preemption opinion, the Court went to great lengths to disabuse this perception. The Court addressed preemption doctrine generally by first acknowledging that its past cases have recognized that the Supremacy Clause may entail preemption of state law either

27. "Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws, insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a) (1982).
28. "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1 144(b)(2)(A).
30. Id.
31. See Martin, supra note 1, at 86 ("The trend toward interpreting the ERISA pre-emption broadly . . . began in the late 1970s but snowballed during the '80s, one of the little-known effects of the Reagan-Bush 'revolution' in the federal courts.").
33. Id. at 138.
expressly, implicitly, or by a conflict between federal and state law. The Court then emphasized, however, that despite these multiple opportunities for federal preeminence, it has never assumed lightly that Congress has derogated state regulation but instead has addressed preemption claims upon the premise that Congress does not intend to supplant state law:

Indeed, in cases like [Travelers], where federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the “assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”36

In determining congressional intent, the Travelers Court began with the text of the preemption provision, which it found “unhelpful,” and then looked instead to the objectives of the ERISA statute as a guide to the scope of state regulatory power that Congress intended to survive.37 The Court found that ERISA’s basic thrust was to permit the nationally uniform administration of employee benefit plans by eliminating conflicting state regulation and reiterated that state laws mandating benefits or otherwise directly regulating the content or administration of plans are preempted. However, the Court distinguished New York’s system from these preempted state laws because the New York law’s purpose was to assist Blue Cross & Blue Shield rather than to regulate the content or administration of employee benefit plans.38

It is unclear how much or how quickly this new exercise of statutory construction will win over risk-averse health care reformers convinced that “ERISA preempts the world”39 and “paralyze[s] state health initiatives,”40 but it is a marked shift from the history of automatically giving ERISA’s preemption clause a broad interpretation. Given the dearth of legislative guidance as to how to read the words of the preemption clause, courts looked only to the words of the statute themselves and generally concluded that “[t]he governing text of ERISA is clearly expansive.”41

Nevertheless, courts have often found ERISA’s preemption provisions to be frustratingly vague, calling them “a veritable Sargasso Sea of obfuscation.”42 The conflicting legislative history supports such exasperation. While

37. Id. at 1677.
38. The Court noted that the state decision to assist the Blues plans was based on its ability to pay hospitals more promptly and its long history of open enrollment. Id. at 1678-79.
40. Id. at 42 (quoting Peter Groom of the New York Department of Insurance).
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Representative John Dent, House sponsor of ERISA, called the broad preemption clause the new legislation's "crowning achievement," Senator Jacob Javits, another sponsor, suggested the need to refine ERISA preemption, emphasizing that the "desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention." Twenty years after Javits's observation, policymakers are asking if that time has come. This Note, following Travelers' lead, submits that it has. While the Supreme Court has remarked previously that ERISA's preemption clause is "not a model of legislative drafting," it has not, until now, advocated "go[ing] beyond the unhelpful text and the frustrating difficulty of defining its key term," and looking instead to the objectives of the ERISA statute. These objectives include "avoid[ing] a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans" but do not include "displac[ing] general health care regulation"—historically a matter of local concern.

A. Legislative History

The history of section 514 of ERISA—which preempts state laws that "relate to any employee benefit plan" but permits states to continue to regulate the business of insurance—indicates that neither the original House nor Senate ERISA bills contained as broad a preemption clause as the final legislation.

The House bill would have limited ERISA preemption to state regulation of matters expressly covered by federal law: reporting, disclosure, and fiduciary responsibilities; funding and financing requirements; and nonforfeitability provisions. After the House approved H.R. 2 and sent it to the Senate, Senator Williams amended the House's version by striking out H.R. 2 and replacing it with H.R. 4200. The Senate version, broader than the House bill, preempted state laws relating to plan administration. Still, both versions had ERISA preempt state laws relating to employee benefit plans only if the state laws directly conflicted with or were identical to ERISA.

A joint conference produced final legislation containing much broader preemption language than either of the earlier proposals. Rather than the test of whether state law relates to ERISA, the final legislation used a much broader test of whether the state law related to any employee benefit plan not otherwise

43. 120 CONG. REC. 29,197 (1974).
44. 120 CONG. REC. 29,942 (1974).
47. Id. at 1672.
48. Id. at 1680.
49. 29 U.S.C. § 1144(a).
exempt from the Act.\textsuperscript{53}

Congress debated and later enacted ERISA during the tumultuous Watergate crisis. Some commentators have suggested that the disruption of Watergate rendered the ERISA framers' intent unreliable and undisciplined and led Congress to fail to consider sufficiently the consequences of unrestrained ERISA preemption.\textsuperscript{54} Courts should thus not consider the original intent of ERISA's chief sponsors regarding its preemptive scope an important guide to subsequent judicial constructions\textsuperscript{55}—especially not to claim a "clear congressional intent" in favor of broad preemption.

Other commentators counter that Congress did not carelessly cause inadvertent preemption of state health care regulation but foresaw and understood the effect of preemption on health care reform.\textsuperscript{56} Some go so far as to claim that the conference committee deliberately inserted the expansive preemption clause during its final negotiations in response to strong opinions voiced by House conferees speaking for powerful interest groups.\textsuperscript{57}

The bill's three major sponsors—Senators Jacob Javits and Harrison Williams and Representative John Dent—each framed the revised preemption clause as a way to eliminate the threat of conflicting and inconsistent state and local regulation of employee benefit plans.\textsuperscript{58} Not surprisingly, interests

\textsuperscript{55} Even when a meaning of a statute is "plain," the Supreme Court perceptively maintains that it cannot properly interpret the statute without analyzing the legislative history. See Train v. Colorado Pub. Interest Research Group, 426 U.S. 1 (1975). \textit{See also} Standard Oil Co. of Cal. v. Agsalud, 442 F. Supp. 695, 703 (N.D. Cal. 1977), \textit{aff'd}, 663 F.2d 760 (9th Cir. 1980), \textit{aff'd mem.}, 454 U.S. 801 (1981). CPIRG establishes the rule of statutory construction that unambiguous evidence in legislation’s structure and history can rebut a contrary presumption created by its unambiguous language. While courts cannot amend statutes in the guise of interpreting them and must presume that Congress meant what it said, the presumption, though heavy, is rebuttable.
\textsuperscript{56} Michael S. Gordon, Address before the National Health Policy Forum's conference on "The Role of Federal Standards in Health Systems Reform: How Much Leash Should ERISA Give the States?" (Nov. 18, 1992) (transcript on file at the YALE LAW & POLICY REVIEW).
\textsuperscript{57} Daniel M. Fox & Daniel C. Shaffer, \textit{Semi-Preemption in ERISA: Legislative Process and Health Policy}, 7 AM. J. TAX POL'Y 47, 48. "[S]hrewd political strategists set out to preempt state action and succeeded in stimulating state policy that was frequently thwarted by federal law." \textit{Id.} at 47.
\textsuperscript{58} \textit{See} 120 CONG. REC. 29,942; 29,933; 29,197 (1974):
Senator Javits: Both House and Senate bills provided for preemption of State law, but—with one major exception appearing in the House bill—defined the perimeters of preemption in relation to the areas regulated by the bill. \textit{Such a formulation raised 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. \textit{Id.} at 29,942 (emphasis added).
Senator Williams: It should be stressed that with the narrow exceptions specified in the bill, \textit{the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.} This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law. \textit{Id.} at 29,933 (emphasis added).
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dedicated to maintaining expansive ERISA preemption continue to offer this rationale. Deborah Steelman, former adviser to President Bush on Social Security and health care, expresses this reservation about the prospect of fifty separate health care systems with conflicting rules and practices when she says, "I don't think anybody is enthusiastic about the balkanization of health care in this country." What preemption proponents neglect to emphasize, however, is the message, brought home by Travelers, that many health reforms can be enacted without running afoul of these ERISA objectives.

B. The "Relate to" Requirement

Preemption has been enormously significant for health policy. As mentioned, courts use a tripartite analysis to determine whether ERISA preempts state law. The first step turns on the phrase "relates to" in section 514(a). To prevent state legislatures from undermining the new national pension system, Congress adopted sweeping language preempting any state laws that "may now or hereafter relate to any employee benefit plan." Whether state law "relates to" employee benefit plans is a preliminary, threshold matter at the heart of the ERISA preemption inquiry. It is difficult to dispute that courts have read the preemption clause broadly. An early case adopting broad preemption was Hewlett-Packard Co. v. Barnes, which involved a state health care reform law similar to many of those in controversy today. The Ninth Circuit Court of Appeals held that ERISA preempted California's revolutionary health care statute, the Knox-Keene Health Care Service Plan Act of 1975. Conspiracy theorists who believe that the conference committee's expansion of the preemption clause was

Representative Dent: Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

Id. at 29,197 (emphasis added).


60. 29 U.S.C. § 1144(a) (1982).


63. Hewlett-Packard, 571 F.2d at 505.

64. CAL. HEALTH & SAFETY CODE §§ 1340-1399.5 (West 1990). The act regulated funding, disclosure, sales practices, and service quality and required that California health care service plans be licensed by the state Commissioner of Corporations. Hewlett-Packard, 425 F. Supp. at 1297. The statute also sought to regulate self-funded plans. Id.
part of a political compromise to achieve passage of ERISA can view the outcome of this case as supporting evidence. The theory suggested that the preemption clause was expanded for the purpose of—and after *Hewlett-Packard*, apparently succeeded in—derailing California's new health care statute.65

In *Alessi v. Raybestos-Manhattan Inc.*,66 the Supreme Court gave the preemption clause an even broader reading by intimating that, although it held the statute in question67 was preempted because of a direct conflict with federal law, a court need not find that a state statute directly conflicts with a substantive ERISA provision in order to find that it “relates to” an employee benefit plan. The case involved a New Jersey statute that eliminated a method for calculating pension benefits (integration) that federal law explicitly permitted.68 Although the Court did not address the limits of ERISA's preemptive language, it stated that “even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.”69

Since the 1983 Supreme Court ruling in *Shaw v. Delta Airlines*,70 courts have given the preemption clause a decidedly expansive reading. *Shaw* involved two New York statutes—one prohibiting discrimination in employee benefit plans on the basis of pregnancy71 and the other requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy.72 The Court concluded that the state laws clearly related to employee benefit plans and stated that it was unquestionably Congress' intent to give the phrase “relates to” a broad, common sense meaning.73

*Shaw*—with its broad proposition that a state law relates to an employee benefit plan “if it has a connection with or reference to such a plan”74—quieted for over a decade the question of which state statutes “relate to” an employee benefit plan and are subject to possible ERISA preemption. In *Travelers*, however, the Court once again addressed the “insofar as they . . . relate to” language and asked whether the words really do much limiting:

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65. Martin, supra note 1, at 40-42; see generally Fox & Schaffer, supra note 57, at 47-48. Fox and Schaffer write: "We tell the story of how shrewd political strategists set out to preempt state action and succeeded in stimulating state policy that was frequently thwarted by federal law. . . . [T]he preemption clause of 1974 was inserted during the final negotiations in the conference committee, in response to strong opinions voiced by House conferees speaking for powerful interest groups." Id.


68. *Alessi*, 451 U.S. at 524.

69. Id. at 525 (emphasis added).


71. N.Y. EXEC. LAW §§ 290-301(a) (McKinney 1993). The law was a comprehensive statute that prohibited discrimination on the basis of sex.

72. N.Y. WORK. COMP. LAW §§ 200-242 (McKinney 1994). The law required employers to pay sick leave benefits to employers unable to work because of nonoccupational injuries or illnesses, including pregnancy.


74. Id. at 98-99.
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If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for "really, universally, relations stop nowhere." But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against preemption out of the law whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to construe the phrase "relate to" does not give us much help drawing the line here. 3

In deciding whether the surcharge statutes at issue made "reference to" or had a "connection with" ERISA plans, the opinion concludes that, since neither infinite relations nor infinite connections can be the measure of preemption, "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 7

C. The Savings Clause

The second step of ERISA preemption analysis involves the "insurance" savings clause. 77 The savings clause, drafted to make ERISA consistent with the McCarran-Ferguson Act, 78 reasserted that state governments, and not the federal government, would be primarily responsible for the regulation of insurance and insurance companies. The clause may thus protect even a state law that "relates to" an employee benefit plan but regulates insurance, banking, or securities. 79

The test set forth in Union Labor Life Insurance Co. v. Pireno 80 for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act appears to be the standard courts will adopt in order to determine whether a state statute is saved from ERISA preemption. The test uses three criteria to ascertain whether the state law affects practice regulation: "first, whether the practice has the effect of . . .

76. Id.
78. 15 U.S.C. §§ 1011-15 (1988). The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:
   No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.
80. 29 U.S.C. § 1144(b)(2)(A), provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."
spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between insurer and insured, and third, whether the practice is limited to entities within the insurance industry."

The Supreme Court used this test in both Metropolitan Life Insurance Co. v. Massachusetts82 and Pilot Life Insurance Co. v. Dedeaux.83 In Metropolitan Life, the Court found that the state statute did regulate insurance and was, therefore, saved. In Pilot Life, the Court concluded that the state law did not regulate insurance and, therefore, was preempted.

In Metropolitan Life, a Massachusetts statute required specified mandatory minimum mental health care benefits for in-state residents insured under a general insurance policy, an accident or sickness insurance policy, or an employee health care plan that covers hospital and surgical expenses. Metropolitan claimed that ERISA preempted the statute's application to any group policy issued for an ERISA plan within Massachusetts. Massachusetts argued that ERISA's savings clause presented the statute as a law that regulates insurance. The Supreme Court agreed with Massachusetts. Metropolitan Life is significant because it allowed states indirectly to regulate employee benefit plans by regulating the terms of group insurance policies whether purchased for the plans or adopted by employers as the terms of their plans. It also meant that employees asserting claims against insurance companies for wrongful denial of benefits could pursue state law causes of action as well as those provided by ERISA.

The question then remained open as to what other state laws, in addition to mandated-benefit statutes, would be saved from preemption. The Supreme Court again considered the issue in Pilot Life, wherein respondent Dedeaux asserted claims of tortious bad faith and breach of contract against petitioner Pilot Life for failing to pay benefits under a group insurance policy. The unanimous Supreme Court explained that although the savings clause was to be interpreted broadly, it could not save from preemption state laws that conflict with substantive provisions of ERISA. ERISA's civil enforcement provisions were the exclusive means for employees to seek such recoveries. The effect was that common law tort and contract causes of action seeking damages for improper processing of an employee benefit plan claim were preempted.

Pilot Life thus further defined the contours of ERISA's preemption provisions. The preemption clause itself generally has been given an expansive reading, in accordance with Shaw, meaning that a wide variety of state laws conceivably could be said to relate to an employee benefit plan. The scope of the savings clause was narrowed by the holding in Metropolitan Life to preserve only state statutes that specifically regulate insurance. The savings

81. Union Labor, 458 U.S. at 129.
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clause, however, does not save state laws of general applicability that may affect incidentally the insurer-insured relationship, such as common law principles of contract and tort.

D. The Deemer Clause

The third step of ERISA preemption analysis concerns the deemer clause. State insurance regulation may be "saved" only to the extent that it regulates genuine insurance companies or insurance contracts. As a result, a state may not "deem" an employee benefit plan an insurer or insurance company in an effort to avoid preemption if the benefit plan would not otherwise qualify as an insurance company or contract. Likewise, employee benefit plans may not escape ERISA by the pretext of operating as an insurance, banking, or security concern. The deemer clause therefore limits the application of the savings clause to conventionally insured employee benefit plans.

A literal reading of the deemer clause subjects insurance companies that sell or administer group policies to state regulation, while leaving self-funded companies free of state regulation. In *Light v. Blue Cross & Blue Shield of Alabama*, the Fifth Circuit addressed the seemingly anomalous distinction between self-funded plans and plans that purchase group insurance. Light, a former South Central Bell employee, sued Blue Cross & Blue Shield under state law seeking benefits allegedly due under Bell's self-funded plan. South Central Bell and Blue Cross & Blue Shield had an agreement whereby the latter was responsible for adjudicating all claims and paying all benefits provided by the plan, a common arrangement for self-funded plans. Although Light conceded that the plan was self-funded, he argued that state law was saved from preemption under *Metropolitan Life*. The Fifth Circuit disagreed, saying that the distinction between a self-funded plan and a plan underwritten by an insurance company or other insurer is critical in determining whether state regulations are preempted.

In *FCM Corp. v. Hollliday*, the Supreme Court granted certiorari to resolve a conflict among circuits over whether ERISA's deemer clause protects self-funded plans from all state insurance regulation or only back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation. The Court held that ERISA preempted application of Pennsylvania's antisubrogation law to an employer's self-funded health care plan. The state law

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85. 790 F.2d 1247 (5th Cir. 1986).
87. *Light*, 790 F.2d at 1248-49 n.3.
89. 75 PA. CONS. STAT. § 1720 (1987). Section 1720 of the law states that "[i]n actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits . . . payable under section 1719."
“related to” the plan, but the plan could not be deemed an insurer.

In elaborating upon the distinction between self-funded plans and plans that purchase group insurance, the Court explained that it was merely giving life to a distinction created by Congress in the deemer clause:

By recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-funded employee benefit plans governed by ERISA, which are not, we observe Congress’ presumed desire to reserve to the States the regulation of the “business of insurance.”

Thus, ERISA’s deemer clause does not except from the savings clause only state insurance regulations that are pretexts for impinging upon core ERISA concerns. The significance of the deemer clause is much broader: it draws the line between standard insurance and self-funded plans.

To summarize the tripartite preemption analysis, section 514(a) provides that ERISA “shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan” covered by the statute, although preemption stops short of “any law of any State which regulates insurance.” This exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not “be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance” just to escape the grip of ERISA. Finally, ERISA saves from preemption “any generally applicable criminal law of a State.”

The Supreme Court’s *Travelers* analysis of the ERISA preemption clause is better than prior expositions because of its blunt honesty: the text is unhelpful and it is immaterial whether this is by accident or by design. The Court looks instead to the objectives of the statute as a guide to permissible state laws, the basic objective being to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans. It finds the purpose of the New York surcharge statutes in *Travelers* to be one of cost-uniformity, almost certainly not an objective of preemption, giving states a green light to try provider taxes, rate-setting schemes, and other reform mechanisms.

Section 1719 refers to benefit payments by “[a]ny program, group contract or other arrangement.”

90. *FCM Corp.*, 498 U.S. at 63.
91. 29 U.S.C. § 1144(a).
96. *Id.* at 1676-77.
II. ERISA IMPLICATIONS FOR STATE HEALTH CARE INITIATIVES

Case law construction and legislative refinements have preserved ERISA's predominance in employee pension and welfare benefit law while simultaneously allowing for dynamic and flexible state initiatives consonant with ERISA's policy of protecting and furthering employee pension and welfare benefit plans. These periodic recalibrations of ERISA preemption, however, have also caused state health planners considerable uncertainty. An alarming 1994 National Governors' Association report warned:

ERISA poses a formidable hurdle to many activities that states would like to undertake as part of health care reform. These strategies, which may be part of comprehensive universal access programs or more incremental steps, can be grouped into four categories: financing, expenditure controls, insurance reform, and administration. 97

Although this Note reaches a different conclusion than the nation's governors, I will use roughly the same categories to examine what health care reforms states clearly can and cannot implement under ERISA's seemingly broad preemption of state law relating to employee benefits. While seeking to provide the clarity states require for health reform, this Note also acknowledges and delineates the truly gray areas and the reforms health planners can argue that they are entitled to implement if the goal is to avoid ERISA preemption.

The Supreme Court has decided several major ERISA preemption cases that bear on health care reform, 98 the most recent being Travelers. 99 While the Court has read the preemption clause broadly, Congress has repeatedly amended ERISA to limit its preemptive scope. 100 The exception for the Hawaii Prepaid Health Care Act is one such example. 101 Remedial amendments have also exempted state domestic relations law property settlements that reach ERISA pension rights. 102

97. NATIONAL GOVERNORS' ASSOCIATION, ERISA: ROADBLOCK TO STATE HEALTH CARE REFORM, Issue Brief, 3 (July 21, 1994).
100. 29 U.S.C. § 1144(b)(2)(A) (1982). Subsection 1144(b) provides several exemptions from the preemption clause: state laws regulating insurance, banking, and securities; state criminal law; the Hawaii Prepaid Health Care Act, as it existed in September 1974; multiple employer welfare arrangements; Medicaid "secondary payer" laws; and domestic relations orders that, for example, divide pension benefits among spouses.
101. See id. § 1144(b)(5)(A) ("Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act."). Pub. L. No. 97-473, 96 Stat. 2611 (1983) made this exception to ERISA's broad preemption section (§ 1144) effective on January 14, 1983.
This is not to say that legislative recalibration of ERISA preemption should be the goal. Rather, these legislative exemptions of innovative state laws from ERISA's preemptive sweep suggest a Congressional intent to allow greater state flexibility. This Note assumes that states would be better served by a different strategy, one of education and demystification, that clarifies what they can and cannot do under the law.

While individual court decisions may resolve specific challenges, they will not clearly delineate the extent of the authority states have to enact broad health care reforms. In fact, states have room to maneuver safely as well as creatively within current ERISA parameters when developing health care reform proposals, without threatening the objectives of pension plan protection that are at ERISA's heart. States should proceed, not by attempting to amend ERISA, but by seeking to understand what they can and cannot do under the law. This section outlines how ERISA affects strategic initiatives that states have enacted or may be considering as components of health care reform in the areas of financing, cost containment, and administration.

A. Financing Strategies

Basic financing models that states are currently considering include a health plan premium tax; an employer mandate; an employer "play or pay" option; an employer tax-based or income tax-based universal system; and provider taxes or excise taxes to subsidize low-income populations or to fund a broader public program.

1. Initiatives Preempted by ERISA

a. Health Plan Premium Tax. ERISA clearly prohibits a health plan premium tax—a state tax on all employee health plan contributions (insured or self-funded), whether to fund a universal system, subsidize care for the poor, or share the risk of uninsurable individuals. Several federal courts have held that states cannot tax employee health plans to fund high risk pools or other initiatives.

b. Employer Mandate. ERISA also prohibits a requirement that

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preemption effective on January 1, 1985.

103. A premium tax is "a state tax on the payments made to an insurance company by policyholders who live in that state." THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 266 (1994).

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employers cover workers and dependents with a minimum defined benefit package and pay a proportion of the premium. Both Oregon and Washington pegged their recent universal access plans to an employer mandate, and Vermont has considered the same. But federal courts that considered such health plan regulation in 1977 involving California’s Knox-Keene Act and the Hawaii Prepaid Health Care Act invalidated both state laws.

Cases challenging these laws 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. Hewlett-Packard ruled the Knox-Keene Act invalid insofar as it applied to employer-paid benefits. In Standard Oil v. Agsalud, the Ninth Circuit held that states cannot mandate that employers offer insurance, invalidating Hawaii’s mandate that all employers offer and partially pay for employee health insurance.

Other cases have made clear that states cannot regulate the terms, conditions, structure, or administration of employee health plans (except indirectly, by regulating insurers). The Supreme Court also recently held that states cannot prescribe the types of benefits an employer must cover if it chooses to offer a plan. Washington’s mandate was due to kick in this past July, but the legislature repealed the keystone employer mandate section on May 8 after failing to obtain an ERISA waiver from Congress. Oregon’s mandate is not due to kick in until 1998 but is certain to provoke an ERISA challenge.

2. Areas of Uncertainty

a. Play or Pay. Although it is clear that a state cannot use an “employer mandate,” the courts have not addressed a modified version of this strategy,

105. Karen Riley, Employers Block Efforts by States to Mandate Health Care Payments, THE WASH. TIMES, June 24, 1994, at B8. An employer mandate is “a requirement that all employers offer and nominally pay for a portion (in the Clinton plan, 80 percent) of their workers’ health coverage. Many small businesses seem to fear that a health insurance mandate would be so costly that it would drive them out of business. Most analysts believe that the costs of employer mandates are largely borne by employees.” MARMOR, supra note 103, at 259.

106. See Jake Brown, Everyone Agrees It’s Time for Health Care Reform, No One Agrees on How to Do It, VT. BUS. MAG., Dec. 1, 1993, at 24. The Vermont Health Care Authority, a state agency created to study the issue, presented two options for health care reform to the 1993 General Assembly: a single-payer plan and a multiple-payer scheme. The latter would require employers to pay 80 percent and employees 20 percent of each employee premiums.


111. Telephone Interview with Pam Thompson, Public Information Officer, Washington Health Care Policy Board (Aug. 19, 1995).

the "play or pay" approach. Under this approach, states would require that employers pay a tax to finance health care (the "pay" option) but permit a credit for actual costs of employee health benefits (the "play" option).113

The "play or pay" strategy, a second cousin of the employer mandate, may be the first state universal health care model to face a court test. A "play or pay" law must satisfy three criteria to avoid preemption: 1) it cannot be directed specifically at ERISA plans; 2) it cannot substantially affect ERISA plans; and 3) it must be a traditional exercise of state authority.

"Play or pay" strategies can also survive if their impact on a plan is merely peripheral. The Supreme Court and many lower federal courts have preserved certain areas for state regulation by following the Shaw dictum that certain impacts of a state law of general applicability may be "too tenuous, remote, or peripheral" to trigger preemption.114 Impacts are peripheral if they do not increase costs to the plan.

The Second Circuit in two cases even upheld state laws that raised plan costs. In Rebaldo v. Cuomo,115 the Second Circuit held that ERISA does not preempt New York's three-year hospital rate-setting Medicare demonstration which prohibited most health plans from discounting rates below state levels even though the provision increased an employee benefit plan's business costs: "Where, as here, a state statute of general application does not affect the structure, administration, or type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated."116 Courts continue to cite Rebaldo for the proposition that state laws can impose costs on ERISA plans.117

In Aetna Life Insurance v. Borges,118 the Second Circuit upheld an escheat law that required ERISA health plans to turn uncashed plan checks over to the state. The Court of Appeals noted that many laws—including labor law, rent control law, and even bridge tolls—affect the cost and administration of pension plans. In reviewing the types of laws that have been preempted, it noted that laws of general applicability that involve traditional exercises of state authority and only incidentally ERISA plans are not to be preempted: "What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and

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113. "Play or Pay [refers to] a health insurance reform plan in which employers either provide their workers with a basic [h]ealth [b]enefits package ("play") or pay into a government insurance pool. The system was popular in 1991 among congressional Democrats." MARMOR, supra note 103, at 265.
114. Shaw, 463 U.S. at 100.
116. Id. at 139.
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the amount of that benefit." The Third Circuit also agreed that ERISA permits states to impose costs on plans if it can be done without affecting their plan structures.

Most recently, the Travelers Court explained that ERISA preempts state laws that mandate employee benefit structures or their administration as well as those that provide alternate enforcement mechanisms. The Court further stated that an indirect economic effect is permissible as long as it does not bind plan administrators to any particular choice or preclude uniform administrative practice or the provision of a uniform interstate benefit package. The existence of other common state actions with indirect economic effects on a plan's cost—such as quality control standards and workplace regulation—renders the intent to preempt even less likely, since such laws would have to be superseded as well.

Massachusetts' 1988 enactment of the Health Security Act pioneered the "play or pay" reform strategy of requiring employers either to insure their workers or to pay a tax to a state insurance program. Economic and political changes prompted the legislature three years later to reverse or delay many of the Act's provisions and to initiate alternative reforms relying more heavily on the private sector. Implementation of the employer "play or pay" requirement was rolled back to January 1995 as part of these changes. This year legislators deferred once again, delaying the state's "play or pay" law one more year to January 1996. In late 1990, the Massachusetts Restaurant Association filed suit to enjoin the Massachusetts law on the ground of ERISA preemption.

Oregon enacted its own "play or pay" legislation in 1989, although it still has not begun implementing most reforms. Like Massachusetts, Oregon adopted a "play or pay" plan that would require all employers either to provide their workers basic coverage or to pay into a state insurance pool. When the bill passed, Democrats controlled the government and business interests were fighting over a proposal to raise the minimum wage. But when Republicans took over the state House of Representatives in 1991, the business lobby turned its attention to the mandate and tried to repeal it. In the end the business lobby settled for a postponement of the effective date from 1992 to 1995. The mandate is now due to take effect in March 1998 for large employers and in

119. Id. at 146-47 (emphasis added).
120. See United Wire, 793 F. Supp at 524.
121. Travelers, 115 S. Ct. at 1678.
122. Id. at 1679.
123. Id.
124. Massachusetts Health Security Act, MASS. GEN. L., ch. 118F; ch. 151A, 14g.
127. Riley, supra note 105.
128. Id.
January 1999 for small ones. The 1993 legislation conditioned implementation of the "play or pay" strategy on the state receiving an exemption from ERISA before January 1996, a clear indication that Oregon assumes that ERISA preempts its plan.

The Massachusetts law appears only to compel employers to pay the tax. It is neutral with respect to whether employers pay or insure their workers. In contrast, the sponsors of the Oregon legislation describe that program as requiring employers to offer benefits or pay a tax. Thus, the Oregon legislation may be more vulnerable to preemption. Although employers apparently can escape the tax by providing some benefits, it is harder to argue that the law's purpose is not to regulate employee benefits. It is therefore important for state health policymakers not to characterize a "play or pay" program as a "mandate" and undermine the more neutral language in the law itself.

To survive, a "play or pay" law must not refer to ERISA plans or be directed specifically to them. Under a broad reading of ERISA preemption, a court could hold that a "play or pay" law relates to an employee health plan because it requires employers and administrators to consider whether or not to modify the plan. On the other hand, the potential breadth of such reasoning could lead a court to hold that ERISA does not preempt a "play or pay" law that is neutral with respect to whether or not an employer offers health benefits.

Furthermore, a state cannot condition the tax credit on the type of benefit package offered or on a minimum employer contribution. Another ERISA preemption trigger is that such a law risks "relating to" an employee benefit plan if it requires employers to evaluate their plans and modify them to minimize their tax burdens. The Travelers Court stated that any conclusion other than the one it drew would have the unsettling result of barring any state regulation on the theory that all laws with indirect economic effects on ERISA plans are preempted. The Court cautioned, however, that it was possible that a state law might produce such "acute, albeit indirect, economic effects as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted."

b. Employer Taxes and Income Taxes. Broad-based revenue sources such as employer taxes and income taxes which fund a publicly financed health care program are more likely than "play or pay" to withstand ERISA preemp-

129. Brock, supra note 112.
132. Id. at 1683.
tion unless the public program causes the discontinuation of most employee health plans. An employer tax can fund a public program to cover all residents. For example, there is a payroll tax that funds hospital charity care in New Jersey and an employer tax has been evaluated in universal access proposals in Vermont. Vermont and other states have also considered income taxes to fund a public program to cover all residents. In November 1994, the California ballot featured a single-payer plan that combined payroll and income taxes.

Although a state cannot tax plans directly because ERISA prohibits a health plan premium tax, ERISA does not prohibit a tax law with only tangential impacts on an employee health plan. Therefore, it is fairly clear that a state can tax employers or use an income tax to finance a less-than-universal program (e.g., for the unemployed, for low-income workers, etc.). ERISA problems arise when a state chooses to use an employer tax or income tax to finance a publicly-funded universal program. ERISA is concerned with the impact on a plan, not an employer. A universal coverage program is much more threatening to a self-funded firm than a less-than-universal program. Any state health care program designed to cover all residents ultimately will be detrimental to most current employee health plans. This is because a firm simply has no incentive to maintain coverage for benefits already covered under a public plan. If employee health plans wanted to continue under such a scenario, they would be reduced to covering only benefits not included in the public program (e.g., dental or optometric care). Therefore, to avoid ERISA problems states should use an employer or income tax to finance a program geared toward a particular population (the unemployed, the uninsurable, etc.) rather than a universal program.

A state can always argue that taxing employers or income constitutes an exercise of its traditional authority to finance health care through taxes. But to avoid ERISA preemption, a tax law would have to meet certain requirements, such as not affecting whether a sponsor could maintain its plan. While an employer tax or income tax might not be directed at employee health plans, it would be difficult—if not impossible—to argue that a public program will have no effect on such plans.

134. Brown, supra note 106, at 24 (noting that under the single-payer proposal, a state agency would collect the $714 million necessary to cover health services, in part, through a payroll tax (between 7.7 percent and 8.4 percent of total payroll) paid by employers).
135. Id. Under the Vermont single-payer proposal, a state agency would also collect an income tax of 3-3.5 percent on household gross income paid by individuals.
136. See Biggest Barrier, supra note 25, at 8.
137. See supra text accompanying notes 103 and 104.
138. Retirement Fund Trust of the Plumbing v. Franchise Tax Bd., 909 F.2d 1266 (9th Cir. 1990).
3. *Initiatives Not Preempted by ERISA*

a. **Provider Taxes.** ERISA preemption problems arise not from the financing source of a universal publicly funded program but from its impact on employee health plans. The same principle determines the viability of rate-setting or provider tax laws. "Provider taxes" and "rate-setting" are often used interchangeably. This Note will discuss provider taxes as a financing strategy (a mechanism put in place to fund new programs) and rate-setting as a cost containment strategy (a process in which a state authority approves a budget or rate structure for hospitals or other providers). To avoid preemption rate-setting or provider tax laws must not require a plan to structure benefits or administer internal affairs in a particular way and must take care not to impose too many additional costs on a plan. For example, some rate differentials may simply create too great a financial burden on plans to withstand ERISA preemption (though the *Travelers* case has probably loosened this rule). The criteria for determining the preemption outcome turns on whether a state law produces such acute economic effects as to force an ERISA plan to adopt a certain scheme of coverage or effectively restrict its choice of insurers.\(^\text{139}\)

Until recently, there was a split among circuits over whether ERISA preempted state attempts to redress adverse selection\(^\text{140}\) by employing traditional hospital rate-setting schemes to cross-subsidize uncompensated care and high-risk pools. It is helpful to take a closer look at the two conflicting federal appeals court rulings that brought the issue of health care provider rate-setting efforts before the Supreme Court in *Travelers*.

In 1992 a U.S. District Court held that ERISA preempted New Jersey's hospital rate-setting law, which among other requirements had imposed a 19\% surcharge on each hospital bill to fund a pool to pay hospitals facing disproportionate burdens of charity care, bad debt,\(^\text{141}\) and other shortfalls.\(^\text{142}\) The Third Circuit reversed the lower court's ruling, holding that states can enact laws that indirectly impose costs on health plans by raising hospital costs as long as the laws do not dictate or restrict the manner in which ERISA plans structure or conduct their affairs.\(^\text{143}\)

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\(^{140}\) Adverse selection is "The process whereby individuals who know they are most at risk of needing to file an insurance claim disproportionately purchase insurance." MARMOR, supra note 103, at 255.

\(^{141}\) Bad debt and free care are "terms [that] apply to hospital bills that are not paid. Free care refers to the bills of those too poor to be expected to pay. Bad debt refers to bills left unpaid by those who reasonably might be expected to pay." *Id.* at 256.


In 1984 the Second Circuit upheld New York's hospital rate-setting law that prohibited hospitals from discounting rates and forced all payers to subsidize Medicaid and Medicare shortfalls and charity care. But then the Second Circuit took a position inconsistent with both its 1984 decision and that of the Third Circuit when it invalidated surcharges that New York's rate-setting law imposed on indemnity carriers and HMOs but not on Blue Cross. The court explicitly disagreed with the holding in the New Jersey case, concluding that while states might impose some costs on plans, both a 24% surcharge on indemnity carriers and a 9% add-on for HMOs were so substantial as to "relate to" health plans. In its Travelers decision, the Supreme Court disagreed.

Minnesota, which led a group of states that supported New York State in the Travelers case, has a major stake in the decision because it is still fighting legal challenges to its broad-based health care reform program, which is financed with a provider tax. Last April, Minnesota's provider tax survived one such ERISA challenge. In 1992 the state had enacted comprehensive health care reform with its HealthRight Act (now renamed MinnesotaCare). The Act included cost containment, small business reforms, and increased access to health care by creating subsidized insurance benefits for the uninsured. The Act was subsidized in part by a two percent tax on the gross revenues of hospitals and other health care providers, including out-of-state hospitals that treat Minnesota residents. Providers could pass the two percent assessment onto insurers.

The board of trustees of a self-funded union-sponsored health plan filed suit to enjoin Minnesota from enforcing the taxing mechanism and sought a ruling that ERISA preempted the taxing provisions. The plaintiffs' arguments were similar to those in the New Jersey case. They alleged that HealthRight related directly to the administration, funding, and terms of the plan and that the two percent assessment subjected the plan to inconsistent state regulation. Further, they alleged that the plan was specifically limited to expending funds only for the benefit of plan participants. But the district court held that ERISA does not preempt Minnesota's provider tax. Despite the early victory, ERISA continues to loom over Minnesota and other states' provider taxes. For example, the universal access laws enacted in Washington and proposed in Vermont to fund public programs or subsidies for low-income

146. Id. at 721.
150. Id.

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individuals must still confront ERISA issues.\textsuperscript{152}

The Second Circuit has recently dealt with two separate challenges to Connecticut surcharge laws. In the first, the New England Health Care Employees Union challenged an 18.7\% surcharge on hospital bills designed to raise $300 million per year. A federal district judge struck down that surcharge in February 1994, but, in the wake of the \textit{Travelers} decision, the Second Circuit reversed the decision and upheld the surcharges.\textsuperscript{153} Seeking an alternative revenue source after the district court ruling, Connecticut placed an 11\% tax on hospital revenues and a 6\% sales tax on patient services. The Connecticut Hospital Association challenged those charges on ERISA grounds and in November 1994 the court struck down that law as well.\textsuperscript{154} An appeal is still pending, and it is likely that the \textit{Travelers} decision will allow the hospital surcharges to survive.

b. \textit{Excise Taxes}. Excise taxes—such as those on the sales of tobacco, alcohol, or gasoline—offer a final financing strategy. Presumably, ERISA should not pose a problem to these types of taxes. Sales or other excise taxes on unhealthful products, commonly referred to as “sin” taxes, are politically popular. Unfortunately, they provide only a small source of revenue and are highly regressive, making them a counterproductive method for protecting low-income populations.

In 1993, Oregon passed legislation related to implementing the Oregon Health Plan. The 1993 law funds the plan for the low-income uninsured through general funds and a ten-cent-per-pack cigarette tax to fund Medicaid expansion.\textsuperscript{155} Massachusetts finances its Healthy Kids program partly through a cigarette tax.\textsuperscript{156} Washington was to raise some of the new revenue for its Health Services Reform Act of 1993 through tobacco, liquor, and beer taxes.\textsuperscript{157} These taxes represent only a small source of revenue, however, and a declining one at that; for example, estimates of tobacco tax revenue to fund ColoradoCare indicate a steep decline of $8 million over a five-year period.\textsuperscript{158}

If excise taxes were a significant source of funds, they might present the same ERISA problems as payroll and income taxes, for it is the impact of the

\begin{thebibliography}{99}
\bibitem{152} See Riley, \textit{supra} note 105.
\bibitem{155} \textit{Oregon Health Care Measure Signed}, \textit{LAS VEGAS REV.-J.}, Sept. 15, 1993, at 1F.
\bibitem{156} \textit{Blue Cross Explains its Interests}, \textit{TELEGRAM & GAZETTE} (Worcester, MA), June 18, 1993, at A8.
\bibitem{158} \textit{COLORADO HEALTH CARE REFORM INITIATIVE, COLORADO CARE PRELIMINARY FEASIBILITY STUDY: REPORT TO THE COLORADO GENERAL ASSEMBLY} (1993), at Chapter 6 (on file with author).
\end{thebibliography}
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entire universal program—not individual revenue sources per se—that poses the preemption problem.

B. Cost Containment Strategies

States are using three main strategies to contain costs. The first, global budgeting, involves establishing overall health care expenditure limits for a defined period in a defined area, institution, or sector. This strategy is preempted by ERISA. The second tactic requires rate-setting, which is a direct fiscal control in which a state authority approves a budget or rate structure for hospitals or other providers. The Travelers Court resolved a split between the Second and Third Circuits on this issue, finding nothing in the legislative history of ERISA's preemption scheme that indicates that Congress intended to frustrate states' rate-setting efforts. The third strategy, a certificate-of-need program, regulates the introduction or expansion of new institutional health facilities and services and does not raise ERISA problems.

1. Initiatives Preempted by ERISA

a. Global Budgets. ERISA prohibits global budgets that affect self-funded plans. There is no case law directly on point, probably because this is one of the more obvious initiatives that would be preempted. ERISA preempts state laws that limit spending by employee health plans that are not offered through insurance carriers. To do so would regulate plan terms, conditions, and administration directly in violation of court interpretations of the preemption clause.

The threat of ERISA preemption, however, has not deterred states from considering global budgets as a key element of health care reform. Indeed, a state could regulate spending by government agencies, traditional insurers, and perhaps even individual residents. The Montana Health Care Authority is currently considering global budgeting; New York is funding the development of global budgeting demonstration projects, and a Robert Wood Johnson Foundation grant is funding development of an annual ceiling for health care expenditures in four other states.

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160. Global budget is defined as follows: "An amount, set by an administrative body, that controls the funds available to pay for medical care services in a region, state, or nation. Usually covering government spending and other insurance payers, global budgets are most often associated with universal health insurance, under which all individuals in a country are covered." MARMOR, supra note 103, at 260. Thus, global budgets limit all health care expenditures, public and private, in a state.

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Vermont has some of the strictest cost containment rules in the country, including global budgeting which it was to begin implementing incrementally in July 1993. That year, the Vermont Health Care Authority set expenditure targets for hospitals and the rest of the health system. The targets were to become limits in 1994, controlling all health services expenditures, and subjecting all hospitals to maximum annual budgets beginning in October 1994. The Authority was scheduled to begin enforcing a binding unified health care budget in July, but it will now implement the budget as data on non-hospital sectors improve. Although the budget applies to all health services, in reality the Authority only has the ability to enforce limits on hospitals.

As mentioned in the subsection on provider taxes, following the veto of a 1991 universal access measure, a bipartisan Minnesota effort in 1992 led to the enactment of the HealthRight universal access law. The law outlined a system to manage costs and set targets for reducing health care cost inflation. "The law creates a health care cost containment commission to collect data on effectiveness and make recommendations on limiting health care cost growth, and sets state and regional boards to recommend how to limit health care cost growth to ten percent annually for five years starting in mid-1993." Minnesota’s integrated service networks and providers outside these networks would both operate under these limits.

While a state may be able to obtain some voluntary compliance with budget targets or caps, true success in global budgeting will require a legislative amendment allowing states to require all health plans—including self-funded plans—to meet such targets.

2. Initiatives Not Preempted by ERISA

a. Rate Setting. Provider rate-setting exists for hospitals in Maryland, New Jersey, and New York, and for outpatient services in Maryland. Rate setting was an area of great uncertainty until Travelers. As mentioned in the discussion of provider taxes, the Supreme Court granted certiorari in Travelers after two Circuit Courts recently reached opposite conclusions about similar state rate-setting plans. In October 1993 the U.S. Court of Appeals for the Second Circuit affirmed a district court decision that New York’s imposition of three surcharges on hospital rates to finance indigent care

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164. States Take Their Own Reform Steps, supra note 3, at 3-4.
165. Jake Brown, No Mandates, No Change, VERMONT BUS. MAG., June 1, 1994, at 33.
167. Donna Halvorsen, Health Care Bill Clears Legislature, STAR TRIB., May 18, 1993, at 1B.
168. Rate setting "refers generally to a government’s setting of prices—whether for electricity, water, or health care. Maryland has had such a system for hospitals since the 1970s." MARMOR, supra note 103, at 266.

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violated ERISA’s preemption clause.\textsuperscript{169} Just six months earlier, a Third Circuit Court of Appeals panel had reversed a lower court ruling to the same effect regarding New Jersey’s uncompensated care surtax.\textsuperscript{170} It then fell to the Supreme Court, which announced in October 1994 that it would hear the New York case, to resolve the matter.\textsuperscript{171} Meanwhile, in March 1995, New York’s Senators secured an amendment extending the waiver authorizing New York to continue its rate-setting practices so that, however the Court ruled, New York’s system would remain in place until at least December 31, 1995.\textsuperscript{172}

The Court ruled that ERISA does not preempt New York’s hospital rate-reimbursement scheme, noting that New York justified its surcharge differentials on the grounds that the Blue Cross & Blue Shield reimburses hospitals promptly and, through open enrollment policies, covers poor patients and other subscribers that commercial insurers would reject as unacceptable risks.\textsuperscript{173} The state imposes surcharges of thirteen percent of commercially insured patients’ hospital bills and up to nine percent of aggregate monthly charges paid by HMOs for members’ hospital care.\textsuperscript{174} For the year ending March 31, 1993, the state imposed an additional 11% surcharge on commercially insured patients for a total surcharge of 24%.\textsuperscript{175}

A group of insurance interests led by Travelers Insurance challenged the surcharges on the grounds that, by increasing hospital costs of patients covered by an ERISA plan, the surcharges “relate to” ERISA plans and are therefore preempted by the federal law.\textsuperscript{176} Lower federal courts agreed,\textsuperscript{177} but the Supreme Court did not. It reasoned that while the surcharges have an indirect economic effect on ERISA plans by increasing the cost of obtaining commercial medical insurance, the levies do not regulate the plans themselves or prevent administrators from carrying out the law’s provisions. Writing for the Court, Justice Souter said that the surcharges “do make the Blues more attractive (or less unattractive) as insurance alternatives and thus have an indirect economic effect on choices made by insurance buyers, including

\textsuperscript{170} United Wire, Metal, and Machine Workers Health Board v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir. 1993), cert. denied, 114 S. Ct. 382 (1993).
\textsuperscript{171} New Jersey legislators had scrapped the surtax by the time the Third Circuit ruled, rendering the disposition mostly moot except for the issue of union-escrowed funds. Id. at 1190.
\textsuperscript{172} Lawmakers Avert NY Funding Crisis, MED. & HEALTH, Apr. 3, 1995, at 1.
\textsuperscript{173} Travelers, 115 S. Ct. at 1678.
\textsuperscript{174} Travelers, 115 S. Ct. at 1674.
\textsuperscript{175} Id.
\textsuperscript{176} Id. at 1675.
ERISA plans.” The Court further noted, however, that while this effect may influence a plan’s choice of insurance, it “does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.” Hospital rate variations are not different from other common state actions, such as implementing quality control and workplace safety programs, that indirectly affect the cost of an ERISA plan, and the Court found it “unlikely” that Congress intended to preempt such state action.

ERISA threatens not only hospital rate-setting laws that impose explicit surcharges for uncompensated care, but also other state programs—e.g., those that set minimum allowable charges (such as diagnosis-related groups (DRGs)), prohibit payers from negotiating lower rates, and include uncompensated care in each hospital’s allowable charges. One state rate-setting program that has survived ERISA over the years is Maryland’s. The Maryland Health Services Cost Review Commission (HSCRC) has been in charge of approving hospital rates since 1977. Maryland is the only state with an all-payer rate-setting system, whereby the HSCRC eliminates cost-shifting by budgeting for uncompensated and charity care in the rates it sets for each hospital. A new Maryland Health Care Access and Cost Commission (HCACC), created in 1993, is charged with establishing a new payment system to provide a framework for determining the ultimate price of health care services. According to one commentator, “[w]hat the Travelers decision really does is reinforce the legal foundations for the reforms under way in Maryland, and for the [HCACC] to move forward with its efforts.”

The Court has now held that ERISA does not preempt a state law as long as its purpose and effect are not to mandate employee benefit structures or their administration or to provide alternate enforcement mechanisms. In the words of Justice Souter, any other conclusion would have the unsettling result of barring any state regulation of hospital costs on the theory that all laws with indirect economic effects on ERISA plans are preempted:

[T]o read the pre-emption provision as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans . . . would effectively read the limiting language in § 514(a) out of the statute. . . . Nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a

178. Travelers, 115 S. Ct. at 1679.
179. Id.
180. Id.
181. A diagnosis-related group is part of a “classification system adopted by Medicare to set standard payments for hospitalization. Payments are predetermined based on the patient’s diagnosis, having been adjusted for the average cost of such care in the area.” Once the DRG is determined, the hospital’s reimbursement is fixed, regardless of the actual cost of treatment. MARMOR, supra note 103, at 259.
182. Rath, supra note 17, at 5 (quoting Bob Murray, HSCRC executive director).
183. Travelers, 115 S. Ct. at 1678.
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matter of local concern.\textsuperscript{184}

Thus, state regulation of hospital costs is permitted. So are other interferences with the hospital services market, such as the basic DRG system.\textsuperscript{185}

Although the case was a clear victory for New York in allowing it to impose surcharges on some hospital services for some insured patients, the Supreme Court ruling remains ambiguous regarding self-funded plans. But these issues are likely to be considered on remand, and many employee benefits experts expect the Second Circuit to apply the Supreme Court's ruling by allowing the surcharges to stand, even if they affect self-funded plans.\textsuperscript{186}

b. Certificate-of-Need. Certificate-of-need (CON) programs contain costs by regulating the introduction or expansion of new institutional health facilities and services. State governments first began passing CON laws in the mid-1960s. Today more than three dozen states have CON programs of one sort or another.\textsuperscript{187} The stated goal was to slow the rate of growth in medical costs by encouraging consolidation and reducing duplication of hospital services. State officials believed, for example, that one efficient and fully utilized piece of equipment was better than two that were underutilized. Health care providers and nursing homes were required to get permission from the state before adding beds or purchasing expensive equipment. In theory, this produces a more rational system and cuts down on duplication and excess capacity.

In practice, extensive research suggests strongly that CON programs have not worked as originally intended. It appears, in fact, that they may have boosted the very costs they were supposed to control because they restrict competition among hospitals and, by curtailing efficient capital investments, actually raise operating costs.

Whatever its modest successes, the certificate process has been notorious for its failures. It has become one of the most heavily lobbied and heavily politicized processes in state government. A number of states have now relaxed, ended, or are planning to end their CON programs altogether\textsuperscript{188} even though such regulations raise no ERISA problems. Wisconsin's CON law met its demise in 1987 deregulation.\textsuperscript{189} Michigan's CON program was

\begin{thebibliography}{99}
\bibitem{184} Id. at 1679-80.
\bibitem{185} Id. at 1681.
\bibitem{187} Mark Tatge, \textit{Ohio's Health Care Regulations Draw Criticism}, \textit{PLAIN DEALER}, Feb. 2, 1995, at 6B.
\bibitem{189} Id.
\end{thebibliography}
reformed in 1988.\textsuperscript{190} Ohio's CON law, frequently criticized for being festooned with exemptions that have benefited special interests,\textsuperscript{191} has been in limbo since it was last tightened by the legislature in 1989. It has been extended several times but never significantly reformed. The Ohio General Assembly extended its existing CON law in 1995.

C. Administrative Strategies

States are trying administrative strategies that include mandatory purchasing pool participation; uniform data reporting and claims procedures; malpractice dispute resolution in managed care plans; insurance market reforms; stop-loss insurance requirements; and managed care regulation. ERISA preempts state efforts to impose administrative requirements directly on health plans. Thus, required participation in purchasing pools, mandatory data reporting standards and certain types of malpractice reforms are beyond the reach of state regulation. On the other hand, states can enact insurance market reforms and can regulate managed care organizations that are not self-funded.

1. Initiatives Preempted by ERISA

a. Mandatory Purchasing Pool Participation. Some proposals would use "managed competition"\textsuperscript{192} (not to be confused with "managed care," discussed at the end of this section) to increase access to insurance and reduce costs; indeed, it was the principal cost containment tool in the Clinton plan and many of the health care bills before Congress.

The concept of managed competition has been developing for over a decade. A central feature of the approach is a new and distinctive consumer-oriented institution: the health insurance purchasing cooperative (HIPC).\textsuperscript{193} These collective arrangements bring health care buyers together into large purchasing groups so that people can choose among regulated health plans that compete on price and quality while offering a standard benefit package.\textsuperscript{194}

\textsuperscript{190} Michigan Gov. James J. Blanchard Announces Public Appearances for Nov. 29 - Dec. 2, PR Newswire, Nov. 28, 1988, available in WESTLAW, PRWIRE.

\textsuperscript{191} Tatge, supra note 187, at 6B. The current CON law has 132 exemptions. Id.

\textsuperscript{192} Managed competition is defined as "both a slogan and a set of ideas about health care reform. Largely embraced by President Clinton as an early label for his reform proposal, it proved a complicated marketing term and was abandoned as a Clinton policy tag. The concept of managed competition combines market forces with government regulation. Large groups of consumers buy medical care (or insurance for care) from networks of providers. The aim is to create price competition among those networks and thereby both restrain prices and encourage high-quality care and responsiveness. The variation among plans described as managed competition is substantial; thus the label is of uncertain worth." MARMOR, supra note 103, at 263.

\textsuperscript{193} Health insurance purchasing cooperative (HIPC) is defined as follows: "An HIPC, like a health alliance, pools individuals or employees for the purpose of buying health insurance. A health alliance, under the Clinton plan, is quasi-governmental. In other proposals, an HIPC is a private, nonprofit organization." MARMOR, supra note 103, at 261.

\textsuperscript{194} See Alain C. Enthoven, The History and Principles of Managed Competition, 12 HEALTH AFF. 25, at 35-37 (1993).
Eleven states have passed legislation concerning health insurance purchasing alliances, and a dozen others have begun similar experiments.\footnote{Lau, supra note 4, at 55.}

A state can assure that firms that buy insurance purchase it through a HIPC but cannot require self-funded employers to buy health benefits through any particular purchasing arrangement. Because states may not require that all employers offering benefits do so only through a HIPC, public and private groups wanting to create broad-based purchasing alliances must encourage voluntary participation. Additionally, many HIPC proponents believe that purchasing cooperatives can more significantly control costs and stabilize markets if they aggregate as many buyers as possible under a given size into one or more buying pools.\footnote{See Enthoven, supra note 194.} This is another reason states need to use strategies that encourage voluntary HIPC participation.

ERISA, after all, creates no barrier to purely voluntary buying pools; in 1993, for example, Iowa Governor Terry Branstad signed a law that would set up voluntary insurance pools.\footnote{States Take Their Own Reform Steps, supra note 3, at 5.} States experimenting with managed competition can use the avenues of insurance regulation or tax policy to encourage HIPC participation or offer incentives for individuals or small employers to buy insurance through a HIPC. While some of these strategies could provoke ERISA challenges, states may be able to avoid ERISA problems by relying on their explicitly sanctioned powers to regulate and tax traditional health insurance carriers.

A state could use its authority to regulate insurance in numerous ways to encourage HIPC participation; doing so is generally compatible with ERISA. For example, exempting HIPCs or carriers offering coverage through HIPCs from certain state insurance requirements would give small employers participating in HIPCs the advantages that larger self-funded firms currently enjoy. Recently, business coalitions have been pushing Congress to amend ERISA “to allow small business owners to voluntarily band together across state lines.”\footnote{Alliances, Coalitions Face Uncertain Prospects on Hill, HEALTH ALLIANCE ALERT, Jan. 13, 1995, at 1 (quoting National Federation of Independent Business’s legislative agenda).} Besides seeking the greater market power that such alliances could wield, this legislative initiative is motivated by a desire to “avoid costly state laws and mandates.”\footnote{Id.} Such initiatives are more wisely implemented at the state level, however, where they can be more closely tailored to existing laws and where the unintended consequences that may accompany broad federal regulation can more easily be avoided. States could also encourage HIPC enrollment simply by prohibiting insurance carriers from offering health
insurance to small groups except through a HIPC.

Another insurance regulatory approach—regulating individual, non-group insurance not offered through an employee health plan—also poses no ERISA problems. A state could require the self-employed or other individuals buying insurance on their own to do so through a HIPC. It is not as clear, however, that states would have similar authority to impose such a requirement with respect to stop-loss insurance (coverage that partially self-funded plans buy to protect themselves against excess loss, e.g., claims over $10,000). Requiring carriers to offer stop-loss coverage to small groups only through a HIPC would strongly influence the underlying primary coverage of a partially self-funded plan. This is more likely to bring an ERISA challenge because, although the federal appellate courts agree that states have some power to regulate stop-loss insurance, they disagree on the extent of that authority. States should be able to regulate stop-loss carriers but cannot intend thereby to regulate the underlying self-funded plan.

A state could also use tax policy, such as tax deductions or tax credits, to encourage the purchase of insurance through a HIPC. Tax credits and deductions offer modest but effective enrollment incentives. A state could provide a tax credit for small firms participating in a HIPC or condition its current business income tax deduction on buying insurance through a HIPC. Still, the purpose of these tax expenditures—to encourage firms to offer insurance—raises ERISA concerns because state prerequisites affecting terms and administration may “relate to” health plans more than peripherally.

More direct uses of the state’s taxation power raise even greater ERISA problems. For example, some state reformers have considered plans to encourage individuals to enroll in plans offered through regional HIPCs subsidized by payroll taxes. This strategy raises ERISA problems because

202. Many regulators believe it is critical that any health insurance reform address the individual insurance market, to which most small-group insurance reforms do not extend. The National Association of Insurance Commissioners has made it a priority to develop a model law to address some of the inequities in the individual insurance market over the coming year. See Hearings on H. 995 Before the Subcomm. on Employee-Employer Relations of the House Comm. on Economic and Educational Opportunities, 104th Cong., 1st Sess. (1995) (prepared testimony of Brian K. Aitchinson, Vice President, National Association of Insurance Commissioners and Superintendent, Maine Bureau of Insurance).

203. One federal appeals court has held that state mandated benefits laws apply to stop-loss carriers (even though these laws indirectly affect self-funded ERISA plans). Michigan United Food and Commercial Workers’ Union v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985), cert. denied, 474 U.S. 1059 (1986) (holding Michigan statute requiring all group disability policies to include coverage for substance abuse not preempted by ERISA). Yet other courts have concluded that these laws do not apply to true stop-loss insurers. Brown v. Granatelli, 897 F.2d 1351-52 (5th Cir. 1990) (holding Texas statute requiring individual and group health insurance policies to provide coverage for newborn babies with congenital defects did not apply to stop-loss policies that insured against catastrophic loss).

The Brown court also suggested that ERISA should not shield employers who purport to create “self-funded” plans with very low deductibles (e.g., $500 per employee). If small employers begin to design coverage in this way, states will need to define “stop loss” and “self-funding.” The courts may also have to clarify states’ authority to regulate stop-loss insurance. Id. at 1355.

204. One such program was proposed in California by Insurance Commissioner John Garamendi in 1992. Lou Cannon, California Official Offers Health Plan; Payroll Tax Would Help Fund
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it would supplant most employee health plans or reduce them to mere supplemental insurers. Rather than using tax policy, a state could avoid ERISA implications yet still induce greater insurance participation by directly subsidizing firms participating in a HIPC, perhaps by targeting subsidies to low-wage or low-profit firms.

Another tax option is to limit the amount of health benefits that employers may deduct and employees may exempt from recognized income in order to encourage more cost-conscious insurance purchases—a tax cap best implemented on the federal level. Absent a change in the federal tax law, however, a state could set the cost of a basic plan and then impose an individual income tax surcharge on the portion of a health insurance premium exceeding that cost and/or limit employer tax deductions to that cost. A tax on individuals to generate revenue is not inconsistent with ERISA but could pose problems insofar as its purpose and effect is to change the health plan terms, conditions, and administration.

Most strategies to encourage HIPC participation are novel and likely to face ERISA challenges. Some strategies use the state's insurance regulation authority, which ERISA preserves. Other strategies—such as certain exercises of tax power—are safe from challenges if they have only a tangential impact on health plans. Still others border dangerously on affecting plan terms or structure in more than a peripheral way.

b. Mandatory Uniform Data Reporting/Uniform Claims Procedures. A majority of states have adopted laws encouraging standardization of billing and reporting systems and establishing a system to gather and use data. Uniform data reporting and claims procedures strategies simplify administration; they represented a $3.4 to $6 billion cost-saving goal that garnered almost universal bipartisan support in the national health care reform debate.205 Unfortunately, ERISA prohibits states from requiring self-funded employee health plans to provide data for claims they pay. Additionally, though states can require their own agencies, insurance carriers, HMOs, and possibly even insurers acting as third-party administrators or stop-loss carriers to use a common form and procedures, states cannot impose this obligation on self-funded plans because ERISA prohibits dictating administrative requirements.

Systematic data collection allows states to analyze and disseminate information on health care systems and the impact thereon of different policies. Uniform collection of use and expenditure data from both providers and third-party payers, as many states are contemplating,206 will typically include

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eligibility, coverage, claims, and payment.\textsuperscript{207}

Planning cost containment, access, and quality assurance strategies requires detailed spending and use pattern data for all types of health care through all payment sources. In addition, such data gathering is integral to managing a system, whether regulators or buyers of competing plans use the data. States have difficulty obtaining such data, however, and ERISA flatly prohibits them from requiring self-funded employee health plans to provide it.

To facilitate data collection, legislation creating comprehensive data systems often requires hospitals, insurers, and other providers to submit detailed information. At least nine states have formal entities that are studying improved health care data collection initiatives for 1995.\textsuperscript{208} In addition, business coalitions have formed in many states to share such information. States may also be able to encourage voluntary data sharing on the theory that it benefits the private as well as the public sector. Yet without the guarantee that data will be provided in sufficient detail and compatible formats, voluntary arrangements are of limited utility and invite free-rider problems.

A related strategy, uniform claims, requires health carriers in a state to use standardized forms and exchange claims-based information. Uniform claims procedures create administrative efficiency for many of the same reasons that uniform data reporting does. First of all, uniform claims forms and procedures can be the vehicle for collecting comprehensive spending and use data. Second, standardizing forms and processing codes greatly streamlines an expensive and time-consuming process, particularly for noninstitutional health care providers for whom billing represents a significant staff cost.

A growing number of states are studying a related concept that would require electronic information, and reform efforts in a few—such as Maine, Nebraska, Maryland, and North Carolina—include comprehensive electronic data interchange.\textsuperscript{209} An extension of electronic transfer is the centralization and integration of claims processing and data collection through a radical "electronic claims clearinghouse."\textsuperscript{210} States would electronically link providers and payers to a central computer clearinghouse through which all claims would be transmitted, services pre-authorized, and coverage verified electronically. New York has experimented with, and Maryland has enacted provisions to develop, such a system.\textsuperscript{211} This is nonetheless another statewide

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administrative reform that states may not mandate.

States wanting to enjoy the efficiencies of uniform claim forms and standardized billing procedures or electronic transfer systems and claims clearinghouses face obstacles similar to states adopting uniform data reporting. The bottom line is that they simply cannot impose a common form and procedures on self-funded plans. They may be able to overcome this bar, however, by exploiting the universal acclaim for uniform data reporting and claims procedures as reform strategies that can address both the real costs of, and symbolic concerns with, unnecessary paperwork and administrative hassles. The large potential benefits give states a tremendous opportunity to obtain universal voluntary compliance.

c. Malpractice Dispute Resolution in Managed Care Plans. The American system of resolving medical malpractice claims has long been criticized as inefficient and time-consuming, even though studies have continually shown that medical malpractice and defensive medicine account for less than one percent of the nation’s total health care tab. Washington and many other states proposed to address malpractice dispute resolution in their health care reforms. Minnesota’s HealthRight law contained medical malpractice reforms, and Vermont also planned medical malpractice reforms, including a plan to require all medical malpractice claims to go first through an arbitration system. States can clearly regulate standards of evidence, judicial procedures, statutes of limitations, and attorneys’ fees. They can also require that individuals use prescribed mediation or arbitration procedures before filing a malpractice suit and can use health professional licensing to compel providers to participate in such mechanisms.

ERISA may, however, limit state authority to regulate malpractice dispute resolution in managed care plans. Courts have held that the Act permits ERISA plan beneficiaries to file medical malpractice claims against physicians and hospitals in state court because such claims do not arise from an ERISA plan’s managed care design. In *Independence HMO, Inc. v. Smith*, for example, a district court found that ERISA did not preempt a patient’s state medical malpractice action even though she failed first to exhaust her internal plan remedies. The court found support in the Supreme Court’s statement in *Mackey v. Lanier Collections Agency & Service*.

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212. Malpractice is defined as "[h]armful or unprofessional treatment or neglect of a patient by a doctor or other medical provider." MARMOR, supra note 103, at 262.
ERISA plans may be sued in a second type of civil action, as well. These cases—lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan—are relatively commonplace. These suits, although obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA § 514(a).\[218\]

The district court determined that the state court tort suit in *Independence HMO* was a “run-of-the-mill” state law claim and, therefore, under *Mackey*, not preempted by ERISA.

While the Court has recognized that ERISA does not preempt every conceivable cause of action that may be brought against an ERISA-covered plan, the issue is less clear when the claim arises out of a health plan’s managed care features, such as utilization review or a requirement to use a plan’s preferred provider panel.\[219\] In *Corcoran v. United Healthcare Inc.*, parents whose unborn child died after their employee disability plan determined that the mother did not need to be hospitalized sued the plan’s utilization review services provider. Although the Fifth Circuit held that ERISA preempted the parents’ tort claim against the utilization review company, leaving them with no remedy,\[220\] it found this outcome troubling and noted that administrative strategies such as utilization review did not even exist when Congress passed ERISA:

Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts . . . .\[221\]

Until such reevaluation, however, the court promised to continue interpreting ERISA in a manner consistent with its framers’ expressed intentions, meaning that it will preempt tort claims against third-party services that a health plan employs as a managed care feature.

Thus, states can regulate most aspects of malpractice litigation and may

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218. *Id.* at 833.
219. *See* *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61 (D. Conn. 1990) (holding that ERISA preempts claims against dental health care plan administrator but not claim against dentist even though dental health care plan recommended dentist to subscribers); *Corcoran v. United Healthcare Inc.*, 965 F.2d 1321 (5th Cir. 1992) (holding that ERISA preempted Louisiana tort action for wrongful death of unborn child allegedly resulting from erroneous medical decision, by provider of utilization review services to disability plan, that mother did not need to be hospitalized).
220. Only one state has explicitly permitted a suit based on a utilization review company’s allegedly negligent decision about medical care to go forward. *See* *Wilson v. Blue Cross of So. California*, 271 Cal. Rptr. 876, 883 (1990) (reversing summary judgment in favor of utilization review company which determined that further hospitalization was not necessary; ERISA not implicated); *see also* *Wickline v. State of California*, 239 Cal. Rptr. 810, 819 (1986) (stating, in dicta, that negligent implementation of cost containment mechanisms such as utilization review can lead to liability; ERISA not implicated), *cert. granted*, 231 Cal. Rptr. 560, *review dismissed, cause remanded*, 239 Cal. Rptr. 805 (1987).
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even require consumers to pursue “traditional” allegations of medical negligence through nonjudicial means. Their ability to prescribe mechanisms to resolve disputes involving managed care requirements, however, is more limited. Consequently, patients may be able to file a claim in state court against an individual provider but not a managed care plan.222

2. Areas of Uncertainty

a. Insurance Market Reforms. As insurers have attempted to reduce premium growth—avoiding risk through experience rating (adjusting premiums to reflect past health care use) and strict underwriting (adjusting prices to reflect actuarially predictable differences due to age, sex, industry, and other factors), many states have enacted health insurance regulatory reforms to reinstate risk spreading and to make coverage more available and affordable. These access reforms, which alter the private health insurance market, are divisible into roughly three categories: medical high-risk pools; basic benefit or bare bones plans; and small-group insurance market reform.

High-risk pools separately insure the individuals most likely to face underwriting problems—those in poor health or considered at high risk of needing extensive care in the future. Bare bones plans compensate for the generally higher prices small groups pay by making a stripped-down benefits plan available to them at a lower price. Small-group insurance market reforms generally limit carrier practices while still allowing some underwriting. Collectively known as health insurance market reforms, these approaches may be used with respect to insurers, but ERISA prohibits their application to self-funded plans. Medical high-risk pools raise the most ERISA concerns, while small-group insurance market reforms raise virtually none.

Medical high-risk pools are especially likely to raise ERISA concerns because they can raise costs to self-funded plans. About half the states have comprehensive health insurance associations—high-risk pools—to make a standard major medical policy available to “uninsurable” individuals who cannot buy one through the regular market.223 Eligibility usually requires one or two rejections by standard plans, although some states use a list of conditions as well.


223. Roger Thompson, Ten Ways to Cut Your Health-Care Costs Now, NATION’S BUS., Oct. 1990, at 21. See also Kala Ladenheim et al., Health Care Reform: 50 State Profiles, INTERGOV’T HEALTH POL’Y PROJ. AT GEORGE WASHINGTON UNIVERSITY, July 1994, at 9 [hereinafter 50 State Profiles]. As of July 1994, 29 states had medical high-risk pools, if a Rhode Island study on the establishment of a high-risk pool and the phasing-out of the Maine pool are included. These states include: Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine (being phased out), Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oregon, Rhode Island (study), South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. Id. at 33-37.
When financed by a premium tax or assessment, the pools spread the excess financial risk of covering uninsurable individuals among all health insurance plans in the state. "Rules governing coverage differ from state to state. For example, some states won’t allow employers to move high-risk individuals into the pool; only the uninsured are admitted. Other states encourage it. Some state pools have waiting lists." To the extent that risk-sharing pools raise costs to insured employee health plans, one can argue that ERISA preempts them. As long as ERISA permits plans to self-fund, the health insurance market will remain fragmented, permitting healthier groups to remain out of community insurance pools.

Additionally, health insurance risk pool premiums—generally limited to a percentage above average premiums for comparable coverage—rarely cover actual costs. Connecticut is the only state that bases premiums for participants on the average group premium rate offered by other insurers in the state. Most pools operate at a financial loss, causing some states to freeze participation. In the past, Wisconsin and Maine subsidized participation in the pool for low-income persons. Arguing that these pools are unnecessary if the market spreads risk, Maine became the first state to phase out its high-risk pool as it phased in individual community rating in 1993.

Thirty-nine states have basic benefit or bare bones plans for small businesses. These low-option ("no frills") affordable policies are generally exempt from costly state benefit and provider mandates. "Typical mandates cover chiropractors, well-baby care, dental checkups, and treatment for alcohol and drug abuse. Some states require coverage for more exotic procedures, such as in vitro fertilization and acupuncture." Basic benefit plans may include high deductibles, low maximum pay-outs, and/or limited services.

The first states to offer such plans often made them available only for businesses that did not have prior coverage and specified what benefits would be covered. More recently, these plans have been incorporated into a commonly adopted set of insurance reforms that include requiring all carriers in the small-group market to offer standardized basic—as well as comprehensive—plans to permit package comparisons. Although ERISA problems are

224. Thompson, supra note 223, at 21.
227. 50 State Profiles, supra note 223, at 33-37. These states include: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Iowa (pilot), Kansas, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina (study), South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.
228. Thompson, supra note 223, at 27.
229. Id.
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minimal to nonexistent, generally low levels of interest on the part of employers and insurers have produced disappointing sales of basic benefits plans, perhaps due to the perceived inadequacy of the benefits they offer or to the availability of other coverage in the same niche.

Forty-four states have small-group insurance market reforms—laws regulating insurers to make it easier for small businesses to buy coverage for workers—that pass ERISA muster.

b. Stop-Loss Insurance. ERISA preemption of efforts to regulate stop-loss insurance carriers that share risk with self-funded health plans remains unclear. The Supreme Court has not addressed whether states may regulate the stop-loss insurance that many self-funded plans use to spread the risk of high-cost cases. The circuits appear to be split on state authority to do so. One federal appeals court has held that state-mandated benefit laws apply to stop-loss carriers (even though these laws indirectly affect self-funded ERISA plans). Another circuit has concluded that these laws do not apply to true stop-loss insurers. Until this difference is resolved, there is a question whether states can regulate stop-loss insurance designed to protect the plan from a catastrophic loss, though states would appear able to regulate stop-loss insurance designed to protect individual enrollees.

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231. 50 State Profiles, supra note 223, at 33-37. This number does not include the three states with "bare bones" policies (Alabama, Georgia, and Nevada). The states with small-group insurance market reform that use guaranteed issue (35 states) and community rating (19 states) include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

232. See generally Actuaries Report Success of Small-Group Market Reforms, Fed. & St. Ins. Wk., Apr. 4, 1994, available in WESTLAW, FEDSTINW, File No. 2536583. In a survey conducted at the request of congressional health care investigators, the American Academy of Actuaries reported that "[e]fforts by states to increase health insurance coverage of small businesses and other small groups have generally been successful." Id.

233. Stop-loss coverage is defined as "[i]nsurance by one insurer of all or part of a risk previously assumed by another insurer (or health plan). It is a form of backup insurance that reimburses a health plan (stops its losses) when the payments it makes exceed the expected outlays. Stop-loss coverage is also known as reinsurance or risk-control insurance." MARMOR, supra note 103, at 268.

234. Michigan United Food & Commercial Workers' Union v. Baerwaldt, 767 F.2d 308 (6th Cir. 1985), cert. denied, 474 U.S. 1059 (1986) (holding that stop loss insurers were required to offer the state's minimum benefits); See also General Motors Corp. v. California State Board of Equalization, 815 F.2d 1305 (9th Cir. 1987), cert. denied 485 U.S. 941 (1988) (holding that ERISA does not prohibit a state from taxing insurance premiums of stop-loss insurers).

235. Brown v. Granatelli, 897 F.2d 1351 (5th Cir. 1990) (holding that stop-loss insurance was not "sickness and accident" group or individual insurance under Texas law—and therefore not subject to the state's mandated benefits law—because a $30,000 stop-loss insurance policy protected the employer's plan from catastrophic loss, not individual employees from health care costs).
3. **Initiatives Not Preempted by ERISA**

a. **Managed Care Organization Regulation.** Health coverage increasingly is offered through managed care organizations—risk-bearing arrangements such as health maintenance organizations (HMOs) and nonrisk-bearing preferred provider organizations (PPOs). Unlike traditional health insurers, HMOs cover all medical needs, including routine preventive care, for a flat monthly fee typically less expensive than traditional health insurance. PPOs provide doctor and hospital services at a discount, usually ten to twenty percent. A PPO encourages its enrollees to choose doctors from its roster by setting no co-payments or deductibles for those doctors' services. Although PPOs do allow enrollees to see doctors not on the roster, enrollees who do so incur greater out-of-pocket expenses because co-payments and deductibles are imposed.

Under managed care, the HMO or other insurer coordinates all the medical services a person receives to eliminate duplication and control expenses. The choice of doctors is limited and the insurer reviews the doctors' orders—for tests, specialists, and so forth. Many health plans may simply include managed care features (e.g., prior approval for elective hospital admissions, second opinions for surgery, utilization review, case management, and discharge planning). As with many of the administrative strategies already discussed—required participation in state purchasing pools, mandatory uniform data reporting and claims procedures, and insurance market reforms—ERISA does not preempt regulation designed to target managed care mechanisms used by insurers but does preempt regulation that affects self-funded plans.

While designed to reduce costs and improve access to appropriate treatment, some managed care features—such as pre-hospital review, second surgical opinions, or a primary care gatekeeper who authorizes referral to diagnostic tests or physician specialists—have significantly frustrated both patients and providers. In response, several states have enacted managed care operations laws that regulate reviewers’ qualifications, appeals procedures, and publication of review standards. Although states can regulate managed care organizations, they cannot require self-funded plans, for example, to use state-

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236. Managed care is defined as follows: "A type of health care organization that means different things to different people. Sometimes it aims to control costs by using gatekeepers—primary-care doctors or caseworkers—to coordinate the use of medical services by patients. Managed-care networks usually are organized by insurance companies, employers, or hospitals. An example is the type of network run by HMOs, in which a patient sees one doctor who determines the medical care, both general and specialized, that he or she will receive. The patient’s access to medical services is thereby controlled." MARMOR, supra note 103, at 263.

237. See Thompson, supra note 223, at 22. HMOs come in four models: staff (physicians on the HMO’s staff); group (a group practice under contract to the HMO); individual practice associations (HMO contracts with doctors who practice in their own offices); and networks (a hybrid that combines one or more of the other three models).

238. Id.
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authorized managed care review organizations or to follow state-imposed review requirements. ERISA bars regulation by a state that wants to permit self-funded plans but regulate the conduct of their managed care activities.

Other laws regulating managed care organizations do not run afoul of ERISA because they fall within the insurance exemption. Seventeen states objecting to limited provider panels have adopted legislation requiring plans to include "any willing provider" so that physicians or pharmacists are not locked out of most of the insurer business in an area. The Supreme Court's *Travelers* decision does not do much to clarify how ERISA preemption of state laws might apply to "any willing provider" laws, as managed care plans and experts hoped it might. But some of the dicta appear to urge courts to lean in favor of state authority to establish "any willing provider" and other laws that govern provider networks. The ruling will make it harder to argue that state "any willing provider" laws have sufficient economic impact on ERISA plans to require preemption.

In *Stuart Circle Hospital v. Aetna Health Management*, 239 the Fourth Circuit held that ERISA does not preempt a Virginia statute that prohibits insurance companies from unreasonably discriminating in establishing PPOs because the law regulates the business of insurance. A few states also prohibit PPOs from requiring a physician gatekeeper to refer enrollees to other providers. Courts have upheld similar laws under ERISA's state insurance exemption. For example, in *Blue Cross & Blue Shield v. St. Mary's Hospital*, 240 the Supreme Court of Virginia held that a statute regulating the manner in which PPOs may be established and operated under preferred provider subscription contracts "regulated insurance" within the meaning of ERISA's preemption exception.

In *CIGNA Healthplan of Louisiana, Inc. v. State, ex rel.*, 241 however, a federal district court in Louisiana ruled that ERISA preempts a state "any willing provider" law aimed at HMOs, PPOs, and self-funded plans. The decision, however, came two weeks before the *Travelers* ruling and Louisiana's "any willing provider" law differs from some others in that it specifically mentions employer-sponsored benefit plans (especially those operated by self-funded employers), likely making it a fact-specific decision rather than a precedent-setting one.

Therefore, in a dispute over whether ERISA preempts a state's "any willing provider" law from barring a managed care practice, one can credibly argue that "any willing provider" laws govern the business of insurance, not employee health benefit plans, and as such are specifically saved from ERISA preemption.

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239. 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 114 S. Ct. 579.
III. CONCLUSION

President Clinton lost political leverage in Congress after the failure of his health care reform plan and a Republican landslide in last November’s elections. But it is premature to assume that health care reform is dead altogether. Instead, action has shifted to the states, where efforts are underway to expand coverage and control medical costs. In all, about 35 states already have enacted or are seriously deliberating reform legislation. \(^2\)

A number of states have enacted reforms which are conditioned upon receiving an exemption from ERISA. \(^4\) While amending ERISA on a case-by-case basis may have some advantages, this Note argues that it is possible for states to enact a number of financing, cost containment, and administrative strategies for health care reform without making any changes to ERISA. Although some states that have begun to implement their health care reform initiatives have encountered ERISA problems, legislative removal of ERISA barriers is not the most immediate answer. Rather, it is important for state health care planners to develop an informed understanding of the regulatory options available to them under ERISA. States can effectively draft health care reform initiatives to circumvent ERISA problems; ERISA has been more of a scapegoat than an actual roadblock.

For those health care reform commentators concerned that “the Supreme Court has not responded adequately to the modern realities of federalism,” \(^2\) \textit{Travelers} suggests a change of mind. Following the \textit{Travelers} ruling, those that challenge state laws under ERISA will have to clear a higher hurdle, proving that a particular law has a direct or extremely acute impact on benefit plans. Now, ERISA’s preemption will be upheld only when the state law forces a plan administrator to change a course of action or make a benefits-related decision that would not have otherwise been made. As a result state laws being challenged in several lesser-known lawsuits that have awaited the \textit{Travelers} decision are more likely to be upheld.

ERISA has always allowed states some flexibility to experiment with health care reforms. The \textit{Travelers} ruling has highlighted and broadened it. The case suggests that state laws affecting employee benefit plans will have to be judged individually on the facts and circumstances of each law. The nature and magnitude of the impact on employee benefit plans of each state law at issue will determine the outcome. Where the state law does not conflict with ERISA

\(^{242}\) State Profiles, supra note 223.
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objectives, it should survive legal challenge. The *Travelers* decision should give state health planners greater confidence that reforms can be crafted that will withstand legal challenge.