Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption

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In recent years, courts have applied the Employee Retirement Income Security Act of 1974 ("ERISA") to pre-empt an increasingly wide scope of state laws, with the effect of limiting remedies of plan participants and beneficiaries and frustrating state health care reform efforts. Professor Jordan argues that the recent Supreme Court decision in New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co. is a signal from the Court that ERISA pre-emption should be applied more narrowly. She first analyzes the Court’s prior pre-emption decisions and identifies delimiting language unheeded by lower courts. She then explores the impact of Travelers on ERISA pre-emption analysis, finding the decision renews emphasis on the historical presumption against pre-empting laws within state police power and takes a more pragmatic approach to discerning congressional intent regarding ERISA pre-emption. Finally, by examining certain emerging pre-emption issues, namely those involving provider taxes and contract and tort claims she assesses the effectiveness of the analytical framework derived from Travelers and prior Supreme Court cases in restraining the scope of ERISA pre-emption. Professor Jordan concludes that the framework can effectively restrain findings of pre-emption and should lead to more rational pre-emption decisions.

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Introduction

While critics have pointed to the failings of the American health care system for many years,¹ the adverse impact of the Employee Retirement

¹ In keeping with our general commitment to free-market capitalism, the U.S. health care system has evolved as an “industry” driven by economic incentives. At the same time, unique aspects of the health care industry preclude it from functioning as a free market. See generally PAUL J. FELDSTEIN, HEALTH CARE ECONOMICS (2d ed. 1983). Federal and state governments recognize the deficiencies of the free market in health care services and have tried to regulate the industry in order to cure them. In a much publicized example, the Clinton Administration proposed a comprehensive federal plan for health system reform in 1993. H.R. 3600, 103d Cong., 1st Sess. (1993), reprinted in 139 CONG. REC. 148, E2571-E2716 (daily ed. Oct. 28, 1993). However, strong for-profit entities have been largely successful in blocking legislative modifications to the
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Income Security Act of 1974 ("ERISA")\(^2\) on the health care system has only recently gained significant attention.\(^3\) Since its enactment in 1974, courts have gradually interpreted and applied ERISA in a manner that affects numerous aspects of the health care system. In particular, during the last decade serious obstacles for health care consumers have arisen as a result of broader application of ERISA's pre-emption provisions. This article explores the viability of expansive interpretations of ERISA pre-emption in light of the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*\(^4\)

Ascertaining the appropriate scope of ERISA pre-emption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. ERISA pre-empts all state laws that "relate to" an employee benefit plan.\(^5\) "Employee benefit plans" are defined to include plans established or maintained by an employer for the purpose of providing medical, surgical, or hospital care benefits.\(^6\) Regardless of whether the benefits are provided through a contract with an insurer, a health maintenance organization (HMO),\(^7\) or a self-funded plan,\(^8\) all health benefit plans obtained through a qualified employer\(^9\) are within the scope of ERISA.\(^10\) Yet, ERISA system, especially at the federal level.

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5. 29 U.S.C. § 1144(a) (1988) (ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .").


8. In self-funded plans, employers decline to contract with private insurance companies or HMOs and instead assume the risk of paying health benefit claims out of a pool of money set aside for that purpose. In some respects, self-insured employers thus operate much the same way that private insurance companies do. To handle claims management functions, however, employers often contract with third-party administrators.

9. ERISA directives do not apply to certain plans. These include governmental plans; church plans, excess benefit plans, plans maintained solely for the purpose of complying with applicable workmen's compensation, unemployment compensation or disability insurance laws, and plans maintained outside of the United States primarily for the benefit of persons who are non-resident aliens. 29 U.S.C. § 1003(b)(1)-(5) (1988).
prescribes only limited substantive regulation to ensure fair and equitable practices by employers, insurers and providers of health care. Thus, ironically, the ever broadening scope of ERISA pre-emption has come at the expense of the very participants in employee benefit plans whom ERISA was intended to protect.

For example, courts have construed ERISA pre-emption in a manner that leaves plan participants and beneficiaries without redress when those administering employer-sponsored health insurance plans act negligently and cause injury. In *Corcoran v. United Healthcare, Inc.*, the plaintiffs brought a wrongful death claim based on negligence committed in the utilization review process. The plaintiffs were insured through an ERISA plan administered by Blue Cross & Blue Shield ("Blue Cross"). Blue Cross contracted with the defendant United Healthcare to perform utilization review and thereby handle the preauthorization process. Despite the attenuated connection between the employer and United Healthcare, the Fifth Circuit held that ERISA pre-empted the negligence claim against United Healthcare for denying

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10. The scope of ERISA pre-emption is complicated by a savings clause, which excepts from pre-emption any law which regulates insurance, banking or securities. 29 U.S.C. § 1144(b)(2)(A) (ERISA shall not "be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."). See generally, Karen A. Jordan, *ERISA Pre-emption: Integrating Fabe into the Savings Clause Analysis*, -- Rutgers L.J. -- (forthcoming 1996). The pre-emption provisions also include a "deemer clause," which qualifies the savings clause by prescribing that employee benefit plans may not be characterized as an insurance company and regulated by the state through insurance laws. 29 U.S.C. § 1144(b)(2)(B) (an ERISA plan "shall [not] be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . . ."). Because of the savings clause, states can try to increase access to health care and control costs by enacting reforms in the health insurance market. However, the deemer clause seriously limits the reach of such reforms because it precludes application of such reforms to self-insured plans.

11. ERISA does not address many issues that have been at the heart of the recent health reform debate, such as pre-existing condition limits, universal coverage, and managed care. When it does address concerns of plan participants and beneficiaries, relief under ERISA is fairly circumscribed; claimants are limited to contractual relief. Punitive damages and extra-contractual damages such as damages for emotional distress are not available. 29 U.S.C. § 1132(a)(1)(B). See also William K. Carr & Robert L. Liebross, *Wrong Without Rights: The Need for a Strong Federal Common Law ofERISA*, 4 STAN. L. & POL'Y REV. 221 (Winter 1992-93); Norman Stein, *ERISA and the Limits of Equity*, 56 LAW & CONTEMP. PROBS. 71 (1993).

12. Congress enacted ERISA in 1974 to protect the interests of participants in employee benefit plans and their beneficiaries by requiring the disclosure and reporting of financial and other information, "by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b) (1988). However, ERISA's substantive protections focus on pension plans. There is virtually no substantive regulation directed at health benefit plans or other welfare plans.

13. 965 F.2d 1321, 1329-34 (5th Cir. 1992) [hereinafter *Corcoran*]. See infra notes 291-300 for more detailed discussion.
hospitalization—even though the plaintiffs were left without a remedy. A logical extension of Corcoran's rationale would similarly result in pre-emption of legislative regulation of the utilization review process, which many states have adopted in recent years in an effort to prevent negligent review procedures.

Moreover, the interests of health care consumers have been compromised by lower court decisions broadly construing ERISA as pre-empting significant aspects of state health reform efforts. ERISA has long been recognized as a barrier to state reform strategies—such as employer mandates or pay-or-play incentives—that require or encourage employers to provide health insurance. Similarly, although states can require insurers to provide standard benefits packages, ERISA's pre-emption provisions block such measures from benefiting many consumers by shielding employers who decide to self-insure from the application of such laws. Preclusion of these basic measures addressing the growing problems of uninsurance and underinsurance is significant, but arguably unavoidable due to Congress's express intent to leave control over employee benefits with the employer.

More recently, however, ERISA pre-emption has been used to challenge even those reform strategies that have a much more tenuous connection with employers: specifically, state efforts to alleviate the problem of "uncompensated" care provided by hospitals to the indigent and uninsured through a process of assessments on hospitals and proportionate redistributions; taxes imposed on health care providers which can be used...

14. Id. at 1333 ("[W]e are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefits plans . . . .").
17. See, e.g., Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733, 739-47 (1985) (although such laws "relate to" ERISA plans, laws regulating "insurance" are exempt from pre-emption through the savings clause).
to increase federal Medicaid matching funds;\textsuperscript{20} state laws regulating the formation of managed care organizations;\textsuperscript{21} and well-established hospital rate-setting programs designed to control rising health care costs.\textsuperscript{22} Strategies such as these are designed to address specific problems in our health care system, and pre-emption would leave states with few effective alternatives. Due to the tenuous connection with employers or ERISA plans, pre-emption of these state laws is questionable.

ERISA pre-emption has been extended to the point that state reform efforts may be seriously hindered. Yet, legislative modifications at the federal level aimed at adjusting the balance between the interests of ERISA plan participants, employers, and states coping with health care reform are unlikely. Rather, the trend at the federal level may be to extend the benefits ERISA provides to large employers which self-insure to smaller employers.\textsuperscript{23} It is therefore up to the judiciary to develop sound doctrines that ensure that ERISA pre-emption is kept within the bounds that Congress intended in 1974.

The Supreme Court recently had an opportunity to address the parameters of ERISA pre-emption in \textit{New York State Conference of Blue Cross \\& Blue Shield Plans v. Travelers Insurance Co.}\textsuperscript{24} In \textit{Travelers}, commercial insurers and an HMO association challenged New York's hospital rate-setting provisions. The rate-setting scheme directs hospitals to add surcharges to the bills of patients covered through commercial insurance or HMOs. The result is that some payers, such as Blue Cross and Blue Shield plans, incur lower hospital charges. The increased costs caused by the surcharges can be passed along to ERISA plans through increased premiums or subscription fees. Because of this indirect economic effect, the insurers and HMO association argued that the rate-setting provisions “related to” ERISA plans. The Supreme

\begin{thebibliography}{99}
\item \textsuperscript{21} See, \textit{e.g.}, Boyle v. Anderson, 849 F. Supp. 1307 (D. Minn. 1994) (addressing pre-emption of a 2\% provider tax enacted as part of Minnesota's Health Right Act).
\item \textsuperscript{22} See \textit{infra} notes 142-54 and accompanying text for detailed discussion of cases addressing ERISA pre-emption of these health care initiatives.
\item \textsuperscript{23} See, Speakers Differ Over Possible Health Care Amendments to ERISA, BNA \textit{HEALTH CARE DAILY}, Feb. 15, 1995, available in WESTLAW, 2/15/95 HCD d6.
\item \textsuperscript{24} 115 S. Ct. 1671 (1995) [hereinafter \textit{Travelers}].
\end{thebibliography}
Court held that this effect on ERISA plans did not warrant pre-emption.\textsuperscript{25}

More importantly, the Court's opinion in \textit{Travelers} can be construed as sending a signal for judicial restraint when determining whether state laws are pre-empted by ERISA. The Court's approach in resolving the issue in \textit{Travelers} and its emphasis on fundamental premises such as the presumption against pre-emption of health care regulations can be construed as suggesting that courts should engage in a more pragmatic and disciplined analysis of ERISA pre-emption issues. This article explores the scope of ERISA pre-emption after \textit{Travelers} and argues that many state laws found by lower courts to be pre-empted could not have been within the realm of Congress's intent in 1974. Proponents of broad ERISA pre-emption will undoubtedly disagree. However, a strong argument can be made that harmonizing \textit{Travelers} with Supreme Court precedent results in a framework for analyzing pre-emption questions that effectively ensures that ERISA pre-emption is restrained within the bounds that Congress intended in 1974.

This article first examines the Supreme Court's ERISA pre-emption cases before \textit{Travelers}, with the following goals: to define the categories of laws found to "relate to" ERISA plans; to identify statements that support liberal findings of pre-emption only if taken out of context; and to explore the Court's statements concerning the outer bounds of ERISA pre-emption. Second, the article analyzes the impact of \textit{Travelers} on the pre-emption analysis, explains how the opinion can be construed as a signal that the scope of ERISA should be restrained, and articulates a framework for the pre-emption analysis after \textit{Travelers}. Lastly, the article assesses the effectiveness of the \textit{Travelers} framework on restraining the scope of ERISA pre-emption by applying it to emerging pre-emption issues, namely cases involving provider taxes and contract and tort claims.

I. ERISA Pre-emption: The Scope of the Phrase "Relate To" Before \textit{Travelers}

Section 514(a) of ERISA prescribes that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."\textsuperscript{26} While the full scope of ERISA pre-emption is modified by the savings and deemer clauses,\textsuperscript{27} the outer bounds of ERISA pre-emption are guided by this key language. The split in the circuits that led to the \textit{Travelers} decision hinged on the proper application of this pre-emption phrase to the rate-setting provisions at issue. The Supreme Court has addressed the

\textsuperscript{25} See infra notes 155-86 and accompanying text for detailed discussion of the holding in \textit{Travelers}.
\textsuperscript{26} 29 U.S.C. § 1144(a) (1988).
\textsuperscript{27} See supra note 10.
scope of ERISA pre-emption in many cases, but had never held that an indirect economic impact on ERISA plans could alone justify a finding that a state law related to the ERISA plan. However, many lower courts had reached that conclusion by drawing upon the Supreme Court’s generally broad approach to ERISA pre-emption.28 This section of the article explains the prior Supreme Court pronouncements concerning the scope of the phrase “relate to,” as well as the application of the Court’s pronouncements by the courts of appeals in Travelers and United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.29

A. Supreme Court Pronouncements

Congressional intent is the ultimate touchstone of any pre-emption analysis.30 However, because of the separate spheres of governmental authority preserved in our federalist system, courts must presume that Congress did not intend to pre-empt traditional state regulation absent some clear indication otherwise.31 Congress’s intent may be “explicitly stated in the statute’s language or implicitly contained in its structure and purpose.”32 The Supreme Court recently clarified that, where an express pre-emption provision provides a “‘reliable indicium of congressional intent with respect to state authority, . . . there is no need to infer congressional intent to pre-empt state laws from the substantive provisions’ of the legislation.”33 ERISA contains an express pre-emption provision: ERISA supersedes state laws that “relate to” ERISA-covered plans.34 An initial issue, then, is whether the phrase “relate to” is a “reliable indicium” of Congress’s intent. Prior Supreme Court cases addressing questions of ERISA pre-emption have implicitly indicated that the phrase is not a reliable indicium. That is, the Court has always looked to the structure of the ERISA statute as a whole, as well as to the pre-emption provisions, and to ERISA’s legislative history.

ERISA was enacted in 1974 to protect the interests of participants in employee benefit plans and their beneficiaries by requiring the disclosure and reporting of financial and other information, “by establishing standards of

28. See, e.g., infra notes 341-46 and accompanying text (discussion of cases in which lower courts have held that indirect economic impact suffices for pre-emption).
32. Id. at 525.
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conduct, responsibility, and obligations for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to [the] Federal courts.\(^3\) ERISA's protections therefore address administrative concerns rather than provide any substantive right to benefits. According to the Court, the pre-emption provision was intended to assure uniform regulation that would minimize the inefficiencies associated with the administration of plans in more than one state.\(^6\) "Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations."\(^3\)

Despite the primary focus on administrative concerns, Supreme Court cases before Travelers broadly interpreted the phrase "relate to" as encompassing any state law that has "a connection with or reference to . . . a[n employee benefit] plan."\(^3\) The Court has stated that ERISA's pre-emption extends beyond state laws specifically directed at employee benefit plans or laws that deal with the subject matters covered by ERISA.\(^3\) ERISA may even pre-empt state laws that are consistent with ERISA's substantive requirements.\(^4\) Notably, however, the Supreme Court expressly acknowledged in its consideration of ERISA pre-emption prior to Travelers that the laws at issue did not present particularly hard questions. Rather, the laws either imposed a duty upon ERISA plans through express reference to ERISA plans in the state laws, or the laws impacted on ERISA plans directly, or if indirectly, in a substantial way. None of the laws caused only indirect economic effects on ERISA plans.

1. Laws Found to "Relate To" ERISA Plans

The Court has found many state laws to be within the scope of the phrase "relates to." Analysis of the cases reveals that, prior to Travelers, certain types of laws had been found to have a sufficient relation to ERISA plans to warrant pre-emption: laws that specifically apply to ERISA plans; laws that impose a duty on ERISA plans by referencing ERISA plans; laws that mandate specific

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39. FMC Corp. v. Holliday, 498 U.S. at 58-59 (limiting the pre-emption clause to state laws relating to specific subjects covered by ERISA would be incompatible with both Houses' rejection of pre-emption clauses that contained such a limitation).
benefit structures or prohibit a method of determining the level of benefits; or common law actions that are within the scope of ERISA's civil enforcement provisions.

The clearest case for pre-emption is found where state laws were designed specifically to apply to ERISA plans or where state laws directly or indirectly mandate that employers provide specific coverage to employees through their ERISA plans. Such laws are plainly inconsistent with Congress's intent. Thus, in Mackey v. Lanier Collection Agency & Service, Inc., the Court held that a Georgia statute which barred the garnishment of funds or benefits of an ERISA plan "related to" ERISA plans. The law was designed to and solely applied to ERISA plans. Similarly, in District of Columbia v. Greater Washington Board of Trade, a District of Columbia workers' compensation provision was found to relate to ERISA plans. The District of Columbia provision prescribed that employers who provide health insurance coverage for an employee must provide health insurance coverage equivalent to the existing coverage of the employee while the employee receives or is eligible to receive workers' compensation benefits. Thus, a duty was imposed on employers through the statute's reference to ERISA plans.

Several Supreme Court cases involved laws that were inconsistent with Congress's desire to leave all control with the employer over decisions about whether to offer benefits and, if so, what level of benefits to provide to employees. In Shaw v. Delta Air Lines, Inc., the Court found that the two state laws at issue related to ERISA plans: (1) human rights laws which prohibited employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy; and (2) disability benefit laws which required employers to pay sick leave benefits to employees unable to work because of pregnancy or other nonoccupational disabilities. Similarly, in Metropolitan Life Insurance Co. v. Massachusetts, the Court held that a state-mandated benefit law, which prescribed the substantive content of health insurance policies that insurers could offer, indirectly related to ERISA plans. The laws in these cases mandated specific benefit structures.

41. 486 U.S. 825, 829-30 (1988) (pre-empted because the statute "referenced" ERISA plans, and was specifically designed to affect such plans).
42. 113 S. Ct. 580 (1992).
43. Id. at 583. Justice Thomas expressly held that the D.C. statute specifically "refers to" welfare benefit plans regulated by ERISA and on that basis alone was pre-empted. In his dissenting opinion, Justice Stevens noted that although the Supreme Court had previously stated that a law is within the scope of the phrase "relates to" if it has a connection with or "reference to" such a plan—"until today that broad reading of the phrase has not been necessary to support any of this Court's actual holdings," Id. at 586 (Stevens, J., dissenting).
44. 463 U.S. 85, 96-97 (1983) (related to ERISA plans because the laws mandated benefits).
45. 471 U.S. 724, 739 (1985) (related to ERISA plans because a mandated benefit requirement bears indirectly but substantially on all insured benefit plans).
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Other laws considered by the Court have affected the administrative practices relating to calculating benefits for ERISA plans. Because of Congress's concern for preventing administrative inefficiencies in plan operations, the Court has readily found such laws to relate to ERISA plans. For example, in *FMC Corp. v. Holliday*, the Court held that a Pennsylvania provision precluding a right of subrogation or reimbursement from a claimant's tort recovery with respect to benefits payable from health benefit plans related to ERISA plans. Similarly, a provision in New Jersey's workers' compensation act which prohibited employers from setting-off amounts received through workers' compensation against retirement pension benefits was found to relate to ERISA plans in *Alessi v. Raybestos-Manhattan, Inc.*

The state laws in *FMC Corp.* and *Alessi* were viewed as eliminating one method of calculating benefits. For example, each law would affect an employer's decision to limit the level of benefits provided by way of offsets or subrogation. The laws would not require the employer to provide a greater level of benefits because the employer could simply select an alternative method to limit benefits, such as estimating the annual amounts involved and correspondingly lowering benefit levels across-the-board. Thus, the laws merely complicated the means of calculating the level of benefits which the employer wished to provide. This type of regulation readily falls within the scope of Congress's concern about administrative inefficiencies because the employer would be required to calculate benefits differently in certain states.

Lastly, because the definition of "State law" encompasses "all laws, decisions, rules, regulations, or other State action having the effect of law," the Supreme Court has held that ERISA pre-empts two state law causes of action. In *Pilot Life Insurance Co. v. Dedeaux*, the Supreme Court readily determined that ERISA pre-empted state common law tort and contract claims based on allegedly improper processing of a claim under an insured employee benefit plan. The Court in *Pilot Life* stressed that the state claims essentially

46. 498 U.S. 52, 59-60 (1990) (antisubrogation law contained a "reference" to benefit plans and had a connection with such plans because it posed the risk of subjecting plan administrators to conflicting state regulations) [hereinafter *FMC Corp.*].
47. 451 U.S. 504, 524 (1981) (the law "related to" an ERISA plan because it eliminated a method of calculating pension benefits that is expressly permitted by ERISA) [hereinafter *Alessi*].
48. In *FMC Corp.*, 498 U.S. at 59-60, the Court found a sufficient connection with ERISA plans because such state laws would complicate the administration of nationwide plans by requiring an employer to consider state law when designing the plan. Employers would have to calculate benefit levels in the states based on expected liability conditions that differ from those in states without similar anti-subrogation legislation. The Court stated that pre-emption was proper where a patchwork scheme of regulation would introduce "considerable inefficiencies" in benefit program operation.
50. 481 U.S. 41 (1987) [hereinafter *Pilot Life*].
51. Id. at 47-48.
sought relief within ERISA's civil enforcement provision; i.e., the action was a claim for benefits under the plan.\textsuperscript{52} The Court stated that subjecting employers to varying state causes of action for claims within the scope of ERISA's enforcement provision\textsuperscript{53} would pose an obstacle to the objectives of Congress.\textsuperscript{54}

More recently, in \textit{Ingersoll-Rand Co. v. McClendon},\textsuperscript{55} the Court examined a state common law action for wrongful discharge. The Texas courts had created an exception to the doctrine of at-will employment where an employee was unlawfully discharged primarily because of the employer's desire to avoid contributing to or paying benefits under the employee's pension fund. The Court held that the cause of action was within the scope of ERISA's pre-emption clause because the existence of an ERISA plan is a critical factor in establishing liability under the newly created cause of action.\textsuperscript{56} However, the Court was also influenced by the fact that the action purported to provide a remedy expressly prescribed by ERISA's enforcement provisions.\textsuperscript{57}

In sum, laws that have been found to be within the scope of ERISA pre-
emtion are generally: (1) laws that specifically apply to ERISA plans, or which impose a duty on ERISA plans by referencing ERISA plans; (2) common law actions that are within the scope of ERISA's civil enforcement provisions; or (3) laws that mandate specific benefit structures or prohibit a method of determining the level of benefits. Further, the purpose of the laws found to be pre-empted was generally to impose a benefit-related requirement upon employers. 58

However, in reaching its decisions in the pre-emption cases, the Court sometimes made statements that, if taken out of the context of the entire case, would arguably support pre-emption of other types of laws. For example, in Mackey v. Lanier Collection Agency & Service, Inc. 59 and Greater Washington Board of Trade, 60 the Court emphasized that the statutes at issue “referred to” ERISA plans. In Ingersoll-Rand the Court made the statement that, “[b]ecause the court’s inquiry must be directed to the plan, this judicially created cause of action ‘relates to’ an ERISA plan.” 61 Further, in Fort Halifax Packing Co. v. Coyne, discussed in the following section, the Court noted that pre-emption may be appropriate where state laws cause inefficiencies in the administrative scheme that might cause employers to reduce benefits or to refrain from creating plans. 62 Yet the force of these statements is generally tempered by thorough and careful scrutiny of the cases. For example, in Greater Washington Board of Trade, the Court arguably clarified its prior statements that “reference to” a plan warrants pre-emption. The Court stated that “any state law imposing requirements by reference to such covered programs must yield to ERISA.” 63 Thus, a mere reference is not sufficient—the consequence of the reference must be to impose a benefit-related duty.

Parties challenging laws as being pre-empted, however, have relied on this dicta as well as the Court’s generally sweeping pronouncements that Congress intended the phrase “relate to” to be given a broad interpretation, and have been very successful in convincing lower courts that a multitude of other types of state laws are pre-empted as well. Most troubling is the increasing pre-emption of state common law causes of action against insurers,

58. E.g., Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) (state law mandated sick leave benefits); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (state law mandated mental health benefits); FMC Corp. v. Holliday, 498 U.S. 52 (1990) (purpose of law precluding subrogation from a tort claimant’s recovery was to prevent employers or insurers from depriving claimants of benefits of tort litigation). The purpose of these laws is distinguishable from the purpose underlying the state law at issue in Travelers which was enacted to promote health policy objectives. See infra notes 107-20 and accompanying text.
60. 113 S. Ct. 580, 583 (1992) [hereinafter Greater Wash. Bd. of Trade].
HMOs, and even providers of health care, grounded in negligence or malpractice. The appropriateness of pre-emption of such laws is questionable, especially given the fundamental premise that state laws within the traditional police power should not be pre-empted absent clear congressional intent.

The questionable nature of pre-emption in such cases is evidenced by the inconsistency in lower court opinions resulting from a few courts which have refused to find pre-emption. The following section demonstrates that the continuing trend of broadening ERISA pre-emption is not required by Supreme Court pronouncements, and indeed, may be a consequence of superficial scrutiny of Supreme Court cases and of the underlying rationale for pre-emption.

2. **Limitations on the Scope of the Phrase “Relate To”**

The Supreme Court acknowledged in virtually all of the cases outlined in the preceding section that the determination whether the particular state laws at issue "related to" ERISA plans was not difficult. Thus, although the Court has often reiterated that there is a limitation to the broad reach of ERISA's pre-emption, the Court has never been required to clarify the outer bounds of the phrase "relate to." The limitation was first mentioned in a footnote in *Shaw v. Delta Air Lines, Inc.*: pre-emption does not occur if the state law has only a "tenuous, remote, or peripheral" connection with covered plans. However, only two cases prior to *Travelers* involved state laws that the Court held did not "relate to" ERISA plans.

In *Mackey v. Lanier Collection Agency & Service, Inc.*, the Court concluded that ERISA pre-emption does not bar a proceeding against a plan under a state's general garnishment statute, even though plan trustees are


65. Indeed, the inconsistencies in lower court opinions could be described as demonstrating utter confusion on the pre-emption issue.


67. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (citing American Tel. and Tel. Co. v. *Merry*, 592 F.2d 118, 121 (2d Cir. 1979) (state garnishment of a spouse's pension income to enforce alimony and support orders is not pre-empted)). *See also* *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1.

68. 486 U.S. 825 (1988) [hereinafter *Mackey*].
served with a garnishment summons, become parties to a suit and must respond and deposit the demanded funds due to the beneficiary debtor. The Court was influenced by language in ERISA and by procedural considerations. Because ERISA expressly prescribes that plans may "sue and be sued," the Court determined that Congress must have contemplated the execution of judgments won against plans. Yet ERISA does not prescribe a procedure for execution of judgments, and the Federal Rules of Civil Procedure direct courts to defer to state law. The Court therefore found that state law methods for collecting judgments must, as a general matter, remain undisturbed by ERISA.

*Mackey* demonstrates that a law can have a "tenuous, remote, or peripheral" connection with covered plans even if the law causes substantial administrative burdens and economic effects on ERISA plans. The Court was not persuaded by the dissent's recitation of burdens such as identifying participants who owe money to the garnishor, calculating participants' maximum entitlements from the plan funds, determining particular amounts owed to the garnishor, making payments into state court, assessing the validity and priority of garnishments, litigating garnishment issues, and being subject to multiple garnishment orders under various state laws. The Court's holding therefore reflects a pragmatic approach to assessing congressional intent regarding the scope of ERISA pre-emption.

*Fort Halifax Packing Co. v. Coyne*, presented an easier case for the Court. The case involved a state law requiring employers to provide a one-time severance payment to employees in the event of a plant closing. The Court held that the law was not within the scope of the phrase "relate to" because, although the law related to "benefits," it did not relate to ERISA "plans," i.e., the employer's obligation was to make a one-time, lump-sum payment which would not require an ongoing administrative program. Thus, the Court did not have to elaborate on the outer bounds of the phrase "relate to." Nonetheless, the Court did so by explaining that pre-emption should further

69. *Id.* at 831-32.
70. *Id.* at 833. Under § 502(d), a plan may sue and be sued, both as to actions pursuant to § 502 as well as run-of-the mill state law claims, including actions for torts committed by an ERISA plan. 29 U.S.C. § 1132(d) (1988 & Supp. 1992).
71. 486 U.S. at 833. The Court also cited language of ERISA indicating that Congress did not intend to bar state law attachment of plan benefits. *Id.* at 835-37 (citing § 206(d)(l)).
72. See FED. R. CIV. PROC. 69(a) (in the absence of an applicable federal statute, "[the procedure on execution . . . shall be in accordance with the practice and procedure of the state in which the district court is held . . . "]).
73. 486 U.S. at 833-34.
74. *Id.* at 842 (Kennedy, J., dissenting).
75. *Id.* at 842 (Kennedy, J., dissenting).
76. 482 U.S. 1 (1987) [hereinafter *Fort Halifax*].
77. *Id.* at 12.

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Congress's purpose in enacting ERISA's pre-emption provisions. The Court reiterated that Congress's fundamental purpose for enacting ERISA was to ensure the administrative integrity of ERISA plans, and that the purpose of pre-emption was to ensure that employers and sponsors were subject to a uniform set of regulations regarding administrative practices, thereby preventing inefficiencies in the administrative scheme of a plan which might lead some employers to reduce benefits or to refrain from creating plans. Further, the Court noted that administrative obligations relevant to ERISA plans include determining eligibility, calculating benefit levels, making disbursements, monitoring plan funds, and record keeping.

Thus, the Supreme Court's notion of administrative practices relevant to the pre-emption question encompasses practices directly related to providing benefits—i.e., health care coverage—to plan participants or beneficiaries. This is supported by the holding in Mackey that other practices or functions—even substantial ones—performed by administrators of a plan are not always relevant to the question of pre-emption. Because the state law at issue did not raise the types of concerns that prompted ERISA pre-emption, holding that the law was not pre-empted was justified even though the law required employers to provide a benefit to employees and thereby could potentially cause some employers to consider a reduction in other benefits to offset the severance pay.

Together, Mackey and Fort Halifax indicate that use by lower courts of broad statements in the Court's dicta to justify pre-emption may be unfounded in many cases. For example, although the Court has stated that pre-emption may be appropriate where state laws cause inefficiencies in the administrative scheme that might cause employers to reduce benefits or to refrain from creating plans, Mackey and Fort Halifax suggest that the scope of the relevant administrative scheme may be fairly narrow. Further, if the burden placed on plan administrators in Mackey did not warrant pre-emption, pre-emption cannot be justified merely because a court may need to look to plan documents to resolve the claim. Instead, both Mackey and Fort Halifax suggest a pragmatic approach to drawing the line delimiting whether a state law has a "tenuous, remote, or peripheral" connection with ERISA plans or whether the law "relates to" ERISA plans. That is, to determine the outer bounds of ERISA pre-emption, courts must accord due regard to traditional state regulation, and carefully balance the promotion of ERISA objectives with the practical consequences of a finding of pre-emption.

78. Id. at 15.
79. Id. at 9-11.
80. Id. at 9.
81. See e.g., id. at 11.
82. See also infra notes 248-59 and accompanying text.
B. Inconsistencies in Applying Supreme Court Precedent

Despite the fact that the Court has reiteratd numerous times that its holdings do not reflect the precise boundaries of ERISA's pre-emption clause, lower courts have latched onto the Court's broad language and have extended ERISA's pre-emptive effect much further than is required by the Supreme Court's holdings. Yet courts have generally failed to engage in a critical analysis of the Court's decisions. In particular, they have failed to heed the Supreme Court's signals to use a pragmatic approach in finding the line delimiting ERISA pre-emption. Instead, courts often find pre-emption because enforcing the law might require "looking at plan documents" or because the law in some way affects "administration of the plan." Further, where a state law has the potential to have some economic effect on ERISA plans, lower courts have justified pre-emption by noting that the state law might cause employers to reduce benefits or to refrain from creating plans. And perhaps most troubling, some lower courts have tended to accord very little deference to the fact that the state law at issue may be one within an area of traditional state regulation.

As a result, ERISA's negative impact on the health care system has become intolerable. In addition to state laws such as those at issue in the Supreme Court cases, lower courts have found the following state actions pre-empted: actions by plan participants alleging fraudulent misrepresentation of the level of benefits under a policy; actions alleging that insurers' conduct violated insurance related statutes or common law doctrines; actions by plan participants injured by negligent commission of utilization review procedures; actions by health care providers against plan administrators for inducing the provision of services by wrongfully failing to inform them that reimbursement would not be available; malpractice actions by plan

84. See, e.g., Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., 947 F.2d 1341, 1350 (8th Cir. 1991).
85. See, e.g., Farlow v. Union Cent. Life Ins. Co., 874 F.2d 791 (11th Cir. 1989) (rejecting state action where plaintiff claimed insurer negligently failed to disclose that its policy did not provide maternity and pregnancy coverage and fraudulently misrepresented the fact that the policy's coverage was coextensive with the claimant's former policy).
86. See, e.g., International Resources, Inc. v. New York Life Ins. Co., 950 F.2d 294, 298-301 (6th Cir. 1991) (pre-empting state actions based on tort of bad faith insurance practices, common law prohibition on insurance policy once liability has attached, and code provision prohibiting unfair and deceptive practices in the business of insurance). However, the claim that the conversion policy did not conform with state statute was not pre-empted. Id.
87. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992).
participants or beneficiaries against providers; and actions for vicarious or direct negligence against managed care organizations.

Moreover, state reform provisions, innovative as well as established practices, are now at risk of pre-emption. In addition to rate-setting legislation such as that in issue in *Travelers*, long a key component of state health policy as a cost containment mechanism, provider taxes, used to increase federal funds for Medicaid programs, and assessments collected from and redistributed to hospitals to compensate for the cost of providing care to those unable to pay, have been challenged and often caught in ERISA's pre-emptive web.

And where pre-emption of the law has left a plaintiff without a remedy for often blatantly unjust conduct by a defendant such as an insurer, an HMO or a provider of care, lower courts often recite the Supreme Court's statement that lack of a remedy does not justify permitting the action to proceed. In many of these cases, pre-emption was based at least in part upon the indirect economic impact on ERISA plans. Courts have found it sufficient for pre-emption that a state law causes an increased cost that may be passed on to a plan, thereby perhaps prompting an employer or plan sponsor to reduce benefits. Given the limitations of the Supreme Court cases, however, inconsistencies have inevitably arisen.

The split in the Circuit Courts on the issue of whether ERISA pre-empts state hospital, rate-setting schemes such as those in New York and New Jersey is a prime example of inconsistent interpretation of Supreme Court precedent. In *Travelers*, the Second Circuit held that New York's rate-setting provisions were pre-empted. Moreover, the Second Circuit expressly declined to follow the Third Circuit's holding in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital*, which held that New Jersey's substantially similar rate-setting scheme was not pre-empted. The

92. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1333 (5th Cir. 1992). See also infra notes 290-321 for a discussion of the appropriateness of this justification.
following subsections describe the state laws at issue in these cases and explain the courts’ underlying rationales.

1. The Hospital Rate-Setting Legislation at Issue

The rate-setting provisions at issue in Travelers and United Wire share the key characteristic of being based on the diagnosis-related group (DRG) methodology developed for use by the Medicare program. The DRG methodology is a case-based system which requires hospitals to charge fixed rates for each patient treated, based upon the patient’s diagnosis rather than on the actual cost of the services.96 The rate for services is therefore determined prospectively, rather than through a retrospective review of hospital charges. Further, the DRG rate for hospital services is an average rate and therefore often lower than actual charges would be.97 Both systems also differentiated among types of payer.

The in-patient hospital reimbursement system used by the state of New York98 sets the rates that hospitals may charge various payers. Travelers Insurance and other commercial insurers instituted the challenge99 to the rate-setting scheme because it requires hospitals to charge a higher rate when billing commercial insurers than when billing other payers. New York’s reimbursement system categorizes payers into three groups. The first consists of state government as payer for Medicaid patients, Article forty-three corporations (e.g., Blue Cross & Blue Shield plans) and HMOs.100 The second group consists of self-insured funds that pay hospitals directly, and

96. The DRG rate in New York is determined by the State Department of Health. N.Y. PUBLIC HEALTH LAW § 2807-c(3) (McKinney 1994 & Supp. 1995). Similar to the DRG reimbursement system used by Medicare, the DRG rate which a hospital may charge is based upon the cost of treating an average patient with a particular primary diagnosis. Id. Under the Medicare DRG system, each diagnosis falls into one of 491 categories, known as diagnostic related groups. Each category is assigned a weight which reflects the intensity of treatment required for an average patient with that primary diagnosis. Hospitals thus receive a predetermined amount for the care rendered to each patient, regardless of the actual resources expended. The system is a cost containment measure because it creates an incentive for hospitals to use their resources efficiently. See generally MARK A. HALL, HEALTH CARE CORPORATE LAW, FINANCING AND LIABILITY §2.2.3 (1994).


99. The commercial insurers, as fiduciaries for ERISA plans, brought suit against Mario Cuomo (the State) and New York Conference of Blue Cross and Blue Shield Plans et al. intervened. The New York State Health Maintenance Organization Conference also joined the action. All parties to the proceeding before the Supreme Court appear in the caption of the decision of the United States Court of Appeals for the Second Circuit. See 14 F.3d 708 (2d Cir. 1993).

100. N.Y. PUBLIC HEALTH LAW § 2807-c(1)(a) (McKinney Supp. 1995).
certain licensed commercial insurers.101 The third group consists of all other payers, including self-pay patients, patients covered by self-insured groups that do not make direct payments to hospitals, and patients covered by commercial insurance policies that do not pay on an expense incurred basis.102

The reimbursement scheme regulates what the hospitals must charge payers on the basis of the category which the payer falls into. Category three is the least regulated—hospitals may charge these payers the actual hospital charges subject only to a statutory limit.103 Hospital charges to payers in the other two categories are determined by use of the DRG methodology. Payers in category one are charged only the DRG rate.104 In contrast, payers in category two, such as commercial insurers, must be charged the DRG rate plus a 13% surcharge.105 In addition, from April 1992 through March 1993, hospitals were required to charge payers in category two an additional 11%.106 The rate-setting system also imposes an additional 9% assessment upon HMOs that fail to enroll a target number of Medicaid patients.107

It is notable that New York's rate-setting scheme was explicitly designed to achieve specific health policy objectives, in particular, to help ensure the continued viability of plans such as Blue Cross & Blue Shield and HMOs, whose underwriting practices enable higher risk individuals to obtain affordable health coverage. Further, this system merely evolved from the practice established in the private health care market. Specifically, the use of the 13% differential evolved from non-regulatory, market-initiated practices which had existed for years in support of Blue Cross and Blue Shield plans.

Some historical information is relevant to an understanding of New

101. That is, those whose coverage is based on all hospital services rendered. This category also includes volunteer firefighters and volunteer ambulance companies, and no-fault insurance. Id. § 2807-c(1)(b).
102. Id. § 2807-c(1)(c). Thus, the rate-setting scheme reaches all payers except those provided to Medicare beneficiaries.
103. The statutory limit is 120% of the rate charged to payers in category two. Id. § 2807-c(1)(c).
104. However, HMOs are permitted to negotiate their payments to the hospital. Id. § 2807-c(2)(b)(i).
105. Id. § 2807-c(1)(b). The result is a rate that is 113% of the DRG rate.
107. N.Y. PUBLIC HEALTH LAW § 2807-c(2-a) (McKinney Supp. 1995). Notably, the HMOs that are parties to the action challenged only this 9% differential; they took no position on the 13% differential. Unlike the other aspects of New York's reimbursement system, the 9% assessment does not impact the amount a hospital may charge an HMO, but, instead, is assessed against the aggregate costs of in-patient hospital care that HMOs pay on behalf of their non-Medicaid members. The 9% assessment is remitted to an agent of the state, who then deposits the money into New York's general fund. The 11% differential, although charged by the hospitals, is also ultimately deposited in New York's general revenues. Hospitals keep the 13% differential. See Brief for Respondents New York Health Maintenance Organization Conference at 2, Travelers, 115 S. Ct. 1671 (No. 93-1408).
York's rate-setting system. In the early twentieth century, private insurance companies were hesitant to issue indemnity insurance because of concerns such as actuarially unpredictable claims and moral hazard. Thus, in the 1930s and 1940s, the American Hospital Association, along with state and local hospital groups sought to assure access to increasingly expensive health care by creating a prepayment system similar to insurance. The hospital groups devised what are known as “service-benefit” plans, i.e., the Blue Cross and Blue Shield plans. Health service benefit plans are in essence contracts with providers, whereby providers agree to provide services to plan subscribers who pay a premium; Blue Cross and Blue Shield plans are underwritten by hospitals and physicians—not insurers—and are issued by not-for-profit health services corporations.

When they emerged, service benefit plans served the increasingly important social function of collective payment of health costs. Thus, in order to foster the growth of the Blues, federal and state legislators exempted health service corporations from general insurance laws and from federal taxation on their income and premiums. In return, the health services corporations had to structure their plans according to certain standards. For example, the plans were required to be open to the whole community through open enrollment and community rating, and to offer “freedom of choice” to both provider and subscriber. Blue Cross and Blue Shield plans were thus able to achieve important social objectives. An open enrollment policy ensures that persons with pre-existing health conditions, the elderly, and other more risky persons will be able to obtain coverage. Community rating renders coverage more affordable because premiums are based on the overall experience of the community, rather than a particular subscriber’s experience. The Blues also provided an important economic factor. Blue Cross plans offer prompt payment to providers and cash advances, thereby providing funds for capital expenditures.

In exchange, and in addition to the exemptions from taxation and insurance regulations, Blue Cross plans historically received substantial

109. Sponsors of Blues sought to provide an alternative to government financing, to secure reimbursement for providers, and to meet the growing public need for collective prepayment. Id. at 17-20.
111. Annas et al., supra note 108, at 18.
112. Id. That is, any hospital must be allowed the freedom to join the plan and any subscriber must have the freedom to choose any participating hospital. The plans were also required to ensure that a majority of the directors of service-benefit plans were representatives of the hospital industry. Id.
113. Brief for Petitioners Blue Cross & Blue Shield at 11, supra note 106.
discounts from hospitals. These discounts, in turn, enabled the Blues to compete with private insurance companies which emerged in the health market after observing the success of the Blues. Commercial insurers have always been more profit-seeking than the Blues. They have never adopted a philosophy of assuring coverage to an entire community, but instead, seek to avoid insuring high risk individuals. By insuring mostly low risk individuals, commercial insurers could price their product more competitively. The non-regulatory, market-initiated hospital discounts to Blues plans helped to offset the competitive advantage of commercial insurance.

The rate-differentials in New York's rate-setting provisions were designed to continue the discounts which the Blues received from the hospitals. In response to a recommendation of the legislatively created Council on Health Care Financings, the New York legislature incorporated the use of differential rates, although at a lower level than had been the practice in the marketplace. Finding a continued justification for a differential, the New York legislature maintained the differential at 13% in rate-setting legislation in both 1990 and 1993. For similar reasons, the New York reimbursement system used the additional 11% differential from April 1992 through March 1993 due to the increasing use of risk selection by commercial insurers which resulted in increasingly higher claims costs for the Blues. As the insurers captured the safer risks in a community, the Blues were left with an increasingly high risk pool of subscribers. The additional 11% was charged only for one year because in April of 1993, legislation went into effect that

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114. Id.
115. Id. Another significant factor in the emergence of commercial insurers was the Internal Revenue Services decision in 1943 that employer contributions to group health insurance were exempt from the employee's taxable income. ANNAS ET AL., supra note 108, at 19.
117. Notably, New York did not engage in government-initiated rate-setting until 1969, when the legislature enacted the Hospital Cost Control Law. Brief for Petitioners Blue Cross and Blue Shield, supra note 106, at 11-12 (citing 1969 N.Y. Laws, ch. 957, 2). Early legislation regulated only the charges to Medicaid and Blue Cross, for the express purpose of permitting those payers to continue meeting a legitimate social need. Rate-setting was extended to all payers in 1983. The all-payer reimbursement system was known as the New York Prospective Hospital Reimbursement Methodology. See id. at 7-13; Brief for Petitioners Hospital Association of New York State at 3-9, (No. 93-1415).
118. The difference between the lower regulated rates and the rates which hospitals could charge other payers ranged between 25% and 40%. See Brief for Petitioners Blue Cross and Blue Shield, supra note 106, at 12-13.
119. The statutory limitation on the differential was initially set between 12% and 15%. From 1986-1987, the reimbursement system limited the differential to 12%. The legislature adopted the DRG-based system in 1988, along with the 13% differential. Continued use of a differential in favor of Blue Cross plans was premised upon (1) prepayment to hospitals by the Blues, which provides working capital and costs savings to hospitals; and (2) social policy factors such as the Blue Cross coverage practices which make insurance available and affordable and which provide indirect financial support to hospitals by averting bad debts. See id.
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required all insurers offering policies to individuals and small groups to do so on a community rated and open enrollment basis.\textsuperscript{120}

HMOs are in the same category as Blue Cross & Blue Shield plans. HMOs also help meet significant economic and social objectives. Although HMOs have existed since the 1930s, their use did not proliferate until recent years when, because of the steep increase in costs of health care in the 1980s, employers and other sponsors of health care sought out alternatives to traditional indemnity insurance.\textsuperscript{121} Although the differences between commercial insurance and coverage through HMOs are blurring, HMOs are not insurers. Rather, HMOs provide or arrange for care through a variety of contractual arrangements with physicians and other providers, including institutional providers such as hospitals.\textsuperscript{122} The coverage offered through HMOs is often more comprehensive than that available through commercial insurers, with an emphasis on primary and preventive care.\textsuperscript{123} In addition, coverage is more affordable. Premiums for HMO coverage are typically below the cost of commercial insurance, and HMOs require few out-of-pocket expenses and impose only minimal co-payments or deductibles.\textsuperscript{124} HMOs, like Blue Cross and Blue Shield plans, have benefited from various enabling provisions.\textsuperscript{125} In return, HMOs have often been required to meet certain obligations, such as the use of open enrollment and community rating policies.

\textsuperscript{120} The 13% differential was retained, however, because the health insurance reforms could not redress all of the inequities in the insurance market. \textit{Id.} at 9 n.8.

\textsuperscript{121} \textsc{Anna\textsc{s} et al.}, \textit{supra} note 108, at 777. See also \textsc{Health Insurance Association of America, Source Book of Health Insurance Data} 19-20 (1990) [hereinafter HIAA Source Book].

\textsuperscript{122} An HMO is an organization in which the HMO itself and/or participating physicians accept contractual responsibility to assure the delivery of a stated set of health care services, including ambulatory and in-hospital care to a voluntarily enrolled population in exchange for an advance capitation payment; the HMO assumes at least part of the financial risk and/or share in the surplus. Randall Boubjerg, \textit{The Medical Malpractice Standard of Care: HMOs and Customary Practice}, 1975 DUKE L.J. 1375, 1376 n.1 (1976) (quoting \textsc{Health Services Information}, Oct. 20, 1975, at 2).

\textsuperscript{123} See Gayle L. Holland, \textit{HMOs Member Physicians Assuming the Risk of Loss Under State and Federal Bankruptcy Laws}, 15 J. LEG. MED. 445, 446-51 (1994) (in return for a fixed fee, the HMO provides unlimited health care). See also HIAA SOURCE BOOK, \textit{supra} note 121 at 33, Table 2.17.

\textsuperscript{124} For example, in 1989, the average monthly premium for coverage under a conventional insurance policy was $119 for an individual and $268 for family coverage. HIAA SOURCE BOOK, \textit{supra} note 121 at 16. In contrast, HMO coverage cost $108 per month for an individual, and $272 for a family. \textit{Id.}

\textsuperscript{125} \textit{E.g.}, the Federal HMO Act of 1973, 42 U.S.C. § 300e (1988), was enacted to encourage the development of HMOs. The Act authorized grants and subsidized loans to meet start-up costs, and ensured access to consumers.

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as well as maintenance of quality of care.\textsuperscript{126}

HMOs are distinct from the Blues in that they are often more profit oriented.\textsuperscript{127} HMOs are providers of care and, like other providers, many are for-profit. Like many for-profit entities, HMOs may resist contracting with purchasers whose ability to pay premiums may be restricted. The 9% assessment that may be imposed on HMOs under New York's rate-setting scheme therefore also promotes the important health policy objective of shifting the Medicaid population to managed care through HMOs.

For instance, in order to contain costs many states are striving to provide health care to Medicaid recipients through managed care organizations such as HMOs. New York established a managed care program for its Medicaid population in 1991.\textsuperscript{128} The state as a payer of Medicaid is within category one and hospitals may charge only the DRG rate when providing services to Medicaid recipients. Because hospital charges are limited, HMOs that provide hospital services may try to limit the number of enrollees that are Medicaid patients.\textsuperscript{129} Yet states have an obligation under federal regulations to assure that Medicaid patients have access to health care services.\textsuperscript{130} Accordingly, access to care for Medicaid recipients through HMOs can be enhanced by requiring hospitals to charge the 9% assessment when the payer is an HMO which has failed to enroll the target number of Medicaid patients.

The \textit{United Wire} case involved a similar rate-setting scheme premised upon the DRG methodology.\textsuperscript{131} New Jersey adopted its prospective DRG-

\textsuperscript{126} See, \textit{e.g.}, FLA. STAT. ANN § 641.3102 (West 1995 Supp.) (prohibiting terminations of coverage on the basis of age, health status, or health care needs); FLA. STAT. ANN. § 641.31(2) (West 1995 Supp.) (prohibiting unfairly discriminatory rates); FLA. STAT. ANN. § 641.51 (West 1995 Supp.) (requiring on-going internal quality assurance program).

\textsuperscript{127} Notably, however, the Blues have begun to shift to a proprietary organizational structure as well. \textit{See, e.g.}, \textit{Insurance: Georgia Blues to Convert to Public For-Profit Insurer}, BNA HEALTH CARE DAILY, Nov. 8, 1995, at d15 ("Like many Blues across the country, Blue Cross Blue Shield of Georgia wanted to make the change to be able to compete against the rapidly growing managed care networks.").

\textsuperscript{128} \textit{See} Brief for Respondents New York Health Maintenance Organization Conference, \textit{supra} note 107 at 1-3.

\textsuperscript{129} Further, to survive, hospitals must able to engage in cost-shifting: i.e., they must be able to shift the cost of caring for patients that cannot pay the hospital in full onto patients with private commercial insurance. On the other hand, hospitals do not mind keeping some Medicaid patients because the regular payments coming in from the state helps pay for some of the hospitals' variable costs. Eugene A. Gotbeck, Remarks at the 16th Annual Health Law Teachers Conference at Loyola Univ. Med. Ctr. (June 1995).

\textsuperscript{130} \textit{See}, \textit{e.g.}, 42 U.S.C. § 1396a(13)(A) (state Medicaid plans must provide for payment through rates which are reasonable and adequate in order to ensure that care conforms with requirements and that eligible individuals have reasonable access).

\textsuperscript{131} Interestingly, by the time of the decision, new legislation had superseded certain aspects of the contested rate-setting scheme. \textit{See} N.J. STAT. ANN. § 26:2H-4.1 (West 1995 Supp.) (enacted 1993).
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based system in 1978.132 The dual purpose of the rate-setting system was to contain the rising costs of health care services and to ensure the financial solvency of hospitals.133 As with the New York scheme, the DRG rate constituted the base rate to which other charges were added.134 First, a statewide charge was added to the basic DRG-rate of all patients in order to generate revenue for redistribution to hospitals in proportion to uncompensated care provided to indigent patients.135 A second charge could then be added to the hospital bill of non-Medicare patients to compensate hospitals for losses incurred through treatment of Medicare patients.136

The New Jersey system also utilized rate differentials. The regulatory scheme permitted the Commission to grant reimbursements to certain classes of payers based upon “quantifiable economic benefits” rendered to particular institutions or to the health care delivery system as a whole.137 These benefits included, for example, benefits to a hospital such as ready capital generated by promptness and volume of payments to hospitals, or benefits to society such as broad provision of health insurance coverages which are not self-supporting.138 The Commission had therefore granted a 2.2% discount to high-volume plans and an 11% discount to plans with open enrollments, such as Blue Cross.139 Moreover, patients who did not belong to plans that received the discounts could be billed at an increased rate to allow hospitals to recover income lost through the discount.140

Both of these rate-setting systems affect ERISA plans to the extent that the payer with which a plan contracts becomes a key determinant of the costs that the plan will incur. Commercial insurers and HMOs that provide coverage for insured ERISA plans are directly affected by the increased rates specified by the laws. However, these entities pass the costs along to their customers in the form of higher premiums or subscription fees. Thus, a plan that provides coverage to employees through a Blue Cross plan will likely be subject to lower premiums than a plan that provides coverage through a commercial

132. See also United Wire, 995 F.2d at 1189 (citing New Jersey Health Care Facilities Planning Act of 1971, as amended by the Health Care Cost Reduction Act of 1978, N.J. STAT ANN. § 26:2H-1, et seq. (West 1987); N.J. ADMIN. CODE tit. 8, § 31B et seq.).
134. United Wire, 995 F.2d 1179, 1189 (3d Cir. 1993).
135. Id.
136. Id.
138. Id.
139. United Wire, 995 F.2d at 1190.
140. Id. The impact on ERISA plans was elevated even more by an “equitable ride-over provision” that permitted uninsured individual payers to appeal the increased bills and to obtain a reduction when equitable. Id. n.1 (citing N.J. ADMIN. CODE tit. 8, § 31B-3.78(a)(viii)). A reduction obtained through such an appeal did not result in another charge being added to the bill of paying patients.
insurer; and ERISA plans that insure with commercial insurers would likely face higher premiums. These factors could influence an employer’s choices about which type of payer to contract with to provide health care benefits. The impact on self-insured plans may be more immediate because the claims are more directly absorbed by a fund or trust supporting the employees’ coverage. Employers who choose to self-insure are in the same category as commercial insurers in the New York system if plan payments are paid directly to hospitals and would not receive discounts under the New Jersey system unless the employer maintained open enrollment policies. Because self-insured ERISA plans would not fall within a group benefitting from the differentials, they would be required to pay higher hospital bills. Though more direct, the impact is still purely economic. Whether the hospital rate-setting schemes at issue were pre-empted by ERISA, hinged on whether this economic impact created a sufficient relation to ERISA plans.

2. The Split in the Circuits

In the United Wire case, the Third Circuit Court of Appeals held that ERISA did not pre-empt New Jersey’s rate-setting system. The Third Circuit recognized that the increased costs from the surcharges would be passed along to the plans. However, the court found this impact to be indistinguishable from that of a multitude of other regulation that increases the costs of goods or services purchased by hospitals, such as utility costs, waste disposal costs, or wages, etc. As with any supplier of goods in our market economy, the costs of such regulations are typically passed on to the consumer. Further, since rates for hospital services vary from region to region notwithstanding state rate-setting, the court found the impact on the administration of multi-state plans to be negligible. Moreover, the court held that the rate-setting scheme does “not direct ERISA plans to structure their benefits or conduct their internal affairs in any particular way.” The court thus held that the scheme did not “relate to” employee benefit plans.

141. See infra notes 228-36 and accompanying text.
142. United Wire, 995 F.2d 1179 (3d Cir. 1993).
143. Id. at 1193.
144. Id.
145. Id.
146. The court also rejected the plans’ arguments that the surcharges were impermissibly requiring them to act in a manner inconsistent with a fiduciary obligation under ERISA to apply fund assets only for the benefit of fund participants. The court noted that Congress surely did not intend that ERISA plans must “look through” to the pricing structure of every health care provider to assure that the price of services correlates directly with the costs of services: “We are unwilling to attribute to Congress . . . an intent to frustrate the efforts of a state, under its police power, to regulate health care costs.” Id. at 1195-96.
There was a strong dissenting opinion, however.\(^\text{147}\) The dissent noted that New Jersey was well aware of the pivotal role that ERISA plans would play, and the presence of specific references to union welfare plans, in the rate-setting scheme.\(^\text{148}\) Further, the dissent pointed out the enormous financial impact of the surcharges on ERISA plans: “ERISA plan participants comprise only about 15% of the hospital patients, but pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts.”\(^\text{149}\) According to the dissent, the surcharges were not comparable to other indirect increases associated with the cost of providing hospital services; rather, “[t]hey are the direct cost of hospital services rendered to other patients, which have been shifted to ERISA plans.”\(^\text{150}\) The regulations should thus have been held pre-empted because they have interfered with the operation of ERISA plans to the point where the plans have suffered large financial losses.\(^\text{151}\)

The Second Circuit in \textit{Travelers} agreed with the dissenting opinion in \textit{United Wire} and held that the New York provisions satisfied the “connection with” requirement for pre-emption.\(^\text{152}\) The court stated that the 13% and 11% differentials would “obviously” affect the ERISA plans’ health care benefits; and that the 9% assessment would interfere with the choices that ERISA plans make for health care coverage.\(^\text{153}\) According to the court, the district court “properly found that the three surcharges ‘relate to’ ERISA because they impose a significant economic burden on commercial insurers and HMOs.”\(^\text{154}\)

Thus, the Supreme Court’s decision in \textit{Travelers} as to the proper scope of the phrase “relate to” provided an opportunity to bring uniformity and predictability to a multitude of potential decisions. Given the ever-broadening trend of lower courts to find health reform legislation pre-empted, as well as the fact that health reform has moved from the national arena back to the states, the time was ripe for the Supreme Court to articulate more clearly the outer bounds of ERISA pre-emption, thereby restraining lower courts from extending pre-emption beyond the scope of what Congress could have intended in 1974.

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\(^{147}\) \textit{Id.} at 1196 (Nygaard, J., dissenting).

\(^{148}\) \textit{Id.} at 1198.

\(^{149}\) \textit{Id.} at 1199-1200.

\(^{150}\) \textit{Id.} at 1202-03.

\(^{151}\) \textit{Id.} at 1203.

\(^{152}\) 14 F.3d 708, 721 n.3 (2d Cir. 1993).

\(^{153}\) \textit{Id.} at 719.

\(^{154}\) \textit{Id.} at 721.
II. The Supreme Court Decision in Travelers

A. An Indirect Economic Impact Is Not a Regulation of an ERISA Plan

The Supreme Court specifically limited the issue before it to the question whether ERISA pre-empted New York’s rate-setting legislation when applied to insured ERISA plans or ERISA plans utilizing HMOs, thereby excluding consideration of its application to self-insured ERISA plans. The Court also recognized that the real issue was whether an indirect economic effect on ERISA plans sufficed to meet the “relate to” requirement of ERISA’s pre-emption clause. In contrast to the district court and the Second Circuit Court of Appeals, the Supreme Court held that the rate-setting legislation did not “relate to” ERISA plans within the meaning of ERISA’s pre-emption provision.

The Court began its analysis of pre-emption by stressing what lower courts had increasingly overlooked—that the resolution of pre-emption claims is premised on a presumption against pre-emption, especially in cases where federal law would be supplanting state action in a field of traditional state regulation such as health care. Further, the Court reiterated that the question of pre-emption depends on Congress’s intent. Following traditional pre-emption analysis, the Court first examined the key language—the phrase “relate to.” Notably, the Court more clearly indicated that ERISA’s express pre-emption provision is not a reliable indicium of congressional intent. The Court stated that, “[i]f ‘relate to’ were taken to

155. Travelers, 115 S. Ct. at 1673-74 (“This case calls for us to decide whether [ERISA] pre-empts the state provisions for surcharges on bills of patients whose commercial insurance coverage is purchased by employee health-care plans governed by ERISA, and for surcharges on HMOs insofar as their membership fees are paid by an ERISA plan.”) (citations omitted); see also id. at 1675 n.4 (“Nor do we address the surcharge statute insofar as it applies to self-insured funds.”). This limitation is interesting given the fact that Travelers Insurance was a party to the suit in its capacity as a fiduciary for self-insured ERISA plans. See id. In United Wire, the plaintiffs were self-insured ERISA plans as well. However, neither appellate opinion expressly addressed whether the status of insured versus self-insured would make a difference in the pre-emption analysis. Both courts framed the issue in the cases more generally as whether the hospital rate-setting systems—which had existed for years and which were enacted to achieve important health policy objectives—had an effect upon insured ERISA plans that was sufficient to render the laws pre-empted. United Wire, 995 F.2d at 1188.

156. The Court highlighted the fact that both the district court and the Second Circuit held that the state law impermissibly related to ERISA plans because the effect on commercial insurers and HMOs, which would or could provide coverage to ERISA plans, could indirectly lead to an increase in plan costs and thereby effect choices made by ERISA plans. Travelers, 115 S. Ct. at 1675-76 (citing 813 F. Supp. 996, 1003-08 (S.D.N.Y. 1993); 14 F.3d 708, 719-21 (2d Cir. 1993)).

157. id.

158. id. at 1676 (citing Cipollone v. Liggett Group, Inc., 505 U.S. 504, 516 (1992)).

159. id. at 1677.
extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for ‘[r]eally, universally, relations stop nowhere.’" 160 The Court also found its prior articulation of the meaning of the phrase, as encompassing laws that have “a connection with or reference to” an ERISA plan, to be unhelpful in this case. The state law did not reference ERISA plans, and “[for] the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections.” 161

Thus, the Court appropriately used an implied pre-emption analysis and looked to the objectives of the ERISA statute as a guide for congressional intent as to the scope of the phrase “relate to.” 162 The Court reiterated the legislative history that it had looked to in prior cases, and found that the “basic thrust of the pre-emption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.” 163 The Court reviewed some of its prior holdings where it had found that a state law “related to” ERISA plans, and concluded that the pre-empted state laws either mandated employee benefit structures or administrative practices of plans, or provided alternative enforcement mechanisms within the scope of ERISA’s civil enforcement provisions. 164

The Court then found that both the purpose and effects of the New York rate-setting provisions distinguished them from laws within the scope of the pre-emption provision. 165 The Court noted that the effect on ERISA plans flows from the purpose underlying the rate-setting provisions—the additional charges imposed on patients of commercial insurers and HMOs make coverage through Blue Cross and Blue Shield plans more attractive and thus have an indirect economic effect on the choices made by purchasers of health coverage such as ERISA plans. 166 The crux of the opinion is the Court’s determination that:

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160. Id. (quoting H. JAMES, RODERICK HUDSON xli (New York ed., World’s Classics 1980)).
161. Id.
162. Id. The Court, therefore, implicitly found that the phrase “relate to” is not a reliable indicium of congressional intent. Id.
163. Id. at 1677-78.
164. Id. at 1678 (“In each of these cases [in which the Court found that a state law ‘related to’ ERISA plans] ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption.”) (citations omitted). This categorization is in accord with the analysis in section I.A. of this article. Presumably, the Court did not include the category of laws that specifically apply to ERISA plans or impose a duty on a plan by referencing ERISA plans because it had already noted that this case did not involve a state law that referenced ERISA plans in any manner.
165. Id.
166. Id. at 1678-79.

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An indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself . . . Nor does the indirect influence . . . preclude uniform administrative practices or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan’s shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.167

The Court bolstered its determination by noting that rate-differentials had been in existence for many years and in many contexts, even absent state regulation. This “common character” of rate-differentials rendered it unlikely that Congress intended to pre-empt such an indirect economic influence.168 Moreover, the Court noted the existence of many other common state regulations that result in a similar indirect economic effect on ERISA plans by virtue of affecting the cost and price of services offered to ERISA plans, such as regulation of quality of care or employment conditions.169 Although the other regulations would be less likely to affect premium differentials between commercial insurers, HMOs and the Blues, the Court concluded that it could not find the additional charges to be pre-empted unless the other regulations with indirect effects on plan costs would be pre-empted as well:170 “The bigger the package of regulation with indirect effects . . ., the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs.”171

Importantly, the Court noted that to hold all state laws affecting costs and charges to be pre-empted on the theory that they indirectly relate to ERISA plans could not be squared with its prior pronouncements that pre-emption is inappropriate if the state law has only a tenuous, remote, or peripheral connection with covered plans. The Court noted that “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 matter of local concern.”172 The Court found that its decision in Mackey supported its holding that the rate-setting provisions were not pre-empted.173 In Mackey,

167. Id. at 1679.
168. Id.
169. Id.
170. Id.
171. Id.
172. Id. (citing Hillsborough County v. Automated Med. Lab., Inc., 471 U.S. 707, 719 (1985) and 1 B. FURROW ET AL., HEALTH LAW §§ 1-6, 1-23 (1995)).
173. Travelers, 115 S. Ct. at 1680.
the Court held that a state garnishment proceeding did not relate to ERISA
plans even though it placed administrative burdens upon ERISA plans.174 "If
a law authorizing an indirect source of administrative cost is not pre-empted,
it should follow that a law operating as an indirect source of merely economic
influence on administrative decisions . . . should not suffice to trigger pre-
emption either."175

Further, the Court readily distinguished Metropolitan Life Insurance Co.
v. Massachusetts.176 Travelers Insurance had argued that Metropolitan Life
supported the proposition that "all laws affecting ERISA plans through their
impact on insurance policies 'relate to' such plans . . . ."177 The Court noted
that the law in Metropolitan Life imposed a substantive coverage requirement
on ERISA plans,178 and thus the case did not require the Court to
"distinguish with any precision the effects on insurers that are sufficiently
connected with employee benefit plans to 'relate to' and those effects that are
not."179 Indeed, the Court explained that Metropolitan Life implicitly
recognized that not all laws that would influence the cost of insurance relate
to ERISA plans.180 The Court pointed out that, if the scope of the phrase
"relate to" was that broad, even the basic tax breaks enjoyed by non-profit
insurers such as the Blues would be pre-empted because of the impact on
insurance prices and plan costs.181

Finally, the Court explored what many believed was the fundamental
factor in this case: that a finding of pre-emption would bar any state regulation
of hospital costs—even use of a basic DRG-rate without any differential
treatment among payers.182 It is difficult to attribute this result to
congressional intent given the fact that rate-setting was in existence when
ERISA was enacted and was actually encouraged by the federal government.
Several states, including New York, regulated hospital rates in 1974, the year
ERISA was passed. Moreover, the National Health Planning and Resources
Development Act of 1974 prescribed grant opportunities for state agencies to,
among other things, demonstrate the effectiveness of health care rate

174. See supra notes 66-75 and accompanying text.
175. Travelers, 115 S. Ct. at 1680.
176. Id. (citing 471 U.S. 724 (1985)).
177. Id.
178. That is, the law required ERISA plans to purchase specified benefits when they
 purchased certain types of insurance. See supra note 44 and accompanying text.
179. Travelers, 115 S. Ct. at 1680-81.
180. Id. at 1681 (quoting Metropolitan Life, 471 U.S. at 741 ("[L]aws that regulate only
 the insurer, or the way in which it may sell insurance, do not 'relate to' benefit plans . . . .").
181. Id.
182. Id. The DRG methodology inevitably impacts insurance prices, and thus would
 indirectly have an economic effect on ERISA plans. Notably, that effect may be positive. If
 hospitals are limited in the amount they may charge, cost of coverage could decrease.
regulation. Accordingly, the Court stated that the “provision for comprehensive aid to state health care rate regulation is simply incompatible with pre-emption of the same by ERISA.”

Thus, New York’s rate-setting provisions as applied to insured ERISA plans or plans utilizing HMOs were saved from ERISA pre-emption. An economic effect that at most only influences decisions concerning benefit structure or administrative schemes is not sufficient for pre-emption. The Court limited its holding, however. The Court noted that a “state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, 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 pre-empted under § 514.” For example, the Court noted that “there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate.”

B. Analysis: A Signal for a More Restrained Application of ERISA Pre-emption?

Although the Court granted certiorari in order to resolve the split in the courts of appeal, the Court’s fundamental reason for hearing the case was to provide more definitive guidance to courts which must identify the line delimiting state laws that Congress intended ERISA to pre-empt. At first blush the holding appears to be narrowly limited. In reality, the opinion sheds substantial light on the proper pre-emption analysis.

First, the case can be construed as an articulation of a tighter standard for determining pre-emption in that category of cases where the state law affects the benefit structure or administrative practices of an ERISA plan. On a narrow view, the case stands for the proposition that state laws that merely have an indirect, economic effect which may influence an employer’s decisions regarding what insurer to deal with, what benefits to offer, the level of benefits, or even how benefits are calculated, do not “relate to” ERISA plans within the meaning of ERISA’s pre-emption provision—unless the influence is so strong that plans have no real choice at all. New York’s rate-setting provisions, as applied to insured plans or plans utilizing HMOs, only influence the employer’s choice as to whether to provide coverage through Blue Cross and Blue Shield plans, and thus were not pre-empted.

183. Id. at 1681-82.
184. Id. at 1682.
185. Id. at 1683.
186. Id. at 1681.
187. See supra notes 41-58 and accompanying text for an explanation of the three categories of state laws that have generally been found to be pre-empted.
Travelers Insurance and ERISA

Viewed more broadly, however, the principle of Travelers could apply beyond laws with an economic effect. This construction is sound because of the Court’s approach to the resolution of the issue. The Court first took a fairly narrow view of its prior ERISA pre-emption cases. The Court concluded that, in addition to laws that specifically regulate ERISA plans or laws that are within the scope of ERISA’s civil enforcement provisions, the laws previously found to be pre-empted “mandated” either employee benefit structures or administrative practices.\(^8\) The Court then determined whether an economic effect created a sufficient connection to ERISA plans by measuring the effect of the rate-setting provision against that standard, i.e., whether the rate-setting scheme “bound” administrators’ or employers’ decisions regarding benefit structures or administrative practices.\(^8\) The principle of Travelers does not therefore need to be limited to cases involving only economic effects. Rather, the principle could apply to any pre-emption challenge to a state law that has an effect on benefit structures or administrative practices.\(^9\) The pre-emption question thus hinges on whether the effect of the law actually or practically binds choices as to benefit packages or structures or administrative practices. Lower courts often stated that it was sufficient if the law had “any” effect—which would include a mere influential effect.\(^1\) Thus, Travelers pronounced a tighter standard than that used by many lower courts.

Second, the Court indicated that both the purpose and the effect of a state law are relevant to the pre-emption issue.\(^2\) The purpose and effect of New York’s rate-setting legislation distinguished it from laws previously found to be within the scope of the “relate to” provision. Yet the effect of a law upon ERISA plans is clearly the more weighty determinant. As noted, the Court’s analysis focused on the effect of the state law on ERISA plans. In relevant prior cases, the effect of the state laws at issue was to mandate employee benefit structures or administrative practices of ERISA plans. The effect of New York’s rate-setting provision did not bind administrators’ choices

\(^8\) Travelers, 115 S. Ct. at 1678.
\(^9\) Id. at 1679-80.
\(^1\) An argument could be made that this reading of Travelers is too broad because there is still a distinction between claims that have an effect on ERISA plans. An intermediate position would be to distinguish laws more readily characterized as involving the administration of the ERISA plan. In such a case, that law probably has an economic impact on the plan, but as well has some bearing on plan administration other than the mere passing through of costs. Thus, an argument could be made that pre-emption would be appropriate if the law somehow implicates core ERISA concerns—even if the effect does not bind administrative functions. However, the Court in Travelers characterized the prior laws that had been pre-empted as having “mandated” administrative practices, and gave no indication of leaving the door open for intermediate situations. It is therefore reasonable and sensible to construe the opinion in this manner.
\(^2\) Travelers, 115 S. Ct. at 1678.
regarding benefit structures or administrative practices. This distinguishable effect was clearly central to the Court's holding.\textsuperscript{193}

The purpose of a state law, however, is also relevant to the pre-emption question. The Court noted the justifications for the rate-differentials—that the Blues reimburse hospitals promptly and utilize open-enrollment practices—but did not expressly note the purpose of the rate-setting scheme. The purpose was to help ensure the continued viability of plans such as Blue Cross and Blue Shield plans and HMOs, whose underwriting practices provide access to coverage for higher risk individuals.\textsuperscript{194} This “health policy” objective is clearly distinguishable from the purpose underlying the laws at issue in prior Supreme Court cases. In all prior cases, except those which involved causes of action within the scope of ERISA’s enforcement provision, the purpose underlying the state laws was, generally, to either assure certain benefits or benefit levels to individuals.\textsuperscript{195} Because the Court did not specifically address the difference in purpose, it is unclear whether a state law that is grounded in health policy may escape pre-emption on that basis alone. However, analysis of Supreme Court precedent suggests not. In \textit{Greater Washington Board of Trade}, the state law was arguably designed to address the growing problem of uninsurance by ensuring that persons receiving workers’ compensation would still receive their health care benefits.\textsuperscript{196} Yet the Court held that the law related to ERISA plans because it imposed a mandate upon employers relating to benefit structure by specific reference to ERISA plans.\textsuperscript{197} Thus, a better interpretation of the \textit{Travelers} opinion may be that the purpose of the state law is relevant to the pre-emption issue to the extent that the purpose reflects a legislative intent to regulate within the scope of traditional state regulations, e.g., health care regulations. The Court in \textit{Travelers} reiterated the importance of the presumption against pre-emption and, in analyzing the issue, found nothing in the language or legislative history of ERISA which indicated an intent to pre-empt general health care regulations.\textsuperscript{198} The purpose of a law therefore helps a court determine whether the law should be accorded the more weighty presumption against pre-emption.

Third, the Court implicitly discounted the relevancy of the fact that the rate-differentials had a disparate impact on ERISA plans, and, indeed, that the state may have understood that the scheme could not accomplish its purpose without a disparate effect on ERISA plans. That is, because a clear majority of health insurance coverage is through ERISA plans, ERISA plans pay a

\begin{footnotes}
\footnote{193}{Id. at 1680.}
\footnote{194}{See supra notes 108-20 and accompanying text.}
\footnote{195}{See supra notes 44-45 and accompanying text.}
\footnote{196}{See supra notes 42-43 and accompanying text.}
\footnote{197}{Id.}
\footnote{198}{Travelers, 115 S. Ct. at 1681.}
\end{footnotes}
significant percentage of the higher charges; and so without ERISA plans the system of differentials would not have accomplished its underlying purpose. The parties argued this point before the Court, and the Second Circuit expressly relied upon it. Yet this factor did not enter into the Court's analysis. Thus, the fact that an indirect economic effect falls primarily upon ERISA plans or that the underlying objective of the state law could not be achieved without the disparate impact on ERISA plans does not support a finding of pre-emption.

Fourth, the Court provided additional guidance to help courts determine congressional intent, the touchstone of any pre-emption analysis. Because the text of ERISA's pre-emption provision provides an unreliable indicium of Congress's intent, the Court clearly indicated that courts should engage in an implied pre-emption analysis. Further, the opinion strongly suggests that the implied pre-emption analysis should incorporate the following premises. Foremost, there is a strong presumption against pre-emption, especially for laws such as health care regulations that are within the traditional police power of the states. Additionally, as previously noted in *Fort Halifax*, a finding of pre-emption should serve a fundamental objective of the ERISA statute, namely to avoid state laws that would interfere with nationally uniform administration of ERISA plans by leaving with employers control over decisions regarding the scope of coverage and the design of key administrative practices. However, rather than using language that could suggest that Congress intended to reach state laws that merely "interfered" with uniform administrative practices, the Court stressed a narrower view of the underlying objective of ERISA. Mere interference is not sufficient; a state law must bind choices as to administrative practices.

Moreover, the opinion suggests that courts should adopt the pragmatic approach demonstrated in *Fort Halifax* and *Mackey*. The Court indicated that it is not appropriate to pre-empt state laws with an effect analogous to that of "common" state laws, especially if such laws have been encouraged by the federal government. The rationale for this limitation is twofold. First, it

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201. *Id.* at 1677-78.

202. The Court expressly stated that cost uniformity is not an object of pre-emption. *Id.* at 1680. And perhaps more importantly, the Court took a narrow view of what constitutes impermissible interference with uniform administration. The Court's findings in *Travelers* indicate that mere "interference" is not sufficient; rather, to constitute a pre-empted "regulation" of ERISA plans, the state law must bind employers or administrators by mandating benefit structures or administrative practices. The Court ignored the language in dicta in prior opinions which arguably would have supported a broader view of ERISA pre-emption. *Id.* at 1681-82.

203. *Id.* at 1679, 1681-82.
is difficult to reach a meritorious conclusion that Congress could have intended to pre-empt state laws within the traditional domain of state power when the effect of the law on core ERISA concerns is slight and where Congress has in some way endorsed the state law. Second, and more informative, the Court implicitly indicated that it is important to be able to identify a logical stopping point to pre-emption. The Court expressed the concern that, if the rate-setting provisions were deemed pre-empted because of their indirect economic effect, than courts would logically have to find that other regulations—such as quality control and workplace regulations—were pre-empted even though they might be “less likely to affect premium differentials.” Yet the Court stressed that the bigger the field of traditional state laws that would logically fall within the scope of pre-emption, the more difficult it is to conclude that Congress intended that result. Thus, in assessing congressional intent, courts should balance the promotion of ERISA objectives with the practical consequences of a finding of pre-emption.

In sum, the opinion provides much needed guidance for courts asked to identify the line delimiting state laws that Congress intended to pre-empt, and suggests that fewer state laws should be pre-empted. The opinion could be construed narrowly as being applicable only to cases involving an indirect economic effect. However, it is equally meritorious to interpret the opinion more broadly, as a strong signal that the scope of ERISA pre-emption should generally be restrained. The approach used by the Court can be construed as suggesting a framework for ERISA pre-emption that restores deference to traditional state regulations and implements a tighter standard for assessing whether the effect of a state law impermissibly infringes on core ERISA concerns. Further, the Court’s emphasis on the need for logical lines of delimitation suggests that in difficult cases courts must carefully scrutinize Supreme Court precedent as well as details relevant to the case.

Harmonizing the principles from Travelers with Supreme Court precedent arguably results in a more pragmatic and delineated framework for analyzing questions of ERISA pre-emption. A court must first assess whether the state law being challenged as pre-empted is a law within the traditional police power of the states, such as health care regulation. The underlying purpose of the law is relevant to this inquiry. That the state may have known that the effect of the law would fall largely on ERISA plans is not a determinative factor. If the law is within an area traditionally of local concern then there should be no pre-emption absent clear congressional intent.

Travelers made clear that the structure of ERISA as a whole and its pre-
emission provisions indicate that laws that may "relate to" to ERISA plans fall into three categories. Thus, the next step in the pre-emption analysis is to identify whether the state law (1) was designed specifically to apply to ERISA plans or imposes a benefit-related duty on employers or administrators by express reference to ERISA plans; (2) is a common law action within the scope of ERISA's civil enforcement provisions and represents an alternative enforcement mechanism; or (3) relates to ERISA plans because of its effect on employer or administrator decisions concerning benefit structure or administration of the plan. If the state law falls within categories (1) or (2), the Supreme Court cases indicate that the law should generally be pre-empted. Travelers provides little specific guidance for the scope of ERISA pre-emption as to laws in these categories. As to laws that fall within category (3), a court should apply the standard used in Travelers: i.e., pre-emption depends on whether the effect of the law binds employers or administrators to particular choices as to, or precludes use of, uniform benefit structures or administrative practices.

Further, in applying the standard from Travelers to any state law, the Court indicated that courts must keep in mind the core congressional concerns underlying the pre-emption provision. If pre-emption will not further key ERISA objectives, than it is difficult to conclude that Congress clearly intended to pre-empt common state laws. Moreover, because of the Court's emphasis on the need for logical lines of delimitation, courts must carefully scrutinize Supreme Court precedent and flesh out factual distinctions relevant to the case at hand to achieve a pragmatic assessment of congressional intent to pre-empt the state laws at issue.

The following section applies this framework to a variety of state laws currently being challenged in the lower courts. The inconsistencies in the lower courts on the issue of pre-emption illustrate that many in the judiciary do not believe that Congress intended ERISA pre-emption to be as broad as some courts are finding. The issue thus becomes whether the analytical framework that can be derived from Travelers can effectively restrain findings of ERISA pre-emption and restore uniformity and predictability to the question of ERISA pre-emption.

III. Application to Emerging Pre-emption Issues

A. Provider Taxes or Other Surcharges that Affect ERISA Plans that Contract for Health Care Coverage

The clearest principle emerging from Travelers is that state laws that have an indirect, economic effect on decisions regarding benefit structures or administrative practices for plans that contract for health care coverage do not
“relate to” ERISA plans within the meaning of ERISA’s pre-emption provision—unless the influence is so strong that, practically speaking, employers or administrators have no choice. Thus, cases that involve state laws that impose taxes or surcharges which only have an indirect economic effect on insured ERISA plans become easy cases and the inconsistency in lower court applications to analogous provisions emerging in many state reform proposals should be resolved.

For example, before Travelers, courts reached different conclusions on the issue of whether surcharges such as provider taxes imposed on hospitals were pre-empted by ERISA. In New England Health Care Employees Union District 1199 v. Mount Sinai Hospital,207 the district court held that Connecticut’s Uncompensated Care Pool Act was pre-empted by ERISA. The Connecticut law at issue was designed to compensate hospitals for the cost of providing care to those unable to pay for services, namely, the indigent, uninsured and underinsured.208 This type of provision has recently been enacted in many states.209 In addition to assessments and taxes on hospital services and charges similar to those in Travelers, the pool was funded by an assessment on all hospitals, i.e., a provider tax.210 The federal district court held that the law related to ERISA plans for two primary reasons: (1) the law contemplated the existence of ERISA plans and depended on their participation for its effectiveness;211 and (2) the law imposed a substantial economic burden on ERISA plans and plans would either increase costs or reduce benefits.212

In contrast, in Boyle v. Anderson,213 the district court held that a 2% provider tax included in the Minnesota Health Right Act was not pre-empted. In resolving the issue, the court used a seven-factor test articulated by the

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208. This is generally termed “uncompensated care.” Legislatures have recently begun trying to assure adequate compensation to hospitals which routinely provide a disproportionate amount of uncompensated care, e.g., public hospitals and not-for-profit hospitals.

209. States use disproportionate share payments as a means to increase federal Medicaid matching funds. In Connecticut, the state qualified for approximately $150 million in federal funds, which it then used to help balance the state budget rather than for its Medicaid program.

210. See 846 F. Supp. at 192 (citing 1993 Conn. Pub. Acts 93-229, §§ 8, 10 (the assessment “shall be a uniform per cent of the charges for patient care services except those rendered to patients whose services are covered by Medicare, [Medicaid] and CHAMPUS.”)).

211. Id. at 195 (ERISA plans pay 70% of the assessments which fall on privately insured patients under the Act; without ERISA plans the Act would not be economically viable).

212. Id. at 196-97 (applying the Second Circuit’s opinion in Travelers). See also Connecticut Hosp. Ass’n v. Pogue, 870 F. Supp. 444 (D. Conn. 1994) (holding that the amendments to the Connecticut law at issue in New England Health Care—which retained a tax on patient care services, imposed a gross earnings tax, and authorized shifting costs of uncompensated care to private pay patients—were pre-empted for similar reasons).

Eighth Circuit and thus several justifications supported its holding. Two reasons are most relevant to this article. First, the court found that the tax did not impose a significant burden on or create conflicting burdens for ERISA plans since the hospital would simply pass-through the charge as a part of the hospital bill. Second, and perhaps more importantly, the court applied the Second Circuit’s holding in Travelers, but held that the indirect economic effect on ERISA plans in this case was not sufficiently substantial to warrant pre-emption.

Application of the Supreme Court’s holding in Travelers readily leads to the conclusion that provider taxes and analogous state laws should not be found pre-empted. Although surcharges and provider taxes are emerging in various forms in state health reform proposals, and thus may differ in some respects from the surcharges in Travelers, practically, the laws are substantially analogous: such provisions result in increased charges being passed along first to payers with whom employers have contracted, and then to insured ERISA plans in the form of increased premiums or subscription fees. While this effect could influence benefit structures because of increased costs, the laws do not bind benefit-related decision-making. Accordingly, in light of Travelers, the Second Circuit reversed the district court’s ruling in New England Health Care, holding that the law’s indirect economic effect on ERISA plans generally will not trigger ERISA pre-emption.

More importantly, the analysis for pre-emption after Travelers is differently focused from the approaches taken by the district courts in these cases. In New England Health Care, the district court was influenced by the fact that the law had a disparate impact on ERISA plans. That is, because a clear majority of health insurance coverage is through ERISA plans, ERISA plans provided 70% of the funding for the Act; thus, without ERISA plans the Act would not have been economically viable. The court found that this constituted a sufficient connection with ERISA plans. Yet Travelers indicates that this fact—which is an inevitable consequence of any surcharge because of the health insurance market—is not significant to the pre-emption issue.

214. See id. at 1312 (citing Arkansas Blue Cross & Blue Shield v. St. Mary’s Hosp., Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991)).
215. Id. at 1315.
216. Id. at 1315-16.
219. Id. at 196.
220. The Second Circuit construed Travelers as “implicitly [rejecting] a market share/dependence approach to ERISA preemption.” New England Health Care, 65 F.3d at 1033.
Similarly, the Court in Travelers implicitly rejected use of the seven-factor approach used by the court in Boyle. These seven factors were whether the state law: (1) negates a provision of an ERISA plan; (2) affects relations between primary ERISA entities; (3) has an impact on the structure of ERISA plans; (4) has an impact on the administration of the plan; (5) has an economic impact on ERISA plans; (6) is an exercise of traditional state power; and (7) whether pre-emption of the state law is consistent with other ERISA provisions.221

Travelers readily suggests that use of these factors renders the scope of pre-emption broader than Congress could have intended. First, when the Eighth Circuit compiled the list of factors from other lower court opinions, the court discounted factor six.222 The court in Boyle therefore did not rely on the fact that the Minnesota law was a health care regulation, and thus an exercise of traditional state power, in finding that the law was not pre-empted.223 Travelers expressly rejected this approach by clarifying that, while all state laws are entitled to a presumption against pre-emption, laws within traditional state power—and specifically health care regulations—should be accorded greater deference in the ERISA pre-emption analysis. Second, factors three, four and five each suggest that any economic impact—or even any non-economic impact—on the structure or the administration of the plan is sufficient. Travelers clearly requires more: to warrant pre-emption, the effect must be sufficiently strong that a court could find that the law effectively binds employers to particular benefit-related choices or precludes a uniform administrative scheme.

Few provider taxes, rate-setting schemes or other surcharges will have such a strong effect on ERISA plans. However, one example of a tax or surcharge that might fall within the scope of ERISA pre-emption as defined by Travelers is a state mandated "pay-or-play" scheme. For example, rather than directly mandating employers to provide health coverage, Massachusetts enacted a tax and credit scheme that encourages employers to provide health insurance coverage to employees.224 Under the scheme, employers must pay a tax called a medical security contribution.225 However, the amount of the medical security contribution can be reduced to zero by deducting an employer's per employee health care costs.226 The tax is comparable to the cost of providing basic health coverage. The effect of such a tax will arguably

221. 849 F. Supp. at 1312.
222. See Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., 947 F.2d 1341, 1350 (8th Cir. 1991).
225. Id. at § 14G(b).
226. Id. at § 14G(c).
be more than merely influential. If a tax is comparable to the cost of coverage, an employer could argue that it is faced with a Hobson's choice—that the result is no real choice at all.227 Most taxing strategies incorporated into today's health reform initiatives do not rise to this level.

In sum, as to taxes or surcharges that indirectly affect ERISA plans, the framework for ERISA pre-emption after Travelers effectively delimits ERISA pre-emption. Indeed, Travelers rejected the need to finely distinguish between the various types of laws that involve taxes or surcharges when the Court broadly stated that cost uniformity was not within the congressional objectives underlying ERISA pre-emption. Thus, despite the fact that new and variant provider taxes or surcharges may emerge in state reform movements, congressional intent regarding pre-emption can be readily determined. Travelers clearly indicates that taxes and surcharges on hospitals or on insurers or HMOs that affect ERISA plans only by causing increased pass-through costs are not within the congressional objectives underlying ERISA and should not be pre-empted.

B. Taxes and Surcharges That Affect Self-Insured ERISA Plans

The Court in Travelers expressly excluded consideration of whether or not the application of New York's rate-setting scheme to self-insured ERISA plans was pre-empted.228 Nonetheless, it is reasonable to conclude that this limitation does not narrow the general principle that state laws that merely have an indirect, economic effect that may influence an employer's decisions regarding benefit structures or administrative practices do not "relate to" ERISA plans within the meaning of ERISA's pre-emption provision.

In fact, the result would likely not have been different if the Court had addressed whether application of New York's rate-setting provisions to self-insured plans is pre-empted. The state law requires hospitals to increase charges on certain patients' bills. When an insured plan is involved, the patient's bill is paid by the payer—the commercial insurer or the HMO with which the employer contracted. The payer then passes the increased costs through to the employer in the form of increased insurance premiums or HMO subscriptions. In the case of most self-insured ERISA plans, the bill is paid

227. On the other hand, a "tax and credit" scheme inherently involves a choice—pay the tax or provide coverage.

228. "This case calls for us to decide whether [ERISA] pre-empts the state provisions for surcharges on bills of patients whose commercial insurance coverage is purchased by employee health-care plans governed by ERISA, and for surcharges on HMOs insofar as their membership fees are paid by an ERISA plan." 115 S. Ct. at 1674-75. See also id. at 4 n.4 ("Nor do we address the surcharge statute insofar as it applies to self-insured funds."). This limitation is interesting given the fact that Travelers Insurance was a party to the suit in its capacity as a fiduciary for self-insured ERISA plans.
from a fund or trust set aside for health care coverage. The fund may or may not be administered by a third-party administrator rather than the employer. In either case, increased hospital charges are not reflected in increased premiums, but are instead passed on as an increased cost of claims and are merely absorbed by the fund or trust supporting the employees' coverage. In that respect, the economic effect on self-insured ERISA plans is more direct. However, for purposes of ERISA pre-emption, an effect is deemed "indirect" any time the state law is not specifically designed to affect ERISA plans. New York’s rate-setting scheme was designed to ensure the viability of plans such as Blue Cross and Blue Shield plans by dictating the amount hospitals could charge, and thus constitutes an "indirect" effect even on self-insured ERISA plans.

More importantly, the economic effect on self-insured plans is still merely influential. Plans that self-insure are generally for large employers for whom the increased charges that must be absorbed would be unlikely to create “no choice” but to switch to Blue Cross plans. Accordingly, upon remand of the case in Travelers, the Second Circuit correctly rejected the insurers' request to let the district court consider whether ERISA pre-empts the New York rate-setting scheme with respect to self-insured plans. The court held that, even as to self-insured plans, the rate-setting provisions were not pre-empted because “whatever pressure the surcharge may exert on an ERISA plan’s decision to self-insure is no different from other economic influences on a plan’s decision to purchase insurance.” Indeed, the court noted that the

229. The degree of economic impact would likely be comparable.

230. See, e.g., Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 524-25 (1981) (noting that the state law that banned pension benefit offsets based on workers' compensation “applies directly” to a calculation technique; yet the Court characterized that statute as having an “indirect” effect since it was accomplished through workers' compensation laws rather than “through a statute called pension regulation.”). See generally, Caster, supra note 18.

232. See Travelers Ins. Co. v. Pataki, 63 F.3d 89 (2d Cir. 1995). Travelers Insurance seized upon this loop-hole left open in the Supreme Court’s opinion because it served as a fiduciary to a self-insured plan. See Travelers, 115 S. Ct. at 1675 n.4. Because the record reflected no material dispute of fact regarding the effect of the surcharges on self-insured plans, the Second Circuit could determine the issue on remand as a matter of law even though the district court had not considered the issue.

233. Travelers Ins. Co. v. Pataki, 63 F.3d 89, 94 (2d Cir. 1995). However, the Second Circuit’s analysis was questionable. The court noted that self-insured plans do not deserve special treatment when determining whether a state law “relates to” an ERISA plan and is thus pre-empted. “[A] plan’s self-insured status matters only if a state law that should generally be pre-empted under § 1144(a) qualifies as a law regulating insurance under the savings clause, § 1144(b)(2)(A).” Id. at 93. The court seemed to be suggesting that a separate pre-emption analysis for self-insured plans was not necessary because ERISA’s deemer clause, § 1144(b)(2)(B), does not protect self-insured plans from laws that do not fall within the scope of ERISA’s “relate to” language. This reading of ERISA’s pre-emption provisions is questionable since some state insurance laws may not “relate to” ERISA plans, and yet, because they are “laws regulating insurance,” are not applicable to self-insured plans under the deemer clause. Moreover, a separate
continued administration of self-insured plans by some of the *Travelers* plaintiffs, despite the surcharge, suggested that few if any plans had decided not to self-insure in light of the rate-setting system.\(^{234}\)

Similarly, applying *Travelers*, the Second Circuit held that Connecticut’s surcharges on providers did not have a sufficient effect on self-insured plans to result in pre-emption.\(^{235}\) The court noted that “[w]e are well aware that self-insured plans feel the bite of a surcharge statute more directly and more deeply than do plans that purchase insurance. But, there was no proof that [the law] actually increased self-insured plans’ costs at all.”\(^{236}\) The court thus found the distinction between insured and self-insured plans to be irrelevant to the pre-emption issue.

Yet, whether a law’s impact on self-insured plans triggers pre-emption will not always be so clear. Self-insured plans may be structured in a multitude of ways. Most employers simply assume the risk of health coverage for their employees, and often contract with third-party administrators. The self-insured plans in *Travelers* and *New England Health Care* fall into this category. An insurer which serves as a third-party administrator, like Travelers Insurance, often performs most functions that it would if it were insuring the fund. That is, the insurer may contract with health care providers, negotiate reimbursement rates, and administer claims by plan participants or beneficiaries. The key distinction is that the insurer serving as the third-party administrator is not underwriting the risks. It is the employer, or several employers in a multi-employer fund, that performs the underwriting function.\(^{237}\)

In contrast, some self-insured ERISA plans may go beyond setting up a

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\(^{235}\) *New England Health Care*, 65 F.3d 1024 (2d Cir. 1995).

\(^{236}\) Id. at 1031. The surcharges imposed on hospitals varied during the course of the litigation. However, unlike the surcharges at issue in *Travelers*, the surcharges imposed by Connecticut law did not in theory increase hospitals fees because hospital rates have always reflected cost-shifting to compensate for care to the indigent; the state law merely formalized that practice. Thus, despite the fact that the self-insured plan was “one step closer to the surcharge than are insured plans,” the economic impact was clearly insufficient to trigger pre-emption. *Id.* at 1032.

\(^{237}\) See Caster, supra note 18 at 419 (“[T]he critical attribute distinguishing self-funded plans from state regulated plan is whether employers or insurance companies bear the risk of paying for claims”).
trust or fund from which to pay for covered benefits and contracting with an administrator. Instead, some employers may elect to have the plan own and operate the facilities that provide health care benefits to plan participants and beneficiaries. This type of self-insured plan presents more complex pre-emption issues. For example, *NYSA-ILA Med. and Clinical Servs. Fund v. Axelrod*,238 involved a pre-emption challenge to the application of a provider tax upon a multi-employer, labor-management trust fund (the "Fund") which provides health care benefits through three medical centers that it owns and operates. The centers provide treatment exclusively to plan participants and beneficiaries.239 The New York provision at issue imposed a tax on the gross receipts from patient care services and general operations of all hospitals and a wide range of medical facilities in the state of New York.240 The amount of the assessment for the Fund’s medical centers was 0.6%.241 Revenue was transferred to the medical centers in various ways, but the pre-emption challenge was limited to the extent that the law imposed a levy on contributions and payments provided by the Fund for health care benefits.242

Before *Travelers*, the Second Circuit in *Axelrod* held that the challenged assessment “related to” the Fund and thus was pre-empted by ERISA. The court noted that the assessment was bound to affect ERISA plans generally: the law targeted only the health care industry and, “[b]ecause this industry is, by definition, the realm where ERISA welfare plans must operate, the [Act] was bound to affect them.”243 Further, because the ERISA plan in this case had chosen to provide benefits through self-run medical centers, the court found that the provision operated as “an immediate tax on payments and contributions . . . .”244 More specifically:

The [tax] thus directly affects the Fund in its principle role as an employee welfare benefits plan. It does not touch the Fund only slightly on the outer limits of its plan activities; it affects the very operations and functions that make the Fund what it is, a provider of medical, surgical, and hospital care to its participants and their beneficiaries . . . . The tax depletes those assets earmarked for the

238. 27 F.3d 823 (2d Cir. 1994), vacated by 115 S. Ct. 1819 (1995) (vacated for review in light of *Travelers* decision) [hereinafter *Axelrod*].
239. Id. at 825.
240. See N.Y. Pub. Health Law § 2807-d (1993) (known as the Health Facility Act, this legislation was enacted in 1990). For purposes of the assessment, “gross receipts” include “all monies received for or on account of hospital and health related services,” subject to a few exceptions. Id. at § 2807-d(3)(c).
241. *Axelrod*, 27 F.3d at 825 (citing Id. at § 2807-d(2)(c)).
242. Id. at 825-26.
243. Id. at 827.
244. Id.
provision of health care benefits and, as a result, will cause the Fund to reduce benefits provided and/or to charge beneficiaries more in the future for benefits received. Both impacts will detrimentally affect the central missions and purpose of the Fund and hence cannot be characterized as remote or tenuous.245

On petition for certiorari, the Supreme Court vacated the Second Circuit’s opinion and remanded for review in light of its decision in Travelers.

Although the Second Circuit has not issued an opinion in this case on remand, the court has indicated that under Travelers the outcome should be different.246 In analyzing the Axelrod case, the Second Circuit clearly used a broader approach to pre-emption than the Court in Travelers. Under Travelers, the first inquiry is whether the provider tax is within the domain of traditional state regulation. Although health care provider taxes are a relatively new legislative strategy, taxes are generally considered to be within a state’s police powers. Further, the purpose of the provider taxes are generally to generate funds to accomplish a health policy objective and the tax has an effect similar to any other tax that the medical centers may be required to remit. Thus, the tax should be accorded the strong presumption against pre-emption.247 The second inquiry is to identify the category of state laws that are generally found to be pre-empted in which the tax falls. The provider tax was not designed to apply to ERISA plans, but, rather, to medical facilities, and does not reference ERISA plans, and the tax is clearly not a cause of action within the scope of ERISA’s enforcement provisions. Thus, if it is to be pre-empted it must be because of an impermissible effect on employer choices concerning benefit structures or administrative practices.

The issue would therefore become whether the economic effect of the state law actually or practically binds employer decisions regarding benefit structures or administrative practices. The state law in Axelrod requires the medical centers to remit an assessment based, inter alia, upon gross receipts from patient care services. Thus, to continue the same operations, the centers will need greater contributions from the Fund. As with all self-insured plans, the tax does not result in increased costs passed through to the plan via a premium. Rather, the tax results in increased costs for services and is more directly absorbed by the Fund. The Second Circuit viewed the depletion of assets earmarked for the provision of benefits as dispositive. It is certainly true

245. Id.
246. See New England Health Care, 65 F.3d at 1032 (2d Cir. 1995) ("[I]n the wake of Travelers . . ., we question whether we should continue to distinguish between laws that directly deplete ERISA plans’ assets and laws that only indirectly do so.").
247. The Second Circuit did not expressly recognize that the state law at issue was a regulation of health care and thus entitled to a strong presumption against pre-emption.
that the employer may need to make some adjustments in the plan. However, the effect of the law does not bind choices as to future benefit levels or structures. Indeed, an employer could continue to offer the same benefits—even in interstate plans if the employer desires.

Nonetheless, because the Fund owns and operates the medical centers and the law requires facilities to remit an assessment, it could be argued that the tax impermissibly mandates an “administrative practice.” Because the holding in Travelers did not elaborate on the types of state-mandated administrative practices that may be pre-empted, it is necessary to draw on Travelers’ more general guidance regarding a pragmatic assessment of congressional intent, namely, that courts must ensure that pre-emption of a law designed to promote health policy objectives will serve the fundamental objectives of the ERISA statute without causing undue adverse practical consequences. The first issue then is whether requiring medical centers owned by ERISA plans to remit a tax is the type of state law that would interfere with nationally uniform administration of ERISA plans. To resolve this question, it, in turn, becomes necessary to determine the appropriate scope of the phrase “administration of the plan” or “administrative practices” for purposes of ERISA pre-emption.

Fort Halifax articulates the clearest guidance from the Supreme Court regarding the administrative practices which Congress was concerned about when it enacted ERISA in 1974. At issue in Fort Halifax was a Maine statute requiring a one-time severance payment to employees. The Court noted that “Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures,” but also that congressional concern regarding uniform procedures would arise only with respect to benefits whose provision “by nature requires an ongoing administrative program” to meet the employer’s responsibility. The Court explained that employers that establish and maintain ERISA plans are faced with the “task of coordinating complex administrative activities,” and “[a]n employer that makes a commitment to pay certain benefits undertakes a host of obligations such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements.” Thus, the Court clearly focused on the “employer’s administrative scheme” or those procedures or practices that

249. Id. at 11.
250. Id. at 11-12.
251. Id. at 11.
252. Id. at 9.
253. Id. at 10.
an employer must perform in order to provide health care coverage.

Further, the Supreme Court's focus was on the on-going processes and practices developed to effectuate the provision of benefits to plan participants or beneficiaries; i.e., benefit-based practices akin to the claims administration functions that an insurer traditionally performs for an insured plan. In *Fort Halifax* the Court found that the law was not pre-empted because the employer would assume no obligation to pay benefits on a regular basis and thus "faces no periodic demands on its assets that create a need for financial coordination and control. . . . To do little more than write a check hardly constitutes the operation of a benefit plan."\(^{254}\) In exploring the relevant administrative practices, the Court also referred to *Alessi* where the Court struck down a statute that prohibited offsetting workers' compensation payments against pension benefits. The Court noted that the effect of that statute was to make the employer follow the benefit payment scheme under New Jersey law or adopt a different payment formula for employees inside and outside of the state.\(^{255}\) These cases reinforce the Court's view that Congress was largely concerned with administrative inefficiencies experienced by the employer.

An employer that elects to join with other employers to provide welfare benefits through an ERISA plan that owns and operates medical centers has certainly undertaken a host of obligations. Further, because of the many costs considerations involved in operating a medical facility, the need to monitor the availability of funds for the provision of benefits becomes particularly crucial. However, a state tax upon medical centers owned by ERISA plans that may cause a depletion of plan assets does not hinder uniformity of administration procedures. Rather, the procedures designed by the employer to monitor the assets can remain uniform. The impact of the tax is simply that the funds may be depleted more rapidly and the employer may need to shop for cost savings as to some aspect of the plan. Thus, limiting the phrase "administration of the plan" to the employer's administrative scheme would result in the conclusion that the state law does not impermissibly interfere with national uniformity of ERISA plans.

Alternatively, the scope of the phrase "administration of the plan" could be viewed as extending beyond the employer's administrative scheme, e.g., to the administrative scheme of an insurer, third-party administrator, or HMO or other managed care organization (MCO) if appropriately limited. Because the Court indicated that Congress was concerned with the on-going processes and practices developed to effectuate an employer's provision of benefits to plan participants or beneficiaries, a logical point of delimitation would be to encompass only those functions provided directly for or specifically pertaining

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254. *Id.* at 12.
255. *Id.* at 10 (citing *Alessi*, 451 U.S. 504 (1981)).
to a particular employer and that employer's plan assets. This might include functions such as determining eligibility of employees, providing information about the plan to employees, processing claims including performing precertification procedures, and managing the assets of the employer. However, given the extreme variability in functions performed by different segments of today's health care industry, precise factual analysis is crucial if pre-emption is viewed as extending to practices performed by entities other than the employer.

Specifically, the health care industry of today is significantly different from what existed in 1974. In 1974, there was little variation in the structure of health care plans. The employer either contracted with a traditional indemnity insurer or elected to self-insure. Today, concepts such as managed competition and managed care have resulted in tremendous variations. Health care is provided through managed care networks or integrated delivery systems. In addition to contracting with third-party administrators or owning or operating medical facilities as in Axelrod, employers that self-insure may contract with integrated delivery systems which will provide care for employees and beneficiaries. Further, a third-party administrator that an employer may contract with may also be a part of an integrated network and provide management services for the network.

Thus, even if the phrase "administration of the plan" is construed as encompassing administrative services provided by other entities, many functions of that entity may not be properly characterized as functions provided directly for or specifically pertaining to a particular employer and that employer's plan assets. Rather, the entity will also be engaging in its own administration of its business. The administration of the entity's business of course depends on the scope of its particular operations. For example, if the entity which contracts with the employer also performs administrative functions for the network, then it may engage in practices such as devising the managed care measures which will be followed, educating the participating providers of those procedures, and creating incentives which will help hold down costs.


258. Employers, business groups and other sponsors of health care coverage, which historically have negotiated independently, are beginning to join forces in negotiating managed care contracts. For example, Monsanto Company,Ralston Purina and a dozen other members of the St. Louis Area Business Health Coalition recently formed a health care purchasing group. "St. Louis Area Businesses Join to Form Purchasing Cooperative," BNA HEALTH CARE DAILY, Aug. 29, 1994, available in WESTLAW, 8/29/94 HCD d4 at 1.
and thereby increase profits for the network.\textsuperscript{259} Because pre-emption only reaches laws that impermissibly infringe on practices that constitute "administration of the plan," courts must distinguish between those practices which pertain specifically to the claims management type of functions the entity is performing for an employer, and those functions it is performing for the network.

Even under this broader interpretation of the scope of the phrase "administration of the plan," the provider tax in \textit{Axelrod} would not be pre-empted. In \textit{Axelrod}, the Fund owned and operated three medical centers and thus is involved in a multitude of processes and practices necessary to function as a provider of health care—e.g., facilities licensure, credentialing of medical professionals, and other quality of care requirements. These practices are in addition to and distinguishable from the functions that relate to providing health care coverage to employees. The tax is imposed on the centers as providers of care. Remission of the tax thus falls within the scope of the administrative practices of the medical center—not within the scope of the "administration of the plan." Although the Fund must somehow find a way to disburse more money to the centers, a pragmatic assessment of the pre-emption question reasonably leads to the conclusion that the state law does not infringe on the types of administrative practices that Congress could have intended to protect. Pre-emption of the tax provision would not further core congressional goals underlying ERISA because the employer's interstate ERISA plans can be maintained and relevant administrative practices can still be designed in a uniform manner.\textsuperscript{260}

Moreover, the "logical stopping point" rationale stressed by the Court in \textit{Travelers} strongly supports this conclusion. If a tax upon a medical facility were to be pre-empted merely because the facility is owned or operated by a self-insured ERISA plan, there would seem to be no logical stopping point to ERISA pre-emption. Other state laws that result in increased costs for providers of care—e.g., heightened quality of care standards—would arguably be pre-empted as well. As the Court in \textit{Travelers} noted, "[t]he bigger the package of regulation with indirect effects that would fall . . . the less likely it is that federal regulation of benefit plans was intended to eliminate state regulation of health care costs."\textsuperscript{261} Thus, even as to self-insured ERISA welfare plans that choose to own or operate the facilities that provide health care services for covered participants and beneficiaries, use of \textit{Travelers}


\textsuperscript{260} Indeed, the Fund in \textit{Axelrod} operated in more than one state.

\textsuperscript{261} \textit{Travelers}, 115 S. Ct. at 1679.
framework along with careful analysis of Supreme Court precedent renders it difficult to reach the conclusion that Congress intended for ERISA to pre-empt provider taxes.

C. Contract and Tort Claims

In addition to provider taxes and other surcharges, lower courts are increasingly finding pre-emption of state law contract and tort claims brought by plan participants or beneficiaries against health care providers or plan administrators or brought by health care providers against plan administrators. As with cases involving surcharges or taxes, the outcomes on the issue of ERISA pre-emption have been inconsistent—indeed, the situation might be characterized as one of utter confusion on the issue.262 Various rationales are used by the courts in resolving the pre-emption issue: e.g., (1) the claim is really a claim for benefits or a claim for improper processing of the claim,263 (2) the claim affects plans by causing pass-through costs that will result in the plan having to choose between higher costs or a reduction in benefits,264 (3) the claim regulates the administration of the plan,265 (4) the claim arises from the provision of benefits pursuant to an ERISA plan266 or (5) the claim requires an examination of plan documents.267 In cases involving contract or tort claims, courts often use several of these rationales.268 The effectiveness of the Travelers framework in restraining the scope of ERISA pre-emption of state contract and tort claims is less clear.269


263. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992).


268. See, e.g., id.; Dukes v. United States Health Care Sys. of Pa., Inc., 848 F. Supp. 39 (E.D. 1994) (holding state tort claims pre-empted), rev’d on other grounds, 57 F.3d 350 (3d Cir. 1995) (holding that action was not removable because tort claims were not within the scope of ERISA § 502(a)).

269. Remember that some courts may not accept the premise that Travelers is applicable to state contract and tort claims because common law claims are clearly distinguishable from legislative provisions imposing rate-setting schemes, provider taxes or other surcharges. However, the central thesis in this article is that the Travelers opinion can be construed as a strong signal that ERISA pre-emption should be restrained. Accordingly, this section of the article explores whether the framework for analyzing ERISA pre-emption after Travelers can effectively limit overly expansive applications of ERISA pre-emption to contract and tort claims.
However, a broad construction of *Travelers* and careful scrutiny of Supreme Court precedent can lead to the conclusion that many claims that lower courts have found to be pre-empted should not be pre-empted, and can lead to more consistent and predictable outcomes.

One reason to believe that *Travelers* will inevitably affect the pre-emption issue as to state contract and tort claims is *Travelers'* emphasis of the fundamental premise that state common law claims should be accorded a weighty presumption against pre-emption. Lower courts have often disregarded this fundamental principle of pre-emption analysis. Without doubt, contract and tort claims are within the domain of traditional state police power. Such claims serve a more fundamental purpose than to impose benefit or administrative obligations upon ERISA plans; rather, common law contract and tort claims help ensure socially responsible behavior. Thus, such claims should not be deemed pre-empted absent clear congressional intent.

Further, use of the *Travelers* framework would likely affect the pre-emption issue in another important way. The pragmatic and more delineated analytical framework could lead lower courts out of the current state of utter confusion. That is, if courts adopt a uniform approach to the pre-emption question, there is at least a greater potential for uniformity in the outcome. In applying the *Travelers* framework to state law causes of action, the threshold inquiry is to identify the appropriate category of laws to which the state claim belongs. That is, (1) is the cause of action one that was designed specifically to apply to ERISA plans or one that imposes a duty on employers or administrators by express reference to ERISA plans; (2) is the claim within the scope of ERISA's civil enforcement provisions; or (3) does the cause of action relate to ERISA plans because of its effect on employer or administrator decisions concerning benefit structure or administration of the plan? Accurately resolving this inquiry and following through with the analysis as detailed below should go a long way toward both restraining and rationalizing pre-emption outcomes.

1. **Claims Designed Specifically to Apply to ERISA Plans or to Impose a Duty on Employers or Administrators by Express Reference to ERISA Plans**

   As noted in section I.A., the Supreme Court has found that common law claims "relate to" ERISA plans in only two cases. In *Pilot Life*, the Court

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found state tort and contract claims based on allegedly improper processing of claims under an insured ERISA plan to be pre-empted.\textsuperscript{272} In \textit{Ingersoll-Rand}, the Court held that ERISA pre-empted a common law claim establishing an exception to the doctrine of at-will employment where an employee is unlawfully discharged primarily because of the employer's desire to avoid contributing to or paying benefits under the employee's pension fund.\textsuperscript{273} The Court expressly stated that the claim in \textit{Ingersoll-Rand} fell within the principle enunciated in \textit{Mackey}—that laws which are specifically designed to affect employee benefit plans are pre-empted. "The facts here are slightly different but the principle is the same: The Texas cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan."\textsuperscript{274} Thus, state common law causes of action can be found to be pre-empted by ERISA if they impose a duty on ERISA plans by reference. In determining whether the pre-emption analysis after \textit{Travelers} can lead to a more restrained application to contract and tort claims, the issue is whether \textit{Travelers} indicates that most contract and tort claims do not fall within this category of state laws.

In \textit{Ingersoll-Rand}, the Court found that the existence of a pension plan and a pension-defeating motive are essential elements in the Texas cause of action.\textsuperscript{275} Thus, in the words used by the Court in \textit{Greater Washington Board of Trade}, the common law duty imposed by the action is established by reference to ERISA plans and indeed does not arise absent an ERISA plan.\textsuperscript{276} Most state contract and tort claims are distinguishable. The elements of the claims can generally be stated without referencing ERISA plans.\textsuperscript{277}

The general common law duties are therefore established by courts without referencing ERISA plans and persons are subject to the common law duties regardless of ERISA plans. Under certain circumstances, however, an argument could be made that contract and tort claims fall within this category of pre-empted state laws. For example, if a claim is for breach of a contractual term set forth in an ERISA plan, then arguably the duty arose only because of the contractual nature of an ERISA plan. If a tort claim is for negligent conduct in conjunction with the provision of benefits under an ERISA plan, then arguably the duty to use care only arose because of the duties undertaken in accordance with the ERISA plan.

Nonetheless, the duty involved in \textit{Ingersoll-Rand} is still distinguishable. In that case, there was no general common law duty relating to the termination

\begin{thebibliography}{9}
\bibitem{272} 481 U.S. 41 (1987). \textit{See supra} notes 50-54 and accompanying text.
\bibitem{274} \textit{Id.} at 140.
\bibitem{275} \textit{Id.}
\bibitem{277} \textit{See} \textit{RESTATEMENT (SECOND) OF TORTS} § 281; \textit{RESTATEMENT (SECOND) CONTRACTS} § 236.
\end{thebibliography}
of an employee. Employers in Texas may generally terminate employees at-will. The cause of action therefore represented judicial creation of a distinct common law duty. Yet contract and tort claims, even if they hinge in some respects on an ERISA plan, do not result in distinct common law duties. Employers, insurers, and plan administrators have a duty to uphold lawful contracts and providers must generally use reasonable care when undertaking to provide services.

A strong argument can be made that Travelers supports this view and can therefore lead to a more restrained application of ERISA pre-emption to contract and tort claims. The field of state regulation via contract and tort law is sufficiently large that, absent clear guidance from Congress, pre-emption is inappropriate. The outer bounds of pre-emption concerning state causes of action that may be characterized as designed specifically to apply to ERISA plans or to impose a duty on employers or administrators by express reference to ERISA plans are far from clear. Precisely because it is not clear to what extent Congress intended to pre-empt common law contract and tort claims, the presumption against pre-emption should apply. Travelers therefore suggests that adopting the narrower approach is more appropriate, i.e., a contract or tort claim should be placed into this category of laws that may be pre-empted only if the claim represents judicial creation of a distinct duty that exists and is imposed only because of the existence of an ERISA plan. Because few contract or tort claims will meet this standard, pre-emption of claims based on this rationale will be restrained.

2. Claims Within the Scope of ERISA's Civil Enforcement Provisions

In Pilot Life and Ingersoll-Rand the Court used the rationale that the claims were within ERISA's civil enforcement provisions to support its holdings that the common law claims at issue related to ERISA plans. In Travelers, the Court expressly referred to this category of state laws as those that provide "an alternative enforcement mechanism."278 However, several lower courts have gone further and held that even common law claims that are not claims under ERISA are pre-empted because they are nonetheless within the scope of Pilot Life.279 Travelers' signal to restrain pre-emption and to identify logical stopping points for ERISA pre-emption arguably leads to the conclusion that these lower courts have expanded pre-emption based on this rationale beyond "clear" congressional intent.

Specifically, the Court's restoration of the presumption against pre-}

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278. 115 S. Ct. at 1678.
279. See, e.g., Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992); Kuhl v. Lincoln Nat'l Health Plan of Kansas City, 999 F.2d 298 (8th Cir. 1993).
emption of state laws within the traditional police power of the states, as well as the Court’s emphasis on identifying logical lines of delimitation, suggest that two issues must be considered. First, it must be determined whether *Pilot Life* justifies pre-emption of claims that are not within the scope of ERISA’s civil enforcement provisions. Stated differently, should ERISA be construed as pre-empting claims—not merely remedies—that are not prescribed by its enforcement provisions? Careful analysis of prior Supreme Court cases suggests not. Further, a strong argument can be made that pre-emption of claims *not* within the scope of ERISA’s civil enforcement provision does not significantly advance core ERISA objectives. Second, courts must distinguish with greater precision claims for benefits or improper processing of claims (which are within the scope of ERISA’s civil enforcement provisions), and, e.g., claims for negligent acts or omissions otherwise committed in the administration of the plan (which may not be within the scope of the civil enforcement provisions). If lower courts consider these issues, then the scope of ERISA pre-emption based on the rationale that a claim is within the scope of ERISA’s civil enforcement provisions may be effectively restrained.

a. **Claims That Are Not Within the Scope of ERISA’s Civil Enforcement Provisions Are Not Automatically Pre-empted**

Careful scrutiny of Supreme Court precedent indicates that ERISA pre-emption should encompass any attempt to obtain, via state contract or tort claim, remedies for wrongs addressed by ERISA that are not expressly prescribed in the civil enforcement provisions set forth in section 502(a) of ERISA. However, the language of ERISA and Supreme Court interpretations do not indisputably support the premise that any contract or tort claim—even those for wrongs not addressed by ERISA—must be pre-empted. Thus, it is meritorious to argue that, if *Travelers* is a signal for restraint in the scope of ERISA pre-emption—especially as to state laws within the traditional domain of state police powers—then courts should adopt the view that contract and tort claims based on wrongs that are not addressed by ERISA are *not* automatically pre-empted.280

Analysis of this argument must begin with the language of section 502(a) of ERISA, which sets forth a comprehensive civil enforcement scheme.281

280. This is not to say that state law causes of action that do not fall within the scope of section 502(a) should never be pre-empted. However, the proper pre-emption analysis is to treat such state law causes of action as other laws that arguably impermissibly affect the benefit structure or administrative practices of ERISA plans. See infra notes 341-91 and accompanying text.

281. In its entirety, § 502(a) reads:
A civil action may be brought —
(1) by a participant or beneficiary —
The section prescribes, *inter alia*, that a civil action may be brought:

(1) by a participant or beneficiary . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; 282

(2) . . . by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title [breach of fiduciary duty];

(3) by a participant, beneficiary or fiduciary (A) to enjoin any act or practice that violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.[.] 283

The language emphasizes that the scheme is largely remedial in nature. The provisions of section 502(a) primarily prescribe what relief certain persons may obtain. The basis for relief—i.e., the wrongs upon which a right to relief under ERISA can be based—are not set forth in section 502(a), but must be derived from the statute as a whole or from the terms of an ERISA plan.

In *Pilot Life*, the Court held that claims against the insurance company, including tortious breach of contract, breach of fiduciary duties, and fraud in the inducement, 284 were pre-empted. The Court characterized these contractually-based claims as being based on "alleged improper processing of
Thus, the claims were construed as seeking either to recover benefits due under the terms of the plan or to obtain relief for breach of a fiduciary duty. In *Ingersoll-Rand*, the claim was based on discharging a plan participant in retaliation for exercising a vested right under the plan, which is rendered unlawful by section 510 of ERISA. The claim could thus be characterized as a claim to enjoin an act that violated ERISA. Both claims were therefore within the remedial provisions prescribed in section 502(a).

In *Pilot Life*, the Court explained that "[t]he civil enforcement scheme of section 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA." Yet the Court merely adopted the argument that:

Congress clearly expressed an intent that the civil enforcement provisions of ERISA § 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries *asserting improper processing of a claim for benefits*, and that varying state causes of action for claims *within the scope of § 502(a)* would pose an obstacle to the purposes and objectives of Congress.

In *Ingersoll-Rand*, the Court explained that *Pilot Life* made clear "that Congress intended § 502(a) to be the exclusive remedy for rights guaranteed

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285. *Id.* at 48. *Pilot Life* does not provide much insight as to the exact nature of the acts which constituted improper processing in that case. The Court in *Pilot Life* merely informs us that the employer had a long-term disability benefit plan established by purchasing a group policy through Pilot Life Insurance Company. The employer forwarded completed claims forms to Pilot Life. Pilot Life bore the responsibility for determining who would receive disability benefits. The plaintiff Dedeaux sought permanent benefits, but Pilot Life terminated benefits after two years and then reinstated and terminated benefits several times during the following three years. The claim, then, was for failure to provide benefits under the plan. A claim seeking benefits is clearly within the scope of ERISA's enforcement provisions.

286. In its entirety, § 510 reads:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, section 1201 of this title, or the Welfare and Pension Plan Disclosure Act [29 U.S.C. § 301 et seq.], or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act. It shall be unlawful for any person to discharge, fine, suspend, expel, or discriminate against any person because he has given information or has testified or is about to testify in any inquiry or proceeding relating to this chapter or the Welfare and Pension Plans Disclosure Act. The provisions of section 1132 of this title shall be applicable in the enforcement of this section.


287. 481 U.S. at 52.

288. *Id.* at 52 (citing Brief for United States as Amicus Curiae at 18-19) (emphasis added).
Therefore, in both cases the Court emphasized the fact that the claims were pre-empted because they were addressed by ERISA's enforcement scheme and involved rights protected by ERISA. The claims could therefore be pursued under ERISA itself.

Nonetheless, lower courts have gone much further by finding state contract and tort claims pre-empted even where the claim is not addressed by ERISA and the plaintiff is thus left with no avenue for relief. For example, in Corcoran v. United Healthcare, Inc., the Fifth Circuit Court of Appeals broadly stated that if a claim involves negligence in making a coverage decision or a benefit determination then it is within the scope of Pilot Life—despite the fact that the claim involved was not within the scope of section 502(a) of ERISA. Corcoran involved a claim for damages as a result of negligence by a defendant in the benefit determination process. The Corcorans' unborn child died after a utilization review provider for the ERISA plan through which the Corcorans obtained health coverage negligently determined that hospitalization of the mother was not necessary. Instead of hospitalization, United Healthcare, the entity which provided utilization review services for the ERISA plan, authorized ten hours per day of home nursing care. During a period of time when no nurse was on duty, the fetus went into distress and died.

The court characterized the claim as "a tort allegedly committed in the course of handling a benefit determination." The court acknowledged that the nature of the benefit determination was different from the type of decision that was at issue in Pilot Life, but held that the mere fact that it was a "benefit determination" sufficed for the claim to fall within the scope of Pilot Life's holding that "ERISA pre-empts state-law claims alleging improper handling of benefit claims."

However, the Corcorans' claim was not addressed by ERISA's enforcement provisions. Although a claim by a participant or beneficiary, the claim was not based on a violation of the terms of the ERISA plan nor on a violation of ERISA. Rather, the Corcorans' claim was essentially a malpractice claim against the utilization review provider for making an erroneous medical determination. In justifying pre-emption of the claim, the court focused on the fact that the Corcorans were seeking remedies not prescribed by ERISA,

290. In addition to the cases discussed in this section, see Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991), cert. dismissed, 113 S. Ct. 2 (1992).
291. 965 F.2d 1321 (5th Cir. 1992).
292. Id. at 1324. The Corcorans' filed a wrongful death claim which alleged that the child died as a result of acts of negligence by United Healthcare.
293. Corcoran, 965 F.2d at 1332.
294. Id.
specifically, emotional distress and mental anguish. 295

Like other courts which have held state law causes of action to be preempted despite the fact that the plaintiff is then left without an avenue for relief, the court in Corcoran noted that:

The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans, the lack of an ERISA remedy does not affect a pre-emption analysis. 296

Notably, this statement reveals that courts are inappropriately equating the term remedy with the term claim. Yet there is a distinction between claims and remedies. 297

Section 502(a) indicates that only certain wrongs can be the basis of a claim under ERISA, and affords distinct remedies for those wrongs. Section 502(a) articulates who can bring a civil action, 298 gives some indication of

295. Id. at 1338. Despite the fact that the Fifth Circuit characterized the action as a claim involving a benefit determination, the court specifically held that the claim did not fall within section 502(a)(3). Id. at 1334-35. In analyzing the issue, the court noted that equitable relief is accorded by that subsection, Id. at 1335 (§ 502(a)(3) provides for "other equitable relief"), and presumed that equitable relief might encompass some "make-whole damages"—that is, damages necessary to make the plaintiff whole. Id. at 1336. The court merely made a presumption because the Supreme Court expressly stated that its holding in Massachusetts Mutual Life Ins. Co. v. Russell, that extra- contractual or punitive damages are not available in a claim for improper processing of a claim, did not address claims within the scope of § 502(a)(3). 437 U.S. 134, 155 (1985) (Brennan, J., concurring). However, the court was confident that § 502(a)(3) would not include damages for the emotional distress and mental anguish. Corcoran, 905 F.2d at 1336.

Similarly, the court in Kuhl v. Lincoln Nat'l Health Plan of Kansas City expressly declined to recognize a claim based on § 502(a)(3)(B) because it held that monetary damages could not constitute "other appropriate equitable relief" within the meaning of the that subsection. 999 F.2d 298, 305 (8th Cir. 1993). But see Warren v. Society Nat'l Bank, 905 F.2d 975, 982 (6th Cir. 1990), cert. denied, 111 S.Ct. 2256 (1991). Yet Justice Brennan, with several justices agreeing, has noted that trust-law remedies, although equitable in nature, can include monetary damages. Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 154 n.10 (Brennan, J., concurring). Thus, even determining what remedies are within ERISA's enforcement provisions will often be a thorny issue.

296. Corcoran, 965 F.2d at 1333 (citations omitted).

297. Whether a plaintiff has a claim depends on whether the substantive law prescribes that a plaintiff can recover for the alleged wrongful acts of a defendant. If so, a distinct remedial inquiry is what relief may be accorded for a violation of a substantive right. See Dan B. Dobbs, LAW OF REMEDIES § 1.1 (2d ed. 1993).

298. E.g., participants and beneficiaries.
the wrongs that can form the basis for the action, and prescribes certain remedies. The claims addressed by ERISA stem from the specific wrongs that can form the basis for the action—i.e., a participant may bring a claim for violation of the terms of the plan or for violation of ERISA's provisions. The remedies available for those wrongs include benefits due, a declaration of rights, or an injunction of acts that violate the statute. Because the claim in Corcoran did not stem from a violation of the terms of the ERISA plan or of ERISA, the claim was not within the scope of section 502(a), and thus not within the scope of Pilot Life.

The distinction between claims and remedies is important because, although the Supreme Court has stated that a lack of a remedy under ERISA does not alter the pre-emptive force of ERISA, the Court has never held that the lack of a claim under ERISA does not affect the scope of ERISA. Further, the statement that lack of a remedy does not negate pre-emption was expressed in the context of justifying pre-emption of a claim within the scope of section 502(a). In Massachusetts Mutual Life Insurance Co. v. Russell, the Court held that extra-contractual and punitive damages are not available in a claim under section 502(a)(1)(B) enforcing a violation of section 409(a) of ERISA. The Court found that the legislative history and structure of ERISA's remedial scheme negated the inference that Congress intended to permit recovery of such damages in a claim for breach of fiduciary duties: "The six carefully integrated civil enforcement provisions found in § 502(a) of the statute . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

In Pilot Life, the Court drew upon Russell's holding to support the finding that ERISA pre-empted the state causes of action seeking relief for improper processing of claims. The Court explained that:

[Section] 502(a) . . . represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and

299. E.g., violation of the terms of the plan or violation of ERISA's provisions.
300. E.g., benefits due, declaration of rights, an injunction of acts that violate the statute.
See also supra note 281.
301. See, e.g., Pilot Life, 481 U.S. at 52-57.
303. Id. at 146. Justice Brennan's concurring opinion reiterated the narrowness of the Court's holding in Russell. "This case presents a single, narrow question: whether the § 409 'appropriate relief' referred to in § 502(a)(2) includes individual recovery by a participant or beneficiary of extra-contractual damages for breach of fiduciary duty." Id. at 149 (Brennan, J., concurring).
the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.305

But *Pilot Life* also involved a claim that the Court readily found to be within the scope of section 502(a)(1)(B)—a claim for benefits under the terms of the plan. In such a case it may be argued that the balance between public and private interests would be disrupted by permitting a plaintiff to recover on a state claim when the plaintiff can recover limited damages, such as recovery of benefits due, under ERISA itself. Arguably, however, the balance between private and public interests is equally undermined if egregious acts of employers or claims administrators go totally unredressed because of an overly broad construction of ERISA pre-emption.

Moreover, the legislative history does not indisputably lead to the conclusion that Congress intended for ERISA to pre-empt claims that are not addressed by section 502(a). The relevant legislative history was discussed extensively in *Pilot Life*. In *Pilot Life*, the Court noted only that "varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress."306 Moreover, the Court quoted from the Conference Report describing section 502(a), which notes that with respect to suits within the scope of section 502(a), "[a]ll such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947 ["LMRA"]."307 The Court explained that Congress was aware that the powerful pre-emptive force of section 301 of the LMRA "displaced all state actions for violation of contracts between an employer and a labor organization, even when the state action purported to authorize a remedy unavailable under the federal provision."308 The Court then noted that Congress's specific reference to section 301 to describe ERISA's civil enforcement provisions "makes clear its intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)."309

Two points drive home the conclusion that the legislative history of section 502(a) impliedly indicates only that where a person has a claim that is addressed by ERISA, that the claimant is limited to the remedies prescribed.

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305. *Id.* at 54.
306. *Id.* at 52 (emphasis added).
307. *Id.* at 55 (quoting H.R. CONF. REP. NO. 93-1280, 93d Cong., 2d Sess. 327 (1974)).
308. *Id.*
309. *Id.* at 56.
First, the statements suggest that both ERISA pre-emption and LMRA pre-emption are limited to claims that are within the scope of the federal statutes: actions based on violations of labor contracts are clearly addressed by the LMRA and actions to enforce rights or to recover benefits due under ERISA plans are addressed by ERISA. Second, the comparison to section 301 is more relevant to jurisdictional issues than to the pre-emption issue. The Conference Report stresses that claims within section 502(a) are to be "regarded as arising under the laws of the United States," and the Court explained that such actions should be treated as "federal questions." These statements can be used as support for use of the complete pre-emption doctrine for purposes of removal jurisdiction more readily than they can be used as an indication of the scope of laws that "relate to" ERISA plans.

Significantly, however, the scope of the complete pre-emption doctrine sheds light on the issue at hand. The doctrine of complete pre-emption is an exception to the general rule that a federal pre-emption defense does not render a plaintiff's state law claim filed in state court subject to removal to federal court. In Metropolitan Life Insurance Co. v. Taylor, the Supreme Court held that a plaintiff's common law state claims were completely preempted—and thus that the action was removable—because the claims were within the scope of section 502(a)(1)(B). That is, because the claims were

310. "[Section] 301(a) of the LMRA applies to all 'suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce . . . or between any such labor organizations.' We have not taken a restrictive view of who may sue under § 301 for violations of such contracts, (citations omitted). But even under §301 we have never intimated that any action merely relating to a contract within the coverage of § 301 arises exclusively under that section. For instance, a state battery suit growing out of a violent strike would not arise under § 301 simply because the strike may have been a violation of an employer-union contract. (citations omitted)." Franchise Tax Bd. of Cal. v. Constr. Laborers Vacation Trust for S. Cal., 463 U.S. 1, 25 n.28 (1983) [hereinafter Franchise Tax Bd.].

311. See, e.g., Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-66 (1987) (after explaining the "complete pre-emption" exception to the well-pleaded complaint rule, the Court held that the exception is narrowly limited in the ERISA context to state common law or statutory claims that fall within the scope of section 502(a) because the "legislative history consistently sets out this clear intention to make [section 502(a)] suits brought by plan participants or beneficiaries federal questions for the purpose of federal court jurisdiction . . . "). See also Warner v. Ford Motor Co., 46 F.3d 531, 535 (6th Cir. 1995) (reiterating that removal and pre-emption are two distinct concepts).

312. By statute, a civil action brought in a state court may be removed to federal court only if the claim is one over which the district courts would have original jurisdiction. 28 U.S.C. § 1441(a) (1988). Among other categories of cases, district courts have original jurisdiction over claims "arising under the Constitution, law or treaties of the United States." 28 U.S.C. § 1331 (1988). A claim arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1987) (citing Gully v. First Nat'l Bank, 299 U.S. 109 (1936); Louisville & Nashville R.R. v. Motley, 211 U.S. 149 (1908)). Federal pre-emption is ordinarily a federal defense; because it does not appear on the face of a well-pleaded complaint, it does authorize removal to federal court. Id.

313. 481 U.S. 58, 66-67 (1987). The claims in Taylor included a breach of contract claim and a tort claim for wrongful termination in retaliation for a workers' compensation claim. The
displaced by federal claims under ERISA, the only claims that existed were
federal claims which the Conference Report indicated should be regarded as
"arising under" the laws of the United States. Removal is appropriate in
such a case in order to preclude plaintiffs who engage in artful pleading from
depriving a defendant of the right to have a federal claim heard in federal
court.

The scope of ERISA pre-emption is clearly broader than the scope of
claims that fall within the complete pre-emption doctrine. Significantly,
however, the scope of claims that may be pre-empted by virtue of falling
within the scope of Pilot Life and Ingersoll-Rand, is arguably the same as the
scope of the complete pre-emption doctrine. In Pilot Life, the Court determined
that the claims were pre-empted because the claims at issue were claims for
benefits "within the scope of section 502(a)." In Taylor, the Court found clear
congressional intent to permit removal of state law claims "within the scope
of section 502(a)." Because the Court used the same language, the scope of
these precedents should be similarly construed.

The Supreme Court has spoken more definitively in the context of the
complete pre-emption doctrine. The Court has indicated that removal should
be limited to those situations where a plaintiff's state law claim is displaced
by section 502(a). That is, if a state claim is not necessarily federal in
nature by virtue of being, in reality, a claim that may be brought under section
502(a), the doctrine of complete pre-emption is not available. That does not
mean that the claim is not pre-empted, but, rather, that the claim is not
removable. Logically, then, a strong argument exists that state law claims
should not be found pre-empted by virtue of falling within the scope of Pilot
Life unless the claim is similarly displaced by section 502(a).

Viewed from this perspective, courts should be hesitant to rely solely on

plaintiff was seeking compensatory damages, reinstatement of benefits and insurance coverage,
and damages for mental anguish. Both claims fell within § 502(a): Taylor was seeking recovery
of benefits and a remedy for a violation of ERISA, which prohibits termination in retaliation for

314. Id. at 66. See also Franchise Tax Bd., 463 U.S. at 25-26 (1983) (finding that the
state's action to enforce a tax against funds in an ERISA plan was not within the complete pre-
emption doctrine because ERISA did not provide an alternative cause of action in favor of the
state).

pleading" doctrine cannot be invoked where a state claim is not within the complete pre-emption
doctrine).

316. See Franchise Tax Bd., 463 U.S. at 25 (noting that § 502(a) "does not purport to
reach every question relating to plans covered by ERISA").

U.S. 1 (1983). See also Dukes v. United States Health Care Sys. of Pa., Inc. 57 F.3d 350 (3d
Cir. 1995). But see Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) (holding that ERISA does not
completely pre-empt claims against ERISA plan administrators based on state law doctrine of
respondeat superior).
a broad interpretation of the reach of *Pilot Life* to find state common law claims pre-empted when the plaintiff is left without any avenue of redress based on ERISA. The legislative history supports only the conclusion that Congress intended for section 502(a) to limit remedies available in claims under ERISA, and to require that claims within the scope of section 502(a) be pursued under section 502(a). And the Court has stated only that the comprehensive legislative scheme of section 502(a) impliedly indicates that, where a person has a claim that is addressed by ERISA, the claimant is limited to the remedies prescribed. Therefore, a reasonable interpretation of ERISA and of the Court’s holdings is that ERISA will not automatically pre-empt state law claims based on wrongs which ERISA does not address.

This conclusion is bolstered by the Court’s characterization of this category of laws in *Travelers*. Rather than labeling this category of laws as claims within ERISA’s enforcement provision, the Court concluded that state claims that constitute an “alternative enforcement mechanism” are pre-empted. If a state claim is for a wrong that is not addressed in section 502(a), then the state claim cannot be an “alternative” to an ERISA action. *Travelers* made clear that pre-emption of laws within the traditional police power is inappropriate absent a clear indication of congressional intent. Application of the framework for the pre-emption analysis after *Travelers* would therefore suggest that claims that do not fall within the scope of section 502(a) of ERISA should not be pre-empted on the basis of being within the scope of *Pilot Life’s* holding.

Rather, a reasonable conclusion is that, in determining whether a law is within the scope of *Pilot Life*, a court should engage in a narrow analysis of whether the specific claim at issue is truly an “alternative enforcement mechanism,” i.e., is a claim within the scope of section 502(a).

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318. For example, the claim in *Ingersoll-Rand* was found to be within the scope of § 502(a) because an employer who terminates an employee for incurring substantial medical expenses covered by the ERISA plan violates the terms of ERISA. The employee as a participant in the plan would be entitled to institute a civil action to enforce the provision in ERISA which precludes retaliatory conduct.


320. 115 S. Ct. at 1678.

321. Notably, this will not always be an easy determination to make because federal courts have been slow to develop claims under the six integrated enforcement provisions in § 502(a). For example, § 502(a)(3)(B) arguably permits a claim for equitable relief by a plan participant or beneficiary against a plan administrator or fiduciary for failing to use diligence and prudence in the benefit determination process as in *Corcoran*. Section 502(a)(3) prescribes that a civil action may be brought “by a participant, beneficiary, or fiduciary . . . to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms or the plan . . . .” 29 U.S.C. § 1132(a)(3) (1988). Further, § 404(a) provides that a “fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . with the care, skill, prudence, and diligence under the circumstances
not to say that state law causes of action that do not fall within the scope of section 502(a) should never be pre-empted. However, the proper pre-emption analysis is to treat such state law causes of action in the same manner as other laws that arguably impermissibly affect the benefit structure or administrative practices of ERISA plans.322

b. Defining a Claim for Improper Processing of Claims

The Travelers framework for ERISA pre-emption also suggests that in analyzing whether a particular state law action should be pre-empted because it is within the scope of Pilot Life’s holding, courts need to distinguish with greater precision a claim for improper processing of claims or a claim for benefits and, e.g., claims for negligent acts or omissions otherwise committed in the administration of the plan. The Court in Pilot Life held that a claim for “improper processing of claims” is within the scope of section 502(a). Further, the Supreme Court has made clear that plaintiffs with claims within the scope of section 502(a) are limited to the prescribed remedies. Because Travelers suggests that the scope of ERISA should be properly restrained, it becomes crucial to accurately determine when a claim is really a claim for “improper processing of claims.”

In Corcoran, the plaintiffs filed a wrongful death claim which alleged that their child died as a result of acts of negligence by United Healthcare.323 The Fifth Circuit held that the cause of action was pre-empted because it was really an action for improper processing of the Corcorans’ claim for benefits, and thus within the scope of Pilot Life’s holding.324 Other lower courts have also broadly held that any claim involving a benefit determination or the process of administering benefits is within the scope of Pilot Life—because it is really

then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . .” 29 U.S.C. § 1104(a) (1988).

If a state law claim is deemed to be within the scope of ERISA’s enforcement provisions—for example, because it is really a claim under § 502(a)(3)—then it would be pre-empted under Pilot Life and Travelers. But the claim could then be pursued as an ERISA claim, although subject to the limited remedies available under ERISA. See Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134, 150 (1985) (Brennan, J., concurring) (expressly stating that the holding that actions under § 502(a)(1) or § 502(a)(2) do not permit extra-contractual or punitive damages does not resolve to what extent extra-contractual damages are available under § 502(a)(3)). The important point is that Travelers arguably provides an argument that if the claim is not within the scope of ERISA’s civil enforcement provisions, it cannot be deemed pre-empted pursuant to Pilot Life. Rather, the pre-emption question must instead hinge on whether the effect of the state cause of action meets the standard set forth in Travelers.

322. See infra notes 341-91 and accompanying text.
323. Corcoran, 965 F.2d 1321 (5th Cir. 1992).
324. Id. at 1332.
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a claim for benefits. These statements flow from language in *Pilot Life* that claims for tortious breach of contract, breach of fiduciary duties, and fraud in the inducement were pre-empted because they were based on "alleged improper processing of a claim for benefits." However, the Court's holding in *Pilot Life* that the claims "related to" ERISA plans was entirely conclusory: "The common law causes of action raised in Dedeaux's complaint . . . undoubtedly meet the criteria for pre-emption under § 514(a)." No rationale for why the claims related to ERISA plans was articulated, and it is not clear what particular acts by Pilot Life constituted the alleged improper processing. It is therefore questionable whether the ambiguous phrase "improper processing of a claim for benefits" should be applied with the broad sweep it has been accorded.

*Pilot Life* provides little insight as to the exact nature of the acts which constituted improper processing in that case. The Court in *Pilot Life* merely informed us that the employer had a long-term disability benefit plan established by purchasing a group policy through Pilot Life Insurance Company. The employer forwarded completed claims forms to Pilot Life. Pilot Life bore the responsibility for determining who would receive disability benefits. The plaintiff Dedeaux sought permanent benefits, but Pilot Life terminated benefits after two years and then reinstated and terminated benefits several times during the following three years. The claim, then, was for failure to provide benefits promised under the terms of the plan. A claim seeking benefits is clearly within the scope of ERISA's remedial provisions and thus is justifiably pre-empted.

However, many cases in which courts have found pre-emption pursuant to *Pilot Life* involve not a claim "for benefits," but a claim for damages as a result of negligence by a defendant that arguably occurred during the benefit determination process. *Corcoran* again provides a good example. *Corcoran* involved a claim against a utilization review provider for an allegedly negligent determination that hospitalization of the mother was unnecessary. The Fifth Circuit held that the cause of action was pre-empted because it was really an action for improper processing of the Corcorans' claim for benefits, and thus within the scope of *Pilot Life*'s holding. Yet, the claim was essentially a malpractice claim: i.e., that United Healthcare made an erroneous medical decision when it denied the hospitalization recommended by Mrs. Corcoran's

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326. *Id.* at 43.
327. *Id.* at 48.
328. *Id.*
329. 965 F.2d 1321, 1324 (5th Cir. 1992). The defendant, United Healthcare, was the entity which provided utilization review services for the ERISA plan. Instead of hospitalization, United Healthcare authorized ten hours per day of home nursing care. During a period of time when no nurse was on duty, the fetus went into distress and died.
physician.\textsuperscript{330}

United Healthcare argued that the decision was not a medical decision, but rather, that United Healthcare was merely performing “claims handling functions” and the decision was made in its capacity as a plan fiduciary about what benefits were authorized under the plan.\textsuperscript{331} The Fifth Circuit agreed with both parties. The court stated that United Healthcare “makes medical decisions—indeed, United gives medical advice—but it does so in the context of making a determination about the availability of benefits under the plan.”\textsuperscript{332} Thus, the court characterized the claim as “a tort allegedly committed in the course of handling a benefit determination.”\textsuperscript{333} The court acknowledged that the nature of the benefit determination was different from the type of decision that was at issue in \textit{Pilot Life}, but held that the mere fact that it was a “benefit determination” sufficed for the claim to fall within the scope of \textit{Pilot Life}’s holding that “ERISA pre-empts state-law claims alleging improper handling of benefit claims.”\textsuperscript{334}

Equating the claim in \textit{Corcoran} to a claim “for benefits within the scope of \textit{Pilot Life}” requires a very liberal construction of \textit{Pilot Life}. The Corcorans’ claim was not based on a violation of the terms of the plan and was not to recover benefits due, to enforce rights, or to clarify rights to future benefits under the terms of the plan.\textsuperscript{335} Nor was the action based on a violation of ERISA or intended to obtain other appropriate equitable relief to redress such violations or to enforce any provisions of ERISA.\textsuperscript{336} Rather, the claim was a wrongful death action seeking monetary damages for emotional distress and mental anguish caused by United Healthcare’s negligence. There was an alleged violation of a tort duty of care, not of the terms of the plan or of ERISA.

\textsuperscript{330} Notably, the Corcorans’ claim was brought pursuant to Article 2315 of the Louisiana Civil Code which provides that “[e]very act whatever of man that causes damage to another obliges him by whose fault it happened to repair it.” \textit{Id.} at 1327. Article 2315 provides parents with a claim for wrongful death of their unborn children, and permits a negligence suit against health care providers when they fail to perform in accord with the applicable standard of care. \textit{Id.} (citing Danos v. St. Pierre, 402 So. 2d 633, 637-38 (La. 1981); Chivleatto v. Divinity, 379 So. 2d 784, 786 (La. App. 4th Cir. 1979)). However, Louisiana had not yet recognized a negligence claim against a third-party provider of utilization review services. \textit{Id.} at 1327. Because some jurisdictions have recognized such negligence claims, (see, e.g., Wilson v. Blue Cross of S. Cal., 222 Cal. App. 3d 660 (1990); Wickline v. State of California, 192 Cal. App. 3d 1630 (1986)), the court in \textit{Corcoran} assumed that, on the facts, the Corcorans might be capable of stating a claim for malpractice.

\textsuperscript{331} \textit{Id.} at 1329-30.

\textsuperscript{332} \textit{Id.} at 1331.

\textsuperscript{333} \textit{Id.} at 1332.

\textsuperscript{334} \textit{Id.}


Similarly, in Kuhl v. Lincoln National Health Plan of Kansas City, the plaintiff was seeking damages for negligence which caused a considerable delay in authorizing Kuhl’s heart surgery. The plaintiff’s employer provided health care benefits by contracting with an HMO, Lincoln National, which was not a provider of care, but which acted more as an administrator whose function was to pay for medical services provided to plan participants and beneficiaries. Lincoln National was not contractually obligated to pay for services rendered outside of the “service area” or by non-participating professionals unless a patient obtained precertification. Kuhl’s primary care physician and participating cardiologist concluded that heart surgery was necessary, and that it should be performed outside of the service area at Barnes Hospital in St. Louis, Missouri. When Barnes Hospital called for the requisite precertification, Lincoln National refused to authorize the surgery. Instead, Lincoln National required Kuhl to see yet another cardiologist to determine whether the surgery could be performed in Kansas City. When this cardiologist concurred that surgery should be performed at Barnes Hospital, Lincoln National authorized the surgery, but a surgery team was not available until September. By September, Kuhl’s heart had deteriorated to the extent that surgery was no longer a viable option. Kuhl died while waiting for a heart transplant.

Three theories in Kuhl—tortious interference, medical malpractice, and breach of contract—were based on Lincoln National’s alleged misconduct in delaying Kuhl’s heart surgery. The court readily found that the plaintiff’s claims were in essence based on the contention that Lincoln National improperly processed Kuhl’s claim for benefits, and the court therefore held that the claims were within the scope of the principle enunciated in Pilot Life: “the decision not to precertify payment related directly to Lincoln National’s administration of benefits.”

Yet it is difficult to characterize the claim in Kuhl as a claim for improper processing or as a claim for benefits. Lincoln National followed the procedures that it had designed and which were likely set forth in Kuhl’s policy, in order to ensure that medical care was provided within the service area when possible—namely, the acquisition of a second opinion. The fact that it obtained second opinions thus did not constitute “improper” processing. Further, because Lincoln National authorized the surgery in St. Louis, there was not a denial of benefits. Rather, Kuhl’s claim might be better characterized

337. 999 F.2d 298 (8th Cir. 1993) [hereinafter Kuhl].
338. Lincoln National arranged for a second opinion by another participating physician; the second opinion confirmed that surgery was necessary. Id. at 300.
339. Barnes Hospital was deemed appropriate because the Kansas City area hospitals did not have the proper equipment. Id.
340. Id. at 303.
as one for failure to use reasonable care in devising the processes for precertification, because Lincoln National failed to include procedures for exigent circumstances. As such, the claim is grounded in Lincoln National’s conduct that very likely pertained to a number of benefit plans. That is, Lincoln National likely had contracts with several employers in the Kansas City area, and all policies likely had the same provisions requiring second opinions. Thus, as in Corcoran, the court in Kuhl applied a very liberal construction of Pilot Life’s holding.

Travelers arguably supports the contention that different results in both Corcoran and Kuhl would be appropriate. Claims such as medical malpractice, or claims that are more accurately characterized as claims for failure to use reasonable care in devising the processes involved in benefit administration, are not “claims for benefits.” Travelers’ emphasis on the presumption against pre-emption and the need for logical stopping points to ERISA pre-emption suggests that courts should be more precise when characterizing claims. Congress could not have envisioned the greater complexity involved in providing health care coverage today, more particularly, the infusion of multiple entities in the provision of benefits due to the formation of integrated delivery networks. Thus, it is not at all clear that Congress intended to pre-empt malpractice claims or negligence claims against such entities. Because ERISA pre-emption extends to claims addressed by ERISA, imprecise classification of such claims will lead to an overly broad application. The Travelers framework therefore suggests that if it is not clear that a state common law claim is really a claim for benefits or a claim within the scope of section 502(a), then courts should not readily conclude that the claim is within the scope of Pilot Life’s holding.

3. Claims That Relate to ERISA Plans Because of Their Effect on Employer Decisions Concerning Benefit Structure or Administration of the Plan

As noted at the beginning of this section on state contract and tort claims, courts use various rationales to justify a finding of pre-emption: e.g., (1) the claim is really a claim for benefits or a claim for improper processing of the claim, (2) the claim affects plans by causing pass-through costs that will result in the plan having to chose between higher costs or a reduction in benefits, (3) the claim regulates the administration of the plan, (4) the claim arises from the provision of benefits pursuant to an ERISA plan or (5) the claim requires an examination of plan documents. Most of these rationales are relevant in resolving the pre-emption issue where the contract or tort claim falls into the third category of laws that the Supreme Court has indicated may be pre-empted: state laws that have an impermissible effect on decisions concerning benefit structure or administration of the ERISA plan. As the preceding
sections of this article note, few state contract or tort actions can be
categorized as being designed specifically to apply to ERISA plans, and few
accurately be characterized as providing alternative enforcement
mechanisms and therefore within the scope of Pilot Life. Thus, most claims
involve state laws that merely affect ERISA plans. This section explores
whether the framework for pre-emption after Travelers will restrain the ever-
increasing scope of pre-emption of this category of state law causes of action
by analyzing the continued validity of the above noted rationales.

a. Claims That Affect Plans by Causing Pass-through Costs

In analyzing whether ERISA pre-empts various state causes of actions,
many courts inquire whether allowing the cause of action to proceed could
result in increased costs being passed on to the ERISA plan. For example, in
Ricci v. Gooberman, the district court justified pre-emption of a
malpractice claim against an HMO by noting that permitting the vicarious
liability claim would require both individual providers and HMOs to carry
liability insurance for acts of the provider, “resulting in higher costs that
certainly trickle down to plan beneficiaries.” Under even a narrow
interpretation, the Court’s decision in Travelers precludes this effect on ERISA
plans from being a sufficient justification for pre-emption.

Under Travelers, if the effect of a state law only influences an employer’s
decisions regarding the benefit structures or administrative practices of an
ERISA plan, then the state law is not pre-empted. A mere trickle-down of
costs in the form of higher premiums or cost-sharing by beneficiaries would
not likely rise to the level of “binding” benefit structures or administrative
practices decisions. Rather, a mere trickle-down of costs due to state contract
or tort actions are analogous to the pass-through costs of provider taxes and
hospital surcharges. A court would therefore be precluded from justifying pre-
emption on this basis alone.

However, other than the court in Ricci, few courts have grounded a pre-
emption decision solely upon a finding of trickle-down costs. For example, in
Corcoran, the Fifth Circuit held that the negligence claim against the
provider of utilization review services for the ERISA plan was pre-empted
because the claim was really a claim for improper processing of the claim and
thus within the scope of Pilot Life’s holding. In addition, however, the

342. Under the theory of vicarious liability, a principle may be held liable for the
negligence of an agent. See RESTATEMENT (SECOND) OF TORTS § 429.
344. Corcoran, 965 F.2d 1321 (5th Cir. 1992).
345. See supra notes 291-94, 323-34 and accompanying text.
court stated that Congress intended that such a claim would be pre-empted because the cost of imposing a negligence duty upon entities providing utilization review for ERISA plans would increase the costs of utilization review services, thereby increasing the cost to health benefit plans "and ultimately decreasing the pool of plan funds available to reimburse participants." The infusion of other rationales for pre-emption of state law claims renders it difficult to definitely conclude that the Travelers decision will restrain findings of pre-emption in cases involving state law contract and tort claims. But without doubt, the decision undermines the ability of courts to use the "trickle-down" effect as a rationale for pre-emption.

b. Claims That Regulate the Administration of the Plan

This article has developed the argument that many claims that courts characterize as being within the scope of Pilot Life are not really claims "for benefits" or claims for "improper processing of claims," and thus should not be pre-empted on that basis alone. However, those claims may be based on allegedly wrongful conduct by plan administrators or providers of health care during the process of a participant's use of benefits, and courts may therefore find another basis for pre-emption. Courts often characterize such claims broadly as involving the "administration of the plan." Drawing upon the Supreme Court's statements that Congress intended to preclude "administrative inefficiencies," lower courts then readily find pre-emption. A similar counterargument can be made as to this rationale: many claims that courts have labeled as involving the "administration of the plan" simply have no effect on the administrative practices relevant to the question of ERISA pre-emption.

Travelers readily supports a finding of pre-emption if the effect of a state law on administrative practices actually or practically binds choices regarding administrative practices or precludes the use of certain administrative practices. Thus, whether state law contract or tort claims that affect ERISA plans should be pre-empted depends on two central issues: (1) whether the effect of the state claim is upon a practice that constitutes "administration of the plan" within the meaning of ERISA's pre-emption provisions, and, if so, (2) whether the effect meets the standard of Travelers, i.e., does it bind decisions regarding the design of the administration of the plan.

Whether a state law contract or tort claim could ever meet the Travelers

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346. 965 F.2d at 1333. See also Dukes v. United States Health Care Sys. of Pa., Inc., 848 F. Supp. 39 (E.D. Pa. 1994), rev'd on other grounds, 57 F.3d 350 (3d Cir. 1995) (citing several reasons for pre-emption of an ostensible agency negligence claim against an HMO: the allegations focus on the representations made by the plan administrator to the plaintiffs; the claim is based on the circumstances of medical treatment; and higher costs will invariably be passed along to health care consumers).
standard is questionable. For example, Kuhl involved a claim for failure to use reasonable care in devising the processes used for precertification.\textsuperscript{347} To assess the effect of a state law negligence claim, a court would need to assume that the claim was not pre-empted and consider the effect of a decision in favor of the plaintiff on ERISA plans. A finding in favor of the plaintiff would send the signal that a tort duty exists and that reasonable care must be used in designing the process used for precertification. However, the specificity of the signal would be limited. For example, the case might be construed as meaning that reasonable precertification procedures must include some means of determining whether the situation is urgent and of modifying the process to expedite authorization of medical care when necessary. It could, of course, be argued that even this limited holding would preclude the use of a particular practice (e.g., second opinions) in all situations. However, a more reasonable interpretation is that the effect would not "bind" choices in designing the administrative process because the employer is still free to chose the means for determining urgency and what the modified procedures will be. Travelers held that, in the absence of clear congressional intent, pre-emption of state laws within the traditional police power is inappropriate. Thus, where it is questionable whether the effect of the state law meets the standard set forth in Travelers, the presumption against pre-emption should control the outcome.

Analysis of the second issue—whether the effect of the state claim is upon a practice that constitutes "administration of the plan" within the meaning of ERISA's pre-emption provisions—similarly leads to the conclusion that the Travelers framework can result in fewer state law claims being subjected to an overbroad application of the pre-emption doctrine. The issue should not be merely whether the claim somehow "involves" the administration of the plan. Rather, the issue is whether allowing the plaintiff to pursue the claim will have a binding effect on those administrative practices that the Supreme Court has indicated are central to the underlying purpose of ERISA pre-emption.

As this article has explained, the Supreme Court has indicated that Congress was largely concerned with administrative inefficiencies experienced by the employer.\textsuperscript{348} Thus, the scope of the phrase "administration of the plan" could arguably be limited to the "employer's administrative scheme" or those procedures or practices that an employer must perform in order to provide health care coverage. Further, the Supreme Court has generally focused on the on-going processes and practices developed to effectuate the provision of benefits to plan participants or beneficiaries, i.e., benefit-based practices akin to the claims administration functions that an insurer traditionally

\textsuperscript{347} Kuhl, 999 F.2d at 303 (the court held that the claims were within the scope of the principle enunciated in Pilot Life: "the decision not to precertify payment relates directly to Lincoln National's administration of benefits.").

\textsuperscript{348} See supra notes 248-59 and accompanying text.
performs for an insured plan. If this interpretation is adopted, the question is whether the state law claim at issue affects the employer’s administrative scheme for the provision of health care benefits.

Notably, the extent of the employer’s administrative scheme will vary from case to case. This article has acknowledged that an employer which elects to provide benefits through a multi-employer ERISA plan that owns and operates the medical centers that provide care exclusively to plan participants and beneficiaries has undertaken a host of obligations including the monitoring of assets in the multi-employer fund. In other situations, however, an employer may simply contract with an insurer, an HMO or other MCO, and it is that entity which accepts the financial risk involved in providing health care to the employees. In such a case, the employer’s administrative scheme may be fairly limited. The employer must make numerous decisions related to the level of benefits, eligible employees, whether to provide the coverage through a traditional insurer versus an HMO or MCO. The employer may also devise a program to educate employees about options that may be available or how to submit claims, etc.

However, the key administrative practice for the employer who contracts with an insurer or HMO or MCO for health care coverage is often simply writing a check. The employer is often only responsible for remitting premiums to the insurer or subscription fees to the HMO or MCO, in whole or in part. This may involve determining eligible employees and calculating benefit levels. However, it is then generally the insurer, HMO or MCO that must develop the sophisticated, ongoing administrative program to meet its contractual responsibility of providing health care coverage to the insured or enrollees.

In Fort Halifax, the Court noted that simply writing a check hardly constitutes the operation of a benefit plan. The employer which elects to

349. See supra notes 248-58 and accompanying text.
350. Cf. International Resources, Inc. v. New York Life Ins. Co., 950 F.2d 294, 298 (6th Cir. 1991) (the employer purchased group medical insurance from a multi-employer trust which served as the administrator; the plan was underwritten by an insurer; in its arrangement with the administrator, the employer’s obligations were minimal—the employer selected the terms and the price for its employees’ coverage and the employer paid the premium).
351. Id.
352. In contrast, when employers undertake to provide a pension for employees, the employer generally accepts the full financial risk involved. The employer cannot merely contract with an entity to assume the risk for providing pension benefits. The employer is more likely to be required to oversee more complex administrative schemes and to undertake, in addition to obligations such as determining the eligibility of claimants, calculating benefit levels and making disbursements, activities such as monitoring the availability of funds for benefit payments and keeping appropriate records in order to comply with applicable reporting requirements. The complexity resulting from the distinct financial obligations involved with a pension plan is likely to be reflected in a more complex administrative scheme for the employer.
use an insured plan has an interest in keeping claims to a minimum to avoid future increases in premiums or fees, but the complex activities related to claims management are administrative practices of the insurer, HMO or MCO which is underwriting the risk of providing health care coverage. The employer does not necessarily face demands that create a need for complex financial coordination and control. To achieve a pragmatic assessment of congressional intent to pre-empt, courts should keep this distinction in mind and scrutinize whether the law at issue mandates an administrative practice that is in fact within the employer’s administrative scheme.

Alternatively, the scope of the phrase “administration of the plan” could be viewed as extending to the administrative scheme of an insurer, third-party administrator, or HMO or other MCO, if appropriately limited. Because the Court has indicated that Congress was concerned with the on-going processes and practices developed to effectuate an employer’s provision of benefits to plan participants or beneficiaries, a logical point of delimitation would be to encompass only those functions provided directly for or specifically pertaining to a particular employer and that employer’s plan assets. This might include functions such as determining eligibility of employees, providing information about the plan, processing claims including performing precertification procedures, and managing the assets of the employer. However, as noted previously, even if an employer contracts with a third-party administrator, many functions of that entity may not be properly characterized as administration of the employer’s plan. Rather, that entity must engage in its own administration of its business. The administration of the entity’s business will depend on the scope of its particular operations. If a third-party administrator that the employer contracts with is also a part of an integrated delivery network and provides management services for the network, then courts must distinguish between those practices which pertain specifically to the claims management function the entity is performing for an employer and those functions it is performing for the network. If the alternative interpretation of the scope of the phrase “administration of the plan” is adopted, the inquiry becomes whether the practice effected—even if performed by an insurer, third-party administrator, or HMO or other MCO—is one of the on-going processes and practices developed to effectuate an employer’s provision of benefits to plan participants or beneficiaries, or whether the practice is more properly characterized as one for the administration of the business of the third-party administrator, or HMO or other MCO.

354. See supra notes 248-55 and accompanying text.
355. That is, a practice performed specifically pertaining to a particular employer and that employer’s plan assets such as determining eligibility of employees, providing information about the plan, processing claims including performing precertification procedures, and managing the assets of the employer.
Because the Supreme Court has suggested that the scope of pre-emption is related to the host of obligations which an employer undertakes when establishing and maintaining a benefit plan, a proper pragmatic pre-emption analysis should include scrutiny of the structure of the particular benefit plan in order to assure that pre-emption is appropriately limited. This should result in a narrowing of the scope of "administration of the plan" in line with Travelers' signal to restrain the scope of ERISA pre-emption. An analysis of two cases demonstrates why this conclusion is sound.

In Nealy v. U.S. Healthcare HMO, the plaintiff's decedent husband Glen Nealy died as a result of myocardial infarction after encountering significant delays in access to his cardiologist. Nealy had been enrolled in an ERISA health care plan provided by his employer through defendant U.S. Healthcare Versatile Plus HMO (U.S. Healthcare). U.S. Healthcare allegedly represented that Nealy would be entitled to uninterrupted medical care for his pre-existing anginal condition, including treatment by the physicians Nealy had previously seen. However, Nealy had difficulty seeing a participating primary care physician because U.S. Healthcare failed to furnish Nealy with proper identification. When the primary care physician finally saw Nealy the physician was unaware of U.S. Healthcare's procedures for referring to a non-participating physician, and Nealy was unable to fill prescriptions because U.S. Healthcare provided incorrect and invalid information to the pharmaceutical provider. Although Nealy first sought care on or about April 2, 1992, Nealy did not receive a referral to visit a participating cardiologist until May 15, 1992. The appointment was set for May 19, 1992; however, the decedent suffered cardiac arrest on May 18, 1992.

The plaintiff's complaint included claims for breach of contract, misrepresentation, professional misconduct, medical malpractice, wrongful death, loss of services, negligent infliction of emotional distress, and breach of fiduciary duty. Interestingly, in resolving the pre-emption question, the court relied upon a Second Circuit opinion which used language very close to the Supreme Court's language in Travelers: namely, that "three types of laws were generally found preempted: (1) those that 'provide an alternative cause of action to employees to collect benefits protected by ERISA'; (2) those that refer specifically to ERISA plans and apply solely to them; and (3) those that 'interfere with the calculation of benefits owed to an employee.' . . . [or have]
an effect on the administration of the plan . . . ."362 Nonetheless, the court's conclusions were based on rationales much more liberal than the quoted language supports.

The court's analysis was sound from the perspective of identifying the category of law that each claim fell within. For example, the court first examined the claims against U.S. Healthcare and its vice president and director, and seemed to identify them as laws which had an effect on the administration of the plan. However, the court's logic broke down when the court broadly concluded that:

In ruling on Plaintiff's claims it will be necessary to determine the benefits that the ERISA plan was to provide to Glenn Nealy. Thus the very existence and core of the plan would have to be scrutinized. In effect, it will require the trier of fact not only to determine the specific benefits, but how these benefits were administered by U.S. Healthcare. This is exactly the situation that Congress wanted to avoid by enacting ERISA and providing for broad pre-emption. U.S. Healthcare and [its director], as the plan providers, are controlled by ERISA and any remedy that Plaintiff is entitled to must derive from the Act itself.363

Thus, although the language the court relied upon correctly suggests that the inquiry turns upon an assessment of the "effect" of the law on the "administration of the plan," the court found it sufficient that resolving the claims would require a court to look at plan documents and assess the administration process. Yet, merely looking at plan documents to determine whether the defendants engaged in misleading or negligent conduct will not have any effect on the actual administration of the plan.364 Indeed, even if the suit proceeded and resulted in a judgment for the plaintiff, the effect on the plan administration would be de minimis and likely not sufficient to meet the standard articulated in Travelers. U.S. Healthcare would simply understand that it must provide timely and accurate information to subscribers and providers. It is not at all clear that this is "exactly the situation that Congress wanted to avoid by enacting ERISA."

Moreover, it is not clear that all of the actions by the HMO in Nealy should have been considered "administration of the plan" within the meaning

362. Id. at 972 (quoting Aetna Life Ins. Co. v. Borges, 869 F.2d 142, 146 (2d Cir.), cert. denied, 493 U.S. 811 (1989)).
363. Id. at 972.
364. See Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151, 155 (10th Cir. 1995) (mere reference to plan documents to resolve the issue of agency in a vicarious liability claim does not implicate the concerns of ERISA pre-emption).
of ERISA. U.S. Healthcare failed to furnish Nealy with proper identification, failed to educate its participating primary care physicians about U.S. Healthcare's procedures for referring to a non-participating physician, failed to provide correct and valid information to its participating pharmaceutical provider, and failed to effectuate Nealy's referral in a timely manner. To resolve whether laws that affect actions by HMOs or other MCOs which contract with an employer to provide care to employees may be pre-empted, courts must consider the appropriate scope of the phrase "administration of the plan" or "administrative practices" for purposes of ERISA pre-emption.

Therefore, the two questions the court should have asked are (1) whether the state law claims at issue affect the employer's administrative scheme for the provision of health care benefits; and (2) whether the practices affected—even if performed by an insurer, third-party administrator, or HMO or other MCO—are practices performed specifically pertaining to a particular employer and that employer's plan assets, such as determining eligibility of employees, providing information about the plan, processing claims including performing precertification procedures, and managing the assets of the employer.

For example, the claims in Nealy would arguably have had some effect on the procedures used to get proper identification to plan enrollees, the processes used to educate participating primary care physicians about U.S. Healthcare's procedures for referring to a non-participating physician, its practices relating to providing correct and valid information to its participating pharmacies, and the processes used to effectuate referrals in a timely manner. Providing identification to enrollees could fall within the employer's administrative scheme, and effectuating referrals could arguably be viewed as a function related to the administration of a particular employer's plan. Yet, educating and providing accurate information to providers and pharmacies could arguably be viewed as functions related to the administration of the health care network. More details are necessary before the key questions can be answered. The important point is, however, that the distinction should be made. Otherwise, the scope of the phrase "administration of the plan" and thus of ERISA pre-emption becomes unjustifiably broad.

The district court opinion in Dukes v. United States Health Care System of Pennsylvania, Inc. provides another good example of the overreaching pre-emptive effect of ERISA when the scope of the phrase "administration of the plan" is not properly limited. In Dukes, the plaintiff's decedent belonged to an employee group health plan administered by the HMO. The decedent had

365. See Nealy, 844 F. Supp. at 969.
366. 848 F. Supp. 39 (E.D. Pa. 1994) [hereinafter Dukes], rev'd on other grounds, 57 F.3d 350 (3d Cir. 1995) (holding that action was not removable because tort claims were not within the scope of ERISA § 502(a)).

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received allegedly negligent medical care from two physicians who were associated with a hospital and a mental health center. However, one claim was against the HMO for its own negligence. Specifically, the plaintiff alleged that the HMO failed to use reasonable care in selecting, retaining, screening, monitoring, and evaluating the other defendants—i.e., the participating providers. The court found the claim pre-empted. The court recognized that the direct negligence claim against the HMO would require an examination of the procedures the HMO used to select the doctors and hospitals with which it affiliates. Yet, the court then held that, because the HMO served as administrator of the employee group health plan, the claims therefore involved "administration of the plan" and thus "related to" the plan.

However, if the court had scrutinized whether the state action would affect a practice that is more properly classified as a function of the administration of the HMO’s own business, the result would have been different. In the emerging integrated delivery systems, some entity must perform the function of deciding which physicians, hospitals, and other health professionals or institutions will comprise the network, as well as which physicians will serve as primary care gatekeepers. This function is clearly attenuated from functions such as claims administration and therefore should be viewed as constituting a part of that entity’s business—i.e., the administration of its business. Even if performed by the entity which also provides administration of plans for employers, the selection of network physicians should not be characterized as administration of an ERISA plan. Adopting the pragmatic approach suggested by Travelers will require courts to scrutinize claims on a case-by-case basis because of the many organizational options available for ERISA plans. For example, one situation

367. Id. at 40.
368. Although not central to its decision, the court in Dukes also equated malpractice claims generally with an assertion that the medical services did not measure to the benefit plan’s promised quality. Casting the claim in a contractual light does render it more susceptible to ERISA pre-emption under Pilot Life because the claim becomes a functional equivalent of a claim for benefits. See 481 U.S. 41. See also Pohl v. National Benefits Consultants, 956 F.2d 126 (7th Cir. 1992) (ERISA pre-empts any attempt to use state law to obtain plan benefits). However, plaintiffs have the right to choose their theories. Claims arising from medical treatment may be cast as negligence claims or breach of contract or warranty, depending on the facts and circumstances. If the facts support a tort claim, it is not appropriate for the court to recharacterize claims in this manner for the purpose of finding pre-emption. See generally Mary P. Twitchell, Characterizing Federal Claims: Preemption, Removal, and the Arising Under Jurisdiction of the Federal Courts, 54 GEO. WASH. L. REV. 812 (1986).
370. Id.
371. An exception may exist if a MCO actually selects a distinct provider network for each employer or sponsor. In that case, the function of selecting providers could be characterized as "administration of an ERISA plan." However, it is unlikely that this an economically sound method of operating a MCO. See generally Uwe E. Reinhardt, Reorganizing the Financial Flows in American Health Care, HEALTH AFFAIRS 172 (Supp. 1993).
where "administration of the plan" could encompass the process of selecting network physicians would be where an employer takes a more central role in the formation of the provider network that serves the employees and thus in selecting providers that will comprise the network. However, the court's statement in Dukes that, because the HMO in the case served as administrator of the employee group health plan, the direct negligence claim involved "administration of the plan" and was thus "related to" the plan, was clearly overbroad. The employer in Dukes merely contracted for health coverage, and the HMO administered the plan. The tort action against the HMO for negligent credentialing arose from the HMO's administration of its own business.

In sum, the framework for ERISA pre-emption after Travelers could lead to a narrowing of the scope of ERISA pre-emption based on a finding that a state cause of action involves the administration of the plan. The Court in Travelers clarified that Congress intended to pre-empt state laws whose effect actually or practically binds employer choices as to administrative practices. However, in light of Travelers emphasis on deference to traditional state common law actions and the need for logical points of delimitation for ERISA pre-emption, courts should engage in closer scrutiny of state contract and tort claims that arguably relate to ERISA plans. To identify the logical point of demarcation for the scope of "administration of the plan," courts should carefully assess whether the practice that the state claim might affect is in fact a function that constitutes a part of the administrative scheme carried out by the employer (or is at least related to a particular employer's plan), or whether it is a function that is better characterized as administration of the business of a plan administrator. Additionally, even in cases where a court determines that the practice that is affected is appropriately classified as "administration of the plan," the court must recognize that a judgment in favor of a plaintiff in a state contract or tort claim will generally have limited impact and that it is therefore difficult to ever conclude that the effect of the claim actually or practically binds choices regarding administrative practices.

c. Claims Arising From the Circumstances of Medical Treatment under an ERISA Plan

The last rationale that lower courts have used to justify pre-emption that this article will consider is that the state claim, generally a malpractice claim against a provider, arises from the circumstances involving medical treatment.

372. E.g., a self-insured plan such as in the Axelrod case where the ERISA plan owns and operates the centers that provide medical care and therefore would have a more affirmative role in building the network. See supra notes 238-42 and accompanying text.

For example, the *Dukes* court, relying on several other lower court decisions, also held that a malpractice claim against the provider and a vicarious negligence claim against the HMO were pre-empted because the claims were based on the "circumstances of medical treatment" provided pursuant to the plan. For the same reason, the court in *Nealy* held that malpractice claims against the providers of care were pre-empted. This justification simply has no support in Supreme Court precedent, and the pre-emption analysis after *Travelers* should therefore result in more restrained pre-emption analyses.

While a cause of action arising from an injury incurred in the course of receiving medical treatment covered by an ERISA plan relates to the plan in some sense, a malpractice claim does not fall within any of the categories of laws that may be pre-empted. Malpractice actions, whether against the providers of care or against an HMO or other MCO on a direct or vicarious liability theory, are not designed to affect ERISA plans and do not impose a duty upon ERISA plans by referencing ERISA plans. Rather, malpractice actions are grounded in the social policy of requiring certain entities within our health care system to meet desired standards of care. They are directed at entities that operate within our health care system. The elements of a cause of action grounded in vicarious or direct negligence can be stated without references to ERISA plans. Further, malpractice actions are clearly not within the scope of section 502(a) and thus cannot be characterized as an alternative enforcement mechanism. Lastly, the claim cannot legitimately be characterized as affecting an administrative practice within the employer's administrative scheme, nor a practice that is within a broader scope of the phrase "administration of the plan." Malpractice claims arising because of the circumstances of medical treatment will affect only the practices relevant to health care provision. Those practices cannot reasonably be deemed within the scope of the administrative practices that Congress intended ERISA to protect.

Moreover, any potential conflicting standards regarding the standard of care would not fall within the scope of Congress's core concern about

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378. See also RESTATEMENT (SECOND) OF TORTS § 429.
379. Cf. Pacificare of Okla., Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995) (holding that, just as ERISA does not pre-empt a malpractice claim against the doctor, it should not pre-empt a vicarious liability claim against an HMO, yet also suggesting that a claim against the HMO based on negligent administration may be within the scope of ERISA pre-emption).
uniformity. Congress intended for ERISA to protect employers and plan sponsors, such as unions, from non-uniform regulation that would complicate administration of nationwide plans or preclude uniform benefit structures. Where the employer or sponsor contracts with an entity, such as an administrator, which then contracts with an HMO or an integrated provider network, imposing tort liability on providers within the delivery network may result in some increased costs, but will not bind administrative decisions. Similarly, imposition of liability on the HMO or MCO for some negligent act in administering the plan may send a signal to use greater care in that aspect of administering the plan but will not bind administrative decisions. Even where an employer or sponsor elects to provide health benefits in a more direct manner, such as by owning facilities and hiring health care providers, malpractice liability would have little more than an influential economic impact on the plan. And if the effect is more than economic, employers and administrators of ERISA plans retain control over what modifications should be made to avoid future tort liability.

Even without the recent guidance from the Court in Travelers, several courts have found that ERISA does not pre-empt state law malpractice claims against providers or vicarious liability claim against HMOs. In the case of first impression at the Federal appellate level, the Tenth Circuit determined that a vicarious liability claim against an HMO was not pre-empted. In Pacificare of Okla., Inc. v. Burrage, the Tenth Circuit rejected the reasoning that a vicarious malpractice claim should be pre-empted because it concerns the delivery of benefits under the plan. Rather, the court in Pacificare followed those courts which took the approach first articulated in Independence HMO, Inc. v. Smith. In that case, the court similarly addressed ERISA pre-emption of a state cause of action based on vicarious liability. The court asked the right question: “Does this sort of state tort action 'impact upon' an employee benefit plan or 'affect the congressional scheme' contained in [ERISA] . . . ?” The court found that the action had nothing to do with any denial of rights under the plan, but, rather, that the plaintiff was seeking redress for physical injuries in which the HMO’s selection of an operating physician allegedly played a part. In the court's opinion, this did not affect the plan, especially since pursuit of the tort did not depend upon the contractual

380. Again, an exception may exist where the employer undertakes to provide care and select the network physicians.
381. See supra notes 162-63 and accompanying text.
382. 59 F.3d 151 (10th Cir. 1995).
383. Id. at 154-55 (also rejecting the rationale that pre-emption could be justified because the claim requires examination of the plan to determine obligations owed under the plan and the relationship between the plan and plan doctors).
385. Id. at 988.
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entitlement to health plan benefits. Many other courts adopted the rationale articulated in Independence. More recently, the court in Smith v. HMO Great Lakes followed this line of reasoning in holding that ERISA did not pre-empt a medical malpractice claim against the HMO arising from certain cost containment procedures. The court noted that the plaintiff’s negligence claims were not based on the “insurance plan” between the plaintiff and the HMO, but on the contractual relationships between the HMO and the providers who treated the plaintiff’s child. Thus, the claims “have nothing to do with any denial of plaintiff’s rights under the plan.” The court specifically noted that the outcome of the lawsuit would not affect the plan. The pre-emption analysis after Travelers readily suggests that the outcomes reached by these courts is more appropriate. Travelers should therefore go a long way toward restraining and rationalizing pre-emption outcomes involving malpractice claims against health care providers as well as claims against HMOs or other MCOs.

Conclusion

The Court in Travelers specifically addressed only the pre-emption of state hospital rate-setting legislation as applied to insured ERISA plans. However, the opinion can be construed as a strong signal that the scope of ERISA pre-emption generally should be more restrained than many courts are concluding. Furthermore, the analytical framework for resolving ERISA pre-emption issues that can be derived from Travelers can effectively restrain findings of pre-emption if appropriate arguments are presented to courts.

The framework for analysis after Travelers leads to the conclusion that emerging state uses of provider taxes and comparable surcharges that are not imposed directly on ERISA plans are not pre-empted, whether or not the plans are insured or self-insured. Although not as clear, use of the Travelers

386. Id.
387. See Pacificare of Okla., Inc. v. Burrage, 59 F.3d at 153 n.2 (collecting cases).
389. Id. at 672 (citing Independence, 733 F. Supp. 983).
390. Id.
391. Notably, some lower have courts also relied on Painters of Phila. Dist. Council No. 21 Welfare Fund v. Price Waterhouse, 879 F.2d 1146 (3d Cir. 1989) as support for a finding of no pre-emption. However, that case addressed the issue in the context of deciding whether ERISA provides an implied cause of action against an auditor for breach of a statutory duty of care. One element in the test for finding an implied right of action is whether the cause of action is one traditionally relegated to state law. Id. at 1151. Thus, although the court stated that “Congress did not intend to preempt a whole panoply of state law” in the area of professional malpractice, Id. at 1153 n.7, the court was not conducting an ERISA pre-emption analysis and did not consider the degree of indirect impact on ERISA plans that could be caused by state medical negligence actions.

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framework should restrain the increasingly common findings of pre-emption of state contract and tort claims that have some effect on ERISA plans. Arguments such as those developed in this article that support a finding of no pre-emption of state contract and tort claims should be accorded greater weight in light of Travelers for two primary reasons. First and foremost, the Court in Travelers reinvigorated the presumption against pre-emption of laws historically within the domain of state police powers. Second, the Court expressly validated the importance of a pragmatic approach in assessing congressional intent and of assuring that logical points of delimitation are developed by the judiciary. It is therefore reasonable to conclude that the Travelers framework can go a long way toward rationalizing and delimiting ERISA pre-emption.