

## ERISA Preemption And State Insurance Regulation of Healthcare Arrangements

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#### 1. Introduction

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., (ERISA), subjects employer provided fringe benefits to federal regulation. It governs both employer provided pension benefits and employer provided welfare benefits, which include employer provided health benefits. ERISA requires employee welfare benefit plans to comply with federal standards governing reporting, disclosure and fiduciary responsibilities. However, it imposes few, if any, substantive requirements upon plans. Nevertheless it contains a very broad provision preempting state laws which touch on the subject. The preemption provision has three components. First, ERISA preempts state laws that "relate to" employee benefit plans.<sup>1</sup> Second, ERISA saves from preemption any state law that regulates insurance.<sup>2</sup> Finally, ERISA provides that no employee benefit plan, or a trust established under it, shall be deemed to be an insurance company or other insurer.<sup>3</sup> This provision, known as the "deemer clause" prohibits any direct state regulation of self-insured employee benefit plans.<sup>4</sup> This paper will examine how each of these components has been interpreted by the Courts in after the Supreme Court's decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S.645 (1995), ("Travelers").

#### 2. Background Of ERISA Preemption Principles

##### a. The "Relates To" Test

In its ERISA preemption cases from 1981 until 1995 the Supreme Court consistently emphasized the sweeping scope of ERISA preemption. A state law "relates to" ERISA plans if it has a "connection with" or "reference to" such plans. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983).<sup>5</sup> State laws that provide alternative causes of action for collecting benefits, such as a state cause of action for improper processing of a claim, relate to plans. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987). However, laws which only have a "tenuous, remote or peripheral connection" to employee benefit plans do not relate to plans. District of Columbia v. Greater Washington Board of Trade, 113 S. Ct. 580, 583 n.1 (1992).

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### [1] "Relates To" Prior to Travelers

Most of the Supreme Court's cases prior to Travelers involved state laws that affected plans by regulating substantive plan conduct or plan administration. Laws which dictate the manner in which plans are structured "relate to" plans. In FMC Corp. v. Holliday, 498 U.S. 52 (1990), the Supreme Court held that a state anti-subrogation law that prohibited health plans from obtaining reimbursement in the event of a tort recovery from a third party related to plans. State mandated minimum benefit laws relate to plans since they dictate what a plan must provide. Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985). State anti-discrimination provisions relate to plans since they required plans to operate in a certain manner. In Shaw v. Delta Air Lines, *supra*, that portion of New York's Human Rights Law which prohibited sex discrimination in employment related to plans because it required plans to provide pregnancy disability benefits. A state law will relate to plans even if its effect is "indirect". In Alessi v. Raybestos-Manhattan Inc., 451 U.S. 504 (1981), the state law at issue affected plans indirectly through a worker's compensation statute. It related to plans because it prohibited plans from using a method to calculate benefits that was permitted by ERISA.

Another line of cases found state laws preempted because they were specifically designed to affect ERISA plans or because they were predicated upon the existence of ERISA plans. In Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990), a state law cause of action for wrongful discharge, based upon an employer's motivation to prevent pension vesting, affected plans only indirectly. The Court held it related to plans because it was predicated upon the existence of a plan. Without a pension plan there was no cause of action. In District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992) a law which imposed requirements only on employers who provided health care benefits and which tied the requirements to the level of benefits provided by the employer's benefit plan related to plans because it referred to and depended upon the existence of plans. Neither of those laws could be meaningfully applied but for the existence of ERISA plans. In Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988), that portion of the state garnishment law which exempted ERISA plans from the law was preempted because it made reference to "ERISA plans" and singled them out for special treatment. Mackey was the only decision of the Supreme Court, prior to Travelers, where the law at issue was found not to "relate to" plans. In Mackey, the generally applicable part of the garnishment statute itself was held not to relate to plans even though it required plan trustees to become parties to state lawsuits and make decisions with respect to the validity and priority of garnishments. The Court rejected the argument that these substantial economic and administrative burdens alone required preemption.

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{2} "Relates To" As Defined In Travelers

[a] The Facts

Travelers involved an ERISA challenge to three separate surcharges imposed upon state regulated hospital rates. New York has a comprehensive hospital reimbursement system based upon a diagnostic related group ("DRG") formula. A patient's hospital bill is based upon one of 794 DRGs, modified by certain hospital specific adjustments. Patients covered by Medicaid, Blue Cross and certain HMOs are billed the basic DRG rate. Patients covered by most third-party payors, including commercial insurers and self-insured funds, were billed 113% of the DRG rate. For a one year period, patients covered by commercial insurance were billed an extra 11% for a total of 124% of the DRG rate. New York also imposed an assessment of up to 9% on the hospital bills of patients covered by certain HMOs which had not complied with a state directive to enroll a certain number of Medicaid recipients. In New York, Blue Cross and Blue Shield Plans historically had voluntarily maintained open enrollment and community rating policies. The state had encouraged these policies but they had resulted in Blue Cross' covering subscribers with higher risks, and therefore higher costs, than commercial insurers. The primary justification of the 13% and the 11% surcharges was to "level the playing field" between Blue Cross and Blue Shield Plans and commercial insurers. The primary justification of the 9% HMO surcharge was to encourage HMOs to enter into managed care contracts with local social service districts so as to enroll a target number of Medicaid recipients.

[b] The Supreme Court Decision

In the Supreme Court, the commercial insurers principal argument was that the purpose and effect of the surcharges was to drive ERISA plans to Blue Cross. They "related to" plans because they "purposefully discriminate among benefit payors in order to influence the choices made by ERISA plans". The Supreme Court found that ERISA did not preempt any of the surcharges insofar as they applied to insured ERISA plans and remanded for the circuit court to decide the issue with respect to self-insured plans.

The Court analysis differed from previous cases in several important respects and indicated that the Court was willing to narrow the scope of preemption. First the Court noted that despite ERISA's broad express preemption provision, the traditional presumption against preemption of traditional state police powers should still be applied. Travelers, 514 U.S. at 655. This presumption against preemption had been largely ignored since the Courts first preemption decision in Alessi.

Turning to the "relate to" language, the Court analyzed the central paradox of ERISA preemption--whether the words of limitation "relate to" in fact do much limiting. The Court concluded that its

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earlier attempts to use a linguistic analysis was not useful since "on a certain level relations stop nowhere." Id. at 655. Instead the Court found that a more useful analysis to give effect to "relate to" as a limitation of preemption begins with a consideration of the structure and purpose of ERISA. Congress passed ERISA to insure that employee benefit plans would be regulated as "exclusively a federal concern." Id. At 656. The goal of ERISA preemption "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit." Id. at 657. The Court rejected the argument that economic impact alone was sufficient to trigger preemption Id. ERISA preemption is only triggered by state laws that dictate or restrict choice of plan benefits or plan administrative structures. A state laws indirect economic impact on the price of benefits does not trigger preemption because it does not mandate plan choices, it simply influences a plan's decisions. Id. at 659-660. The Court cautioned, however, that preemption may be justified where a state law produces an "acute, albeit indirect, economic effect ... as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers." Id. at 668.

[3] "Relates To" Issues After Travelers

[a] Dillingham-- The Supreme Court meant what it said

After Travelers, it was unclear whether the Supreme Court was really prepared to take a restrained approach to ERISA preemption, or whether the decision was an anomaly. Many lower courts were reluctant to apply the analysis used by the Supreme Court in Travelers outside of the health care field. However, the Supreme Court's decision in California Division of Labor Standards Enforcement et al v. Dillingham Construction Inc, 519 U.S. 316 (1997) resolved the doubts of many observers and signaled that the Travelers decision was not an aberration.

Dillingham, involved the application of a California labor Law that required public work contractors to pay its workers the prevailing wage in the projects locale, but allows payment of a lower wage to state approved apprentices. A contractor that ran an unapproved apprentice program refused to pay its apprentices the journeylevel wage and sued claiming ERISA preemption, when the state tried to enforce its law. The Supreme Court upheld the statute, applying the Travelers analysis and concluding that "in every relevant respect, California's prevailing wage statute is indistinguishable from New York's surcharge program". 519 U.S. at 330. The Court summarized its current analysis as a two part inquiry. A law relates to a covered benefit plan if it has a "reference to" or a "connection with" a covered plan. Id. at 324. "Where a State's law acts "immediately and exclusively upon ERISA plans as in Mackey, or where the existence of ERISA plans is essential to the law's operation, as in Greater Washington Bd.. Of Trade and Ingersol Rand, that "reference" will result in preemption". Id. at 325.

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It was in the analysis of the "connection" prong of the inquiry that the Supreme Court's complete adoption of the Travelers analysis became apparent as the Court continually referred to and reaffirmed that analysis. The Court reaffirmed that an "uncritical literalism" in applying the "relate to" standard offers "scant utility" in determining the breath of preemption. Id. at 835. Rather in determining whether a state law has a connection to a plan the court affirmed that one must look "both to the objectives of the ERISA statute as a guide to determine what the scope of state law Congress and the nature of the effect of the state law on ERISA plans." Finally the Court reaffirmed that in areas of "traditional state regulation" the presumption is against preemption, unless it is the clear and manifest purpose of Congress". Id. at 838. Applying this analysis to the prevailing wage statute the court held that 1)the statute was one in an area of traditional state concern; 2)that wages to be paid on public work projects, and substantive standards to be applied to apprenticeship training programs are quite remote from the areas with which ERISA is concerned; and 3)the statute did not bind ERISA plans to anything because while it operated as an economic incentive for contractors to use approved apprentices, it did not require it.

Justice Scalia, joined by Justice Ginsburg, wrote a concurring opinion which demonstrated that some members of the court had all but abandoned the prior case law. Justice Scalia advocated "frankly acknowledging" that relates to is not a test for preemption, but that it defines the field for apply ordinary field preemption.

[b] Direct v. Indirect- DeBuono v. NYSA-ILA Medical & Clinical Services Fund, 520 U.S. 806 (1997)

Prior to Travelers, the Second Circuit in NYSA-ILA Medical and Clinical Services Fund v. Axelrod, 27 F.3d 823, vacated sub nom, Chassin v. NYSA-ILA 514 U.S. 1094 (1995), held that ERISA preempted a generally applicable hospital tax to the extent it was imposed upon a medical center owned and operated by an ERISA plan. Id. at 827. The Court also held that the assessment was a direct tax on employer contributions to the fund, which depleted those assets earmarked for the provision of health care benefits. Id. The Supreme Court granted New York's petition for a writ of certiorari and remanded the case for further consideration in light of its decision in Travelers. On remand the Second Circuit adhered to its previous decision holding that Travelers was distinguishable because in this case "no third party stands between the tax and the fund." NYSA-ILA Medical and Clinical Services Fund v. Axelrod, 74 F.3d 28 (2d Cir. 1996). New York again petitioned the Supreme Court which heard the case.

The Supreme Court reversed the Second Circuit in a 7-2 decision in DeBuono v. NYSA-ILA Medical & Clinical Services Fund, 520 U.S. 806

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(1997). The Court once again indicated that it was going to follow a Travelers approach. The HFA operated in a area of traditional state regulation and did not have effect upon a plan other than an economic one. Id The Court rejected the direct/indirect distinction relied upon by the Second Circuit and held that any state tax or other law that increases the cost of benefits may have some impact on plan administration. Perhaps the most interesting aspect of this decision was what it did not do. By relying on the Travelers analysis, the Court refused to take Justice's Scalia's invitation and adopt a new test for ERISA preemption.

[c] Conflict preemption lives -Boggs v. Boggs, 520 U.S.833 (1997)

Boggs involved the Louisiana community property law which allowed a non-participant spouse to transfer by testamentary instrument an interest in undistributed pension plan benefits. Isaac Boggs first wife transferred two thirds of her estate to her sons. After she died Isaac remarried and then retired. Upon his death a dispute arose between the sons and the second wife as to ownership of part of the benefits paid to the second wife as surviving spouse. All agree that under ERISA all the benefits would belong to the second wife. However, under Louisiana community property law, the sons would be entitled to part of the benefits under the first wife's testamentary transfer because she had an interest in the undistributed pension benefits.

The Supreme Court ruled that ERISA preempted the law, without ever mentioning the 'relate to" language. The Court reasoned that the annuity at issue was a qualified joint and survivor annuity the terms of which are mandated by ERISA. The Court held that the state law at issue regulated whether and how much a surviving spouse can receive of the participants annuity and as such was in direct conflict with these provisions of ERISA. ERISA's solicitude for the economic security of surviving spouses would be undermined by allowing a predeceasing spouses heirs and legatees to have a community property interest in the survivors annuity.

[B] The Insurance Savings Clause

This part of ERISA's preemption provision "saves" from preemption state laws which relate to plans but which regulate insurance. This year in Unum Life Ins. Co. Of America v. Ward, 119 Sup. Ct. 1380(1999). The Supreme Court addressed the scope of the insurance savings clause for the first time since it changed the direction in preemption analysis in Travelers. The Court's decision clearly indicates that the narrow reading that many lower courts had previously given the insurance savings clause is out of step with the Supreme Court's current approach to preemption analysis. Courts had used two tests for determining if a law "regulates insurance", a "common sense" test and the three factor

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test used under the McCarran Ferguson Act to determine whether a law is exempt from federal antitrust regulation as the "business of insurance." In Unum, the Court indicated that the common sense test was the principle test to be used in determining if a law comes within the protective scope of the insurance savings clause. 119 S Ct. at 1389. The McCarran Ferguson factors are simply "checking posts" or guideposts" used to "verify[ing] the common sense view" Id.

### [1] The Common Sense Test

Under this test, laws which regulate insurance are laws that are "specifically directed toward the industry," as opposed to laws that "just have an impact on the industry." Pilot Life Insurance Co. v. Dedeaux, supra. In Pilot Life, the common law tort claim for improper processing of benefits failed to satisfy the common sense test since it was not limited to the insurance industry. In Unum the Court distinguished California's Notice prejudice rule from the tort claim in Pilot Life because it is a "rule of law governing the insurance relationship distinctively". 119 S Ct.at 1389. In Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985), the Supreme Court found that a law which required insurers to include minimum mental health benefits met the common sense test. Interestingly, in that case the law, on its face, also applied to self-insured funds. Massachusetts conceded that the law could not be so applied and had not enforced it against self-insured funds. Nevertheless, the law, as written, was not directed only at traditional insurance companies. Some lower courts have held that state "any willing provider" laws which apply to employers and self-insured trusts do not meet the common sense test. See discussion at Section 3 [2].

### [2] The McCarran-Ferguson Factors

The three McCarran-Ferguson factors to determine what constitutes the "business of insurance" are: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities in the insurance industry. Unum makes clear that none of the three factors is determinative and therefore a law could regulate the "business of insurance" even if all three factors were not met.

Most Courts have taken a narrow approach to interpreting these factors. While the factors are to be far less rigidly applied after Unum, they have not been eliminated. Although not directly on point, the Supreme Court's decision in United States Department of Treasury v. Fabe, 113 S. Ct. 2202 (1993), lends strong support for a more expansive interpretation of these factors when evaluating state laws for preemption purposes. In Fabe, the Court held that an Ohio liquidation statute which gave policyholders' claims a preference in the dissolution of a bankrupt insurance carrier was not preempted by federal

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law. The McCarran-Ferguson Act has two separate provisions which concern the "business of insurance." The first reserves to the states the power to regulate insurance and provides that federal law shall not "supersede any law enacted by any state for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). The second clause exempts the "business of insurance" from federal antitrust laws. Id. In Fabe, the Court noted the different language and the different purposes of the two clauses. While the second clause was intended to "carve out only a narrow exemption ... from the federal antitrust laws," the first clause was intended to give the states "broad regulatory authority" over the business of insurance." Fabe, 113 S. Ct at 2210. The Court stated that the "broad" category of laws enacted for the purpose of regulating insurance consists of laws that "possess the 'end, aim, or intention' of adjusting, managing or controlling the business of insurance." Id. The Court also concluded that laws which protect the relationship between the insurer and insured "indirectly" were laws regulating the business of insurance. Id. at 2208. Since ERISA's insurance savings clause serves the same purpose as the first clause of the McCarran-Ferguson Act, Fabe could help in affording the insurance savings clause a broader interpretation than Courts had been willing to give it in the past.

New York made similar arguments, as amicus curiae, in Franklin H. Williams Insurance Trust v. The Travelers Insurance Co., 50 F.3d 144 (2d Cir. 1995). The case involved an ERISA preemption challenge to a New York Insurance law which requires that interest on the proceeds of a life insurance policy be computed from the date of death. The Court noted that Fabe makes clear that the Supreme Court continues to grant considerable deference to State regulation of insurance. While the Court did not decide whether the common sense test and the McCarran Ferguson test must both be met in order to come within the savings clause, it held that Metropolitan Life, in its view, placed primary emphasis on the common sense test and simply supplemented that assessment with its discussion of the McCarran-Ferguson standards. The law at issue meets the common sense test, according to the Second Circuit, since it is directed at the insurance industry and governs payments made with in connection with death benefits. Relying on Fabe, the court held that the date the interest accrues impacts "to some degree" the transfer of risk but it is arguable whether this choice is an "integral part" of the relationship. The law, however, was limited to entities in the insurance industry. Other Courts have rejected Fabe as being "legally irrelevant" to the scope of the ERISA savings clause. Prudential Insurance Co. V. National Park Medical Center Inc., 154 F.3d 812, 828 (8th Cir. 1998)

Despite Fabe, most courts have addressed the McCarran-Ferguson Act factors using the more rigorous "whether the practice that is the subject of the law regulates the business of insurance".

[c] The Deemer Clause

The deemer clause exempts self-funded ERISA plans from state laws

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that "regulate insurance" within the meaning of the savings clause. FMC Corp. v. Holliday, supra. The practical effect of the deemer clause is to immunize self-funded plans from any requirements. State regulation is barred and ERISA imposes no substantive requirements upon plans. However, simply because self-insured funds may not be deemed insurance for purpose of the savings clause does not mean they are not insurance entities for purposes of the analysis of the savings clause to other entities. Courts that have refused to find statutes saved as applied to insurance companies, because they attempt to cover self insured plans, are applying questionable analysis.

### 3. Application to State Insurance Regulation of Healthcare Arrangements

#### [a] Risk-Sharing Arrangements

Various states have enacted risk-sharing arrangements designed to increase the availability of affordable health care. Prior to the Supreme Court's decision in Travelers, these programs were at risk. In fact, New York's risk-sharing statute was initially held by the district court to be preempted by ERISA. However, these programs, as they apply to insurers and HMOs, should now be able to avoid ERISA preemption.

In 1992, New York was the first state to enact a mandatory open enrollment and community rating law for the individual and small group insurance market. As part of the law, the Superintendent of Insurance was directed to develop a reinsurance or pooling process designed to share the risk of high costs claims, high cost persons and cost variations based upon demographics. HMOs, which initially were paying into the pools, raised their premiums to their members and thereafter challenged the pooling process as preempted by ERISA. The district court held that the law related to plans because of its economic impact upon plans and was not saved because HMOs did not engage in the business of insurance. The Second Circuit, in NYS Health Maintenance Org. Conference v. Curiale, 64 F.3d 794, 803 (2d Cir. 1995), reversed, holding that the only link the pooling regulation had with ERISA plans was its "indirect effect on rate diversification among insurers" which, after Travelers, was not enough to trigger preemption. The Court also rejected the HMO's argument that the law made reference to plans.

Wisconsin has also enacted a Health Insurance Risk Sharing Plan in order to make health insurance available to high risk individuals who could not obtain private insurance. An insurer who provided 'stop loss' coverage to self-insured plans was subjected to the assessment and challenged it as preempted by ERISA. In Safeco Life Ins. Co. v. Musser, 65 F.3d 647 (7th Cir. 1995), the Court relied upon Travelers in holding that the law had a solely indirect economic effect upon ERISA plans and thus was not preempted.

New Jersey has also enacted a law which required the distribution of losses incurred by insurers of high risk individuals to other

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insurers who "fail to equitably participate in the market". In Health Maintenance Org. of New Jersey v. Whitman, 1994 WL 549626 (D.N.J. October 3, 1994), the Court, following the lead of the Third Circuit's decision in United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993), held that the indirect economic impact of the law did not result in preemption.

### [b] Managed Care Laws

Managed care enrollment has grown rapidly in the last fifteen years. Although, its most common forms are HMOs and Preferred Provider Organizations (PPOs) there are many emerging managed care organizations with names like Physician-Hospital Organizations, Managed Care Organizations, Provider Service Networks and Organized Delivery Systems. Some of these entities contract with HMOs or PPOs, while others contract directly with employers. State regulation of the various forms of managed care is limited by ERISA but is not eliminated. The question of which types of healthcare arrangements constitute the "insurance industry" becomes significant as States begin to regulate various aspects of managed care.

### [1] HMO Regulation

Most states regulate HMOs in some manner, usually through HMO licensure statutes. Recently more and more states are considering passing HMO patients bill of rights laws. The regulation of HMOs can, after Travelers, be examined in a more detailed way for the "relates to" analysis. For example, state laws that are aimed at solvency; i.e. that require HMOs to hold minimum reserves, to hold them for certain minimum times, to be examined by the state, to prepare detailed financial reports, be audited by outside certified public accounting firm, and to have losses certified by qualified actuaries do not relate to ERISA plans that contract with HMOs since these laws have, at most, an indirect economic impact upon plans. Other laws, like any willing provider laws come closer to the concept of mandating plan administration structure. While in the past all the courts held these type of laws relate to ERISA plans, recently some courts have determined that they only relate to third party providers to plans and not ERISA plans themselves. Other laws will be preempted unless the HMO regulation falls within the insurance savings clause. The courts are split on the issue of whether HMOs are part of the insurance industry and, therefore, covered by ERISA's insurance savings clause.

Both the district court and the Court of Appeals in Travelers held that the 9% surcharge on HMOs did not meet the common sense test because HMOs do not engage in the business of insurance as a matter of law. See Travelers, 14 F.3d at 722 n.5, 723 n.6. The court based this conclusion on the fact that in New York, HMOs are licensed under the health law and not the insurance law. Other cases which take the

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position that HMOs do not come within the insurance savings clause are Prudential Ins. Co of America v. National Park Medical Center, 154 F.3d 812 (8th Cir. 1998); Texas Pharmacy Ass'n v. Prudential Insurance Co. Of America, 105 F.3d 1035; O'Reilly v. Ceuleers, 912 F.2d 1383 (11th Cir. 1990); Ryan v. Fallon Community Health Plan, 1996 WL 161797 (D. Mass. April 4, 1996). Cases which hold that HMOs engage in the business of insurance, at least when they offer health care to subscribers for a set fee and assume the risk that the actual cost of services will be greater than the fee, include: Anderson v. Humana Inc., 24 F.3d 889,892 (7th Cir. 1994); Ocean State Physicians' Health Plans Inc. v. Blue Cross & Blue Shield, 883 F.2d 1001(1st Cir. 1989), cert. denied 494 U.S. 1027 (1990); Klamath-lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau, 701 F.2d 1276 (9th Cir.), cert. denied, 464 U.S. 822 (1983); Physicians Health Plan, Inc. v. Citizens Ins. Co. of America, 673 F. Supp. 903 (W.D. Mich. 1987). American Drug Stores Inc. V. Harvard Pilgrim Health Care Inc., 973 F.Supp 60 (1997); Community Health Partners Inc. V. Commonwealth of Kentucky, 14 F. Supp. 991 (W.D. Ky. 1998)

### [2] PPO Any Willing Provider Laws

Many states have enacted or are considering enacting laws that require preferred provider organizations (PPOs) to accept any provider who is willing and able to meet the terms of its provider contracts. Other states require health plans to offer subscribers the opportunity to buy a plan that permits non-network use. Other states prohibit health plans from imposing any monetary penalty upon the use of certain providers. ERISA challenges to such laws have been litigated with different results. Most, but not all courts have found that these laws "relate to" plans despite Travelers, because they have an impact on the structure and administration of plans. If an ERISA plan wants to limit coverage to a selective network, these laws would prohibit this decision. These laws go beyond an effect upon the cost of benefits, they affect the number and identity of providers from whom benefits can be obtained. Therefore, the sustainability of these laws usually depends upon a savings clause analysis. Many of these cases employ an savings clause analysis that is outmoded after Unum.

In Stuart Circle Hosp. Corp. v. Aetna Life Ins. Co. Management, 995 F.2d 500 (4th Cir.), cert. denied, 114 S. Ct. 579 (1993), the Court of Appeals held that Virginia's any willing provider law related to plans but was saved from preemption under ERISA's insurance savings clause. The statute prohibited insurance companies from unreasonably discriminating in establishing PPOs by prohibiting exclusion of providers and insurers. While the statute related to plans, it was saved from preemption because from a common sense perspective it was directed only at insurers. Since the statute affected the type and cost of treatment available, it affected the spreading of risk of the insured by spreading the cost of including more providers among all insurers. For the same reason it was found to be integral to the policy relationship.

In CIGNA Health Plan of Louisiana v. Louisiana, 82 F.2d 642 (5th

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Cir. 1996), the Court of Appeals affirmed the district court ruling that a Louisiana law requiring PPOs to accept any willing provider was preempted by ERISA. The insurers claimed that by selectively contracting with providers, they, and the ERISA plans who contracted with them, were able to reduce and control costs and assure quality. The statute prohibited them from doing so. The court held the statute "related to" plans for several reasons; it limited an ERISA plan's range of decisions as to how it would be structured by prohibiting the exclusion of providers by the plan it referred to and expressly applied to ERISA plans. The Court of Appeals distinguished the law from the surcharges in Travelers saying "unlike the New York law at issue in Travelers, Louisiana's Any Willing Provider statute specifically mandates that certain benefits available to an ERISA plan must be constructed in a particular manner." Id. at 4. The law was not saved as the regulation of insurance because it applied to entities outside the insurance industry, such as employers and Taft-Hartley trusts, and therefore, failed the common sense test. For the same reason it failed to meet the third prong of the McCarran-Ferguson test. In Texas Pharmacy Association v. Prudential Insurance Co. of America, 105 F. 3d 1035 (5th Cir. 1997), the Texas Any Willing Provider statute, limited to insurance companies, was held to be saved from preemption. The court followed the court's analysis in Stuart Circle, supra. However, the amended statute which applied also to HMOs and PPOs, which the Fifth Circuit has held are not in the insurance business, was held to be preempted because it was not directed towards the insurance industry exclusively. In Prudential Insurance Co of America v. National Park Health Medical Center, 154 F.3d 812 (8th Cir 1998) the Arkansas Patient Protection Act, which allowed patients to see the health care provider of their choice by providing that all willing providers must be able to participate in a health plan and no monetary penalty could be imposed a patient for choice of one provider over another. The Court held that the act related to ERISA plans because it had a reference to them. (The act attempted to exclude from its reach self funded ERISA plans). The Court held the statute was not specifically directed toward the insurance industry because it covered entities not in the industry, Like HMOs and that it did not meet any of the McCarran Ferguson act factors. See also Blue Cross and Blue Shield of Alabama v. Nielsen, 917 F. Supp. 1532 (N.D. Ala. 1996). (Alabama's dental and pharmaceutical Any Willing Provider Acts, along with its Assignment Act, which required that assignments to non-contracting providers be honored and paid at the same rate as contracting providers, was held to be preempted).

Recently courts have applied a more Travelers friendly analysis have found these statutes are not preempted. In American Drug Stores Inc v Harvard Pilgrim Health Plan, 973 F. Supp. 60 (D. Mass. 1997) a pharmacy any willing provider act that applied to "carriers" was held not to relate to ERISA plans that contract with carriers. Applying a Travelers analysis the court concluded that the selection of providers was not a traditional function of ERISA plans and not an ERISA plan

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administrative practice or benefit structure. Therefore the law that restricted provider choices did not relate to any ERISA plan functions. For the same reason the Court also rejected the argument that the law interferes with the ability of carriers to make decision in their capacity as ERISA plan fiduciaries and administrations. The court also concluded that the law was saved in any event. In Community Health Partners Inc. V. Commonwealth of Kentucky, 14 F. Supp. 991 (W.D. Ky. 1998), the court held that Kentucky's any willing provider law did not refer to ERISA plans, despite an express reference to health benefit plans, because the existence of ERISA plans was not essential to the operation of the law, it did not depend upon the existence of ERISA plans. The Court found it did have a connection to ERISA plans because there was little practical difference between it and the mandated benefit laws at issue in Metropolitan Life. In an opinion which is very much in sync with the Supreme Court's Unum analysis, the Court found the statute was saved from preemption by the insurance savings clause. It found that the law was directed towards the insurance industry as a matter of common sense because it was focused solely on the relationship between health benefit plans and health care providers. It rejected the argument that all three McCarran-Ferguson needed to be met. And although it only mentioned Fabe in passing, it applied the three factors in a less restrictive manner. The most interesting analysis was of the third factor, was the law limited to entities within the insurance industry. Defendants argued that the law was not so limited because it covered HMOs, MEWAs and provider sponsored health care delivery networks. The Court held that to fail to recognize these entities as being within the insurance industry would be to elevate form over substance.

### [c] Alternative Provider Statutes

These type of statutes require health care coverage for alternative treatments. In Washington Physicians Service Ass'n v. Gregoire 147 F.3d 1039 (9th Cir 1998) the court held the Washington statute which was carefully drafted to cover only health carriers did not relate to ERISA plans. The Court differentiated between ERISA plans and third party providers to plans such as HMOs and insurance companies. The Court then reasoned that the act may imposed burdens on carriers but it does not require ERISA plans to offer any welfare benefit or impose any burden on the plan administering any benefit it wishes to provide. Id at 1044-45. The court went on to hold that the act, in any event was saved from preemption by the savings clause.

### [d] HMO Negligence Acts

Texas is the first state to address head on the perceived problem with managed care entities limiting access to healthcare through treatment decisions. The Texas Health Care Liability Act allows an individual to sue a health insurance carrier, HMO or other managed care entity for damages resulting from negligent treatment decisions. It also establishes an independent review process for adverse treatment

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decisions. It also prevents removal of a doctor for advocating on behalf of a patient. In Corporate Health Insurance Inc. v. Texas Department of Insurance, 12 F.Supp.2d 597 (1998) the court held that certain parts of the statute were preempted. The Court began its analysis holding the statute was not saved from preemption because, under Fifth Circuit precedent, HMOs were not in the business of insurance. The court accepted the argument that the carriers were not ERISA plans, but held that was of no significance because certain provisions did relate to ERISA plans. Id. at 611. The Court held that the independent review provisions mandata plan administration and therefore were preempted. Id. At 625. The Court held the physician removal provisions mandate benefit structure. Id. At 627. The Court held, however, that the negligent care provisions were not preempted because they only related to the quality of a benefit, not its administration or structure. Id. at 620.

### [e] Provider Networks and Capitation

Insurance has been defined as "an arrangement for transferring and distributing risk." Group life & Health Ins. C. v. Royal Drug Co., 440 U.S. 205, 211 (1979). Some provider networks are bearing risk by accepting a single payment for the promise to provide needed service over a specific period of time. Traditionally, states have regulated entities that bear risk, such as insurance companies and, more recently, HMOs, to protect consumers against insolvency and unfair practices. The National Association of Insurance Commissioners (NAIC) has taken the position that when groups of health care providers accept risk on a prepaid basis (i.e. capitation), they are engaging in the business of insurance and should be licensed as an insurer or an HMO.<sup>6</sup> The NAIC would except an entity which accepts "downstream" risk from a duly licensed health carrier, such as an HMO, on the carrier's subscribers.<sup>7</sup>

What little case law there is in the area suggests that courts are inclined to take the narrow view that state laws requiring providers who bear risk to be licensed may be preempted on the grounds that they relate to plans but are not saved as regulation of insurance. Oracare, DPO, Inc. v. Merin, 1991 WL 113149 (D.N.J. 1991), concerned New Jersey's Dental Plan Organization Act which required dental plans have a Certificate of Authority to operate. In that case the Commissioner of Insurance, pursuant to the Act, refused to approve the charges in a contract between a dental plan and an employee benefit plan. The court found that the Act related to plans. The court found that the act was not saved because historically New Jersey had not considered health care services plans as insurance companies. A similar analysis resulted in the decision in Michigan Podiatric Medical Association v. National Foot Care Program, Inc. 175 Mic. App. 723, 438 N.W. 2d 349 (1989). The court found that a corporation licensed as an alternative health care maintenance organization which provided prepaid podiatric services was not an insurer, or in the business of insurance for purposes of the Michigan Prudent Purchaser Act, or the Michigan Insurance code. Even

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though the plan would reimburse subscribers for treatment by non-contracting podiatrists, the corporation was primarily concerned with providing services.

### [d] Stop Loss Regulation

Beginning in the 1970s, some employers that had opted to self-insure their employee benefit plans turned to various new insurance products, such as stop-loss or excess risk insurance to minimize their risks. Stop-loss insurance reimburses the employee benefit plan for claims that exceed a certain agreed upon amount, the attachment point. There are two types of attachment points, individual and aggregate. The individual attachment point is the amount above which the stop-loss carrier must reimburse the plan for eligible claims made by an individual during a year. The aggregate attachment point is the amount above which the stop-loss carrier must reimburse the plan for all claims. Many states are becoming concerned that stop-loss policies are being used by plans to obtain the risk spreading benefits of insurance while avoiding state insurance regulation. The perceived problems with stop-loss insurance were described by a Maryland district court as follows: "If a stop-loss policy issued to an employer contains very low attachment points then the stop-loss carrier essentially acts as a typical insurer the obligations of which arise after a specified deductible is satisfied. In this manner a self-funded or self-insured plan bears very little responsibility for making benefit payments itself, and at the same time it avoids the minimum coverage mandated by Maryland law." American Medical Security, Inc., v. Bartlett, 915 F.Supp. 740, (D.Md.1996).

New York studied stop loss policies and determined that while they are not a traditional type of insurance contract, they are "substantially similar" to accident and health policies. In 1985 New York's Department of Insurance issued an actuarial letter which addressed requirements applicable to stop-loss contracts. The letter imposed a number of requirements upon the stop-loss carrier. It required that (1) the insurer undertake to ensure that the statutorily mandated benefits requirements be met by employers, (2) the stop loss carrier or another carrier provide the required individual conversion policies to covered employees in the event the stop-loss policy is terminated; (3) it give notice to employees to the extent of the stop-loss insurers obligation for run-off claims; (4) it agree to pay run-off claims unless replaced by another insurer, (5) it maintain sufficient reserves to pay run-off claims; (6) it write stop-loss contracts only for appropriate groups as defined in the Insurance law; and (7) it file its rates with the Insurance Department. These requirements were challenged by insurance companies which issued stop-loss insurance in the Travelers case.

The court found that requirements 1, 2, 3,4 and 5, related to plans but did not regulate insurance. The Travelers Insurance Co. v. Cuomo, 14 F.3d 708, (2d Cir. 1994). They related to plans because they

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were an attempt to mandate, through the stop loss carrier, the benefits and administrative functioning of ERISA plans. They failed the common sense test, according to the court, because they were being used as a pretext to regulate self-funded plans. Id. at 724. The court also found that they failed the McCarran-Ferguson factors because they did not spread risk between the stop-loss carrier and the plan but instead provided additional benefits and protection to plan participants. Nor were they limited to entities in the insurance industry because they were also directed at plan sponsors. Id. at 725.

The court's opinion, however, is based upon a very narrow view of the savings clause and a very broad view of the deemer clause. Other courts may take a different view. The Sixth Circuit's decision in Lincoln Mutual Casualty Co. v. Lectron Products Health Benefit Plan, 970 F.2d 206, 210 (6th Cir. 1992), for example, takes a more balanced view of the interrelationship between the savings clause and the deemer clause.

Maryland's attempt to address the problem of ERISA plans using stop-loss insurance to avoid state insurance regulation was invalidated in American Medical Security, Inc., v. Bartlett, 111 F.3d 358 (1997) cert. den. sub. nom. Larson v. American Medical Security, 118 S.Ct. 2340 (1998). The Maryland regulations defined what would be considered true stop-loss insurance and what would be considered a standard health insurance policy by defining the minimum attachment points. If a policy contained a individual attachment point it must be at least \$10,000. The aggregate attachment point must be 115% of the expected claims of all participants. A stop-loss policy need not contain both types of attachment points but the attachment point it contains must meet the minimum requirements of the law. The court rejected Maryland's argument that Travelers was applicable because the regulation only had an indirect economic effect on the relative cost of health insurance plans available to ERISA plans. The court concluded that the regulations related to plans because they were specifically designed to affect employee benefit plans since the regulation concerned a form of insurance which is sold only to employee benefit plans. The court then concluded that the regulation addressed the business of insurance and that it met the first McCarran-Ferguson factor because it allocated risk. However, the Court concluded that the applicability of the second and third factor were complicated by the fact that the intent and affect of the regulations was to reach the relationship between ERISA plans and their participants. The court held the regulation ran afoul of the deemer clause and held that it was preempted. However, the court limited its decision and stated "this is not to say that Maryland may not regulate stop loss policies" Id. At 365. Maryland recently passed legislation that prohibits insurers from issuing, delivering or offering stop loss policies in Maryland if those stop loss policies contain a specific attachment point of \$10,000 or an aggregate attachment point of less than 115% of the amount of projected claims. Litigation over that statute has just commenced.

[e] Insurance Contract Regulation

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Several cases have concerned miscellaneous provisions in the insurance laws of the several states. Two cases in particular have held that state insurance laws which are codifications of general contract interpretation law, relate to ERISA plans and are not saved by the insurance savings clause because they are not specifically directed towards the insurance industry. In Davies v. Centennial Life Insurance Co. 128 F.3d 934 (6th Cir. 1997) an insurers claim for recession of a health insurance policy under an Ohio Insurance Statute that allowed for recession under certain circumstances was preempted by ERISA. The Court held that although at first glance it appeared that the statute is specifically directed towards the insurance industry because it resides in the Ohio Insurance code, that was not the case. The law had its roots in the general principles of contract law. Thus the court concluded that whether it comports with the common sense definition of contract regulation was a close question. Applying a very narrow interpretation of the McCarran-Ferguson criteria the court held that the law did not spread risk because it did not spread the risk of health insurance coverage for which the parties contracted. The court also held that it did not meet the second factor because it was not an integral part of the contract. It relied on its rooting in general contract law to hold it did not meet the third factor. The Ninth Circuit reached the exact same result in Security Life insurance Co. Of America v. Meyling, 146 F3d 1184(Th Cir 1998).

### ENDNOTES

1. ERISA § 514(a), 29 U.S.C. § provides: "Except as provided in subsection (b) of this section, the provisions of this subchapter ...shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

3. ERISA Section 514(b)(2)(A) provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance."

4. ERISA Section 514(b)(2)(B) provides: "an [self-insured] employee benefit plan ...shall [not] be deemed to be an insurance company or other insurer...for purposes of any law of any State purporting to regulate insurance companies, insurance contracts."

4. Some employee benefits plans such as governmental and church plans are exempt from ERISA coverage. 29 U.S.C. § 1003(b)(1).

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5. ERISA's "reference to" test was applied by the Supreme Court in Mackey v. Lanier Collection Agency & Serv. Inc., 486 U.S. 825 (1988) which held that a law which exempted "ERISA plans" from state garnishment procedures related to plans since it singled out employee benefit plans for different treatment and was specifically designed to affect them.

6. See National Association of Insurance Commissioners Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups (August 10, 1995).

7. Exempting risk bearing provider networks which contract with licensed entities could create a preemption problem if self-insured funds argued that this was an attempt to regulate self-insured plans in violation of the deemer clause.