ERISA
AND
STATE REGULATION
OF HEALTH CARE

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Insurance Law
Spring 2001
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ERISA and State Regulation of Health Care

Introduction

In 1974, the Employee Retirement and Income Security Act (ERISA), 88 Stat. 829, as amended, 29 U.S.C. §1001 et. seq., was passed by Congress and signed into law. The legislation was formed from trust law and enacted for the sole purpose of ensuring proper management of employee pension plans. Its aim was not to overlay principles of fiduciary duties for pension plans on managed health care. Indeed, the managed health care environment as we know it today, and in which ERISA is being implemented, did not exist in 1974. Today’s employee benefit plans intertwine the functions of providing pensions and financing health care in a restrictive and chaotic environment. As a result, the original scope of ERISA has extended beyond ensuring the integrity of corporate pension funds to the regulation of local health care delivery at the federal level.

This paper will discuss the federal-state tension concerning the regulation of health care and the impact of ERISA on this relationship. Part I discusses the historical basis for state regulation of health care. Part II is a basic primer on ERISA including a review of its legislative history. Part III reviews the Supreme Court’s treatment of preemption. Part IV discusses some of the current state health regulatory efforts with ERISA, in the background, as the omnipresent trump card. Part V concludes asserting that states are the logical site for regulation of health care and that a federal-state partnership is the best environment in which to address ERISA complexities.
I. State Regulation Of Health Care: In the Beginning

Historically, the primary responsibility for regulating health care fell within the domain of the states. In one of the earliest cases to address this, the Supreme Court recognized that it was a "solemn duty of a state, to advance the safety, happiness and prosperity of its people, and to provide for its general welfare...." Local and state ordinances related to health and safety were not traditionally invalidated under the Supremacy Clause of the Constitution and the presumption was that historic police powers of the States were not to be overruled by Federal legislation unless it was the clear and manifest purpose of Congress. The ability of states to regulate health care, or at least the health insurance sector, was given further weight with the passage of the McCarran-Ferguson Act, 15 U.S.C. § 1011 et. seq. in 1945.

Congress' primary concern in passing the McCarran-Ferguson Act was to ensure that states would continue to have the ability to tax and regulate insurance. The McCarran-Ferguson Act provides that: "The business of insurance and every person engaged therein, shall be subject to the laws of the several states which relate to the regulation or taxation of such business." Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria to be used in determining if a particular practice falls within the Act's "business of insurance" language:

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 within the insurance industry.
Before ascertaining if the McCarran-Ferguson factors are satisfied, the simpler question of whether the state law in question "fits a common-sense understanding of insurance regulation" is asked. The factors are then "considerations to be weighed in determining whether a state law regulates insurance."5

Until the passage of ERISA, states retained the primary responsibility for regulating health insurance, as well as ensuring health access for its citizens. With the passage of the ERISA, this authority has diminished and is often open to differing interpretations by the courts. Nowhere did the drafters of ERISA mention, let alone foresee, the impact of the legislation on the structure and regulation of health care. The basic effects of ERISA allow employment-related insurance to subvert state regulation and impede state efforts to increase access to health care or implement meaningful health care reform.7

II. A through Z on ERISA: A Basic Primer

Originally passed to end the raiding of employee benefit plans by insolvent companies and dishonest corporate executives, the actual impact of ERISA has broadened beyond the wildest dreams (or nightmares) of Congress. The sponsor of ERISA, Senator Jacob Javitz, said the purpose of the legislation was "to maintain the voluntary growth of private pension and employee benefit plans while at the same time making needed structural reforms in such areas as vesting, funding, termination, etc. so as to safeguard workers against loss of their earned or anticipated benefits...."8 Senator Williams, a sponsor of the Senate
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version of ERISA said, in support of the legislation, that if a business ended and there were insufficient funds to meet the vested claims of the participants, employees had no recourse. Fresh in the minds of the drafters of ERISA was the 1963 shutdown of a Studebaker plant in South Bend, Indiana resulting in over 4,500 workers losing 85 percent of their vested benefits because the plan had insufficient assets to pay its liabilities. Additionally, the Departments of Labor and Treasury reported 19,000 workers losing vested benefits in 1963 because of the termination of insufficiently funded plans.9

ERISA’s narrow and intended focus on pension benefit plans, rather than permeating states’ regulation of health care, is supported by its legislative history and by other Congressional activity in the early 1970s. The same Congress that enacted ERISA, subsequently passed the National Health Planning and Resources Development Act of 1974 (NHPDRA)10 which “sought to encourage and help fund state responses to growing health care costs and the widely diverging availability of health care services.”11 This legislation envisioned health planning agencies coordinating the development of state based health services and policy.12 Even more recent federal legislation concerning health care, such as Medicaid managed care, supports the premise that Congress envisions states as “laboratories of change” with respect to health care policy and services.13

The aim of Congress in enacting ERISA in 1974 was two-fold: first, develop a uniform set of rules and regulations that benefit plans would be bound by without consideration as to what state the plan may be operating in; and second, minimize the administrative and financial burdens to set up and maintain
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employee benefit plans such that employers would be more apt to develop such plans. To that end, Congress established extensive reporting, disclosure and fiduciary duty requirements to ensure that poor management by the plan administrator would not undermine employee benefit plans. ERISA defines its focus, the employee benefit plan, as:

"[A]ny plan, fund, or program which was heretofore or is hereafter established by an employer or by an employer organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants... (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits...or prepaid legal services...."

The above mention of health care benefits is one of its few references in the entire ERISA legislation thus lending further support that health care regulation was not its primary intended focus. However, Congress did state clearly in the language of the ERISA that state laws relating to employee benefit plans should be invalidated, except for state insurance regulation. This nullification creates a legislative void or an ERISA vacuum. States cannot regulate concerning the structure or administration of ERISA employee benefit plans and Congress did not offer any guidance, other than relying on disclosure requirements and fiduciary obligations, for employee benefit plans. An early Supreme Court case in the ERISA lifecycle, Metropolitan Life Insurance Co. v Massachusetts, held that regulation of the substantive terms of insurance contracts falls squarely within the domain of state insurance as defined by McCarran-Ferguson and thus is regulated by the states. States also regulate some managed care organizations to the extent that the regulation is
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characterized as the business of insurance. This position has been undermined somewhat by the pervasive, and often still evolving practice of preemption of state laws under ERISA.

The "crowning achievement" of ERISA is its broad preemption provision set forth in §514 (a). The provision explicitly says that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." The legislation is to "preempt the field" of employee benefit and pension plans thereby "eliminating the threat of conflicting or inconsistent State and local regulation." This preemption clause, primarily relates to, overrules any state law that mandates the structure or the administration of an employee benefit plan. This is augmented by the implicit preemption contained in §502(a). This provision allows federal court jurisdiction over claims relevant to ERISA plans basically negating state law claims. The Supreme Court has interpreted this section to imply that Congress intended to preempt the entire field of employee benefits allowing claims asserted in state court to be removed to federal court. Sec. 502 (a) provides that ERISA will be the "exclusive remedy" for beneficiaries therefore State law claims such as contract breach or tort are instead brought in federal court and recharacterized as claims for denial of benefits or breach of fiduciary duty. Removal to federal court by the defendant is permitted under the "complete preemption" or "superpreemption" exception to the well-pleaded complaint rule.

The well-pleaded complaint rule normally permits removal to federal court of only those claims specifically raised in the plaintiff's complaint. Under §502 (a),
this rule is essentially ignored and state law claims are recharacterized as federal claims; the claims are then removed to federal court under Congress' power to completely occupy the field related to employee benefits. Thus complete preemption operates as an enhanced version of federal jurisdiction.24

The only counterbalance to this broad reach is § 514(b)(2)(A), the savings clause, which returns to the states the regulation of insurance. It reads, "...nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."25 The savings clause, using the same language of the McCarran-Ferguson Act, - any law of any state which regulates insurance -, ensures that regulation of insurance is left to the states.26 Under Metropolitan Life, a law regulating insurance must not just have an impact on the insurance but must be directed towards that industry thus state laws of general applicability, such as tort, bad faith, and breach of contract, are thwarted by ERISA preemption. A companion to the savings clause, §514 (d), states that "nothing in ERISA shall be construed to alter, amend, modify, invalidate, impair, or supercede any law of the United States."27 Courts have used this section to support that the McCarran-Ferguson Act is not superceded by ERISA."28

The reach of the savings clause is limited by §514(b)(2)(B), the deemer clause, which says "Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, ... to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies,
insurance contracts...

The deemer clause does not allow states to regard employee benefit plans, either insured plans or self funded plans, as insurance so these plans are preempted by ERISA precluding state regulation. Unlike a fully insured plan, a self-funded plan does not purchase policies from insurance companies to satisfy its obligations to its employees; rather, the plan pays the actual health care costs incurred by employees. However, self-funded plans often purchase 'stop-loss' insurance to limit liability and negative financial impact to the business. Despite purchasing the stop-loss insurance, self-funded plans generally do not fall under the regulation of insurance by states. The distinction is that even though self-funded plans use stop-loss insurance coverage to minimize loss, employees in such plans still face risk of not being able to recover claims from a stop-loss insurer in the event that the employer becomes insolvent.

The broad preemption and impact on state laws that has resulted was not in the initial design of ERISA. In the original drafts of the legislation, only state laws, which dealt with the same subjects specifically regulated by ERISA, were preempted. The preemption clause was significantly broadened at the last minute to preempt all state laws that relate to benefit plans out of a concern that state professional organizations would hinder the development of employee benefit programs such as prepaid legal services. There is little to suggest that the preemption clause was broadened out of a concern about state regulation of health care beyond a general concern about conflicting state laws. Prior to ERISA's passage, the reconciliation of the Senate and House versions of the legislation in the Conference Committee resulted in an expanded preemption
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clause. This change gave significant importance to the savings clause; however, the savings clause did not undergo any changes in the Conference Committee to compensate for the enlargement of the preemption clause. There were no comments on the floor of either chamber concerning the savings clause and changes to the preemption clause were not disclosed until the Committee’s report was filed in Congress. This occurred only ten days before final action was to taken on ERISA. Likewise, there is little to support that §514 (d), the companion clause to the savings clause, was to have significance importance when interpreting ERISA.34

Courts struggle with how to interpret and apply the preemption, savings, and deemer clauses. The explicit preemption clause in § 514 (a) has received the most scrutiny by the Supreme Court, as it has been the topic of nearly two dozen opinions.35 Justice Stevens noted that a LEXIS search produced 2800 citations to ERISA preemption in lower federal courts.36 Justice Souter commented that the “relate to” provision in §514(a) if “taken to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course for ‘really, universally, relations stop nowhere.’”37 Even Justice Scalia said that the Supreme Court should admit that their “first take on this [ERISA] statute was wrong....” He urged the court to return to applying principles of ordinary field preemption which would presume that ERISA applies to the field of employee benefits plans rather than allowing the “relate to” language in the preemption provision of §514 (a) set forth a test for preemption. He even goes as far to say that the “relates to” provision, so central to the Court’s interpretation of
ERISA, would become irrelevant noting, "as many a curbstone philosopher has observed, everything is related to everything else."  

The above sentiments reflect the Court's frustration with ERISA. It is not clear, however, how this frustration or the state-federal tension will be resolved. Currently, there is hesitancy by the Court to allow federal legislation to reach States via the Commerce clause. On the other hand, the ever-changing legislative political landscape ensures that the struggle between states' rights and federal legislation will continue. Future decisions by the Supreme Court may determine the reach of ERISA.

III ERISA and the Supreme Court: A Frequent Flyer

State and federal governments can both legislate or have concurrent jurisdiction under the United States Constitution. The Supremacy Clause, Commerce Clause and Congressional powers in Article I are then used to mediate concurrent jurisdiction. The Dormant Commerce clause, always lurking in the shadows, invalidates state laws which burden interstate commerce in areas where Congress has not yet legislated. Using its powers to support a policy of national unity, national common market, and federal supremacy, Congress can authorize legislation that can trump state legislation.

In addition to the above constitutional preemption, Congress may, through legislative preemption, assert that they will occupy the field that pertains to the legislation and invalidate any conflicting state laws in the process. ERISA is legislative preemption; Congress expressly said in §514 (a) that ERISA "shall
supercede any and all state laws in so far as they....relate to any employee benefit plan." Federal preemption of the whole field of employee benefits will be assumed when “the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject.” To this end, courts historically have engaged in a textual analysis of ERISA scrutinizing its language and structure to determine to what extent Congress meant to invalidate state law pertaining to the field of employee benefit plans. Until recently, courts used this textual analysis or “plain meaning” approach to sanction the broad preemption reach of ERISA.

In one of the first Supreme Court cases interpreting the “relate to” provision of §514 (a), the Court said the ERISA is a “comprehensive statute” intending to occupy the entire field of employee benefit plans and the preemption provision should be interpreted broadly. Thus, ERISA overruled any state law that related to an employee benefit plan even if such law was not directed at these plans. The only limit that the Court placed on the preemption provision was that it would not apply if the state law relation to the employee benefit plan is “too tenuous, remote, or peripheral.”

This literal interpretation of “relate to” was the tool used by the Supreme Court from the 1980s through the mid-1990s expanding preemption of state laws which either had a “reference to” or a “connection with” employee benefit plans. During this time, the Court found preemption of a variety of state laws under §514 (a) including:

- New York laws that prohibited employment discrimination on the basis of pregnancy and would have required ERISA plans to
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provide a certain level of disability benefits thus mandating the structure of a benefit plan. One of the laws was saved under §514 (b)(2)(A) or savings clause.46

- A Massachusetts law requiring mental health benefits for every health insurance policy for Massachusetts's residents. Although the Court found the law was preempted under ERISA, it ultimately found that it was “saved” from preemption under §514 (b)(2)(A).47

- A Pennsylvania law which prohibited employee benefit plans from invoking subrogation rights concerning monetary recovery in tort actions. The Court found the language in the Pennsylvania law referring to “any program, group, contract, or other arrangement or the payment of benefits” was sufficient reference to an employee benefit plan to warrant exemption under §514 (a). The Court held that the Pennsylvania law was saved from preemption under §514 (b)(2)(A).48

- Mississippi state common law claims of breach of good faith and fair dealing for improper claims processing and failure to pay benefits under an insurance policy thus “related to” employee benefit plans were preempted by ERISA. The Court also said such state law claims were laws of general applicability not directed toward the insurance industry and as such were not saved under §514 (b)(2)(a).49

- A District of Columbia law, which mandated that employers who offer health insurance to provide equivalent benefits for, injured employees eligible for workers' compensation. As the state statute referred to 'health insurance', the Court found that this was enough of a reference to employee benefit plans, that ERISA preemption was warranted.50, 51

Justice Steven's dissents in two cases in the early 1990's may have signaled that the tide was turning in the Court with respect to broad ERISA
preemption of state laws. First, in *FMC Corp. v. Holliday* 111 S. Ct. 403, 412 (1990), Justice Stevens argued that "the Court has endorsed an unnecessarily broad reading of the words 'relate to...,' as they are used in the basic preemption clause of §514 (a)...I am persuaded that Congress did not intend this clause to cut nearly so broad a swath in the field of state laws as the Court's expansive construction will create." Then, in *District of Columbia v. The Greater Washington Board of Trade*, 506 U.S. 125, 135 (1992), the Justice said, "it is time to take a fresh look at ERISA preemption."

In the mid-1990s, following Justice Steven's premonitions, the Court decided a trilogy of cases narrowing the Court's interpretation of ERISA preemption. The earliest and most significant of these three cases, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645 (1995), marks the point at which the Court turned away from a strict literal interpretation of the ERISA statute and looked to congressional intent. In *Travelers*, the Court settled the lower courts' question of whether state statutes, aimed at imposing hospital surcharges designed to fund uncompensated health care, were preempted by ERISA as an interference with the administration of employee benefit plans. Judge Souter, delivering the opinion for a unanimous court, systematically approached preemption noting at the outset that:

"[The Court] has never assumed lightly that Congress has derogated state regulation [of health care], but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.... We have worked on the assumption that the historic police powers of the States were not to be superceded by the Federal Act unless that was the clear and manifest purpose of Congress."
Justice Scalia and Justice Thomas, both strict textualists, signed onto the unanimous opinion of the Court agreeing with:

"Since pre-emption claims turns on Congress’s intent, we begin as we do in any exercise of statutory construction with the text of the provision in question, and move on, as need be, to the structure and the purpose of the Act in which it occurs...The governing text of ERISA is clearly expansive...if “relate to” were carried to the furthest stretch of its indeterminacy, then for all practical purposes, pre-emption would never run its course..."54

The Court continued saying if state laws which had an “indirect economic influence” on ERISA plans were preempted, then the limiting language of §514 (a) (insofar as they...relate); the decision in Shaw holding that state law provisions relate to an ERISA plan if they have a “connection with” the plan and not just a “tenuous, remote, or peripheral” connection, the National Health Planning and Resources Development Act of 1974 with its devolution of health planning to the states, and even Medicare regulation would all be irrelevant and trumped by broad ERISA preemption.55

Following Travelers, the new test used to ascertain preemption is not whether the state law ‘relates to” the employee benefit plan, but whether those state laws either indirectly or directly require plan administrators to adopt a minimum level of benefits, has an effect on the administration of the plan, or precludes the uniform administration of benefit plans.56 For the purposes of preemption and state law, when the challenge is to the procedure, administration or structure of an employee benefit plan, ERISA preemption is triggered.

Although ERISA is still the Goliath to the states’ David, Travelers marked an end to ever-burgeoning ERISA preemption of state laws concerning health
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care. For example, twenty-two states have enacted laws to impose taxes on health care providers and seventeen states have created high-risk insurance pools by imposing taxes on commercial health insurance. Under traditional analysis of ERISA, these laws risked preemption and invalidation. *Traveler's* ratcheting down of ERISA preemption gives states more leverage and a "legally viable tool" for health care regulation than previously available.\(^{57}\)

**IV. States' Efforts to Regulate Health Care**

The *Travelers* decision is still new enough that there is not a repository of federal court decisions to give courts and the legal community guidance in how modern ERISA preemption is to be applied. However, under *Travelers*, states have more opportunity than in the past to implement meaningful health care reform. This section focuses on some of the state laws that have been challenged by ERISA.

**MANAGED CARE REGULATION:**

Generally, unless state laws have a direct economic effect on health plans, the laws will not be preempted.\(^ {58}\) The Supreme Court did not overrule its previous decisions by *Travelers*, but concluded that the surcharges related to ERISA plans in a way that Congress never intended to preempt; much like the "too tenuous, remote, or peripheral" connection in *Shaw v. Delta Airlines*. The "tenuous, remote, or peripheral" narrowing of preemption and recognition of State's police powers was relied on in a recent lower court decision that has been granted certiorari by the Supreme Court. In *Corporate Health Ins., Inc. v.*
Texas Dep't of Ins., 215 F.3d 525 (5th Cir. 2000), cert. granted, 121 S. Ct. 753 (Jan. 8, 2001), the court said that Texas asserted its police power by:

1) Creating a statutory cause of action against managed care entities that fail to exercise ordinary care for health treatment decisions,
2) Establishing procedures for independent review of health care decisions and
3) Protecting physicians from imposed indemnity clauses and retaliation from Health Maintenance Organizations.

The Fifth Circuit then held that only the independent review procedures are preempted by ERISA signaling perhaps a broader role for states in the regulation of managed care. Thus, Travelers, decided nearly twenty years after the passage of ERISA, put the brakes on broad preemption of state laws and opened the door for States, such as Texas, to successfully implement meaningful health care regulation and reform which specifically addresses state specific health care issues.

STOP-LOSS INSURANCE:

States have been aggressive in implementing health care regulation and enforcing patient protection laws by maximizing the reach of the savings clause. However, self-funded plans, even those with significant stop-loss insurance coverage, continue to be immune from state regulation. Stop-loss insurance is purchased by an employer to prevent against catastrophic losses, limit financial impact of health care claims on a business’ bottom line and “fine-tune the amount of risk transferred by the employer to the insurer, resulting in a plan which is neither fully insured…. The majority of circuits hold that the purchase of stop-loss insurance does not exclude a self-funded plan from the protection of the deemer clause. This loophole, allowing self-funded plans to
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evade state regulation, has been exploited by insurance companies that develop "synthetic insurance plans" paying out or "attaching" at levels as low as $5000 per employee. Fourteen states have adopted laws, patterned after the National Association of Insurance Commissioners (NAIC) Stop Loss Insurance Model Act (Act), that sets a minimum attachment point of $20,000 per plan participant or an aggregate attachment point of between 110%-120% of total expected annual claims.63 (Table 1)

Intended to stop self-funded employers from circumventing state regulations, laws patterned after the Act have led to opposite court opinions in the Fourth Circuit and a Kansas state court. The Fourth Circuit held the law was preempted by ERISA because it violates the deemer clause. The court focused on the stated purpose of the state regulation "to protect Maryland residents from self-funded ERISA plans and from insurers that sought to deprive citizens of mandated health benefits."64 The court noted that their decision does not effect Maryland’s efforts to regulate stop-loss insurance policies.

The Maryland legislature would have been wise to draft with the language of Travelers as instruction such that laws with an indirect effect on ERISA plans will less likely face preemption. That opinion was clear that a state law could still have an indirect economic effect on a health plan which “forced an ERISA plan to adopt a certain scheme of ...coverage...or restrict its choice of providers...and that law would be preempted under §514”; however, generally indirect laws are not preempted.65 By stating that the purpose was to basically rein in self-insured plans, the Maryland legislature opened the door to the deemer clause. A better
course would have been to omit the reference to self-funded plans and stress the traditional role of the states in regulating insurance under the savings clause and the McCarran-Ferguson Act.

Just as his dissents signaled a change leading up to the Traveler’s decision, Justice Steven’s dissent in FMC Corp. v. Holliday may also shed light on the deemer clause. He views the differential treatment between beneficiaries of self-funded plans and insured plans as “illogical...disparate treatment of similar situated beneficiaries...[leading one] to expect that reasons for drawing such an apparently irrational distinction would be discernible in the legislative history or in the literature discussing the legislation [of ERISA].” This preferential treatment of self-funded plans has ramifications for states’ efforts to provide access to affordable health insurance and mandated benefits for high-risk individuals. ERISA prevents optimal operation of state programs, such as high-risk insurance pools or indigent care financing designed to provide health care coverage for individuals without private insurance, as states are unable to tax self-funded ERISA plans to the same extent as insured plans.

However, legislation, unlike the Maryland stop loss legislation, that is not specifically directed at self-funded plans but rather applied uniformly to all plans as a state tax, has been upheld as safe from ERISA preemption. In addition to the Traveler’s decision upholding hospital surcharges on commercial carriers with low Medicaid enrollment, Wisconsin imposes a tax on carriers, including stop-loss insurance carriers offering coverage to self-funded plans, which is then used to fund indigent health care. This surcharge legislation, successful at
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escaping ERISA preemption and generic enough to be applied to all health plans, is an example for states to follow in drafting legislation aimed at maximizing the quality and funding of health care.

**PATIENT PROTECTION BILLS:**

In an effort to improve the quality of health care, and perhaps out of a frustration with the patchwork approach of federal legislation, states have been very proactive in passing patient protection legislation. The legislation, enacted in a majority of the states, typically focuses on three areas: grievance procedures, consumer protections, and mandated benefits. Grievance procedures center on internal and external review processes; consumer protections focus on plan product offerings and design; and mandated benefits require a minimum package of benefits such as forbidding drive-by deliveries, thus requiring a forty-eight hour hospital stay following childbirth, and allowing direct access to some specialists and emergency rooms.70

In addition to state patient protection bills, similar bills have been passed and are being considered at the federal level leading to concern about the erosion of state laws by federal legislation. In addressing this potential conflict, the National Association of Insurance Commissioners, has urged Congress to adopt the language in the Health Insurance Portability Act of 1996 (HIPAA), an amendment to ERISA, which establishes the “prevents the application” standard. This standard says that federal law “shall not be construed to supercede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance carriers except to the
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extent that such standard or requirement prevents the application of a federal requirement. It basically says that the federal legislation sets a minimum level of compliance allowing states to implement matching or better legislation, thus preventing forum shopping by health plans seeking to evade state protections for perhaps a leaner federal version.

Part V Conclusion

This paper has focused on ERISA and the unease with which the legislation has been molded and retrofit into today's dynamic and unsettled health care environment. It is important to not lose sight of the devastating problems faced by employees with insolvent benefit plans in the 1970’s and the need for national uniformity in pension plan oversight. However, the current tension between states and the federal government about the degree to which states can regulate health care is not resolved and will only escalate. It is questionable whether this escalation can be prevented or mitigated except by Congressional amendments to ERISA. Issues such as the need to retool the savings clause to broaden the reach of the business of insurance and the disparate remedies available to those under self-funded plans – free from state regulation but thrust into an environment where federal law has not yet evolved—need to be addressed. This must be done while considering both state and federal interests. The one-size fits all approach ERISA took to pension benefits fails when applied to managed care. The recommendation by the National Association of Insurance Commissioners of considering the HIPAA “prevents the
application” standard as setting a minimum or a federal “floor” which states can meet or exceed should be used as a model for conflicting state and federal legislation.
STATES THAT HAVE ENACTED
STOP LOSS INSURANCE MODEL ACT
(Update 1999)

Table 1

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<th>State</th>
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<td>NV</td>
<td>NEV. REV. STAT. § 689C.940 (1997) (Authority to adopt regulation)</td>
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<td>OR</td>
<td>OR. REV. STAT. § 742.065 (1993)</td>
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<td>PA</td>
<td>PA. ADMIN. CODE tit. 31 §§ 89.471 to 89.474 (1992).</td>
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<td>TN</td>
<td>BULLETIN dated 7/1/94</td>
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National Association of Insurance Commissioners
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Footnotes

1 Mayor of the City of New York v. Miln, 36 U.S. (11 Pet.) 102 (1837)
2 Hillsborough County v. Automated Medical Lab., Inc., 105 S. Ct. 2371, 2376 (1985)
   ("presumption that state and local regulation of health and safety matters can constitutionally coexist with federal regulation.").
3 Id. citing 59 Stat. 34, 15 U.S.C. §1012 (a)
4 Metropolitan Life Insurance Co. v. Massachusetts, 105 S. Ct. 2380, 2391 (1985) citing Union
8 Margaret G. Farrell, ERISA Preemption and Regulation of Managed Health Care: The Case for
   Managed Federalism, 23 Am. J. L. and Med. 251, 251 (1997) citing Michael S. Gordon,
   Overview: Why was ERISA enacted in U.S. Senate Spec. Comm. on Aging, 98th Cong., 2d
   Print 1984).
9 ERISA legislative history, 2 Leg. Hist. 1599-1600 cited in Nachman Corp. v. Pension Benefit
10 National Health Planning and Resources Development Act of 1974 (NHRPDA), Pub. L. 93-641,
   1671, 1682 (1995)
12 Id.
13 General Accounting Office reports describing State’s efforts with Medicaid Managed Care:
   Medicaid: States’ Efforts to Educate and Enroll Beneficiaries in Managed Care, GAO/HEHS-96-184, September 1996; Medicaid Section 1115 Waivers, Flexible Approach to Approving
   Standards Enforcement et al., v. Dillingham Construction, 117 S. Ct. 832, 839 (1997)
15 29 U.S.C. §1002 (1)
16 Margaret G. Farrell, ERISA Preemption and Regulation of Managed Health Care: The Case for
   Managed Federalism, 23 Am. J. L. and Med. 251, 251 (1997)
17 Metropolitan Life 105 S. Ct. at 2389
18 Margaret G. Farrell, ERISA Preemption and Regulation of Managed Health Care: The Case for
   Managed Federalism, 23 Am. J. L. and Med. 251, 267 (1997)
20 ERISA §514 (a); 29 U.S.C. § 1144 (a)
   Williams); id. at 29,942 (statement of Sen. Jeffits)
22 ERISA § 502 (a); U.S. Code § 1132 (a)
24 Id.
25 ERISA § 514 (b) (2) (A); 29 U.S.C. § 1144 (b)(2)(A).
26 Metropolitan Life 105 S.Ct. at 2391.
27 ERISA § 514 (d); 29 U.S.C. § 1144 (d).
28 Id.
29 ERISA § 514 (b) (2) (A); 29 U.S.C. § 1144 (b)(2)(A).
30 FMC Corp. v. Holliday, 111 S. Ct. 403, 408 (1990) (discussion on deemer clause)
31 FMC Corp. 111 S. Ct. 403 at 405
32 Id.
33 Metropolitan Life 105 S. Ct. at 2392, n. 22, 23, 24
34 Id.
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40 Margaret G. Farrell, ERISA Preemption and Regulation of Managed Health Care: The Case for
41 ERISA §514 (a); 29 U.S.C. § 1144 (a)
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47 Metropolitan 105 S.Ct. 2380 (1985)
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[Footnotes]

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