ERISA Preemption Primer

It is helpful for state health policymakers to know about ERISA because of its potential negative impact on state health care legislation, including health insurance regulation. Courts have held that ERISA (the federal Employee Retirement Income Security Act of 1974)[1] supersedes some state health care initiatives, such as employer insurance mandates and some types of managed care plan standards, if they have a substantial impact on employer-sponsored health plans. Several recent U.S. Supreme Court opinions limit ERISA's impact on state authority, but many uncertain areas remain. State policymakers face ERISA issues as they consider proposals to expand access to health care, regulate managed care and other health insurers, prescribe appeal rights of health plan enrollees, and monitor health care costs and quality. This primer provides a basic outline of ERISA's implications for state health care initiatives. More detailed analysis and source materials are provided in the *ERISA Preemption Manual for State Health Policymakers*, published by the Alpha Center and the National Academy for State Health Policy.

This primer provides an overview of ERISA preemption principles relevant to state health policy.

Because ERISA policy is developed through court interpretations of federal law, it is complex and leaves many unanswered questions. This primer provides an overview of ERISA preemption principles relevant to state health policy, but simplifying these complicated concepts runs the risk of misleading the reader. Consequently, we urge state policymakers interested in exploring ERISA implications for specific proposals to consult both the Manual and their own legal advisors as they develop health policy initiatives.

What is ERISA and why was it enacted?

Congress enacted ERISA primarily to establish uniform federal standards to protect private employee pension plans from fraud and mismanagement. But the federal statute also covers most other types of employee benefits plans, including health plans.

What kinds of plans does ERISA regulate?

ERISA applies to all employee pension, health, and other benefits plans established by private-sector employers (other than churches) or by employee organizations such as unions. If they meet certain requirements, employee plans are "ERISA plans" even if they offer benefits through state-licensed insurers.[2] ERISA does not apply to plans administered by federal, state, or local governments. It does not apply to plans established solely to meet state workers' compensation, unemployment compensation, or disability insurance laws.

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What does ERISA require?

For pension plans, ERISA provides detailed standards for vesting, funding, solvency insurance, disclosure and reporting to plan participants, beneficiaries, and the U.S. Department of Labor, nondiscrimination, and administrator fiduciary requirements. For health plans, federal law prescribes fewer substantive standards: administrators' fiduciary standards (to administer the plan in the best interests of beneficiaries) and requirements for plan descriptions to be given to enrollees, reporting to the federal government, and certain minimum standards ("continuation" health coverage; group plan guaranteed issue and renewability; pre-existing condition exclusion requirements; nondiscrimination in premiums and eligibility; maternity hospital length-of-stay standards; post-mastectomy reconstructive surgery; and limited mental health "parity"). States impose some of these types of standards on HMOs and other insurers, but these laws cannot directly regulate private-sector employer-sponsored plans.

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

Several of ERISA's provisions preempt state law. ERISA's "preemption clause," Section 514, makes void all state laws to the extent that they "relate to" employer-sponsored health plans.[3] (This clause states that "the provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....") The Supreme Court has interpreted the preemption clause very broadly to carry out the congressional objective of national uniformity in rules for employee benefits programs. The Court has held that ERISA preempts state laws that either refer explicitly to ERISA plans (i.e., all plans offered by private-sector employers)[4] or have a substantial financial or administrative impact on them.[5] Consequently, courts have held that ERISA prohibits both state laws that *directly* regulate employer-sponsored health plans, such as mandating that employers offer health insurance, and some laws that only *indirectly* affect plans, such as regulating the provider networks ERISA plans may use.

How do recent ERISA amendments affect state health policy?

Congress has begun to exercise more control over insurance and managed care, creating new models of federal-state jurisdiction. For example, a 1996 ERISA amendment prescribes minimum maternity hospital length-of-stay, but allows certain specific types of state maternity stay laws.[6] Sections enacted in 1996 and 1998 require insurers to provide both mental health parity (preempting state law that prevents application of federal law) and breast reconstruction for post-mastectomy patients (permitting existing state laws that require at least the same coverage as federal law).[7] Finally, provisions added by HIPAA in 1996 mandate insurance market reforms, prescribing several specific areas where state laws may differ from federal law.[8] The 106th Congress also is debating additional types of managed care regulation, some of which might apply to insurers that have been traditionally subject to state law. Proposals for increasing access to and quality of health coverage would use this approach to shared federal-state authority over health insurance.

Who interprets and enforces ERISA?

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

Are there exceptions to ERISA preemption?

ERISA's preemption provisions contain an exception important to state health policy that allows states to continue to regulate "the business of insurance" (authority that Congress gave to the states in the McCarran-Ferguson Act of 1945).[9] Courts have interpreted ERISA's insurance regulation "savings clause" to allow states to regulate traditional insurance carriers conducting traditional insurance business. This includes, for example, mandating the benefits that insurers must offer. Some courts have held, however, that states cannot regulate all activities of insurers. For instance, when insurers act only in an administrative capacity, such as administering a health plan but not bearing any risk, some courts have held that states cannot impose insurance requirements, such as health benefits mandates, on them.

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

Under the insurance regulation savings clause, states can regulate the terms and conditions of health insurance, for example, the benefits in an insurance policy or the rules under which the health insurance market must operate. But through its so-called "deemer clause,"[10] the statute prohibits states from regulating plans that "self-insure" by bearing the primary insurance risk, even though by bearing risk they appear to be acting like insurance companies. The Supreme Court recognized that this distinction creates two classes of employer-sponsored health plans.[11] Plans funding coverage through insurance are subject to state insurance regulation, while those that self-insure are completely beyond state jurisdiction. This creates an important distinction between insured and self-insured employer-sponsored health plans. *Both types of plans are still ERISA plans*, but only the former are subject to some types of state oversight.

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

The number of employer-sponsored health plans that self-insure has grown over the last 20 years. While no detailed data are currently available, it is estimated that between 33 and 50 percent of employees throughout the country are in self-insured plans, though the number varies among states.[12] An intermediate estimate of 43 percent means that about 53 million of the 123 million

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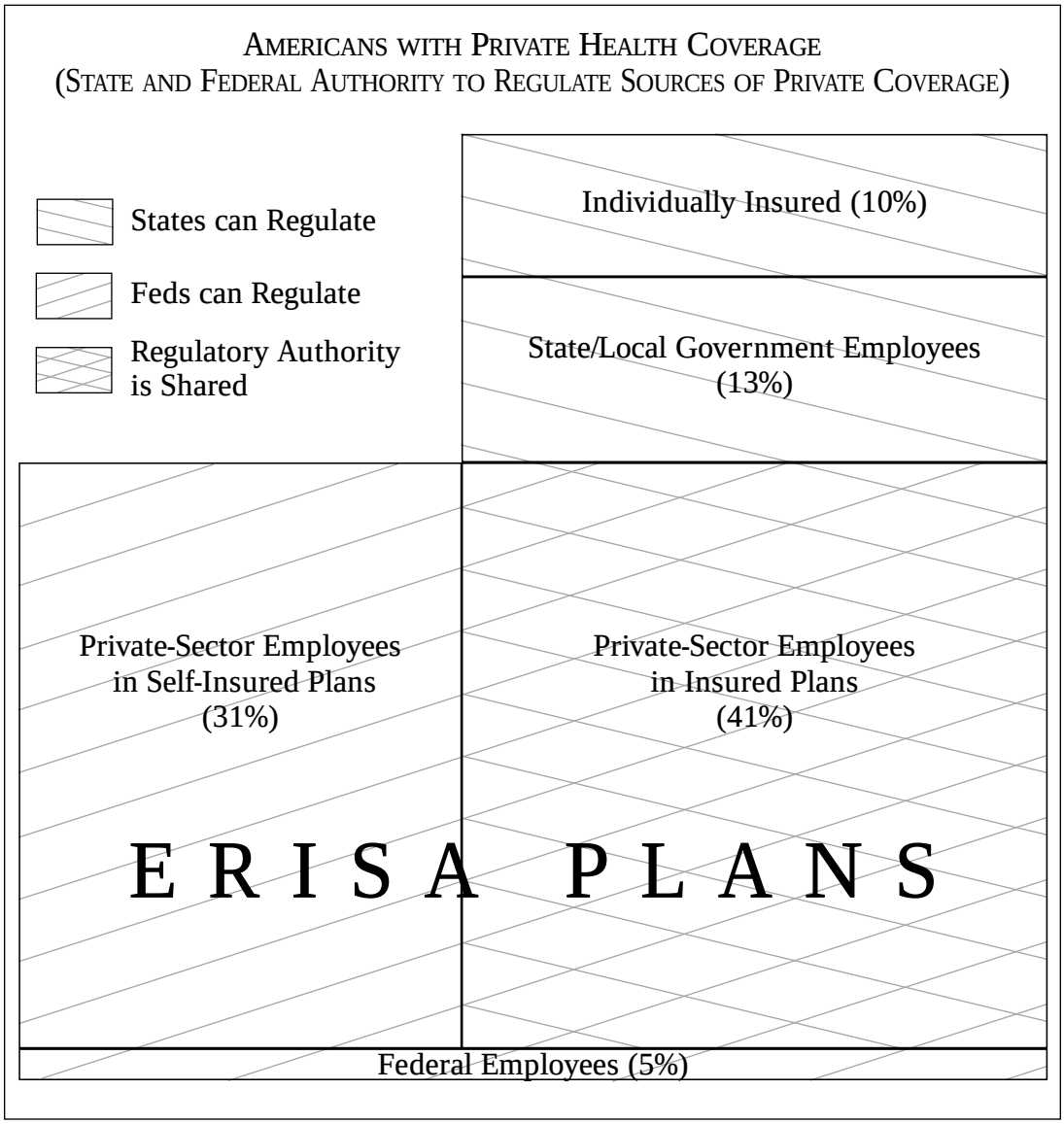
Americans receiving coverage though the workplace in 1997 were not covered by state regulation. State insurance laws could regulate health plans covering about 70 million Americans in insured, private-sector, employer-sponsored plans plus 23 million insured employees of state and local governments and 18 million people in individual health insurance plans.

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

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



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

While not overruling earlier preemption opinions, Supreme Court decisions in 1995, 1997, and 1999 narrowed the scope of the preemption provisions and broadened the scope of the insurance savings clause. For example, in the 1995 *Travelers* decision,[13] the Supreme Court held that ERISA did not preempt a state's hospital surcharges that employer-sponsored health plans had to pay, which provides support for other types of state health care taxes that might affect ERISA plans. Consequently, the Supreme Court recently appears more favorably disposed to the exercise of state authority.

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

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

- tax and regulate traditional insurers performing traditional insurance functions;[14]
- regulate multiple employer welfare arrangements (where two or more employers jointly sponsor health coverage);[15]
- regulate hospital rates charged to insurers and others who pay health care bills, and by extension, probably tax health care providers;[16] and
- provide remedies for injuries when a health plan controls medical care delivery (traditional medical malpractice cases).[17]

Court decisions have also made clear that states generally cannot:

- directly regulate private employer-sponsored health plans;
- mandate that private employers offer or pay for insurance;[18]
- tax private employer-sponsored health plans themselves;[19]
- regulate self-insured private employee plan benefits or financial solvency;[20]
- indirectly affect employer-sponsored health plans by imposing substantial costs on plans.[21]

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

- many types of managed care regulation, such as any-willing-provider laws;
- independent ("external review") appeals programs;
- regulation of stop-loss insurance (purchased by employer-sponsored health plans to share the risk of high-cost cases);

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- employer pay-or-play health care programs;
- employer health coverage tax credits;
- regulation of third-party administrators (TPAs) that administer self-insured health plans;
- requirements that public health care access programs coordinate closely with employment-based coverage;
- requirements that employee plans pay health care provider assessments directly to state agencies; and
- regulation of non-traditional insurers, such as provider-sponsored organizations, accepting risk from ERISA plans.

How might ERISA affect state health care access programs?

States have considered several approaches to make health care coverage broadly available, such as employer mandates, individual mandates, or government-operated programs, most of which raise ERISA preemption issues. Only Hawaii's employer health coverage mandate has been explicitly litigated, and Congress authorized this employer mandate in a 1983 ERISA amendment.[22]

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

ERISA also can impede state approaches to finance health care for uninsured people with low incomes or medical conditions that make them "uninsurable." For example, about half the states operate risk pools for uninsurable people, most of which are funded by taxes or assessments on health insurance companies. As more employer-sponsored health plans have become self-insured, the financing source of traditional insurance companies has declined. ERISA prohibits states from imposing such assessments on employer-sponsored health plans.[23] Following the analysis of the Supreme Court's 1995 *Travelers* decision, some lower courts have held that ERISA does not preempt state hospital charity care assessments or other provider taxes.[24] Consequently, programs for low-income or uninsurable people could be financed by taxing providers, even though the providers are likely to pass these taxes on to employer-sponsored health plans.

How does ERISA affect state health insurance regulation?

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

Court decisions suggest that ERISA permits states to adopt standards to make the health insurance market function more fairly.

States have begun to regulate managed care plans, for example, by adopting standards for provider network structure, enrollee choice of provider, and definitions of services such as emergency care. Relatively few of these standards have been challenged in court, although the courts are split on whether ERISA preempts any-willing-provider laws (requiring health plans to contract with all providers willing to accept their contract terms) as applied to insured as well as self-insured ERISA plans.[25] Requirements that regulate the relationship between plans and providers (such as provider selection and termination standards) face a more difficult challenge under ERISA because they do not resemble traditional insurance regulation.

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

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

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

These dispute resolution initiatives raise ERISA preemption issues. For example, while states have long required HMOs to provide grievance procedures, some state standards would conflict with rules proposed by the U.S. Department of Labor in September 1998. States can probably supplement such federal rules as long as there is no direct conflict with them.[26] A Texas district court held that ERISA preempts that state's external review law as applied to insured and self-insured ERISA plans.[27] And many federal courts, relying on Supreme Court precedent,[28] have held

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that ERISA preempts lawsuits for damages from injuries due to health plan coverage denials or delays[29] (although the courts generally allow medical malpractice lawsuits against plans that directly control or influence clinicians' medical practice). Because ERISA plans include all private-sector employer plans (not just those that self-insure), ERISA preempts state court damages suits against managed care plans and other insurers — not just against self-insured employee plans — challenging benefit denials.

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

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

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

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

What is Congress' current approach to health care legislation?

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

What are prospects for congressional revision to ERISA?

As the current congressional debate on expanding federal standards over ERISA plans has shown, powerful forces have aligned to resist amending ERISA. For several reasons, businesses, unions, and others that administer multi-state employer-sponsored health plans oppose narrowing ERISA's preemption provisions. In fact, some congressional proposals would expand preemption of state law, for example, eliminating state authority to regulate Multiple Employer Welfare Arrangements (MEWAs) and other multiple employer arrangements. Opponents of repealing ERISA's preemption provisions argue that by prohibiting potentially conflicting state laws that regulate employer-sponsored health plans, ERISA preemption has saved multi-state plans from costly administrative requirements. Businesses also assert that they have saved money because ERISA allows them to develop innovative benefits design, such as managed care. They point to any-willing-provider laws in the majority of states that permit all health care providers of a specific type, such as pharmacies, to participate in managed care organizations as examples of state laws that inhibit cost control. On the other hand, advocates of greater state flexibility under ERISA first point out that states, with their historic (sometimes even state constitutional) obligation to care for low-income and disadvantaged people, are ultimately accountable for health care access within their borders. Even though most large businesses insure workers and dependents, they also fail to insure many workers, who may become a state responsibility.

Proponents of ERISA change also note that, while not every state would seek to address access and managed care standards in the same way, those that achieve locally acceptable policy and are willing to devote local resources to enforce it should be given the tools to implement their laws and not be held hostage by national interest groups. Finally, they note that employers are subject to many interstate differences, such as taxes and employee workplace protections, as well as differing court interpretations of ERISA, belying the notion of uniform national standards.

How can states navigate through ERISA's preemption provisions to achieve their health policy goals?

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

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Notes

1. ERISA is codified in volume 29 of the U.S. Code, starting with section 1001. Regulations of the Department of Labor are published in volume 29 of the Code of Federal Regulations, starting at section 2509.

2. 29 U.S.C sections1002 (1), (3).

3. 29 U.S.C. section 1144(a).

4. *Mackey v. Lanier Collection Agency,* 486 U.S. 834 (1988); *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992).

5. *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983); *Metropolitan Life In. Co. v. Massachusetts,* 471 U.S. 724 (1985); *Alessi v. Raybestos-Manhattan, Inc.* 451 U.S. 504 (1981).

6. 29 U.S.C. section 1185.

7. 29 U.S.C. section 1185a; 29 U.S.C. section 1185b.

8. 29 U.S.C. sections 1181 - 1183.

9. 29 U.S.C. section 1144(b)(2)(A).

10. 29 U.S.C. section 1144(b)(2)(B).

11. *Metropolitan Life In. Co. v. Massachusetts,* 471 U.S. 724 (1985).

12. Jensen, G. A. and M.A. Morrisey. December 1999. "Employer-Sponsored Health Insurance and Mandated Benefit Laws." *Milbank Quarterly*, citing studies by Gabel and Jensen.; Marquis, S. and S. Long. 1999. "Recent Trends in Self-Insured Employer Health Plans." *Health Affairs* 18(2):161-166.

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

14. *Metropolitan Life In. Co. v. Massachusetts,* 471 U.S. 724 (1985).

15. 29 U.S.C. section 1144(b)(6)(A).

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

17. An example of such a case is *Dukes v. U.S. Healthcare System of Pa.,* 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 516 U.S. 1009 (1995).

18. *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

19. *Bricklayers' Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*, 771 F. Supp. 771 (E.D. La. 1991); *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (D. Wis. 1981).

20. *Standard Oil v. Agsalud*.

21. *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*

22. 29 U.S.C. 1144 (b)(5)(A).

23. *Bricklayers' Local No. 1 Welfare Fund v. Louisiana Health Ins. Assoc.*; *General Split Corp. v. Mitchell*.

24. *Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied*,. 516 U.S. 1173 (1996); *New England Health Care Employees Union v. Mount Sinai Hospital*, 65 F.3d 1024 (2d Cir. 1995); *Connecticut Hosp. Assoc. v. Weltman*, 66 F.3d 413 (2d Cir. 1995).

25. *Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993); *CIGNA Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996) *cert. denied*, 519 U.S. 964 (1996; *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) *cert. denied*, 118 S. Ct. 75 (1997); *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997).

26. This was suggested by the recent U.S. Supreme Court decision, *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999).

27. *Corporate Health Ins. Inc., et al. v. Texas Dept. of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998).

28. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

29. Recent cases so holding include: *Hull v. Fallon*, 188 F.3d 939(8th Cir. 1999); *Danca v. Private Healthcare Systems, Inc*., 185 F.3d 1 (1st Cir. 1999); *Bast v. Prudential Ins. Co*, 150 F. 3d 1003 (9th Cir. 1998), *cert denied*, 68 U.S.L.W. 3022 (1999); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997); *cert. denied*, 118 S. Ct. 1512 (1998); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996).