
Update - January 2001

ERISA Preemption Manual
for State Health Policy Makers

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The National Academy for State Health Policy is pleased to provide this update to our ERISA Preemption Manual, published last year by NASHP and the Alpha Center. NASHP is committed to providing up-to-date information to the states and is pleased that Pat Butler initiated and completed this *Update*.

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ERISA PREEMPTION UPDATE - JANUARY 2001

Since the *ERISA Preemption Manual for State Health Policy Makers*¹ was published in January 2000 by the National Academy for State Health Policy and the Alpha Center, several courts have decided ERISA preemption cases important to state health policy makers. Additionally, in November 2000 the US Department of Labor (DOL) issued final regulations on how ERISA health and disability plans must process claims and adjudicate health benefits disputes. This *Update* explains the essential features and state health policy implications of these judicial and administrative developments in four categories: state external review laws, state managed care regulation, state HMO liability laws, and the DOL claims payment regulations. This *Update* summarizes briefly the ERISA preemption issues raised in these four areas of state health policy and the implications of the new developments for state policy. Detailed discussions of the background and purposes of ERISA preemption and its interpretation by the courts can be found in the *Preemption Manual*.

ERISA PREEMPTION

ERISA, the federal Employee Retirement Income Security Act of 1974, may raise problems for state health policy because of its preemption of state laws that have an impact on private sector employee health plans (“ERISA plans”).² Because ERISA governs private sector health plans, which cover the majority of Americans, it limits states’ ability to enact broad-based health care reforms. ERISA raises two types of preemption problems. First, as with any federal law, where state law directly conflicts with federal law, federal law prevails. Second, ERISA includes a very broad provision, commonly called the “preemption clause,” that preempts state laws that “relate to” private sector employee benefit plans.³ As discussed more fully in the *Preemption Manual*, courts historically interpreted this clause very broadly, although the reach of the preemption clause has narrowed considerably since the Supreme Court’s 1995 *Travelers Insurance* case. If a court holds that a state law relates to a private sector employee benefits plan, the law may still avoid preemption if it regulates insurance under the so-called insurance “savings clause.”⁴ But a state may not deem self-insured employer plans to be insurers in order to regulate them. The cases and regulations discussed below involve both types of preemption as well as interpretations of the insurance savings clause.

STATE EXTERNAL REVIEW LAWS

Two-thirds of the states (39) have enacted laws allowing people covered by HMOs and other health insurers to appeal certain coverage disputes to a review organization independent of the insuring organization.⁵ While these laws vary in scope, most permit review of an insurer’s decision to deny coverage because it was not “medically necessary.”⁶ Although not yet widely

used, these programs are regarded as fair and valuable by consumers, regulators and health plans.⁷

State external review laws raise two potential ERISA preemption problems.⁸ They arguably “relate to” ERISA plans because they affect a plan’s ability to determine coverage by dictating a mechanism to resolve coverage disputes.⁹ When these laws are designed to regulate only HMOs and other insurers, they may be protected under ERISA’s savings clause. But even then, they face an additional preemption problem: by adding a step to ERISA’s current, limited benefits dispute appeals procedure,¹⁰ a state external review law arguably conflicts with ERISA’s intentionally narrow remedial scheme.¹¹ Two different federal Courts of Appeal recently examined these preemption problems and reached different conclusions about the legality of state external review laws.

In *Corporate Health Ins. Inc. v. Texas Dept. of Ins.*, the Fifth Circuit held that ERISA preempts the Texas external review law (while upholding the state’s law entitling enrollees to sue their HMOs and other health insurers, discussed below).¹² Although the court upheld the Texas requirement that medical malpractice-type disputes first be appealed to external review,¹³ it held that ERISA preempts the external review law as applied to disputes over medical necessity or appropriateness of a requested benefit, because the law attempts “to impose an administrative regime governing coverage determinations.” The Court decided that HMOs can be regulated as insurers¹⁴ and the law meets the other tests of insurance regulation so it might be saved from preemption. But it held that the “supplemental” remedy of external review conflicts with ERISA’s limited set of remedies. The Court of Appeals denied a request by the state and lawyers for the DOL to reconsider its decision about the external review law.¹⁵

The recent decision of a different federal Court of Appeals is much more favorable to state external review programs. In *Moran v. State of Illinois* the Seventh Circuit Court of Appeals held that ERISA does *not* preempt Illinois’ external review law. The state’s law authorizes an appeal to an independent physician of a dispute involving whether a requested service is medically necessary.¹⁶ The Court agreed that external review does relate to private sector employee benefit plans because mandating the procedure for benefits determinations affects benefits administration. But it held that the external review law is saved from preemption because it regulates insurance.¹⁷ Finally, the Court addressed the arguable conflict between a state external review law and ERISA’s more limited appeal process. Explicitly disagreeing with the Fifth Circuit in the Texas case, the Seventh Circuit held that external review is not inconsistent with ERISA’s appeal procedures because by amending all health insurance contracts, it simply adds an appeal step that an insured health plan must provide – creating “additional safeguards to preserve the integrity of the decision-making process.”¹⁸

These decisions are binding in only a few states (the Fifth Circuit decision in Louisiana, Mississippi, and Texas and the Seventh Circuit decision in Illinois, Indiana, and Wisconsin), but the Seventh Circuit’s opinion provides precedent for other states to defend their external review laws.¹⁹ Its decision relied very heavily on the fact that by mandating insurers to provide external review, the state incorporated this appeal process into all health insurance contracts.²⁰ Consequently, the decision will be most directly

helpful to other states whose external review laws are similarly drafted.

STATE MANAGED CARE REGULATION

States continue to enact laws regulating managed care organizations and other health insurers, some of which raise ERISA preemption problems. In 2000, several courts have examined these ERISA issues.²¹

Any Willing Provider Laws. More than half the states have adopted some form of “any-willing-provider” (AWP) law that requires HMOs and other managed care organizations to permit any provider (most often pharmacies but sometimes physicians and other practitioners) to participate in a plan’s network by agreeing to accept payment levels and other contract terms. Federal courts remain divided on the question of whether ERISA preempts these laws.²² The Sixth Circuit Court of Appeals recently upheld Kentucky’s AWP law.²³ The Court held that the Kentucky law relates to ERISA plans because it both refers to them (by excepting them from the law) and has a connection with them by affecting how they structure their health benefits. But the Court held that the Kentucky AWP law is saved from preemption; it regulates insurance because it is generally directed at organizations engaged in the business of insurance and increases the scope of benefits available to people insured under the plan.²⁴

Provider Payment Mandates. State provider payment mandates require that health insurers include specified categories of providers (such as chiropractors, nurse midwives, or optometrists) who will be paid for rendering services covered by the insurance policy. Provider mandates differ from AWP laws because they do not guarantee all providers a right to participate in a managed care organization network. An Alabama federal district court held that ERISA preempts the state’s law mandating that insurers, such as managed care plans and Blue Cross, and other types of health plans pay physician assistants.²⁵ After deciding that the Alabama law relates to ERISA plans because it can affect their structure and administration, the court held that it was not saved as insurance regulation. Even though the law is part of the state insurance code, the court held it did not regulate the business of insurance because it applied to organizations such as organized delivery systems and possibly also to self-funded employer plans and therefore failed to satisfy the McCarran-Ferguson criteria.²⁶ This case contrasts with the 1998 Ninth Circuit Court of Appeals’ decision upholding Washington State’s broad provider mandate, which provides more helpful precedent for defending these types of state laws.²⁷ States can most easily defend provider mandates (and all other managed care laws) if they draft them to apply only to insuring entities.

Pharmacy “Freedom of Choice” Requirements. “Freedom of Choice” (FOC) laws permit enrollees in HMOs and other managed care organizations to obtain covered services from a non-network provider. These laws were designed to achieve the same policy objectives as AWP laws while interfering somewhat less with health plan network management. In the first case to examine a state consumer FOC law, a federal district court upheld Missouri’s statute requiring HMOs to permit their enrollees to choose (without higher cost sharing) retail pharmacies rather than only mail-order pharmacies.²⁸ The court held that this regulation does not relate to ERISA plans because it has a minimal impact on their structure or administration since HMOs can still use mail-order pharmacies and ERISA plans could purchase indemnity insurance, not regulated by the state FOC law.²⁹ The court also held that the state’s FOC law is insurance regulation, exempt from preemption under ERISA’s savings clause.³⁰ This case is important for state policy makers in the 22 states with FOC laws because it categorizes these laws as provider mandates, which appear easier to defend than AWP laws. (The only court to hold that ERISA preempts a provider mandate is the Alabama case discussed above, whereas several courts have held that ERISA preempts AWP laws.)

MANAGED CARE ORGANIZATION LIABILITY

State HMO Liability Laws

By the end of 2000, eight states (Arizona, California, Georgia, Louisiana, Maine, Oklahoma, Texas and Washington) had enacted laws permitting injured health plan enrollees to sue their plans to recover damages for certain types of plan misconduct. The courts continue to struggle with ERISA implications of both these statutes and the general right under state common law (judge-made law) principles to sue health plans. Even the U.S. Supreme Court, in a case not involving preemption, commented on these issues in 2000.

As it does for state external review programs, ERISA raises two types of preemption problems for state court damages lawsuits by enrollees in private sector employer health plans: 1) the potential that these lawsuits relate to ERISA plans but are not saved as insurance regulation and 2) the argument that a suit for damages conflicts with ERISA’s limited remedy allowing a federal court suit for only the cost of disputed benefits.³¹ In grappling with many difficult cases of people injured by health plan actions with no real legal remedy, the federal courts have created a distinction between:

- Traditional malpractice-type actions where health insurance plans can be held responsible in state court for the negligence of a physician or other practitioner either the plan employs or whose practice it substantially controls; most courts hold that ERISA does not preempt these types of cases.³²
- Disputes over the interpretation of what benefits the health plan will cover, which all courts hold ERISA does preempt.³³

The distinction between medical malpractice-type cases and those involving health plan coverage decisions may be difficult to draw. For example, managed care organizations often condition coverage of a service on its being “medically necessary.” A dispute over medical necessity, therefore, generally involves questions of both health plan coverage (subject to only ERISA remedies) and what is appropriate medical practice (subject to state court medical malpractice litigation). A few recent cases suggest that the courts may be more willing to categorize a mixed coverage and medical decision as a malpractice action that can proceed in a state court.³⁴ But the courts still read ERISA as limiting the ability of people injured by utilization review decisions or coverage denials and delays to sue for damages.

In the same decision invalidating the Texas external review law, the Fifth Circuit Court of Appeals upheld Texas’s 1997 statutory right to sue managed care plans that make “health care treatment decisions” (i.e., that become involved directly in a physician’s medical practice).³⁵ Consistent with all other courts that have considered health plan liability, however, the Court of Appeals noted that ERISA would preempt cases brought under the law seeking damages for health plan coverage decisions.

The U.S. Supreme Court has not yet considered a health plan liability case raising ERISA preemption issues. But in spring 2000 it decided a case that some commentators believe predicts how the Court would treat a health plan liability preemption case. The plaintiff in *Pegram v. Herdrich*³⁶ sued her health plan for injuries resulting from a burst appendix allegedly caused by a delay in referring her to the health plan’s distant diagnostic facility for an ultrasound test. The plaintiff sued the physician for malpractice but asserted that the health plan had violated ERISA by breaching its fiduciary duty (the high duty owed by a trustee to trust beneficiaries) to all health plan enrollees by using financial incentives to limit use of medical care, for example, discouraging physicians from referring patients to non-network providers.³⁷ The Supreme Court held that while HMOs and other health insurers contracting with private sector employee health plans may act as ERISA fiduciaries under some circumstances, a health plan’s financial incentives do not automatically create a fiduciary breach.³⁸ The Court said that the plaintiff’s ERISA claim was no more than a federal claim for the same conduct that can already be litigated in state court malpractice suits. This language is cited by some commentators to suggest that the Supreme Court will be favorably disposed to hold that ERISA does not preempt state damages suits alleging injury from both traditional malpractice and even “mixed” treatment and eligibility decisions.³⁹ It is likely that the Court’s language will encourage more state court litigation and may prompt lower federal courts to hold that ERISA does not preempt close cases where treatment and coverage decisions intermingle.

State Medical Board Discipline of Health Plan Medical Directors

Some state physician licensing boards have taken the position that HMO and other managed care plan medical directors are practicing medicine when they review coverage decisions, must be licensed in the

state, and are subject to discipline by the board for inappropriate decisions.⁴⁰ In the first court decision about ERISA implications of asserting such jurisdiction, a federal district court held that ERISA preempted the attempt by the Texas State Board of Medical Examiners to discipline an HMO's medical director for disagreeing with the physician of an enrollee in a self-insured employer health plan about appropriate treatment.⁴¹ The medical director had determined that requested care in a nursing facility was custodial and consequently not covered by the plan. The court held that ERISA preempts the Board's actions because it mandates an ERISA plan's definition of custodial care and provides an alternative enforcement mechanism to ERISA's limited remedies to resolve enrollee-health plan disputes. This decision is important for state health policy makers working with their medical licensing boards. A state might be able to assure that health insurers' medical directors who make medical decisions are licensed in the state by enacting such a requirement in the state's insurance law (which might be saved from preemption as insurance regulation).

U.S. DEPARTMENT OF LABOR CLAIMS PROCEDURE REGULATIONS

In November 2000, the DOL issued final regulations (effective January 1, 2002) on how ERISA health and disability plans must process claims for benefits and appeals of adverse benefit determinations.⁴² State policy makers have been interested in these regulations because some of the proposed rules raised ERISA preemption issues regarding state insurance laws governing the same subject areas.⁴³ Even though state insurance law is saved from preemption, federal law would preempt state law that directly conflicts with federal law, so state insurance regulators were concerned about the specific standards in final federal rules. The final regulations and DOL's interpretive comments suggest that the new federal rules should not pose irreconcilable conflicts with state law.

The federal regulations prescribe standards for private sector employee plans offering health benefits through insurance or self-insured arrangements in the following areas:

- Maximum allowable time frames to:
 - determine initial coverage of urgent, non-urgent, and pre-and post-care coverage claims⁴⁴
 - resolve appeals of urgent and non-urgent claims⁴⁵
 - decide whether a claim is incomplete⁴⁶
 - extend the decision deadline for non-urgent claims⁴⁷
- Information that must be provided to plan participants regarding:
 - how to obtain pre-service authorization⁴⁸
 - the basis of a claim denial⁴⁹
- Procedures for conducting appeals of denied claims, including:
 - prohibiting plans from requiring fees to be paid for the appeal⁵⁰
 - qualifications of the reviewer⁵¹

- obligation to consider all information submitted by the claimant and to review the decision “de novo”⁵²
- use of a qualified health professional for claims involving medical judgment⁵³
- authority to require up to two levels of review within the plan before claimant can go to federal court⁵⁴
- authority to use binding arbitration under only limited circumstances⁵⁵

In an unusual acknowledgment of concerns expressed by several state insurance regulators, the final rules and DOL preamble explicitly address the potential conflict between federal regulations and state health insurance law.⁵⁶ The regulation states that “Nothing in this section shall be construed to supercede any provision of state law that regulates insurance except to the extent that such law *prevents the application* of a requirement of this section” (emphasis added).⁵⁷ This fairly narrow standard for finding a preemptive conflict between federal and state law was expressed in the U.S. Supreme Court’s 1999 *UNUM v. Ward* decision.⁵⁸ The DOL preamble notes that state laws prescribing stricter time frames for review or allowing oral appeals would not prevent application of the federal law and would, therefore, not be preempted. The federal rule also explicitly states that: 1) there is no direct conflict with state independent/external review procedures as long as the external review is conducted by parties other than the insurer, employer plan or their agents or fiduciaries and 2) using the state external review law would not be necessary before filing an ERISA lawsuit under the federal law.

The new federal claims procedures rules substantially increase consumer protections for enrollees in self-insured ERISA health plans, which state insurance laws cannot regulate, by expediting coverage determination and appeal time frames, enhancing notice requirements, and setting standards for the independence of internal plan appeals. The regulation also creates a federal floor of standards for insured plans in the same way as the 1996 Health Insurance Portability and Accountability Act (HIPAA). In contrast to the proposed rules, which arguably conflicted directly with some insurance appeals standards in several states (for example, by prohibiting more than one level of internal review while many states permit two levels), the final rules do not appear to pose impermissible conflicts with state law. And while the DOL interpretation of ERISA’s preemption of state external programs or other insurance laws is not binding on the courts, its unique discussion of preemption can only help states that may need to defend these laws against ERISA challenges.

CONCLUSION

ERISA preemption continues to pose challenges for state health policy makers. Because the preemption clause can be interpreted definitively only by the courts, states often cannot be certain whether their health care financing programs, insurance standards, or consumer protection laws are immune from contest. Following the U.S. Supreme Court’s more recent narrowing interpretation of ERISA preemption, lower courts have upheld state managed care laws, external review programs, and authority to sue health plans. Other courts have invalidated some state laws dealing with these subjects. Yet, as the *Preemption Manual* and this *Update* suggest, when laws are drafted carefully, states often can avoid ERISA preemption lawsuits and successfully defend their laws in court.

ENDNOTES

1. The *Preemption Manual* is available on the web at www.statecoverage.org (the web site for the “State Coverage Initiatives” program of the Academy for Health Services Research and Health Policy (formerly the Alpha Center)).
2. All private sector health plans offered by employers (other than churches) or unions are ERISA plans subject to limited federal regulation. State laws may be preempted if they either directly conflict with federal law or are held to relate to these private sector (ERISA) plans.
3. As discussed in the *Preemption Manual*, ERISA also contains several narrow preemption provisions (most of which were enacted by the Health Insurance Portability and Accessibility Act of 1996), such as setting standards for pre-existing condition exclusion periods.
4. To be insurance regulation under the savings clause, the Supreme Court has held that a state law must be directed at the insurance industry (the so-called “common sense test”) and meet at least some of the following criteria: integrally affect the relationship between the insurer and insured person, spread risk, or regulate the only insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) and *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999).
5. As is true for all state laws, states have no authority to require self-insured ERISA health plans to submit coverage disputes to external review.
6. For a detailed outline of these state laws, see, Molly Stauffer, *Consumer Grievance Procedures: Internal and Independent Appeals* (Washington, D.C.: Health Policy Tracking Service 2000).
7. See, e.g., Karen Pollitz, Nicole Tapay and Geraldine Dallek, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* (Menlo Park CA: Kaiser Family Foundation, 1998) and Geraldine Dallek and Karen Pollitz, *External Review of Health Plan Decisions: An Update* (Menlo Park CA: Kaiser Family Foundation, 2000).
8. ERISA issues raised by state external review laws are discussed in the *Preemption Manual* pages 81-82.
9. The courts have consistently held that state laws regulating plan administration relate to ERISA plans, *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).
10. ERISA requires that plans must provide a “full and fair” means for plan participants to appeal benefits coverage disputes (29 U.S.C. section 1133) and then allows dissatisfied plan participants to sue in federal court to enforce their rights to plan benefits or to denied payments (29 U.S.C. section 1132(a)). These requirements are amended by the DOL claims procedures rules discussed in this *Update* at pages 6-7.
11. This is one of the grounds for the U.S. Supreme Court’s decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), which held that an ERISA plan participant could not sue a disability insurer for punitive damages under state law for wrongfully denying benefits because punitive damages were inconsistent with Congress’s purpose in creating ERISA’s limited appeals system. As discussed in the text at page 7, the DOL has taken the position in its recently issued claims procedures regulations that state external review mechanisms do not conflict with ERISA appeals procedures.

12. 215 F. 3d 626 (5th Cir. 2000).

13. This part of the opinion was consistent with the court's decision (discussed below on page 5) that ERISA does not preempt the right-to-sue law insofar as it authorizes suits for health plans' involvement in medical treatment decisions but would (consistent with *Pilot Life*) preempt the state law if it authorized a damages suit over a dispute about whether coverage was improperly denied.

14. This observation is important because some courts have held that HMOs are not insurers so that laws regulating them are not "saved" from preemption (see cases cited in *Preemption Manual* pages 35-36, end note 88).

15. In *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 220 F. 3d 641 (5th Cir. 2000), the Court of Appeals noted that the independent review procedure binds HMOs to pay for treatment the reviewer mandates and substitutes the medical judgment about medical necessity of an outsider for the HMO's or treating physician's judgment.

16. October 19, 2000 7th Cir. [Available on web at www.findlaw.com/caseload/courts]. This case involves an ERISA insured plan participant's attempt to appeal a medical necessity benefits coverage dispute to external review. The Texas case challenged that state's law before it was implemented and before a particular individual sought external review.

17. The Court held that: the Illinois law is directed at the insurance industry, HMOs are insurers, and the appeals process is incorporated into insurance policies by operation of state law and therefore integral to the insured/insurer relationship.

18. This position is consistent with the US DOL regulations discussed in this *Update*, pages 6-7, and with the DOL's position in *amicus curiae* briefs in the 5th Circuit case.

19. The Texas Attorney General filed a petition for U.S. Supreme Court review of the Fifth Circuit case, citing the split between the Fifth and Seventh Circuits. As this *Update* went to press, the Court had not announced whether it would accept the appeal.

20. Four judges dissented from the Court of Appeals' decision not to rehear the case, arguing that the Fifth Circuit's analysis was more sound and that by holding that the state's external review law, which substitutes an outside physician for the plan's medical necessity determination process, becomes a part of all insurance contracts, it "effects a substantial change in the employer's plan" and conflicts with ERISA's statutory remedies. The dissenters assert that the court's holding "invites states to evade the preemptive force of ERISA simply by deeming its regulations of ERISA plans to be plan terms."

21. Courts have also upheld against ERISA preemption challenges state laws prohibiting a health plan from requiring physicians to indemnify the plan if the plan is sued for the physician's error (*Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 220 F. 3d 641 (5th Cir. 2000)) and a state "prompt-payment" law setting time limits for insurers to pay health providers (*Lakeland Anesthesia, Inc. v. Aetna U.S. Healthcare, Inc.*, No. 00-1061, E.D. La., June 14, 2000).

22. As discussed more fully in the *Preemption Manual* (pages 24 and 67-68), the Fourth Circuit Court of Appeals upheld Virginia's law (*Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993)) and a federal district court upheld the Massachusetts statute (*American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass.

1997)), while the Fifth and Eighth Circuits held that ERISA preempts laws in Texas, Louisiana, and Arkansas (*Cigna Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996), *cert. denied*, 117 S. Ct. 387 (1996); *Texas Pharmacy Association v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997), *cert. denied*, 118 S. Ct. 75 (1997); *Prudential Insurance Co. v. National Park Medical Center*, 154 F.3d 812 (8th Cir. 1998)).

23. *Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F. 3d 352 (6th Cir. 2000).

24. The Kentucky legislature had revised its definition of organizations subject to the AWP law from “health benefits plans” to “insurers,” a term that applies to HMOs as well as self-insured plans not exempt by ERISA. Consequently, although the state law applies to HMOs and self-insured public and church plans, the court held that it was still directed at organizations engaged in the business of insurance. In this respect the Sixth Circuit disagreed with the Eighth Circuit’s *Prudential* decision (cited in note 22) but noted that the AWP law could not be applied against HMOs or other administrators of self-insured plans that did not themselves bear insurance risk. The Court further held that the Kentucky AWP law meets the McCarran-Ferguson criteria of regulating insurance by spreading policyholders’ risk by expanding the provider network, regulates the terms of the insurance policy, and is directed only at insuring entities. One Circuit Court judge strongly dissented from the holding that the AWP law regulates insurance.

25. *Hobbs v. Blue Cross and Blue Shield of Alabama*, 100 F. Supp. 2d 1299 (M.D. Ala. 2000).

26. The court held that the statute does not spread insurance risk, is not an integral part of the insurance policy (because it involves insurer-third party contracts), and is not limited to insuring organizations. While this analysis is consistent with the Fifth Circuit Court of Appeals’ reasoning in the *Cigna Louisiana AWP* case (cited in note 22), the district court did not cite *Cigna* or other AWP cases. Nor did it cite *Washington Physician Serv. Ass’n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), or attempt to distinguish that court’s reasons for upholding the substantially similar Washington statute.

27. *Washington Physicians Service* (cited in note 26). This law prohibits health plans from excluding categories of providers that are licensed to provide services the law requires plans to cover, such as acupuncture, massage therapy, and chiropractic care. These issues are discussed in the *Preemption Manual*, pages 23 and 67.

28. *Express Scripts, Inc. v. Wenzel*, 102 F. Supp. 2d 1135 (W.D. Mo. 2000).

29. The district court thereby distinguished the Fifth Circuit’s *Cigna* and *Texas Pharmacy Association* cases as well as the Eighth Circuit’s *Prudential Insurance* case. Since Missouri is in the Eighth Circuit, the *Express Scripts* decision might be threatened if it were appealed.

30. The district court held that HMOs are insurers so that the Missouri law meets the “common sense” test of insurance regulation and also that it meets the three McCarran-Ferguson criteria. The court held that by requiring the class of retail pharmacies to be part of networks, this consumer FOC law is more like the provider mandate upheld in *Washington Physicians Serv. Ass’n v. Gregoire* (cited in note 26), than the AWP laws that the Eighth and Fifth Circuits held preempted in the *Prudential*, *Cigna*, and *Texas Pharmacy* cases.

31. These issues are discussed in the *Preemption Manual* at pages 3-4 and 82-83.

32. See cases cited in *Preemption Manual*, note 35, page 87.
33. See cases cited in *Preemption Manual*, note 31, page 86. These cases may be brought in either federal or state court but involve only issues of federal (ERISA) law.
34. In *Bauman v. U.S Healthcare, Inc.* 193 F. 3d 151 (3rd Cir. 1999), *cert. denied*, 120 S. Ct. 2687, a federal court held that the plan's maternity length of stay policy (whose objective was to change physician practice) was a medical treatment decision, so that ERISA did not preempt a suit for injuries due to premature discharge. In *Spear v. Caron Foundation* (No. 99-0706, E.D. Pa, Sept. 28, 1999), a federal court held that ERISA did not preempt a suit against a health plan for its involvement in terminating hospital care. In *DeLucia v. St. Luke's Hospital*, No. 98-6446, E.D. Pa. May 25, 1999, WL 387211), a federal court held that ERISA did not preempt a suit against a health plan for injuries caused by sending an infant home without a breathing monitor because he didn't meet the plan's coverage criteria. In *Morton v. Mylan Pharmaceuticals* (No. 99-6896, E.D. Pa., March 22, 2000), a federal district court held that ERISA did not preempt a suit against a health plan for injury from the use of a prescription drug even when the plaintiff alleged that the injury resulted in part from the plan's restrictions on covered drugs. See also, the discussion of *Pegram v. Herdrich*, page 5 of this *Update*)
35. *Corporate Health Insurance, Inc.*, note 15.
36. 120 S. Ct. 2143 (2000).
37. In this case the health plan and clinics were owned by the physicians who also faced incentives to conserve funds by limiting use of care. The remedy for a breach of fiduciary duty under ERISA is not damages for injuries but repayment of profits to the plan to be used for the benefit of all plan participants.
38. The Court held that managed care plan physicians' decisions about how to diagnose or treat a patient involves both "treatment" and "eligibility" decisions and that when the eligibility decisions cannot be separated from a physician's judgment about reasonable medical treatment they are not fiduciary decisions actionable under ERISA.
39. The U.S. Supreme Court also sent back to the Pennsylvania Supreme Court a case, *Pappas v. Asbel* (675 A. 2d 711 (Pa. Sup. Ct. 1996)), that had been appealed to it, with directions to reconsider its decision in light of *Pegram*. In *Pappas*, the state supreme court had held that ERISA did not preempt a damages suit for an injury allegedly due to a delay in transferring the plaintiff to a non-network hospital, caused in part by uncertainty over whether the health plan would cover the cost of care. The new opinion in *Pappas* should offer an early view of how lower courts interpret the relevance of *Pegram* to ERISA health plan malpractice and coverage cases. In its *amicus curiae* brief to the Pennsylvania Supreme Court, the DOL argued that the malpractice action in *Pappas* is not preempted to the extent that it challenges mixed eligibility and treatment decisions, a new position for the DOL.
40. See, for example, *Murphy v. Bd. of Medical Examiners*, 949 P. 2d. 530 (Ariz. 1998).
41. *United Healthcare Ins. Co. v. Levy*, No. 3:00-CV-0569-M, N.D. Tex., Sept 8, 2000.
42. 65 *Federal Register* 70246-70271 (Nov. 21, 2000).
43. These issues are discussed in the *Preemption Manual* at pages 42-43.

44. Urgent claims must be determined within 72 hours and non-urgent ones within 15 days if they involve a decision before care is rendered (pre-service determination) or 30 days for a post-service determination, 29 C.F.R. 2560.503-1(f).

45. Appeals (“reviews”) of denied claims must be resolved in 72 hours for urgent claims, 30 days for non-urgent pre-service claims, and 60 days for non-urgent post-service claims, *ibid*.

46. A decision on whether an urgent care claim is incomplete must be made within 24 hours of filing the claim; no extension of the decision time frames is permitted, even for incomplete requests. Decision on an incomplete claim for non-urgent care can be extended up to 15 days, *ibid*.

47. A plan can extend the deadline on pre- or post-service non-urgent claims by 15 days if the delay is beyond the plan’s control (e.g., incomplete information), which can extend the date for determining the claim, *ibid*.

48. 29 C.F.R.2560.503-1(b)(2).

49. If the plan used a protocol in denying the claim, it must include in the notice of decision either a copy of the protocol or notice of the right to request a copy. The plan also must explain the scientific or clinical judgment it used in deciding that a requested service was not medically necessary or was experimental or investigational if these were the reasons for denying the claim 29 C.F.R. 2560.503-1(g)(v).

50. 29 C.F.R. 2560.503-1(h).

51. The reviewer on appeal must not be the person who made the initial decision or his/her subordinate, 29 C.F.R. 2560.503-1(i).

52. “De novo” review means that the reviewer must not give deference to the initial decision and must consider all materials submitted by the claimant even if not considered in the initial decision, *ibid*.

53. This health professional must be appropriate by training and experience and not involved in the initial review, *ibid*.

54. The regulation permits up to two levels of review within the plan for non-urgent claims but both must be completed within the appeal time frames: 30 days for pre-service and 60 days for post-service reviews, 29 C.F.R. 2560.503-1(c)(2).

55. Plans can require participants to arbitrate claims only if arbitration is one of the permitted two levels of review, arbitration complies with all other applicable regulations (e.g., no fee required, time frames, etc.) and the dissatisfied claimant is not prohibited from going to federal court, 29 C.F.R. 2560.503-1(c)(4).

56. Although in recent years the DOL has submitted many *amicus curiae* briefs in support of state laws against ERISA preemption challenges, it has never before addressed preemption in regulation.

57. 29 C.F.R. 2560.503-1(k).

58. Cited in note 4.