



# issue brief

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## ERISA Update: The Supreme Court Texas Decision and Other Recent Developments

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*This issue brief is part of a continuing series of policy papers published by The Robert Wood Johnson Foundation's State Coverage Initiatives program, housed at AcademyHealth, and the National Academy for State Health Policy on the state health policy implications of ERISA's preemption clause.<sup>1</sup> The purpose of the brief is to explore the U.S. Supreme Court's June 2004 decision that ERISA preempts the Texas HMO liability law and its effects on other state health plan liability laws. The brief also examines implications of ERISA preemption for state health insurance regulation, “pay or play” health coverage laws, and premium assistance programs.*

### ERISA Preemption Principles

ERISA, the Employee Retirement Income Security Act of 1974, is the federal law governing pension and other employee benefit plans sponsored by private-sector unions or employers (other than churches). Such employee benefit packages, which include health coverage, are “ERISA plans,” regardless of whether they are offered through insurance or self-insured by the sponsor. While regulating pension plans in considerable detail, ERISA provides limited federal regulation of health plans.

Nevertheless, the Act contains a broad preemption provision stating that federal law supercedes any state law that relates to ERISA plans, except those that regulate insurance, banking, and securities. States cannot deem employee plans to be insurers. Consequently, states are prohibited from regulating employee health plans directly. However, they can regulate the insurers with which the employee plans contract, creating the distinction between insured plans (which

states can regulate) and self-insured plans (which they cannot).

Because ERISA's preemption provisions are not particularly clear on their face, courts have been interpreting them in the 30 years since ERISA was enacted. For two decades, the U.S. Supreme Court took an expansive view of ERISA state law preemption. The Court noted, for example, that the preemption clause was “conspicuous in its breadth,” and overturned state laws with any impact on or reference to an ERISA plan's benefits, structure, or administration.

In 1995, however, in the *Travelers Insurance* case, the Court narrowed the reach of ERISA preemption by limiting the types of impacts on state laws that relate to ERISA plans.<sup>2</sup> It held that ERISA did not preempt New York's hospital rate-setting law, even though the legislation imposed some costs on ERISA health plans. The Court's reason was that the law would not compel plan administrators to structure benefits in a particular way



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or to limit a plan's ability to design uniform interstate benefit packages.

The Court also has interpreted ERISA's so-called insurance savings clause, which exempts state insurance regulations from preemption. In the 2003 *Kentucky Association of Health Plans* decision, for example, it upheld Kentucky's "any willing provider" (AWP) law.<sup>3</sup> The Court ruled that state laws are exempt from preemption if they are directed at insurance practices of insurance organizations (e.g., HMOs and indemnity carriers) and substantially affect risk-pooling arrangements between the insurer and insured people. The Court also recently upheld the Illinois law providing an external review process that health insurance enrollees can use to appeal benefit denials.<sup>4</sup>

In addition to applying the preemption clause, the Supreme Court also held that some ERISA provisions directly conflict with state law and, under general constitutional principles of federalism, "completely preempt" it. For example, in its 1987 *Pilot Life* decision, the Court held that ERISA preempted a state law authorizing damages suits against insurers because the law conflicts with ERISA's remedies for plan misconduct.<sup>5</sup> ERISA allows injured plan enrollees to sue the plan administrator to pay for benefits that were improperly withheld or otherwise enforce the plan's terms.

However, it does not provide for damages for injuries that a plan's benefit delay or denial may have caused, such as lost wages, pain and suffering, or punitive damages. The Supreme Court's 2004 HMO liability decision follows the reasoning in *Pilot Life* in holding that states cannot authorize ERISA health plan enrollees to sue for damages that occur when HMOs deny coverage.

### The Supreme Court's *Aetna v. Davila* Decision

As more enrollees of managed care plans have sued for damages allegedly resulting from health plan actions, federal courts have created a distinction between traditional medical malpractice actions (which ERISA generally does not preempt) and disputes over interpretation of what benefits the health plan will cover (which ERISA generally does preempt).<sup>6</sup> This distinction was often described as "quality" vs. "quantity" of care cases, and courts acknowledge the difficulty of drawing this line.<sup>7</sup>

### The Texas HMO Liability Law

In 1997, Texas became the first state to enact a law authorizing enrollees of HMOs and other insurers to sue in state court if the health plan or its employees or agents fail to "exercise ordinary care in making health care treatment decisions."<sup>8</sup> The purposes of the law were to allow damages lawsuits against a health plan for both: 1) medical malpractice<sup>9</sup> of medical care practitioners operating under the plan's control (i.e., plan "vicarious liability" for negligence of its employees or agents), and 2) the plan's improper coverage decisions.

The Fifth Circuit Court of Appeals upheld this statute against a general ERISA challenge on the ground that ERISA does not preempt provisions of the law authorizing suits against health plans for negligent delivery of care by their network physicians.

### The Texas ERISA Cases

Since the law was enacted, health plan enrollees in Texas have filed more than a dozen cases against their HMOs, most of which involved injuries allegedly resulting when health plans delayed authorizing coverage or denied coverage for services.<sup>10</sup>

The Supreme Court decision involved two such cases. Juan Davila sued Aetna Healthcare for injuries he suffered when the health plan refused to cover his physician's preferred arthritis medication until he had tried two less expensive ones, one of which caused an adverse reaction that resulted in hospitalization. Ruby Calad sued Cigna Healthcare, which authorized only one day of inpatient care for her hysterectomy and denied her physician's request for additional hospitalization. After being discharged, Ms. Calad experienced post-surgical complications that required re-hospitalization.

Although lower federal courts held that ERISA preempted these cases brought under the Texas HMO liability law, the Fifth Circuit Court of Appeals held that ERISA did not preempt the law.<sup>11</sup>

### The Supreme Court Decision

In *Aetna Health, Inc. v. Davila*,<sup>12</sup> the Supreme Court overturned the Appeals Court decision, stating that ERISA preempts cases brought in state courts for damages allegedly resulting from health plans' coverage decisions. When brought by enrollees of insured or self-insured private-sector employer-spon-

sored plans, these cases may be tried only in federal court under ERISA, which does not authorize awards of monetary damages.

The Court's decision reaffirmed its longstanding ruling in *Pilot Life* that ERISA's limited remedies are an inherent part of Congress' "careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of the employee benefit plans."<sup>13</sup> ERISA preempts "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy..."

The Court noted that, because plaintiffs Davila and Calad disputed coverage under their employer-sponsored health plans, requiring interpretation of plan terms, they could have sought injunctions under ERISA to compel the health plans to provide needed care. Alternately, they could have obtained the care and later sued the plans for reimbursement. The Court further held that the Texas law is not saved from ERISA preemption as a law regulating insurance because the savings clause does not apply when there is a direct conflict between state and federal law, as in the case of remedies for ERISA health plan coverage decisions.<sup>14</sup>

The Supreme Court's decision is consistent with the position taken by most federal Courts of Appeal deciding cases in the absence of state health plan liability laws, which have maintained that ERISA preempts health plan coverage decisions, including deciding whether a requested service is "medically necessary" as required by the plan's terms.<sup>15</sup>

### Implications for Other State Managed Care Plan Liability Laws

Eleven other states<sup>16</sup> have enacted some type health plan liability laws similar to those in Texas.<sup>17</sup> Because these laws authorize state court suits for damages for health plan coverage decisions, the Supreme Court's decision will limit their application to enrollees in public-sector employment or individual health plan coverage.

The decision also might be grounds to challenge enrollees' access to state courts to enforce decisions by external review organizations. Although *Davila* would prohibit suits for damages when a health plan refuses to follow an external review decision, based

on the *Moran* decision upholding external review procedures, it could be argued that ERISA does not prohibit state court injunctions to enforce external review decisions.

Some state laws, such as those in Arizona, Georgia, and West Virginia, provide a remedy only for decisions that relate to coverage, while those in other states also address health insurer involvement in care delivery. The *Davila* decision limits ERISA plan enrollees' access to state courts for coverage decisions but does not affect their right to sue health plans for more traditional medical malpractice—for example, by employees or other practitioners over which plans exercise control. Such “vicarious liability” suits, typically available under state common law principles, also might be facilitated by laws like those in Texas (i.e., sections of the law upheld by the Fifth Circuit and not involved in the *Davila* case), Maine, and Washington if physicians are health plan employees or agents.<sup>18</sup>

### Implications for Health Plan Consumer Protection

There is considerable debate about the importance of state court litigation for health plan enrollee injuries. In contrast to ERISA's limited remedies, the threat of liability for economic damages for needed additional medical care, pain, and suffering and punitive damages for “outrageous” health plan actions may deter health plan misconduct. Health plans dispute this notion and assert that these cases drive up insurance premiums by discouraging effective utilization review.

Yet, despite a few well-publicized large jury awards, very few cases have been brought under state managed care liability laws. This is perhaps due to the complexity of pursuing them and the uncertainty over their ERISA implications.<sup>19</sup> Further, health plan coverage denials have become easier to challenge under both state external review laws and 2002 ERISA health plan appeal regulations by the U.S. Department of Labor.

There also may be less discontent with health plan coverage decisions as plans have loosened restrictions on access to providers and services in recent years; they may also cover more marginally necessary care to thwart adverse publicity. But many advocates, analysts, and federal judges are calling for Congress to expand ERISA's limited remedies for injured health plan enrollees.<sup>20</sup>

## State Insurance Regulation under ERISA's Savings Clause

### Application of the Miller “Savings Clause” Analysis

In *Kentucky Association of Health Plans v. Miller*, the Supreme Court revised its former standard for deciding whether a state law regulates insurance under ERISA's savings clause.<sup>21</sup> The new standard examines whether the state law is directed toward insurers' insurance practices and substantially affects insurer-insured risk-sharing arrangements.<sup>22</sup> The former test is relatively straightforward, but how to apply the latter is less clear.

The Court in *Miller* held that the state AWP law affected risk-spreading by expanding access to health care services and raising subscribers' costs. State managed care laws designed to expand consumer access to services are likely to meet the new standards; however, some state regulations of managed care provider contracts may not.<sup>23</sup> It will be important for state policymakers to understand how the courts apply the new *Miller* tests in order to draft insurance laws that withstand ERISA preemption challenges.

Federal courts have decided several dozen post-*Miller* savings clause cases. For example, a federal district court in Arkansas reinstated an AWP law that it had previously held preempted by ERISA.<sup>24</sup> Most of these cases do not, however, involve state managed care or traditional insurance regulation. Many are damages lawsuits against health or disability insurers for allegedly denying claims in “bad faith” under state laws prohibiting unfair claims procedures or deceptive trade practices.

Most of these cases hold that state laws authorizing damages suits against insurers are directed at the insurance industry but fail the second *Miller* test because they do not affect risk-spreading.<sup>25</sup> On the other hand, some courts maintain that such laws do affect risk-spreading, because they raise costs by reducing the incentive to deny claims, for example.<sup>26</sup>

All but a few courts also assert, however, that ERISA preempts these state lawsuits because, under the rationale of *Pilot Life*, the state remedies are inconsistent with ERISA's limited remedies for plan claims denials. This position is consistent with the Supreme Court's 2004 *Davila* decision.<sup>27</sup>

Another line of savings clause cases considers state “anti-subrogation” legislation (sometimes called “coordination of benefits” laws), which prohibits insurers from recouping payments made to insured people by other sources (such as medical payments by auto insurers). Some courts have ruled that these laws affect insurer risk-spreading arrangements by dictating terms under which insurers must cover certain claims and thereby raise insurance costs.<sup>28</sup>

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The several dozen savings clause cases decided in the year after *Miller* do not offer much guidance on how to decide if a state law substantially affects insurer-insured risk-spreading arrangements. This new test seems likely to give states broad latitude to regulate health insurers. Yet, by replacing the former savings clause analysis—where risk-spreading was only one factor to be considered—with a mandatory test, *Miller* may limit application of ERISA savings clause to some types of state laws.<sup>29</sup>

### State Stop-Loss Regulation Authority

The *Miller* analysis also could be used to support more active state regulation of stop-loss insurance. Both self-insured and insured health plans often buy “stop-loss” insurance to protect themselves against very expensive cases, such as claims exceeding \$10,000 to \$25,000 per individual or \$100,000 for the entire group (these thresholds are called “attachment points”). Some ERISA health plans claim to self-insure despite purchasing stop-loss coverage with very low attachment points (sometimes only a few hundred dollars), thereby evading state benefits mandates and insurance taxes.

While ERISA's deemer clause prevents states from regulating the underlying self-insured plan, more than a dozen states regulate stop-loss insurance. For example, many states follow a model law drafted by the National Association of Insurance Commissioners (NAIC) prohibiting carriers from selling policies with attachment points below \$10,000 to \$20,000 per individual case or a higher aggregate limit.<sup>30</sup>

Courts in some older cases have held that ERISA preempts various state stop-loss regulations.<sup>31</sup> But the *Miller* case supports state regulation of stop-loss insurance attachment points. These laws not only are directed at insurers' practices, they affect risk-spreading by imposing greater risk on the self-insured plan and less on the insurer. The new savings clause analysis should encourage more states to regulate stop-loss insurance attachment points.<sup>32</sup> One ERISA researcher argues that *Miller* supports even more intrepid state stop-loss regulation, for example, prohibiting the sale of health care stop-loss coverage unless the underlying plan includes all state-mandated benefits.<sup>33</sup>

### Prohibiting Insurance Contract Discretionary Clauses

Insurers frequently include in their insurance contracts clauses that make claims decisions or contract interpretation a matter of the insurer's discretion.<sup>34</sup> The significance of these clauses is that they affect the standard by which a court would review an insurer's decision, such as a denial of benefits. If the contract gives the insurer such discretion, federal courts (where most of these cases are tried, especially after *Davila*) will overturn the insurer decision only if it is "arbitrary and capricious" (i.e., it has no rational basis at all). Decisions by insurers without discretionary clauses in the insurance policy can be overturned if they are not based on "substantial evidence," a much easier standard for an aggrieved insured person to meet.

NAIC has taken the position that discretionary clauses in insurance contracts are inconsistent with consumer rights. Its policy is similar to long-standing court decisions stating that ambiguities in insurance contracts must be interpreted in favor of the insured person. These clauses also might be inconsistent with many state-mandated

insurance benefits. Further, they would be incompatible with the independent review laws enacted in most states that allow external reviewers to make independent decisions. NAIC has developed a Model Act prohibiting the use of discretionary clauses in health insurance contracts.

Many states report that they prohibit discretionary clauses under laws, regulations, bulletins, or their general authority to review insurance policy terms. Some insurers have challenged state authority to prohibit these clauses as preempted by ERISA. While no court has yet examined this issue, states seem to be on firm ground to defend such a ban. These laws certainly fit the *Miller* tests for insurance regulation because they are directed at insurers and affect insurer-insured risk spreading.

And in *Rush-Prudential v. Moran*, the Supreme Court upheld the Illinois external review law against an assertion that ERISA prohibited the state from creating a standard for reviewing claims decisions.<sup>35</sup> Consequently, states should be able to defend a ban on discretionary clauses against an ERISA preemption challenge.

### Taxing and Regulating MEWAs

Multiple Employer Welfare Arrangements (MEWAs) are employee benefit plans created by more than one employer.<sup>36</sup> Because some MEWAs have been undercapitalized and failed to pay claims,<sup>37</sup> Congress amended ERISA in 1983 to allow states considerable authority to regulate both insured and self-insured MEWAs. States can require fully insured MEWAs to meet state insurance reserve and contribution levels and all other MEWAs to meet any insurance laws that do not conflict with ERISA.

Representatives from self-insured MEWAs in at least one state have asserted that MEWAs are not subject to taxes (for example, to fund a high-risk pool for uninsurable people). They argue that paying state tax would violate the fiduciary duty that ERISA imposes on plan administrators because they would not be spending plan assets exclusively for the benefit of plan participants. This argument seems disingenuous in light of ERISA's explicit authority for states to impose insurance regulations on self-insured MEWAs, which are then likely to impose costs on ERISA plans.

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### ERISA Implications for State "Premium Assistance" Programs

More than a dozen states have chosen to assist Medicaid and State Children's Health Insurance Program (SCHIP) enrollees to purchase employer-sponsored health coverage by paying the employee or family premium share. Federal law permits states to adopt such "premium assistance" programs if the state spends no more for the enrollee using private coverage than it would spend for purely public coverage.<sup>38</sup> These programs can maximize limited state resources by capturing employer premium contributions and reducing potential "crowd-out" of private by public coverage. SCHIP law prohibits its coverage from substituting for private group health coverage.

ERISA complicates states' ability to use premium assistance programs efficiently. First, it limits states' authority to obtain information about the plan to evaluate whether premium assistance would be cost-effective for a particular public program enrollee. Furthermore, employers offering only an annual "open enrollment" period make it difficult for Medicaid or SCHIP eligibles to enroll promptly in the employer plan.



### Obtaining Information about Employer-Sponsored Plans

In order to decide whether subsidizing employer plan premiums is cost-effective, states need information about an employer-sponsored plan's benefits, premium sharing, and eligibility requirements (e.g., minimum work hour requirements, access to family coverage, or probationary periods during which new workers are not eligible for the plan). Because employer-sponsored plan benefits or premium sharing and employee eligibility for the plan may change, states need to update this information periodically. States also might want to require employers to inform their employees about public buy-in opportunities or remit public funds to insurers.

No courts have addressed the issue explicitly, but existing case law strongly suggests that ERISA's preemption clause prohibits a state from requiring that private-sector employer or union plans furnish this information.<sup>39</sup> Consequently, states can only request that employers provide this information voluntarily.<sup>40</sup> While many do so, the uncertainty has led other states to request Medicaid or SCHIP enrollees to obtain this information themselves.<sup>41</sup>

ERISA requires employers to provide to employees a "Summary Plan Description" (SPD) describing their health coverage. The SPD usually provides sufficient information for states to evaluate cost effectiveness. ERISA also requires employers to provide employees a detailed schedule of benefits, which can be requested when the SPD is not sufficiently detailed for state evaluation. Employees obtaining the SPD or schedule of benefits could furnish it to state Medicaid and SCHIP eligibility staff.

There is precedent for Congress to amend ERISA to allow states to obtain this type of information from employer-sponsored health plans. A 1998 ERISA amendment under the Child Support Performance and Incentives Act requires employers to provide health plan information to state child support enforcement agencies (and health insurers) to ensure that dependents obtain court-ordered coverage under parents' health plans.<sup>42</sup> Congress could enact a parallel ERISA amendment requiring employers to provide health coverage information to state Medicaid and SCHIP agencies for the purposes of facilitating premium assistance programs.<sup>43</sup>

### Expanding Enrollment Opportunities

Some employer-sponsored plans limit employees who become eligible for Medicaid or SCHIP premium assistance to an annual "open enrollment" period. These employers do not consider eligibility for Medicaid or SCHIP premium assistance to be a "qualifying event," such as marriage or childbirth, that allows health plan enrollment outside the annual period.

A related problem is that, when Medicaid or SCHIP enrollees lose their eligibility for public coverage between annual open enrollment periods, they cannot disenroll from the employer plan even if they find that employer coverage is no longer affordable without state premium assistance.

In 1996, as part of the Health Insurance Portability and Accountability Act, Congress amended ERISA to allow states to require insurers to include Medicaid and SCHIP eligibility as qualifying events that permit these newly eligible people to enroll.<sup>44</sup> This law applies only to insurers, however, not to self-insured ERISA plans. The federal FY 2005 budget proposes amending ERISA to permit enrollment outside the annual enrollment period. It would not, however, provide an opportunity to disenroll from employer plans when the employee loses Medicaid or SCHIP eligibility.

### Other ERISA Preemption Developments

#### Regulating TPAs

TPAs (third-party administrators), insurers, and other organizations that administer self-insured ERISA plans often assert ERISA as a shield to avoid state licensure, taxes, and requirements to provide information to state agencies. ERISA should not preempt state TPA licensure or registration requirements. Several older court decisions held that ERISA preempts state TPA taxes.<sup>45</sup> However, because these cases pre-date the *Travelers Insurance* decision, it may be possible for states to draft TPA taxes that do not pose an ERISA preemption problem.

A federal district court in Maine recently ruled that ERISA does not preempt the Maine Health Data Organization's requirement that TPAs (along with third-party payers) file health care claims data, such as information on providers, payment, diagnoses, and

member demographics.<sup>46</sup> This should be a useful precedent for other states seeking information from TPAs.

### California's Employer "Pay or Play" Law

An employer "pay or play" law creates a public health coverage purchasing program funded by employer contributions, but allows employers offering coverage a credit against the contribution. A few states, such as Washington, recently have considered enacting such laws. In fall 2003, California enacted SB 2, which requires employers to pay a fee to fund a public health insurance program for workers and dependents in large firms.<sup>47</sup> The fee would be waived for firms whose employee health coverage includes all state-mandated benefits and that pay at least 80 percent of the premium.<sup>48</sup>

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The California law raises ERISA preemption issues because its provisions arguably attempt to regulate employer-sponsored health coverage directly (not just through regulating insurers, which would be permissible under ERISA's savings clause).<sup>49</sup> No courts have decided whether ERISA preempts state pay or play employer coverage laws.<sup>50</sup> It seems likely that states can enact pay or play laws that can be defended against ERISA preemption challenges—for example, ERISA should not preempt a state law that does not impose any conditions (like benefits or premium sharing requirements) in order for the employer to obtain a credit against the contribution.<sup>51</sup> If California's law survives a November 2004 referendum, it is likely to be challenged in court on both ERISA and employer-sponsors state constitutional grounds.<sup>52</sup>


## Conclusion

Because it involves a direct conflict between ERISA and state health plan coverage dispute remedies, the Supreme Court's *Davila* decision does not signal a retreat from the Court's 10-year trend of supporting state health policy and insurance regulation against ERISA preemption challenges. But the decision disappointed many state policymakers and consumer advocates who hoped the Texas HMO liability law and its counterparts in other states would be upheld to protect enrollees of private-sector health plans.

By affirming its 1987 *Pilot Life* decision, the Court refused to acknowledge that managed care plan pre-treatment coverage decisions can lead to injury when care is delayed or

foregone to justify allowing state courts to provide a damages remedy for such injuries. In the wake of *Davila*, states should encourage enrollees to use external review to quickly address coverage disputes and minimize patient injury. They should also use their authority to oversee insurance and monitor health plan behavior.

While some state liability laws may still be useful in suing health plans for direct involvement in medical care, damages lawsuits for inappropriate health plan coverage decisions will require Congress to amend ERISA and may revive interest in long-stalled federal "Patient's Bills of Rights." Congressional action also would be useful to eliminate information and enrollment barriers

to effective state administration of Medicaid and SCHIP premium assistance programs. Courts have not had an opportunity to review state managed care and other insurance laws under the Supreme Court's ERISA insurance savings clause tests set out in its 2003 *Miller* case. States can use these new tests to support more active regulation of stop-loss insurance attachment points. 

## About the Author

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## Endnotes

- 1 Butler, P. *ERISA Preemption Manual for State Health Policy Makers*. National Academy for State Health Policy and AcademyHealth, January 2000; Butler, P. *Issue Brief: ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High Risk*. AcademyHealth, August 2000; Butler, P. *Update to ERISA Preemption Manual for State Health Policy Makers*. National Academy for State Health Policy, January 2001; Butler, P. *ERISA Pay or Play: How States Could Expand Employer-Based Coverage within ERISA Constraints*. National Academy for State Health Policy, May 2002; Butler, P. *Supreme Court Upholds State External Review Law*. National Academy for State Health Policy, 2002; Butler, P. *Kentucky's "Any Willing Provider" Law and ERISA: Implications of the Supreme Court's Decision for State Health Insurance Regulation*. National Academy for State Health Policy, 2003.
- 2 New York Conference of *Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).
- 3 *Kentucky Association of Health Plans v. Miller*, 123 S. Ct. 1471 (2003).
- 4 *Rush-Prudential v. Moran*, 536 U.S. 355 (2002).
- 5 *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
- 6 Discussed in Butler, 2001 ERISA Update, *supra* note 1 and Andrea L. Ben-Yosef. "Analysis & Perspective: Supreme Court to Give Guidance on ERISA Preemption of Negligence Suits." *BNA Pension & Benefits Reporter*, Vol. 30, No. 44, November 11, 2003.
- 7 See, e.g., *DiFelice v. Aetna U.S. Healthcare*, 346 F. 3d 442 (3rd Cir. 2003).
- 8 Texas Civil Practice and Remedies Code Title 4 section 88.001 et seq. Background about the law's enactment is described in Butler, P. *Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation*. Menlo Park: Kaiser Family Foundation, 1997.
- 9 Although most states allow medical malpractice cases to be brought against a medical practitioner's employer under theories of "vicarious liability," the Texas law not only made this standard explicit but also eliminated the previous ban on suing corporations for medical malpractice (the so-called "corporate practice of medicine" prohibition).
- 10 Hall, M.A. and G. Agrawal. 2003. "The Impact of State Managed Care Liability Statutes." *Health Affairs*, Vol. 22, No. 5, pp. 138–143.
- 11 *Roark v. Humana, Inc.*, 307 F. 3d 298 (2002).
- 12 542 U.S. \_\_\_\_ (June 21, 2004).
- 13 Slip opinion at p. 6, citing *Pilot Life*, 481 U.S. at 41.
- 14 The Court also disagreed with plaintiffs and many lower courts that had asserted that these types of state law cases were supported by language in a recent Supreme Court decision, *Pegram v. Herdrich*, 530 U.S. 211 (2002). In *Pegram*, the Court held that a physician-operated HMO was not a "fiduciary" under ERISA that could be sued for, essentially, a conflict of interest in making "mixed eligibility-treatment decisions" about patient's coverage for care. Because the HMO defendants in this case did not employ the plaintiffs' treating physicians, the *Davila* Court held that *Pegram* did not apply, but rather would apply where "the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer." (slip opinion at p. 19.)
- 15 See cases cited in Ben-Yosef "Analysis and Perspective" *supra* note 6. The Supreme Court's decision may encourage health plans to define coverage (for example, medically necessary care) so as to require more cases to involve an interpretation of plan terms rather than arguably affecting physicians' medical decision-making.
- 16 Arizona, California, Georgia, Louisiana, Maine, New Jersey, North Carolina, Oklahoma, Oregon, Washington, and West Virginia.
- 17 See Hall and Agrawal, *supra* note 10, and P. Butler. *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience*. Menlo Park: Kaiser Family Foundation, 2001. [www.kff.org](http://www.kff.org). The Louisiana law authorizes only suits challenging the health plan's appeal procedures involving disputes over medical necessity. The Oregon law authorizes damages suits only if the plan fails to follow the external review organization's decision and its policy terms state that the plan is not bound by external review decisions. New Mexico authorizes damages suits for violations of its "patients' bill of rights," which might be interpreted to include disputes over coverage denials, but the statute does not explicitly authorize such types of claims. A list of citations to these laws is available from the National Conference of State Legislatures at [www.ncsl.org/programs/health/liable.htm](http://www.ncsl.org/programs/health/liable.htm).
- 18 The decisions in *Davila* and *Pegram* appear to allow enrollees in staff or group model HMOs (that employ or exclusively contract with physicians) to sue the HMOs (as well as the physicians) for medical decisions causing injury that result from financial incentives encouraging physicians not to provide the disputed treatment.
- 19 Hall and Agrawal, *supra* note 10; Agrawal, G.B. and M.A. Hall. 2003. "What if you Could Sue your HMO? Managed Care Liability Beyond the ERISA Shield." *St. Louis Univ. Law Journal*, Vol. 47, No. 2, pp. 235–298.
- 20 See, e.g., Justice Ginsburg's concurring opinion in *Davila* and the concurring opinions in *DiFelice v. Aetna U.S. Healthcare*, 346 F. 3d at 453.
- 21 The Court formerly asked whether the law regulated insurance from a "common sense" viewpoint and then whether the law spread risk between insurer and insured, was integral to the insurer-insured policy relationship, and/or was limited to insurance industry entities.
- 22 Some courts consider the new tests a mere restatement of the old ones (e.g., *Elliott v. Fortis Benefits Ins. Co.*, 337 F. 3d 1138 (9th Cir. 2003); *Kidneigh v. UNUM Life Ins. Co.*, 345 F. 3d 1182 (10th Cir. 2003)), but the former criterion that the law affect risk-pooling was only a guideline, whereas the requirement that the state law affect the risk-pooling arrangement is mandatory.

- 23 Butler, "Any Willing Provider" Law, *supra* note 1.
- 24 The district court judge dissolved his injunction against the law in *Prudential Insurance Co. of America v. National Park Medical Center* (E.D. Ark. 2/12/04, *BNA Pension & Benefits Reporter*, Vol. 31, No. 9, p. 534), although Arkansas Blue Cross and Blue Shield has appealed this ruling. Another federal court ruled that ERISA does not preempt California's "process of nature" rule to decide when a medical condition becomes a disability because that state rule affects insurer risk-sharing in a way similar to that of the "notice prejudice" rule upheld by the Supreme Court in *UNUM Life Ins. Co. v. Ward* (526 U.S. 358 (1999)), *Anderson v. Continental Cas. Co.*, 258 F. Supp 2d 1127 (E.D. Cal. 2003).
- 25 *Kidneigh v. UNUM Life Ins. Co.*, 345 F. 3d 1182 (10th Cir. 2003); *Nguyen v. Healthguard of Lancaster, Inc.*, 282 F. Supp. 2d 296 (E.D. Pa. 2003).
- 26 *Elliott v. Fortis Benefits Ins. Co.*, 337 F. 3d 1138 (9th Cir. 2003); *Stone v. Disability Management Services, Inc.*, 288 F. Supp. 2d 684 (M.D. Pa. 2003); *Rosenbaum v. UNUM Life Ins. Co.* (E.D. Pa. 9/8/03, 2003 Lexis 16562).
- 27 *Stone and Rosenbaum*, *supra* note 26, held ERISA's remedies do not preempt the state insurance damages lawsuits.
- 28 *Singh v. Prudential Health Care Plan, Inc.*, 335 F. 3d 278 (4th Cir. 2003); *Levine v. United Healthcare Corp.*, 285 F. Supp. 2d 552 (D.N.J. 2003).
- 29 It is unclear, for example, whether requirements recently enacted in California that HMOs and other health insurers can offer only employer policies where the employer pays at least 80 percent of the premium would pass the second *Miller* test.
- 30 Korobkin, R. "The Battle over Self-Insured Health Plans, or 'One Good Loophole Deserves Another,'" *Yale Journal of Health Policy, Law & Ethics*, 2004 (forthcoming).
- 31 The 4th Circuit Court of Appeals held that ERISA preempted state stop-loss regulation in *American Medical Security v. Bartlett*, 111 F. 3d 358 (4th Cir. 1997), *cert. denied*, 524 U.S. 936 (1998). The Maryland stop-loss rule was revised to address issues raised by the *Bartlett* decision and has not subsequently been challenged. (Korobkin, *supra* note 30, criticizes the *Bartlett* court for misapplying ERISA savings and deemer clause principles.) The 2d Circuit Court of Appeals held that ERISA preempted a state law prohibiting stop-loss insurers from covering plans that did not include all state-mandated benefits, *Travelers Ins. v. Cuomo*, 14 F. 3d 708 (2d Cir. 1993, reversed in part by 514 U.S. 645 (1995)). In *American Trust Administrators v. Sebelius*, 981 P. 2d 248 (Kansas 1997) a court held that ERISA did not preempt stop-loss rules but they exceeded the commissioner's state law authority. A subsequently revised state law was upheld in *American Trust Administrators v. Sebelius*, 44 P. 3d 1253 (Kansas 2002).
- 32 Korobkin, *supra* note 30.
- 33 Korobkin, *supra* note 30, argues that the New York stop-loss law at issue in *Travelers v. Cuomo*, requiring insurers to assure that self-insured health plans include state-mandated benefits, easily meets the new *Miller* tests. This reasoning also might support state requirements that stop-loss carriers insure only health plans offering external review or meeting state managed care plan standards like AWP laws (see footnote 1 in *Miller*, 538 U.S. at 336).
- 34 Discretionary clauses became popular after the Supreme Court decided *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), which held that a court should review a decision by self-funded employee benefit plan without a discretionary clause independently ("*de novo*"), not giving deference to the plan administrator. The Court noted that had the plan included a discretionary clause, the decision could have been overturned only if it was arbitrary and capricious.
- 35 536 U.S. 355 at 385–386.
- 36 MEWAs do not include plans established by collectively bargaining or rural electric or telephone cooperatives. Health plans serving multiple employers sometimes claim to be collectively bargained, and evaluating these claims has been a major issue for the U.S. Dept. of Labor (which administers ERISA). See Kofman, M., K. Lucia and E. Bangit. 2003. *Health Insurance Scams: How Government is Responding and What Further Steps are Needed*. New York: The Commonwealth Fund.
- 37 See, e.g., Kofman, M., E. Bangit and K. Lucia. 2004. *MEWAs: The Threat of Plan Insolvency and Other Challenges*. New York: The Commonwealth Fund.
- 38 The cost-effectiveness standard is imposed by the Medicaid law for state Medicaid programs and SCHIP programs that are part of Medicaid. Unless states have received a waiver of federal requirements, they must supplement employer coverage with public payment for Medicaid benefits not covered by the private plan. The SCHIP statute specifies that "child health assistance" in separate child health program may include "premiums for private health insurance coverage." The SCHIP law imposes the cost-effectiveness standard on waivers for the purchase of family coverage under a group health plan; SCHIP regulations apply the cost-effectiveness standard to premium assistance programs for children only and for families.
- 39 One possible argument could be based on ERISA's so-called "equal dignity" clause, 29 U.S.C. 1144(d). That part of the statute provides that "nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supercede" any federal law. ERISA preemption of state employer information requirements could be argued to impair the premium assistance provisions of the Medicaid and SCHIP statutes, but this argument may be difficult to assert because premium assistance programs are only voluntary under these statutes so that ERISA preemption does not "impair" them. Furthermore, in enacting SCHIP Congress stated that it did not affect or modify ERISA "with respect to group health plans" (42 U.S.C. 1397ii(a)(2)), suggesting it did not intend to require employer plans to submit information to states.
- 40 See Zabawa, B. "Breaking through the ERISA Blockade: The Ability of States to Access Employer Health Plan Information in Medicaid Expansion Initiatives." *Quinnipiac Health Care*, Vol. 5, No. 1, 2001, pp. 1–33.
- 41 Tollen, L. 1999. *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States*. Washington, D.C.: Institute for Health Policy Solutions. Federal Medicaid law prohibits states from requiring children eligible for or receiving Medicaid to obtain this information, but some states do deny eligibility for adults for lack of cooperation.
- 42 29 U.S.C. 514(b)(7) and 1069(a); 29 C.F.R. 2590 (2000).
- 43 Presentation of Tricia Leddy, administrator, Center for Child and Family Health, Rhode Island Department of Human Services, *ERISA 101: Obstacles and Opportunities*, NASHP 16th Annual Health Policy Conference, Portland, Ore., August 4, 2003. Zabawa, *supra* note 40, suggests it could be possible for state Medicaid and SCHIP agencies to obtain health from state child support enforcement agencies, but this may be cumbersome and would not involve all employer plans of interest to state Medicaid and SCHIP agencies.
- 44 29 U.S.C. 1191(b)(2)(F).
- 45 *NGS Am. Inc. v. Barnes*, 998 F. 2d 296 (5th Cir. 1993); *E-systems v. Pogue*, 929 F. 2d 1100 (5th Cir. 1991).
- 46 *Patient Advocates, LLC v. Prysunka*, Civ. No. 03-118-P-H, March 24, 2004. The court's decision was based on the decision that this information was not "plan assets" that the TPA was bound not to disclose. The federal magistrate who initially heard the case also noted in his recommendations to the judge that the state law did not single out ERISA plans for separate treatment (cited in *BNA Pension & Benefits Reporter*, Vol. 31, No. 4, pp. 236–237, January 27, 2004).
- 47 The Health Insurance Act of 2003, SB 2, became effective in the fall of 2003. Employers with 200 or more workers must pay the fee for covering their employees and dependents on January 1, 2006; employers with 50 to 199 workers must pay for covering their workers on January 1, 2007. Employees must contribute up to 80 percent of the premium (but workers with incomes under 200 percent of the federal poverty level cannot be asked to pay more than 5 percent of their wages). The law also requires HMOs and other health insurers to offer group plans only where the employer pays at least 80 percent of the premium.
- 48 If the primary waiver is declared invalid, the law includes an alternative waiver provision for employer-sponsored plans costing at least as much as the state's "Healthy Families" (SCHIP) or 150 percent of Medicaid adult coverage.
- 49 For a detailed ERISA analysis of SB 2, see Butler, P. *ERISA Implications for SB 2: Full Report*. Oakland, CA: California Healthcare Foundation, 2004. [www.chcf.org](http://www.chcf.org).
- 50 A pay or play law enacted by Massachusetts in 1988 was challenged in court, but the law was never implemented and the lawsuit was not pursued.
- 51 For a discussion of ways to design a state pay or play law to minimize ERISA preemption challenges, see Butler, P. *ERISA Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints*, Portland, ME: National Academy for State Health Policy, 2002.
- 52 The California Constitution requires a 2/3 vote of both houses of the legislature to impose a tax; opponents of SB 2 assert that the "fee" is really such a tax. See Butler, P. *California Constitutional Barriers to Implementation of SB 2*. Oakland, CA: California Healthcare Foundation, 2004. [www.chcf.org](http://www.chcf.org).