
THE CRITICAL ROLE OF ERISA IN STATE HEALTH REFORM

by Mary Ann Chirba-Martin and Troyen A. Brennan

Prologue: *During the 1993 sessions of state legislatures, virtually every state considered proposals that, if approved, would have changed the way medical care is financed and delivered in their jurisdictions. Of the states that have acted, both in 1993 and in previous legislative sessions, eight states (Florida, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, Vermont, and Washington) have enacted laws with the ultimate objective of ensuring access to medical care for all of their citizens. With the exception of Hawaii, none of the states that have enacted universal coverage laws have fully implemented them. As authors Mary Ann Chirba-Martin and Troyen Brennan discuss here, states have been prevented from implementing health care financing reform measures because of federal preemption by the Employee Retirement Income Security Act of 1974 (ERISA). While the Clinton administration's Health Security Act, by its very nature, underscores the need to reform ERISA to grant states greater flexibility, it fails to address each of the preemption problems raised by the federal law. Chirba-Martin, a lawyer, lectures at Boston College's Law School. She is also seeking a master's degree in public health at the Harvard School of Public Health. Her particular research interests revolve around health law and product liability. Brennan is a professor of law and public health and an associate professor of medicine, both at Harvard. He holds degrees in law, medicine, and public health from Yale University and a master's degree in political economy from Oxford University. His research interests focus on the legal aspects of health care reform, quality improvement, and medical ethics.*

Abstract: Despite prominent roles for employers and state regulation in the Clinton administration's Health Security Act, relatively little attention has been accorded to the impact of federal preemption of state legislation through the Employee Retirement Income Security Act (ERISA). As interpreted by the U.S. Supreme Court, ERISA permits state regulation of insured employee health plans but otherwise preempts analogous regulation relating to self-insured benefit plans. This has prompted lower courts to find that hospital rate-setting legislation, regulation of preferred provider organizations (PPOs), and medical malpractice suits for utilization review decisions are preempted by ERISA. Several issues with major implications for health reform remain unresolved, such as the availability of ERISA preemption to self-insured health alliances and health maintenance organizations (HMOs).

While eagerly awaiting federal health care reform, states have experimented with various reform measures to address the inter-related problems of health care cost and access. Yet states are increasingly thwarted in implementing more generalized health care financing measures because of federal preemption by the Employee Retirement Income Security Act of 1974 (ERISA).¹ The Health Security Act promises to preserve and, indeed, encourage state flexibility. It also envisions state oversight of health alliances to implement managed competition. This simply cannot be accomplished, however, unless the aspects of ERISA that relate to health care are thoroughly rewritten.

ERISA's prominence in health care has grown over the past few years, as the U.S. Supreme Court has broadly construed ERISA's preemption provisions. In effect, federal district and circuit courts, following the Supreme Court's decisions, have prohibited almost any state legislation designed to ameliorate the current health care crisis. Remarkably, in the ongoing debate regarding health care reform, little attention has been paid to this very real and virtually insurmountable, federally imposed barrier to change. The only exceptions to this silence have been several recent papers discussing ERISA curbs on state-mandated benefits.² Yet these papers completely overlook perhaps the most important aspect of ERISA preemption: the manner in which it blocks any sort of structural reform of health insurance by states.

The Health Security Act demonstrates a recognition of the critical nature of ERISA reform, but, as currently stated, it does not comprehensively address each of the preemption problems raised by ERISA. In this paper we review ERISA preemption as it pertains to state health care financing and delivery reform efforts, summarize the manner in which it appears that the Health Security Act will change matters, and suggest some further reforms that may be necessary. We agree with the Clinton administration that state experimentation is integral to any solution to the multifaceted and deeply complicated health care crisis. Achieving this laudable goal is not possible, however, unless the ramifications of ERISA preemption are carefully addressed.

ERISA Preemption Of State Law

ERISA was enacted by Congress in an effort to protect participants in employee pension and benefit plans and their beneficiaries from abuses by those who invest and manage such plans. As defined by the statute, these include benefit plans that “through the purchase of insurance or otherwise” provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death.

As set forth in Section 1001(a) of the statute, Congress perceived ERISA as a form of redress for specific kinds of problems, which it thought could best be remedied through uniform federal standards. Congress was particularly cognizant of the need for “equitable standards of plan administration; . . . minimum standards of plan design . . . [and] fiscal responsibility” as well as the need to insure the vested portion of unfunded liabilities against premature plan termination and expand and increase participation in private retirement plans.³

Legislative history evidences congressional concern over the absence of any substantive fiduciary standards in previous federal regulatory laws. The availability of “traditional equitable remedies of the common law of trusts” was deemed inadequate since, for the same set of facts, interstate plans could face differing standards from state to state.⁴ In contrast, Congress hoped that ERISA’s uniform standards would enable “administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.”⁵

Although promulgated for the purpose of protecting employees, ERISA is favored by employers—especially interstate employers—because of its preemption of state law.⁶ Despite its broad preemption of state law, ERISA imposes virtually no substantive requirements regarding employee benefit plans. Moreover, the Department of Labor, charged with administering ERISA, has not promulgated any meaningful regulations pertaining to the substance of employee benefit plans and has focused instead on pension plans—which inspired Congress to enact ERISA in the first place.

The “relate to” requirement. A three-part analysis is used to determine whether ERISA preempts state law. First, preemption is presumed if the state law “relate[s] to” any employee benefit plan. ERISA’s preemption provision was originally drafted to “relate to” the subject matters regulated by ERISA. Thus, only state laws pertaining primarily to funding and disclosure requirements would face preemption. The broader language of relating to “any employee benefit plan” was characterized by ERISA’s principal sponsors as intended to avert “the threat of conflicting or inconsistent State and local regulation of employee benefit plans.”⁷

The “relate to” requirement has been construed not to preempt laws

having only a remote impact on ERISA plans.⁸ Yet most courts have emphasized the expansion of the “relate to” clause during the statute’s drafting process as indicative of congressional intent that ERISA preempt any state law having any impact on an ERISA-qualified plan, no matter how attenuated the impact.⁹ Under this extremely inclusive interpretation, even state laws that are consistent with ERISA have been preempted.¹⁰

Opponents of such broad preemption have argued that when Congress adopted the revised “relate to” language, it did not intend to preempt virtually any state law having any tangential impact on an ERISA-qualified plan.¹¹ Thus, it is not at all clear from ERISA’s legislative history that Congress intended, directly or indirectly, to preempt state statutes that do not target ERISA plans. Yet this is precisely what has occurred through judicial interpretation of ERISA.

The “savings” clause. Second, a state law relating to an employee benefit plan may be saved from preemption under ERISA if it regulates insurance, banking, or securities. Obviously, with regard to health care legislation, regulation of insurance is most pertinent to determining whether a state law is “saved” and, therefore, not preempted. Invoking the McCarran-Ferguson Act’s antitrust criteria, the courts will characterize a practice as “the business of insurance” if it involves the transfer or spread of risk, is integral to the insurer/insured relationship, and is limited to entities within the insurance industry. What qualifies as “the business of insurance” rendered susceptible to state regulation by virtue of the savings clause has been the focus of ongoing and ever-intensifying judicial inquiry.¹²

The “deemer” clause. The third step of the ERISA preemption analysis concerns the “deemer” clause. State insurance regulation may be saved only to the extent that it regulates genuine insurance companies or insurance contracts. As a result, a state may not “deem” an employee benefit plan to be an insurance plan in an effort to avoid preemption if the benefit plan would not otherwise qualify as an insurance company or contract. The “deemer” clause therefore limits the application of the “savings” clause to conventionally insured employee benefit plans.

A self-insured plan does not carry on the “business of insurance” since the policyholder does not transfer risk or spread risk across a pool larger than the policyholder itself. Self-insured plans frequently contract with insurance companies to render administrative services to such plans. In this context, the insurance company acts only as a noninsurer/third-party administrator providing managerial functions. Consequently, a state law cannot simply deem a self-funded plan to be insurance for the purpose of being saved from ERISA preemption.¹³

Thus, through the intricate three-step dance of the “relate to,” “savings,” and “deemer” clauses, ERISA permits states to regulate insurance plans but

preempts any such regulation of self-insured or noninsured plans. Perhaps the Supreme Court's most compelling ground for adhering to this interpretation of the interaction of these provisions is that, at least since the 1985 case of *Metropolitan Life Insurance Company v. Massachusetts*, Congress has been aware of the distinction or "disuniformity" between insured and self-insured plans and, whether through design or neglect, has not amended the statute to alter its preemptive effect. However, this may simply be a function of congressional gridlock or a measure of the success of various employer-sponsored interest groups in resisting state regulation, rather than a reflection of legislative intent or approval.¹⁴

Still, judging from its recent decision in *District of Columbia v. Greater Washington Board of Trade*, the Supreme Court remains undaunted in its expansive reading of ERISA's preemption provisions.¹⁵ There, workers' compensation legislation required employers who provided health insurance for their employees to provide equivalent coverage for injured employees. The statute did not regulate the ERISA plan itself or impose any standards regarding how those plans should be administered or what such plans should provide. Instead, the state law simply stated that employers providing benefits through ERISA plans must make equivalent benefits available to workers' compensation claimants. Nevertheless, ERISA preempted this as "related to" an ERISA employee benefit plan that was not otherwise "saved" from preemption.

Consequently, the statute was overturned because it expressly tied the mandated workers' compensation benefits to employer-provided health insurance coverage—even if it did so simply to give the employer a straightforward index for calculating benefits or to ensure parity of treatment for both work- and nonwork-related health problems. Thus, any attempt by states to rationalize various employment-related benefits seems destined to fail by virtue of ERISA preemption, regardless of how beneficial to the employee such efforts might be.

The net effect of this tripartite analysis is to preempt states from regulating self-insured plans. This creates an almost irresistible incentive to employers to self-fund in order to escape state regulation, while all but denying states the ability to develop effective reforms to improve health care access or to modify conventional insurance risk pooling.

Initially, only organizations with relatively large and healthy employee populations opted for self-funding since their large size facilitated risk spreading. However, as ERISA preemption has been used to provide an ever-expanding shield from state regulation, self-funding is growing in popularity among employers irrespective of size.¹⁶ Our conversations with private-sector human relations administrators indicate that employer preference for self-funding continues to increase dramatically; it now accounts

for about 65 percent of all ERISA-qualified employee health benefit plans.¹⁷

Steady Erosion Of State Health Care Financing Reform Efforts

In the absence of any meaningful federal efforts over the past decade, states have formed the vanguard in trying to reform health care financing. To date, states have relied upon rate-setting measures and employer mandates to enhance coverage while overcoming some of the financing obstacles created by conventional insurance risk pooling. By the 1970s states such as New York, New Jersey, Maryland, and Massachusetts began to regulate the rates that hospitals could charge various insurers.¹⁸ Hospital cost controls were meant not only to moderate the rise of health care costs, but also to ensure that there was some system of subsidizing the cost of care for poor patients.¹⁹

As the access and cost problems worsened in the 1980s, several states began to consider employer mandates as a means of requiring employee benefit plans to provide certain kinds and/or levels of benefits to employees—something that ERISA does not do.²⁰ In *Metropolitan Life Insurance Company v. Massachusetts*, a state statute required “insured” benefit plans to cover mental health services. It was designed in part to reduce the problem of adverse selection in mental health insurance. Since healthy persons are less likely to purchase insurance coverage, the remaining pool consists of high-risk individuals more likely to use services and file claims. Adverse selection results in the inability to distribute risk over a heterogeneous pool and therefore drives up the cost of coverage for the sick.

Noting that a majority of states use mandated benefit statutes to regulate the substantive content of insurance contracts, the *Metropolitan Life* court ruled that such laws are “saved” from preemption to the extent that they qualify as permissible state regulation of the “business of insurance” under the McCarran-Ferguson Act criteria. The court’s ruling came only after an exhaustive analysis of the relationship between the “savings” and “deemer” clauses and their relationship to the insured/self-insured distinction. It is worth noting the inhibitory impact of ERISA preemption as exemplified by *Metropolitan Life*. What really “saved” the Massachusetts legislation was the state’s decision not even to attempt to enforce the part of the statute that imposed the same mandate upon self-insured plans.

Metropolitan Life essentially frees the self-insured plan from state oversight. Because ERISA does not mandate that benefit plans be provided or maintained at any particular level, an employer can revise such a plan without the consent of the employee. ERISA only requires that a plan amendment not discriminate against participants or interfere with or retali-

ate for a participant's exercise of rights under the plan. Absent a contract of assurance that benefits will continue, an employer is free to increase or reduce benefits without notice to or consent of the employee.²¹

Thus, in *Vasseur v. Halliburton Company*, an employer could modify a benefit plan to limit inpatient coverage to licensed hospitals rather than rehabilitation facilities.²² Similarly, in *McGann v. H&H Music Company*, an employer was permitted to reduce lifetime medical benefits of \$1 million per participant to \$5,000 for acquired immunodeficiency syndrome (AIDS)-related claims after learning that one of its employees had AIDS.²³ Because the reduced coverage would pertain to any employee who developed AIDS rather than to just the identified individual, the modification was not unlawfully discriminatory under ERISA. *McGann*, recently affirmed by the Supreme Court without comment, could be logically extended to permit "after-the-fact" termination or reduction of benefits for other "high-ticket" health problems such as cancer, while leaving states powerless to halt such activities.²⁴

With the growing awareness of the extent of ERISA preemption, employee benefit plans now are asserting their right to be completely free of states' health care financing regulation. State attempts to redress adverse selection by employing traditional hospital rate-setting schemes to cross-subsidize uncompensated care and high-risk pools are being challenged and overturned on ERISA preemption grounds. In *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Insurance Association*, ERISA preempted a Louisiana statute that created a state health insurance association to fund and administer a catastrophic health insurance program.²⁵ Funding would have occurred through service charges of \$1.50-\$2 per patient per day to be assessed against hospital and outpatient surgery visits. The statute required payment from the patient's "insurance arrangement," "insurer," or "self-insurer" as a "mandated benefit." The federal district court found that the law could not be applied to ERISA plans, whether or not such plans were self-insured, because it effectively required plans to pay for persons who were neither participants in nor beneficiaries of such plans.

New York's hospital rate-setting scheme was struck down for similar reasons in *Travelers Insurance Company v. Cuomo*.²⁶ That statute imposed a series of surcharges over the basic diagnosis-related group (DRG) rate based on the patient's kind of coverage. The surcharges were intended to reduce hospital rate disparities among commercial insurers and Blue Cross/Blue Shield plans and preserve the Blues plans' economic viability.

The Blues were required by state law to cover anyone who applied and to employ community rather than experience rating. Consequently, they were less able than commercial insurers to exclude unhealthy persons from the risk pool or to increase rates to reflect increased claims. In contrast, com-

mercial insurers, operating largely through ERISA plans, tend to insure healthier pools and can use experience rating to reflect the cost of unexpectedly high claims. There was no dispute in the case that the Blues carried a disproportionate share of high-risk persons or that the surcharges were intended to help spread this risk more symmetrically.

Invoking ERISA preemption, the court in *Travelers* reasoned that the surcharges imposed a substantial economic burden on commercial insurers and HMOs providing coverage or services to employee benefit plans, since the surcharge would be passed through to participants and curtail the use of plan resources. ERISA preemption thus was warranted to prevent multi-state plans from facing inconsistent obligations in differing states.²⁷

The application of New York's payer differentials and surcharges for uncompensated care have come under renewed attack.²⁸ Recently, Sen. Daniel Patrick Moynihan (D-NY) managed to rescue New York's rate-setting scheme through a special amendment to the federal tax code. Basically, self-insured employers now must pay the surcharge or lose their tax deduction for health insurance costs.²⁹ This stop-gap measure only underscores the need for relief from ERISA and the extreme difficulty of obtaining it.

New Jersey provides another example of ERISA's curtailment of state rate-setting efforts. The state's then-current rate-setting legislation was deemed to be unenforceable by the trial court in *United Wire, Metal, and Machine Health and Welfare Fund v. Morristown Memorial Hospital*, which employed a rationale quite similar to that of the *Travelers* court.³⁰ The New Jersey law granted discounts to certain payers while including charges in the DRG rate to subsidize uncompensated care and inadequate Medicare reimbursement. Although this rate-setting legislation was the oldest of its kind and did not explicitly regulate the terms or conditions of ERISA benefit plans, the trial court still found it to be preempted for "relating to" such plans. Since the law did not purport to regulate insurance, the trial court further decided that it could not be saved from preemption. The New Jersey legislature subsequently passed new legislation that abandoned rate setting.

In a remarkable departure from the clear trend of recent ERISA preemption cases, however, the Third Circuit Court of Appeals reversed the *United Wire* trial court's decision and found that the rate-setting legislation did not "relate to" ERISA plans.³¹ While purporting to rely on recent Supreme Court rulings, the appeals court effectively articulated a new definition of what satisfies the "relate to" criterion of ERISA preemption. It found that a state statute relates to an ERISA benefit plan if it is (1) specifically designed to affect such plans; (2) singles out such plans for special treatment; or (3) creates rights or restrictions predicated on the existence of such plans.

While the *United Wire* appellate decision is a bit too facile in dealing with “binding” precedent, the court should be commended for attempting to protect a state’s ability to regulate and improve health care financing mechanisms. It also created a direct conflict between the Second and Third Circuits concerning the appropriate interpretation of the “relate to” clause. Nevertheless, the Supreme Court has denied further review of *United Wire* and thus continues its refusal to address ERISA’s growing role in the nation’s health care crisis.³²

Currently pending in Minnesota is an ERISA challenge to that state’s efforts to finance health care for the uninsured through a 2 percent tax on the gross revenues of hospitals and other health care providers.³³ The general trend of recent case law (*United Wire* notwithstanding) indicates that the state would do well to consider alternative financing mechanisms.

State Health Care Delivery Regulation

As damaging as the Supreme Court’s preemption analysis has been to state health care financing efforts, there is potential for even greater harm, depending on the court’s disposition of several unresolved questions concerning health care delivery. It is not now clear whether state regulation of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) will be undermined by ERISA preemption; whether permissible state insurance regulation will include the ability to regulate relations between insurers and providers; or whether state common law causes of action challenging utilization review determinations will be preempted.

Early indications from lower courts indicate that ERISA’s influence will grow. ERISA preemption was recently invoked but ultimately failed to block Virginia’s efforts to regulate PPOs. *Stuart Circle Hospital Corporation v. Aetna Health Management* involved Aetna’s challenge of a Virginia statute regarding various requirements in negotiating with providers to participate in PPO contracts.³⁴ The trial court found that the statute “related to” ERISA employee benefit plans because it regulated insurer-established PPOs, which served as a vehicle for delivering health care services to employees covered by such plans. Yet the statute could not be “saved” from preemption because it did not regulate “the business of insurance”—the insurer’s relationship with the insured—but focused instead on the relationship between the insurer and providers.

The *Stuart Circle* decision was later reversed on appeal.³⁵ The Fourth Circuit Court characterized the statute as the kind of insurance regulation properly saved from preemption because it was part of Virginia’s overall insurance code and also regulated “the business of insurance.” In this regard, the court reasoned that while the statute did focus on the

insurer/provider relationship, it indirectly regulated the insurer/insured relationship. Moreover, because the law sought to protect an insured's choice of providers, it affected how the insured's cost or "risk" would be spread over the risk pool and, as such, deserved to be saved from preemption.

Currently, Virginia is one of twenty-eight states regulating PPOs. While Virginia's PPO legislation has managed to survive preemption thus far, the Supreme Court's continued allegiance to giving ERISA such an exceedingly broad preemptive effect could portend the eventual overturn of such statutes. Since the Supreme Court has not resolved the insurer status of HMOs, PPOs, and other managed care entities, lower courts will continue to reach conflicting results in determining whether such entities are insurers subject to the ERISA preemption savings clause.³⁶

The impact of ERISA preemption on utilization review decisions also is unclear. Utilization review is a common feature of employee health plans intended to contain costs by requiring review and authorization of medical services. ERISA preempted an employee's ability to challenge a utilization review decision in *Corcoran v. United Health Care, Inc.*³⁷ There, the plaintiff was covered by a self-funded employee benefit plan that required participants to obtain precertification from United Health Care, an independent utilization review organization hired by the plan. United Health Care denied plaintiff precertification of hospitalization for a high-risk pregnancy despite the plaintiff's history of similar problems, her obstetrician's vigorous recommendation of hospitalization, and its own independently retained expert's opinion that hospitalization was necessary to permit constant fetal monitoring. Instead, United authorized in-home nursing care for ten hours per day. At a time when no nurse was on duty, the fetus became distressed and died. The plaintiff attempted to assert state common law claims against United, arguing that its medical decision in denying hospitalization was negligent. There was no attempt to sue the self-funded plan itself.

Nevertheless, the tort action was deemed preempted by ERISA because the state law that might have permitted such a claim "related to" ERISA benefit plans. Acknowledging that utilization review determinations were in fact "medical decisions," the court found that such decisions were not actionable because they were made in the context of determining the availability of benefits under self-funded plans. In the court's view, permitting such decisions to be challenged through state tort remedies would undermine the uniform regulation of benefit plans that Congress intended to secure through ERISA preemption. The court observed that the lack of an ERISA remedy could not alter the seeming inevitability of ERISA preemption. It noted, too, that while an area traditionally accorded to state regulation will typically escape federal preemption, this is not the case with

ERISA. Rather, “the fact that states traditionally have regulated in a particular area has functioned as no impediment to ERISA preemption.”³⁸

The *Corcoran* court was obviously disturbed by its decision, which left the plaintiff with “no remedy, state or federal, for what may have been a serious mistake.”³⁹ As interpreted by that court, ERISA preemption immunizes utilization review determinations from generally applicable liability rules, thereby fostering substandard decision making and decreasing a benefit plan’s incentives to “seek out the [utilization review] companies that can deliver both high quality services and reasonable prices.”⁴⁰ Feeling constrained by the congressional goal of uniform regulation to rule as it did, the court did not overlook the irony of applying a statute designed to safeguard workers in a manner so obviously detrimental to the plaintiff employee. The Supreme Court refused to review *Corcoran*, but it is likely to face repeated challenges to ERISA preemption of utilization review decisions.⁴¹

The Health Security Act And Congressional Legislation

ERISA preemption has been used to eviscerate state attempts to regulate both health care financing and health care delivery. Preemption has undercut efforts to implement employer mandates and to cross-subsidize uncompensated care and high-risk pools. It is now being invoked to deny the states any meaningful role in regulating HMOs, PPOs, and insurer/provider relations. All of this is occurring despite the absence of any countervailing federal substantive regulation of such entities and their activities.

While the Supreme Court’s liberal use of ERISA preemption is clearly wreaking havoc on the ability of states to respond to the constantly intensifying need for health care reform, only Justice John Paul Stevens, the lone dissenter in recent ERISA preemption cases, has called for a reexamination of preemption analysis, arguing that Congress never intended such far-reaching eradication of state law.⁴² Not surprisingly, he finds strong support among state legislators.⁴³ A few reform measures even have been attempted within Congress itself, but these attempts have been highly controversial and unsustainable.

Today, however, all bets are off. A House subcommittee recently reported out a bill that would grant ERISA waivers to four states.⁴⁴ None of these waivers were eventually granted in large part because of the vigorous opposition of the recently formed Coalition for the Preservation of ERISA Preemption, consisting of over 100 self-insured employers and trade groups.⁴⁵ New York managed to obtain some relief from ERISA preemption of its rate-setting scheme—not by a waiver but by Senator Moynihan’s “display of sheer political power” in obtaining a limited amendment to the federal tax code.⁴⁶ Those states involved in thoroughgoing reform all recog-

nized the need for ERISA revisions.

So, too, the Clinton administration in its Health Security Act demonstrates a reasonable grasp of the critical role of ERISA reform in health care financing regulation. Unfortunately, it does not provide all of the relief needed by states to implement health care delivery reform and to manage competition effectively. Under the proposal, employers with more than 5,000 employees could elect to form corporate alliances. A corporate alliance could self-fund and thus assume insurance risk, while a regional alliance is expressly forbidden from bearing such risk. The corporate alliance also can take advantage of experience rating.

It is important to note that the Health Security Act has been characterized by Hillary Rodham Clinton as a place to begin federal health care reform. Consequently, the 5,000-person limit on corporate alliances may very well decrease in the legislative process. This will be critical, as the corporate alliance will be able to take advantage of many of the preemption protections now offered under ERISA. Any lowering of the threshold for forming a corporate alliance will lead to greater prevalence of ERISA-type preemption of state regulation.

With regard to financing issues, the Health Security Act provides states with some ERISA overrides. For example, a state may adopt a single-payer approach for all employers and individuals, including those who otherwise would qualify for corporate alliances. The act also states that even though they are protected by ERISA, health plans in corporate alliances may not terminate, restrict, or limit applicability of the nationally guaranteed comprehensive benefit package. By requiring corporate alliances to provide such coverage, the act should preclude *McGann*-type restrictions on benefits as long as the benefit package is reasonably broad.

In contrast, the act does little to curtail ERISA preemption regarding the delivery of medical care under corporate alliances. Thus, even though the act requires states to manage competition, ERISA would preempt states from regulating managed care operations under contract with corporate alliances. The act therefore creates and then ignores the dilemma of how states are to manage competition when a significant portion of the market is beyond their control. ERISA also would continue to prevent those injured by utilization review decisions under corporate alliance plans from bringing malpractice litigation. These omissions from the Health Security Act's revisions of ERISA impair the ability of states to manage competition effectively and, thus, undercut the act itself. Clearly, then, the authors of the Health Security Act had a reasonable understanding of *McGann v. H&H Music*, but their grasp of the other important cases in the field, including *Corcoran*, *Stuart Circle*, and *Travelers*, was less firm. As national health reform evolves, those who favor state regulation and reform of

health care delivery will be well advised to inform their congressional representatives of the importance of more comprehensive ERISA revisions.

Like most of the more controversial elements of the Clinton plan, the details of amending ERISA are quite sketchy, and competing proposals pay even less attention to this complicated and politically contentious issue. The Clinton administration undoubtedly recognizes that the availability of self-funding and ERISA preemption will be important bargaining chips. But it also knows that permitting too many employers to opt out of regional health alliances and/or unduly limiting state flexibility to regulate health care delivery will jeopardize the entire reform effort. Whether these interests can be accommodated remains to be seen. However, one thing is clear: The problems of ERISA preemption are likely to endure for some time.

It is highly questionable that Congress really intended to make health policy when it chose to enact ERISA's disclosure, reporting, and minimum reserve requirements almost twenty years ago. Rather than protecting employees from fraud and abuse in the investment and management of benefit plans, ERISA has assumed the dubious function of creating a roster of "haves" and "have-nots" in the health benefits game while preempting states from leveling the playing field. Still, the U.S. Supreme Court has not wavered in its insistence that only Congress can alter the preemptive effect of ERISA on health care reform. Thus, as Congress finally confronts reform, it must address the appropriate role of ERISA preemption in the regulation of both health care financing and delivery.

NOTES

1. P.L. 93-406, 88 Stat. 832, as amended 29 U.S.C., Sections 1001-1461, paragraph 1144. Space limitations preclude complete legal citations here. These are available from the authors at Harvard School of Public Health, Department of Health Policy and Management, 677 Huntington Avenue, Boston, MA 02115.
2. See, for example, W.K. Mariner, "Problems with Employer-Provided Health Insurance—The Employee Retirement Income Security Act and Health Care Reform," *The New England Journal of Medicine* 327 (1992): 1682-1685; and L.O. Gostin and A.I. Widliss, "What's Wrong with the ERISA Vacuum?" *Journal of the American Medical Association* 269 (1993): 2527-2532.
3. H. Rep. 93-533 (Education and Labor Committee), 93d Cong., 2d Sess., reprinted in 1974 *U.S. Code Congressional and Administrative News*, 4639-4670.
4. *Ibid.* See also S. Rep. 127, 1974.
5. *Ibid.*
6. Congress's preoccupation with ensuring uniformity of regulation from state to state was obviously intended to protect interstate employee benefit plans. Yet, ERISA preemption does not distinguish between inter- and intrastate plans and protects both from state regulation.
7. Remarks of Sen. Harrison A. Williams (R-NJ), 22 August 1974, *Congressional Record* 120, S15737, reprinted in 1974 U.S.C.C.A.N. 5177-5190; accord remarks of Rep. John H. Dent (D-PA), 20 August 1974, *Congressional Record* 120, 29197, reprinted in Senate

- Subcommittee on Labor and Public Welfare, *Legislative History of the Employee Retirement Income Security Act of 1974* (1976), 4670–4671.
8. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 at 100, no. 21.
 9. See, for example, *Dist. of Columbia v. Greater Wash. Brd. of Trade*, 113 S.Ct. 580, 583 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). In recent months a few cases have dared to interpret the “relate to” clause more narrowly. See discussion at Note 31.
 10. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). *Accord*, *Mackey v. Lanier Collection Agency and Serv., Inc.*, 486 U.S. 825 (1988).
 11. Remarks of Sen. Jacob Javits (D-NY), 22 August 1974, *Congressional Record* 120, 29942, *Legislative History*, 4770–4771.
 12. See *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); and *Metropolitan Life*, 471 U.S., 743.
 13. See *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).
 14. Our discussions over the past six months with various representatives of both business and organized labor indicate that support for ERISA within these constituencies is deep and broad. See also D.M. Fox and D.C. Schaffer, “Health Policy and ERISA: Interest Groups and Semipreemption,” *Journal of Health Politics, Policy and Law* 14 (1989): 239.
 15. *Dist. of Columbia v. Greater Wash. Brd. of Trade*.
 16. E. Felsenthal, “Self-Insurance of Health Plans Benefits Firms,” *The Wall Street Journal*, 11 November 1992, 1.
 17. See, for example, R.A. Padgug and G.M. Oppenheimer, “AIDS, Health Insurance, and the Crisis of Community,” *Notre Dame Journal of Law and Ethics* 5 (1990): 35–57.
 18. A.R. Somers, “Sounding Board: Moderating the Rise in Health Care Costs—A Pragmatic Beginning,” *The New England Journal of Medicine* 306 (1982): 944–946.
 19. C. Eby and D. Cohodes, “What Do We Know about Rate Setting?” *Journal of Health Politics, Policy and Law* 10 (1985): 299–327.
 20. R. Blendon, “Making the Critical Choices,” *Journal of the American Medical Association* 267 (1992): 2509–2520.
 21. See *Shaw*, 463 U.S. 85; *McGann v. H&H Music Co.*, 946 F.2d 401, 405–408 (5th Cir. 1991); and L.P. Francis, “Consumer Expectation and Access to Health Care,” *University of Pennsylvania Law Review* 140 (1992): 1881.
 22. *Vasseur v. Halliburton Co.*, 950 F.2d 1002 (5th Cir. 1992).
 23. *McGann v. H&H Music Co.*, cert. denied sub nom *Greenberg v. H&H Music Co.*, 113 S.Ct. 482 (1992). See also *Westhoven v. Lincoln Food Service Products, Inc.*, Ind. Ct. App. no. 35 A02-9206-CV-260, 6 July 1993, *BNA’s Health Law Reporter* 2 (1993): 1031 (employer’s reduction of health benefits for employees with AIDS was not actionable under state antidiscrimination law due to ERISA preemption).
 24. As elsewhere in health policy, ERISA has been evaluated through the lens of AIDS, but its impact is really much broader. See Mariner, “Problems with Employer-Provided Health Insurance;” and Gostin and Widliss, “What’s Wrong with the ERISA Vacuum?” The *McGann* case has been relatively widely discussed in the health policy literature. Remarkably, however, neither of these recent articles even mentions the case law discussed here. This is yet another indication of how underappreciated the impact of ERISA is.
 25. *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Insurance Association*, 771 F.Supp. 771 (E.D.La. 1991).
 26. *Travelers Ins. Co. v. Cuomo*, 14 F.3d. 708 (2d Cir. 1994).
 27. In finding the surcharge statute to “relate to” an employee benefit plan, the district court rejected the Second Circuit’s earlier decision of *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), which had employed a narrower reading of the “relate to” clause. That case had found that a New York statute did not relate to and thus was not preempted

- by ERISA because it did not “purport to regulate . . . the terms and conditions of employee benefit plans” (Ibid., 137). The broader interpretation of the “relate to” clause was supported by the Court of Appeals for the Second Circuit in *Cuomo* as well as *Smith v. Dunham-Bush, Inc.*, 959 F.2d 6 (2d Cir. 1992) at 9, n. 3, citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 484 (1990).
28. Trustees of Hosp. Ben. Plan of Electric Industry v. Cuomo, E.D.N.Y., CV92-5589 (25 November 1992).
 29. M.M. Kahn, “Budget Translated: Tough Sledding for Self-Insured, Medicare Funds Skimpier,” *Health Care Competition Week* 10 (1993): 46.
 30. United Wire, Metal, and Machine Health and Welfare Fund v. Morristown Memorial Hospital, 793 F.Supp. 524 (D.N.J. 1992), *reversed and remanded*, 995 F.2d 1179 (3d Cir. 1993), *cert. denied* 114 S.Ct. 382 (1993).
 31. *Ibid.*, 995 F.2d. 1179 (3d. Cir. 1993). While the appeals court reversed the lower court’s ERISA ruling, it affirmed other portions of the trial court’s decision that were unrelated to ERISA.
 32. A petition for a grant of certiorari was filed with the U.S. Supreme Court 22 July 1993.
 33. *Boyle v. McClung*, no. 3-92-CV602 (D.Minn. filed 2 September 1992).
 34. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 800 F.Supp. 328 (E.D.Va. 1992), *vacated, remanded*, 995 F.2d 500 (4th Cir. 1993), *cert. denied* 114 S.Ct. 579 (1993).
 35. *Ibid.*, 995 F.2d 501 (4th Cir. 1993). *Accord*, *Blue Cross and Blue Shield v. St. Mary’s Hosp. of Richmond, Inc.*, 426 S.E. 2d 117 (Va. 1993). Supreme Court of Virginia also finds PPO statute to be saved from preemption.
 36. See, for example, *Travelers*, 813 F.Supp. at 1007, n. 14 citing *O’Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990); *Physicians Health Plan, Inc. v. Citizens Ins. Co.*, 673 F.Supp. 903, 907–908 (W.D. Mich. 1987); and *Elesser v. Hosp. of Phila. College*, 802 F.Supp. 1286 (E.D. Pa. 1992).
 37. *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir. 1992), *cert. denied*, 113 S. Ct. 812 (1992).
 38. *Ibid.*, 1334.
 39. *Ibid.*, 1338.
 40. *Ibid.*
 41. *Ibid.*
 42. See, for example, *Dist. of Columbia v. Greater Wash. Brd. of Trade* (Justice J.P. Stevens dissenting); and *FMC Corp. v. Holliday*.
 43. *BNA’s Health Law Reporter* (17 September 1992): 15.
 44. *BNA Health Care Policy*, “House Panel Includes ERISA Waivers in Markup of Reconciliation Bill” (17 May 1993): 484.
 45. “State ERISA Waivers Threatened,” *Medicine and Health* (26 July 1993): 3.
 46. Kahn, “Budget Translated.”

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