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REIGNING IN ERISA PREEMPTION?
ANY WILLING PROVIDER STATUTES AFTER
NEW YORK BLUE CROSS PLANS v.
TRAVELERS INSURANCE CO.

The Employee Retirement Income Security Act of 1974 ("ERISA" or "the Act")1 is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans."2 ERISA regulates employee benefit plans of private employers,3 impacting the eighty-eight percent of non-elderly Americans who have private health insurance through their employee benefit plans.4

Congress passed ERISA in response to widespread mismanagement of employee benefit plans that placed participants' benefits at risk.5 ERISA protects participants and their beneficiaries by imposing participation, funding, and vesting requirements on pension plans.6 ERISA also establishes "various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans."7

5. ERISA § 2(a), 29 U.S.C. § 1001(a) ("[O]wing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits."). One instance of plan mismanagement that prompted Congress to act was the closing of the Studebaker Auto plant in South Bend, Indiana in 1963. The plant closing resulted in the loss of pension benefits by nearly 11,000 employees who had been employed at the plant. See JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 62-63 (2d ed. 1995).
7. Id. ERISA covers two broad categories of plans, "pension benefit plans" and
Through enactment of ERISA, Congress sought to replace an assortment of federal labor laws\(^8\) and state regulations\(^9\) with uniform federal regulations governing employee benefit plans.\(^10\) To achieve uniformity, Congress included in ERISA an express preemption provision.\(^11\) Section 514(a) of the Act provides that the provisions of Titles I and IV "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."\(^12\) The remainder of section 514 establishes exceptions to the general preemption rule and further clarifies the scope of ERISA’s preemption provisions.\(^13\)

The inherent vagueness of the phrase "relate to" in the preemption provision is the subject of extensive commentary\(^14\) and a key issue in ERISA litigation. The "relate to" test was at the center of a recent conflict between the United States Court of Appeals for the Second Circuit and the United States Court of Appeals for the Third Circuit. This conflict culminated in the United States Supreme Court’s 1995 decision in *New*


\(\text{\textsuperscript{10}}\) See *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (addressing the uniform administration scheme established by ERISA); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141 (1990) (discussing the "goal of uniformity that Congress sought to implement" through ERISA).

\(\text{\textsuperscript{11}}\) See 29 U.S.C. § 1144(a). Preemption means that the Supremacy Clause of the United States Constitution, U.S. Const. art. VI, § 2, overrides state legislation because it cannot be reconciled with federal legislation. See also *Black’s Law Dictionary* 1440 (6th ed. 1990) (definition of supremacy clause). The use of an express preemption provision such as 29 U.S.C. § 1144 obviated the application of the implied preemption analysis that arises under the Supremacy Clause.

\(\text{\textsuperscript{12}}\) ERISA § 512(a), 29 U.S.C. § 1144(a).

\(\text{\textsuperscript{13}}\) ERISA § 514(b)-(d), 29 U.S.C. § 1144(b)-(d). See also *infra* notes 35-43 and accompanying text.

\(\text{\textsuperscript{14}}\) See, e.g., Killberg & Inman, *supra* note 8, at 1316 n.11 ("Judicial failure to apply rigorously the text of ERISA’s preemption provisions to the facts of particular cases springs more from inability than from judicial activism. Section 514 appears at first inspection to provide little guidance in determining whether a state law ‘relate[s] to’ an employee benefit plan.’").
York Blue Cross Plans v. Travelers Insurance Co.\textsuperscript{15}

Prior to its decision in \textit{Travelers}, the Supreme Court relied upon its statement that a state law "relates to" employee benefit plans, and thus is preempted by ERISA, if the state law has a "connection with or reference to"\textsuperscript{16} ERISA plans as the standard for ERISA preemption.\textsuperscript{17} This standard, nearly as vague on its face as the statutory "relates to" language, was easy for courts to apply if a state law specifically referred to ERISA plans or directly regulated the benefits or administration of ERISA plans. However, courts had difficulty applying this standard in marginal cases where a state law, challenged under ERISA's preemption provisions, did not directly affect ERISA plans.\textsuperscript{18}

The breadth of the language of ERISA's preemption provision,\textsuperscript{19} and its similarly broad application by the courts,\textsuperscript{20} has led commentators\textsuperscript{21} to argue that ERISA prevents states from enacting health care reform measures or measures to pay for health care programs.\textsuperscript{22}

In 1993, Travelers Insurance Company challenged the validity of three surcharges imposed on them under the New York Public Health Law,\textsuperscript{23} alleging that ERISA preempted the surcharges.\textsuperscript{24} The surcharges effectively raised the cost of health care to persons using commercial insurers or self-insured plans, creating an incentive to enroll in the Blue Cross

\textsuperscript{15} 115 S. Ct. 1671 (1995).
\textsuperscript{18} See, e.g., Shaw, 463 U.S. at 100 n.21 (declining to decide "where it would be appropriate to draw the line" in borderline cases). See also Alessi, 451 U.S. at 525 n.21 ("express[ing] no views on the merits of" cases less clear than the one before the Court).
\textsuperscript{19} See ERISA § 514(a), 29 U.S.C. § 1144(a) (1994).
\textsuperscript{20} See infra notes 60-66 and accompanying text.
\textsuperscript{22} Id. at 410.
\textsuperscript{23} N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1988) (repealed 1993). The law required that insurance carriers of patients covered by health plans other than Blue Cross Plans, health maintenance organizations ("HMOs"), or government insurance, must pay a 13% surcharge over the diagnosis-related group ("DRG") rate. \textit{Id.} The law imposed an additional 11% surcharge on DRG rates for patients covered by commercial health insurance carriers, \textit{Id.} § 2807-c(11)(i) (McKinney Supp. 1993), and assessed an additional surcharge of 9% over the DRG rate against HMOs that did not meet a quota of patients covered by Medicaid. \textit{Id.} § 2807-c(2-1)(a) (McKinney Supp. 1993). See infra Part II.
plans and to encourage health maintenance organizations ("HMOs") to enroll additional Medicaid patients.\textsuperscript{25} The United States District Court for the Southern District of New York held that ERISA preempted the three surcharges.\textsuperscript{26} On appeal, the United States Court of Appeals for the Second Circuit upheld the decision of the District Court.\textsuperscript{27} The Second Circuit held that the surcharges had a sufficient "connection with" ERISA plans to meet the "relate to" standard for preemption under section 514(a) because the surcharges were designed to make certain health coverage options less appealing for ERISA plans.\textsuperscript{28}

The Supreme Court reversed the Second Circuit in \textit{Travelers.}\textsuperscript{29} This Note considers the new standard enunciated by a unanimous Supreme Court and the impact of the Court's decision on health care reform efforts in state legislatures. This Note assesses the viability of "Any Willing Provider" ("AWP") statutes in light of the Court's decision. AWP statutes require "managed care"\textsuperscript{30} health insurance plans to accept the services of any doctor willing to abide by the plan's regulations and fee schedule. Two cases challenging Arkansas' recently enacted AWP statute, the Patient Protection Act of 1995,\textsuperscript{31} are pending in federal district court.\textsuperscript{32}

Part I analyzes the text and legislative history of ERISA's preemption provision, and certain key court decisions. Part II discusses the background and rationale of the New York surcharges at issue in \textit{Travelers}.

\textsuperscript{25} Id. at 999-1000.
\textsuperscript{26} Id. at 999.
\textsuperscript{27} Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 719 (2d Cir. 1993).
\textsuperscript{28} Id.
\textsuperscript{29} 115 S. Ct. 1671 (1995).
\textsuperscript{30} Under managed care health plans, beneficiaries:
    either see doctors who work directly for a health maintenance organization, or
    see independent doctors who are on contract—a setup called a preferred provider network. Managed care physicians are obligated to keep costs down—for instance, by charging less and not ordering a full battery of tests for patients. In return, they get more patients.
\textsuperscript{32} Prudential Ins. Co. of Am. v. Arkansas, No. LR-C-95-514 (E.D. Ark. filed July 27, 1995) (Prudential, Tysons Foods, and two labor organizations argue that the AWP statute is unconstitutional and violates ERISA, the Federal Health Maintenance Organization Act, and the Federal Employee Health Benefits Act); Arkansas Blue Cross and Blue Shield v. American Med. Int'l, No. LR-C-95-414 (E.D. Ark. filed June 30, 1995) (Arkansas Blue Cross and Blue Shield contends that the AWP statute is unconstitutional and violates ERISA).
Reigning in ERISA Preemption?

Part III addresses the rationale of the United States District Court for the Southern District of New York and the United States Court of Appeals for the Second Circuit in holding that the statutes were preempted by ERISA, and discusses the resulting conflict with the United States Court of Appeals for the Third Circuit. Part IV analyzes the decision of the Supreme Court reversing the lower courts and announcing a new standard for determining whether a state law "relates to" employee benefit plans within the meaning of ERISA's preemption provision. Part V addresses the impact of the Court's decision on the litigation that is currently pending in Arkansas, and on the future of AWP statutes. This Note concludes that although the Travelers decision appears to remove ERISA preemption as an obstacle to the imposition of provider taxes to fund health care programs, and to enact some innovative health care reform measures, the Court will need to clarify its decision and revisit the meaning of ERISA's preemption provision in light of the two current challenges to Arkansas' AWP statute.

I. ERISA's Preemption Provision

A. Provisions of Section 514

Section 514 of ERISA\(^3\) sets forth the statute's preemption provisions. Section 514(a) provides that "the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."\(^4\) Section 514(b)\(^5\) exempts from preemption those state laws

34. ERISA § 514(a), 29 U.S.C. § 1144(a). The range of plans regulated by ERISA is defined as follows:
   (a) Except as provided in subsection (b) of this section and in sections 201, 301, and 401, this title shall apply to any employee benefit plan if it is established or maintained-
      (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
      (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
      (3) by both.
   (b) The provisions of this subchapter shall not apply to any employee benefit plan if -
      (1) such plan is a governmental plan (as defined in section 3(32));
      (2) such plan is a church plan (as defined in section 3(33)) with respect to which no election has been made under section 410(d) of the Internal Revenue Code of 1954;
that "regulate[] insurance, banking or securities," criminal laws, domestic relations orders, and other laws that fall within specified statutory guidelines. Section 514(c) is a definitional provision. Section 514(d) addresses the impact of title I's provisions on other federal laws.

Challenged state laws that regulate employee benefit plans are not necessarily preempted. However, if a challenged state law is alleged to regulate an employee benefit plan that is not of a type specified in section 4(b) of ERISA, the first step in the preemption analysis is to determine whether the state law "relate[s] to" the plan. If a court finds that the

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;
(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or
(5) such plan is an excess benefit plan (as defined in section 3(36)) and is unfunded.

35. ERISA § 514(b), 29 U.S.C. § 1144(b).

The insurance savings clause is subject to an exception, referred to as the "deemer clause" of ERISA § 514(b)(2)(B), which provides that "no employees benefit plan ... shall be deemed to be an insurance company ... for purposes of any law of any State purporting to regulate insurance ... ." ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). See, LANGBEIN & WOLK, supra note 5, at 452-53.
40. ERISA § 514(c), 29 U.S.C. § 1144(c).
41. Section 514(c)(2) defines the term "State" to include "a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter." ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2). The term "State law" includes "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1).
42. ERISA § 514(d), 29 U.S.C. § 1144(d).
43. ERISA § 514(d), 29 U.S.C. § 1144(d) provides that "[n]othing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States ... or any rule or regulation issued under any such law." See Guidry v. Sheet Metal Workers Nat'l Pension Fund, 493 U.S. 365, 375 (1990).
44. See infra notes 61-64, 68 and accompanying text.
state law “relate[s] to” the plan, the court must then determine whether the law is saved from preemption because it regulates insurance, banking, or securities.49

Congress enacted ERISA’s preemption provision to provide uniformity in the administration of employee benefit plans.50 Congress sought to prevent the undermining of ERISA’s goals by state legislation affecting employee benefit plans and to simplify administration of these plans for multistate employers through the establishment of national regulations.51

The version of section 51452 that emerged from the Conference Committee was the most expansive preemption language considered by Con-

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45. Killberg & Inman, supra note 8, at 1317-18.
46. ERISA § 514(b), 29 U.S.C. § 1144(b).
47. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (“[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”). See supra note 36.
49. See supra note 36.

Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . . nor any trust established under such a plan, shall be deemed to be an insurance company or . . . to be engaged in the business of insurance or banking for purposes of any law of any state purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.


53. Senator Williams, Chairperson of the Committee on Labor and Public Welfare, stated that ERISA would “preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.” 120 CONG. REC. 29,933 (1974).
gress during the legislative consideration of ERISA. Other proposed versions of section 514 considered by Congress limited preemption to state laws containing subject matter actually regulated by ERISA. Both the expansive preemption language enacted by Congress that originated in the Conference Committee and the legislative history of ERISA have led to a broad interpretation of ERISA's preemption clause. The broad language of Section 514 enacted by Congress provides the context for a discussion of ERISA's preemption provision because courts deciding ERISA preemption cases rely on its breadth to support a broad application of the provision to preempt state law.

C. ERISA's Preemption of State Law

The Supreme Court's decisions in ERISA preemption cases indicate four ways a "state law" may "relate to" an employee benefit plan within the meaning of ERISA's preemption provision and, therefore, be subject to preemption: (1) a direct conflict may exist between the provisions of ERISA and the provisions of the state law; (2) the state law may make reference to an employee benefit plan; (3) the state law, without any

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56. See id. at 48-52 (discussing the circumstances surrounding the Conference Committee's deliberations regarding ERISA's preemption provision).
57. See ERISA § 514(a), 29 U.S.C. § 1144(a).
58. See Schaffer & Fox, supra note 55, at 48-52.
59. See supra note 53 (discussing the comments of Senator Williams). See also comments of Representative Dent, Chairman of House Labor and Education Committee, 120 CONG. REC. 29,197 (1974) (characterizing ERISA § 514 as "the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans").
61. See Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 525 (1981). Alessi, the Supreme Court's first ERISA preemption decision, has been described as "the prototype of 'substantive' or 'content conflict' preemption." LANGBEIN & WOLK, supra note 5, at 427. In Alessi, the Court struck down a New Jersey statute that prohibited a method of computing a plan participant's pension benefits in a manner specifically authorized by ERISA. See Alessi, 451 U.S. at 524.
62. See, e.g., FMC Corp. v. Holliday, 498 U.S. 52, 61-62 (1988) ("Pennsylvania's antitrustubrogation law has [included] a 'reference' to benefit plans governed by ERISA."); Ingersoll-Rand Co., 498 U.S. at 140 ("Texas' cause of action [is preempted by ERISA because it] makes specific reference to, and indeed is premised on, the existence of a pension plan."); Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 829 (1988) ("The Georgia statute at issue here expressly refers to—indeed, solely applies to—ERISA employee benefit plans."). In these three illustrative cases, the Court based its decision, that an explicit reference to an ERISA plan falls within the scope of the "relate to" language of § 514(a), upon its earlier pronouncement in Shaw: "A law 'relates to' an employee benefit
reference to an employee benefit plan or any conflict with ERISA, none-the-less may have been intended by the legislature to affect ERISA plans, and (4) the state law may produce an indirect effect on an employee benefit plan substantial enough to warrant preemption. The Supreme Court has explained that: "A state law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Courts have relied upon this language as the test for preemption of a state law.

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63. See *FMC Corp.*, 498 U.S. at 61. The Court's statement in *FMC Corp.* that "[s]tate laws directed toward the [employee benefit] plans are preempted because they relate to an employee benefit plan," id., apparently provides a broader scope of preemption than applied to the first two types of state laws preempted under § 514(a). See supra notes 60-61. An example of this third type of state law would be a state law enacted with the purpose of affecting the costs of employee benefit plans. See *Rebaldo v. Cuomo*, 749 F.2d 133, 134, 139-40 (2d Cir. 1984), cert. denied, 472 U.S. 1008 (1985) (New York statute that precluded self-insured employee benefit plans from negotiating discount rates with hospitals was not preempted by ERISA because no evidence was introduced in *Rebaldo* that the state legislature intended to impair employee benefit plans). The Second Circuit later retreated from this decision. See infra note 135 and accompanying text (discussing refusal of Second Circuit to follow *Rebaldo* in a later decision).

64. See *FMC Corp.*, 498 U.S. at 59-60. Using the "connection with" language of *Shaw*, 463 U.S. at 96-97, see infra note 65 and accompanying text, the Court preempted a Pennsylvania anti-subrogation law, finding that the law both made reference to, and had a connection with, an ERISA covered plan. See *FMC Corp.*, 498 U.S. at 59-60. Holding that the state law had a "connection with" an employee benefit plan, the Court, citing *Shaw*, noted that "[i]n the past, [it had] not hesitated to apply ERISA's pre-emption clause to state laws that risk subjecting plan administrators to conflicting state regulations." *Id.* at 59. The Court also noted that "[i]n order to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits." *Id.* at 60 (citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)). According to the Court, "[a]pplication of differing state subrogation laws . . . frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *Id.* In the eyes of the Court, this result would run counter to ERISA's goals of uniformity of administration for plan administrators and would be an indirect effect on the administration of the plan. *Id.*


While the Court has applied the broad language of section 514(a) to preempt a wide variety of state laws,67 "the preemption clause is neither absolute nor indiscriminate."

For example, the Court has held that ERISA does not preempt state-mandated benefit regulation,68 criminal law,70 severance pay at plant closings,71 and garnishment of ERISA welfare benefit plans.72 Generally, state laws that are not preempted by ERISA are those regulating areas traditionally left by Congress to the states,73 which have only an incidental effect on ERISA regulated plans.74

II. NEW YORK'S REGULATION OF HOSPITAL RATES

A. Background

Until the 1960's, New York did not regulate prices charged to insurers by hospitals for patient care. Rather, hospitals generally negotiated rates with Blue Cross plans that were less than their published rates. Hospitals accepted the lower rate, known as the "charge differential," because Blue Cross plans paid their bills promptly and served an important community purpose by providing a health coverage option to the less fortunate.75

By the late 1970's, federal and state laws regulated the rates charged to patients covered by programs such as Medicare, Medicaid, Blue Cross plans, and HMOs. To preserve the revenues of these plans, hospital rates for patients covered by unregulated payors were as much as twenty-five to forty percent higher than those charged to regulated payors.76

In 1983, New York enacted a hospital rate reimbursement system that established rates paid by all payors. Under the 1983 law, hospitals billed patients covered by Medicaid, Medicare, HMOs, and Blue Cross plans the same rate. Hospitals were required to bill all other patients at uni-

67. See supra notes 61-64.
68. Holloway, supra note 21, at 421 (citing David L. Gregory, ERISA Law in the Rehnquist Court, 42 SYRACUSE L. REV. 945, 957-64 (1991)).
(1994) ("Subsection (a) of this section shall not apply to any generally applicable criminal
law of a State.").
71. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 23 (1987).
73. See Metropolitan Life Ins. Co., 471 U.S. at 740-42.
74. See Mackey, 486 U.S. at 830-38 (discussing the effects of different state laws on
ERISA plans).
75. Brief of Petitioner Mario M. Cuomo, et al., New York Conference of Blue Cross
Cuomo].
76. Id. at 2.
form rates not exceeding 115% of the Blue Cross rate.\textsuperscript{77} This regulation of hospital rates reduced charges to "charge payors"\textsuperscript{78} by eight to eighteen percent.\textsuperscript{79}

New York justified the statutory imposition of the "charge differential" on both economic and social policy grounds:

Charge differentials in favor of Blue Cross and HMOs are justified by cost savings to hospitals and positive social policy outcomes. The principal cost savings accrue from prompt payment which provides working capital to hospitals and saves them money by reducing collection costs. The positive social policy outcomes include insurance coverage practices, most notably open enrollment and community rating, which make health insurance more available.\textsuperscript{80}

Thus, New York made no secret of the fact that it was intentionally increasing the rates of certain health insurance plans to make the Blue Cross plans more competitive.

\textbf{B. The Challenged Provisions of New York Public Health Law  \\ § 2807-c}

In 1988, New York enacted a prospective reimbursement system to set hospital rates.\textsuperscript{81} The system relies upon a case payment methodology by which hospital patients are placed in categories known as a diagnosis-related group ("DRG"). The rate charged by the hospital is based on the DRG, not the actual cost of providing the patient's treatment. The DRG rate is increased by a "payor factor" which accounts for differences in health coverage and costs to the hospital of providing care to a given patient.\textsuperscript{82}

The 1988 statute required insurance carriers, other than the Blue Cross plans, HMO's, or any government insurance plan, to pay a thirteen per-

\textsuperscript{77} Id. at 2-3.
\textsuperscript{78} "Charge payors" include commercial insurance companies and self-insured groups. Id. at 3.
\textsuperscript{79} Id.
\textsuperscript{80} Id.
\textsuperscript{81} N.Y. PUB. HEALTH LAW § 2807 (McKinney Supp. 1995). See also Brief of Mario M. Cuomo, \textit{supra} note 75, at 4 (discussing enactment of New York's hospital rate setting system).
\textsuperscript{82} Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 712 (2d Cir. 1993). See also Paul R. Koster, Note, Thomas Jefferson University v. Shalala: The Illogical Restriction of Medicare's Funding of Graduate Medical Education, 12 J. CONTEMP. HEALTH L. & POL'Y 269, 275-76 (1995) (discussing Medicare's Prospective Payment System, which also reimburses providers based on pre-scheduled rates for services rendered).
cent surcharge above the DRG rate.\(^8^3\) This differential was meant to contain hospital costs and increase availability of health insurance to New York residents unable to afford other health insurance.\(^8^4\) The goal of the surcharge was to level the playing field for the Blue Cross plans enabling them to attract more customers, including employee benefit plans regulated by ERISA.\(^8^5\)

In 1992, New York imposed two additional surcharges. The first was an additional eleven percent charge on the DRG payment rates charged to patients covered by commercial health insurance carriers.\(^8^6\) The second surcharge added a nine percent assessment on HMOs that failed to enroll a minimum number of Medicaid eligible persons.\(^8^7\) The hospitals kept the proceeds of the original thirteen percent surcharge to help contain costs, while the proceeds of the eleven percent surcharge were paid into the state’s general fund. HMOs paid the nine percent surcharge directly to a designated HMO “pool,” which was also ultimately deposited into the state’s general fund.\(^8^8\)

As the Second Circuit observed:

> The obvious effect of the 11% surcharge is to increase commercial insurers’ costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.\(^8^9\)

Because different employee benefit plans provide health insurance to employees through different types of health insurance plans,\(^9^0\) the rates paid by ERISA plans were affected by each of the three surcharges.

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\(^8^3\). N.Y. PUB. HEALTH LAW § 2807-c(1)(b).
\(^8^4\). Travelers Ins. Co., 14 F.3d at 712.
\(^8^5\). Id.
\(^8^6\). 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. PUB. HEALTH LAW § 2807-c(11)(i)).
\(^8^7\). 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. PUB. HEALTH LAW § 2807-c(2-a)(a)).
\(^8^9\). Travelers Ins. Co., 14 F.3d at 712.
\(^9^0\). ERISA plans provide health insurance through the purchase of commercial health insurance, self-insurance, subscription to an HMO, and coverage through non-profit health service corporations such as the Blue Cross Plans. Id. at 711.

A. Objections to the New York Statutory Scheme

Travelers Insurance Company and The Health Insurance Association of America challenged the statutes, alleging that the surcharges were preempted by ERISA’s preemption provision. The New York State Health Maintenance Organization Conference intervened as a plaintiff, while the New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (“the Blues”), and the Hospital Association of New York State intervened as defendants.

B. Decision of the District Court

The United States District Court for the Southern District of New York held that “the three statutory provisions at issue are all preempted by ERISA,” and therefore invalidated the surcharges. Relying upon the statement of the United States Supreme Court that a law “relates to” an employee benefit plan “in the normal sense of the phrase, if it has a connection with or reference to such a plan,” as well as the legislative history of ERISA’s preemption provision and the decisions of other courts, the district court found that a broad reading of the preemption provision was required. The district court, however, acknowledged the limits of ERISA’s preemption provision before analyzing whether the New York surcharges were preempted by ERISA.

According to the district court, “[a]lthough the 9%, 11% and 13% Surcharges do not expressly refer to ERISA plans, it is clear that those statutes have a ‘connection with’ such plans.” The district court ac-

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92. Id.
93. Id.
94. The surcharges were also challenged as preempted under the Federal Employee Health Benefits Act, id.; Travelers Ins. Co., 14 F.3d at 714-17, and as violative of the Tax Injunction Act. Travelers Ins. Co., 813 F. Supp. at 1000-01. These issues were not considered by the Supreme Court. Travelers Ins. Co., 115 S. Ct. at 1675.
96. Id. at 1002; See also supra notes 52-59 and accompanying text (discussing the legislative history of ERISA’s preemption provision).
99. Id. at 1003.
100. Id.
knowledged that "the Surcharges do not directly increase a plan's costs or affect the level of benefits to be offered." However, because the surcharges would be passed along to ERISA plans, the surcharges "lead, at least indirectly, to an increase in plan costs." This "indirect" connection with employee benefit plans regulated by ERISA was sufficient to trigger preemption. The district court also placed great emphasis on the fact that this result is the goal of the surcharges—to increase the costs of commercial health insurance plans and HMOs—thereby encouraging enrollment in Blue Cross Plans.

The district court rejected the defendants' argument that the surcharges should not be considered as "relating to" employee benefit plans within the meaning of ERISA's preemption provision. According to the district court, the surcharges "do not impact the structure or administration of employee benefit plans, impose requirements on use of plan resources, or impose inconsistent obligations upon multi-state plans," which was the purpose of including the preemption provision in the legislation. Even under this analysis the surcharges would be pre-empted because the surcharges burden commercial insurers and HMOs that provide services to employee benefit plans. Therefore, "those Surcharges may effect the structure and/or administration of such plans." Because the cost increases caused by the surcharges are passed on to the plans, the plan administrators may adjust the benefits they provide employees rather than pass the costs on to employees. This result would burden plan administration in a way ERISA was enacted to avoid.

The State of New York and the Blues relied on Rebaldo v. Cuomo, a decision in which the United States Court of Appeals for the Second Circuit held that an earlier version of New York's rate setting statute, giving Blue Cross Plans a discount off the DRG rate, was not preempted by ERISA. In Rebaldo, the Second Circuit held that "a state law must purport[ ] to regulate . . . the terms and conditions of employee benefit

101. Id.
102. Id.
103. Id. See also supra notes 83-89 and accompanying text.
105. See supra notes 52-53 and accompanying text.
107. Id.
108. Id.
110. Id. at 139.
plans' to fall within the preemption provision." Moreover, the Second Circuit found that "if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress." Thus, New York and the Blues argued that an indirect effect on hospital rates should not automatically bring about ERISA preemption.

The district court did not follow *Rebaldo* because it determined that the case had "been abrogated by later Supreme Court cases." It pointed out that the Second Circuit previously recognized the Supreme Court's rejection of this limitation of ERISA preemption. Despite agreeing that a broad reading of the ERISA preemption provisions may bring about the undesirable result of preemption in all marginal cases, the Second Circuit found this result to be the consequence of the broad preemption language.

The district court analyzed whether the surcharges were saved by the insurance savings clause. To avoid preemption under the insurance savings clause, a court must determine that the state law not only impacts the insurance industry, but also that the law is "specifically directed toward that industry." Additionally, the court must determine whether the law regulates a practice which constitutes the business of insurance under the McCarran-Ferguson Act. The Act establishes the following criteria: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

The district court found that the surcharges did not "regulate insurance" within the meaning of the insurance savings clause because HMOs and self-insured plans do not engage in the business of insurance as a

111. *Id.* at 137 (citation omitted).
112. *Id.* at 138-39.
114. *Id.* (citing *Smith*, 959 F.2d at 9 n.3 (citing Ingersoll-Rand Co. v. McLendon, 498 U.S. 133, 141 (1990))).
115. *Id.* at 1006.
116. *Id.* at 1006-07.
117. *Id.* at 1006 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 41, 50 (1987); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990)).
119. *Id.* (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).
Thus, the nine percent surcharge and the portions of the thirteen percent surcharge relating to self-insured plans do not qualify as "regulating insurance." Additionally, because the goal of both the eleven percent surcharge and the thirteen percent surcharge is to regulate hospital rates, neither of these surcharges qualify as "regulating insurance."

Applying the McCarran-Ferguson Act factors, the district court found that, while the eleven percent surcharge and the thirteen percent surcharge spread the cost of insuring high risk individuals, neither of the surcharges relate directly to the relationship between the insurer and the insured, nor are they limited to the insurance industry. Accordingly, the district court held that the surcharges were preempted by ERISA and not saved from preemption by the insurance savings clause.

C. Decision of the Court of Appeals for the Second Circuit

The State of New York and the Blue Cross Plans appealed the district court's decision. The United States Court of Appeals for the Second Circuit also held that the surcharges were preempted by ERISA. The Second Circuit acknowledged the breadth of ERISA's preemption provision, as well as its limits.

New York and the Blue Cross Plans argued that the district court erred in concluding that the indirect impact of the surcharges was substantial and impermissibly affected the administration or type of benefits furnished by a plan. The Second Circuit agreed with the district court that the surcharges satisfied the less stringent "connection with" standard an-
nounced in Ingersoll-Rand v. McClendon. According to the Second Circuit, by making some health coverage options more expensive, and therefore less attractive, to ERISA plans, "the surcharges purposely interfere with the choices that ERISA plans make for health care coverage," thereby constituting a sufficient "connection with" ERISA plans to trigger preemption. Because the surcharges "force ERISA plans to increase either plan costs or reduce plan benefits," the "connection with" standard is met. The Second Circuit also upheld the district court's determination that the surcharges were not saved by the insurance savings clause.

Defendants relied on Rebaldo to support their arguments on appeal. The Second Circuit, however, adopted the district court's view that the premise of Rebaldo was rejected by the Supreme Court. The Second Circuit also rejected defendants' contention that ERISA's preemptive effect is limited to those laws that purport to regulate employee benefit plans.

D. Conflict with the Third Circuit

The United States Court of Appeals for the Second Circuit acknowledged that its holding conflicted with the Third Circuit's decision in United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital. In that case, the plaintiffs challenged a New Jersey statute which imposed surcharges on DRG rates, the proceeds of which reimbursed hospitals for providing uncompensated and Medicare services. The statute also granted discounts to certain classes of payors.

The United States Court of Appeals for the Third Circuit held that the statute did not "relate to" employee benefit plans in a way that implicated ERISA's preemption provisions. Additionally, the Third Circuit found that the connection between the statute and the ERISA plans was too tenuous and remote "because [they were] dealing with a statute of general applicability that is designed to establish the prices to be paid for

130. Id.
131. Id.
132. Id. at 720.
133. Id.
134. Id. at 721-22.
135. Id. at 719.
136. Id. at 721 n.3.
137. 995 F.2d 1179 (3d Cir. 1993).
138. Id. at 1189-90.
139. Id. at 1191.
hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans."\textsuperscript{140} The statute's "indirect ultimate effect of increasing plan costs" removed the statute from the scope of ERISA preemption.\textsuperscript{141} The Third Circuit held that ERISA did not preempt the statute.\textsuperscript{142} The Supreme Court granted certiorari\textsuperscript{143} to resolve the conflict between the circuits.\textsuperscript{144}

IV. THE SUPREME COURT'S DECISION

In an opinion written by Justice Souter, a unanimous Supreme Court reversed the decision of the Second Circuit.\textsuperscript{145} As an initial matter, the Court reviewed the congressional intent in drafting section 514 to establish the appropriate breadth of the provision.\textsuperscript{146} Justice Souter acknowledged the expansive language of section 514(a), noting that "one might be excused for wondering, at first blush, whether the words of limitation ('insofar as they . . . relate') do much limiting."\textsuperscript{147} He also pointed out that if the phrase "relate to" were applied to its broadest possible meaning, Congress' words of limitation would be "a mere sham."\textsuperscript{148} Further, such an interpretation would "read the [general] presumption against pre-emption out of the law whenever Congress speaks to the matter with generality."\textsuperscript{149}

Following this preliminary analysis of section 514(a), the Court acknowledged that its prior explanations of the phrase "relate to" were "[not] much help" in deciding the case.\textsuperscript{150} As did the district court and the Second Circuit, the Court followed its holding in Shaw v. Delta Air Lines\textsuperscript{151} that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a

\textsuperscript{140.} Id. at 1192.  
\textsuperscript{141.} Id. at 1193-95.  
\textsuperscript{142.} Id. at 1191.  
\textsuperscript{145.} Id. at 1673, 1676.  
\textsuperscript{146.} Id. at 1677. Justice Souter reiterated the Court's general principle that when a federal law is said to preempt state action in an area traditionally regulated by the states, the Court works on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." Id. at 1676 (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)).  
\textsuperscript{147.} Id. at 1677.  
\textsuperscript{148.} Id.  
\textsuperscript{149.} Id.  
\textsuperscript{150.} Id.  
\textsuperscript{151.} 463 U.S. 85 (1983).
plan." The Court dismissed the "makes reference to" standard as a basis for preemption of the surcharges because the surcharges were imposed on patients and HMOs regardless of whether the coverage was secured by an ERISA plan and because employee benefit plans are not mentioned in the statute.

A. Reworking the "Connection with" Prong of the "Relate to" Test for Preemption under ERISA Section 514

The Court analyzed whether New York's challenged surcharge scheme had a "connection with" ERISA plans. Because a literal application of the phrase "connection with" would be equally unhelpful as the literal application of the phrase "relate to," the Court looked to the objectives and legislative history of ERISA to determine "the scope of the state law that Congress understood would survive." Initially, Justice Souter noted that the Supreme Court had consistently accepted congressional intent to "establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" Relying on its earlier findings regarding congressional intent, as well as the floor statements of two of the congressional sponsors of ERISA, the Court determined that "[t]he basic thrust of the pre-emption clause then was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."

According to Justice Souter, this principle is illustrated by analyzing the Court's decisions in Shaw, FMC Corp. v. Holliday, and Alessi v.

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153. Id.
154. See supra notes 82-88 and accompanying text.
156. Id.
157. Id. (quoting Alessi v. Raybestos-Manhattan, Inc. 451 U.S. 504, 523 (1981)).
158. See Ingersoll-Rand v. McClendon, 498 U.S. 133 (1990). In Ingersoll-Rand, the Court found that with the passage of section 514(a) Congress intended: to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.
Ingersoll-Rand, 498 U.S. at 142.
159. Travelers Ins. Co., 115 S. Ct. at 1677. See also supra notes 52, 58 and accompanying text.
Raybestos-Manhattan Inc.163 “In each of these cases, ERISA preempted state laws that mandated employee benefit structures or their administration.”164

In Shaw, the Court held that state laws “which prohibit[ ] employers from structuring their employee benefit plans in a manner that discriminates on the basis of pregnancy, and . . . which require[ ] employers to pay employees specific benefits, clearly ‘relate to’ benefit plans.”165 Because varying benefits when the laws might apply, or requiring plans to provide every beneficiary with benefits established by state law if the law required the benefits for any beneficiary, ERISA preempted the challenged statute.166

In Holliday, the Court held that ERISA preempted a state law that prohibited “plans from being structured in a manner requiring reimbursement in the event of recovery from a third party” and “require[d] plan providers to calculate uniform benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation,” thus “frustrat[ing] plan administrators’ continuing obligation to calculate benefit levels nationwide.”167 Essentially, this law entitled employees who had recovered against tortfeasors to be “entitled to benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employers in other States.”168

In Alessi, the Court held that a State law could not “prohibit plans from setting workers’ compensation plans off against employees’ retirement benefits or pensions because doing so would prevent plans from using a method of calculating benefits permitted by federal law.”169

For the Court, the charge differentials ought not trigger preemption under ERISA because unlike the statutes at issue in these three cases, the charge differentials were justified on the basis of the Blue Cross Plans’ efficient payment to hospitals170 and the coverage of individuals who are less likely to obtain health insurance from commercial insurers or

165. Shaw, 463 U.S. at 97.
167. FMC Corp., 498 U.S. at 60.
169. Id. (discussing the Court’s holding in Alessi).
170. Id.
Acknowledging that "their effects flow from their purpose," the Court accepted that the surcharges make the Blue Cross Plans "more attractive (or less unattractive) as insurance alternatives" for ERISA plans.

The Court qualified the impact of New York's surcharges on ERISA plans as "[a]n indirect economic influence" on the decisions of insurance purchasers, including ERISA plans. However, this "indirect influence" on ERISA plans did not "function as a regulation of an ERISA plan itself" because the surcharges did not bind the decisions of ERISA plan administrators. Similarly, the surcharges did not affect the uniform administration of ERISA plans because they affected only the cost of the plan, not the administration of, or benefits provided by, a given employee benefit plan.

The Court also acknowledged numerous examples of state laws with so-called indirect economic influences which could affect a plan's costs. State regulation of quality standards and employment conditions, if not applied uniformly to all aspects of hospital activities, might impact the costs of services paid by plans, constituting an indirect economic effect on the plans. Although these indirect economic effects may have less of an impact on the premiums charged, and costs paid, by employee benefit plans than the challenged surcharges, Justice Souter pointed out that "in the absence of a more exact guide to intended pre-emption than 514, it is fair to conclude that mandates for rate differentials would not be preempted unless other regulation with indirect effects on plan costs would be superseded as well." Without reading some limit on the scope of preemption into section 514, the limiting language would be effectively "read out" of the statute. Such a conclusion would violate basic rules of statutory interpretation and be incompatible with the Court's position.

171. Id. For the Court, the Blues' open enrollment policy was a particularly important rationale for the charge differential. Id. See supra notes 75-80 and accompanying text (discussing open enrollment).
173. Id.
174. Id.
175. Id.
176. Id. For Justice Souter it was readily apparent that "commercial insurers and HMOs may still offer more attractive packages than the Blues." Id.
177. Id.
178. Id.
179. Id. The Second Circuit rejected this argument. Travelers Ins. Co., 14 F.3d at 719-21.
that "[p]reemption does not occur... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general applicability."\textsuperscript{181} State laws such as New York's, that create an indirect economic effect on employee benefit plans, leave plan administrators with the same responsibility to find the best insurance value for plan beneficiaries. Such state laws are not the types of "conflicting directive[s]" Congress sought to avoid with the implementation of ERISA.\textsuperscript{182} Accordingly, the Court held that a state law with such an "indirect economic effect" did not have the requisite "connection with" ERISA plans to bring about preemption under section 514 of ERISA.\textsuperscript{183}

B. Support for the "Indirect Economic Effect" Test

1. Mackey v. Lanier Collection Agency

The Court further relied on its decision in \textit{Mackey v. Lanier Collection Agency}\textsuperscript{184} to support its distinction between direct and indirect effects on ERISA plans. In \textit{Mackey}, the Court held that ERISA's preemption provision did not prevent a general state garnishment statute from applying to participants' benefits held by an ERISA plan.\textsuperscript{185} ERISA's preemption language indicated that "Congress did not intend to forbid the use of state-law mechanisms of executing judgments against ERISA welfare benefit plans, even those mechanisms prevent plan participants from receiving their benefits."\textsuperscript{186} Thus, "[i]f a law authorizing an indirect source of administrative cost is not pre-empted, it should follow that a law operating as an indirect source of merely economic influence on administrative decisions, as here, should not suffice to trigger pre-emption either."\textsuperscript{187}

2. Rejection of Metropolitan Life Insurance Co. v. Massachusetts

The commercial insurers which opposed the New York surcharges argued that the Court's decision in \textit{Metropolitan Life Insurance Co. v. Massachusetts},\textsuperscript{188} where the Court relied on ERISA to strike down a law

\textsuperscript{181} \textit{Id.} at 1679 (quoting District of Columbia v. Greater Wash. Bd. of Trade, 113 S. Ct. 580, 583 n.1 (1992) (internal quotation marks and citation omitted)).
\textsuperscript{182} \textit{Travelers Ins. Co.}, 115 S. Ct. at 1680.
\textsuperscript{183} \textit{Id.}
\textsuperscript{185} \textit{Id.} at 840.
\textsuperscript{186} \textit{Id.} at 831-32.
\textsuperscript{187} \textit{Travelers Ins. Co.}, 115 S. Ct. at 1680.
\textsuperscript{188} 471 U.S. 724 (1985).
mandating coverage of certain minimum mental health care benefits, required that the New York surcharges also be struck down. In Metropolitan Life, the Court determined that the policies regulated by the New York statute included those bought by employee welfare benefit plans and therefore "directly affected" such plans. Although the Court determined that the state law at issue in Metropolitan Life was saved from preemption by the insurance savings clause, the commercial insurers in Travelers relied on the Court's initial determination of a direct effect in arguing that "all laws affecting ERISA plans through their impact on insurance policies 'relate to' such plans and are pre-empted unless expressly saved by the statute." 

Rejecting this argument, the Court differentiated the two statutes because the challenged statute in Metropolitan Life made express reference to employee benefit plans. The Court also noted that in Metropolitan Life there was no need to distinguish between the effects of state laws regulating insurers that are sufficiently "connected with" employee benefits plans to "relate to" the plans and those effects that are not. The Court noted that in Metropolitan Life, the challenged state law related to employee benefit plans because it bore "indirectly but substantially on all insured benefit plans, . . . requir[ing] them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of common insurance policy." Even in Metropolitan Life, however, the Court acknowledged that laws that "regulate only the insurer, or the way in which it may sell insurance," do not "relate to" employee benefit plans.

Based on the Court's reasoning in Metropolitan Life, the basic tax exemption enjoyed by the Blue Cross Plans in New York "since the days long before ERISA" do not relate to employee benefit plans. The New York surcharges did not place the same substantive coverage re-

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189. Id. at 727.
190. Id. at 739.
193. Id. at 1680-1681 (citing Metropolitan Life Ins. Co., 471 U.S. at 730-31).
195. Id. (citations omitted).
quirements on plan administrators as did the challenged law in *Metropolitan Life.* Some surcharges could leave plan administrators with a "Hobson's choice," requiring them to contract with the Blues. The challenged surcharges, however, were not preempted because they "[did] not require plans to deal with only one insurer, or to insure against an entire category of illnesses they might otherwise choose to leave without coverage."  

3. A New Understanding of the Legislative History of ERISA

Justice Souter looked beyond the language of section 514 and statements of key members of Congress to determine congressional intent regarding ERISA's preemption provision. He relied on two additional historical facts to reject a broader interpretation of "relate to" that would bar any state regulation of hospital costs. First, the DRG scheme, even without the challenged surcharges, would be preempted under the broader understanding of ERISA's preemption provisions. According to Justice Souter, this result would be "startling" because several states, including New York, regulated hospital rates at the time ERISA was passed by Congress. Further, the absence of any discussion regarding elimination of state regulation of hospital rates in ERISA's legislative history indicated that Congress did not intend to end state regulation of hospital costs.

Second, the same session of Congress that adopted ERISA also adopted the National Health Planning and Resources Development Act of 1974 ("NHPRDA") just months later. The purpose of the NHPRDA was to encourage and fund state responses to growing health care costs. As a part of the program, the federal government would

200. *Id*.
201. *Id*.
202. See supra notes 81-82 and accompanying text.
204. *Id*.
205. *Id*.
assist state agencies in regulating health care costs by promulgating "[a] uniform system for calculating rates to be charged to health insurers and other health institutions payors by health service institutions." Requiring such federal assistance for state regulation of health care costs would be incompatible with preemption of these same rates by ERISA. Thus, the broad interpretation of ERISA's preemption provision urged by those challenging the New York scheme would have "rendered the entire NHPRDA utterly nugatory, since it would have left States without the authority to do just what Congress was expressly trying to induce them to do by enacting the NHPRDA." The fact that the same session of Congress passed both ERISA and NHPRDA indicates that Congress did not intend such a broad reading of ERISA's preemption provisions. This is the case because under the broader understanding of the "relate to" language, the programs anticipated by the NHPRDA would be preempted. This provides further support of a narrower understanding of the "relate to" test.

D. Express Limitation of the Court's Holding

Without any qualification or limitation of the Court's decision, it is apparent that states would have nearly unlimited authority to pass laws that impact employee benefit plans regulated by ERISA without fear of pre-emption, so long as the effect on employee benefit plans is an "indirect economic effect" not bearing directly on the administration of, or benefits provided by, the plan. However, the Court placed an express caveat in its decision:

we do not hold today that ERISA pre-empts only direct regulation of ERISA plans, nor could we do that with fidelity to the views expressed in our prior opinions on the matter. We acknowledge that a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514.

Thus, despite the Court's unanimous decision, this limitation leaves questions as to the extent of ERISA preemption on statutes with indirect ef-

209. 88 Stat. at 2254.
211. Id.
212. Id.
213. Id. at 1683 (citations omitted).
fects on employee benefit plans, and the impact of preemption on state regulation of health care.

V. Can Any-Willing-Provider Laws Survive an ERISA Challenge in Light of New York Blue Cross Plans v. Travelers Insurance Co.?

A. Background

As employers have looked for ways to minimize the growing costs of providing health insurance to employees, managed care has become an increasingly popular and prevalent mode of providing health insurance. In managed care, insurance companies establish provider networks such as HMOs or Preferred Provider Networks ("PPOs"). Under managed care plans, insurance companies "save money by steering patients to selected doctors who agree to accept discounted fees and by reducing the use of specialists."214

Critics of managed care argue that HMOs reduce costs at the expense of quality medical care. Proponents of managed care argue that without limits, doctors "milk[ ] money from patients and insurers by giving unnecessary or inappropriate care."215

As enrollment in managed care plans proliferate, so do the concerns of providers excluded from these plans. The excluded doctors, in an effort to keep their patients (and their income), have encouraged legislators to enact legislation to require managed care plans to accept any doctor willing to provide services to a patient within the guidelines and fee schedule of the managed care plan. Some form of this AWP legislation, often termed "Patient Protection Acts," was enacted in five states in 1995, while twenty-five others rejected these measures.216

Lobbying efforts surrounding these bills have been intense.217 On one side are doctors excluded from managed care networks who argue that HMOs limit patient choice and lower the quality of care by limiting the patient's choice of doctors to a pre-approved list. Predictably, managed care plans, as well as some employers and unions, oppose these measures,

arguing that the only way to guarantee quality and limit costs is to choose the providers with whom they contract.

B. Arkansas' Patient Protection Act of 1995

Arkansas' Patient Protection Act of 1995\textsuperscript{218} is among the strongest AWP legislation in the country.\textsuperscript{219} The statute includes findings of the legislature that patients "should be given the opportunity to see the health care provider of their choice."\textsuperscript{220} To accomplish these goals, the Patient Protection Act prohibits insurers from charging fees or higher copayments, or imposing any incentive or disincentive for plan participants from seeing certain doctors instead of others.\textsuperscript{221} Further, the law imposes civil penalties, including injunctive relief for an aggrieved doctor, and fines of not less than $1,000.\textsuperscript{222}

C. Pending Litigation in Federal Court

Opponents of the Arkansas legislation did not stop their fight upon

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{219} Havemann, \textit{supra} note 214, at A4.
\item \textsuperscript{220} \textsc{Ark. Code Ann.} § 23-99-202.
\item \textsuperscript{221} \textit{Id.} § 23-99-204. That section provides:
\begin{enumerate}
\item A health care insurer shall not, directly or indirectly:
\begin{enumerate}
\item (A) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those health care providers who participate in the health benefit plan according to the terms offered.
\item (B) Impose upon a beneficiary any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class, or copayment level under that health benefit plan when the beneficiary is receiving services from a participating health care provider pursuant to that health benefit plan; or
\item (C) Prohibit or limit a health care provider that is qualified ... and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan.
\end{enumerate}
\end{enumerate}
\item \textsuperscript{222} \textit{Id.} § 23-99-207.
\end{enumerate}
\end{footnotesize}
passage of the statute. Since the enactment of the Arkansas law, two lawsuits were filed in federal district court challenging the law. Both of these suits rely on the argument that the AWP legislation is preempted by ERISA and therefore should be struck down.

D. Issues Affecting the Outcome of the Pending Litigation

In determining whether Arkansas' Patient Protection Act is preempted by ERISA, the district court, and possibly the court of appeals and the Supreme Court, will be asked to determine whether the statute is preempted by section 514 of ERISA. The first step is to analyze whether the statute "relates to" ERISA protected plans within the meaning of section 514. This analysis will rely on the reasoning of Travelers, which clarified the test laid out in Shaw. Under Shaw, the test was whether there is a "reference to" or "connection with" the ERISA plan. Travelers modified the analysis of whether a state law has a "connection with" an ERISA plan by asking whether the law brought about an indirect economic effect that merely affected the rates charged by plans, not the choices made by plan administrators. However, the Travelers decision is not carte blanche for states to enact any regulation with an indirect economic effect on ERISA plans. Rather, if the economic effect is so acute as to effectively force certain decisions of plan administrators, the law may nonetheless be preempted.

Turning to the treatment of AWP statutes generally, and the Arkansas Patient Protection Act specifically, under ERISA's preemption provision, and in light of Travelers, the issue for a court faced with an ERISA preemption problem is whether the AWP statute restricts the choices of ERISA plans as to their organization, structure, and administration. If the AWP has no such impact, then the economic effect of the statute must be

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228. Id. at 1683.
assessed. If so, the preemption determination focuses on whether the effect is so acute as to warrant preemption.

After analyzing the Court's decision in *Travelers*, the basic arguments for each side in the Arkansas litigation are easy to anticipate. Proponents of the statute will argue that the AWP statute does not mandate benefits, impose new plan regulations, or affect the uniform administration of ERISA plans. As with the surcharges in *Travelers*, the AWP statutes leave plan administrators with the same responsibility to find the best insurance value for plan beneficiaries.229

Opponents of the statutes will argue that, like the statute at issue in *Metropolitan Life*,230 AWP statutes directly regulate the decisions of plans and plan administrators as to which doctors will be able to participate in providing health coverage to plan beneficiaries. Thus, AWP statutes are more than a mere "indirect economic effect" on ERISA plans; they actually dictate the decisions of plan administrators as to doctors, preventing plans from regulating quality or costs by picking and choosing among doctors. Additionally, AWP statutes stifle the "gatekeeper" function of managed care plans by which these plans guide beneficiaries to certain providers in order to limit costs and maintain quality.

In *Cigna Healthplan v. State of Louisiana*,231 the United States Court of Appeals for the Fifth Circuit held that ERISA preempted the AWP provisions of Louisiana's Health Care Cost Containment Act.232 The Louisiana statute prohibited preferred provider networks which contract with "group purchasers" of health care services from excluding a licensed provider of health care services from any network of preferred providers.233 The statute specifically included ERISA plans in the definition of "group purchasers."234 According to the opinion in *Cigna*, because the Louisiana

231. 82 F.3d 642 (5th Cir. 1996).
232. *Id.* at 644-45 (holding that ERISA preempted LA. REV. STAT. ANN. § 40:2201-02 (West 1992)).
233. LA. REV. STAT. ANN. § 40:2202(5)(c). No licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider to offer health services within the limits of his license. *Id.*

Under the statute, the preferred provider organizations are defined as "contractual . . . agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment . . . ." *Id.* at 40:2202(5).
234. *Id.* § 40:2202(3). According to the Louisiana Health Care Cost Control Act:
"Group purchaser" shall mean an organization or entity which contracts with
statute specifically mentioned ERISA plans and affected employee benefit plans, ERISA preempted the statute.\textsuperscript{235}

According to the Fifth Circuit, the Supreme Court's decision in \textit{Travelers} did not change this result, reading that case as saving from preemption only those statutes with an indirect economic effect on the prices of insurance policies purchased by ERISA plans.\textsuperscript{236} Under this analysis, the fact that the Louisiana AWP statute affected the nature and structure of the benefits provided by ERISA plans, and not merely the price of these benefits, the \textit{Travelers} analysis did not prevent preemption.\textsuperscript{237} Thus, the Fifth Circuit applied a very literal and limited reading of the Supreme Court's ERISA preemption cases and \textit{Travelers} to hold Louisiana's AWP statute preempted by ERISA.

The decision in \textit{Cigna} will be of precedential value in the United States District Court for the Western District of Arkansas, where the litigation over the Arkansas Patient Protection Act is pending. However, the two statutes can be differentiated in at least one important respect. The Louisiana statute made specific reference to ERISA plans,\textsuperscript{238} while the Patient Protection Act regulates health plans generally.\textsuperscript{239} Thus, the Patient

\begin{itemize}
\item providers for the purpose of establishing a preferred provider organization.
\item "Group purchaser" may include:
\item (a) Entities which contract for the benefit of their insured[sic], employees, or members of such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self-funded trusts or programs.
\item (b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers, or other intermediaries.
\end{itemize}

\textit{Id.} This definition specifically includes ERISA plans. \textit{See} 29 U.S.C. § 1002(1)(A) (1994) (defining an employee welfare benefit plan as "any plan, fund, or program which . . . is . . . maintained by an employer . . . to the extent that such plan, fund, or program . . . is maintained for the purpose of providing for its participants . . . medical . . . care or benefits . . . ").

\textsuperscript{235} \textit{Cigna Healthplan}, 82 F.3d at 648-49.
\textsuperscript{236} \textit{Id.} at 649.
\textsuperscript{237} According to the Fifth Circuit:
\textit{Louisiana's Any Willing Provider statute specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner. In other words, the Louisiana statute does not merely raise the cost of implicated benefits; it dictates their very structure. As such, the statute falls outside the purview of the limited \textit{Travelers} holding: The Court there repeatedly recognized that ERISA preempts "state laws that mandate[e] employee benefit structures."}

\textsuperscript{238} \textit{See LA. REV. STAT. ANN.} § 40:2202(3).
\textsuperscript{239} \textit{See ARK. CODE ANN.} § 23-99-204(a) (Michie Supp. 1995) (prohibiting "health care insurer" from placing any monetary incentive or penalty that would affect the choice to receive health care from a provider willing to abide by the plan's rules and regulations).
Provider Act is more a regulation that affects plan prices than one which singles out ERISA plans and affects the structure of benefits. This factor reduces the likelihood that the Patient Protection Act would be construed as having such an acute effect on ERISA plan administrators as to warrant preemption. Under the statute, all health insurance plans would be subject to the AWP statute, whether managed care or traditional fee-for-service plans. Further, the statute provides explicitly that it does not regulate the benefits or guidelines of a given plan. Accordingly, in light of Travelers, even if the Patient Protection Act were to raise the cost of HMO coverage to ERISA plans, the statute would not be preempted because the effect of the statute is not so acute as to bind the decisions of the plan administrators.

VI. CONCLUSION

Following the Court's decision in New York Blue Cross v. Travelers Insurance Co., commentators were divided over the practical impact of the ruling. Employee benefit consultants and commercial insurers were generally concerned that states would read the decision as an opportunity to impose new provider taxes, regulations, or other indirect assessments on employee benefit plans. However, organizations representing states and state insurance commissions, as well as advocates of comprehensive health care reform, praised the decision as preserving states' abilities to control their own health care systems. From a practical

The term "health care insurer" is defined as "any entity, including, but not limited to: (1) Insurance Companies; (2) Hospital and medical services corporations; (3) Health maintenance organizations; (4) Preferred provider organizations; (5) Physician hospital organizations; (6) Third party administrators; and (7) Prescription benefit management companies; authorized to administer, offer, or provide health benefit plans." Id. § 23-99-203(f).


241. Id. § 23-99-205.


243. Id. Bill Gradison, President of the Health Insurance Association of America, remarked that "[i]n effect, [the people of New York] are being asked to subsidize the Blues."

Supreme Court Says ERISA Doesn't Preempt Surcharge on Insurers, FED. & STATE INS. WEEK (May 1, 1995) No. 18 Vol. 9. The Association of Private Pension and Welfare Plans was "deeply concerned" by the decision and indicated that "[o]ne thing seems certain: several states will now presumably enact a variety of laws that will impose new cost burdens on plan sponsors." U.S. Supreme Court Rejects Challenge to State Surcharges on Hospital Bills, 22 Pens. & Ben. Rep. (BNA) No. 18 at 1129 (May 1, 1995).

244. According to Lee Douglass, the President of the National Association of Insurance Commissioners, the decision recognized "that states have the right to treat the purchases of health care coverage differently, in terms of hospital rates." Supreme Court Says ERISA
standpoint, though, two courts quickly followed the Court's lead and upheld state laws imposing surcharges similar to those at issue in Travelers.

Safeco Life Insurance Co. v. Muller\textsuperscript{245} and Boyle v. Anderson\textsuperscript{246} relied upon the decision in New York Blue Cross Plans to uphold state laws assessing additional costs on ERISA plans.\textsuperscript{247} In each of these cases the courts of appeal found that the state law at issue constituted an indirect economic effect under the Court's decision in Travelers.\textsuperscript{248} Accordingly, the trend in the lower federal courts after New York Blue Cross Plans seems to be to uphold statutes, such as provider taxes, that merely impose an indirect economic effect on ERISA regulated employee benefit plans. Thus, as states consider provider taxes to fund health care programs, taxes or surcharges on employee benefit plans may now be enacted by state legislatures without threat of ERISA preemption.\textsuperscript{249} While it remains to be seen whether states will actually turn to provider taxes as a source of revenue to support health care programs, in light of the Travelers decision, there is little doubt that such laws will be upheld.

\textit{Doesn't Preempt Surcharge on Insurers}, FED. & ST. INS. WEEK (May 1, 1995) No. 18 Vol. 9. Douglass went on to argue that states need to control their health care system "includ[ing] having the ability to make health plans that do not pay their fair share contribute to the cost of the health care system. This applies to self-funded as well as traditional insurers and HMO's." \textit{Id.}

Similarly, Daniel Sisto, President of the Healthcare Association of New York, praised the decision. "[This decision] means that states such as New York . . . can continue to reform their health care delivery systems to meet the needs of all persons." \textit{U.S. Supreme Court Rejects Challenge to State Surcharges on Hospital Bills}, 22 Pens. & Ben. Rep. (BNA) No.18 at 1129 (May 1, 1995).

\textsuperscript{245} 65 F.3d. 647 (7th Cir. 1995). In Safeco, the United States Court of Appeals for the Seventh Circuit upheld Wisconsin's Health Insurance Risk Savings Plan, which imposes assessments on insurance policies, including ERISA plan policies, to fund major medical insurance for eligible uninsured. \textit{Id.} at 648-50.

\textsuperscript{246} 68 F.3d 1093 (8th Cir. 1995). In Boyle, the United States Court of Appeals for the Eighth Circuit upheld the Minnesota Health Right Act, which funds several programs to make health insurance available to more Minnesota citizens through a two percent tax on the gross patient revenues of hospitals, a two percent tax on the gross revenues of non-hospital health care providers, a cigarette tax increase, and other taxes. \textit{Id.} at 1097-98. The Minnesota law allows providers to transfer the cost of the tax to third party purchasers, including insurance companies, HMOs, or self-insured employee benefit plans. \textit{Id.} at 1098.

\textsuperscript{247} Safeco, 65 F.3d at 652-54 (following the Court's "pragmatic" approach in Travelers decision); Boyle, 68 F.3d at 1109-10 (applying rationale of the Court in Travelers).

\textsuperscript{248} Id.

\textsuperscript{249} Id. According to Trish Riley, Executive Director of the National Academy for State Health Policy, a provider tax could be one of the few options available to states to offset potential loses from Medicaid cuts. Similarly, some employee benefits consultants have indicated that should block grants replace current Medicaid funding formulas, some states will be forced to examine alternative financing options such as provider taxes. Falk, supra note 242, at 348-49.
In *New York Blue Cross Plans v. Travelers Insurance Co.* the Supreme Court clearly announced a much more specific standard for section 514's "relate to" language that would result in preemption of state laws with indirect effects on ERISA plans. The fact that the decision was unanimous, a rarity given the composition of the current Court, indicates that the Court as a whole is willing to give states leeway to enact health care reform programs. Given such unanimity, it is difficult to envision a state law with no reference to employee benefit plans and with only indirect economic effects on employee benefit plans that would create acute effects on the administration of employee benefit plans so as to compel a majority of the Court to rule the state law preempted.

Lower courts are already giving states wide latitude to impose provider taxes that affect employee benefit plans, and it seems unlikely that ERISA preemption will be an obstacle to future state health care reform efforts such as AWP statutes when the statutes are tailored to the *Travelers* standard.

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