Insurance Law: Employee Retirement Income Security Act (ERISA) & Preemption

Korey D. Harvey
Vice President & Deputy General Counsel
Blue Cross and Blue Shield of Louisiana
**Covering Risks: Insurance**

- Insurance is a promise to indemnify in the event of a defined eventuality. It is the spreading of risk. A gamble. A bet.
- In the arena of health insurance specifically, there are largely two ways of indemnification: fully-insured arrangements and self-insured arrangements.

<table>
<thead>
<tr>
<th>Self-funded Plans</th>
<th>vs.</th>
<th>Fully-insured Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer/employee pays into fund</td>
<td>PAYMENT</td>
<td>Policyholder pays premium to insurance company</td>
</tr>
<tr>
<td>Employer assumes RISK</td>
<td></td>
<td>Insurer assumes</td>
</tr>
<tr>
<td>Employer has control PLAN DESIGN</td>
<td></td>
<td>Insurer has control</td>
</tr>
<tr>
<td>Employer has more ability to control COSTS/TREND</td>
<td></td>
<td>Insurer attempts through purchase power, plan design, utilization review</td>
</tr>
</tbody>
</table>
Before ERISA

- ERISA’s enactment was made possible in 1944, when SCOTUS decided *United States v. South-Eastern Underwriters Association*, 322 U.S. 533. In that case, the Court held that the Sherman Act, the primary federal antitrust statute, did apply to insurance companies, and that the business of insurance did fall under Congress’s Commerce Clause authority.

- Prior to *South-Eastern*, the Court had held in *Paul v. Virginia*, 75 US 168 (1869), that corporations were not citizens with respect to the Privileges and Immunities Clause (Art. IV, §2,Cl. 1), and that the issuance of policies of insurance did not constitute a transaction of commerce under the Commerce Clause (Art. I, §8, Cl. 3).

- In response to *South-Eastern*, Congress enacted the McCarran–Ferguson Act, 15 U.S.C. §§ 1011-1015, in 1945, which gives the business of insurance a broad exemption from federal law, including to a limited extent, an exemption from federal antitrust law. This has been, piece by piece, partially abrogated by the later enactment of several statutes including ERISA, COBRA, HIPAA, and most of all, the ACA.
ERISA

• Enacted in 1974 as Public Law 93-406, codified at 29 USC §1001 et seq. Note that federal laws have their own internal numbering system and the numbering of many titles of the US Code remains “unofficial.” For example, the preemption clause of ERISA, 29 USC §1144, is the codification of Public Law 93-406, §514, often usually referred to as “ERISA section 514.”

• Complex statute that federalizes the law of employee benefits by establishing a comprehensive regulatory framework for employee pension plans and also preempts most state laws relating to “employee welfare benefit plans,” a broad category that includes nearly all employer-sponsored and union-sponsored health plans.

• Prior to ERISA’s enactment, the regulation of nearly all health plans was almost exclusively under the purview of state governments, through legislatures and state insurance commissioners.

• ERISA’s purpose was to preempt numerous and varying state laws that regulated employer-sponsored health plans in order to allow companies that do business, and offer health insurance coverage in several states, to have a single, uniform plan design and administration.
Is it an “ERISA plan”?

- The term “employee welfare benefit plan” and “welfare plan” include “any program...established or maintained by an employer or employee organization...for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise” with any of a broad range of benefits, including “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment.” 29 USC §1002(1).

- By definition, an ERISA plan includes both self-insured and fully-insured plans sponsored by employers. Colloquially, self-insured plans are often called “ERISA plans” or sometimes even “true ERISA plans”, while fully-insured employer-sponsored plans are often thought of as non-ERISA plans.

- Whether an ERISA plan is governed fully and exclusively by ERISA (what people often call “true ERISA plans”) is determined by ERISA’s preemption clause & savings clause (fully-insured plans), the definition of “employee welfare benefit plan” (multiple employer arrangements excluded), and ERISA’s specific exemptions.

- ERISA specifically excludes from the law’s expansive reach: church plans (maintained by a church for its employees); non-federal governmental plans; MEWAs (sort of); and plans maintained solely for compliance with state worker’s comp., unemployment, and disability laws.
ERISA: What does it require?

- Ignoring the law’s pension plan provisions, the health plan provisions require that health plans do certain things for employees who are covered by a plan:
  - Give employees written summaries of coverage (summary plan description)
  - Give employees a copy of the plan’s annual report, including a copy of its Form 5500, which is filed with the US Dept. of Labor
  - Imposes fiduciary duty upon those who administer the plan to operate the plan solely in the interests of those covered by the plan. Breach of fiduciary responsibility subjects the plan fiduciaries to personal liability under ERISA.
  - Requires a grievance and appeals process for plan members
  - Gives plan members the right to sue fiduciaries for breach of fiduciary duty
  - ERISA guarantees (through amendments by subsequent acts of Congress): continuation coverage; certain pre-existing conditions exclusion prohibitions; new-born and mother’s health protections; and mental health parity, among others.
ERISA: What it does NOT require

• ERISA does not impose any solvency standards for health plans. Fully-insured plans subject to state insurance laws have clear solvency standards and are closely regulated for plan solvency.
• No prior review or prior approval of the plan documents are required. Plan documents are reviewed by the DOL usually only after complaints have been lodged by plan members.
• Many of the “Market Reforms” of Title I of the ACA do not apply to self-insured ERISA plans. Examples of the market reforms that apply to fully-insured plans, but do not apply to self-insured ERISA plans:
  • Prohibition on discrimination based on salary
  • Medical Loss Ratio (MLR)
  • Rebate of premiums under the MLR
  • Review of rates
  • Premium restrictions (age; tobacco use; geography; family size)
  • Essential Health Benefits package; mandated coverages
Preemption

• Express preemption: a federal statute explicitly supplants state laws. Courts then generally must determine the scope of the express preemption.

• Implied preemption has two broad categories...clearly it involves a federal statute that lacks an express preemption clause.
  • (1) Conflict preemption: when a state law imposes requirements or otherwise makes it impossible for a person to comply with both state and federal law, conflict arises. Another example is when the purpose of a federal statute would be thwarted by a state statutory scheme. In such cases, the Supremacy Clause requires that the state law fall.
  • (2) Field preemption: though Congress has not expressly preempted state laws, Congress has designed a broad statutory or regulatory scheme that is so pervasive that it implies that no room has been left for states to legislate.

• Do not confuse questions of preemption with questions of federal subject matter jurisdiction. Although the scope of ERISA’s preemption clause is highly litigated and involves an interpretation of federal law, it is not a federal question.
Preemption

- The question of preemption of state laws by ERISA’s preemption clause is often a complex question primarily because of the broad terminology of the preemption clause and the multiple stages of analysis required by the clause.

- What does the ERISA preemption clause actually say?
  - “…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.”

- But that’s not the end of it….because the ERISA preemption clause has a **savings clause**….”Except as provided in subparagraph (B), [referring to the deemer clause] nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.” In other words, ERISA generally does not prohibit states from applying state insurance laws to entities engaged in the business of insurance.

- But that’s not the end of it….because the ERISA preemption clause has a **deemer clause**….
The **deemer clause**…”Neither an employee benefit plan described in 29 U.S.C. §1003(a) of this title, which is not exempt under §1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer….or to be engaged in the business of insurance…for purposes of any law of any State purporting to regulate insurance companies, insurance contracts…”

What does this mean in effect? The preemption clause intends to bring about the over-all statutory goal of allowing large employers to have nation-wide uniformity by preempting state laws. But the Savings Clause of the Preemption Clause is consistent with McCarran-Ferguson, because ERISA contains an “equal dignity” clause which states “nothing 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.” (referring to McCarran-Ferguson among others). So….the savings clause saves state insurance laws from preemption…but as an extra check on states, the deemer clause prohibits states from back-end regulation of employee benefit plans by “deeming” any such plan an insurance plan.

If an employee benefit plan purchases any insured product, state law applies.
“Supersede”; “relate to”; “saved”; “deems”; “business of insurance”

• What do these terms lead to? Confusion. And naturally, multi-part tests.
• Multiple circuits don’t agree on what some of these terms mean or when to pull the trigger on preemption even when they do agree.
• Vague preemption clauses lead to or allow unpredictable SCOTUS decisions like that in Kentucky Association of Health Plans v. Miller (2003), in which the court declared its prior jurisprudence a failure to “provide clear guidance”, “added little relevant analysis”, and thus required “a clean break.”

“Relate to”

New York enacted its Human Rights and Disabilities Law, which contained a number of employment discrimination provisions. The disabilities provisions required employers to provide employees the same benefits for pregnancy as were provided for other disabilities. Does this law “relate to” employee benefit plans?

The court said yes, according to the “normal sense of the phrase, if it has a connection with or reference to such a plan.”
Preemption: SCOTUS Jurisprudence


The Court said that ERISA does not only preempt state laws that deal with requirements covered by ERISA (reporting, fiduciary responsibility, etc.), nor does it merely preempt state laws specifically directed to employee benefit plans...

State laws that indirectly “relate to” such plans may also be preempted.

The court said some state laws may “affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding” that it “relates to” the plan.

So... both provisions of the NY law “relate to” a plan... but are the two provisions “saved” from preemption?

NY argued that the Human Rights law was saved from preemption because it was integral to enforcing federal equal employment laws under Title VII. The court rejected this assertion because the NY law went further than Title VII protections.

The Disability law was more nuanced. The court said that insofar as a state law related to a self-funded disability plan or portion of an employee benefit plan, it was preempted. But, a state can require an employer to establish a fully-insured disability plan that complies with state law.
Preemption: SCOTUS Jurisprudence


  The most important take away from the *Shaw* case is the over-all framework that the Court laid down in determining the question of whether a state law “relates to” an employee welfare benefit plan.

  The Court said that a state law relates to such plans when it has a (1) connection with and/or (2) reference to such plans.

  The importance of this two-fold possibility of relating to employee benefit plans should be kept in mind as we move forward.
Preemption: SCOTUS Jurisprudence


Mass. enacted a statute mandating coverage of mental health benefits. The statute applied only to insurance plans, but was broad enough to include an insurance plan purchased by an employee benefit plan. Mass. conceded the statute “related to” employee benefit plans, but argued that it was saved from preemption because it regulated insurance policies.

The court explained that ERISA does not distinguish between “traditional and innovative insurance laws.”

The court followed by stating there is a presumption against preemption and gave us a (self-described) “common-sense view” of the savings clause. The Court used prior jurisprudence interpreting the phrase “business of insurance” under McCarran-Ferguson (reverse preemption analysis) to determine if a practice is the business of insurance…which impliedly (to the court) meant that the statute could be saved from preemption.

In *Union Labor Life v. Pireno*, 458 U.S. 119 (1982), the court established a three-pronged test to determine what is the “business of insurance” under McCarran-Ferguson. The *Pireno* court said that not all three-prongs must be satisfied to divine the answer.
Preemption: SCOTUS Jurisprudence

- *Metropolitan Life Ins. Co. v. Massachusetts*, [cont’d]
  That three prong test:
  (1) Does the practice have the effect of “spreading a policyholder’s risk”?
  (2) Is the practice an “integral part of the policy relationship between the insurer and the insured”?
  (3) Is the practice “limited to entities within the insurance industry”?
  The Court said that the Mass. law passed all three prongs of the test. And the court recognized that it the decision allows for results where insured and self-insured plans have differing degrees of direct regulation.

  Lawyers in MS argued that state common law tort and contract claims applied to the processing of benefits under an employee benefit plan.
  The Court: the claims “relate to” the plan and are not saved from preemption....the Court employed the McCarran-Ferguson test and said that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but be *specifically directed* toward that industry.”
Preemption: SCOTUS Jurisprudence

• *Pilot Life Ins. Co. v. Dedeaux*, [cont’d]
  ERISA took deliberate care to craft civil enforcement remedies for its substantive provisions. This deliberate care clearly evidences an intent to be the exclusive remedy.
  State common law torts and contract claims are preempted because of the care ERISA took to create remedies and because neither tort or contract claims asserted were directed to nor involved with the business of insurance.
  But the Court went a step further and declared that all state laws that “supplemented or supplanted” the causes of action and remedies available under ERISA were preempted, regardless of whether they regulate insurance within the meaning of the savings clause.

• *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)
  PA statute prevented employee benefit plans from subrogating a plan beneficiary’s tort recovery involving moto vehicle-related accidents.
  The statute clearly related to employee benefit plans because it expressly referenced such plans.
  The Court said that the statute also fell *within* the savings clause as an insurance regulation….BUT
Preemption: SCOTUS Jurisprudence

- **FMC Corp. v. Holliday**, [cont’d]
  The statute is not “saved” to the extent that it touches self-funded employee benefit plans because the deemer clause exempts such plans from state laws that regulate insurance.
  “[I]f the plan is uninsured, the State may not regulate it.”

  ERISA preempts a statute requiring an employer to provide employees who were eligible for workers comp benefits with the same coverage the employer provided through its health insurance program if one was offered.
  The statute related to an employee welfare benefit plan because it specifically mentioned such plans. Unlike the *Shaw* case, which allowed indirect regulation of such plans when they purchase an insured product, this benefit mandate was tied directly to the terms of the employer’s employee benefit plan...and mentioned the existence of such plans in the statute itself.
  The Court said that the statute was preempted “on that basis alone.”
  This expands the enormous breadth of ERISA’s preemption clause when a state statute literally references an employee benefit plan.
Preemption: SCOTUS Jurisprudence

  Georgia had two garnishment statutes. One was a general garnishment statute; the second was a special statute that was enacted to garnish plan benefits for debtors that have benefits under an employee benefit plan.
  The question of preemption of the special statute was easily decided; the express reference to ERISA plans, even if the statute itself was designed to be less harsh on ERISA plans than the general statute, “suffices to bring it within the federal law’s preemptive reach.”
  The question of whether the general garnishment statute is preempted because of a “connection with” an ERISA plan was more nuanced. Congress considered language, but rejected language, to ban garnishment of ERISA plan benefits. That indicates that such general state garnishment laws are left undisturbed by ERISA’s preemptive reach.

  NY statute imposed a surcharge on covered lives of commercial insurers and HMOs (which often perform work for ERISA plans).
  There was no statutory reference to any ERISA plan; so the question turned on the question of whether the surcharge “related to” plans.
Preemption: SCOTUS Jurisprudence

- *Travelers* (cont’d)

  The district court held that the surcharge related to ERISA plans because the surcharge had the effect of increasing costs to commercial insurers and HMOs directly, which indirectly had the effect of increasing costs to ERISA plans that contracted with commercial insurers and HMOs to administer ERISA plan benefits. The Court concluded that the statute did not have a connection with ERISA plans because an indirect economic influence is not a sufficient connection to trigger preemption if it does not bind plan administrators to any particular choice or preclude uniform administrative practices.

  The *Travelers* Court in its dicta clarified that state statutes that “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…might indeed be preempted.”

  *Travelers* is an important case because it has weakened the “connection with” prong of the “relate to” plan.

  The Court’s prior ERISA cases evidenced the Court’s belief that Congress intended ERISA’s preemption clause to be expansive in its reach. In *Travelers*, the Court explicitly rejected its prior stance and said that the presumption is against preemption.
Preemption: SCOTUS Jurisprudence


CA’s minimum wage law allowed a lesser wage for workers that participated in approved apprenticeship programs. The statute made no express reference to ERISA. However, the overwhelming majority of such programs were administered and funded by ERISA plans. Does the fact that most plans are ERISA plans effectively mean that the statute references such plans, even if the statutory language does not do so?

The Court noted that the absence of such a reference terminates the inquiry into whether there was a reference. A reference must include a reference.

The Court then turned to the question of whether the statute had a “connection with” ERISA plans due to the economic effects of the statute. The Court, echoing its retreat in *Travelers*, admitted that prior jurisprudence possessed “an uncritical literalism” in laying out the outermost limits of the preemption clause. The Court looked to the “objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans.”
Preemption: SCOTUS Jurisprudence

• *California Division of Labor Standards Enforcement v. Dillingham*, (cont’d)
  The Court again starts with a presumption against preemption; Congress did not intend to preempt areas of traditional state sovereignty. The areas covered by the state laws in *Dillingham* and *Travelers* were “quite remote from the areas with which ERISA is expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.”
  The Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprenticeship wages and wages to be paid for public works contracts.
  Like *Travelers*, the state law may have indirectly increased costs for plan administration, but it did not bind ERISA plans to any particular system.

• *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997)
  NY enacted a hospital tax, which the state attempted to enforce against a medical clinic owned and operated exclusively by and for an ERISA plan.
  The Second Circuit found the tax preempted. The Supreme Court vacated and remanded in light of *Travelers*. 
DeBuono (cont’d)

The Second Circuit again held the statute preempted, finding that the tax in this case was distinguishable. It was a direct tax on the ERISA plan itself and directly depleted plan assets; it was not an indirect economic cost as was the case in *Travelers*.

The Court reversed and again intimated that the central thrust of *Travelers* was that pre-*Travelers* jurisprudence employed too strict and too literal interpretations of “connection with.”

In order to overcome a presumption against preemption, one “must go beyond the unhelpful text [of the preemption clause]...and instead look to the objectives of the ERISA Statute...”

Furthermore, the Court explained that state laws of general applicability would have a fair shot at avoiding preemption:

“Any state tax or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted...”

In a footnote, the Court conceded that there may be some state law lingering in the shadows, that though of general applicability, would have an economic impact so great as to cause a “connection with” threshold to nonetheless be reached.
Preemption: SCOTUS Jurisprudence

• *DeBuono* (cont’d)

In *DeBuono* the Court pushed forward with weakening the preemptive reach of ERISA regarding the “connection with” prong of “relates to.” However, the Court reaffirmed the robust power of preemption when a reference to ERISA is involved (as was not the case here); the Court identified as among the types of state laws that Congress intended to supersede as “ones in which the state statute contains provisions that expressly refer to ERISA or ERISA plans.”


This case is a great one because it is the first case in years where the Court goes through a complete analysis of the entire preemption clause.

John Ward had a claim for disability benefits. The policy was employer-sponsored; the employer’s ERISA plan was administered by Unum Life Insurance Co. The policy contained language setting deadlines for filing claims. Ward did not submit his claim to Unum within the deadline. However, CA jurisprudence makes employers *de jure* agents of insurance companies with employer-sponsored plans. In other words, when Ward gave notice to his employer (within the time frame), but failed to file his claim with Unum, he had effectively done so anyway because his employer is an agent of the insurer.
The district court simply held that the statute related to an ERISA plan and was preempted. The Ninth Circuit reversed the district court on multiple grounds finding that even if the CA jurisprudential rule governing agency relates to an ERISA plan because it has a connection with such plans, it is nonetheless saved from preemption because it is clearly a law that regulates insurance.

The Ninth Circuit, which offered multiple alternatives for avoiding preemption, also said that the jurisprudential rule (and its exception: the notice-prejudice rule which trumps the jurisprudential rule where significant prejudice would result) was one of general applicability, and thus did not “relate to” ERISA plans.

SCOTUS affirmed in part and reversed in part. Employing both the McCarran-Ferguson test and a common-sense view of the meaning of the phrase “business of insurance”, the Court said that the state jurisprudential rule was clearly one regulating the business of insurance.

The Court then rejected Unum’s arguments that the notice-prejudice rule conflicted with ERISA’s requirement that fiduciaries act in accordance with plan documents. Such an argument would preempt any state law contrary to any plan document, which would “virtually read the savings clause out of ERISA.”
Preemption: SCOTUS Jurisprudence

- *Unum* (cont’d)

Unum also argued that ERISA’s civil remedies preempt any action for plan benefits brought under state rules. This argument was summarily disposed of by pointing out that the cause of action in this case was actually brought pursuant to ERISA §502. However, the Court nonetheless found the jurisprudential rule preempted because, though it (1) does not reference ERISA; (2) is in fact a law aimed at insurance [passes the savings clause test]; it does (3) violate the “deemer” clause of the preemption clause because “deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration.”

Therefore….the jurisprudential rule ultimately “relates to” an ERISA plan and is preempted.
Preemption: SCOTUS Jurisprudence

  Kentucky enacted two any-willing provider laws: one requiring that insurers include in their networks all providers willing to agree to uniform contract terms; the second requiring that insurers offering chiropractic benefits accept any willing chiropractic provider.
  The statutes contained no reference to ERISA.
  There was little dispute that the effect of the laws meant that the laws relate to ERISA plans.
  The question for the Court was whether the savings clause of ERISA’s preemption clause allowed the laws to avoid preemption.
  In making its determination, the Court announced a new, two-prong test for determining whether a state law regulates insurance. It was a break from two decades of jurisprudence.
  Prong 1: The state law must be “specifically directed towards entities engaged in insurance”. It must be more than a law of general application. But even a law aimed at insurers, must regulate with respect to the insurer’s insurance practices.
  Prong 2: The state law must “substantially affect the risk pooling arrangement between the insurer and the insured,” which was a clean break from the Court employing the McCarran-Ferguson test.
Preemption: SCOTUS Jurisprudence

• Kentucky Association of Health Plans v. Miller, (cont’d)

Prong 1: The state law must be “specifically directed towards entities engaged in insurance”.

Petitioner argued that the laws were not specifically directed at the insurance industry because the laws had a strong impact on health care providers and because the application of the laws to self-insurers and other arrangements that are not exempt from state regulation by ERISA.

The Court rejected these arguments. The Court said that all laws that regulate insurers will have some impact on entities that have relationships with those insurers. Regarding the scope of the laws, the court point out that ERISA’s savings clause requires a state law “regulate insurance,” not “insurance companies” or “the business of insurance”, which is language from McCarran-Ferguson, not ERISA. Therefore the fact that the laws apply to self-insurers, for example, which do similar business, does not forfeit the laws’ status as laws regulating insurance within the meaning of the savings clause. ERISA’s deemer clause prevents states from regulating self-funded ERISA plans that they could otherwise regulate.
Preemption: SCOTUS Jurisprudence

• Kentucky Association of Health Plans v. Miller, (cont’d)

Prong 2: The state law must “substantially affect the risk pooling arrangement between the insurer and the insured,” which was a clean break from the Court employing the McCarran-Ferguson test.

The Court said that this requirement does not actually require that the state law “spread risk,” or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the savings clause. The second part of the test is met by “altering the scope of permissible bargains between insurers and insureds in a manner similar to the mandates benefit laws upheld in Metropolitan Life, and the notice prejudice rule sustained in Unum.

The full impact of this case remains to be seen. It could be used to both save more state laws from preemption (because it no longer uses the strict McCarran-Ferguson factors) but could lead to more preemption because the McCarran-Ferguson factors were guideposts, not strict requirements as this new two-prong test appears to be.

So, from now on...McCarran-Ferguson’s “business of insurance” test does NOT equate to “insurance” laws for purposes of ERISA’s preemption clause (savings clause).
Preemption: SCOTUS Jurisprudence


  The Court’s most recent ERISA preemption case involved a Vermont law that required self-insured ERISA plans (all plans of any kind, in fact, it had no reference to ERISA), through their third-party administrators, to report all claims data to an all-payer claims database.

  Vermont argued that the state law was aimed at public health rather than the area of employee benefits, and that the incidental costs to ERISA plans did not rise to the level of “relate to”.

  The Court rejected this argument, in line with prior jurisprudence, that reporting was a core function of ERISA’s regulatory framework, and thus was intended to supplant any state-imposed reporting requirement.

  The Court said that “preemption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.” Because federal authority entirely occupies the field (essentially, “field preemption”), no further inquiry as to the degree of actual burden is required.
Recent Non-SCOTUS cases of Note

• In *Hansen et al v. Group Health Cooperative*, (9th Cir. 2018) the Court held that a state claim under Washington’s Unfair and Deceptive Trade Practices Act was not preempted by ERISA because the defendant’s duty to refrain from deceptive and misleading practices was a duty that was independent of ERISA.

• In *Pharmaceutical Care Management Association v. Gerhart* (8th Cir. 2017), the Court invalidated an Iowa law attempting to regulate PBMs. The law required PBMs to provide information to the Insurance Commissioner on pricing methodologies, limited the types of drugs that PBMs could apply MAC pricing to, limited the sources from which PBMs could utilize information to set MAC pricing, and required PBMs to provide information on pricing methodologies and to allow appeals procedures through which pharmacies could get retroactive payments. The law was declared preempted by ERISA because it contained both express and implied references to ERISA, and the law had an impermissible connection with ERISA plans.

• The 8th Circuit decided another case, relying on *Gerhart, Pharmaceutical Care Management Association v. Rutledge*, after Arkansas enacted a law preventing pharmacists from being forced to sell generic drugs at a loss and also included an option for pharmacists to refuse to dispense a drug. The Court invalidated the provision relating to pricing of generic drugs under the preemption clause of the Medicare Act and under ERISA. Regarding ERISA, the Court found a reference to and that the law related to ERISA plans.
Recent Non-SCOTUS cases of Note

Most importantly in this case, the Court made clear that even if the state law did not have an explicit or express mention of ERISA, because PBMs are plan administrators for ERISA-covered plans, the mere regulation of PBMs in particular created an impermissible reference to ERISA.

Regarding Medicare, the Medicare Act at 42 USC 1395w-26(b)(3), sets pricing rules for Medicare plans, including Part D plans and that under the Medicare Act, where the federal government has set standards, it has acted to preempt state laws on the same subject.

The court permitted the refuse-to-dispense provision because it did not conflict directly with ERISA or the Medicare Act and had no actual effect on plans.

(8th Cir. 2018)
Conclusion (pt. 1)

• Besides state laws discussed earlier, ERISA specifically preempts all state common law tort and contract claims if those claims arise under or relate to the ERISA-covered health plan. In such cases, the only remedy is through the federal courts system. 42 USC 502(a)(1)(B).

• If state claims are preempted by ERISA, and parties find themselves in federal court, standard tools and remedies ordinarily available in state courts are not available in federal court under ERISA:
  • Punitive or extra-contractual damages
  • Attorney’s fee awards
  • Award of court costs
  • Pre-judicial interest
  • Full judicial review! (A party can only prevail if the judge determines that the plan administrator abused discretion).

• If parties find themselves in federal court, the following types state law claims are NOT preempted by ERISA:
  • Worker’s comp
  • Claims related to benefits that are not part of the ERISA-covered plan
  • Claims, even if under a plan, if the plan is sponsored by a Church or is sponsored by a non-federal governmentally entity
Conclusion (pt. 2)

- Subject to the savings clause, state laws that “relate to” ERISA plans are preempted by ERISA.
- “Relate to” means having a reference to or connection with an ERISA plan.
- A state law of general applicability that has indirect effects on ERISA plans, does not “relate to” an ERISA plan.
- The status of a law that is otherwise “saved” from preemption that regulates insurance is not changed even if the law has the effect of indirectly regulating the substance of ERISA plans that purchase fully-insured products.
- While states can regulate the business of insurance and the terms of insurance contracts, they cannot apply such laws directly to ERISA plans.
- A state’s law is saved from preemption to the extent that it regulates insurance even if the law’s application to non-insurers is preempted.
- Persons drafting state laws or regulations should never include the acronym “ERISA” or any similar, clearly identifiable references to ERISA.
- The Court will probably change its mind again within ___ years?...