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He Who Laughs Last: Will Missouri's Attempt to Crack Down on Managed Care Entities Survive ERISA Preemption?

I. INTRODUCTION

In June 1997, Missouri enacted sweeping legislation which subjects managed care entities to extensive regulation and liability. As with all health care reform efforts at the state level, preemption by the Employee Retirement Income and Security Act of 1974¹ (ERISA) is a serious concern. This Law Summary analyzes prior caselaw regarding ERISA preemption of state initiatives, details the Missouri regulatory scheme and describes the issues that will arise when the courts determine ERISA preemption of the Missouri plan.

II. LEGAL BACKGROUND

A. ERISA Preemption of State Law Regarding HMOs

ERISA is the primary federal law governing employee benefits. The statute does not require that employers provide certain minimal benefits, but rather focuses on the administration of such benefit plans.² ERISA preemption of state law causes of action is broad in scope.³ Preemption occurs when a state law "relate[s] to" an employee benefit plan.⁴ A "savings clause" prevents ERISA from preempting a state law regulating insurance.⁵ The "deemer clause" prevents states from labeling an employee benefit plan as an insurance plan to avoid preemption.⁶

ERISA preemption is important in the health care context because recoveries under the federal statute are limited to the amount of the benefit the HMO should have provided.⁷ In other words, neither extra-contractual

1. 29 U.S.C. §§ 1001-1461 (1994).

2. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 651 (1995).

3. *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 64 (D. Conn. 1990).

4. 29 U.S.C. § 1144(a) (1994).

5. 29 U.S.C. § 1144(b)(2)(A) (1994). A state law regulates insurance when: (1) it has the effect of transferring or spreading the policyholder's risk; (2) it is an integral part of the policy relationship between the insured and the insurer; (3) it is limited to entities within the insurance industry. *United of Omaha v. Business Men's Assurance Co. of Am.*, 104 F.3d 1034 (8th Cir. 1997). *United of Omaha* is interesting because, after finding that the statute in question related to employee benefit plans but was saved by the insurance savings clause, the court went on to examine whether the statute conflicted with ERISA. *Id.* at 1041.

6. 29 U.S.C. § 1144(b)(2)(A) (1994).

7. L. Frank Coan, Jr., *You Can't Get There From Here—Questioning the Erosion*

compensatory nor punitive damages are recoverable under the statute. Furthermore, jury trials are disallowed under ERISA.⁸ Preemption virtually disallows the traditional medical malpractice action.

ERISA preemption ensures that benefit plans and their employer-sponsors are subject to a uniform body of benefits law.⁹ Uniformity minimizes both the administrative and financial burden of compliance with conflicting state directives.¹⁰ "Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries."¹¹ Statutes or common law causes of action that subject employee benefit plans to inconsistent regulatory schemes are "consistently held pre-empted" because they increase inefficiency and may cause employers to respond by reducing the level of benefits.¹²

Regarding the vicarious and direct liability of HMOs, courts have varied in their treatment of ERISA preemption.¹³ Some jurisdictions have taken the position that ERISA preempts both types of claims.¹⁴ One court argued that to hold otherwise (direct claims preempted; vicarious claims not preempted) would result in HMOs facing less liability as their role in the treatment of patients increased.¹⁵ Because direct claims will be preempted, and direct claims involve the actions of the managed care organization more than vicarious claims, ERISA preemption should correlate with the extent of its involvement in providing treatment. Additionally, it has been argued that to allow vicarious claims to proceed in state courts would result in HMOs being forced to purchase malpractice insurance.¹⁶ The cost of this insurance, it has been argued, would result in "higher costs that certainly trickle down to plan beneficiaries."¹⁷

Other jurisdictions have taken the approach that only claims of direct negligence by the HMO will result in preemption.¹⁸ In *Corcoran v. United Healthcare, Inc.*, the Fifth Circuit made the distinction between a medical

of ERISA Preemption in Medical Malpractice Actions Against HMOs, 30 GA. L. REV. 1023, 1036 (1996).

8. *Id.*

9. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

10. *Id.*

11. *Id.*

12. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir. 1992).

13. Claims arising solely from the negligence of a provider (doctor, nurse, etc.) are considered "vicarious," while claims arising from some action or inaction of the managed care organization (MCO) are termed "direct" for purposes of this Law Summary.

14. *Butler v. Wu*, 853 F. Supp. 125 (D.N.J. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316, 317 (D.N.J. 1993); *Altieri v. Cigna Dental Health*, 753 F. Supp. 61, 62 (D. Conn. 1990).

15. *Ricci*, 840 F. Supp. at 318.

16. *Id.*

17. *Id.*

18. *Pacificare v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

decision and a benefit decision.¹⁹ *Corcoran* involved a suit against a utilization review provider.²⁰ If utilization review were deemed a medical decision, state law would more likely govern, while a benefit decision would more likely be preempted by ERISA.²¹ The court held that utilization review was a “medical decision incident to a benefit determination,” and the cause of action must be preempted.²²

The *Corcoran* court noted that Congress’ goal in passing ERISA was uniformity of benefit law among the states.²³ While holding utilization review entities directly liable might “deter[] poor quality medical decisions, there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states.”²⁴ In the Fifth Circuit’s view, preemption also was justified by the fact that the goal of utilization review was cost containment.²⁵ Cost containment relates to the objective of uniformity among plans offered in the various states.

The Eighth Circuit also has addressed the issue of direct HMO liability. In *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, the court was faced with a plan beneficiary who was denied treatment by the plan administrator.²⁶ The plaintiff tried to characterize the actions of the administrator as giving medical opinions regarding the necessity of the treatment.²⁷ The court rejected this argument, stating that the defendant was accused of merely improperly processing the plaintiff’s claim.²⁸ Because ERISA contains its own provisions for the recovery of benefits due under a plan, the claim was preempted.²⁹

Courts have varied in their treatment of ERISA preemption of state laws that affect the “structure” of a benefit plan. The United States Supreme Court addressed this issue in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*³⁰ In *Travelers*, New York placed a surcharge on hospital rates for patients with commercial insurance, while patients with Blue Cross and Blue Shield plans which offer open enrollment³¹ were not subject

19. *Corcoran*, 965 F.2d at 1329.

20. *Id.* at 1323. Utilization review is an external evaluation based on clinical criteria conducted by third-party payors or health care organizers to evaluate the appropriateness of medical care in a given situation. *Id.* (citing John D. Blum, *An Analysis of Legal Liability in Health Care Utilization Review & Case Management*, 26 HOUS. L. REV 191, 192-93 (1989)).

21. *Corcoran*, 965 F.2d at 1329.

22. *Id.* at 1331.

23. *Id.* at 1333.

24. *Id.*

25. *Id.* at n.16.

26. 999 F.2d 298, 300 (8th Cir. 1993).

27. *Id.* at 302.

28. *Id.*

29. *Id.* at 303.

30. 514 U.S. 645 (1995).

31. Open enrollment provides coverage for all who seek it. The Blue Cross-Blue

to the surcharge.³² The Second Circuit Court of Appeals held that ERISA preempted the surcharge because the surcharge interfered with the choices that ERISA plans make in choosing health coverage.³³

The Supreme Court began its analysis by determining whether the surcharge related to employee benefit plans.³⁴ Agreeing that the surcharge had an indirect economic effect on choices made by ERISA plans, the Court then addressed whether the economic effect of the surcharges should result in preemption.³⁵ The Court found that ERISA did not indicate congressional intent to displace state health care regulation, which had been a matter of local concern historically.³⁶ Furthermore, the Court stated that “cost-uniformity was almost certainly not an object of pre-emption.”³⁷

In *Metropolitan Life Insurance Co. v. Massachusetts*, the Court had held that a state law requiring all insurers to carry mental health benefits related to ERISA plans.³⁸ In *Travelers*, the Court distinguished *Metropolitan Life* because the surcharges involved in the former case did not impose the substantive coverage requirements that the Massachusetts statute did.³⁹ Because the surcharges did not require the ERISA plans to insure “against an entire category of illnesses they might otherwise choose to leave without coverage,” and because cost-uniformity was not a goal of ERISA preemption, the surcharges did not relate to employee benefit plans.⁴⁰

The Fifth Circuit Court of Appeals addressed the “structure” preemption issue in *CIGNA Healthplan of Louisiana, Inc. v. Ieyoub*.⁴¹ In this post-*Travelers* decision, Louisiana had passed an “any willing provider” statute.⁴² The statute provided that preferred provider organizations (PPOs)—arrangements between insurance purchasers and health care providers whereby the purchasers use a select group of providers in return for discounted services—must accept any

Shield plans bear the costs of many patients the commercial insurers would reject. *Id.* at 658.

32. *Id.*

33. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 14 F.3d 708, 719 (2d Cir. 1994), *rev'd*, 514 U.S. 645 (1995).

34. *Travelers*, 514 U.S. at 655.

35. *Id.* at 660.

36. *Id.* at 661.

37. *Id.* at 662.

38. 471 U.S. 724 (1985). ERISA preemption was nonetheless avoided in *Metropolitan Life* due to the insurance savings clause. *Id.* at 740.

39. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 664 (1995).

40. *Id.*

41. 82 F.3d 642 (5th Cir. 1996).

42. *Id.* at 645.

health care provider who agrees to abide by the terms of the PPO arrangement.⁴³ Louisiana provided for the formation of PPOs by statute.⁴⁴

The Fifth Circuit observed that “ERISA preempts ‘state laws that mandat[e] employee benefit structures or their administration.’”⁴⁵ The court held that the “any willing provider” statute related to ERISA plans because the Louisiana statute authorizing the formation of PPOs included ERISA plans as potential purchasers of the PPO service.⁴⁶ In other words, Louisiana prevents ERISA plans from purchasing PPOs that do not include any willing provider.⁴⁷ “By denying insurers, employers, and HMOs the right to structure their benefits in a particular manner, the statute is effectively requiring ERISA plans to purchase benefits of a particular structure when they contract with Connecticut General Life Insurance Company (CIGNA).”⁴⁸ The Louisiana scheme did not benefit from the insurance savings clause because it provided that self-funded groups, in addition to insurers, were subject to the PPO and any willing provider provisions.⁴⁹

B. Missouri Managed Care Liability

Missouri courts have had few opportunities to address the issue of managed care liability. In *Harrell v. Total Health Care, Inc.*,⁵⁰ the plaintiff alleged that the defendant HMO was negligent in failing to investigate the credentials or reputation of one of its participating physicians.⁵¹ The cause of action was labeled as one of corporate negligence resting on the HMO’s non-delegable duty to carefully select physicians.⁵² Because the physician in question was the object of numerous claims of medical malpractice, and Total Health Care made no investigation of the physician’s competence, the Missouri Court of Appeals for the Western District held that the plaintiff had a valid cause of action for corporate negligence.⁵³ The court observed that the common law duty to investigate the physicians resulted from the unreasonable risk of harm that could

43. *Id.*

44. *Id.* See LA. REV. STAT. ANN. § 40.2201 (West 1992 & Supp. 1996).

45. *Ieyoub*, 82 F.3d at 647 (quoting *Travelers*, 514 U.S. at 658).

46. *Id.* at 648.

47. *Id.*

48. *Id.*

49. *Id.* at 649.

50. *Harrell v. Total Health Care, Inc.*, No. WD 39809, 1989 WL 153066 (Mo. Ct. App. Apr. 25, 1989)

51. *Id.* at *3.

52. *Id.*

53. *Id.* at *6. The action for corporate negligence seems to be one of direct negligence. Although the complaint is with the quality of care delivered by the physician, the corporate negligence lies in the HMO’s choice of participating physicians. See *supra* note 13.

result to patients if their physician choices were limited and the physicians were unqualified or incompetent.⁵⁴

The HMO nonetheless avoided liability because Missouri had given not-for-profit "health services corporations" immunity from negligence actions and the HMO qualified as a health service corporation.⁵⁵ Affirming, the Missouri Supreme Court held that this grant of immunity did not violate the "open courts" provision of the Missouri Constitution.⁵⁶ Subsequently, as part of a broader tort immunity for not-for-profit entities, Missouri passed legislation stating that HMOs were not practicing medicine for the purposes of tort actions against health care providers.⁵⁷

Other jurisdictions have held HMOs liable for the negligence of their physicians on the basis of agency principals⁵⁸ and the doctrine of *respondet superior*.⁵⁹ Missouri, however, has never held an HMO vicariously liable for the negligence of its participating providers.

III. RECENT DEVELOPMENTS

In June 1997, Missouri Governor Mel Carnahan signed House Bill 335 into law. This legislation provides for extensive regulation of HMOs and utilization review providers.⁶⁰ This Section discusses the changes in Missouri's regulatory scheme resulting from the recent legislation.

With House Bill 335, the General Assembly repealed prior legislation providing HMOs immunity for tort actions based on improper care,⁶¹ and added HMOs to the definition of "health care provider" for tort actions against providers.⁶² The statute does not distinguish actions for direct negligence from vicarious actions based on the negligence of a physician or other provider. The same statutory section defines "health care services" as those services a provider renders to a patient in the ordinary course of the provider's profession or, if the provider is institutional, "in the ordinary course of furthering the purposes for

54. *Id.* at *5.

55. *Id.* at *8.

56. *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58, 62 (Mo. 1989). MO. CONST. art. I, § 14.

57. MO. REV. STAT. § 354.505(3) (Supp. 1997).

58. *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

59. *Lighterman v. Porter*, 548 So. 2d 891 (Fla. Dist. Ct. App. 1989).

60. MO. REV. STAT. §§ 354.400-354.636 (Supp. 1997); MO. REV. STAT. §§ 376.510-376.1399 (Supp. 1997).

61. MO. REV. STAT. § 354.505(3) (Supp. 1997)

62. MO. REV. STAT. § 538.205(4) (Supp. 1997).

which the institution is organized.”⁶³ This latter definition may signify legislative intent to authorize direct actions only.

The legislation also governs the quantity and quality of care an HMO provides its enrollees in several ways. First, HMOs are prohibited from restricting the information that providers disclose to their patients regarding the availability of alternative treatments, the decision of a plan to authorize or deny services, or the utilization review process of the plan.⁶⁴ Any such “gag clauses” in a contract between the HMO and the provider will be void.⁶⁵ Additionally, HMOs may not prohibit a provider from advocating on behalf of enrollees within the utilization review process.⁶⁶

The legislation also contains several provisions regarding access to care. An HMO’s application for a certificate of authority from the Department of Insurance must demonstrate that the HMO “has provided its enrollees with adequate access to health care providers.”⁶⁷

The statute defines the term “emergency medical condition” as a sudden, unexpected health condition with symptoms “that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required.”⁶⁸ The prudent layperson standard prevents a managed care administrator from denying coverage based on the findings of the visit, so long as a prudent layperson would believe that medical care is required. The statute requires coverage for pregnant women having contractions who believe there is inadequate time to effect transfer to another facility before delivery.⁶⁹

The legislation also requires that HMOs, as well as insurance companies, offer coverage for treatment of recognized mental illnesses, including at least two visits each year for the purpose of diagnosis or assessment, which cannot be subject to pre-approval.⁷⁰ This requirement applies to self-funded plans only to the extent that such regulation is not preempted by federal law.⁷¹

63. MO. REV. STAT. § 538.205(5) (Supp. 1997). Additionally, HMOs are subject to regulation as utilization review agents pursuant to MO. REV. STAT. §§ 376.1350-376.1390 (Supp. 1997).

64. MO. REV. STAT. § 354.441 (Supp. 1997).

65. MO. REV. STAT. § 354.441 (Supp. 1997).

66. MO. REV. STAT. § 354.606(10) (Supp. 1997).

67. MO. REV. STAT. § 354.405.3(13) (Supp. 1997). If access becomes inadequate after the certificate of authority has been granted, the Department of Insurance may place conditions or restrictions on the certificate of authority. MO. REV. STAT. § 354.470(1) (Supp. 1997).

68. MO. REV. STAT. § 354.400(5) (Supp. 1997).

69. MO. REV. STAT. § 354.400(5)(e)(a) (Supp. 1997).

70. MO. REV. STAT. § 376.811.4 (Supp. 1997). The coverage must be subject to the same coinsurance, copayment or deductible payments as visits for physical illnesses.

71. MO. REV. STAT. § 376.810(5) (Supp. 1997).

Health carriers must now offer an open referral plan in addition to any gatekeeper plan they offer group contract holders.⁷² When the employer holder has fifty employees or less, the employer decides which plan will be used.⁷³ For employers with more than fifty employees, the employees decide whether they will enroll in an open referral or gatekeeper plan.⁷⁴

The managed care statute also requires carriers to implement provider selection standards for primary care physicians as well as specialists.⁷⁵ These standards may not work to exclude providers who practice in geographic areas with a high-risk or high-utilization population.⁷⁶ Nor can the standards operate to exclude providers who specialize in treating high-risk or high-utilization populations.

The statute also states that a "carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to an enrollee."⁷⁷ While the wording of the statute could be construed to forbid capitation agreements,⁷⁸ another provision of the legislation requiring disclosure of certain financial arrangements between HMOs and providers states that capitation arrangements need not be disclosed.⁷⁹ It therefore seems unlikely that the quoted language will be interpreted to forbid capitation agreements.

HMOs cannot "discriminate between health care professionals when selecting such professionals for enrollment in the network or when referring enrollees for health care services to be provided by such health care professional who is acting within the scope of his professional license."⁸⁰ More specifically, except for good cause, an HMO is forbidden from discriminating between optometrists and ophthalmologists in enrollment or referral, so long as the provider is practicing within the scope of the provider's license.⁸¹

72. MO. REV. STAT. § 354.618 (Supp. 1997). A gatekeeper plan is defined as one in which the enrollee must obtain a referral from a primary care provider to receive care from a specialist. Open referral plans do not require such a referral.

73. MO. REV. STAT. § 354.618.1(1) (Supp. 1997).

74. MO. REV. STAT. § 354.618.1(1) (Supp. 1997).

75. MO. REV. STAT. § 354.606.6 (Supp. 1997).

76. MO. REV. STAT. § 354.606.6(a) (Supp. 1997).

77. MO. REV. STAT. § 354.606.9 (Supp. 1997).

78. A capitation agreement requires a provider to be responsible for the care of a set number of enrollees. The provider receives a certain amount of compensation regardless of how much the allotted enrollees utilize the provider's services.

79. MO. REV. STAT. § 354.443 (Supp. 1997).

80. MO. REV. STAT. § 354.606.17 (Supp. 1997).

81. MO. REV. STAT. § 354.618.5 (Supp. 1997). The legislation also provides that the HMO must disclose descriptions of coverage, grievance procedures and utilization review procedures to enrollees upon request. MO. REV. STAT. § 354.442 (Supp. 1997).

IV. DISCUSSION

The Missouri legislation's addition of HMOs to the definition of health care provider will not achieve the desired result. While the statute authorizes suits against HMOs, it does not distinguish between direct and vicarious claims. Direct claims will almost certainly be preempted because even jurisdictions that distinguish between direct and vicarious claims hold direct claims preempted. *Corcoran v. United Healthcare, Inc.*,⁸² if followed, would hold direct claims preempted on the grounds that Missouri's approval of such suits would subject an ERISA plan provider to differing regulation in Missouri than in other states. Other jurisdictions which would object to subjecting HMOs to state vicarious liability, would not hesitate to go one step further and protect the HMO from state direct liability. Nonetheless, inasmuch as the Missouri law could be construed to authorize claims for vicarious liability, a court may choose to follow decisions like *Corcoran* and allow the vicarious claim to proceed in state court.

To the extent that other aspects of the legislation may set the standard of care to which HMOs are subjected, the legislative goal may again be frustrated. Assume an enrollee files suit against an HMO for its use of gag clauses in provider contracts or on the basis of the HMO having an inadequate provider network. The court may well characterize this direct action as one for benefits due under an ERISA plan, and hold the claim preempted.⁸³

Although not as likely as preemption of direct claims against HMOs, the alterations to the structure of HMO delivery plans also may be preempted.⁸⁴ These structural alterations include the prohibition of gatekeeper plans as the exclusive delivery option,⁸⁵ the prohibition of discrimination between health care providers for enrollment and referral,⁸⁶ and the implementation of provider selection criteria.⁸⁷

Whether structural alterations to HMOs' delivery plans will result in preemption may turn on the treatment of the Supreme Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*⁸⁸ Although the New York statute at issue was held not to be preempted, *Travelers* has not led to a curtailment of ERISA preemption as many had expected.⁸⁹ After reviewing some of its past ERISA decisions, the Court stated

82. 965 F.2d 1321 (5th Cir. 1992).

83. See *supra* note 29 and accompanying text.

84. This would not require a direct suit against an HMO. For instance, the State of Missouri may bring a civil enforcement action against the HMO and the HMO may raise the defense of ERISA preemption.

85. MO. REV. STAT. § 354.618 (Supp. 1997).

86. MO. REV. STAT. § 354.606.17 (Supp. 1997).

87. MO. REV. STAT. § 354.606.6 (Supp. 1997).

88. 514 U.S. 645 (1995).

89. See Paul J. Ondrasik, Jr., *The Travelers Decision—One Year Later—'Much Ado About Nothing'?*, 5 NO. 4 ERISA LITIG. REP. 4 (1996) ("Concern among plans and

that “[i]n each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration.”⁹⁰ This broad language easily could be read to call for preemption of the Missouri scheme.

Travelers also touched on the issue of structure preemption when the Court distinguished the surcharges from substantive coverage requirements. “[T]here might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate.”⁹¹ The Missouri open-referral scheme could be deemed to bind ERISA plans to a particular choice—that of an open-referral delivery scheme whenever a gatekeeper plan is offered—and therefore be more likely to be preempted.

Because the Missouri statute requires that all health plans offered to employers contain an open-referral delivery system, it could be considered to mandate the benefit structure. *CIGNA Healthplan of Louisiana v. Ieyoub*⁹² would support preemption of the open-referral provision because, like Louisiana’s “any willing provider” statute, it requires ERISA plans to purchase benefits of a particular structure. Specifically, “any willing provider” legislation most resembles the open-referral and “non-discrimination between providers” aspects of the Missouri plan. All three affect the relationship between the enrollee and their physician. The first governs who can be the enrollees’ physician and the latter two dictate the situations in which enrollees can see a specialist physician.

The efficacy of Missouri’s scheme may, in the end, depend on whether a court finds that it regulates the business of insurance.⁹³ Some aspects of the statute may be found to spread the policyholder’s risk. The inclusion of mandated mental health benefits almost certainly will be found to spread the enrollee’s risk of costs associated with mental health illnesses. The consequence of other provisions, like the abolition of gag clauses and the open referral plan, are less clear.

Whether the statute regulates an integral part of the policy relationship between the insurer and insured will vary from provision to provision. Again,

plan sponsors that the decision would allow states greater freedom to regulate such programs, and thereby limit plan choices in this area. To date, these fears have not been borne out.”).

90. *Travelers*, 514 U.S. at 658.

91. *See id.* at 659-60.

92. 82 F.3d 642 (5th Cir.), *cert. denied*, *Louisiana v. Cigna Healthplan of La., Inc.*, 117 S. Ct. 387 (1996).

93. It is important to understand the order of the normal ERISA preemption analysis. First, the state action must relate to an employee benefit plan. Then the issue is whether the law regulates the business of insurance. Finally, a state cannot deem an employee benefit plan to be an insurance plan to avoid preemption. The analysis in this section therefore comes only after the law has been found to relate to an employee benefit plan. *See supra* notes 4-6; Karen A. Jordan, *ERISA Pre-Emption: Integrating Fabe into the Savings Clause Analysis*, 27 RUTGERS L.J. 273 (1996).

gag clauses regulate the relationship between the insured and the provider and between the insurer and the provider, but may not regulate an integral part of the policy relationship between the insurer and insured. The new definition of “emergency medical condition” however will be found to regulate an integral part of this relationship.

To determine whether the statute is limited to entities within the insurance industry may depend on statutory construction. Only the requirement that mental health coverage be offered provides a disclaimer that the statute applies to self-funded plans only to the extent not preempted by federal law.⁹⁴ If the statute received the benefit of the savings clause but applied to both self-funded and traditionally-insured ERISA health plans, a court could read an exception similar to the one for mental health benefits into the statute. To this extent, the Missouri legislation may not achieve its intended goal because some ERISA health plans are self-funded and beyond the reach of the savings clause.⁹⁵

V. CONCLUSION

If allowed, the Missouri plan will drastically alter the practices of managed care entities in the state. ERISA preemption will most likely turn on the application of the insurance savings clause exception to preemption. The issue of ERISA preemption is important to all states that consider health care reform, regardless of the method by which they attempt such reform. Any attempt to alter the structure of ERISA health benefit plans that is not done with precision and with an eye toward ERISA’s broad preemptive provisions may be abortive. The Missouri scheme is susceptible to preemption because it subjects HMOs to liability and proscribes health benefit plans of a certain structure.

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94. See *supra* note 71 and accompanying text.

95. See *CIGNA Healthplan of La. v. Ieyoub*, 82 F.3d 642 (5th Cir. 1996).

