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CIGNA HEALTHPLAN OF LOUISIANA, INC. V. LOUISIANA:
UNWILLING TO SAVE LOUISIANA'S ANY WILLING
PROVIDER STATUTE FROM
ERISA PREEMPTION

I. INTRODUCTION

The health care crisis in the United States continues in the wake of the failure of President Clinton's much-trumpeted Health Security Act.¹ The statistics are staggering. From 1988 to 1992, the increases in expenditures for health care were in the "double-digit[s] and near-double-digit[s]."² In 1994, the latest year for which data has been calculated,

1. H.R. 3600, S. 1757, 103d Cong., 1st Sess. (1993). On November 20, 1993, President Clinton introduced the Health Security Act. He had one hundred cosponsors of the bill in the House of Representatives and thirty in the Senate. See Gary A. Francesconi, Note, *ERISA Preemption of "Any Willing Provider" Laws—an Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227, 228 n.5 (1995) (describing introduction of Health Security Act into Congress) (citing Steven Findlay, *Jockeying for Position*, BUS. & HEALTH, Jan. 1994, at 18). At the end of the term of the 103rd Congress, however, President Clinton and other Democratic leaders announced that the health care bills could not withstand Republican opposition. See *id.* (stating that demise of health care bill was result of Democrats' failure to get votes necessary to stop promised Republican-led Senate filibuster on any health care bill proposed by Democrats and citing Dana Priest, *Democrats Pull the Plug on Health Care Reform*, WASH. POST, Sept. 27, 1994, at A1). As a result, Congress never voted on the health care bill. See *id.* (describing failure of Congress to even vote on health care bill as "anticlimactic finale to 21 months of national debate" over health care reform and citing Dana Priest & Michael Weisskopf, *Health Care Reform: The Collapse of a Quest; Clinton's Top Domestic Priority Succumbed to Miscalculation, Aggressive Opposition and Partisanship*, WASH. POST, Oct. 11, 1994, at A6). For an overview of the Clinton Health Care Plan as proposed during the 1992 presidential campaign, see Bill Clinton, *The Clinton Health Care Plan*, 327 NEW ENG. J. MED. 804, 804 (1992) (identifying problems with present system and proposing plan for reform); see also Robert Pear, *Clinton's Health Plan: The Overview; Congress is Given Clinton Proposal for Health Care*, N.Y. TIMES, Oct. 28, 1993, at A1 (detailing certain aspects of Clinton health care plan).

2. Spencer Rich, *Rise in Health Care Spending Slows; Lowest Growth Rate in Three Decades Tied to HMOs, Low Inflation*, WASH. POST, May 28, 1996, at A9. After years of dramatic increases, national health care spending rose only 6.4% in 1994. See *id.* The Medicare Office of National Health Statistics reported that this was the slowest growth rate recorded in more than thirty years. See *id.* This slow growth rate was attributable to employers switching coverage for their employees from conventional "fee-for-service" plans to less expensive health maintenance organizations (HMOs) and other managed-care plans. See *id.* (noting that low rate of inflation also contributed to slower increase in spending).

Some commentators and politicians believe that these statistics support the argument that increasing competition in the health industry is cutting down on waste and limiting cost growth. See *id.* (citing to arguments from health analysts and GOP members of Congress that competition in health care industry pushes costs down). Representative Nancy L. Johnson (R-Conn.) stated that these figures demonstrate that, in the private sector, "managed care and competition are lower-

(1255)

health expenditures totaled \$949.4 billion, or 13.7% of the gross domestic product.³ Although some commentators suggest that health care spending has leveled off, the Department of Labor announced in February 1996 that the cost of medical care rose by 3.9% in 1995, a rate well above the general rate of inflation.⁴ In addition, the American Hospital Association recently announced that, by 2002, seven million more Americans will not have health insurance, bringing the total number of uninsured to forty-six million.⁵

These statistics demonstrate the acute need for health care reform.⁶ Despite the lack of comprehensive national health care reform, many

ing the rate of cost increases in health care.” *Id.* (quoting Representative Johnson).

3. *See id.* (stating that expenditures are \$3510 for each person in United States and noting that health care spending in United States accounts for greater proportion of gross domestic product than in any other developed nation).

4. *See* Stephen E. Winn, *The Health Care Crisis, Continued*, KAN. CITY STAR, Feb. 4, 1996, at J2 (reporting cost of medical care rose at rate higher than inflation). Although the increase in health care spending in 1995 was the smallest in decades, the health care statistics are still cause for concern. *See id.* (explaining that decreases in health care spending do not necessarily warrant optimism). For example, there are some troubling considerations: the statistics do not fully account for reductions in medical coverage by businesses and health insurance companies; some of the savings from managed care are the result of cost shifting when medical providers raise prices on other patients to compensate for the discounts demanded by managed-care systems; and some employers are considering reducing or eliminating coverage for future retirees. *See id.* (explaining factors for which lower health care spending statistics do not account).

5. *See* Robert A. Rosenblatt, *Number of Americans Lacking Health Insurance On Rise; Benefits: Now 15.1% Are Without Medical Coverage and the Figure Is Expected to Climb to 16.2% by 2002, Study Finds. Shifts In Economy Are Blamed*, L.A. TIMES, Sept. 11, 1996, at A21 (reporting statistics from American Hospital Association report and stating that percentage of those without health insurance, 15.1% in 1996, will climb to 16.2% over next six years).

According to the study, the proportion of U.S. employees and their family members covered by health insurance peaked at 77% in 1990. *See id.* Since 1990, that figure has steadily decreased to 73.9% in 1995. *See id.* According to the study's predictions, the coverage rate will fall to 70.4% by 2002. *See id.*

The rising number of uninsured Americans is partly attributable to shifts in the economy. *See id.* (stating that changes in manufacturing and service industries have impacted number of uninsured Americans). The economy is growing rapidly in the service sector, where companies are less likely to offer health insurance. *See id.* Conversely, the economy is shrinking in the manufacturing sector, reducing the number of union-dominated industries that have traditionally provided health insurance coverage. *See id.*

In addition, many companies are increasingly using outside contractors for many jobs. *See id.* Often, these contractors do not provide health care coverage for their employees. *See id.* The American Hospital Association report also stated that some employers are reducing or eliminating coverage for employees who retire early. *See id.*

6. *See* MAKING HEALTH REFORM WORK: THE VIEW FROM THE STATES 1 (John J. DiIulio, Jr. & Richard R. Nathan eds., 1994) [hereinafter MAKING HEALTH REFORM WORK] (stating that two fundamental truths have emerged about health care finance in United States: “First, the system is in bad shape. Some citizens have no health insurance at all, while others with insurance have a difficult time negotiat-

states have increased their initiatives in this area.⁷ One of the hurdles that states face, however, is the Employee Retirement Income Security Act of 1974 (ERISA).⁸ ERISA's broad preemption provision thwarts many

ing the system. Second, costs are spiraling and rules are choking the management of health care finance. Reform is needed."); *see also* 142 CONG. REC. S371 (1996) (statement of Sen. Kassebaum) ("The health insurance problem is not merely one of perception. The number of uninsured and underinsured Americans continues to climb."); Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 258 (1990) (stating that health care system in United States is "plagued with serious distributional inequalities that prevent some from securing access to health care" and that "[d]espite widespread public dissatisfaction with the current system, politicians have rejected a radical restructuring of it").

7. *See* MAKING HEALTH REFORM WORK, *supra* note 6, at 17 ("Every state is wrestling, with varying speed and success, to initiate reforms to meet state needs."); HENRY H. PERRITT, JR., HEALTH CARE LEGISLATION UPDATE AND ANALYSIS §§ 5.18-5.28 (1995) (analyzing reform plans of California, Florida, Hawaii, Maine, Massachusetts, Minnesota, Oregon, Pennsylvania, Tennessee and Washington); *see also* Margaret M. Keefe, *Three States Focus on Reform at Home*, 48 EMPLOYEE BENEFIT PLAN REV. 38 (1993) (summarizing state health care reform proposals in Colorado, Minnesota and Vermont); Walter E. Schuler, Note, *The ERISA Pre-emption Narrows: Analysis of New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company and Its Impact on State Regulation of Health Care*, 40 ST. LOUIS U. L.J. 783, 785 (1996) (stating that state legislatures of every state except Nevada and Wyoming considered proposals to change health care financing and delivery in their respective states).

Many reform advocates believe that the problems facing the health care system cannot wait for federal action. *See* Catherine L. Fisk, *The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 35 (1996) (stating that future of health care reform, if it has any, lies with states); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121, 121 (1993) (finding that because "the problems facing the health care system cannot wait for federal action[,] states are addressing these problems). Rather, these reformers assert that the states are better suited to the task. *See id.* at 122. The states have been described as "laborator[ies]" for "social and economic experiment," closer to the people and, therefore, more likely to be effective in handling many social problems. *Id.* (quoting *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

8. *See* Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1994)) (regulating pension plans and providing protections to plan participants). President Gerald Ford signed ERISA into law on Labor Day of 1974. *See* David L. Gregory, *A Symposium Conference Upon the Twentieth Anniversary of ERISA: Introductory Remarks*, 68 ST. JOHN'S L. REV. 317, 317 (1994). The final version of ERISA was the culmination of various pension retirement security initiatives begun by the Eisenhower administration and continued through the Kennedy, Johnson and Nixon administrations. *See id.* at 317-18 (explaining pre-ERISA development in pension retirement security).

For a detailed treatment of ERISA, *see* BARBARA J. COLEMAN, PRIMER ON EMPLOYEE RETIREMENT INCOME SECURITY ACT (3d ed. 1989) (summarizing major provisions of ERISA); RONALD J. COOKE, ERISA PRACTICE AND PROCEDURE (1995) (discussing coverage and scope of ERISA, procedural and participation requirements and many other aspects of statute); ERISA: A COMPREHENSIVE GUIDE (Martin Wald & David E. Kenty eds., 1991) (analyzing statutory provisions and their practical application); JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION & BENEFIT LAW (2d ed. 1995) (discussing origins and enforcement of ERISA law).

state health care reform efforts by effectively preventing states from exercising their police powers and generally interfering with their ability to establish comprehensive health care policies.⁹ The far-reaching effects of

9. See 120 CONG. REC. 29197 (1974) (statement of Rep. Dent) (discussing intended scope of ERISA preemption). Representative Dent emphasized the significance of the preemption clause:

I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

Id.

As Representative Dent observed, Congress included in ERISA broad preemption provisions that were originally intended to eliminate a patchwork of state regulation in favor of a uniform body of federal law governing pension plans. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) (“The basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (holding that preemption clause “establishes as an area of exclusive federal concern the subject of every state law that ‘relate[s] to’ an employee benefit plan governed by ERISA”); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 9-11 (1987) (finding that Congress intended ERISA preemption to assure uniform regulation of benefit plans, which would minimize inefficiencies when plans administer benefits in more than one state); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (“The pre-emption provision was intended to displace all state laws that fall within its sphere, even including state laws that are consistent with ERISA’s substantive requirements.”); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981) (finding that Congress “meant to establish pension plan regulation as exclusively a federal concern”); Daniel A. Engel, *ERISA: Where’s the Preemption Now?*, 27 TORT & INS. L.J. 523, 524 (1992) (stating that primary purpose of ERISA is uniformity in employee benefit plan laws through comprehensive preemption provisions that oust all state laws relating to such plans).

These preemption provisions, however, have had a disastrous effect on state health care reform legislation. See *Parmet*, *supra* note 7, at 132-33 (“Medicare and Medicaid present practical and financial impediments to state health care reforms, but ERISA forms the major legal barrier. . . . The impact of ERISA preemption on state health policy became apparent in the late 1970s as state laws mandating benefits in health insurance policies were challenged.”); see also *Bobinski*, *supra* note 6, at 274 (“In the context of state level efforts to improve access to health care, . . . ERISA’s preemption doctrine can be . . . accurately termed a disaster.”); Vicki Gotlich, *ERISA Preemption: A Stumbling Block to State Health Care Reform*, 26 CLEARINGHOUSE REV. 1469, 1469 (1993) (noting that ERISA preemption bars many state reform efforts); James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for “Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 439 (1994) (finding that although ERISA exempts some areas from preemption, these exemptions “do not give states the flexibility to broadly formulate health care policy”); Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383, 383 (1995) (stating that ERISA has had “disastrous” effect on state health care reform).

In one commentator’s opinion, ERISA’s preemption of state laws to insure uniform regulation of benefit plans at the federal level is justifiable, but preemption of state level solutions to the health care crisis in the absence of federal substantive regulation is “a perverse obstacle to improving access to health care for millions of the uninsured.” *Bobinski*, *supra* note 6, at 274-75. The magnitude of

ERISA preemption led one commentator to remark that ERISA is the “law that ate health care reform.”¹⁰

the obstacles that ERISA creates for state health care reformers was clear from the comments at the National Governors' Association's annual meeting in 1994. See Jesselyn Alicia Brown, Note, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 YALE L. & POL'Y REV. 339, 342 (1995) (noting comments of conference participants). One participant remarked that

[r]ather than encouraging state experimentation with new approaches to health care delivery, [ERISA] is likely to stifle innovation. . . . If Congress does not enact a comprehensive universal federal program, it is only through relief from ERISA that states can regulate insurance markets and delivery systems to achieve equity in coverage and financing.

PATRICIA A. BUTLER, NAT'L GOVERNORS' ASS'N, ROADBLOCK TO REFORM: ERISA IMPLICATIONS FOR STATE HEALTH CARE INITIATIVES 33 (1994).

Another commentator, however, has suggested that ERISA is not a roadblock to state health care reform, but a “scapegoat,” and that in many cases, states do not need explicit legislative relief from ERISA to implement health care reforms. See *id.* at 344 (stating that “ERISA preemption is not as stifling to reform as many state policymakers believe” and that “ERISA does . . . allow states substantial flexibility to enact health reform initiatives”). This is not the prevailing view, though. Rather, most commentators believe that the states are “powerless to act unless Congress grants so-called ‘ERISA waivers.’ That is, in order for states to have authority to reform private health care payment systems, Congress must amend section 514(a) of . . . [ERISA], which broadly preempts state laws that ‘relate to’ employee benefit plans.” Fisk, *supra* note 7, at 35.

10. Nina Martin, *ERISA: The Law That Ate Health Care Reform*, CAL. LAW., May 1993, at 40 (explaining how “a pension reform law from the early ‘70s helped create America’s health care nightmare”). Another commentator noted that the courts’ broad interpretation of ERISA in the last ten years has contributed to the health care problem. See Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 257 (1996) (“[C]ourts have gradually interpreted and applied ERISA in a manner that affects numerous aspects of the health care system. In particular, during the last decade serious obstacles for health care consumers have arisen as a result of broader application of ERISA’s pre-emption provisions.”).

Other commentators have also criticized ERISA and its preemption provisions in particular. See Bobinski, *supra* note 6, at 274-75 (stating that ERISA creates “perverse obstacles” to health care access and preempts many state attempts to regulate employee health plans); Jay Conison, *ERISA and the Language of Preemption*, 72 WASH. U. L.Q. 619, 620 (1994) (“[I]f the language of [the preemption clause] was truly chosen to prevent litigation over the scope and meaning of the clause, Congress badly missed the mark.”); Fisk, *supra* note 7, at 38 (“It is a rich irony that ERISA, which was heralded at its enactment as significant federal protective legislation, has through its preemption provision been the basis for invalidating scores of progressive state laws.”); Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109, 110 (1985) (“[I]t is clear that the inclusion of [ERISA’s preemption provision] was a mistake. Given well-established judicial doctrines of preemption, [this provision] was unnecessary.”); Jordan, *supra*, at 271 (“ERISA’s negative impact on the health care system has become intolerable.”); William J. Kilberg & Paul D. Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 TEX. L. REV. 1313, 1316 (1984) (finding that ERISA preemption clause provides little guidance in determining whether state law “relates to” employee benefit plans); Paul O’Neil, *Protecting ERISA Health Care Claimants: Practical Assessment of a Neglected Issue in Health Care Reform*, 55 OHIO ST. L.J. 723, 723-24 (1994) (observing that although Congress intended to protect participants in employee benefit plans

Because of wide-ranging precedent affirming the strength of ERISA's preemption clause, state lawmakers' freedom to enact new health care legislation is extremely limited.¹¹ Several options exist, however, to facilitate state health care reform.

One option is to repeal or amend the ERISA preemption provisions to allow for more state regulation of health care.¹² Another way some states are trying to overcome ERISA preemption is by obtaining an ERISA

when it enacted ERISA, ERISA is now used as "shield for employers, insurance companies, and plan administrators, rather than to protect participants' rights"); Nicole Weisenborn, *ERISA Preemption and Its Effect on State Health Reform*, 5 KAN. J.L. & PUB. POL'Y 147, 147 (1995) (stating that "ERISA's broad preemption can have extremely detrimental effects" on state regulation of health care).

Not all commentary has criticized ERISA preemption, however. One commentator remarked that ERISA is a model of "viable federalism in the employment law context." David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 430 (1987). According to Gregory, although ERISA preemption of state employee benefit law is "extensive," it "has been neither absolute nor indiscriminate." *Id.* at 429. He added that

[t]hrough both case law construction and subsequent enlightened legislative amendments during the past decade, the scope of ERISA preemption has been periodically recalibrated. These responsible judicial and legislative refinements have preserved ERISA's strong federal primacy in employee pension and welfare benefit law, while simultaneously allowing for dynamic and flexible state initiatives consonant with ERISA's policy of protecting and furthering employee pension and welfare benefit plans. The cumulative result yields a study in Hamiltonian federalism.

Id.

11. See Fisk, *supra* note 7, at 35 (stating that "the future of health care reform, if it has any, . . . lie[s] in the states," but "conventional wisdom is that . . . states are powerless to act unless Congress grants so-called 'ERISA waivers'"); Parmet, *supra* note 7, at 122 (stating that legal barriers to state reform are daunting because values such as federal supremacy and interstate harmony often dominate legal analysis); Hancock, *supra* note 9, at 383 (noting that some states have actually enacted reform measures, but many of these have been blocked by ERISA's preemption doctrine); Schuler, *supra* note 7, at 783-84 (stating that ERISA has stood as "most formidable obstacle to state health care reform efforts with its broad preemption provision"); Weisenborn, *supra* note 10, at 147 ("[M]any state attempts to reform health care have failed as federal district and circuit courts apply broad statutory preemption."). For further discussion of the cases affirming ERISA's broad preemption, see *supra* note 9 and accompanying text.

12. See 29 U.S.C. § 1144(a) (1994) (stating that ERISA "supersede[s] any and all State laws" that relate to employee benefit plans). Narrowing this preemption clause would allow states to enact their own health care measures.

One way to narrow the preemption language would be to adopt the language originally proposed in the House of Representatives in 1973. See Fisk, *supra* note 7, at 52-53 (discussing scope of preemption under House bill). This version would have preempted state laws that "relate to the reporting and disclosure responsibilities and fiduciary responsibilities of persons acting on behalf of ERISA-covered plans." *Id.* (quoting H.R. 2, 93d Cong., 1st Sess. (1973)). The bill also would have preempted state laws that "relate to funding and benefits-vesting provisions of pension plans." *Id.* at 53. If the preemption clause were narrowed in this manner, ERISA would preempt only those laws that directly conflict with ERISA's substantive regulatory provision; therefore, some state health care reform measures would escape preemption. See *id.* at 52-53 (discussing Supreme Court's recognition that early versions of ERISA tied scope of preemption to scope of ERISA regulation).

waiver.¹³ Finally, the judiciary can save health care reform legislation

Another legislative option would be to expand the savings clause to exempt more state legislation from preemption or to repeal or limit the deemer clause. The deemer clause prescribes which entities can qualify for an exemption to preemption under the insurance savings clause. See 29 U.S.C. § 1144(b)(2)(B) (1994) (limiting those entities that can be considered insurers within ERISA). By repealing or limiting the deemer clause, more entities would qualify for the insurance savings clause and would escape preemption.

This would not be an easy task, however, given the usual political gridlock in Congress. See Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 635 (1995) ("Various proposals have arisen in Congress to lessen the preemptive bite of ERISA for state health care reform efforts. The greatest commonality among these proposals is that they have all failed miserably."). Despite the failure of various reform efforts, there appears to be some support for ERISA reform, especially from representatives and senators from states that wish to enact health care reform legislation. See *id.* at 635-48 (discussing reform proposals sponsored by various senators and representatives). In the past, ERISA reform efforts were often opposed because of the view that national health care reform was a better alternative. See *id.* at 630 ("Until recently, the potential for ERISA reform was subsumed by the broader political agenda of national health care."). Now that national health care reform has stalled, there is perhaps more hope for ERISA reforms that would allow states to experiment with their own health care initiatives. See *id.* (stating that "chances of ERISA reform may be greater since the political focus has shifted away from a national solution," therefore, making Congress more likely to allow states to act).

There is still considerable opposition to amendments that would limit the scope of ERISA preemption, however. Employers and employee benefit plan administrators are likely to oppose any attempt to narrow the preemption clause because they usually find preemption of state regulation desirable. See HENRY H. PERRITT, JR., *State Health Care Reform and ERISA Preemption*, in WILEY EMPLOYMENT LAW UPDATE 346 (Henry H. Perritt, Jr. ed., 1995) (noting that if state regulation is preempted, plans and their employer sponsors have greater flexibility in designing and administering their health care plans). On the other hand, state lawmakers and plan claimants generally wish to avoid ERISA preemption because state health care reform provisions are more likely to favor claimants than are the corresponding ERISA provisions. See *id.* Even if employer interest groups manage to successfully lobby against amending the ERISA preemption language, other options exist to loosen the grip of ERISA preemption, as this Note suggests.

This Note advocates that the courts narrow their interpretation of the preemption language. This would allow states to begin their reform efforts without awaiting legislative action to amend ERISA. Other commentators agree that the best approach to reformulating ERISA preemption is to encourage the judiciary to narrow its interpretation of the preemption provisions. See Jordan, *supra* note 10, at 260 ("[L]egislative modifications . . . are unlikely. . . . It is therefore up to the judiciary to develop sound doctrines that ensure that ERISA pre-emption is kept within the bounds that Congress intended in 1974.").

13. See generally Fisk, *supra* note 7, at 35 n.1 (defining ERISA waivers). An ERISA waiver is an "amendment to the ERISA preemption provision to eliminate preemption of state law in a particular circumstance," as opposed to a general amendment of the preemption language. *Id.* For a detailed discussion of the potential role of ERISA waivers in the future of state health care reform, see Groves, *supra* note 12 (examining impact of ERISA on state health care reform efforts and proposals before Congress for waivers).

Such a waiver would permit states to regulate directly or indirectly employee benefit plans in a particular way. So far, only Hawaii has been successful at obtaining an ERISA waiver. See 29 U.S.C. § 1144(b)(5)(A) (1994) (stating that preemption clause "shall not apply to the Hawaii Prepaid Health Care Act"). This

from preemption by reinterpreting the preemption provisions in a way that enables states to achieve health care reform without sacrificing the original goals of ERISA.¹⁴ The Supreme Court has already taken a step in this direction with its decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*¹⁵

Despite the *Travelers* decision, courts continue to broadly construe the preemption language to defeat state health care reform measures. In *CIGNA Healthplan of Louisiana, Inc. v. Louisiana*,¹⁶ the United States Court of Appeals for the Fifth Circuit invalidated a Louisiana statute that required preferred provider organizations to accept into their networks any health care provider willing to meet the terms and conditions of the preferred provider organization (PPO).¹⁷ This decision, besides creating an

waiver exempts the Hawaii Prepaid Health Care Act ("Hawaii Act") from preemption, but preempts amendments of the Hawaii Act "to the extent [they] provide[] for more than the effective administration of such Act." *Id.* § 1144(b)(5)(B)(ii); see Hawaii Prepaid Health Care Act, HAW. REV. STAT. § 393 (1993). Prior to the enactment of this waiver, the Ninth Circuit had held that ERISA preempted the Hawaii Act. See *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 765-66 (9th Cir. 1980) (finding ERISA preemption language broad enough to encompass Hawaii Act), *aff'd*, 454 U.S. 801 (1981).

14. See *Jordan*, *supra* note 10, at 260 (stating that it is up to judiciary to develop sound doctrines that ensure ERISA preemption is kept within limits that Congress intended in 1974); *Weisenborn*, *supra* note 10, at 157 (stating that Supreme Court's traditional interpretation stifles state health care regulation so "when the Court grants certiorari to its next ERISA preemption case, political reality demands a change in . . . interpretation of ERISA preemption").

15. 514 U.S. 645 (1995). In *Travelers*, the Court held that ERISA does not preempt a New York statute that requires hospitals to collect surcharges from patients insured by a commercial insurer, but not from patients covered by a Blue Cross/Blue Shield plan. *Id.* at 658-62. Narrowly construing the "relate to" clause of ERISA's preemption provision, the Court held that the surcharge provisions do not have a sufficient "connection with" employee benefit plans within the meaning of ERISA and, therefore, are saved from preemption. See *id.* at 662. The Court explained that cost uniformity was not an object of preemption and that a law's indirect economic effect on the cost of various health insurance packages are a "far cry" from the "conflicting directives" from which Congress intended to insulate ERISA plans. See *id.*

16. 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996).

17. *Id.* at 650. The Fifth Circuit held that ERISA preempted Louisiana's Any Willing Provider Statute "as it relates to third party administrators and health care plans that provide services to ERISA-qualified benefit plans." See *id.* Many states' preferred provider organization (PPO) statutes include an "any willing provider" requirement. See James C. Deschene, *Preferred Provider Organization*, in *HEALTH CARE CORPORATE LAW: MANAGED CARE 2-46* (Mark A. Hall & William S. Brewbaker, III eds., 1996) ("Any willing provider requirements have been included in the PPO laws of a significant number of states."). At least twenty-five states have enacted some form of "any willing provider" statutes. See Angela Mickelson et al., *Managed Care Potpourri II: What's New in the Regulatory Market*, 16 WHITTIER L. REV. 1005, 1017 (1995) (stating that "any willing provider" laws are most popular of antimanaged care legislative efforts). These laws require PPOs to include in their networks all providers willing to accept the terms and conditions the PPOs offer to providers. See Deschene, *supra*, at 2-46 to 2-47 (discussing requirement to include all providers but finding unpersuasive justification for such requirement).

apparent circuit split,¹⁸ demonstrates the magnitude of the obstacles that states face when attempting to implement health care reform legislation.

This Note suggests that, in the absence of legislative action, courts should narrowly construe the ERISA preemption language to accommodate state health care reform legislation.¹⁹ Part II of this Note briefly explains ERISA's preemption doctrine.²⁰ Part III discusses the Supreme Court's decision in *Travelers* as a turning point in the Court's analysis of ERISA preemption.²¹ Finally, Part IV addresses the Fifth Circuit's recent application of the preemption precedent in *CIGNA Healthplan* and advocates that the Fifth Circuit should have followed the lead of the *Travelers* Court and narrowed its interpretation of ERISA preemption, particularly the "relate to" clause.²²

These laws have been controversial. Generally, "any willing provider" legislation has been supported by provider groups "who fear that substantial numbers of providers will be arbitrarily cut out of PPO networks." *Id.* at 2-47. In their amicus brief in *CIGNA Healthplan*, the Louisiana State Medical Society and the Louisiana Dental Association stated that they "strongly endorse and support ["any willing provider" statutes], as [they] directly and tangibly serve[] the public interest of assuring access to quality medical and dental care and freedom of health care provider choice." Brief of Amicus Curiae for Louisiana State Medical Society and the Louisiana Dental Association in Support of Appellants at 1, *CIGNA Healthplan* (No. 95-30481). Those opposed to "any willing provider" statutes have argued that "any willing provider" laws could seriously undermine a provider network's ability to exclude "competent, yet lower quality, physicians." See Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 915 (1995) [hereinafter Jordan, *Managed Competition*] (stating that "any willing provider" laws, because they undermine ability to exclude competent, yet lower quality physicians, "constitute a clear barrier to quality-focused selective contracting of network physicians"); see also Christine C. Dodd, Comment, *The Exclusion of Non-Physician Health-Care Providers From Integrated Delivery Systems: Group Boycott or Legitimate Business Practice?*, 64 U. CIN. L. REV. 983, 989 (1996) (stating that "any willing provider" laws destroy HMOs' competitive advantage and, in particular, their ability to selectively contract).

This Note does not evaluate the desirability of enacting "any willing provider" laws. Rather, it merely addresses a state's ability to enact this type of legislation and similar health care reform measures given the current interpretation of ERISA preemption.

18. See *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 505 (4th Cir. 1993) (sparing similar "any willing provider" statute from preemption). The *Stuart Circle* court held that, although the statute fell within the preemption provision of ERISA, the savings clause exempted the statute from preemption. *Id.*

19. For a discussion of the narrow construction of ERISA preemption which this Note suggests that courts adopt, see *infra* notes 146-86 and accompanying text.

20. For a discussion of ERISA's preemption doctrine, see *infra* notes 23-98 and accompanying text.

21. For a discussion of the *Travelers* decision, see *infra* notes 80-96 and accompanying text.

22. For a discussion of the Fifth Circuit's recent application of the preemption precedent, see *infra* notes 97-145 and accompanying text.

II. BACKGROUND

Commentators have remarked that “ERISA is one of the most difficult areas of the law to understand, let alone master.”²³ Congress enacted this complex and comprehensive legislation to protect the rights of employees who earn pension benefits.²⁴ Congress was concerned that abuses in the private pension system were denying pensions to many workers.²⁵ To prevent these abuses, ERISA “set standards for participation, vesting and funding, established an insurance system to protect pension plans and provided express statutory fiduciary responsibility and full disclosure requirements” for both pension and welfare plans.²⁶ ERISA broadly defines

23. Martin Wald & David E. Kenty, *Preface of ERISA: A COMPREHENSIVE GUIDE*, *supra* note 8, at iii. In fact, one commentator remarked that “according to legend, ERISA is an acronym for Every Ridiculous Idea Since Adam.” Jayne Elizabeth Zanglein, *Employee Benefits for General Practitioners: Ten Rules Every Attorney Should Know About ERISA*, 26 TEX. TECH L. REV. 579, 580 (1995). Another commentator remarked that “[i]n most quarters, merely mentioning ERISA is like spraying the air with a potent toxin that glazes the eyes and dulls the brain.” Martin, *supra* note 10, at 42-43. In particular, ERISA’s preemption provisions have been likened to a “veritable Sargasso Sea of obfuscation.” *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993), *rev’d sub nom.* *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

24. See Thomas W. Jennings, *Introduction to ERISA: A COMPREHENSIVE GUIDE*, *supra* note 8, at 1 (discussing ERISA’s protections against pension benefit abuse and stating that ERISA’s “mandate to encourage plan participation has been attained”); see also Gregory, *supra* note 10, at 432 n.6 (stating that primary policy objective of ERISA is to encourage and enhance greater pension retirement security in private sector of United States, but without government compulsion of universal pension coverage).

25. See COLEMAN, *supra* note 8, at xiii (“The major impetus for the enactment of . . . ERISA was abuse and mismanagement in the private pension system.”); see also Larry J. Pittman, *ERISA’s Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355, 357-58 (1994) (stating that Congress enacted ERISA to stop certain abuses that were occurring in employee pension plans, such as insufficient funding and employer schemes to avoid paying pensions to employees who had given many years of service). In his concluding speech to Congress on ERISA in 1974, Senator Jacob Javits emphasized that many pensioners were losing their pensions because of technical violations of complicated vesting rules, retirement before age sixty-five and bankruptcy of companies with inadequately funded pension plans. See Michael S. Sirkin, *The 20 Year History of ERISA*, 68 ST. JOHN’S L. REV. 321, 323 (1994) (explaining that ERISA was intended to redress these problems by protecting workers, ensuring adequate retirement benefits upon retirement and assuring adequate funding).

26. Jennings, *supra* note 25, at 1; see also Bobinski, *supra* note 6, at 275 (stating that Congress enacted ERISA “to set minimum standards of information disclosure and to establish fiduciary responsibilities in . . . establishment, operation, and administration of employee benefit plans”); Karen A. Jordan, *ERISA Pre-emption: Integrating Fabe into the Savings Clause Analysis*, 27 RUTGERS L.J. 273, 279 (1995) (noting that purpose of ERISA was to protect interests of participants in employee benefit plans and their beneficiaries by requiring disclosure and reporting of other financial information, by “establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.” (quoting 29 U.S.C. § 1001(b) (1994))); Robert S. McDonough, Note, *ERISA Preemption of State Mandated-Provider Laws*, 1985 DUKE L.J. 1194, 1198 (1985) (discussing ERISA’s leg-

“welfare plan” as “any plan, fund, or program . . . maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical . . . benefits.”²⁷

Prior to the enactment of ERISA, the regulation of employee benefit plans varied widely from state to state.²⁸ Congress’s main goals in enacting ERISA were to create a uniform national law governing employee benefit plans and to eliminate “‘the threat of conflicting or inconsistent State and local regulation.’”²⁹ To achieve these goals, Congress included a

islative history and noting that its purpose was to impose reporting, disclosure, participation, funding and vesting standards on pension plans and to place fiduciary duties on plan managers).

27. 29 U.S.C. § 1002(1) (1994).

28. See Robert M. Goldich & Jonathan D. Wetchler, *Civil Enforcement, in ERISA: A COMPREHENSIVE GUIDE*, *supra* note 8, at 244 (noting “tremendous” variation among employee benefit plan regulation prior to ERISA). One of the first major private pension plans in the United States was created by the American Express Company in 1875. See Gregory, *supra* note 10, at 437. Later, some unions began to provide pension plans for their members. See *id.* In the early twentieth century, some state and local governments also began to provide pensions to their public sector employees. See *id.* at 438.

Employers viewed early pension plans solely as gratuities, rather than as accrued vested rights or as forms of deferred compensation. See *id.* (noting that result was that law did not consider employees to have property claims to pensions and, therefore, their legal status as beneficiaries was not secure). In addition, early pension plans were usually unfunded and contained no real safeguards to insure that employees would ever receive their pensions upon retirement. See *id.* (noting risks that employees faced before ERISA set standards for pension plans). Gradually, various trusts were established to administer pension plans. See *id.* at 439 (stating that, nonetheless, individual state law primarily governed pension regulation).

29. Kurt R. Anderson, *Current Issues in ERISA Preemption, in ERISA: A COMPREHENSIVE GUIDE*, *supra* note 8, at 250 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987)); see also *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522-23 (1981) (stating that Congress intended to establish pension plan regulation as exclusively federal concern); Gregory, *supra* note 10, at 454-58 (discussing Congress’s intent that ERISA not be compromised by host of potentially contradictory state laws); Pittman, *supra* note 25, at 375 (stating that Congress enacted preemption provisions to achieve its goal of avoiding regulation of ERISA plans by multiple and conflicting state laws); Rebecca S. Fellman-Caldwell, Note, *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: The Supreme Court Clarifies ERISA Preemption*, 45 CATH. U. L. REV. 1309, 1312 (1996) (noting that purpose of preemption clause is to ensure national uniformity of pension benefit protections); McDonough, *supra* note 26, at 1200-01 (discussing that ERISA’s legislative history shows that Congress intended preemption clause to occupy entire field of employee benefit plan regulation).

broad preemption³⁰ provision in the statute.³¹

Unfortunately, Congress did not clearly delineate the scope of ERISA preemption and, as a result, there have been thousands of judicial opinions attempting to settle the matter.³² Any analysis of ERISA preemption must begin with the interpretation of three clauses: the preemption clause, the savings clause and the deemer clause.

30. See Goldich & Wetchler, *supra* note 28, at 244 (discussing preemption). Preemption refers to the power granted by Article VI of the United States Constitution, the Supremacy Clause, to the federal government to supplant state law in those areas in which the federal government has regulatory powers under the Constitution. See U.S. CONST. art. VI, § 2 (“[T]he Laws of the United States . . . shall be the supreme Law of the Land . . .”). The Supremacy Clause “may entail preemption of state law either by express provision, by implication, or by a conflict between federal and state law.” New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995); see also Pacific Gas & Elec. Co. v. Energy Resources Conservation & Dev. Comm’n, 461 U.S. 190, 204 (1983) (stating that state law is preempted to extent it conflicts with federal law—for example, “when ‘compliance with both federal and state regulations is a physical impossibility’ . . . or where state law ‘stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress’” (quoting Florida Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142-43 (1963)) (citations omitted)); Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (stating that Congress may preempt state law by including express language in federal law to prohibit states from regulating area that federal law addresses); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947) (discussing that Congress may preempt state law by implication when “scheme of federal regulation [is] . . . so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it” or “the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the same subject”).

31. See 29 U.S.C. § 1144(a) (“[T]he provisions of this subchapter . . . 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.”). This provision is “notable for its breadth.” United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem’l Hosp., 995 F.2d 1179, 1191 (3d Cir. 1993); see also FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (stating that preemption clause is “conspicuous for its breadth”); Pilot Life Ins. v. Dedeaux, 481 U.S. 41, 45-46 (1987) (finding that Congress chose “deliberately expansive” language for preemption clause). Commentators have even remarked that the language of the preemption clause “sweeps as broadly as the English language allows.” Irish & Cohen, *supra* note 10, at 110; see also Gregory, *supra* note 10, at 430-31 (stating that Congress included in ERISA one of most sweeping preemption clauses ever included in any federal legislation). For a detailed treatment of the preemption provisions, see *infra* notes 33-57 and accompanying text.

32. See Perritt, *supra* note 12, at 346 (“A recent LEXIS search indicates that there are now over 2800 judicial opinions addressing ERISA pre-emption.”) (citing District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125, 135 n.3 (1992) (Stevens, J., dissenting)). Since Justice Stevens’s count in the *Greater Washington* case, the body of ERISA case law has continued to grow. See Fisk, *supra* note 7, at 59 & n.106 (observing that recent search in Westlaw “Allfeds” data-base (ERISA /p preempt!) produced 3330 cases). The complexity and ambiguity of the ERISA preemption provisions fuels the litigation associated with ERISA preemption. Even the Supreme Court has remarked that “the two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting.” Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985).

A. *The Preemption, Savings and Deemer Clauses*

The preemption clause identifies those state laws that ERISA will preempt.³³ It provides that the ERISA provisions “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.”³⁴

This expansive language in the preemption clause is reined in by the savings clause. The savings clause exempts from preemption state laws that would otherwise be included within the broad scope of the preemption clause.³⁵ The savings clause provides that “[e]xcept as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”³⁶ Much of the confusion in preemption analysis stems from the relationship between the language of the preemption and savings clauses, because while the “general preemption clause broadly pre-empts state law, the savings clause appears broadly to preserve the States’ lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.”³⁷

The savings clause was added to make ERISA consistent with the McCarran-Ferguson Act,³⁸ and to reassert that state governments, not the federal government, would primarily be responsible for the regulation of

33. See 29 U.S.C. § 1144(a) (defining scope of preemption).

34. *Id.*

35. See generally Perritt, *supra* note 12, at 255 (analyzing case law holding that ERISA also preempts various state common law claims).

36. 29 U.S.C. § 1144(b)(2)(A). This Note will only focus on the savings clause analysis as it applies to insurance laws.

37. *Metropolitan Life*, 471 U.S. at 739-40. The Court noted that many commentators have urged Congress to amend the preemption provisions to eliminate this confusion. See *id.* at 740 n.16 (citing Theodore Paul Manno, *ERISA Preemption and the McCarran-Ferguson Act: The Need for Congressional Action*, 52 TEMP. L.Q. 51, 77 (1979); F. Okin, *Preemption of State Insurance Regulation by ERISA*, 13 A.B.A. FORUM 652, 678 (1978)).

38. 15 U.S.C. §§ 1011-1115 (1994). The McCarran Act was passed in 1945 to clarify the federal and state governments’ roles in the regulation of insurance. See Brown, *supra* note 9, at 351 n.78 (noting purpose of McCarran Act). Now known as the McCarran-Ferguson Act, it provides in pertinent part:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, that . . . [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012(b). For treatment of the relationship between the McCarran-Ferguson Act and ERISA, see McDonough, *supra* note 26, at 1206-10.

insurance and insurance companies.³⁹ Unfortunately, the application of the savings clause is complicated by the deemer clause.⁴⁰ Congress included this clause to prevent states from regulating employee benefit plans through state insurance law.⁴¹ The difficulty with the deemer clause is determining the meaning of the phrase “business of insurance” as it is used in the McCarran-Ferguson Act.⁴²

In *Metropolitan Life Insurance Co. v. Massachusetts*,⁴³ the Supreme Court explained the framework used to mark the boundaries between those regulations that come within the preemption clause and those regulations that the savings clause rescues, while recognizing the deemer clause’s effect on this framework.⁴⁴ At issue in *Metropolitan Life* was a Massachusetts statute requiring that certain minimum mental health care benefits be provided to Massachusetts residents who were insured by a general health insurance policy or under an employee health care plan that covers hospital and surgical expenses.⁴⁵ Massachusetts argued that its mandated benefit law, as applied to insurance companies that sell insurance to benefit plans, is a law that “regulates insurance” and, therefore, is saved from preemption.⁴⁶ The Court agreed.⁴⁷

39. See Brown, *supra* note 9, at 351 (noting savings clause reasserted that state governments are responsible for regulating insurance); see also Goldich & Wetchler, *supra* note 28, at 245 (noting that ERISA also contains deemer clause which has purpose of preventing “states from regulating employee benefit plans via state insurance law”).

40. See 29 U.S.C. § 1144(b)(2)(B) (providing for deemer clause).

41. See Goldich & Wetchler, *supra* note 28, at 245 (noting purpose of deemer clause); see also Groves, *supra* note 12, at 623 (stating that obvious purpose of deemer clause is to ensure that states cannot affect employee benefit plans under guise of insurance regulation).

42. 15 U.S.C. § 1012(b). The Supreme Court has not written many opinions explaining the scope of ERISA’s savings clause. See Jordan, *supra* note 26, at 280 (stating that Supreme Court has not had many opportunities to precisely articulate scope of ERISA’s savings clause). The savings clause is problematic because it seems to contradict the expansive preemption clause by preserving the states’ law-making power over many laws that meet the “relate to” test and, therefore, would otherwise be preempted. See *id.* (noting apparent conflict between savings and preemption clauses).

43. 471 U.S. 724 (1985).

44. See *id.* at 740-43. This framework was originally set forth in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 127-28 (1982).

45. *Metropolitan Life*, 471 U.S. at 727.

46. See *id.* at 733. In 1979, the Massachusetts Attorney General brought suit in Massachusetts superior court for declaratory and injunctive relief to enforce its mandated benefit law. See *id.* at 734. Massachusetts asserted that insurers had issued policies to group policyholders located outside Massachusetts that provided for hospital and surgical coverage for certain residents of Massachusetts. See *id.* Massachusetts also asserted that those policies did not provide Massachusetts-resident beneficiaries the mental-health coverage required by the statute and that the insurers intended to issue more of these policies because they believed that the statute did not apply to policies issued outside of Massachusetts. See *id.*

47. See *id.* at 746 (finding no preemption when state law “regulates insurance”).

The *Metropolitan Life* Court explained that determining whether a statute regulated the “business of insurance” within the meaning of the savings clause is a two-step process.⁴⁸ First, the Court examined whether the statute at issue met the commonsense definition of an insurance regulation.⁴⁹ Then, the Court analyzed three factors relevant to determining whether the statute came within the savings clause’s phrase “business of insurance”: (1) whether the statute has the effect of transferring or spreading a policyholder’s risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.⁵⁰ The Court found that all three factors of the “business of insurance” test were met.⁵¹ The Court also noted that its decision “results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, [it] . . . merely give[s] life to a distinction created by Congress in the ‘deemer clause.’”⁵² The addition of the deemer clause further complicates the above analysis. The deemer clause limits the exemptions to ERISA preemption set forth in the savings clause by providing that no employee benefit plan shall be deemed to be an insurance company for the purpose of any state law purporting to regulate insurance companies.⁵³

48. *Id.* at 740-43. The Court stated that after a court determines if a statute meets a commonsense definition of insurance regulation, it then considers whether statute falls within savings clause. *See id.* at 741.

49. *See id.* at 740 (noting that commonsense analysis is reinforced by deemer clause). The statute at issue required that general health insurance policies and employee health care plans that cover hospital and surgical expenses also provide certain minimum mental health care benefits to their Massachusetts plan participants. *See id.* at 730 (stating specifically that Massachusetts statute “requires that a health-insurance policy provide 60 days of coverage for confinement in a mental hospital equal to that provided by the policy for nonmental illness, and certain outpatient benefits”). The Court found that this statute met the commonsense definition of the business of insurance because it regulates the terms of certain insurance contracts. *See id.* at 740 (“To state the obvious, the Massachusetts statute regulates the terms of certain insurance contracts, and so seems to be saved from pre-emption by the savings clause as a law ‘which regulates insurance.’”).

50. *See id.* at 743 (citing *Union Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) and establishing three factor test).

51. *See id.* (applying principles set forth in *Union Life*). First, the Court stated that the statute “obviously” met the spreading of risk factor because it was “intended to effectuate the legislative judgment that the risk of mental-health care should be shared.” *Id.* Second, the Court also found that the statute directly regulated an “integral part of the relationship between the insurer and the policyholder by limiting the type of insurance that an insurer may sell to the policyholder.” *Id.* Finally, the statute met the third factor because the Court found that mandated benefit statutes “impose[d] requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.” *Id.*

52. *Id.* at 747.

53. *See* 29 U.S.C. § 1144(b)(2)(B) (1994) (setting forth deemer clause). The statute provides that

Basically, the deemer clause prevents a state from deeming an employee benefit plan an insurance company in an attempt to avoid preemption if the benefit plan would not otherwise be considered an insurance company.⁵⁴ The language of the deemer clause is so broad that it could be interpreted to nullify the savings clause.⁵⁵ Canons of statutory construction, however, require that statutes be construed to give effect to every provision.⁵⁶ The courts have adhered to this principle and have interpreted the deemer clause in a way that “save[s] some scope of operation for the savings clause.”⁵⁷

B. *Traditional Approach to ERISA Preemption*

Since ERISA was enacted, the Supreme Court has written opinions in twelve ERISA preemption cases.⁵⁸ Traditionally, the Supreme Court has

[n]either an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 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, bank, trust company, or investment company or to be engaged in the business of insurance or banking for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id.

54. See *Metropolitan Life*, 471 U.S. at 740 (stating that this “common sense view” is reinforced by language of statute).

55. See PERRITT, *supra* note 12, at 362 (discussing boundary between deemer clause and savings clause).

56. See *id.* (noting that “such an interpretation of the deemer clause would eliminate any scope for the savings clause and thus make its inclusion in the statute purposeless”).

57. *Id.*

58. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995) (finding that state statute did not “relate to” employee benefit plans under ERISA and was not preempted); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 106 (1993) (holding that “free funds” were under discretionary management of insurer and subject to ERISA fiduciary obligations); *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 126-27 (1992) (stating that ERISA preempted District of Columbia statute requiring health insurance coverage for injured employees); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 145 (1990) (“[I]t is no answer to a preemption argument that a particular plaintiff is not seeking recovery of pension benefits.”); *FMC Corp. v. Holliday*, 498 U.S. 52, 65 (1990) (finding ERISA preempts application of state motor vehicle financial responsibility law to company’s salaried health care plan); *Massachusetts v. Morash*, 490 U.S. 107, 117-21 (1989) (finding that employer’s paying discharged employees unused vacation time out of its general assets was not preempted by ERISA as “employee welfare benefit plan”); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 841 (1988) (holding that ERISA preempts Georgia antigarnishment provision); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 23 (1987) (finding that one-time severance payment to employees upon plant closing was not preempted by ERISA); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) (finding that state lawsuit regarding processing of ERISA claims was preempted by federal law); *Metropolitan Life*, 471 U.S. at 758 (holding that ERISA does not preempt state law mandating

broadly construed the preemption provisions.⁵⁹ For example, in *Shaw v. Delta Air Lines, Inc.*,⁶⁰ the Court stated that “[t]he breadth of . . . [ERISA’s] pre-emptive reach is apparent from [its] language.”⁶¹ This language was “deliberately expansive.”⁶² 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.”⁶³ The Court has also noted that, provided a connection to

minimum health benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 108 (1983) (holding that although state disability benefit law “relates to” employee benefit plan, ERISA does not preempt it because it was not maintained “solely for the purpose of complying with applicable . . . disability insurance laws”); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526 (1981) (stating use of workers’ compensation to offset pension benefits did not violate ERISA). Two other cases address ERISA preemption in the context of removal jurisdiction. See *Metropolitan Life*, 481 U.S. at 59-60 (stating that Congress intended ERISA to preempt employees’ common law and tort claims); *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 28 (1983) (holding suit by state in attempt to collect taxes from welfare benefit trust was not removable to federal court on ERISA preemption question); see also Fisk, *supra* note 7, at 58 n.104. These cases were originally filed in state court and then removed to federal court on the grounds of complete preemption. See *id.* (noting removal issues involved in cases).

59. See, e.g., *Greater Washington*, 506 U.S. at 129 (giving “relate to” clause of section 514(a) its broad, ordinary meaning as used in Sixth Edition of Black’s Law Dictionary); *FMC Corp.*, 498 U.S. at 58 (noting that preemption clause is “conspicuous for its breadth”); *Pilot Life*, 481 U.S. at 46 (finding that Congress chose “deliberately expansive” language for preemption clause); *Shaw*, 463 U.S. at 96-97 (finding law “relates to” covered employee benefit plan if it has connection with or reference to such plan).

60. 463 U.S. 85 (1983).

61. *Id.* at 96. The *Shaw* Court noted that the Court had recently considered ERISA’s preemption clause in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). *Shaw*, 463 U.S. at 96 n.15. In *Alessi*, a New Jersey statute prohibited a method of calculating pension benefits which the Court found Congress intended to permit when it enacted ERISA. See *Alessi*, 451 U.S. at 524 (holding that ERISA preempted New Jersey statute because Congress intended to establish pension plan regulation as exclusively federal concern and New Jersey statute eliminated method of calculating pension benefits that federal law permits). In reaching its holding, the *Alessi* Court relied primarily on the state law’s frustration of congressional intent rather than the preemption clause’s language. *Id.* The *Shaw* Court explained that in *Alessi* the focus shifted from the preemption language to congressional intent because of the tension between state and federal law in that particular case, a tension that does not exist in all preemption cases. *Shaw*, 463 U.S. at 96 n.15.

62. *Pilot Life*, 481 U.S. at 46.

63. *Shaw*, 463 U.S. at 96-97. A law will also relate to an ERISA plan if it singles out such a plan for special treatment. See *Mackey*, 486 U.S. at 838 n.12 (holding that portion of Georgia’s garnishment statute “which singles out ERISA plans, by express reference, for special treatment is pre-empted”); see also *McCoy v. Massachusetts Inst. of Tech.*, 950 F.2d 13, 19-20 (1st Cir. 1991) (holding ERISA preempts Massachusetts lien statute that “expressly singles out ERISA plans for special treatment”). Another way a statute can relate to an ERISA plan is if the rights or restrictions it creates are predicated upon the existence of such a plan. See *McClendon*, 498 U.S. at 142-45 (holding ERISA preempts employee’s state law wrongful discharge claim when claim was based on allegation that discharge was motivated by employer’s desire to avoid making contributions to employee’s pension fund); *United Wire Metal & Mach. Health & Welfare Fund v. New Jersey*, 995 F.2d 1179,

such a plan exists, ERISA will preempt a state law even if the law “is not specifically designed to affect such [employee benefit] plans, or the effect is only indirect.”⁶⁴

The preemption doctrine, however, does have its limitations. In *Shaw*, the Court stated that there may be cases in which “state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.”⁶⁵ Despite the Court’s recognition of the limits of ERISA preemption, the Court’s expansive interpretation of the “relate to” clause does not allow many state laws to have such a tenuous connection and escape preemption.⁶⁶

1192 (3d Cir. 1993) (citing *Greater Washington*, 506 U.S. at 126-27 (holding ERISA preempts District of Columbia statute requiring employers who provide health insurance for their employees to provide equivalent health insurance coverage for injured employees eligible for workers’ compensation benefits)).

64. *McClendon*, 498 U.S. at 139 (quoting *Pilot Life*, 481 U.S. at 47).

65. *Shaw*, 463 U.S. at 100 n.21. In *Shaw*, the Supreme Court had to determine whether ERISA preempted two New York statutes. *Id.* at 88. The first was the New York Human Rights Law, N.Y. EXEC. LAW §§ 290-301 (McKinney 1983), a comprehensive antidiscrimination statute that prohibited, among other practices, discrimination in employee benefit plans on the basis of pregnancy. *See Shaw*, 463 U.S. at 88. The other statute, the Disability Benefits Law, required employers to pay certain benefits to employees unable to work because of nonoccupational injuries or illnesses, including pregnancy. *See N.Y. WORK COMP. LAW* §§ 200-242 (McKinney 1983); *Shaw*, 463 U.S. at 89.

In a unanimous opinion, the *Shaw* Court held that ERISA preempted the Human Rights Law. *Id.* at 100. The Court stated that “[t]he breadth of [ERISA’s] pre-emptive reach is apparent from [its] language.” *Id.* at 96. After giving effect to the statute’s plain language, the *Shaw* Court had no difficulty in finding that ERISA preempted the New York statute. *Id.* at 100. Although the Court indicated that a statute’s plain language will not always “settle an issue,” it was compelled to give effect to the plain language in this case because it had no “good reason to believe Congress intended the language to have some more restrictive meaning.” *Id.* at 97. Using a phrase which has become the touchstone for interpreting the “relate to” language, the Court stated 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.” *Id.* at 96-97.

66. *See Weisenborn*, *supra* note 10, at 148 (“Rather than preempting laws that have only a remote impact on ERISA plans or preempting only state regulation that might impinge on the core protective aims of ERISA, the Court has interpreted the clauses more broadly.”) (citing *McClendon*, 498 U.S. at 139).

Courts have construed these provisions to preempt state laws dealing with mandated benefits,⁶⁷ plans to cover the uninsured⁶⁸ and general state contract and tort claims.⁶⁹ By preempting state regulations, ERISA has created an “enormous, unanticipated ‘regulatory vacuum.’”⁷⁰ One

67. See, e.g., *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985) (holding that ERISA preempts Massachusetts statute requiring minimum mental health care benefits be provided to plan participants as it applies to self-insured funds); *Aloha Airlines, Inc. v. Ahue*, 807 F. Supp. 1501, 1504-05 (D. Haw. 1992) (holding that ERISA preempted Hawaii statute that required employers to pay for physical examinations of flight captains required by Federal Aviation Association). In *Metropolitan Life*, the Court held that ERISA did not preempt a Massachusetts statute requiring that certain minimum mental health care benefits be provided to Massachusetts residents who are insured under general health insurance policies or employee health care plans that cover hospital and surgical expenses. *Metropolitan Life*, 471 U.S. at 758. The Court’s holding, however, indicated that the statute as it applied to *self-insured* funds was preempted by ERISA. See *id.* at 747 (noting that uninsured or self-insured plans are not open to indirect regulation).

68. See, e.g., *Bricklayers Local No. 1 Welfare Fund v. Louisiana Health Ins. Ass’n*, 771 F. Supp. 771, 776 (E.D. La. 1991) (holding that ERISA preempts Louisiana statute establishing catastrophic health insurance fund financed by service charges imposed on insurers and self-insurers to extent that it applies to self-insured plans).

69. See Weisenborn, *supra* note 10, at 151-53 (discussing application of ERISA preemption). With respect to state tort and contract laws, “state courts have refused to hear cases addressing fraudulent misrepresentation, bad faith refusal to pay [a] claim and intentional infliction of emotional distress claims on the ground that ERISA preempted the state law claims.” *Id.* at 152.

70. Fisk, *supra* note 7, at 37; see Parmet, *supra* note 7, at 135-36 (stating that antiregulatory bias is inherent in ERISA’s structure because ERISA preempts state laws, but does not provide much substantive regulatory content in health area); Pittman, *supra* note 25, at 360 (stating that ERISA’s preemption clause is being interpreted to “give paramount importance to a policy of creating a uniformity of laws governing ERISA plans—to protect employers and benefit plans by preempting state law obligations—even when those obligations will cause no harm to ERISA’s primary purpose of protecting employees and beneficiaries from administrative and funding abuses”). Ironically, the expansive scope of ERISA preemption “has come at the expense of the very participants in employee benefit plans whom ERISA was intended to protect.” Jordan, *supra* note 10, at 258.

Some areas in which ERISA preemption has created a regulatory void include, among others, workers’ compensation programs, prevailing wage laws and statutes allocating damages in tort and wrongful death actions. See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 126-27 (1992) (holding that ERISA preempted District of Columbia law regarding health benefits for injured employees eligible for workers compensation); *McInnis v. Provident Life & Accident Ins. Co.*, 21 F.3d 586, 589-90 (4th Cir. 1990) (holding ERISA preempts North Carolina statute that limits medical expense reimbursement to insurer from estate of deceased); *Travitz v. Northeast Dept. ILGWU Health & Welfare Fund*, 13 F.3d 704, 710 (3d Cir. 1994) (holding ERISA preempts Pennsylvania statute precluding persons from recovering damages arising out of motor vehicle use from culpable tortfeasor if claimant is otherwise eligible to receive those benefits from any program, group contract or other arrangement); *Benson v. Wyatt Cafeterias, Inc.*, 780 F. Supp. 1132, 1134 (N.D. Tex. 1991) (holding ERISA preempts state workers’ compensation claims); *Chamber of Commerce v. Bragdon*, 769 F. Supp. 1537, 1547 (N.D. Cal. 1991) (holding ERISA preempts prevailing wage rate legislation), *aff’d*, 64 F.3d 497 (9th Cir. 1995); see also Fisk, *supra* note 7, at 37 & nn.6-15.

commentator noted that “ERISA’s sweeping preemption of state laws . . . is odd, because ERISA itself has little to do with the regulation of health finance; it simply imposes fiduciary and reporting obligations on private employee benefit plans.”⁷¹

C. Modern Approach to ERISA Preemption

Two recent cases have signaled a change in the courts interpretation of ERISA preemption: *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*⁷² and the *Travelers* decision.⁷³ These cases demonstrate that the courts appear to be retreating from the broad approach to ERISA preemption exemplified in *Shaw*.⁷⁴

In *United Wire*, the Third Circuit had to determine whether ERISA preempted a New Jersey hospital rate-setting statute that allowed hospitals to charge insurers and self-funded employee benefit plans for losses incurred from providing care to indigent and Medicare patients.⁷⁵ The

71. Fisk, *supra* note 7, at 36. This commentator goes on to compare ERISA’s “sparse regulation of health and other benefit plans” with its comprehensive regulation of pension plans. *Id.* at 36 n.5. Professor Fisk concludes that the broad preemption of state laws related to pension plans has not created the same regulatory vacuum that ERISA has caused in the area of nonpension (welfare benefit) plans. *See id.*

72. 995 F.2d 1179 (3d Cir. 1993).

73. *See* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 658 (1995) (holding that ERISA does not preempt New York statute that requires hospitals to collect surcharges from patients insured by commercial insurers except those of Blue Cross and Blue Shield).

74. *See Travelers*, 514 U.S. at 662 (explaining that cost uniformity was not object of preemption and “far cry” from attempt by Congress to insulate ERISA plans); *United Wire*, 995 F.2d at 1195 (narrowing focus of “relate to” clause by rejecting argument that ERISA preempted statute merely because it mentioned types of ERISA plans in its definitional section). For a discussion of the *Travelers* decision, see *infra* notes 81-94 and accompanying text.

75. *United Wire*, 995 F.2d at 1189. Several self-insured employee benefit plans and several individual participants in the plans filed suit to prevent New Jersey’s statutory hospital rate setting scheme from applying to them. *See id.* at 1188. They also requested restitution of money paid under protest under that statutory scheme. *See id.* They argued both that ERISA preempted the New Jersey statute and that the application of the statute was an unconstitutional taking of property without just compensation. *See id.*

After quickly finding that the statute did not constitute an unlawful taking of property without just compensation, the Third Circuit addressed a “somewhat thornier question”: whether ERISA preempted the rate setting scheme. *Id.* at 1190-91. Because the plans were covered by ERISA, the issue before the court was whether the statute “related to” the plans in a way that mandated preemption. *See id.* at 1191.

The Third Circuit held that the statute did not “relate to” the plans in such a way as to trigger preemption. *See id.* Significant to the court’s decision was the fact that the statute did not single out ERISA plans for special treatment. *See id.* at 1192 (stating that because statute was one of general applicability that did not single out ERISA plans for special treatment and because statute functions without reference to ERISA plans, “the cases which have cordoned off this area of preemption are inapplicable”). The *United Wire* court also refused to find preemption on the

court held that ERISA did not preempt the hospital rate-setting plan because the New Jersey statute was a generally applicable law that (1) was not intended to regulate the affairs of ERISA plans; (2) neither singled out such plans for special treatment nor predicated rights or obligations on the existence of an ERISA plan; and (3) did not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state.⁷⁶

The Third Circuit's opinion is noteworthy for its willingness to narrow the focus of the "relate to" clause. The court rejected the plans' argument that ERISA preempted the statute merely because it expressly referred to a type of ERISA plan when defining some of the statute's terms.⁷⁷ The court stated that "where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for . . . [purposes of the 'relate to' clause.]"⁷⁸ The court's narrow approach to the "relate to" clause was also evident in its refusal to find preemption simply because the statute may have the indirect ultimate effect of increasing plan costs.⁷⁹ This view was affirmed by the Supreme Court in *Travelers*.⁸⁰

In *Travelers*, the Court spared from preemption a New York statute requiring hospitals to impose surcharges on patients insured by commer-

grounds that when, like New Jersey's rate setting scheme, a generally applicable statute does not affect the structure, administration or type of benefits provided by an ERISA plan, the mere fact that the statute has some economic effect on the plan does not mandate preemption. *See id.* at 1194 (stating that mere economic impact on ERISA plan will not invalidate generally applicable statute that does not affect structure, administration or type of benefits of ERISA plan).

76. *See United Wire*, 995 F.2d at 1195.

77. *See id.* at 1192 n.6. The plans argued that because the statute referred to "self-funded union" plans as one example of a "third party payor," ERISA preempted it. *See id.* As an example, the court also stated that a hypothetical state statute providing that "no employer, including an ERISA plan, shall discriminate on grounds of race or gender" would not be preempted despite its reference to an ERISA plan. *Id.*

78. *Id.*

79. *See id.* at 1193 (observing that when there is no direct nexus between state statute and ERISA plans, and no effect on such plans' manner of conducting business or their ability to operate in interstate commerce, courts have upheld such statutes despite fact that they may indirectly increase plan costs). To hold otherwise, and find that ERISA invalidated every state law that may increase the cost of operating employee benefit plans, would give those plans "a charmed existence that never was contemplated by Congress." *Id.* at 1194.

80. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995). The *Travelers* Court stated that to interpret preemption provision as "displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies . . . would effectively read the limiting language in . . . [the "relate to" clause] out of the statute, a conclusion that would violate basic principles of statutory interpretation." *Id.*

cial insurers, but not on patients covered by Blue Cross/Blue Shield plans.⁸¹ In doing so, the Court held that ERISA does not preempt state laws that have only an indirect economic effect on employee benefit plans, and do not function as a regulation of an ERISA plan.⁸²

The *Travelers* Court began its analysis by noting that “despite the variety of . . . opportunities for federal preeminence, we have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law.”⁸³ Thus, at the outset, the Court presumes a state statute to be valid.⁸⁴ This presumption is especially true in cases in which “federal law is said to bar state action in fields of traditional state regulation.”⁸⁵ In these cases, like the *Travelers* case, the Court will assume 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.’”⁸⁶

Despite this presumption against preemption, the *Travelers* Court noted that the preemption language is “clearly expansive,” because this language “marks for preemption ‘all laws insofar as they . . . relate to any employee benefit plan’ covered by ERISA.”⁸⁷ The Court even “wonder[ed], at first blush, whether the words of limitation (‘insofar as they . . . relate’) do much limiting.”⁸⁸ The Court concluded that the words must actually do some limiting because “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.”⁸⁹ This interpretation, however, would “be to read Congress’s words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality.”⁹⁰

81. *Id.* at 645. Although the Court granted certiorari to resolve the circuit split on the validity of state “hospital rate setting” laws, the Court’s fundamental reason for hearing the case was to provide more definitive guidance to courts that must determine which state laws Congress intended ERISA to preempt. See Jordan, *supra* note 10, at 286 (asserting that Court’s decision reflects “new, tighter standard” for determining preemption in cases in which state law affects benefit structure or administrative practices of ERISA plan).

82. See *Travelers*, 514 U.S. at 662 (“[L]aws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those ‘conflicting directives’ from which Congress meant to insulate ERISA plans.”).

83. *Id.* at 654.

84. See *id.* at 655.

85. *Id.* at 655 (citing *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985)).

86. *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

87. *Id.*

88. *Id.* (quoting 29 U.S.C. § 1144(a) (1994)).

89. *Id.*

90. *Id.* Additionally, the Court admitted that “our prior attempt to construe the phrase ‘relate to’ does not give us much help drawing the line here.” *Id.*

Because the Court did not find the text of the preemption clause helpful, it looked to the objectives of the ERISA statute as a guide for determining the scope of state laws that Congress intended to survive preemption.⁹¹ The objective of the preemption clause was “to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”⁹² Even given this objective, the Court noted that “nothing in the language of . . . [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern.”⁹³ In sum, the Court found that the New York surcharges did not “relate to” ERISA plans within the meaning of the preemption clause.⁹⁴ The holding was based on the conclusions that the surcharges had only an indirect economic effect on ERISA plans, and furthermore, do not force ERISA plans to adopt a particular scheme of substantive coverage.⁹⁵

This holding, although not a complete departure from past precedent, represented a shift from the Court’s traditionally broad interpretation of ERISA preemption.⁹⁶ In the recent Fifth Circuit case, *CIGNA Healthplan*, Louisiana urged the court to apply the *Travelers* Court’s analy-

91. *See id.* at 656 (“We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.”).

92. *Id.* at 657.

93. *Id.* at 661 (citing *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985)).

94. *See id.* at 668 (acknowledging that ERISA would preempt state laws that cause acute, even if indirect, economic effects such that ERISA plans might be forced to adopt particular scheme of coverage or restrict its choice of insurers but New York statute at issue did not do either).

95. *See id.* (“[T]hey affect only indirectly the relative prices of insurance policies, a result no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”).

96. *See Fisk*, *supra* note 7, at 39-40 (expressing relief that Supreme Court changed its approach in interpreting ERISA’s preemption provisions). Professor Fisk stated that

[f]ortunately, the Supreme Court . . . decided a case that suggests that the Justices have realized they erred and are taking a different approach, if not to statutory interpretation in general, at least to ERISA preemption of state law [T]he Court abandoned its slavish devotion to literalist textualism in interpreting ERISA’s broad preemption provision and instead adopted a pragmatic approach. The Court will no longer look to the dictionary definition of the words of . . . [the preemption clause], but instead will ask whether preemption of state law will serve the objectives of ERISA. This signals a long overdue and laudable reorientation in the Court’s approach to ERISA preemption.

Id. Other commentators agree that *Travelers* represented an important milestone in preemption analysis:

The Court’s opinion in *Travelers* can be construed as sending a signal for judicial restraint when determining whether state laws are pre-empted by ERISA. The Court’s approach in resolving the issue . . . and its emphasis on fundamental premises such as presumption against pre-emption of health care regulations can be construed as suggesting that courts should

sis to spare a Louisiana statute from ERISA preemption.⁹⁷ The Fifth Circuit, however, distinguished *Travelers* from the case at bar and consequently found preemption.⁹⁸

III. CIGNA HEALTHPLAN OF LOUISIANA, INC. v. LOUISIANA

A. Facts and Procedural History

In *CIGNA Healthplan*, the Fifth Circuit held that Louisiana's "any willing provider" statute⁹⁹ ("the Any Willing Provider Statute") relates to employee benefit plans within the meaning of ERISA's preemption clause, and that the statute is not exempt from preemption by ERISA's insurance savings clause.¹⁰⁰ In doing so, the court created an apparent circuit split

engage in a more pragmatic and disciplined analysis of ERISA pre-emption issues.

Jordan, *supra* note 10, at 261; see also Goldich & Wetchler, *supra* note 28, in ERISA: A COMPREHENSIVE GUIDE 98 (Martin Wald & David E. Kenty eds., Supp. 1996) (noting that, in *Travelers*, Supreme Court implicitly endorses Third Circuit's approach in *United Wire* and signifies retreat from broad view of ERISA preemption); L. Frank Coan, Jr., Note, *You Can't Get There from Here—Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions against HMOs*, 30 GA. L. REV. 1023, 1025 (1996) (stating that *Travelers* represents retreat from Supreme Court's traditionally broad reading of ERISA's preemption clause); Fellman-Caldwell, *supra* note 29, at 1343 (noting that *Travelers* marks turning point in evolution of ERISA preemption because it changes broad interpretation of preemption clause); David T. Shapiro, Note, *The Remission of ERISA Preemption: An Examination of Blue Cross/Blue Shield v. Travelers Insurance Co.*, 28 CONN. L. REV. 917, 946 (1996) (stating that *Travelers* decision put ERISA preemption back in harmony with current needs of nation because it refocused scope of preemption clause to protect ERISA plans from state laws that directly target plan administration and are inconsistent with national legislation). But see Seymour LaRock, *Have Tax-Exempt Managed Care Entities Been Given Competitive Advantage by High Court?*, 50 EMPLOYEE BENEFIT PLAN REV. 10 (Oct. 1995) ("Reports of the demise of ERISA preemption are greatly exaggerated. While a number of recent decisions, including *Travelers*, address the limits of its reach, ERISA preemption continues to provide vital and vibrant protection to employee benefit plans and their sponsors and administrators.").

97. See Brief for Appellant at 13, *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996) (No. 95-30481) (stating that Louisiana statute "provides for only a possible indirect economic effect, if any, on all insurance products" and, therefore, should not be preempted by ERISA under *Travelers* analysis).

98. See *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 650 (1996) (noting that unlike statute at issue in *Travelers*, this statute mandates that certain benefits available to ERISA plans must be constructed in particular manner and recognizing that ERISA preempts "state laws that mandate employee benefit structures").

99. LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992).

100. *CIGNA Healthplan*, 82 F.3d at 650. The *Health Law Litigation Reporter* observed that the effect of the court's decision was that employer sponsored preferred provider organizations may include and exclude whatever health care providers they wish, notwithstanding the contrary language of the Louisiana statute. 5th Cir.: *Any Willing Provider Statute Preempted by ERISA*, HEALTH L. LITIG. REP. (Andrews Publications, Inc.), June 1996, at 16.

regarding the application of ERISA's preemption doctrine to "any willing provider" statutes.¹⁰¹

In 1984, the Louisiana legislature enacted the Health Care Cost Control Act ("the Act")¹⁰² to reduce health care costs without jeopardizing the quality of care received by patients.¹⁰³ The Act specifically provides for the formation of PPOs, which the statute defines as "contractual . . . agreements between a provider or providers and a group purchaser or purchasers to provide for alternate rates of payment."¹⁰⁴ The Act defines "group purchaser" as "an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization."¹⁰⁵ To illustrate types of entities that fit within the "group purchaser" definition, the Act states that "group purchaser" may include:

- (a) Entities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self-funded trusts or programs.
- (b) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers, or other intermediaries.¹⁰⁶

Under the Any Willing Provider Statute, "no licensed provider . . . who, agrees to the terms and conditions of the preferred provider contract shall

101. See *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 500 (4th Cir. 1993) (sparing similar Virginia "any willing provider" statute from preemption). The Fourth Circuit held that, although the statute "related to" ERISA plans, it escaped preemption because it came within the insurance savings clause. See *id.* at 503. The Virginia statute at issue in *Stuart Circle*, however, was not identical to the one in *CIGNA Healthplan*. See *id.* (noting that Virginia statute was "part of a comprehensive code regulating accident and sickness insurance," and its language was directed only at insurance companies). The statute provided that [a]ny such insurer shall establish terms and conditions that shall be met by a hospital, physician or [other provider] in order to qualify for payment as a preferred provider under the policies or contracts. . . . No hospital, physician or [other provider] willing to meet the terms and conditions offered to it or him shall be excluded.

VA. CODE ANN. § 38.2-3407(B) (Michie 1990). The Virginia statute did not cover entities beyond the insurance industry. See *Stuart Circle*, 995 F.2d at 503. In comparison, the Fifth Circuit found that the Louisiana statute encompassed entities other than insurers. See *CIGNA Healthplan*, 82 F.3d at 650 ("On its face, Louisiana's statute obviously is not 'limited to entities within the insurance industry.'").

102. LA. REV. STAT. ANN. §§ 40:2201-2253 (West 1992).

103. See *CIGNA Healthplan*, 82 F.3d at 645 (describing reasons for Act).

104. LA. REV. STAT. ANN. § 40:2202(5).

105. *Id.* § 40:2202(3).

106. *Id.* § 40:2202(3)(a), (b); see *CIGNA Healthplan*, 82 F.3d at 645 (explaining Act's definition of "group purchaser"). To provide "incentive for purchasers and providers" of health care "to strive for more cost-efficient and effective methods of providing quality patient care and more efficient payment for services rendered," the Act authorizes the "formation of preferred provider organizations." LA. REV. STAT. ANN. § 40:2202(5)(c).

be denied the right to become a preferred provider."¹⁰⁷ In February 1993, the Louisiana Attorney General's office issued an advisory opinion indicating that the "arbitrary exclusion from a PPO of a licensed physician who is 'willing and able to accede to the terms and conditions of the preferred provider contract' constitutes both a violation of the Any Willing Provider statute and an unfair trade practice under Louisiana Law."¹⁰⁸

Both CIGNA HealthPlan ("CIGNA") and Connecticut General Life Insurance Company ("CGLIC") are "group purchasers" within the terms of the Act. CIGNA is a licensed health maintenance organization (HMO) that provides prepaid coverage to enrolled subscribers.¹⁰⁹ To provide this coverage, CIGNA contracts with selected physicians, hospitals and other health care providers who agree to adhere to CIGNA's quality control requirements and to offer their services to CIGNA subscribers at discounted rates.¹¹⁰

CGLIC is a licensed health insurer that markets CIGNA's provider network in Louisiana.¹¹¹ CGLIC also contracts with CIGNA for the right to use the provider network that CGLIC offers to, and administers for, its clients.¹¹² Both CIGNA and CGLIC have clients who include the sponsors of ERISA-qualified employee welfare benefit plans.¹¹³

In 1994, CIGNA notified one of the physicians in its provider network that it was terminating his contract.¹¹⁴ The physician sued CIGNA, alleging that his termination was in violation of the Any Willing Provider Statute.¹¹⁵ After a temporary restraining order was issued against CIGNA, the parties reached a settlement and the suit was dismissed.¹¹⁶

This, however, was not the end of CIGNA's legal troubles. The Louisiana Attorney General's office notified CIGNA that a doctor had filed a formal complaint alleging that CIGNA violated the Any Willing Provider Statute by rejecting his application to its provider network.¹¹⁷ In addition, CIGNA had received applications to its provider network from several physicians that it wanted to reject.¹¹⁸ Because of these events, plaintiffs feared

107. LA. REV. STAT. ANN. § 40:2202(5)(c).

108. *CIGNA Healthplan*, 82 F.3d at 645 (quoting A Qualified Provider Cannot Be Arbitrarily Excluded from a PPO Contract, La. Att'y Gen. Op. No. 92-824 (1993)).

109. *See id.*

110. *See id.*

111. *See id.* at 646.

112. *See id.*

113. *See id.*

114. *See id.*

115. *See id.* Dr. Ronald Sylvest filed a private suit against CIGNA after he had been given sixty days notice that he would be removed from CIGNA's provider network. *See id.*

116. *See id.*

117. *See id.*

118. *See id.* CIGNA had already contracted with the "optimum" number of health care providers of these physicians' specialties. *See* Brief for Appellee at 6, *CIGNA Healthplan* (No. 95-30481) (stating that CIGNA wanted to contract selec-

suit by both private parties and the Attorney General for alleged violations of the Any Willing Provider Statute.¹¹⁹ Because plaintiffs believed that this statute was preempted by ERISA, they brought an action for declaratory and injunctive relief.¹²⁰

CIGNA and CGLIC filed suit against the State of Louisiana seeking, among other things, (1) a declaratory judgment holding that ERISA preempts Louisiana's Any Willing Provider Statute¹²¹ and (2) an injunction prohibiting the filing of any action against them for alleged violations of the Any Willing Provider Statute.¹²² The district court granted the plaintiffs' motion for summary judgment by holding that ERISA preempts the Any Willing Provider Statute to the extent that it relates to employee welfare benefit plans governed by ERISA.¹²³ The district court also issued

tively with providers to ensure that "their provider network included an optimal number of highly skilled providers in each specialty to meet the needs of the subscriber population efficiently and to maintain an effective program of quality control and utilization management").

119. See Brief for Appellee at 6, *CIGNA Healthplan* (No. 95-30481) (stating that in addition to possibility of encouraging lawsuits, plaintiffs feared damage to their reputation).

120. See *id.*

121. See LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992) ("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.").

122. See *CIGNA Healthplan*, 82 F.3d at 644.

123. See *CIGNA Healthplan of La., Inc. v. Louisiana*, 883 F. Supp. 94, 102-104 (M.D. La. 1995) (addressing preemption issue after disposing of some preliminary issues such as standing, subject matter jurisdiction and plaintiffs' due process claims), *aff'd*, 82 F.3d 642 (5th Cir. 1996). The court observed that the preemption text is "notably loose." *Id.* Yet, the court also recognized that preemption is not limitless. See *id.* at 103. The court, however, declined to find that the case before it fell beyond the limits of ERISA preemption. See *id.* at 104. The court agreed with CIGNA that the plain language of Louisiana's Any Willing Provider Statute showed that it related to employee benefit plans within the meaning of ERISA. See *id.* at 103. The court stated that "the language of the Act betrays the State's perception that the statute is no more than a law of general applicability, with no specific reference to ERISA-governed plans." *Id.* In particular, the court observed that several provisions point to the Act's express reference and applicability to employee benefit plans. See *id.* For example, under the Act, "group purchasers" are defined to include benefit plans such as those operated by CIGNA. See *id.*

After finding that the Any Willing Provider Statute related to ERISA plans, the court then considered whether the statute was nonetheless saved from preemption as a law regulating insurance. See *id.* at 104. First, the court analyzed whether the statute fit the commonsense definition of an insurance regulation. See *id.* Second, the court applied the three *Metropolitan Life* factors: "(1) whether the statute has the effect of spreading the policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry." *Id.* In summary fashion, the court found that Louisiana's Any Willing Provider Statute failed the common sense test because it was not specifically directed towards the insurance industry, but rather, expressly applied to entities outside the insurance industry, such as employers and Taft-Hartley trusts. See *id.* For this same reason,

an injunction barring enforcement of the statute against CIGNA and CGLIC.¹²⁴

B. *The Fifth Circuit's Analysis*

The Fifth Circuit held that ERISA preempted Louisiana's Any Willing Provider Statute.¹²⁵ The court began its analysis by setting forth the preemption language stating that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."¹²⁶ Even after acknowledging that "ERISA preemption is not without limits," the court nevertheless broadly construed the "relate to" language and found that this language encompassed Louisiana's Any Willing Provider Statute.¹²⁷ The court found that the statute referred to ERISA-qualified plans and that this was enough to satisfy the "relate to" requirement.¹²⁸

Notably, the court reached this conclusion even though the Any Willing Provider Statute does not expressly refer to ERISA plans; it merely requires that PPOs must accept any licensed provider who "agrees to the terms and conditions of the preferred provider contract."¹²⁹ It is only by piecing together the various definitions in the Act that the court determined that the Any Willing Provider Statute referred to ERISA-qualified plans.¹³⁰ Under the Act, a preferred provider contract is an agreement "between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment specified in advance for a defined period of time."¹³¹ According to the Act, group purchasers may include such entities as "insurers, self-funded organizations, Taft-Hartley trusts or employers who establish or participate in self-funded trusts or programs."¹³² Because the court found that the entities which may constitute

the court found that the statute failed the third *Metropolitan Life* factor and, therefore, was preempted by ERISA. *See id.*

124. *See id.*

125. *See CIGNA Healthplan*, 82 F.3d at 650. The court first found that Louisiana's Any Willing Provider Statute related to employee benefit plans within the meaning of ERISA. *See id.* at 647. The court then found that the statute was not exempted from preemption by the savings clause. *See id.* at 650. The court began and finished its analysis with the third factor of the *Metropolitan Life* test. *See id.* The court found that "[o]n its face, Louisiana's statute obviously is not 'limited to entities within the insurance industry,'" so ERISA's insurance exception did not save the statute from preemption. *Id.*

126. *Id.* at 646.

127. *Id.* at 647.

128. *See id.*

129. LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992).

130. *See CIGNA Healthplan*, 82 F.3d at 647-48, 648 n.36 (admitting that "in holding that the statute refers to ERISA plans, we rely heavily on language that is found not in the text of the statute itself, but rather in the surrounding provisions of the Act that define the key terms of the statute").

131. LA. REV. STAT. ANN. § 40:2202(5)(a).

132. *Id.* § 40:2202(3)(a).

group purchasers under the Act may be ERISA-qualified plans, it held that ERISA preempted the statute.¹³³

As an alternative ground for finding that the statute “relate[s] to” ERISA plans, the court found that the Any Willing Provider Statute was “connected with such plans” because it prohibited “those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider.”¹³⁴ Quoting *Travelers*, the court stated that preemption was appropriate on this ground when statutes “‘mandate employee benefit structures or their administration.’”¹³⁵ The court then found that the Any Willing Provider Statute mandated employee benefit plan structures, and therefore, this was sufficient to meet the “relate to” requirement.¹³⁶

In preemption analysis, a court’s inquiry does not end when it has determined that a statute falls within the preemption clause. The court must still determine whether the savings clause rescues the statute from preemption.¹³⁷ After satisfying itself that the Louisiana statute was within the preemption clause, the Fifth Circuit turned to the savings clause.¹³⁸ The court identified the framework for savings clause analysis set forth in *Metropolitan Life*.¹³⁹

Under this framework, to qualify for the savings clause exception to preemption, a statute must first meet the commonsense definition of an insurance regulation.¹⁴⁰ Next, the statute must meet *Metropolitan Life*’s three factor test: (1) the statute must have the effect of spreading the policyholder’s risk; (2) the statute must deal with an integral part of the policy relationship between the insurer and the insured; and (3) the statute must only apply to entities in the insurance industry.¹⁴¹ The court noted that if a statute fails to satisfy either the commonsense definition of insurance regulation, or any one of the three *Metropolitan Life* factors, the savings clause does not exempt it from preemption.¹⁴² The court began and concluded its analysis with the consideration of the third factor of the *Metro-*

133. See *CIGNA Healthplan*, 82 F.3d at 648 (“Given that these enumerated entities constitute ERISA-qualified plans, the Act, and through it the Any Willing Provider statute, expressly refers to ERISA plans.”).

134. *Id.*

135. *Id.* (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995)).

136. See *id.* (holding that statute connected with ERISA plans by prohibiting selection of PPO not including any willing, licensed provider).

137. For a general discussion of the preemption framework and analysis, see *supra* notes 33-98 and accompanying text.

138. See *CIGNA Healthplan*, 82 F.3d at 650 (setting forth ERISA’s savings clause).

139. See *id.* at 650. The court noted that the Fifth Circuit adopted the *Metropolitan Life* test for savings clause analysis in *Tingle v. Pacific Mutual Insurance Co.*, 996 F.2d 105 (5th Cir. 1993). See *CIGNA Healthplan*, 82 F.3d at 650.

140. See *CIGNA Healthplan*, 82 F.3d at 650.

141. See *id.* (noting that all three prongs must be satisfied for exemption and that failure of any one prong would defeat exemption claim).

142. See *id.* (applying *Metropolitan Life* test for preemption).

politan Life test: the Louisiana statute was not limited to entities within the insurance industry.¹⁴³ Even though the statute lists insurers as one group covered by its terms, the court remarked that it also specifies, “in a non-exclusive list, that it applies to ‘self-funded organizations, Taft-Hartley trusts or employers who establish or participate in self funded trusts or programs.’”¹⁴⁴ According to the court, this “non-exclusive list” was enough to disqualify the statute from the savings clause and to hold that ERISA preempted Louisiana’s Any Willing Provider Statute.¹⁴⁵

IV. HOW THE FIFTH CIRCUIT FAILED TO CONTINUE THE WORK OF THE TRAVELERS COURT

The Fifth Circuit’s decision in *CIGNA Healthplan* represents poor preemption analysis in light of the Supreme Court’s narrow construction of ERISA preemption in *Travelers*.¹⁴⁶ There, the Supreme Court took a narrow view of ERISA preemption, whereas the Fifth Circuit distinguished this precedent and reverted back to the expansive view of preemption that the Supreme Court announced in *Metropolitan Life*.¹⁴⁷ Although the Fifth Circuit stated a legitimate basis upon which to distinguish *Travelers*—that the New York statute in *Travelers* did not “bind plan administrators to any particular choice,”¹⁴⁸ whereas the Louisiana statute “specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner”¹⁴⁹—this distinction was more apparent than real.¹⁵⁰

143. *See id.* (concluding that statute failed third prong of *Metropolitan Life* test, and therefore, court did not need to examine first two prongs or whether statute satisfied commonsense definition of insurance regulation).

144. *Id.* (quoting LA. REV. STAT. ANN. § 40:2202(3)(a) (West 1992)).

145. *See id.* (“[W]e may start and finish with the third factor of the Metropolitan Life test: On its face, Louisiana’s statute obviously is not ‘limited to entities within the insurance industry.’”).

146. *See* Leslie J. Gold, *Louisiana Preemption Ruling May Limit Ability of States to Regulate Networks*, 23 Pens. & Ben. Rep. (BNA) 1279 (May 13, 1996) (stating that attorneys interviewed by Bureau of National Affairs after April 30, 1996 Fifth Circuit ruling agreed that court’s decision appeared to be at odds with rulings on scope of ERISA in recent cases such as *Travelers*).

The same article reported that in a May 6, 1996 statement, “CIGNA said that it was pleased with the ruling because it affirmed the right of health maintenance organizations, insurers and self-insured benefit plans to use selective provider panels.” *Id.* Richard Smith, the Vice President for health care policy at the Association for Private Pension and Welfare Plans in Washington, D.C., was also pleased with the decision. *See id.* In his opinion, it “shows there’s real teeth left in ERISA preemption.” *Id.*

147. For a discussion of the *Travelers* decision, see *supra* notes 80-96 and accompanying text.

148. *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649 (1995).

149. *CIGNA Healthplan*, 82 F.3d at 649.

150. *See* LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992). Contrary to the court’s finding, Louisiana’s statute does not mandate the benefit structure of ERISA plans. *See id.* Rather, the statute only requires that once the plans have set the terms and conditions of their plans, they must accept any provider willing to meet

The few cases that have addressed the validity of “any willing provider” laws have glossed over the threshold preemption issue.¹⁵¹ Courts have almost taken it for granted that the broad “relate to” language of the ERISA preemption clause encompasses these statutes. The main inquiry of these opinions, then, was the scope of the insurance savings clause.¹⁵² Most of the courts that have considered “any willing provider” laws have focused on whether the statute in question fits neatly into (or at least can be manipulated into) the savings clause.

Courts should not summarily find that all laws having any relation to ERISA plans qualify for ERISA preemption. Rather, courts should perform a fresh¹⁵³ analysis in light of *Travelers* to determine if these laws really impose any substantive requirements on the benefit plans, or if “[s]uch state laws leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money.”¹⁵⁴ This Note advocates that courts should perform a closer analysis of whether the “any willing provider” laws actually “relate to” an ERISA plan. A closer analysis seems to suggest that these laws have a more “tenuous, remote or peripheral” connection and, therefore, should escape preemption.¹⁵⁵ For example, the Louisiana Any Willing Provider Statute that was preempted in *CIGNA Healthplan* does not mandate or restrict an ER-

those terms and conditions. *See id.* For a discussion of Louisiana’s Any Willing Provider Statute and its impact on employee benefit plans, see *supra* notes 99-108 and accompanying text.

151. *See* *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir. 1993) (finding that “any willing provider” statute relates to ERISA plans because it applies to health benefit programs operated by insurers); *Texas Pharmacy Ass’n v. Prudential Ins. Co. of Am.*, 907 F. Supp. 1019, 1025 (W.D. Tex. 1995) (finding, without further elaboration, that “any willing provider” statute relates to ERISA plans because statute impacts ERISA plans), *modified*, 105 F.3d 1035 (5th Cir. 1997). These cases, however, were decided before the Supreme Court’s latest pronouncement on ERISA preemption in *Travelers*, which indicated that courts should scrutinize more closely the extent that a statute “relates to” an ERISA plan. *See Travelers*, 514 U.S. at 662 (narrowing focus of “relate to” clause by stating that cost uniformity was “far cry” from what Congress intended to be preempted by ERISA).

152. *See, e.g., Stuart Circle*, 995 F.2d at 503 (affirming district court’s finding that Virginia “any willing provider” statute related to employee benefit plans within meaning of ERISA and focusing majority of its opinion on analyzing scope of insurance savings clause).

153. *See* *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 135 (1992) (Stevens, J., dissenting) (“[I]t is time to take a fresh look at the intended scope of the pre-emption provision that Congress enacted.”). Justice Stevens criticized the majority for “converting unnecessarily broad dicta interpreting the words ‘relate to’ as used in [the ERISA preemption clause], into a rule of law.” *Id.* at 133 (Stevens, J., dissenting). He added that “until today that broad reading of the phrase has not been necessary to support any of this Court’s actual holdings.” *Id.* at 135 (Stevens, J., dissenting).

154. *Travelers*, 514 U.S. at 662.

155. *See* *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983) (providing that statutes with “tenuous, remote or peripheral” connection to ERISA plans will not give rise to preemption).

ISA plan's benefits, structure or administration.¹⁵⁶ Instead, this statute merely protects the right of a health care provider to join a provider network if he or she is willing to meet its terms and conditions.¹⁵⁷ This connection to an ERISA plan is too tenuous to trigger preemption, especially in light of the *Travelers* decision.¹⁵⁸

Despite this tenuous connection to an ERISA plan, the *CIGNA Healthplan* court held that the Louisiana Any Willing Provider Statute "relate[d] to" employee benefit plans within the meaning of ERISA and, therefore, was preempted.¹⁵⁹ The *CIGNA Healthplan* court found that the statute related to ERISA plans for two reasons. First, the statute required ERISA plans that elected to use PPOs to select a PPO that would accept any willing provider.¹⁶⁰ Second, the Court reasoned that the statute applied to ERISA plans because its definition section refers to entities that may include ERISA plans.¹⁶¹

156. See LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992).

157. See *id.* ("[N]o licensed provider . . . who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider . . .") (emphasis added).

158. See *Travelers*, 514 U.S. at 672 (diminishing reach of "relate to" clause). Any connection the Louisiana statute has to ERISA plans is too tenuous to trigger preemption because its effect is not to "mandate employee benefit structures or their administration" or "produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of coverage or effectively restrict its choice of insurers." *Id.* at 646. Rather, the Louisiana statute may have an indirect economic effect on ERISA plans, but such "an indirect economic influence . . . does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan." *Id.* at 659.

159. See *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 648 (5th Cir. 1996).

160. See *id.* at 648. The court stated that the statute "relates to" ERISA plans in the sense that it is connected with such plans. The Supreme Court has emphasized that preemption is appropriate on this ground when statutes "mandate employee benefit structures or their administration." In the instant case, ERISA plans that choose to offer coverage by PPOs are limited by the statute to using PPOs of a certain structure—i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use PPOs from selecting a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

Id. (quoting *Travelers*, 514 U.S. at 657).

161. *Id.* at 647. The court stated that the Any Willing Provider Statute referred to ERISA plans because it requires that PPOs accept all licensed providers "who agree to the terms and conditions of the preferred provider contract." *Id.* (citing LA. REV. STAT. ANN. § 40:2202(5)(c)). Then the court noted that according to the Act, a preferred provider contract constitutes an agreement "between a provider . . . and a group purchaser . . . to provide for alternative rates of payment specified in advance for a defined period of time." *Id.* at 647-48. The court observed that under the Act "group purchasers" may include entities such as Taft-Hartley trusts or employers who establish or participate in self-funded programs that contract with health care providers for the benefit of their employees. See *id.* at 648. Because these entities constitute ERISA plans, the court held that the Act referred to ERISA plans. See *id.* The court recognized, however, that "in holding

ERISA should not preempt Louisiana's Any Willing Provider Statute because it does not "relate to" employee benefit plans within the meaning of ERISA. Despite the Fifth Circuit's ruling to the contrary, the Any Willing Provider Statute does not mandate the structure of ERISA plans, nor is the statute's mere reference to ERISA plans sufficient to trigger preemption.

A. *Louisiana's Any Willing Provider Statute Does Not Mandate the Structure of ERISA Plans*

The general rule for ERISA preemption is that ERISA preempts state laws that "relate to" an employee benefit plan.¹⁶² In *Shaw*, however, the Supreme Court recognized that ERISA does not preempt a state law if it affects employee benefit plans in "too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."¹⁶³ The difficulty of preemption analysis is determining the boundary between laws that relate to employee benefit plans and laws that do not warrant preemption because their effect on employee benefit plans is too tenuous, remote or peripheral.¹⁶⁴

To make this determination, "as in any pre-emption analysis, '[the] purpose of Congress is the ultimate touchstone.'"¹⁶⁵ Congress's purpose in enacting the preemption clause was to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."¹⁶⁶ That is, ERISA preemption was designed to avoid con-

that the statute refers to ERISA plans, we rely heavily on language that is found not in the text of the statute itself, but rather in the surrounding provisions of the Act that define the key terms of the statute." *Id.* at 648 & n.36.

162. See 29 U.S.C. § 1144(a) (1994) (preempting state laws if they "relate to any employee benefit plan" as defined by ERISA).

163. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100 n.21. (1983).

164. For further discussion of the difficulty of determining what laws fall within ERISA preemption's "relate to" clause, see *supra* notes 33-57 and accompanying text.

165. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) (quoting *Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978)); see also *Travelers*, 514 U.S. at 662 (using congressional intent as guide to interpreting ERISA preemption provisions); *Shaw*, 463 U.S. at 95 ("In deciding whether a federal law preempts a state statute, our task is to ascertain Congress' intent in enacting the federal statute at issue.").

166. *Travelers*, 514 U.S. at 657. See, e.g., *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (holding that ERISA preempted Pennsylvania antisubrogation statute that prevented Pennsylvania plans "from being structured in a manner requiring reimbursement in the event of recovery from a third party"); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 526 (1981) (holding that ERISA preempted New Jersey statute to extent that it prevents ERISA plans from decreasing benefits by amount recipient is awarded in workers' compensation); *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726, 730 (4th Cir. 1992) (holding that ERISA preempted North Carolina antisubrogation statute); *National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir. 1992) (holding that ERISA preempted administrative determination of Oklahoma's prevailing wage statute to extent it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an

flicting regulations that would make it difficult for plan sponsors to administer their benefit plans.¹⁶⁷ These conflicting regulations may arise when state laws mandate the structure and administration of employee benefit plans.¹⁶⁸ The *Travelers* Court explained that to remedy this problem, ERISA will preempt state law when the law “bind[s] plan administrators to any particular choice and thus function[s] as a regulation of an ERISA plan itself.”¹⁶⁹

ERISA plan”); *Michigan Carpenters Council v. C.J. Rogers, Inc.*, 933 F.2d 376, 384 (6th Cir. 1991) (holding that ERISA preempted Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans).

167. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-11 (1987) (determining whether ERISA preempted Maine statute that required employers, in event of plant closing, to provide one-time severance payment to employees not covered by express contract providing for severance pay). Holding that ERISA did not preempt the Maine statute, the *Fort Halifax* Court explained the congressional intent in enacting the preemption clause. *Id.* at 15. The Court stated that

[a]n employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payment, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. . . .

. . . .
 . . . It is . . . clear that ERISA’s preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id. at 9-11; see also *United Wire, Metal & Mach. Health & Welfare Fund v. New Jersey*, 995 F.2d 1179, 1192 (3d Cir. 1993) (observing that ERISA preemption was prompted by recognition that employers establishing employee benefit plans are faced with task of coordinating complex administrative activities and that patchwork scheme of regulation would cause many inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits and those without existing plans to refrain from offering them).

168. See *Fort Halifax*, 482 U.S. at 11 (“It is for this reason that Congress preempted state laws relating to *plans* rather than simply to *benefits*.”).

169. *Travelers*, 514 U.S. at 659. In previous cases in which the Court has held that ERISA preempted state law, the Court has found that the state law at issue mandated the structure of employee benefit plans. In its analysis, the Court cited *Shaw*, in which the Court held that the New York law at issue “prohibit[ed] employers from structuring their employee benefit plans in a manner that discriminate[d] on the basis of pregnancy.” *Travelers*, 514 U.S. at 657 (citing *Shaw*, 463 U.S. 85, 96 (1983)). Another case in which the Court found ERISA preemption based on the fact that the state law mandated employee benefit plan structure or administration was *FMC Corp. v. Holliday*. See *FMC Corp.*, 498 U.S. at 60 (holding

In *CIGNA Healthplan*, the Fifth Circuit should not have held that ERISA preempted Louisiana's Any Willing Provider Statute because the statute does not bind plan administrators to a particular choice, nor does it function as a regulation of ERISA plans.¹⁷⁰ The Fifth Circuit incorrectly stated that Louisiana's Any Willing Provider Statute "specifically mandates that certain benefits available to ERISA plans must be constructed in a particular manner."¹⁷¹ Furthermore, the court made the inaccurate conclusion that the statute did not have a mere indirect economic effect on the plans, but rather the statute delineated the very structure of the benefit plans.¹⁷²

This conclusion is not accurate. As the Louisiana State Medical Society and the Louisiana Dental Association asserted in their amicus curiae brief, the court failed to recognize that by requiring CIGNA to include in its network any provider willing to meet the terms and conditions of the network, the statute does not mandate that employee benefit plans adopt any particular structure.¹⁷³ Rather, the employee benefit plans retain control over the terms and conditions of their plans and the terms of their provider contracts. In addition, the Any Willing Provider Statute does not impair a plan sponsor's ability to offer the same benefits to employees in

that ERISA preempted Pennsylvania antisubrogation statute). The *Travelers* Court noted that the Pennsylvania statute at issue in *FMC Corp.* "prohibit[ed] 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 benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation,' thereby 'frustrat[ing] plan administrators' continuing obligation to calculate uniform benefits levels nationwide.'" *Travelers*, 514 U.S. at 657-58 (quoting *FMC Corp.*, 498 U.S. at 59).

170. See *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996) (stating that statute mandates construing ERISA benefits in specific way as grounds for preemption). For a further discussion of the court's holding and analysis in *CIGNA Healthplan*, see *supra* notes 98-145 and accompanying text.

171. *CIGNA Healthplan*, 82 F.3d at 649.

172. See *id.*

173. Brief of Amicus Curiae of the Louisiana State Medical Society and the Louisiana Dental Association in Support of Appellants at 8-9, *CIGNA Healthplan* (No. 95-30481). According to the Louisiana State Medical Society and Louisiana Dental Association,

[r]equiring [CIGNA and CGLIC] to include health care providers willing and able to meet CIGNA's and CGLIC's contractual requirements does not require employee benefit plans to structure their benefits or conduct their internal affairs in any particular way. The any-willing-provider statute does not prohibit an employee benefit plan from offering coverage through a preferred provider organization or specify the terms of the provider contract. It does not impair a plan sponsor's ability to offer the same benefits to employees in different states. It does not require any ERISA plan . . . to pay any benefit, any level of benefit, or any particular amount of a patient's medical bill. It does not impose any substantive administrative requirements on ERISA plans.

Id.

different states, nor does it require any ERISA plan to pay any particular benefits or any particular amounts of patients' medical bills.¹⁷⁴

For these reasons the Any Willing Provider Statute does not mandate any particular structure or administrative scheme for employee benefit plans in Louisiana. Rather, the statute only becomes an issue for a PPO *after* its plan administrators determine its benefit structure, terms and conditions. Consequently, contrary to the Fifth Circuit's holding, plan administrators still control the substantive content of their PPO, and the statute avoids ERISA-related concerns.

B. *Mere Reference to an ERISA Plan Should Not Trigger Preemption*

The second basis upon which the Fifth Circuit held that the Louisiana Any Willing Provider Statute related to ERISA was the court's improper conclusion that the statute referred to ERISA plans.¹⁷⁵ As previously discussed, under *Travelers*, ERISA does not preempt state laws if they affect ERISA plans in a tenuous, remote or peripheral manner.¹⁷⁶ For ERISA preemption to operate, a state law must mandate or restrict the choices offered under an ERISA plan.¹⁷⁷ Notwithstanding the Fifth Circuit's holding, a mere reference to an ERISA plan, without more, is insufficient to trigger preemption.¹⁷⁸

In *United Wire*, the Third Circuit summarily dismissed an argument similar to the explanation offered by the Fifth Circuit to justify its ruling that the Louisiana statute related to ERISA plans.¹⁷⁹ In *United Wire*, the appellee benefit plans argued that the New Jersey hospital rate-setting statute at issue "related to" ERISA plans because it expressly referred to "self-funded union plans" as one example of a "third party payor" as used in the statute.¹⁸⁰ The court responded that "[w]here, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in

174. See LA. REV. STAT. ANN. § 40:2202(5)(c) (West 1992) ("[N]o licensed provider . . . who agrees to the terms and conditions of the preferred provider contract shall be denied the right to become a preferred provider.") (emphasis added).

175. See *CIGNA Healthplan*, 82 F.3d at 647. For a further discussion of the court's holding and analysis, see *supra* notes 98-145 and accompanying text.

176. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 672 (1995). For a further discussion of the *Travelers* decision, see *supra* notes 80-96 and accompanying text.

177. See *Travelers*, 514 U.S. at 672 (discussing diminishing reach of "relate to" clause).

178. See *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp.*, 995 F.2d 1179, 1192 n.6 (3d Cir. 1993) ("Where, as here, a reference to an ERISA plan can be excised without altering the legal effect of a statute in any way, we believe the reference should be regarded as without legal consequence for [preemption] purposes.")

179. *Id.* For a further discussion of the *United Wire* decision, see *supra* notes 72-79 and accompanying text.

180. *United Wire*, 995 F.2d at 1192 & n.6.

any way, we believe the reference should be regarded as without legal consequence for [preemption] purposes.”¹⁸¹

Like the New Jersey statute, Louisiana’s Any Willing Provider Statute indirectly refers to ERISA plans because it lists Taft-Hartley trusts and self-funded benefit plans as examples of entities that may constitute group purchasers under the Act.¹⁸² The Act is not limited to these entities, but rather these entities are mentioned merely by way of example.¹⁸³ Like the self-funded union plans mentioned in the New Jersey statute, this reference to Taft-Hartley trusts and self-funded benefit plans can be excised from the Louisiana statute without altering its legal effect.¹⁸⁴ Accordingly, under the *United Wire* rationale, this reference was an insufficient basis for the Fifth Circuit to hold that the Louisiana statute related to ERISA and, as a result, was preempted.¹⁸⁵

By ignoring the Third Circuit’s sound reasoning, the Supreme Court’s modified approach to ERISA preemption in *Travelers* and the limiting language of *Shaw*, the Fifth Circuit revived a broader view of ERISA preemption. This sweeping view of ERISA preemption will continue to have adverse effects on state health care reform legislation and impede any resolution to the nation’s health care crisis.¹⁸⁶

181. *Id.* This approach is consistent with the *United Wire* court’s overall narrow approach to ERISA preemption. *See id.* at 1194 (holding ERISA does not preempt New Jersey hospital rate-setting program because it was not intended to regulate affairs of ERISA plans, did not single out ERISA plans for special treatment and did not dictate or restrict manner in which ERISA plans structure or conduct their affairs, nor did it affect their ability to operate simultaneously in more than one state). Accordingly, the Third Circuit held that ERISA did not preempt New Jersey’s hospital rate-setting scheme. *See id.* at 1196.

182. *See* LA. REV. STAT. ANN. § 40:2202(3)(a) (West 1992) (listing examples of included entities). For a discussion of the Louisiana Any Willing Provider Statute and its defined terms, see *supra* notes 99-108 and accompanying text.

183. *See* LA. REV. STAT. ANN. § 40:2202(3) (stating that entities may include any enumerated in subsequent part of statute).

184. *See id.* § 40:2202(3)(a) (defining “group purchaser” as “[e]ntities which contract for the benefit of their insured, employees, or members such as insurers, self-funded organizations, Taft-Hartley trusts, or employers who establish or participate in self-funded trusts or programs”); § 40:2202(5)(a) (defining “preferred provider organization”); § 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 [or her] license.”).

185. *See* CIGNA Healthplan of La., Inc. v. Louisiana, 82 F.3d 642, 648 (5th Cir. 1996) (holding that enumeration in statute does constitute grounds for finding that statute relates to plans, so preemption is justified).

186. For a discussion of ERISA’s devastating effect on state health care reform measures, see *supra* notes 9-11 and accompanying text.

VI. CONCLUSION

Currently, a great need exists for health care reform.¹⁸⁷ Because the federal government has not succeeded in implementing the necessary reforms, the states have taken up the task.¹⁸⁸ Many state reform efforts, however, are blocked by ERISA's broad preemption scheme.¹⁸⁹ The Supreme Court has recently narrowed its interpretation of the preemption framework to afford states a greater opportunity to exercise their traditional police powers in the area of health care legislation.¹⁹⁰ In light of the Supreme Court's direction, the lower courts must continue to narrowly interpret the ERISA preemption language in a way that permits states to experiment with health care reforms, yet does not betray Congress's original intent in enacting the preemption clause. To do this, the courts should preempt only those state laws that restrict an ERISA plan's benefits, structure or administration in violation of ERISA's substantive requirements, rather than unnecessarily expanding the scope of the "relate to" clause to encompass every state statute that has a remote connection with an ERISA plan.¹⁹¹

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187. For a discussion of the acute need for health care reform in the United States, see *supra* notes 1-6 and accompanying text.

188. For a discussion of state health care reform initiatives, see *supra* note 7 and accompanying text.

189. For a discussion of how ERISA thwarts state health care reform efforts, see *supra* notes 9-11 and accompanying text.

190. For a discussion of the *Travelers* decision, see *supra* notes 80-96 and accompanying text.

191. For a discussion of why the courts should interpret the "relate to" clause in future preemption cases, see *supra* notes 146-86 and accompanying text.