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# BALANCING THE INTERESTS OF STATE HEALTH CARE REFORM AND UNIFORM EMPLOYEE BENEFIT LAWS UNDER ERISA: A “UNIFORM PATIENT PROTECTION ACT”

## I. INTRODUCTION

The Employee Retirement Income Security Act of 1974<sup>1</sup> (ERISA) aims to standardize employee benefit laws and protect the beneficiaries of employee benefit plans<sup>2</sup> by setting administrative and substantive standards for the operation of employee benefit plans.<sup>3</sup> In

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1. 29 U.S.C. §§ 1001-1461 (1994).

2. ERISA defines an “employee benefit plan” as “an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.” 29 U.S.C. § 1002(3). This Note will address health coverage under an employee welfare benefit plan. ERISA defines “employee welfare benefit plan,” in relevant part, as

any plan . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan . . . is maintained for the purpose of providing[,] . . . through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

*Id.* § 1002(1). ERISA does not apply to governmental plans, church plans, plans maintained outside of the United States that primarily benefit non-resident aliens, excess benefit plans, or plans maintained for the sole purpose of complying with laws relating to disability insurance, worker’s compensation, or unemployment compensation. *See id.* § 1003(b)(1)-(5).

3. Congress’s findings and policy declaration for ERISA state in relevant part:

[O]wing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; . . . [i]t is therefore desirable in the interests of employees

enacting ERISA, Congress sought to balance the need for uniform regulation of multi-state employers'<sup>4</sup> employee benefit plans with states' freedom to regulate issues of local concern.<sup>5</sup> Accordingly, Congress furnished ERISA with a broad preemption clause<sup>6</sup> and

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and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

*Id.* § 1001(a). Accordingly, ERISA requires employers to disclose to plan participants and their beneficiaries financial and other information regarding employee benefit plans "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." *Id.* § 1001(b).

4. For the purposes of this Note, the term "multi-state employer" refers to an employer whose operations are interstate in nature, and whose employee benefit plans operate, therefore, on an interstate scale. *See id.* § 100(a).

5. *See* Nicole Weisenborn, *ERISA Preemption and Its Effect on State Health Reform*, 5 KAN. J.L. & PUB. POL'Y 147, 147 (1985) (discussing ERISA's underlying purpose).

As states can best assess the health needs of their own citizens and enact laws to address those needs, health care is "primarily, and historically, a matter of local concern." *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985) (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). States derive their authority to regulate health care from the state police power, which states, in turn, derive from the Tenth Amendment. *See Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905) (holding that state police power necessarily includes the authority "to enact quarantine laws and 'health laws of every description'" (quoting *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824))). If state health care regulation conflicts with a unique federal interest, however, such as Congress's power to regulate interstate commerce, the pertinent federal law will preempt the state regulation. *See* U.S. CONST. art. VI, cl. 2 (Supremacy Clause); *see also* Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993) (providing an overview of traditional preemption analysis).

6. *See* 29 U.S.C. § 1144(a). Section 514(a) of ERISA provides, in relevant part, that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." *Id.* ERISA defines "State Law" as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." *Id.* § 1144(c)(1).

The Supreme Court has summarized Congress's underlying purpose for enacting ERISA's broad preemption clause:

An 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 payments, 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.

*Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).

Neither the House nor the Senate originally contemplated including such a broad preemption provision in ERISA. *See* Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383, 390-95 (1994-95). The

ected to regulate the administration of benefit plans rather than regulate employees' substantive rights to benefits under such plans.

Although ERISA provides some substantive protections for pension plan participants and their beneficiaries, it provides virtually no such protection for participants in, and beneficiaries of, health benefit plans or other welfare plans.<sup>7</sup> Despite ERISA's lack of substantive standards for health benefit plans, courts have broadly interpreted ERISA's preemption clause and narrowly construed exceptions to ERISA preemption in order to protect the free market of health insurance.<sup>8</sup> These judicial interpretations of ERISA have posed great challenges to state health care reform initiatives.<sup>9</sup> As the broad scope of ERISA preemption has thus thwarted many states' legislative efforts to reform health care,<sup>10</sup> and as comprehensive health care reform has not occurred on a national level,<sup>11</sup> a "regulatory vacuum"<sup>12</sup> now exists in the health care arena. This regulatory vacuum has rendered essential the establishment of an appropriate balance between ERISA's objective of providing uniform employee benefit laws and the states' interests in enacting consumer-oriented health care reform measures.

Part II of this Note provides a summary of the current state of health care in the United States. Part III examines both the role that

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Conference Committee, which convened to resolve discrepancies between the House and Senate versions of ERISA, adopted section 514(a)'s broad "relationship to any employee benefit plan" preemption standard after the Committee's final negotiations. See H.R. REP. NO. 93-1280, at 383 (1974), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5162. The Committee then presented ERISA's broader preemption clause to Congress only ten days before Congress passed the legislation. See *id.* For a discussion of the preemption provisions that the House and the Senate originally considered, see Hancock, *supra*, at 390-95.

7. See Daniel C. Schaffer & Daniel M. Fox, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 55-56 (1988). Schaffer and Fox characterize ERISA's effect on health insurance as "semi-preemption" because it allows states to regulate some aspects of health insurance if the employer purchases insurance rather than insuring employees itself. See *id.* at 48; see also *infra* notes 63-65 and accompanying text.

8. For a discussion of the preemption analyses used by federal courts in invalidating state laws, see *infra* Part III.A-B.

9. These challenges are manifest in current litigation involving ERISA preemption of state "Any Willing Provider" statutes. See discussion *infra* Part III.C.

10. See *infra* notes 45-46 and accompanying text and Part III.

11. See discussion *infra* note 37 and accompanying text.

12. One of ERISA's drafters originally coined the term "regulatory vacuum" to describe ERISA's preemptive effect on health care law. See Schaffer & Fox, *supra* note 7, at 48.

ERISA has played in preventing states from enacting consumer-oriented health care reform legislation and the judicial interpretation of ERISA's preemption clause. Part III also discusses the burgeoning ERISA—state health care debate in recent litigation over the viability of “any willing provider” statutes. Part IV analyzes the competing interests of state health care reform and uniform employee benefit laws, drawing upon recent Supreme Court decisions, Circuit Court decisions, and practical consequences of some state laws that survive a preemption challenge. Part V then proposes the enactment of a Uniform Patient Protection Act. Such an Act would effectively address state health care reform initiatives while avoiding preemption by ERISA. Part V additionally proposes that Congress amend ERISA to require that all employers who self-insure their employee benefit plans meet certain minimum certification standards, thereby guaranteeing standard protection to all employees who receive health coverage through their employers' plans.<sup>13</sup>

## II. THE PRESENT STATE OF HEALTH CARE AND THE CALL FOR REFORM

Health care reform is one of the most important political issues of this decade. Reform is necessary for several economic reasons. Health care accounts for approximately fourteen percent of the United States's gross national product,<sup>14</sup> yet approximately forty million Americans do not have health insurance.<sup>15</sup> Moreover, advances in medical technology have caused an increase in overall health care expenditures as patients request, and doctors occasionally prescribe, unnecessary tests or procedures.<sup>16</sup> To complicate matters,

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13. Under ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B) (1994), employers who self-insure their employee benefit plans are exempt from state insurance regulations. As a result, state legislatures that enact health care reform legislation through their power to regulate insurance are currently unable to guarantee that self-insured employee benefit plan participants and beneficiaries will receive the protection of state health care laws. *See* discussion *infra* notes 63-65 and accompanying text.

14. *See* CONGRESSIONAL BUDGET OFFICE, U.S. CONG., *MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING* 1 (1993).

15. *See id.*

16. In addition, the increase in medical malpractice litigation has caused an increase in the practice of “defensive medicine.” Defensive medicine is the medical practice by which health

the human life expectancy is now longer than ever before; and as the amount of money expended for medical care during the last few months of an individual's life steadily has increased, insurance premiums and Medicare expenditures have skyrocketed.<sup>17</sup>

Any discussion of health care reform must address the emergence of "managed care" in the health care industry.<sup>18</sup> Managed care organizations charge their members a fixed rate for health care services and administer the health care that each member receives.<sup>19</sup> Managed care organizations operate under an efficiency-driven strategy, employing practices such as utilization review,<sup>20</sup> the use of gatekeepers,<sup>21</sup> capitation,<sup>22</sup> pre-admission certification,<sup>23</sup> co-

care practitioners go beyond simply erring on the side of caution and perform marginally necessary tests or procedures in order to decrease their risk of incurring malpractice liability. *See id.*

17. *See* Rashi Fein, *Health Care Reform*, in *THE SOCIOLOGY OF HEALTH & ILLNESS* 275, 276-77 (Peter Conrad & Rochelle Kern eds., 4th ed. 1994).

18. The shift from traditional fee-for-service health care to managed care began in the 1980s. The shift occurred in response to the economic status of America's health care industry in the 1980s. During the 1980s, health care costs steadily increased while patient volume for physicians and hospitals decreased. *See* D. H. COWAN, *PREFERRED PROVIDER ORGANIZATIONS* 34 (1984). This decreased volume was attributable in part to the continuing growth of the pool of practicing physicians, combined with patients' reluctance to seek preventive or non-emergency care. *See id.* In addition, increases in unemployment during the 1980s created a larger pool of uninsured Americans, many of whom could not afford to seek non-emergency care and treatment. *See* Patricia A. Butler, *New Initiatives in Financing and Delivering Health Care for the Medically Indigent: Report on a Conference*, 13 *L. MED. & HEALTH CARE* 225, 229 (1985). Furthermore, the growing number of physicians, combined with the decline in patient volume, ultimately created greater competition among health care practitioners and, thus, greater financial pressure on the health care industry. *See* Cathy L. Burgess, Comment, *Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 *J. CONTEMP. HEALTH L. & POL'Y* 275, 278 (1988).

19. *See* PRACTICING LAW INSTITUTE, *HEALTH CARE LAW* 1993, at 549-50 (1993); Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 *AM. J.L. & MED.* 301 (1996).

20. Also referred to as "cost-efficient medicine," utilization review is a cost-containment mechanism that controls the administration of care received by patients. *See* Burgess, *supra* note 18, at 282-83.

21. In a managed care organization, a gatekeeper physician, usually a primary care practitioner, evaluates patients' health to determine whether their conditions warrant additional medical attention by other network practitioners. *See id.* at 283.

22. Under a system of capitation, a payor, such as an employer, pays a managed care organization a set rate per patient to provide health care services to the payor's designated group of patients. Presumably, a health care provider affiliated with managed care organization will have cost-containment incentives to provide only necessary services. This follows from the fact that health care providers assume the actual cost of providing treatment. *See* Kinney, *supra*

payments,<sup>24</sup> and the requirement of second opinions for medical treatment. The managed care industry is comprised of two primary entities: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs provide enrollees with comprehensive health care services under pre-paid plans<sup>25</sup> by directly contracting with health care providers. By contracting exclusively with network practitioners for a pool of enrollees and by charging enrollees capitated premiums, HMOs aim to guarantee access to all necessary health care with the network's own resources.<sup>26</sup> HMOs also embody a risk-shifting element. By accepting capitated payments from enrollees, HMOs assume the risk that some enrollees may require care in excess of the value of their paid premiums. Moreover, by providing cost-containment financial incentives to the practitioners within the network, HMOs shift a degree of that risk to the practitioners.<sup>27</sup>

PPOs contract with a panel of health care providers to provide medical services to enrollees on a discounted fee-for-service basis or through another payment mechanism.<sup>28</sup> PPOs also may provide

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note 19, at 301.

23. Pre-admission certification is a process by which managed care organizations can determine the medical necessity of a scheduled inpatient medical procedure. Managed care organizations may also use pre-admission certification when a patient requests a procedure performed on an outpatient basis, or when a patient requests otherwise expensive health care treatment, such as physical therapy. See Burgess, *supra* note 18, at 282.

24. Managed care organizations typically require co-payments in one of two situations. First, a plan participant may seek treatment for which the plan does not provide full coverage, such as dermatology. Second, a plan participant may seek care or treatment from a practitioner who is not a member of the managed care network. Some "looser" managed care networks, such as a Preferred Provider Organizations (PPOs), will pay a portion of a participant's costs to visit such a non-member practitioner; however, it is more cost-efficient for a participant to seek care from practitioners who are members of the PPO's network. See *id.* at 276.

25. Once enrolled in an HMO, enrollees typically pay, if anything, only a co-payment for services. However, in non-emergency situations, enrollees may use only the HMO's provider network in order to receive coverage. See Robert A. Blum & William F. Brossman, *Basic Legal Issues for Employers in Managed Care*, 799 A.L.I.-A.B.A. 509, 514-15 (1993).

26. See *id.*; see also Jeffrey B. Schwartz, *The Preferred Provider Organization as an Alternative Delivery System*, 6 J. LEGAL MED. 149, 150 (1985) (discussing basic theories underlying the practices of HMOs).

27. See Blum & Brossman, *supra* note 25, at 515; see also 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, 229 n.10 (1995) (discussing basic features of HMOs).

28. See Burgess, *supra* note 18, at 275-76.

utilization and claims reviews. PPOs are distinguishable from HMOs in several ways. First, PPOs provide enrollees with more choices in care and treatment by enabling enrollees to seek services from practitioners outside of the network.<sup>29</sup> Second, PPOs exert less administrative power over the care that enrollees may receive because they operate on a fee-for-service basis rather than a capitation basis.<sup>30</sup> Third, PPOs do not shift to their member practitioners the risk that services might exceed enrollee payments. Instead, PPO payors accept the risk of the enrollees' need for more extensive treatment.<sup>31</sup>

Managed care provides both advantages and disadvantages to enrollees of employee health benefit plans. Advantages of managed care include discounted health care costs and the elimination of unnecessary medical tests and procedures.<sup>32</sup> On the other hand, several disadvantages inhere in the organization of managed care employee health benefit plans. Enrollees in managed care networks usually sacrifice some degree of choice when selecting their medical care practitioners. This sacrifice is necessary because managed care networks typically limit the number of health care providers that are available to their enrollees.<sup>33</sup> When employers provide managed care health coverage, employees may not have the financial resources to seek alternative means of obtaining health care if the managed care

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29. However, PPOs usually pay only a small portion of the discounted fee offered by network practitioners. See Schwartz, *supra* note 26, at 150.

30. See Francesconi, *supra* note 27, at 229 n.8.

31. See *id.* In addition to HMOs and PPOs, other more choice-oriented managed care entities have emerged in recent years. A Point of Service ("POS") Plan combines features of both HMOs and PPOs with traditional indemnity features to enable enrollees to determine the level of benefits they receive, based upon their choice of provider and whether the provider adheres to the plan's requirements. See Rebecca L. Jackson & Karen W. Levy, *Innovations in Managed Care*, in HEALTH CARE REFORM LAW INSTITUTE 1994, 249, 253-54 (PLI Com. Law & Practice Course Handbook Series No. 700, 1994). Another entity, the Physician-Hospital Organization, contracts with managed care plans to arrange medical and hospital services. See *id.* at 254. Additionally, an Integrated Health Care Delivery System, encompassing one or more hospitals, a large number of physicians, and a broad range other health care practitioners, may offer its own managed care system. See *id.* at 258.

32. See Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 1-3 (1994).

33. See The Health Care Study Group, *Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL. POL'Y & L. 499, 531-32 (1994).



plan is unsatisfactory.<sup>34</sup> Critics of managed care networks also note that the networks are disadvantageous to practitioners because managed care networks routinely shut out non-network practitioners.<sup>35</sup> As a result, these practitioners lose a large volume of patients who cannot afford to continue seeking their services after having joined a managed care network.

In recent years, managed care's conflicting goals of containing costs and providing quality health care have clashed violently as health care reform has moved to the forefront of political debate. Despite the general consensus that health care reform is necessary,<sup>36</sup> efforts to accomplish comprehensive reform on a national level have failed.<sup>37</sup> As a result, many state legislatures have passed their own

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34. See *id.* at 532. For example, if an employee's long-time family physician does not belong to the managed care network, the employee has a financial disincentive to maintain that well-established relationship because the network likely will not contribute to the employee's expense of seeking care outside of the network. See *id.* This scenario is more likely if the employee belongs to a "closed" HMO that refuses to provide co-payments to practitioners with which it has not contracted. See VERGIL N. SLEE & DEBORA A. SLEE, *HEALTH CARE TERMS* 195, 195 (2d ed. 1991).

35. See Susan D. Goold, *Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision Making or the Veil of Ignorance?*, 21 J. HEALTH POL. POL'Y & L. 69, 77 (1996).

36. See Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 610 (1995); William J. Bahr, Comment, *Although Offering More Freedom to Choose, "Any Willing Provider" Legislation Is the Wrong Choice*, 45 U. KAN. L. REV. 557, 559-61 (1997).

37. For example, in 1993 Congress rejected President Clinton's proposed Health Security Act (HSA), H.R. 3600, 103d Cong. (1993), S. 1757, 103d Cong. (1993). The HSA would have benefited Americans in three ways. First, it provided for standardized benefit packages and forms. See Bruce W. Karrh, *Health Care Reform in the United States*, 13 DEL. LAW. 17, 19 (1995). Second, it provided for universal health care coverage by broadening the present employer-based system of health insurance and creating greater tax incentives for employers to provide such coverage to their employees. See *id.* Third, from a quality-of-care standpoint, the HSA focused on preventive health care. See *id.* However, the HSA had its drawbacks. Most significantly, the plan was so complicated that implementing it likely would have required the creation of a new governmental bureau. Additionally, some critics opposed the HSA because it would have resulted in inconsistencies among the various states' laws by giving states too much regulatory authority. Critics claimed that such inconsistencies would have caused compliance problems for multi-state employers. See *id.* One further drawback of the HSA was that it focused only minimally on medical malpractice issues. See *id.*

Another reform plan, the proposed Managed Competition Act of 1993 (MCA), H.R. 3222, 103d Cong. (1993), received significant attention in the 103d Congress. Sponsored by Congressmen Cooper (D-Tenn.) and Grandy (R-Iowa), the MCA, like the HSA, provided for an employer-based system of coverage. Also like the HSA, the MCA provided for a standard benefits package and focused on prevention. See Karrh, *supra*, at 19-20 (outlining elements of

reform legislation, much of which aims to improve the quality of health care that patients receive in managed care systems.<sup>38</sup> Much of

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the proposed legislation). It also undertook the task of Medicare and Medicaid reform and established an outcome and patient satisfaction data system to guide future improvements. The premise of the MCA derived from "managed competition," *see id.*, which occurs "when health care providers compete to provide services through a market driven by purchasers of health care insurance. The theory is that an improved health care market will emerge from competition based on quality and cost." Francesconi, *supra* note 27, at 227 n.4. Congress ultimately rejected the MCA because it did not require employer-provided health insurance, because it abolished Medicare, and because it had inadequate tax provisions. *See* Karrh, *supra*, at 20. For further discussion of health care reform legislation that failed to win both House and Senate approval, *see generally id.*

Congress finally advanced a step toward health care reform by passing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 105-191, 110 Stat. 1936 (codified in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C. (1994)). The stated objectives of HIPAA are

to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, [and] to simplify the administration of health insurance . . . .

Pub. L. No. 105-191, preamble 110 Stat. 1936, 1936 (1996).

To accomplish increased insurance portability, HIPAA limits pre-existing condition exclusions, prohibits discrimination against individual participants and beneficiaries based on health status, and guarantees renewability in multi-employer plans and multiple employer welfare arrangements. *See id.* § 701. In addition, HIPAA increases the portability of group market health insurance by limiting pre-existing condition exclusions, prohibiting discrimination against individual participants and beneficiaries based on health status, guaranteeing availability of individual health insurance coverage to certain individuals with prior group coverage, and guaranteeing renewability of individual health insurance coverage. *See id.* § 702. Additionally, to prevent health care fraud and abuse, HIPAA establishes a Fraud and Abuse Control Program. *See id.* §§ 200-271, 110 Stat. at 1937-38. Finally, HIPAA creates tax incentives for medical savings accounts. Medical savings accounts are trust or custodial accounts created for the sole benefit of the account holder. Such accounts permit deductions from individual income taxes. For example, employer MSA contributions will be excludable from an employee's taxable income. *See id.* §§ 300-323, 110 Stat. at 1938. Although HIPAA represents an important advance in the evolution of health care reform, it fails to address many of the quality of care issues arising in today's health care marketplace.

38. For example, during 1995 more than twenty state legislatures considered bills targeted toward managed care organizations. *See* George Anders & Laura Johannes, *Doctors Are Losing a Lobbying Battle to HMOs*, WALL ST. J., May 15, 1995, at B1. Critics of these states' legislative efforts to improve the quality of health care have dubbed such state efforts "anti-managed care" legislation on the basis that they disregard the objectives of administrative efficiency and cost containment. For example, the Model Patient Protection Act, sponsored by the American Medical Association in 1994, would have required a managed care plan to disclose to prospective enrollees detailed information regarding the plan's terms, conditions, and contracts with its providers. *See* Bruce D. Platt & Lisa D. Stream, *Dispelling the Negative Myths of Managed Care: An Analysis of Anti-Managed Care Legislation and the Quality of*

this reform legislation is based on the American Medical Association's Model Patient Protection Act,<sup>39</sup> and generally is referred to as "patient protection legislation." Typical patient protection legislation may provide for HMO disclosure requirements, direct access to specialists such as OB/GYNs, processes for appealing denied claims, minimum hospital maternity stays, mandated coverage for emergency room visits, and prohibitions against "gag clauses"<sup>40</sup> in physician contracts.<sup>41</sup> Not surprisingly, the managed care industry has criticized these reform efforts. For example, HMO proponents argue that required disclosure of plan terms, conditions, and provider contracts would overload participants with information.<sup>42</sup> In addition, HMO proponents argue that direct access to specialists would increase the unnecessary use of these practitioners and would undermine the gatekeeper's function of determining the most proper and cost-effective course of treatment.<sup>43</sup> Furthermore, HMO proponents contend that existing HMO grievance procedures

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*Care Provided By Health Maintenance Organizations*, 23 FLA. ST. U. L. REV. 489, 493-94 (1995). In addition, the Act would have required each plan to establish a system for credentialing practitioners and prevented HMOs from rejecting qualified practitioners who applied for credentials. *See id.* at 496. Furthermore, the Act reserved to physicians, rather than to plan administrators, the authority to make decisions concerning treatment and denial of coverage. *See id.* at 496-97 (discussing Florida's version of the Model Patient Protection Act).

39. *See supra* note 38 for a discussion of the American Medical Association's Model Patient Protection Act.

40. A gag clause prohibits physicians from disclosing to patients information about coverage limits and capitation incentives that a network has instituted to reduce its operating costs. Gag clauses have received considerable criticism from physicians who claim that disclosing such information could result in termination of their affiliation with the network or the receipt of fewer referrals. *See* DAVID HIMMELSTEIN & STEFFIE WOOLHANDLER, *THE NATIONAL HEALTH PROGRAM BOOK* 218 (1994); Erik Larson, *The Soul of an HMO*, TIME, Jan. 22, 1996, at 44.

41. *See* American Political Network, *Statelines 50-State Report I: AHL Tracks Health Care Activity*, AMER. HEALTH LINE, June 7, 1996, available in Westlaw, 6/7/96 APN-HE 5. Some state legislatures have gone beyond patient protection legislation and enacted broader health care reform measures in an effort to provide universal health coverage and restructure delivery systems. *See, e.g.*, The Oregon Health Plan, OR. REV. STAT. 442 *et seq.* (1993). For a discussion of Oregon's ration-based health care system, see generally Eric Lamond Robinson, Note, *The Oregon Basic Health Services Act: A Model for State Reform*, 45 VAND. L. REV. 977 (1992); Kenneth K. Schmitt, Comment, *Waiver Quest: Oregon's Attempt to Re-Ration Health Care*, 36 ST. LOUIS U. L.J. 947 (1992).

42. *See* Platt & Stream, *supra* note 38, at 494.

43. *See id.* at 500.

sufficiently address treatment denial decisions.<sup>44</sup>

Despite such defense of the managed care industry, patient protection legislation has moved to the forefront of state lawmakers' agendas.<sup>45</sup> Much of this reform legislation has failed, however, not on the merits of its provisions, but because ERISA preempted it.<sup>46</sup> Due to the uncertainty surrounding a state law's survival of an ERISA preemption challenge, health care reform has remained relatively stagnant. Examining the evolving operation of ERISA's preemption clause provides a helpful background for discussing the current challenges facing state health care reform.

### III. ERISA'S IMPACT ON STATE HEALTH CARE REFORM

#### A. ERISA's Preemption Clause

Prior to ERISA's enactment in 1974, employee benefit law lacked uniformity among the states, thereby burdening employers with inconsistent legal standards concerning the establishment, operation, and administration of employee benefit plans.<sup>47</sup> Congress responded

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44. See *id.* at 497-98.

45. In 1996 and 1997, state legislatures have focused on drafting laws that mandate coverage for minimum hospital maternity stays and mastectomy stays, as well as laws that require coverage for breast cancer patients' bone marrow transplants. See *Statelines 50-State Report*, *supra* note 41, at \*1-2; American Political Network, *Statelines Legislative Update: South Dakota Through Wyoming*, AMER. HEALTH LINE, Jan. 10, 1997, available in Westlaw, 1/10/97 APN-HE 5; American Political Network, *Statelines Legislative Update: New Mexico Through South Carolina*, AMER. HEALTH LINE, Jan. 9, 1997, available in Westlaw, 1/9/97 APN-HE 7; American Political Network, *Statelines Legislative Updates: Maryland Through New Jersey*, AMER. HEALTH LINE, Jan. 8, 1997, available in Westlaw, 1/8/97 APN-HE 4; American Political Network, *Statelines Legislative Outlooks: Georgia Through Maine*, AMER. HEALTH LINE, Jan. 7, 1997, available in Westlaw, 1/7/97 APN-HE 4; American Political Network, *Statelines Legislative Outlooks: Alabama Through Florida*, AMER. HEALTH LINE, January 6, 1997, available in Westlaw, 1/6/97 APN-HE 6.

46. See generally *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992) (preempting a District of Columbia statute requiring continuation of health coverage); *Insurance Bd. Under Soc. Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3d Cir. 1987) (preempting a state law that regulated the contents of employee health care benefit plans); *New Jersey Bus. & Indus. Ass'n v. New Jersey*, 592 A.2d 660 (N.J. Super. 1991) (preempting a New Jersey law that required employers to continue providing health benefit plans for absent employees during authorized periods of family leave).

47. For example, state laws did not prescribe substantive fiduciary standards for those parties who made decisions regarding the administration of employee benefits plans. In addition, conflict and choice of law questions constantly arose in litigation of employee benefit

to this situation by enacting ERISA and, more specifically, by providing ERISA with a broad preemption clause.<sup>48</sup> Courts have broadly interpreted ERISA's preemption clause so as to promote the uniformity of employee benefit laws that Congress sought to achieve under ERISA.<sup>49</sup> Courts have developed a three-part analysis for determining whether ERISA preempts a state law that affects employee benefit plans. This analysis considers both the language of ERISA and Congress's goals in enacting ERISA.<sup>50</sup> Specifically, the preemption analysis addresses: (1) whether a state law "relates to" ERISA-covered employee benefit plans;<sup>51</sup> (2) whether a state law that relates to ERISA-covered employee benefit plans is exempt from preemption because it falls within the state's power to regulate insurance, banking, or securities;<sup>52</sup> and (3) whether, in the case of state insurance regulation, a state law as applied to self-insured employee benefit plans is nevertheless preempted by operation of ERISA's deemer clause, which exempts self-insured employee benefit plans from state insurance regulation.<sup>53</sup>

### 1. Preemption of State Laws that "Relate to" ERISA-Covered Employee Benefit Plans

During the twenty years following ERISA's enactment, there have emerged three categories of state laws that "relate to" ERISA-covered employee benefit plans and, thus, have been preempted by ERISA.<sup>54</sup> The first category consists of laws that specifically apply to ERISA plans or that require employers to provide specific coverage to employees through the employers' ERISA plans.<sup>55</sup> The second

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disputes. See FRANK CUMMINGS, *ERISA Litigation: An Overview of Major Claims and Defenses*, ALI-ABA COURSE OF STUDY 511, 517-19 (1996).

48. See discussion *supra* note 6.

49. See discussion *supra* note 3.

50. See discussion *supra* note 3.

51. See 29 U.S.C. § 1144(a) (1994).

52. See *id.* § 1144(b)(2)(A).

53. See *id.* § 1144(b)(2)(B).

54. See Karen A. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Preemption*, 13 YALE J. ON REG. 255, 263-70 (1996) (outlining the history of major ERISA preemption cases).

55. See *id.* at 264. For example, in *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992), a District of Columbia workers' compensation provision required that

category encompasses laws that either mandate a specific structure for benefit plans or prohibit a method of determining the level of benefits.<sup>56</sup> The third category of laws that “relate to” ERISA includes laws that impose a duty on ERISA plans by merely referencing ERISA plans.<sup>57</sup>

## 2. The Preemption Exemption for State Laws that Satisfy ERISA’s Insurance Savings Clause

After determining that a state law “relates to” an ERISA plan, courts must analyze whether the law falls within ERISA’s savings clause, which exempts from preemption state laws that regulate insurance,<sup>58</sup> banking, or securities.<sup>59</sup> In *Metropolitan Life Insurance*

employers who provide health insurance to employees maintain coverage equivalent to an employee’s existing coverage while the employee either received or was eligible to receive workers’ compensation benefits. *See id.* at 127 (citing D.C. CODE ANN. § 36-307(a-1)(1) (Supp. 1992)). The Supreme Court concluded that the workers’ compensation statute related to ERISA plans because it expressly referred to ERISA plans. *See id.* at 130.

56. *See Jordan, supra* note 55, at 263-65. For example, in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), New Jersey’s workers’ compensation law prevented employers from offsetting amounts received by employees through workers’ compensation claims against those employees’ pension benefits. *See id.* at 506 (citing N.J. STAT. ANN. § 34:15-29 (West Supp. 1980-81)). Because the provision at issue eliminated one of ERISA’s permitted methods of calculating benefits, specifically, integration of pension funds with other “public income maintenance moneys,” the Court concluded that the New Jersey statute related to ERISA plans. *See id.* at 524.

57. The Supreme Court endorsed this broad interpretation of ERISA’s preemption clause in *Shaw v. Delta Air Lines, Inc.* 463 U.S. 85 (1983). In *Shaw*, the Court declared 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. In effect, the Court concluded that “Congress used the words ‘relate to’ in [section] 514(a) in their broad sense.” *Id.* at 98; *see also* *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *Holliday*, the Court determined that a Pennsylvania law that precluded a right of reimbursement or subrogation for benefits available under a tort claimant’s health benefit plan related to ERISA plans and, therefore, was preempted by ERISA. *See id.* at 59. The Court found that the law related to ERISA because the law specifically referred to benefit plans and, therefore, risked subjecting plan administrators to conflicting state regulations. *See id.* at 60.

58. The savings clause’s exemption for state insurance laws encompasses state laws that address health care.

59. *See* 29 U.S.C. § 1144(b)(2)(A) (1994). ERISA’s savings clause provides that “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.” *Id.* If a state law does not purport to regulate insurance, banking, or securities, then a preemption analysis will focus only on whether the law “relates to” an ERISA plan under section 514(a) of ERISA.

By preserving states’ power to regulate insurance, the savings clause ensures consistency

*Co. v. Massachusetts*,<sup>60</sup> the Supreme Court declared that ERISA's insurance savings clause will exempt a state law from preemption only if the state law (1) is specifically directed toward the insurance industry and, therefore, regulates insurance under a "common sense" view, (2) has the effect of transferring or spreading risk, (3) regulates the relationship between the insurer and the insured, and (4) focuses exclusively upon the insurance industry.<sup>61</sup> However, even if a law

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between ERISA and the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1994). The McCarran-Ferguson Act confirms states' authority to regulate insurance. The Act provides, in relevant part:

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

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 federal antitrust laws] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

*Id.* § 1012(a)-(b).

Congress failed to define the phrase "business of insurance" within the McCarran-Ferguson Act. Accordingly, in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), the Supreme Court set forth three factors for determining whether a practice qualifies as the "business of insurance": "[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Id.* at 129.

60. 471 U.S. 724 (1985).

61. *See id.* at 740, 743. In *Metropolitan Life*, a Massachusetts statute required that every general health insurance policy providing hospital and surgical coverage, and every benefit plan including such coverage, also provide a minimum level of mental health coverage. *See id.* at 729-30. In enacting the statute, the Massachusetts legislature sought to combat "adverse selection" in mental health insurance. *See id.* at 731. Adverse selection occurred when healthy individuals, who were considered good insurance risks, declined to purchase mental health coverage, thereby generating an increase in mental health insurance premiums for people who otherwise might elect to purchase mental health insurance. *See id.* By mandating minimum mental health coverage levels, the Massachusetts legislature aimed to "effectively forc[e] the good-risk individuals to become part of the risk pool, and [to] enabl[e] insurers to price the insurance at an average market rather than a market retracted due to adverse selection." *Id.*

In determining that ERISA's insurance savings clause saved the statute from preemption, the Supreme Court outlined the proper saving clause analysis for determining whether a state law regulates the "business of insurance." First, the Court adopted a "common-sense view" of the phrase "regulates insurance," recognizing that it was compelled to "begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Id.* at 740 (quoting *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985)). Then, upon determining that the state law met

falls within the savings clause, ERISA will still preempt the law if it conflicts with ERISA's civil enforcement scheme.<sup>62</sup>

### 3. State Insurance Laws that are Subject to ERISA Preemption as Applied to Self-Insured Employee Benefit Plans through ERISA's Deemer Clause

If a state law that regulates the business of insurance survives the savings clause analysis, courts must still analyze it under ERISA's "deemer clause." ERISA's deemer clause sets forth exceptions to ERISA's savings clause that subject employee benefit plans to ERISA, rather than to state law.<sup>63</sup> Specifically, ERISA's deemer

this first requirement, the Court proceeded with the three-part "business of insurance" analysis articulated in *Pireno*. See *id.* Later, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court clarified that "in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically directed toward that industry*." *Id.* at 50.

62. ERISA's civil enforcement provision, as applied to private causes of action, provides in relevant part:

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (C) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

....

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief

(i) to redress such violations or

(ii) to enforce any provisions of this subchapter or the terms of the plan . . . .

29 U.S.C. § 1132(a) (1994).

Consistent with its broad interpretation of ERISA's preemption clause, the Supreme Court has held that ERISA's civil enforcement scheme precludes a party from bringing a law suit against an employer under state common law or statutory law if the law suit in any way "relates to" an ERISA plan. See *Ingersoll-Rand Co. v. McLendon*, 498 U.S. 133, 137 (1990) (holding that ERISA preempted the common law wrongful discharge claim of an employee whose employer discharged him to prevent him from receiving benefits under the employer's ERISA plan).

63. ERISA's deemer clause provides in relevant part: "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [and] insurance contracts . . ." 29 U.S.C. § 1144(b)(2)(B). Notably, the Supreme Court in *Metropolitan Life* concluded that ERISA would preempt the Massachusetts statute as applied to self-insured employers because of



clause exempts self-insured<sup>64</sup> employers from state insurance regulation, thereby omitting such employers from the savings clause's definition of being engaged in the "business of insurance."<sup>65</sup> As self-insured employers are not engaged in the business of insurance, ERISA preempts state laws that "relate to" ERISA plans and regulate such employers.

### *B. The Development of Courts' Modern Application of the Preemption Clause*

For many years, lower courts inconsistently interpreted Supreme

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ERISA's deemer clause. *See* 471 U.S. at 746-47. Although the Court recognized that its holding would create inconsistencies by subjecting all employee benefit plans except self-insured plans to direct and indirect state regulation, *see id.* at 747, the Court offered no suggestions for correcting this inconsistency. Instead, the Court stated that "[a]rguments as to the wisdom of these policy choices must be directed at Congress." *Id.*

64. In a self-insured plan, an employer pays the employees' health benefit claims out of a fund reserved for that purpose rather than contracting with private insurance companies and managed care organizations. The employer, therefore, bears much of the financial risk associated with its employees' health care expenses. *See* U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-95-167, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA (1995), available in LEXIS, Legis Library, Gaorpt File [hereinafter "ISSUES, TRENDS, AND CHALLENGES"]. Although a majority of the employers providing ERISA plans purchase health care coverage from third-party insurers, approximately forty percent of these employers adopt self-funded plans, thereby avoiding state insurance regulation. *See* ISSUES, TRENDS, AND CHALLENGES at 4. Thus, of the 44% of the United States population (114,000,000 people in 1995) receiving health coverage from ERISA plans, an estimated 44,000,000 individuals do not receive the protection of state insurance regulation. *See id.*

65. Self-insured plans' exemption from state regulation has become the subject of considerable criticism. Some commentators note that self-insured plans' coverage decisions may lack medical merit because benefits managers in such plans have broad discretion in allocating health benefits. *See* Weisenborn, *supra* note 6, at 155 ("The distinction between self-funded and commercially-insured plans had led to a subversion of ERISA's purposes and deprived employees of many benefits necessary for adequate health care."). A Fifth Circuit Court of Appeals decision illustrates the inadequacy of ERISA's substantive provisions for protecting self-insured health plan participants and beneficiaries. In *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991), the Fifth Circuit upheld a self-insured employer's reduction of lifetime medical coverage for employees with Acquired Immunodeficiency Syndrome (AIDS) from \$11,000,000 per participant to \$5,000 per participant. *See id.* at 408. The employer in *McGann* made this drastic change in coverage upon learning that one of its employees had AIDS. *See id.* The court held that ERISA's exclusive enforcement scheme, section 502(a) of ERISA, preempted the employee's state law claim. *See id.* The court reasoned that ERISA does not require employers to provide health coverage to employees and "does not prohibit welfare plan discrimination between or among categories of diseases." *Id.* (emphasis added).

Court precedent when applying the above three-part preemption analysis. As a result, the outcome of litigation concerning state law viability under ERISA became increasingly unpredictable.<sup>66</sup> For example, the Third Circuit Court of Appeals in *United Wire, Metal, & Machine Health & Welfare Fund v. Morristown Memorial Hospital*<sup>67</sup> and the Second Circuit Court of Appeals in *Travelers Insurance Co. v. Cuomo*<sup>68</sup> reached different conclusions when analyzing ERISA's preemptive effects on two similar state regulations governing hospital rates.

Under the statute at issue in *United Wire*, New Jersey imposed a state-wide surcharge on patients' hospital expenses in order to provide hospitals with assistance in covering their uncompensated health care expenses.<sup>69</sup> Additionally, the New Jersey statute provided financial relief to hospitals that incurred economic losses in treating Medicare patients by enabling such hospitals to assess a surcharge against non-Medicare patients.<sup>70</sup> Several self-insured employee benefit plans and individual plan participants sought an injunction

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66. See Jordan, *supra* note 54, at 271-81 (analyzing cases in detail).

67. 995 F.2d 1179 (3d Cir. 1993).

68. 14 F.3d 708 (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).

69. In both *United Wire* and *Travelers*, the state hospital rate-setting provisions required hospitals to charge fixed rates for each patient based upon the patient's diagnosis, rather than upon the actual cost of the services. See *id.* at 711 (citing N.Y. PUB. HEALTH LAW § 2807-c(3) (McKinney 1994 & Supp. 1995)); *United Wire*, 995 F.2d at 1189 (citing N.J. STAT. ANN. §§ 26:2H-1 to -26 (West 1987 & Supp. 1992-93)). Hospitals employed a Diagnostic-Related Group (DRG) methodology to arrive at these figures. The expense of treating an average patient with a particular initial diagnosis provides the basis for the DRG rate chargeable by a hospital to provide care for that patient. See, e.g., N.Y. PUBLIC HEALTH LAW § 2807-c(3) (McKinney 1994 & Supp. 1995). Under the New Jersey statute at issue in *United Wire*, the DRG rate for a particular hospital included the weighted average for both that hospital's expenses incurred in treating a specific condition and the average expense incurred by other New Jersey hospitals in treating the same condition. See *United Wire*, 995 F.2d at 1189 (noting that under the DRG system, the hospitals that benefited incurred expenses less than the state average for that particular DRG service, while the hospitals that experienced financial loss incurred expenses above the state average for that particular DRG service because hospitals receive only the fixed DRG rate for procedures performed). In order to provide hospitals with financial assistance to cover uncompensated health care expenses, the statute imposed a state-wide charge over the DRG rate, with the revenue providing the appropriate aid to such hospitals. See N.J. STAT. ANN. §§ 26:2H-1 to 26:2H-26 (West 1987 & Supp. 1992-93).

70. See *United Wire*, 793 F. Supp. at 527-28. The statute aimed to contain health care service expenses and maintain hospital financial solvency. See N.J. STAT. ANN. § 26:2H-1 (West 1987).

against the application of the rate-setting scheme to their plans, arguing that ERISA preempted the statute.<sup>71</sup> The District Court of New Jersey held that the statute related to ERISA plans and, therefore, warranted preemption because the statute effectively required self-insured ERISA plans to pay for services provided to non-members,<sup>72</sup> thereby hindering the administration of such plans.<sup>73</sup>

The Third Circuit reversed, however, concluding that the rates too remotely affected ERISA plans to warrant ERISA preemption.<sup>74</sup> The court reasoned that although ERISA's preemption clause was broad, it was not so comprehensive that it invalidated any state law that increased the administrative costs of employee benefit plans.<sup>75</sup> According to the court, such a broad interpretation of ERISA's preemption clause would erode state police power<sup>76</sup> and give ERISA plans "a charmed existence that was never contemplated by Congress."<sup>77</sup> Rather than adopting such a broad interpretation, the court acknowledged that most health care regulations would inevitably have an indirect effect upon ERISA plans<sup>78</sup> and adopted a balancing approach that would implicate ERISA's preemption clause only when state police power regulations (1) purposely focused on ERISA plans for special treatment, (2) restricted the choices of such plans, or (3) detrimentally affected their ability to function in multiple states.<sup>79</sup>

In contrast to the *United Wire* court, the Second Circuit in *Travelers Insurance Co. v. Cuomo*<sup>80</sup> concluded that New York's hospital rate-setting provisions related to ERISA plans because the

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71. See *United Wire*, 793 F. Supp. at 528.

72. ERISA's deemer clause did not "rescue" the self-insurers from the hospital rate-setting provisions because the statute did not purport to regulate insurance. See *id.*

73. See *id.* at 535-36.

74. See *United Wire*, 995 F.2d at 1194.

75. See *id.*

76. For a discussion of states' use of their police power to regulate the health and general welfare of their citizens, see *supra* note 5 and accompanying text.

77. *United Wire*, 995 F.2d at 1194 (citing *Rebaldo v. Cuomo*, 749 F.2d 133, 138 (2d Cir. 1984)).

78. See *id.*

79. See *id.* at 1195.

80. 14 F.3d 708 (2d Cir. 1993), *aff'g* 813 F. Supp. 996 (S.D.N.Y. 1993), *rev'd sub nom.* *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

provisions had the requisite "connection with" ERISA plans to warrant preemption.<sup>81</sup> Like the New Jersey statute in *United Wire*, the New York statute imposed a surcharge on HMOs.<sup>82</sup> The surcharge served as a direct payment to the state's general fund rather than as an increase in hospital rates.<sup>83</sup> In addition, the New York statute assessed a nine percent charge on HMOs that failed to enroll a requisite number of Medicare patients.<sup>84</sup> Several commercial insurers and their trade associations filed suit against the state officials, the New York State Conference of Blue Cross and Blue Shield ("The Blues"), and the Hospital Association of New York State, claiming that ERISA preempted the surcharge statutes.<sup>85</sup> The U.S. District Court for the Southern District of New York held that ERISA preempted the surcharges imposed by the statute and enjoined the state from enforcing the surcharges against commercial insurers and HMOs that provided coverage for ERISA plans.<sup>86</sup>

On appeal, the Second Circuit affirmed the district court's decision.<sup>87</sup> The court declared that the surcharges for commercial insurers could "obviously" impact health care benefits in ERISA

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81. See *id.* at 721. Under New York's rate-setting scheme, the type of health coverage a patient carried determined the DRG amount that a hospital could charge for the patient's care. Adjustments to a particular hospital's operating costs affected the amount of DRG charges allowable with respect to that hospital's operating costs. See *id.* at 712. The rate schedule differentiated among three kinds of payors: (1) those whose rates hinged upon DRG rates, including the state government paying for Medicaid patients, nonprofit corporations such as Blue Cross & Blue Shield, and HMOs; (2) those who paid the DRG rates plus a thirteen percent surcharge, such as self-insured groups that paid hospitals directly and commercial insurers whose coverage was based on all hospital services rendered; and (3) those who paid actual hospital charges, including all other payors such as self-paying patients, patients covered by commercial insurance policies that did not adopt an expense-incurred basis for payment, and self-insured groups that did not pay hospitals directly. See N.Y. PUB. HEALTH LAW § 2807-c(1)(a)-(C) (McKinney Supp. 1993).

82. See § 2807-c(1)(a)-(c).

83. See *Travelers*, 813 F. Supp. at 1000.

84. See *id.* The effect of these provisions was to ensure the economic viability of plans that provided affordable health coverage to high-risk individuals by offsetting the commercial insurers' competitive advantage. See *id.*

85. See *id.*

86. See *id.* at 1012. The court reasoned, "To the extent that the Surcharges impose a substantial economic burden on the commercial insurers and HMOs which provide services to employee benefit plans, those Surcharges may [a]ffect the structure and/or the administration of such plans." *Id.* at 1004. The court concluded, therefore, that the surcharges related to ERISA plans and, thus, fell within ERISA's preemption clause. See *id.*

87. See 14 F.3d 708, 719 (2d Cir. 1993).

plans.<sup>88</sup> Moreover, the court noted that the nine percent assessment on HMOs that failed to enroll the requisite number of Medicare patients would interfere with employers' health care coverage choices for ERISA plans.<sup>89</sup> The court concluded that the surcharges incorporated into the rate-setting provisions related to ERISA plans and, therefore, warranted preemption.<sup>90</sup>

The Supreme Court, in *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>91</sup> provided the necessary resolution to the inconsistent decisions of *United Wire* and *Cuomo*. In *Travelers*, the Court signaled that the time to restrain ERISA's preemption of state law had arrived. Reversing the decision of the Second Circuit, the Supreme Court held that ERISA did not preempt New York's hospital rate-setting schedule.<sup>92</sup> The Court reasoned that the statutes' indirect effect on ERISA plans<sup>93</sup> was insufficient to trigger preemption.<sup>94</sup> The Court refused to read ERISA's preemption clause so broadly as to supersede all state laws

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88. *See id.*

89. *See id.*

90. *See id.* at 721.

91. 514 U.S. 645 (1995).

92. *See id.* at 662.

93. Specifically, the statutes increased the attractiveness of the Blues' plans in light of the additional charges imposed upon patients of commercial insurers and HMOs.

94. *See id.* at 660. First, the Court reaffirmed that the basic purpose of ERISA's preemption clause was "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657. Second, the Court noted that preemption should occur only if a state law mandated employee benefit structures or administration, or if it provided for an alternative enforcement mechanism. *See id.* at 658. The Court found that the purpose and the effects of the New York surcharge statutes distinguished this case from the cases in which preemption was proper. *See id.* Third, the Court noted that the statutes' effect of making the Blues more attractive as insurance alternatives indirectly followed from the purpose of the rate-setting provisions, which was to preserve the viability of "open enrollment" insurers who provided coverage for high-risk individuals. *See id.* at 658-59. The Court stated that the Surcharges' creation of economic incentives for choosing one insurer over another

[did] not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself. . . . Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the relative costs of competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but it does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

*Id.* at 659-60.

and charges merely because they indirectly relate to ERISA plans that purchase insurance or HMO memberships providing the same services.<sup>95</sup> The Court declared that “nothing in the language of the Act or the context of its passages indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern . . . .”<sup>96</sup> Although the Court held that ERISA would not preempt a state law that produces an economic effect that at most would influence decisions concerning benefit structure or administrative schemes, it left open the possibility that “a state law might produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be pre-empted under § 514.”<sup>97</sup> Thus, the *Travelers* Court left somewhat unresolved the “indirect effect” question of ERISA preemption.

Two recent Supreme Court decisions confirm the Court’s shift to a more restrained application of ERISA’s preemption clause. In *California Division of Labor Standards Enforcement v. Dillingham Construction, Inc.*,<sup>98</sup> the Court held that California’s prevailing wage

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

96. *Id.* at 661. The Court noted that ERISA’s preemption of New York’s rate-setting statutes would “bar any state regulation of hospital costs,” *id.* at 664 (emphasis added), including a basic DRG system free of surcharges. *See id.* The Court found this prospect unacceptable for two reasons. First, several states, including New York, had regulated hospital charges in some manner at the time of ERISA’s enactment in 1974. *See id.* at 665. In addition, the National Health Planning and Resources Development Act of 1974 (NHPDA) provided grant opportunities to states “for the purpose of demonstrating the effectiveness of State Agencies regulating rates for the provision of health care . . . within the State.” *Id.* at 666 (quoting National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, §§ 1-3, 88 Stat. 2225, 2249, repealed by Pub. L. No. 99-660, § 701(a), 100 Stat. 3799). The Court concluded, therefore, that the federal government’s encouragement of rate-setting, through the NHPDA’s provision providing aid for state health care regulations, was “simply incompatible with preemption of the same by ERISA.” *Id.* at 667. The *Travelers* Court also confirmed that its limitation on ERISA’s preemption clause was consistent with its precedent of declining to find preemption when state law authorized an indirect source of administrative cost. *See id.* at 662 (citing *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 831-32 (1988) (holding that ERISA did not preempt Georgia’s general garnishment statute, which could apply to participants’ benefits under ERISA welfare benefit plans)).

97. *Id.* at 668. For example, the Court noted that “there might be a point at which an exorbitant tax leaving consumers with a Hobson’s choice would be treated as imposing a substantive mandate . . . .” *Id.* at 664.

98. 117 S. Ct. 832 (1997).

law did not “relate to” ERISA and, therefore, was not preempted by ERISA.<sup>99</sup> The statute at issue in *Dillingham* mandated that contractors on a public works projects pay their workers “the prevailing wage in the project’s locale.”<sup>100</sup> However, the statute carved out an exception for workers who participated in approved apprenticeship programs, permitting the contractor to pay such workers a lower wage.<sup>101</sup> Relying on *Travelers*, the Court looked to “ERISA’s objectives as a guide to the scope of the state law that Congress understood would survive, and to the nature of the law’s effect on ERISA plans . . . .”<sup>102</sup> The Court drew a parallel between California’s wage law and the rate-setting provisions at issue in *Travelers*, noting that states had long regulated wages paid on state public works and apprenticeship standards.<sup>103</sup> The Court also noted that the apprenticeship portion of the statute “[did] not bind ERISA plans to anything,”<sup>104</sup> and that, like New York’s rate-setting provisions, California’s wage law impacted the incentives, rather than the choices, facing ERISA plans.<sup>105</sup>

The Supreme Court reconfirmed its unwillingness to apply ERISA’s preemption clause so broadly as to disturb state police power to regulate health care in *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*.<sup>106</sup> In *DeBuono*, the Court evaluated New York’s Health Facility Assessment (HFA), which taxed the gross receipts for patient services at treatment and diagnostic centers. Rather than looking to the text of ERISA’s preemption clause, the Court followed the *Travelers* approach of examining ERISA’s objectives and concluded that the HFA was not the type of state law

99. *See id.* at 842.

100. *Id.* at 835.

101. *See id.*

102. *Id.* at 834 (citing *Travelers*, 514 U.S. at 646, 654).

103. *See id.* at 841.

104. *Id.* at 841.

105. *See id.* The Court also noted that, like the rate-setting provisions in *Travelers*, the wage statute was “no different from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.” *Id.* at 842 (quoting *Travelers*, 514 U.S. at 668). Thus, the Court concluded that “[w]e could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort.” *Id.*

106. 117 S. Ct. 1747, 1752-53 (1997).

that Congress intended to preempt.<sup>107</sup> Specifically, the Court noted that the HFA fell within an area traditionally regulated by the states, namely, health and welfare.<sup>108</sup>

The *Travelers* progeny has addressed the importance of preserving the state police power in regulating the general health and welfare of citizens.<sup>109</sup> However, these cases offer little guidance in answering preemption questions regarding state laws that regulate

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107. See *id.* at 1751. The Court confirmed its rejection of a “strictly literal” reading of ERISA’s preemption clause, because the “‘relates to’ language was not intended to modify ‘the starting presumption that Congress does not intend to supplant state law.’” *Id.* (quoting *Travelers*, 514 U.S. at 654).

108. See *id.* Moreover, the Court rejected the Second Circuit’s conclusion that the HFA was distinguishable from the rate-setting provisions in *Travelers* because the HFA directly impacted benefit plans. See *id.* at 1752. The Second Circuit concluded that the HFA related to ERISA plans because it reduced the amount of fund assets that would be available for benefits by assessing a tax on “‘payments and contributions which were intended to pay for participants’ medical benefits . . . .” *Id.* at 1750 (quoting *NYSA-ILA Medical and Services Fund v. Axelrod*, 27 F.3d 823, 827 (2d Cir. 1994)). The Second Circuit also determined that this reduction in assets could result in fewer benefits or higher fees for plan participants. See *id.* In response, the Supreme Court emphasized that had the plaintiff benefit plan trustees chosen to purchase medical services indirectly through an independent hospital, rather than providing those benefits directly, the HFA’s impact would have been identical. See *id.* at 1752-53. Specifically, the Court noted that independent hospitals would have increased their rates in order to pass the HFA costs on to the fund. See *id.* at 1752. Therefore, the HFA’s impact, though indirect, would have been the same “in all relevant aspects.” *Id.* at 1752-53.

109. See *Jordan*, *supra* note 54, at 286-91. *Jordan* suggests that *Travelers* established the proper ERISA preemption analysis for ameliorating the inconsistency that developed in ERISA preemption litigation prior to *Travelers*. *Jordan* asserts that *Travelers* indicated a “tighter standard for determining pre-emption in that category of cases where the state law affects the benefit structure or administrative practices of an ERISA plan.” *Id.* at 286. The preemption question then turns upon whether the effect of the state law “actually or practically binds choices as to benefit packages or structures or administrative practices.” *Id.* at 287. Moreover, both the purpose and the effect of the state law are relevant to determining preemption. If the focus of the state law in question is health policy, as it was in *Travelers*, then preemption is less likely. See *id.* at 288.

*Jordan* also suggests that “the fact that an indirect economic effect falls primarily upon ERISA plans or that the underlying objective of state law could not be achieved without the disparate impact on ERISA plans does not support a finding of preemption.” *Id.* at 289. Additionally, *Jordan* argues that courts should adopt a narrower view of the underlying objective of ERISA. *Jordan* cites as an example of such a view the Supreme Court’s opinion in *Travelers*, which indicates a strong presumption against preemption for state laws that fall within traditional state police power, such as health care regulations. See *id.* at 289 (citing *Travelers*, 115 S. Ct. at 1681). *Jordan* concludes that “[m]ere interference is not sufficient; a state law must bind choices as to administrative practices.” *Id.* The Supreme Court’s decisions in *DeBuono* and *Dillingham* support this analysis. See *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 117 S. Ct. 1747 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 117 S. Ct. 832 (1997).



health care indirectly through insurance regulation.<sup>110</sup> Such measures that survive ERISA preemption through the insurance savings clause continue to create significant discrepancies in the legal rights afforded to participants in third-party payor, as opposed to self-insured, benefit plans. Specifically, ERISA's savings clause empowers states to regulate the former, but ERISA's deemer clause operates to leave the latter unregulated.<sup>111</sup> Neither the Supreme Court nor Congress has addressed this discrepancy. Meanwhile, state health care reform efforts continue to spark controversy over the proper balance between uniform employee benefit laws and the states' power to enact such reform measures. State health care reform efforts also continue to engender debate over the proper balance between cost-efficiency and quality in health care. This controversy is manifest in the current debate surrounding state "any willing provider" statutes.

*C. The "Any Willing Provider" Debate: An Illustration of ERISA's Recent Preemptive Effect on State Health Care Reform*

"Any willing provider" statutes require managed care organizations to accept as a covered health care provider any provider who wishes to join the managed care network and meets the network's selection criteria.<sup>112</sup> Proponents of these statutes emphasize

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110. Much of the legislation that affects the managed care industry falls within this category. For a discussion of state legislative efforts to address quality of care issues that have arisen in managed care plans, see *supra* notes 38-46 and accompanying text.

111. For a discussion of ERISA's insurance savings clause and deemer clause, see *supra* notes 59-61, 63-65 and accompanying text.

112. These statutes typically fall within one of four categories:

"[1] "freedom of choice" laws that require insurers to reimburse a non-network provider as long as the provider agrees to accept the insurer's level of reimbursement for the service; . . . [2] "mandatory admittance" laws that require insurers to include in a network any provider willing to abide by the terms and conditions of the network, including price; . . . [3] "due process" laws that require insurers to follow certain procedures in creating and maintaining a network, such as publishing the criterion for participation in the network and providing for an appeal process in the event of termination of a provider from participation in a network; . . . [4] "essential community provider" laws that require insurance networks to contract with essential community providers serving medically needy, poor populations, e.g. community health centers and AIDS providers."

that any willing provider laws enable employees whose employers provide health care coverage through managed care networks to choose physicians and other health care providers who are not part of the managed network.<sup>113</sup> Proponents also emphasize that health care practitioners who have found themselves excluded from such networks can continue to maintain profitable practices rather than lose their patients to HMOs and PPOs.<sup>114</sup> On the other hand, critics of any willing provider laws argue that requiring managed care networks to accept such practitioners erodes the networks' ability to provide health care at a discount and, thus, threatens to raise premiums.<sup>115</sup>

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Francesconi, *supra* note 27, at 230 n.11 (quoting Andrew L. Jiranek & Susan D. Baker, "Any Willing Provider" Laws: Regulating the Health Care Provider's Contractual Relationship with the Insurance Company, HEALTH LAW. (ABA Forum on Health Law), Winter 1994-1995, at 3).

113. See Hancock, *supra* note 6, at 404. For example, suppose that Employee A's employer has provided health coverage under a traditional indemnification insurance policy for the past twelve years. A and A's family have seen the same primary care physician for those twelve years. A's employer then announces that it has joined a managed care network, and that, in the future, A and A's family must see one of the health care providers within the network in order to receive coverage. Suppose also that A's family physician does not belong to the network. If A or someone in A's family has a particular condition for which the family physician has consistently provided treatment, an any willing provider law would enable A and A's family to continue seeing that physician, but only if the physician agrees to abide by the terms of the network when treating A and A's family.

114. See *id.* at 406. For example, in rural areas, the number of available health care practitioners is limited. If an employer with a branch office in a smaller community shifts its employee benefit health plan to a managed care network, the economic impact on a physician who has not been asked to join the network may be devastating.

115. See, e.g., Francesconi, *supra* note 27, at 248-49 n.86 (discussing the impact of any willing provider laws on the economic foundations of PPOs). Francesconi observes that under any willing provider statutes, "the number of providers in the preferential arrangement is mandated by the any willing provider law rather than determined by factors of economic efficiency." *Id.* at 249.

Four primary arguments against the statutes have emerged. First, critics argue that managed care organizations' ability to contract selectively with health care providers, and thereby obtain volume discounts for their enrollees, suffers drastically. See Recent Legislation, 109 HARV. L. REV. 2122, 2125 (1996). Thus, as more enrollees seek health care from providers outside of their network who agree to abide by their network's terms, HMOs in particular will lose bargaining power in negotiating with providers to join the network because the number of guaranteed patients will decrease. As a result, premiums for coverage with such managed care organizations will increase so that networks can remain profitable. See *id.* Second, critics argue that administrative expenses for managed care organizations, especially HMOs, will increase as the number of providers that the networks oversee increases. See *id.* Third, opponents argue that any willing provider statutes could cause significant increases in the expenses associated with establishing HMOs in states with low ratios of HMOs. See *id.* Fourth, HMOs potentially can set

These opposing interests recently have culminated in a significant amount of litigation as opponents of the statutes have challenged the statutes' viability under ERISA's preemption clause. This rise in litigation started at nearly the same time as the rise in litigation involving hospital rate-setting statutes; however, unlike the rate-setting statutes, the ultimate status of any willing provider laws under ERISA's preemption clause remains unresolved. An examination of the Fourth and Fifth Circuits' different approaches to ERISA's preemptive effect on any willing provider statutes sheds light on the opposing ideologies regarding the role of ERISA in state health care reform.

In *Stuart Circle Hospital Corp. v. Aetna Health Management*,<sup>116</sup> the Fourth Circuit considered whether ERISA preempted Virginia's any willing provider statute, which prohibited insurance companies from unreasonably discriminating against health care providers in establishing PPOs.<sup>117</sup> Aetna Life Insurance Company, which had

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their network qualification standards higher in order to include very few providers. See *Applying Physician Criteria Protects Against AWP Risk*, PHYSICIAN MANAGER, Apr. 7, 1995. Such tactics, however, ultimately may provide little economic benefit to HMOs as the health care providers who meet more selective network qualification standards are likely to expect higher payments per patient than less "decorated" providers. See *Recent Legislation, supra*, at 2126. Consequently, the discounts that normally inhere in HMOs may suffer nonetheless. See *id.*

Such criticism has drawn considerable support from entities outside of the managed care industry. For example, the Federal Trade Commission has issued a letter warning of the anti-competitive effects of any willing provider legislation in some states, and both the National Association of Insurance Commissioners and the National Governors Association have issued statements opposing any willing provider statutes because of potential harm to consumers in the form of increased costs. See *American Political Network, Inc., Access/Quality/Cost "Any Willing Provider": Past Applies to Future Legislation*, AMER. HEALTH LINE, September 24, 1996, available in Westlaw, 9/24/96 APN-HE 14 [hereinafter *Access/Quality/Cost*].

116. 800 F. Supp. 328 (E.D. Va. 1992), vacated, 995 F.2d 500 (4th Cir. 1993).

117. See *Stuart Circle*, 995 F.2d at 501. The Virginia statute stated in relevant part:

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded.

established a PPO in Richmond, Virginia as part of its employee benefit package, did not designate Stuart Circle Hospital as one of its PPO provider facilities, despite the hospital's willingness to comply with Aetna's terms.<sup>118</sup> When Stuart Circle brought suit against Aetna for violating the Virginia statute, Aetna responded that ERISA preempted the statute.<sup>119</sup> The District Court for the Eastern District of Virginia concluded that Virginia's any willing provider statute related to employee benefits plans and, therefore, was preempted by ERISA.<sup>120</sup>

On appeal, the Fourth Circuit agreed with the district court's conclusion that the statute related to employee benefit plans.<sup>121</sup> However, in its savings clause analysis, the court concluded that the statute regulated the "business of insurance"<sup>122</sup> and, therefore, was

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E. For purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.

VA. CODE ANN. § 38.2-3407 (Michie 1994), *quoted in Stuart Circle*, 995 F.2d at 501.

118. *See Stuart Circle*, 800 F. Supp. at 329.

119. *See id.*

120. *See id.* at 337. The district court cited other district court decisions that had held that state laws regulating PPOs "relate to" employee benefit plans and, therefore, are preempted by ERISA. *See id.* at 332-33. Next, the court rejected the hospital's argument that the statute satisfied the Supreme Court's test for regulating the "business of insurance" within the meaning of ERISA's insurance savings clause. *See id.* at 334.

121. *See Stuart Circle*, 995 F.2d at 502. The court noted that the statute applied to "health benefit programs" operated by insurers and that the statute expressly addressed the benefits that an insured could receive from the insurer's PPO. *See id.* Thus, the court concluded that the statute restricted an insurance company's ability "to limit the choices of providers that otherwise would confine the participants of an employee benefit health plan to those preferred by the insurer." *Id.*

122. The court found that the statute regulated the "relationship between the insurer and insured [and] the type of policy which could be issued." *Id.* (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985)). Therefore, the court reasoned that the statute regulated insurance in the "common-sense view" because it prohibited an insurer's "unreasonable restriction of the insured's choice of physician and hospital," *id.* at 503, even though such regulation occurred indirectly through the PPO's structure. *See id.* Additionally, the court concluded that the statute met each of the three factors of the *Metropolitan Life* test for interpreting the phrase "business of insurance." *See Stuart Circle*, 995 F.2d at 502 (citing *Metropolitan Life*, 471 U.S. at 743-44). First, the Virginia statute had the effect of transferring or spreading the policyholder's risk by prohibiting unreasonable restrictions on providers. *See id.* at 503 (citing *Metropolitan Life*, 471 U.S. at 743). Second, the court found that the statute addressed an "integral part of the policy relationship between the insurer and the insured," *id.* at 503 (quoting *Metropolitan Life*, 471 U.S. at 743), because it regulated treatment and cost,

not preempted by ERISA.<sup>123</sup> The court thus concluded that the Virginia legislature's decision to afford a greater degree of protection to preserving an insured's choice of doctors and hospitals than to preserving low insurance premiums did not warrant preemption by ERISA. The court declared that "the wisdom of this decision is a concern of the legislature, not the judiciary."<sup>124</sup>

In contrast to the Fourth Circuit, the Fifth Circuit has twice concluded that ERISA preempts any willing provider legislation. In *CIGNA Health Plan, Inc. v. Louisiana*,<sup>125</sup> the district court examined Louisiana's any willing provider statute, which prohibited PPOs from excluding any licensed provider, other than a hospital, if the provider agreed to the PPO's terms and conditions.<sup>126</sup> The provisions of the statute indicated that it applied not only to the insurance industry, but also to entities such as Taft-Hartley trusts and employers who established, or participated in, self-funded trusts or programs that contracted with health care providers.<sup>127</sup> CIGNA Health Plan of Louisiana ("CIGNA") and Connecticut General Life Insurance Company (CGLIC), both of which qualified as "group purchasers" under the statute, challenged the statute's viability under ERISA's

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both of which were important elements of health insurance. *See id.* at 503. Finally, the statute was "limited to entities within the insurance industry," *id.* at 504 (quoting *Metropolitan Life*, 471 U.S. at 743), by its own terms. *See id.* at 504.

123. *See id.* at 503.

124. *Id.* at 504-05.

125. 883 F. Supp. 94 (M.D. La. 1995), *aff'd*, 82 F.3d 642 (5th Cir. 1996).

126. *See id.* at 95 (citing LA. REV. STAT. ANN. § 40:2202(5)(C) (West 1992)). Specifically, the statute provided that "[n]o 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." § 40:2202(5)(C).

127. *See CIGNA*, 82 F.3d at 645 n.10 (citing § 40:2202(3)). References to these entities appeared in the statute's section that defined "group purchaser" for the purpose of identifying PPOs. *See id.* The statute defined "group purchaser" as follows:

(3) "Group purchaser" shall mean an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "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.

*Id.* (quoting § 40:2202(3)).

preemption clause. The district court granted summary judgment for CIGNA and CGLIC, concluding that ERISA preempted the statute to the extent that it related to employee benefit plans covered under ERISA.<sup>128</sup>

On appeal, the Fifth Circuit affirmed the district court's decision.<sup>129</sup> After taking into account the *Travelers* opinion, the court analyzed the Louisiana statute by broadly interpreting ERISA's preemption clause and narrowly interpreting ERISA's insurance savings clause.<sup>130</sup> Within this framework, the Fifth Circuit concluded that the statute related to ERISA plans because it referred to ERISA-qualified plans,<sup>131</sup> and because it "mandat[ed] employee benefit structures or their administration."<sup>132</sup> Acknowledging that the ERISA

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128. See *CIGNA*, 883 F. Supp. at 104. The court determined that the statute had a direct impact on how employers or plan sponsors could structure health benefits under employee benefit plans. See *id.* at 103. Moreover, the court declared that the statute "explicitly direct[ed] that [employers or plan sponsors] may not structure their programs so as to exclude any provider willing and able to participate." *Id.* The court concluded, therefore, that the statute related to ERISA plans for preemption purposes. See *id.*

Next, the court analyzed whether the statute regulated the "business of insurance" under ERISA's savings clause. The court determined that the statute did not fit within the "common sense" definition of "regulating insurance" because the statute was not "specifically directed toward the insurance industry, but, rather, it expressly applie[d] to entities outside the insurance industry, such as employers and Taft-Hartley trusts." *Id.* at 104 (citing § 40:2202(3)(a)-(b)).

129. See *CIGNA*, 82 F.3d at 650.

130. See *id.* at 647. First, the court confirmed that ERISA would preempt state laws that "mandat[e] employee benefit structures or their administration." *Id.* (brackets in original) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995)). Next, the court strictly construed the *Travelers* Court's declaration that ERISA would not preempt state laws having "only an indirect economic effect on the relative costs of various health insurance packages' available to ERISA-qualified plans." *Id.* at 647 (quoting *Travelers*, 514 U.S. at 662). Finally, the court emphasized that preemption "stops short of 'any law of any State which regulates insurance.'" *Id.* (emphasis added) (quoting *Travelers*, 514 U.S. at 651).

131. See *id.* Specifically, the court noted that within the statute's definition of a preferred provider contract, group purchasers included entities such as "Taft-Hartley trusts or employers who establish or participate in self funded trusts or programs," which "contract [with health care providers] for the benefit of their . . . employees." *Id.* at 648 (brackets in original) (quoting § 40:2202(3)(a)). Because the court found that ERISA expressly incorporated these entities into its definition of an "employee welfare benefit plan," See *id.* at 648 n.34 (discussing 29 U.S.C. § 1002(1)(A)-(B) (1992)), the court concluded that the any willing provider statute, as part of Louisiana's Health Care Cost Control Act, expressly referred to ERISA plans and, thus, related to ERISA plans. See *id.* at 648.

132. *Id.* Relying on dicta from the *Travelers* opinion, the court distinguished Louisiana's any willing provider statute from the rate-setting statute at issue in *Travelers*, *id.* (quoting *Travelers*, 514 U.S. at 658), emphasizing that Louisiana's statute required that employers

preemption analysis was not complete, however, the court examined the statute under ERISA's insurance savings clause.<sup>133</sup> The court concluded that the statute failed the third prong of the *Metropolitan Life* "regulating insurance" test because it applied to entities beyond the insurance industry.<sup>134</sup> Accordingly, the court concluded that ERISA preempted Louisiana's any willing provider statute.<sup>135</sup>

The Fifth Circuit revisited the issue of ERISA's preemption of any willing provider statutes in *Texas Pharmacy Ass'n v. Prudential Insurance Co.*<sup>136</sup> and concluded that ERISA preempted Texas's amended any willing provider pharmacy statute.<sup>137</sup> The parties in *Texas Pharmacy* did not contest whether the any willing provider statute related to ERISA plans because, like Louisiana's statute in *CIGNA*, it eliminated one method of structuring employee benefit plans "by prohibiting plans from contracting with pharmacy networks that exclud[ed] any willing provider."<sup>138</sup> Instead, the parties disputed whether the Texas statute was exempt from preemption under ERISA's insurance savings clause. Relying on *CIGNA*, the Fifth Circuit concluded that the statute did not fall within ERISA's savings clause.<sup>139</sup>

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structure the particular benefits available to their ERISA plan participants in a specific manner. The court declared that "[I]n other words, the Louisiana statute does not merely raise the cost of the implicated benefits; it delineates their very structure." *Id.* at 649. The court reasoned that Louisiana's any willing provider statute limited ERISA plans that chose to offer coverage by PPOs to "using PPOs of a certain structure—i.e., a structure that includes every willing, licensed provider." *Id.* at 648. Additionally, the court noted that while an ERISA plan may elect not to offer its beneficiaries PPO coverage, "[i]t is sufficient for preemption purposes that the statute eliminates the choice of one method of structuring benefits." *Id.*

133. *See id.* at 649.

134. *See id.* at 650 (citing § 40:2202(3)(a) - (b)).

135. *See id.*

136. 105 F.3d 1035 (5th Cir. 1997).

137. *See id.* at 1042. Prior to the statute's amendments, the District Court for the Western District of Texas concluded that Texas's any willing provider pharmacy statute fell within ERISA's savings clause and, therefore, escaped preemption by ERISA. *See Texas Pharmacy Ass'n v. Prudential Ins. Co. of America*, 907 F. Supp. 1019, 1025 (W.D. Tex. 1995). Crucial to the district court's holding was the statute's express limitations to the health insurance industry. *See id.*

138. *Texas Pharmacy*, 105 F.3d at 1037.

139. *See id.*

The court observed that while the statute's application formerly was limited to the insurance industry, the statute, as amended, also applied to managed care plans.<sup>140</sup> The court found, therefore, that the amended statute was not limited to entities within the insurance industry and, thus, failed the third prong of the *Metropolitan Life* "regulating insurance" test.<sup>141</sup> The court recognized that "there is room to doubt . . . [whether] ERISA's drafters intended that it would preempt any-willing-provider statutes."<sup>142</sup> However, considering the broad scope of ERISA's preemption clause and the lack of guidance from Congress or the Supreme Court in addressing any willing provider statutes, the court determined that preemption in this case

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140. See *id.* at 1036 (quoting TEX. INS. CODE ANN. art. 21.52B, § 2(a) (West Supp. 1997)). The amended statute prohibited a health insurance policy or managed care plan from limiting or interfering with a beneficiary's choice of pharmacist. See art. 21.52B, § 2(a)(1). The statute also prohibited these entities from denying a pharmacist the opportunity to participate in the policy or plan if the pharmacist agreed to meet all terms and requirements of the policy or plan. See *id.* § 2(a)(2). The 1995 amendments also added a broad definition of "managed care plans" to include "a health maintenance organization, a preferred provider organization, or another organization that, under a contract or other agreement entered into with a participant in the plan . . . provides health care benefits . . ." 105 F.3d at 1037 (quoting art. 21.52B, § 1(6)).

141. See *id.* at 1038. However, the court acknowledged that the original statute, which affected only insurance policies, would have come within ERISA's savings clause and escaped preemption. See *id.* at 1040. In analyzing the pre-1995 statute, the Court relied in part on *Stuart Circle* in concluding that a statute which affects a policyholder's choice of provider would meet the first prong of the *Metropolitan Life* test for spreading risk. See *id.* at 1041 (discussing *Stuart Circle*, 995 F.2d at 503-04). The *Texas Pharmacy* Court stated:

By requiring policies to give the beneficiary the option of obtaining pharmaceutical services from any pharmacy, and requiring pharmacy networks to admit any willing provider, we believe that the prior statute influenced which costs were ultimately borne by the insurer and which were borne by the beneficiary, and whether insurers would be willing to offer pharmacy coverage at all.

*Id.*

Moreover, the court found that Texas's statute affected a policyholder's choice of provider even more directly than the Virginia statute in *Stuart Circle*. See *id.* at 1042. The Texas statute prohibited insurance policies from

"prohibit[ing] or limit[ing] a person who is a beneficiary of the policy from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy[,] [from] furnish[ing] pharmaceutical services offered or provided by that policy[,] or [from] interfer[ing] with that person's selection of a pharmacy or pharmacist."

*Id.* (quoting art. 21.52B § 2(a)(1)). The court noted that the 1995 amendments had not changed this provision. See *id.* at 1042 n.39.

142. *Id.* at 1039.



was compelled.<sup>143</sup>

In the absence of any guidance from the Supreme Court, the ultimate status of any willing provider statutes remains uncertain as ERISA challenges to any willing provider statutes continue to seep into federal district courts. Faced with the possibility that ERISA will preempt these statutes, many state legislatures focusing on health care reform have shifted their attention away from any willing provider statutes<sup>144</sup> in favor of other forms of patient protection legislation. Such alternate patient protection legislation focuses on quality of care and other consumer interests that may not directly implicate the administration of employee benefit plans.

#### IV. AN ANALYSIS OF THE COMPETING INTERESTS OF STATE HEALTH CARE REFORM AND UNIFORM EMPLOYEE BENEFIT LAWS

The debate surrounding the viability of any willing provider laws illustrates two sets of competing interests. First, ERISA's objective of preserving uniformity in employee benefit laws conflicts directly with states' interest in enacting health care legislation to target quality-of-care issues. Determining the necessary balance between these interests requires an analysis of their respective merits. In enacting ERISA, Congress sought to encourage employers to provide employee benefit plans voluntarily by creating a uniform set of procedures for their administration.<sup>145</sup> By drafting a broad preemption clause, Congress manifested its intent to protect employers from the burden of inconsistent state law standards.<sup>146</sup>

There must be a limit, however, on the reach of ERISA's preemption of state law under section 514's "relate to" language. When Congress enacted ERISA in 1974, Congress did not contemplate that ERISA would have the effect of impeding health

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143. *See id.*

144. Although twenty-four states have enacted some form of any willing provider legislation in the past twenty years, the majority of these statutes do not extend to cover physicians, unlike those that have faced strong ERISA challenges. *See Access/Quality/Cost*, *supra* note 120, at \*2. In 1994, nine states enacted any willing provider legislation; however, in 1995 and 1996, only three states enacted such legislation. *See id.*

145. For a discussion of the goals underlying ERISA, see *supra* note 3 and accompanying text.

146. *See supra* note 6.

care reform efforts.<sup>147</sup> In the *Travelers* progeny, the Supreme Court correctly articulated that state laws that have only an indirect effect on the administration of employee benefit plans do not “relate to” ERISA plans and, therefore, should not be preempted.<sup>148</sup> Furthermore, the Court acknowledged that Congress did not intend for section 514 of ERISA to displace general health care regulation, an area traditionally of local concern.<sup>149</sup>

Assuming, however, that states should have the option to fashion health care reform measures so long as they do not directly affect ERISA plans or, in the alternative, so long as they fit within ERISA’s savings clause for regulating the “business of insurance,”<sup>150</sup> ERISA still presents a significant obstacle to health care reform. As *Stuart Circle*, *Cigna*, and *Texas Pharmacy* indicate, any willing provider statutes and, presumably, other patient protection statutes that exclusively target the health insurance industry will survive an ERISA preemption challenge through operation of the insurance savings clause.<sup>151</sup> Employers who self-insure, however, remain exempt from such regulations under ERISA’s deemer clause.<sup>152</sup> As a

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147. See *Hancock*, *supra* note 6, at 405.

148. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 662 (1995). Although the Court left open the possibility that in some limited circumstances an indirect effect may be so severe as to warrant preemption, *see id.* at 668, this Note suggests that in order for preemption to occur, the state law should have a severe effect on the employee benefit plan.

This approach is consistent with the Supreme Court’s earlier ruling in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), in which the Court addressed the administrative practices of employee benefit plans that Congress envisioned when enacting ERISA. *See id.* at 9-11. In *Fort Halifax*, a Maine statute required employers to pay a one-time severance pay to employees upon termination of employment. *See id.* at 3, 5. After acknowledging that Congress intended ERISA’s sweeping preemption provision to provide employers with uniform administrative procedures, *see id.* at 11, the Court declared that concern for such uniformity applied only to benefits that “by nature require[] an ongoing administrative program.” *Id.* The Court reasoned that a one-time severance payment would “hardly constitute[] the operation of an employee benefit plan” because the employer would face “no periodic demands on its assets that create a need for financial coordination and control.” *Id.* at 12; *see also Jordan*, *supra* note 54, at 300-04, for an analysis of practices that constitute “administration of the plan” for preemption purposes.

149. See *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 117 S. Ct. 1747, 1752 (1997).

150. See *supra* notes 60-61 and accompanying text.

151. See *Texas Pharmacy*, 105 F.3d 1035, 1040-41 (5th Cir. 1997); *Stuart Circle*, 995 F.2d 500, 502-04 (4th Cir. 1993).

152. See 29 U.S.C. § 1144(b)(2)(B) (1994); *see also supra* notes 63-65 and accompanying

result, the deemer clause now creates a dichotomy between commercially insured plan participants and beneficiaries, who receive the protection of such legislation, and self-insured plan participants and beneficiaries, who receive no such protection.<sup>153</sup> The deemer clause initially served an important purpose because Congress sought to encourage a voluntary system of employee benefit plans when it enacted ERISA.<sup>154</sup> By shielding multi-state employers who self-insured from conflicting state insurance laws, the deemer clause furthered ERISA's objective of establishing uniform employee benefit laws. However, this dichotomy between plan participants and beneficiaries of commercially insured employers, as opposed to self-insured employers, creates the possibility of gross inequity in the quality of health care that plan participants and beneficiaries receive. As one of the premises of ERISA is the protection of these parties,<sup>155</sup> it is unlikely that Congress intended to create this anomaly.

Some advocates of state-level health care reform have suggested that Congress pass a limited waiver of ERISA preemption to provide states with more options for regulating health care.<sup>156</sup> One rationale for the enactment of such a waiver provision is that successful state reform efforts could serve as models both for other states' reform initiatives as well as for subsequent national reform.<sup>157</sup> Although there is significant support for the proposition that states should serve as "laboratories" for national health care reform,<sup>158</sup> preemption

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text.

153. ERISA provides virtually no substantive rights for health benefit plans. Thus, self-insured plan participants and beneficiaries get caught in the "regulatory vacuum" that ERISA has created in the arena of health care. *See supra* note 7.

154. *See supra* notes 64-65 and accompanying text.

155. *See supra* note 3.

156. *See, e.g., Groves, supra* note 36, at 613. In 1983, Hawaii's health care program became the only state program to be exempt from ERISA. *See* 29 U.S.C. § 1144(b)(5)(A)-(C) (1994). Under Hawaii's Prepaid Health Care Act, HAW. REV. STAT. ANN. § 393 (Michie 1994), employers must provide coverage to all full-time employees and contribute at least half of the health insurance premium for each employee. *See id.* § 393-13. The primary reason Congress granted Hawaii a waiver from ERISA preemption was that Hawaii's Act predated ERISA. *See* S. REP. NO. 97-646, at 17 (1982), *reprinted in* 1982 U.S.C.A.N. 4580, 4595; *see also* Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REFORM 109, 151-53 (1985) (outlining the legislative history of Congress's decision to amend ERISA to grant a waiver to Hawaii's Prepaid Health Care Act).

157. *See id.*

158. *See id.*; *see also* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing*

waivers would frustrate ERISA's purpose of establishing and maintaining uniformity in employee benefit laws.<sup>159</sup> Moreover, waivers may actually discourage multi-state employers from expanding available benefits if variations in state laws burden the administration of benefit plans. Thus, preserving the underlying goals of ERISA, while at the same time granting states the opportunity to reform their health care systems, requires the establishment of a balance between these conflicting, yet legitimate, interests.

The controversy surrounding recent state health care reform efforts reflects a second set of competing interests, cost containment and quality of care in health care delivery. The any willing provider statutes preempted by ERISA sought to protect consumers by assuring quality of care, but they failed to achieve the appropriate balance of these opposing interests. In theory, these broad-reaching any willing provider laws could provide consumers with one of the most important protections in health care delivery: choice of providers. However, the effect of any willing provider statutes may ultimately work against consumers by increasing premiums and narrowing coverage. State legislatures seeking to preserve consumer choice and access to care must therefore craft patient protection legislation that balances these two important goals.

## V. PROPOSAL: A UNIFORM PATIENT PROTECTION ACT

A Uniform Patient Protection Act (UPPA), drafted with the foregoing concerns in mind, can achieve the proper balance between (1) uniform employee benefit laws and state health care reform, and (2) cost containment and quality health care.<sup>160</sup> As an initial step in drafting the UPPA, the National Conference of State Legislatures (NCSL) and the National Association of Insurance Commissioners

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*Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255 (1990); Angelo A. Stio III, Note, *State Government: The Laboratory for National Health Care Reform*, 19 SETON HALL LEGIS. J. 322, 339-64 (1994) (discussing Hawaii's Employer Mandate Model, Florida's Managed Care Model, and Oregon's Rationing Model).

159. See *supra* note 3.

160. Uniform health-related laws have effectively addressed a number of other quality of care and patient choice issues. See, e.g., UNIF. HEALTH-CARE DECISIONS ACT (1993); UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989); UNIF. HEALTH-CARE INFO. ACT (1985); UNIF. LAW COMM'R'S MODEL HEALTH CARE CONSENT ACT (1982).

(NAIC) should determine which types of patient protection provisions are essential at the state level. These provisions should include, at a minimum, the following: (1) requirements that managed care organizations disclose, upon consumer request, information regarding physician qualifications, plan coverage, benefits, satisfaction statistics, and loss ratios; (2) prohibitions against gag clauses in physician contracts; (3) mandatory procedures for claim-denial appeals; and (4) required options for qualifying plan participants to select specialists such as OB/GYNs as their gatekeeper physicians.<sup>161</sup> After determining which issues to address in the UPPA, the drafters should make efforts to draft provisions that will not give rise to an ERISA preemption challenge by taking into account the Supreme Court's deference to state police power as discussed in *DeBuono*,<sup>162</sup> its "indirect effect" analysis in *Travelers*,<sup>163</sup> and its test for regulating the business of insurance under *Metropolitan Life*.<sup>164</sup>

The drafters of the UPPA should abide by the judicially interpreted constraints of ERISA's preemption clause to ensure the UPPA's viability. Under the *Travelers* progeny,<sup>165</sup> UPPA provisions such as HMO disclosure requirements and gag clause prohibitions should survive a preemption challenge because of their minimal effect on the administration of employee benefit plans. HMO disclosure requirements would require managed care organizations to provide consumers with already available information regarding the operation and conditions of health plans. Moreover, removing gag clauses from physician contracts would require little administrative effort.

In addition, UPPA provisions imposing procedural requirements for claim-denial appeals and requirements that patients have the

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161. Providing this option will enable plan participants to choose gatekeepers who have the most intimate knowledge of their personal health.

162. 117 S. Ct. 1747, 1751 (1997).

163. 514 U.S. 645, 659 (1995).

164. See *Metropolitan Life*, 471 U.S. 724, 738-39 (1985).

165. See generally *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 117 S. Ct. 1747 (1997); *California Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 117 S. Ct. 832 (1997); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995).

option of choosing specialists as their gatekeeper physicians should fall within ERISA's savings clause because they regulate the business of insurance.<sup>166</sup> Such provisions regulate insurance in the "common sense view"<sup>167</sup> because they specifically target the insurance industry. These provisions also regulate the business of insurance because they spread risk by allocating the cost component of policyholders' risks among all insureds to provide an appeals process and to enable patients to choose approved specialists as their gatekeepers.<sup>168</sup> In addition, because managed care insurers determine their enrollees' choice of providers and because claims decisions and appeals deal exclusively with patients, insurers, and plan managers, these provisions regulate the relationship between the insurer and the insured.<sup>169</sup> Finally, the UPPA drafters should limit the application of the terms of those provisions to entities within the "insurance industry."<sup>170</sup>

State legislatures would have an incentive to follow the UPPA as closely as possible so as to maintain its uniformity. While such deference to the UPPA provisions will necessarily require that states sacrifice some measure of their freedom to craft unique legislation, the UPPA ultimately will allow states to effectuate, rather than merely attempt, patient-oriented health care reform. Additionally, as long as states adhere closely to the UPPA, multi-state employers essentially will have only two legal standards with which they need to comply, namely, the law of states that have adopted the Act and the law of states that have not. Moreover, as representatives from all states will play a role in developing the provisions of the UPPA, the Act likely will represent state interests without overstepping the

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166. See 29 U.S.C. § 1144(b)(2)(A) (1988). For a discussion of the "business of insurance" test under ERISA's savings clause, see *supra* notes 60-61 and accompanying text.

167. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985).

168. Cf. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 503 (4th Cir. 1993) ("By its prohibition against unreasonable restriction of providers, the Virginia Statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.")

169. Cf. *Metropolitan Life*, 471 U.S. at 743 (noting that mandated benefit laws regulate "an integral part of the relationship between the insurer and the policy holder" by limiting the type of coverage that an insurer may sell to the policyholder).

170. See *id.*

boundaries of ERISA's limitations.

Additionally, to ameliorate the injustice caused by ERISA's deemer clause,<sup>171</sup> it is imperative that Congress provide adequate safeguards for self-insured benefit plan participants and plan beneficiaries. Toward this end, the NAIC and the NCSL should submit to Congress a list of guidelines, consistent with the objectives targeted in the UPPA, for establishing "certification requirements" for self-insured employers. Congress then should amend ERISA to require self-insured employers to meet these certification guidelines in order to receive their exemption from state insurance regulation.<sup>172</sup> Requiring such certification will ensure substantially similar protection for individuals covered under the UPPA who receive coverage through commercial insurers and managed care organizations. Such certification requirements will also promote uniform employee benefit laws, which are vital to multi-state employers who provide health benefit plans to their employees. Finally, requiring such certification will further ERISA's principal objective of protecting the beneficiaries of employee benefit plans.<sup>173</sup>

## VI. CONCLUSION

Nearly a quarter of a century has passed since Congress enacted ERISA. As the cost of health care steadily has increased, managed care has served an important function by establishing a framework under which consumers can receive affordable health care. However, there inheres in managed care organizations a conflict between cost-containment practices and the quality of care that patients receive. This conflict has generated much controversy between the managed care industry and consumers, necessitating consumer-focused legislation to temper the economically driven administration of managed care health plans. A Uniform Patient Protection Act, drafted within the boundaries of ERISA and designed to address consumer concerns such as access to information, will provide the necessary

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171. See *supra* notes 63-65, 151-55 and accompanying text.

172. See American Political Network, *The Playing Field Reforming States Group: Promoting "New Federalism,"* AMERICAN HEALTH LINE, available in Westlaw, 2/3/95 APN-HE 10.

173. See *supra* note 3.

balance between uniform employee benefit laws and state health care reform. Moreover, a Uniform Patient Protection Act ultimately may serve as a catalyst for comprehensive health care reform on a national level.

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