White Paper | ERISA Preemption

Understanding the Importance of ERISA Preemption for Self-Insured Health Plans

SIIA.ORG

Summary Overview

Organizations (e.g., private-sector companies, non-profit institutions, and labor unions) that sponsor self-insured health plans traditionally employ individuals who live and work in multiple States across the country. In order to promote the sponsorship of health benefits – and in an effort to keep plan costs low – Congress understood that self-insured health plans should be subject to a uniform Federal system of regulation, instead of a "patchwork" set of requirements established by each State.

More specifically, Congress recognized that if each State was permitted to impose benefit and insurance mandates on a self-insured health plan, the plan sponsor would be forced to comply with a "patchwork" set of rules when offering coverage in different States, which would increase costs for the organization. In turn, these increased costs would adversely affect the sponsor's ability to offer health benefits, including the level of benefits covered and cost-sharing obligations for participants.

This recognition led to the enactment of ERISA and ERISA's preemption provision.

According to ERISA's preemption provision, if a State law "directly" impacts a self-insured health plan's (1) administration, (2) structure, or (3) design, the State law is preempted and is ***not*** applicable to the self-insured plan. For example, a State law that requires a self-insured health plan to cover a specified medical benefit, this law directly impacts a self-insured plan's administration and structure, and thus, is preempted by ERISA.

ERISA preemption – and its design to supplant State laws regulating self-insured health plans – (1) enables the provision of uniform benefits and (2) encourages the development of innovative plan designs, which reduces costs for plan sponsors, and correspondingly, for plan participants.

As a result, any weakening of ERISA's preemption powers at the Federal and State level is contrary to Congress's original intent, and any such efforts will (1) increase the cost and complexity of offering self-insured health benefits to workers and their families and (2) frustrate innovations intended to improve quality and health outcomes.

1. What is ERISA?

ERISA – formally called the Employee Retirement Income Security Act – is a Federal law that governs the provision of employee benefits offered to workers employed by private-sector companies, non-profit institutions, and unionized employers. These employee benefits range from retirement and health plans to group term life insurance and apprenticeship programs.

The U.S. Department of Labor (DOL) is responsible for enforcing ERISA's requirements for employee benefit plans. As discussed, because ERISA is a Federal law, State Legislatures and Executive Departments (such as Departments of Insurance) have ***no*** jurisdiction over ERISA and ERISA-covered employee benefit plans. This is by design, because as also noted, Congress sought to enact a unified, simplified, and consistent regulatory environment within which employee benefit plans operate. Congress also sought to preempt any State law attempting to regulate ERISA-covered employee benefit plans.

2. ERISA Requirements Applicable to Self-Insured Health Plans

With respect to a self-insured health plan – which itself is an employee benefit plan providing health coverage to workers and their dependents – ERISA sets forth specific requirements that the plan, and its sponsor, must comply with.

For example, a self-insured health plan – which is considered a "group health plan" under ERISA[1] – must satisfy specific coverage requirements that were added to law through the enactment of the Affordable Care Act (ACA). Here, ERISA section 715 incorporates by reference the "group health plan coverage requirements" Congress added to the Public Health Service Act (PHSA). These requirements include, among other things, pre-existing condition protections, a prohibition against imposing annual and lifetime dollar limits on certain benefits covered under the plan, and providing free coverage for certain preventive services[2].

In addition to these coverage requirements, if a self-insured plan sponsor chooses to provide coverage for mental health and substance abuse disorder (MH/SUD) benefits, the Mental Health Parity and Addition Equity Act requires the plan sponsor to ensure that any restrictions or limitations placed on MH/SUD benefits can be no greater than the restrictions or limitations placed on medical and surgical (M/S) benefits covered under the plan (i.e., "parity" among MH/SUD and M/S benefits is required).[3] In addition, if a self-insured plan provides maternity benefits and coverage for cancer-related services, the plan must provide specified coverage for mothers and newborns due to the enactment of the Newborns' and Mothers' Health Protection Act[4] and protections for women with breast cancer on account of the enactment of the Women's Health and Cancer Rights Act.[5]

Self-insured health plans must also offer continuation of health coverage in certain circumstances as required under the Consolidated Omnibus Budget Reconciliation Act of 1996 (i.e., COBRA coverage),[6] and self-insured plans must afford participants certain "special enrollment rights" and must not discriminate against plan participants as to eligibility or contributions for health benefits based on health-related factors as required under the Health Insurance Portability and Accountability Act (HIPAA).[7]

---

[1] ERISA §733(a) defines an ERISA-covered "group health plan" as an employee welfare benefit plan to the extent that the plan provides medical care…to employees or their dependents directly or through insurance, reimbursement, or otherwise.

[2] More specifically, through ERISA section 715, all ERISA-covered "group health plans" – including self-insured health plans – must: Eliminate all pre-existing condition exclusions for all plan participants [*see* PHSA section 2704]; Stop imposing annual and lifetime limits on the "essential health benefits" covered under the plan [*see* PHSA section 2711]; Provide coverage for certain preventive health services with no cost-sharing [*see* PHSA section 2713]; Cover "adult children" up to age 26 [*see* PHSA section 2714]; Stop rescinding coverage absent fraud or misrepresentation [*see* PHSA section 2712]; Include new internal and external appeals processes (and provide notice) [see PHSA section 2719]; Allow participants a choice of primary care physician/pediatrician/OB/GYN [*see* PHSA section 2719]; Provide direct access to emergency services [*see* PHSA section 2719A]; Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information [*see* PHSA section 2705]; Limit the plan's cost-sharing to certain maximum out-of-pocket limits [*see* PHSA section 2707(b)]; Eliminate waiting periods that exceed 90 days [*see* PHSA section 2708]; Cover the cost of clinical trial participation [*see* PHSA section 2709]; Provide participants with a summary of benefits and coverage [*see* PHSA section 2715]; Provide annual reports describing the plan's quality-of-care provisions [*see* PHSA section 2717].

[3] ERISA §712.

[4] ERISA §711.

[5] ERISA §713.

[6] ERISA §§601-609.

[7] ERISA §§701-702.

With respect to those organizations sponsoring self-insured health plans, these plan sponsors must comply with ERISA's notice and disclosure requirements, including, among other things, furnishing plan participants with a Plan Document and Summary Plan Description, a Summary of Benefits and Coverage, and other notices related to a participant's coverage or change in coverage.[8] Plan sponsors must also report specific information about the plan (e.g., the number of participants, the plan's financials, and certain compensation paid to service providers) to the DOL on a Form 5500.[9] Plan sponsors are also subject to ERISA's fiduciary duties, which require the sponsoring organization to (1) act in the best interests of plan participants, (2) act with care, skill, and prudence, and (3) undertake actions to keep plan costs low.[10]

ERISA also affords plan participants a process through which they can appeal benefit denials (i.e., procedures under which participants can file claims for benefits and appeal denials of benefits).[11] And, ERISA gives (1) participants the ability to file suit for denied benefits or violations of a fiduciary's duties and (2) the DOL civil and criminal enforcement authority.[12]

Enacted in 1974, and improved upon in each decade since, ERISA's substantive Federal regulation of self-insured health plans has proven exceedingly successful for nearly 50 years. Another successful aspect of ERISA – and arguably the most important – is ERISA's preemption provision.

3. ERISA's Preemptive Provision

A. The Statute

ERISA's preemption provision is housed in Section 514 of the statute, providing that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan."[13] A "state law" is defined to include "all laws, decisions, rules regulations, or other state actions having the effect of law, of *any* State."[14] While ERISA's preemption provision appears to preempt any State law, ERISA's preemption is not absolute.

For example, ERISA contains an exception under which States retain the right to regulate the "business of insurance."[15] Specifically, ERISA section 514(b)(2)(A) – commonly referred to as the "savings clause" – exempts State laws that regulate insurance, banking, and securities from ERISA's broad preemptive scope. However, ERISA section 514(b)(2)(B) – commonly referred to as the "deemer clause" – limits the "savings clause" by providing that a State may not deem an ERISA-covered plan to be an insurance company, bank, trust company, or investment company for purposes of circumventing ERISA preemption by treating a plan as an insurance company.

In the case of ERISA preemption and, for example, an ERISA-covered health plan (which may include a fully-insured and self-insured health plan), the "deemer clause" is often times not relevant, while determining whether the State law is "saved" from ERISA's preemption is indeed relevant.

[8] ERISA §§101-102, 104.
[9] ERISA §103.
[10] ERISA §404(a)(1)(A), (B).
[11] ERISA §503.
[12] ERISA §501-502.
[13] ERISA §514(a).
[14] ERISA §514(c).
[15] ERISA §514(b)(2)(A).

However, the *most* relevant question that *must* be asked when determining whether ERISA preempts a State law is: Does the State law at issue "relate to" the ERISA-covered health plan? This question is of paramount importance because while ERISA sets forth a statutory structure for ERISA preemption, whether a State law is truly found to be preempted by ERISA has historically been determined in a court of law. In other words, to determine whether a State law is indeed preempted by ERISA, a court must ultimately make this determination. This has resulted in the formulation of decades worth of judicial prudence and precedential standards on which courts will rely to ultimately decide the question: Is a State law preempted because it "relates to" an ERISA-covered health plan?

B. Litigation and Supreme Court Precedent

The legislative history of ERISA section 514 illustrates the broad scope of ERISA's preemption provision, as articulated by one of ERISA's chief sponsors, Representative Dent:[16]

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

This, however, has resulted in continuing litigation over Congress's underlying intent of whether and when a State law is preempted by ERISA.

For example, in the first two cases in which the U.S. Supreme Court interpreted ERISA section 514, the Court chose to define the term "relate to" broadly.[17] Specifically, in *Shaw v. Delta Air Lines,* the Supreme Court stated that the term "relate to" was to be given a broad, common sense meaning, and if a State law has "a connection with" or "reference to such plan," this State law "relates to" the plan and thus is preempted.[18] The Court noted, however, that if the relationship between an ERISA plan and a State law is "too tenuous, remote, or
peripheral," ERISA preemption may not apply.[19]

This latter concept was subsequently applied by the Supreme Court in *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co*. in which the Court determined that "preemption does not occur…if the state law has only a tenuous, remote, or peripheral connection with covered plans as is the case with many laws of general applicability."[20] In *Travelers*, the Court found that a New York State surcharge law's "connection with" the ERISA plan at issue was "indirect," and therefore, was not substantial enough to trigger preemption.[21] Specifically, the Court concluded that the State law had an "indirect economic influence on plan administration," thereby failing to bind plan administrators to any particular course of action, and therefore, failing to function as a regulation of an ERISA plan.[22]

---

[16] 120 CONG. REC. 29, 197 (Aug. 20, 1974); *see also, New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) (quoting Senator Williams in which the Senator stated that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions…are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans").

[17] *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1980); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983).

[18] *Shaw,* 463 U.S. at 97 (1983) (finding that a state regulation that "prohibits employers from structuring their employee benefit plans in a [particular] manner" is preempted).

[19] *Id*. at 100, n.21.

[20] 514 U.S. 645, 662 (1995).

[21] *Id*. at 660-661 (1995).

[22] *Id.*

ERISA practitioners agree that *Travelers* was the beginning of a trend to limit the broad scope of ERISA preemption, resulting in post-*Travelers* courts narrowing the term "relate to" and holding that if a State law (1) has an "indirect" economic impact on an ERISA-covered plan or (2) "indirectly" affects the plan's structure or administration, ERISA preemption is not triggered.[23]

C. Impact on Cost vs. Impact on Plan Administration, Plan Structure, or Plan Design

Since the *Travelers* decision was handed down in 1995, courts – including the Supreme Court – have focused on whether a State law "directly" or "indirectly" impacts the (1) plan administration, (2) plan structure, or (3) plan design of an ERISA-covered plan.

Most recently, the U.S. Supreme Court quoted this precedential standard in *Rutledge v. Pharmaceutical Care Management Association.*[24] In the *Rutledge* case, the Supreme Court made clear that ERISA preempts any State law that "bind[s] plan administrators to [a] particular choice" concerning the substance of plan benefits.[25] The *Rutledge* Court further explained that ERISA is "primarily concerned with preempting [state] laws that require [plan sponsors] to structure benefit plans in particular ways."[26]

The Supreme Court ruling in *Rutledge* also relied on precedent, highlighting that if a State law merely affects "the cost" of an ERISA-covered plan by, for example, regulating the price at which Pharmacy Benefit Managers (PBMs) reimburse pharmacies for the cost of those drugs covered by the plan, this State law is not preempted.[27] The *Rutledge* Court explained that notwithstanding the fact that ERISA preempts any State law that binds plan administrators to a particular choice (as noted above), "not every state law that affects an ERISA plan or causes some dis-uniformity in plan administration [is preempted]…[t]hat is especially so if a law merely affects costs."[28]

4. The Significance of ERISA Preemption for Self-Insured Health Plans

As noted, an ERISA-covered health plan may be a fully-insured or self-insured health plan. However, ERISA's preemption provision applies differently to each type of health plan.

The difference in application is on account of the "savings clause," which (as discussed above) is an exception to ERISA's preemption powers and which allows a state to regulate the "business of insurance." According to the "savings clause," states are able to enact a law that regulates the terms and conditions of the underlying insurance contract issued to the sponsor of a fully-insured plan. One of the best examples of a state law that is "saved" from ERISA's preemption is a "benefit mandate" law (i.e., a state law that requires the insurance contract to cover a specified medical item or service).

---

[23] *See, e.g., De Buono v. NYSA-ILA Medical and Clinical Services Fund,* 520 U.S. 806 (1997) (holding that the state law at issue was on of general applicability that imposed some burdens on the administration of ERISA plans, but nevertheless did not "relate to" ERISA plans); *California, Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997) (concluding that state regulation of apprenticeship programs did not have a "connection with," and therefore did not "relate to" an ERISA-covered plan).

[24] 141 S. Ct. 474 (2020) (a case that examined whether a state law that regulated reimbursement levels paid by Pharmacy Benefit Managers (PBMs) to local pharmacies is preempted by ERISA).

[25] *Id.* at 480.

[26] *Id.* In another recent Supreme Court case (*Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. 312 (2016)), the Court invalidated a Vermont law that required self-insured health plans to report comprehensive medical claims data to the state, finding that this state law impermissibly impacted plan administration.

[27] *Rutledge*, 141 S. Ct. at 480 (2020).

[28] *Id.*

Unlike a fully-insured plan, the "savings clause" is NOT applicable to a self-insured health plan because a self-insured plan is not underwritten by an insurance company and no insurance contract is present. Therefore, to determine whether, for example, a state "benefits mandate" law applies to a self-insured plan, the relevant question to ask is: Does this State "benefits mandate" law "relate to" the self-insured health plan? Here, the answer is YES, because courts have been unanimous that a State "benefits mandate" law impacts the plan's structure and design.[29]

Why? Because if a State "benefits mandate" law was not preempted by ERISA, self-insured plans would be required to comply with a "patchwork" set of requirements that would – as the Supreme Court has described it – require self-insured plan sponsors to "master the relevant laws of 50 states," which would "undermine Congress's purpose of enabling plan sponsors to establish a uniform administrative scheme," where such uniformity would be "impossible if plans [are] subject to different legal obligations in different states."[30]

Even the *Rutledge* Court recognized Congress's desire "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, thereby minimiz[ing] the administrative and financial burden of complying with conflicting directives" and ensuring that plans "do not have to tailor substantive benefits to particularities of multiple jurisdictions."[31] This is in accord with the Supreme Court's – and Congress's – concern that a "patchwork scheme of [state] regulation would introduce considerable inefficiencies in benefit program operation, which might lead those [plan sponsors] with existing plans to reduce benefits, and those without such plans to refrain from adopting them."[32]

For nearly 50 years, ERISA's preemption provision has been instrumental in establishing a consistent and reliable statutory and regulatory framework that enables self-insured plan sponsors to design and uniformly administer their health plans for workers located in multiple States. This does not mean that States cannot continue to regulate insurance products and reimbursement practices for fully-insured plans operating in their own State (which, as stated, Congress allows through the "savings clause"). However, ERISA preemption is critical for ensuring that State statutes and regulations do not impede the ability of self-insured health plans to function in a uniform manner nationally.

5. Future of ERISA Exemption

Despite the ebbs and flows of how courts have interpreted ERISA's preemption provision, this main provision has withstood the test of time. However, in recent years, States have sought to enact certain laws requiring self-insured plans "to do something," ranging from requiring self-insured plans to furnish claims data to a State All-Payer Claims Database (APCD) to telling plans how they must structure their prescription drug networks and plan designs.

---

[29] *See, e.g., Pegram v. Herdrich* 530 U.S. 211, 213 (2000) (finding that a state law that prohibits ERISA plans from incorporating step therapies of fail first protocols into their benefit offerings is preempted).

[30] *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 149-150 (2001); see also, Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9-11 (1987).

[31] *Rutledge* at 480 (2020) (quoting *Gobeille* at 320 (2016)).

[32] *Fort Halifax* at 11 (1987).

The U.S. Supreme Court has made it clear that a State law compelling self-insured plans to furnish data to a State APCD is preempted by ERISA.[33] However, whether ERISA preempts a State law regulating PBMs (that requires self-insured plans to change their prescription drug networks and plan designs) is still making its way through the courts.[34]

Defenders of these State PBM-related laws argue that the Supreme Court's ruling in *Rutledge* serves as a shield against ERISA preemption. However, these defenders misunderstand that the *Rutledge* Court examined a State PBM law that regulated "the cost" of prescription drugs, which only has an "indirect" impact on self-insured plans, and thus, is not preempted. However, the recently enacted State PBM laws impact a plan's structure and design, which as is indeed preempted because they have a "direct" impact on self-insured plans.

At the Federal level, certain stakeholders are lobbying members of Congress to amend ERISA to exempt these State PBM laws from the scope of ERISA preemption, similar to how the "savings clause" operates. Such lobbying efforts are being met with strong opposition from the employer and labor union communities, who argue that any erosion of ERISA's preemption powers will increase costs for plan sponsors and participants by requiring plans to adhere to differing requirements in multiple States; something that the original drafters of ERISA and the Supreme Court agree is against public policy and detrimental to workers and their families.

While ERISA's preemption provision will continue to stand and be a bulwark for self-insured health plans, the continued assault on ERISA's preemption powers means that the self-insurance industry must remain vigilant in our defense of ERISA and its ability to maintain a uniform set of regulations for self-insured plans.

[33] *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. 312 (2016).

[34] The 10th Circuit Court recently overturned a District Court ruling, finding that an Oklahoma law that (1) eliminated mail-order only networks (including specialty networks) by requiring all pharmacy networks to meet certain geographic restrictions; (2) required inclusion of any willing pharmacy into a plan's preferred network; (3) prohibited use of cost-sharing discounts to incentivize use of particular pharmacies; and (4) prohibited terminating a pharmacy's contract based on whether one of its pharmacists is on probation with the State Board of Pharmacy is indeed preempted by ERISA. *See Pharmaceutical Care Management Association (PCMA) v. Mulready,* No. 22-6074 (10th Cir. Aug. 15, 2023). It remains to be seen whether the 10th Circuit ruling will be appealed to the Supreme Court.

THIS
is where the business
of self-insurance gets done.

SIIA.ORG