

**AHIP COMMENTS & PROPOSED REVISIONS on PAGES 6,7,16,20,21,22
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**Health and Welfare Plans Under the Employee Retirement Income Security Act:
Guidelines for State and Federal Regulation
Draft Revisions**

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B. Key United States Supreme Court Opinions On ERISA’s Preemption Provisions

The interplay between ERISA’s preemption, saving and deemer clauses and the impact of these clauses on state regulatory authority has been the subject of a multitude of cases presented before the judiciary. The Supreme Court established tests to be used when evaluating whether a state law is preempted because it “relates to” an employee benefit plan or because the state law “deems” an employee benefit plan to be an insurer or to be engaged in the business of insurance. The Court also established tests to be used when evaluating if a state law is “saved” because it regulates “the business of insurance.”

The guidance established in the Supreme Court cases is further augmented by lower court opinions. While the Supreme Court has provided the lower courts with direction not readily apparent in the statutory language, the complexity of the statute and the fact-specific nature of the cases that the courts must decide results in an uncertain judicial decision making process. Lower courts often reach conflicting decisions in interpreting similar state laws. As a consequence, legislators, regulators,

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employers, and insurers sometimes have difficulty predicting what the courts will consider a “preempted” or “saved” regulatory initiative.

The Supreme Court further complicated the issue in the April 2003 decision, *Kentucky Association of Health Plans v. Miller*¹, when it announced a “clean break” from the tests the Supreme Court relied upon previously in interpreting the saving clause. There is uncertainty about the impact of the *Miller* case on future cases and on the precedential value of the Court’s previous ERISA preemption cases. See the summaries of a number of the key Supreme Court cases provided below.

SHAW v. DELTA AIR LINES,
463 U.S. 85 (1983)

In *Shaw v. Delta Air Lines*, the Supreme Court decided whether New York’s Human Rights Law and Disability Benefits Law were preempted by ERISA. *Shaw* is particularly valuable because of its efforts to define what the phrase “relate to” means in the context of the ERISA preemption clause and to clarify the breadth of the states’ reserved authority to regulate state-mandated disability, unemployment, and workers’ compensation benefit plans.

New York’s Human Rights Law contained a number of employment discrimination provisions, including one prohibiting employers from discriminating against their employees on the basis of sex, and defining sex discrimination to include discrimination on the basis of pregnancy. New York’s Disability Benefits Law required employers to provide employees the same benefits for pregnancy as were provided for other disabilities.²

In its analysis, the Court held that both of these state laws “related to” employee benefit plans. The Court’s interpretation of “relate to” was according to “the normal sense of the phrase, if it has a connection with or reference to such a plan.”³ The Human Rights statute prevented employers from structuring their employee benefit plans in a discriminatory fashion on the basis of pregnancy. The Disability Benefits statute required employers to include certain benefits in their employee welfare benefit plan.⁴

The Court noted that ERISA does not merely preempt state laws that deal with requirements covered by ERISA, such as reporting, disclosure, and fiduciary responsibility. Nor does the Act merely preempt state laws specifically directed to employee benefit plans.⁵ State laws that indirectly “relate to” employee benefit plans may also be preempted by ERISA. The Court did note that some state laws “may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law “relates to” the plan.”⁶

¹ 123 S.Ct. 1471 (2003)

² *Shaw v. Delta Air Lines*, 463 U.S. 85, 88-9 (1983).

³ *Id.* at 96-97.

⁴ *Id.* at 97.

⁵ *Id.* at 98.

⁶ *Id.* n. 21, at 100.

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Following its conclusion that both state laws “related to” employee benefit plans, the Court proceeded to inquire whether either of the laws was nevertheless exempt from ERISA preemption. The state argued that the Human Rights Law was exempt from ERISA preemption because ERISA’s “equal dignity” clause prohibited interpretations that impaired other federal laws and state fair employment laws were integral to the federal enforcement scheme under Title VII. The Court rejected this claim, noting that ERISA preemption of the Human Rights Law as it related to employee benefit plans did not impair Title VII because Title VII did not prohibit the practices under consideration in this case.⁷

With respect to the Disability Benefits Law, the Court noted that ERISA specifically exempts from coverage those plans which are “maintained solely for the purpose of complying with applicable ... disability insurance laws.”⁸ Consequently, the Court held that states cannot apply their laws to multi-benefit ERISA plans which may include disability benefits, but can require the employer to administer a separate disability plan which does comply with state law.⁹

**METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS,
471 U.S. 724 (1985)**

In *Metropolitan Life v. Massachusetts*, the Court reviewed whether a state statute mandating coverage of mental health benefits was preempted by ERISA as applied to insurance policies purchased by employee welfare benefit plans. All insurance policies within the scope of the statute, including policies purchased by ERISA health plans, were required to include the mandated mental health benefit. Because the statute had the effect of requiring insured employee benefit plans to provide a particular benefit, the Commonwealth of Massachusetts did not dispute that the statute “related to” ERISA plans.¹⁰ The Commonwealth did claim, however, that the law regulated the business of insurance, and thus, was saved from ERISA preemption.¹¹

In its analysis, the Court highlighted that ERISA does not distinguish between “traditional and innovative insurance laws.”¹² Further, the Court noted that “[t]he presumption is against preemption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope.”¹³ The Court also noted that Congress did not intend to preempt areas of traditional state regulation.¹⁴

The opinion adopted a “common-sense view” of the saving clause, observing that it would seem to “state the obvious” that a law which “regulates the terms of certain insurance contracts” is “a law ‘which

⁷ *Id.* at 103-04.

⁸ *Id.* at 106; See 29 U.S.C. § 1003(b)(3) (2004).

⁹ *Id.* at 107-08.

¹⁰ *Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724, 739 (1985).

¹¹ *Id.* at 733.

¹² *Id.* at 741.

¹³ *Id.* at 741.

¹⁴ *Id.* at 740.

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regulates insurance” within the meaning of the saving clause.¹⁵ The Court explained further that the case law interpreting the phrase “the business of insurance” under the McCarran-Ferguson Act “also strongly supports the conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the saving clause as laws ‘which regulate insurance.’”¹⁶ Under the McCarran-Ferguson Act, “Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, directly or indirectly, are laws regulating the ‘business of insurance.’”¹⁷ The Court reviewed the McCarran-Ferguson “reverse preemption” cases as an aid to determine if a practice is the “business of insurance”.¹⁸

- (1) Does the practice have the effect of “spreading a policyholder’s risk”?
- (2) Is the practice an “integral part of the policy relationship between the insurer and the insured”?
- (3) Is the practice “limited to entities within the insurance industry”?

The Supreme Court opinion that established this three-pronged test, *Union Labor Life v. Pireno*¹⁹, specifically stated that not all of these prongs are necessary and noted, in particular, that the third prong of the test was not dispositive to a determination that an entity was engaged in the business of insurance.²⁰

The Court held that the Massachusetts law met all three of the Pireno criteria derived from the McCarran-Ferguson Act. It found that:

- (1) The law regulated the spreading of risk since the state legislature’s intent was that the risk associated with mental health services should be shared;
- (2) The law directly regulated an integral part of the relationship between the insurer and the policyholder
- (3) The law met the third prong because it only imposed requirements on insurers.²¹

The Court acknowledged, “we are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we

¹⁵ *Id.* at 740.

¹⁶ *Id.* at 742–43.

¹⁷ *Id.* at 744, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

¹⁸ *Id.* at 742, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). Although some courts, including on occasion the Supreme Court itself, have cited *Metropolitan Life* and/or *Pireno* as supporting the proposition that courts should evaluate whether the law itself “has the effect of spreading a policyholder’s risk,” that is not how the standard was originally formulated by the Court.

¹⁹ *Union Labor Life v. Pireno*, 458 U.S. 119 (1982).

²⁰ *Id.* at 133.

²¹ *Metropolitan*, 471 U.S. at 743.

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merely give life to a distinction created by Congress in the “deemer clause,” a distinction of which Congress is aware and one it has chosen not to alter.”²²

It is important for regulators to keep in mind that this distinction between indirectly regulated insured plans and unregulated self-funded plans is the result, not the source, of states’ reserved authority to regulate insurance. Thus, the applicability of state insurance law to an insurance policy purchased by an employee benefit plan is not conditional on some prior determination that the plan is an “insured” plan.

**PILOT LIFE INS. CO. v. DEDEAUX,
481 U.S. 41, (1987)**

Pilot Life Ins. Co. v. Dedeaux involved state common law tort and contract claims as applied to the processing of claim benefits under an employee welfare benefit plan. In *Pilot Life*, a unanimous Court held that the plaintiff’s common law causes of action for the insurer’s alleged bad faith handling of the plaintiff’s disability claim “related to” an employee benefit plan and were preempted by ERISA because they involved the processing of claims under an employee benefit plan.²³

The Court found that the state law bad-faith common law tort claims were not protected by the “saving clause.” The Court stated that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but be *specifically directed* toward that industry.”²⁴ Applying the criteria used to determine whether a practice constitutes the business of insurance for purposes of the McCarran-Ferguson Act, the Court determined that: (1) the common law tort of bad faith did not effect a spreading of the risk; (2) the tort was not integral to the insurer-insured relationship; and (3) because common law tort claims were not limited to entities within the insurance industry, the McCarran-Ferguson “business of insurance” test did not save the state law claims.²⁵ Further, the Court stated that “the deliberate care with which ERISA’s civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA’s civil enforcement remedies were intended to be exclusive.”²⁶

The Court went beyond considering the exclusive remedy as an additional factor in support of its conclusion that the bad faith tort does not “regulate insurance” within the meaning of the saving clause – the Court concluded that even if Mississippi’s law did regulate insurance, it would still be preempted. The Court distinguished *Metropolitan Life* on the ground that it “did not involve a state law that conflicted with a substantive provision of ERISA.”²⁷ The Court concluded that all state laws that

²² *Id.* at 747

²³ *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

²⁴ *Id.* at 50. Emphasis supplied.

²⁵ *Id.* at 57.

²⁶ *Id.* at 54.

²⁷ 481 U.S. at 56–57.

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“supplemented or supplanted” the causes of action and remedies available under ERISA were preempted,²⁸ whether or not they “regulated insurance” within the meaning of the saving clause.

ERISA preemption also controls the forum in which the complaint is to be heard. The Federal Rules of Civil Procedure provide that “any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.”²⁹ In a companion case to *Pilot Life, Metropolitan Life Ins. Co. v. Taylor*,³⁰ the Supreme Court held that state court cases can be removed to federal court if the common-law cause of action is preempted by ERISA, even though no federal law issues appear in the complaint. The Court held that this doctrine, originally developed in the context of labor law preemption,³¹ was equally applicable to ERISA preemption.³²

The deference that the Court afforded to the civil enforcement scheme of ERISA stressed the need for exclusivity and uniformity of ERISA plan remedies.³³ As a result, it is important to distinguish state insurance regulation and enforcement relating to claims handling, utilization review, grievance handling and coverage or claim appeals from civil remedies. The *Pilot Life* “conflict” exception to the saving clause should not be invoked by a court reviewing an insurance regulatory provision relating to these topics because they are not a “civil remedy” for the participant, even if they have the effect of providing restitution to consumers.

**FIRESTONE TIRE & RUBBER CO. v. BRUCH,
489 U.S. 101 (1989)**

While *Firestone Tire & Rubber Co. v. Bruch* is often cited for the proposition that ERISA plan administrators (including insurers when the plan provides insurance benefits) are entitled to broad discretion, that is not actually what the Court held. To the contrary, the Court rejected the standard that had previously been widely applied in the lower federal courts, under which plan administrators were understood to have inherent discretionary authority, so that courts could only overturn the

²⁸ *Id.* at 56. The Court based its analysis on legislative history, submitted by the Solicitor General as *amicus curie*, indicating that the preemption provisions in ERISA were based on the broad exclusive remedy provisions in the Taft-Hartley Act (LMRA), 29 U.S.C. § 185. The Taft-Hartley Act does not contain an insurance saving clause, a difference from ERISA that was not addressed by the *Pilot Life* Court. See *UNUM Life Ins. Co. v. Ward*, 526 U.S. at 376 n.7.

²⁹ 28 U.S.C. § 1441(a) (1994).

³⁰ *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987).

³¹ See *Avco Corp. v. Machinists*, 390 U.S. 557 (1968). In *Avco*, the Court permitted the removal of cases purporting to be based only on state law causes of action in labor cases preempted by § 301 of the Labor Management Relations Act.

³² *Taylor* at 66-67. However, as noted by the U.S. Supreme Court in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), for non-diversity of citizenship cases, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case arises under federal law. Federal law as a defense is generally not sufficient to remove an action to federal court. The cause of action must come within the scope of ERISA’s civil enforcement provisions (29 U.S.C. §502).

³³ William A. Chittenden, III, *ERISA Preemption: The Demise of Bad Faith Actions in Group Insurance Cases*, 12 S. Ill. U.L. J., 517 (1988).

Comment [tp1]: A general revision to consider including in the summary a footnoted reference to *Conkright v. Frommert*, 130 S. Ct. 1640 (2010).

The *Conkright* decision held that a court must give deference to a plan administrator’s interpretation of plan terms even if the administrator’s original good-faith interpretation of that language was an abuse of discretion. *Conkright* at 1646-47. It was brought in response to a *Firestone* standard “carve-out” created by the 2d Circuit; a carve-out the Supreme Court found had “no basis in the Court’s holding in *Firestone*, which set out a broad standard of deference without any suggestion that the standard was susceptible to ad hoc exceptions”. *Conkright* at 1647.

With *Firestone*’s inclusion in the revised handbook for purposes of discussing its *de novo* review standard, it may be helpful to direct readers to *Conkright* for purposes of further clarifying and/or expanding on the rationale behind the *Firestone* standard.

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administrator's decisions if it was arbitrary and capricious.³⁴ Instead, the Court held that such decisions are subject to *de novo* review by the courts unless the terms of the plan expressly grant discretionary authority to the administrator.

Firestone was neither an insurance case nor a health benefit case. It involved a dispute over the employer's severance payment plan that arose after the employer sold five of its plants to another employer. The trial court had granted summary judgment to Firestone on the basis that its denial of severance pay was not arbitrary and capricious, but the Third Circuit reversed on the ground "that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, its decision to deny benefits should be subject to *de novo* judicial review. It reasoned that in such situations deference is unwarranted given the lack of assurance of impartiality on the part of the employer."³⁵

The Supreme Court affirmed this standard of review. Although "ERISA abounds with the language and terminology of trust law,"³⁶ the "arbitrary and capricious" standard of review lower courts had often applied in ERISA cases was not based on general principles of trust law, but on precedent under the Taft-Hartley Act. Under the Taft-Hartley Act, a suit against a trustee is an extraordinary remedy; by contrast, Congress expressly provided for judicial review of decisions by ERISA fiduciaries.³⁷ Under general principles of trust law, a dispute over interpreting the terms of a trust is resolved by the court, not by the trustee. Therefore, the Court held that the default standard under ERISA should be *de novo* review, and noted that this standard is consistent with the standard applied under contract law to employee benefit plans before ERISA was enacted.³⁸

However, the Court also provided guidance for mitigating the impact of the *de novo* standard. Despite acknowledging that one of the purposes of ERISA was "to protect contractually defined benefits,"³⁹ the Court interpreted ERISA as replacing contract law with trust law as the governing principle for resolving employee benefit disputes, and stated that when the trustee is exercising a discretionary power that has been expressly granted by the terms of the trust instrument, trust principles then "make a deferential standard of review appropriate."⁴⁰ In this case, though, there was no discretionary clause, so the *de novo* standard was fully applicable. Finally, the Court cautioned: "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest," as when an insurer or employer adjudicates a claim for benefits that would be paid out of its own assets, "that conflict must be weighed as a factor in determining whether there is an abuse of discretion."⁴¹

FMC CORP. v. HOLLIDAY,

³⁴ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109–110 (1989).

³⁵ *Id.* at 107–108.

³⁶ *Id.* at 110.

³⁷ *Id.* at 109–110. Another crucial difference between ERISA and the Taft-Hartley Act is that Congress did not make Taft-Hartley's exclusive remedy provision subject to a saving clause for insurance laws, a distinction that the *Pilot Life* Court did not take into account in its analysis. See *supra* note --- <#53 in 2004 edition, #6 in this draft>

³⁸ *Id.* at 112.

³⁹ *Id.* at 113.

⁴⁰ *Id.* at 111.

⁴¹ *Id.* at

Comment [tp2]: Not accurate. Risks overstating the decision. Suggest replacing "expressly grant" with "gives".

In *Firestone* the Court wrote: "Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone* at 116 (emphasis added)

The *Firestone* decision didn't specify "how" that discretion may be given - i.e. "expressly" or otherwise. Instead, whether a plan may grant that discretionary authority either "expressly" or by inference is a matter of law that lower courts have split on.

Indeed, there are scores of cases litigating whether a plan's language is sufficient to confer discretion on the plan's administrator or fiduciary.

For example, some lower courts maintain that the discretionary authority must be expressly granted in the language of the plan. See, e.g., *Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447*, 47 F.3d 139, 142 (5th Cir. 1995) (holding administrator has no discretion to determine eligibility or interpret plan unless plan language expressly confers such authority).

Other lower courts have held that a grant of discretion might be inferred from a plan. See, e.g., *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 619 (7th Cir. 2008) (finding magic words unnecessary); see also *Post v. KidsPeace Corp.*, 98

Comment [tp3]: Risks overstating the degree to which the Court is able to utilize trust law when analyzing such disputes. Suggest adding a footnoted reference to *Conkright v. Frommert*, 130 S. Ct. 1640 (2010).

In *Conkright* the Court wrote: "While we are 'guided by principles of trust law' in ERISA cases [citing *Firestone*], we have recognized before that 'trust law does not tell the entire story,' *Varity Corp. v. Howe*, 516 U.S. 489, 497, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996); see *ibid.* ('In some instances, trust law will offer only a starting point, after which courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purposes require departing from common-law trust requirements'); Brief for Respondents 50 (pressing same view as the dissent but concluding that the dispute over trust law "need not be resolved"). Here trust law does not resolve the specific issue before us, but the guiding principles we have identified underlying ERISA do." *Conkright* at 1649

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498 U.S. 52 (1990)

At issue in *FMC Corp. v. Holliday* was a Pennsylvania state statute that prevented employee welfare benefit plans from subrogating a plan beneficiary's tort recovery involving motor vehicle-related incidents. The plan at issue was a self-funded employee welfare benefit plan.⁴²

The Court concluded that the statute "related to" the employee benefit plan because it referenced such plans and was connected to such plans by subjecting multi-state self-funded plans to conflicting state regulations.⁴³ The Court also concluded that the statute fell within the "savings" clause as an insurance regulation.⁴⁴

Nevertheless, after concluding that the statute "related to" the employee benefit plan and regulated insurance, the Court ultimately held that the statute was not "saved" to the extent that it regulated ERISA-covered self-funded employee welfare benefit plans. Since the "deemer" clause exempts ERISA plans from state laws that regulate insurance, the state could not apply laws directed at the business of insurance to self-funded employee welfare benefit plans or to the terms of the plans.⁴⁵ The Court reaffirmed that the "savings" clause "retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee welfare benefit plans."⁴⁶ Specifically, the Court stated that "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it."⁴⁷

**DISTRICT OF COLUMBIA v. GREATER WASHINGTON BOARD OF TRADE,
506 U.S. 125 (1992)**

In *District of Columbia v. Greater Washington Board of Trade*, the Supreme Court held that ERISA preempted a statute that required an employer to provide employees who were eligible for workers' compensation benefits with the same coverage the employer provided through its health insurance program if one was offered.⁴⁸

The Court noted that the statute clearly "related to" employee welfare benefit plans because it specifically mentioned them.⁴⁹ The Court rejected the District of Columbia's reliance on *Shaw* because *Shaw* had specifically held that a state cannot apply a statute directly to an employee welfare benefit plan. Although *Shaw* does allow a state to require an employer to set up a separate plan to comply with laws directed at benefits not covered by ERISA, such as disability, unemployment, and workers'

⁴² *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

⁴³ *Id.* at 58-60.

⁴⁴ *Id.* at 60-61.

⁴⁵ *Id.* at 65.

⁴⁶ *Id.* at 64.

⁴⁷ *Id.*

⁴⁸ *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 126-27 (1992).

⁴⁹ *Id.* at 130.

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compensation benefits, the District of Columbia law did not do so.⁵⁰ The benefit it mandated was tied directly to the terms of the employer's ERISA plan.⁵¹

NEW YORK BLUE CROSS PLANS v. TRAVELERS INS. CO.
514 U.S. 645 (1995)

In *New York Blue Cross Plans v. Travelers Ins. Co.*, the Court upheld a statute which required that hospitals impose one level of surcharge on patients insured by commercial insurers, another level of surcharge on patients insured by HMOs, and no surcharge on patients insured by Blue Cross and Blue Shield plans. Commercial insurers challenged the state law, claiming that the statute was preempted by ERISA because the state law "related to" the bills of patients whose insurance was purchased by employee welfare benefit plans.

The District Court held that the surcharges "related to" ERISA plans and were thus preempted because they had the effect of increasing the costs to commercial insurers and HMOs and therefore, indirectly increasing the costs to employee welfare benefit plans. Consequently, the District Court enjoined the enforcement of the surcharges. The Court of Appeals affirmed the District Court's decision, reasoning that the "purpose[ful] interfer[ence] with the choices that the ERISA plans make for health care coverage ... is sufficient to constitute [a] "connection with" ERISA plans."⁵²

In a unanimous decision, the Supreme Court reversed the holding of the Court of Appeals. The Court noted that the statute did not make "reference to" an employee welfare benefit plan because the surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.⁵³

After reviewing the purposes and objectives of Congress in enacting the ERISA statute, the Court also concluded that the statute did not have a "connection with" employee welfare benefit plans. The Court held that an indirect economic influence is not a sufficient connection to trigger preemption if it does not bind plan administrators to any particular choice or preclude uniform administrative practices. While a surcharge may increase plan costs and affect its shopping decisions, it does not preclude the plan from seeking the best deal that it can obtain. The Court noted that the state laws which have an indirect economic effect on the relative costs of health insurance packages leaves "plan administrators where they would be in any case, with the responsibility to choose the best overall coverage for the money."⁵⁴

The *Travelers* Court clarified that state statutes that "produce such acute, albeit indirect, economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers ... might indeed be preempted."⁵⁵ Because the

⁵⁰ *Id.* at 132.

⁵¹ *Id.* at 132.

⁵² *New York Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 1675-7 (1995).

⁵³ *Id.* at 1677.

⁵⁴ *Id.* at 1680.

⁵⁵ *Id.* at 1683.

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hospital surcharge statute only indirectly affects the cost of insurance policies, it does not fall into this category of indirect regulation preempted by ERISA.

**CALIFORNIA DIVISION OF LABOR STANDARDS ENFORCEMENT v. DILLINGHAM
519 U.S. 316 (1997)**

At issue in *California Division of Labor Standards Enforcement v. Dillingham* was whether ERISA preempted California's minimum wage law to the extent that it allowed payment of a lesser wage to workers that participate in a state-approved apprenticeship program. The Supreme Court considered whether the state law "related to" an ERISA plan and was therefore preempted under ERISA § 502(a). The Court utilized a two-part inquiry to determine whether California's minimum wage law "related to" an ERISA plan. The Court considered whether the state law had either a "reference to" or a "connection with" an ERISA plan.⁵⁶

The Court noted common characteristics among the cases where it had held that certain state laws made "reference to" an ERISA plan. The Supreme Court highlighted cases "[w]here a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Board of Trade* and *Ingersoll-Rand*, that "reference" will result in preemption."⁵⁷ The Court determined that California's minimum wage law, as it applied to apprentice wages, applied to more than just ERISA plans and, as a result, did not make "reference to" ERISA plans.

In order to determine whether a state law has a "connection with" an ERISA plan, the Court acknowledged that "an 'uncritical literalism' in applying the 'connection with' standard offers scant utility in determining Congress' intent to the extent of the reach of the preemption clause."⁵⁸ In applying the "connection with" standard, the Court looked to the "objectives of the ERISA statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans."⁵⁹

With respect to the issue of Congressional intent, the Supreme Court's analysis starts with a presumption against preemption—Congress did not intend to preempt areas of traditional state regulation absent evidence that it was the clear and manifest purpose of Congress.⁶⁰ In *Travelers*, the Court stated that "the preemption of areas of traditional state regulation where ERISA has nothing to say would be "unsettling."⁶¹ California's minimum wage laws, like the hospital surcharge law at issue in the *Travelers* case, involved issues traditionally regulated by the states. In addition, the Court observed that the areas covered by the state laws at issue in both cases were "quite remote from the areas with which ERISA is

⁵⁶ 519 U.S. 316, 324, quoting the test used in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 (1992) (quoting *Shaw v. Delta Airlines, Inc.* 463 U.S. 85, 96-97 (1983)).

⁵⁷ *Id.* at 325.

⁵⁸ *Id.* citing *Travelers*, 514 U.S. at 656.

⁵⁹ *Id.* citing *Travelers*, 514 U.S. at 658-659.

⁶⁰ *Id.* citing *Travelers*, 514 U.S. at 655, quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)(citation omitted).

⁶¹ *Id.* at 330, citing *Travelers* at 665 n 7.

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expressly concerned—reporting, disclosure, fiduciary responsibility, and the like.”⁶² Therefore, the Supreme Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprentice wages and wages to be paid on public works contracts.

In past ERISA preemption cases decided by the Supreme Court, a “connection with” an ERISA plan was observed when the state law at issue had either “mandated employee benefit structures or their administration.”⁶³ The Court compared the effect of the New York law on ERISA plans in the *Travelers* case to the effect of the California law on ERISA plans in the instant case. The indirect economic influence that resulted from the state law at issue in *Travelers* did not force ERISA plans to make a particular choice, nor did it regulate the ERISA plan itself. Similarly, California’s prevailing wage statute did not bind ERISA plans to any particular decision.⁶⁴ The Court stated that “[t]he [California] law only alters the incentives, but does not dictate the choices facing ERISA plans.”⁶⁵ The Court reasoned that the California minimum wage law was no different “from myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate.”⁶⁶

The Court concluded that California’s prevailing wage law had neither a “connection with” nor did it make “reference to” an ERISA plan. Therefore, it did not “relate to” an ERISA plan so as to be preempted under Section 514(a) of ERISA.

DeBUONO v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND
520 U.S. 806 (1997)

At issue in this case was the application of a New York hospital tax to medical centers operated by an ERISA plan. The Court of Appeals for the Second Circuit held that the New York tax was preempted because it “related to” an ERISA plan within the meaning of ERISA §514(a). The case was appealed to the United States Supreme Court. The Supreme Court remanded the case for reconsideration in light of its opinion in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,⁶⁷

The Second Circuit reconsidered its opinion and, distinguishing the tax at issue in *Travelers* from the tax at issue in this case, again held the law preempted as it applied to hospitals owned by ERISA plans. The Second Circuit reasoned that in *Travelers*, the surcharge only impacted ERISA plans indirectly by influencing a plan administrator’s decision. However, in this case, the impact of the tax on ERISA plans was direct, by depleting the funds assets.⁶⁸

⁶² *Id.* at 330, citing *Travelers*, 514 U.S. at 661 (quoting *Shaw*, 463 U.S. at 98)

⁶³ *Id.* at 328. citations omitted.

⁶⁴ *Id.* at 332.

⁶⁵ *Id.* at 334.

⁶⁶ *Id.* at 334. citing *Travelers*, 514 U.S. at 668.

⁶⁷ 514 U.S. 645.

⁶⁸ *Id.* at 812 citing *NYSA-ILA Medical Center and Clinical Services Fund v. Axelrod*.

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On petition before the Supreme Court for the second time, the Court reversed the Second Circuit and held that the New York tax did not “relate to” an ERISA plan, and therefore, was not preempted as it applied to hospitals owned by ERISA plans. The Court explained that the holding in *Travelers* required re-evaluation of its previous interpretations of the “relates to” phrase. Prior to its decision in *Travelers*, cases requiring the Court to interpret the “relates to” language in ERISA had obvious connections to or made obvious references to ERISA plans.⁶⁹ The Court’s decision in *Travelers* rejected a strict and literal interpretation of “relates to.”⁷⁰

The Court explained that the “relates to” language in §514(a) does not modify the starting presumption that Congress does not intend to preempt state law.⁷¹ In order to overcome this presumption against preemption, one “must go beyond the unhelpful text . . . and instead look to the objectives of the ERISA Statute as a guide to the scope of the law that Congress understood would survive.”⁷²

The Court reiterated that the scope of ERISA’s preemptive reach was not intended to extend to the historic police powers of the states, which includes matters of health and safety.⁷³ The Court observed that the tax at issue in this case, while a revenue raising measure and not a hospital regulation per se, clearly occupied a realm that was historically a state concern.⁷⁴ Consequently, the Fund had the “considerable burden” of overcoming the presumption against preemption of state law.⁷⁵

The Court explained that the New York hospital tax was a law of general applicability. All hospitals were required to pay the tax regardless of their relationship to an ERISA plan. Laws of general applicability may impose burdens on the administration of ERISA plans and still not “relate to” an ERISA plan.⁷⁶ The Court observed that “any state tax or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute.”⁷⁷ In a footnote the Court reiterated a statement from *Travelers* conceding that there may be a situation where the economic impact of the state law is so great that an ERISA plan would be forced to buy certain coverage or not use certain insurers, in which case there may be preemption.⁷⁸ However, the tax at issue in this case was not such a law. The tax was held not to “relate to” an ERISA plan and was not preempted by ERISA.⁷⁹

UNUM LIFE INS. C^oO. v. WARD,

⁶⁹ *Id.* at 813 citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85.

⁷⁰ *Id.* at 812.

⁷¹ *Id.* at 813 citing *Travelers* at 655 citing *Rice v. Sante Fe Elevator Corp.*, 331 U.S. 218, 230.

⁷² *Id.* at 813, 814 citing *Travelers* 514 US at 656.

⁷³ *Id.* at 814.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.* at 815 citing *Travelers* 514 U.S. at 668.

⁷⁷ *Id.* at 816.

⁷⁸ *Id.* at n.16 citing 514 U.S. at 668.

⁷⁹ *Id.* at 816-817.

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526 U.S. 358 (1999)

This case involved John Ward's claim for disability benefits pursuant to a policy provided by his employer. Mr. Ward filed his claim with UNUM Life Insurance Company after the expiration of the deadline provided for in his insurance policy. Consequently, UNUM denied his claim. Mr. Ward filed suit under ERISA §502(a) for benefits due under the terms of the plan, claiming that under California law, *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731, UNUM had received timely notice of Ward's disability. Under *Elfstrom*, an employer that administers a group health plan is the agent of the insurer. Therefore, the notice that Ward provided to his employer, which was within the timeframe set forth the insurance policy, served as notice to UNUM. The district court, however, disagreed and granted summary judgment in favor of UNUM. The district court reasoned that the *Elfstrom* rule did not apply to Mr. Ward's situation because the rule "related to" an ERISA plan and was therefore preempted.

Ward appealed to the Court of Appeals for the Ninth Circuit, which reversed the district court's decision and remanded. First, the Ninth Circuit held that a doctrine of California law, known as the notice-prejudice rule, operated to prevent UNUM from denying Ward's claim as untimely unless UNUM could show that it had been prejudiced by the delay. Alternatively, the Ninth Circuit held that, if UNUM could show that it was prejudiced by the delay, the *Elfstrom* rule would prevent UNUM from denying Ward's claim for benefits. According to the Ninth Circuit, the notice-prejudice rule was saved from preemption because, although it "relates to" an ERISA plan, it was nevertheless "saved" from preemption as a law that "regulates insurance." within the meaning of ERISA § 514(b)(2)(a). The *Elfstrom* rule also was not preempted, according to the Ninth Circuit, because as a law of general application, it did not "relate to" an ERISA plan.

The decision of the Ninth Circuit was affirmed in part and reversed in part by the Supreme Court. The Supreme Court conducted a two-part analysis into whether the notice-prejudice rule was a law that "regulates insurance" within the meaning of ERISA's saving clause. First, the Court considered whether the law regulates insurance from a "common-sense" perspective. Second, the Court considered three factors used to determine whether a state law is the "business of insurance" within the meaning of the McCarran-Ferguson Act.⁸⁰ Under the first factor, the Court considers whether the law "has the effect of transferring or spreading a policyholder's risk." Under the second factor, the Court considers "whether the law is an integral part of the policy relationship between the insurer and the insured." Under the third factor, the Court considers "whether the law is limited to entities within the insurance industry." The three factors assist the Court in "verify[ing] the common sense view" of whether a law regulates insurance. The Court clarified that the three McCarran-Ferguson factors are not mandatory requirements.⁸¹ Each factor does not need to be met individually, but instead serve as "guideposts"⁸² or "considerations to be weighed"⁸³ when determining whether a law "regulates insurance" within the meaning of ERISA's saving clause.

⁸⁰ 526 U.S. at 367.

⁸¹ *Id.* at 372.

⁸² *Id.* at 374.

⁸³ *Id.* at 373.

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The Court applied this two-part analysis to the notice-prejudice rule. The Court first considered whether the law regulated insurance from a common sense perspective. Observing that the notice-prejudice rule “controls the terms of the insurance relationship,” is “directed specifically at the insurance industry” and is “grounded in policy concerns specific to the insurance industry,” the Court found that the notice-prejudice rule clearly regulated insurance.

The Court considered the second part of the “regulates insurance” analysis—the three factors used to determine whether a state law regulates the business of insurance within the meaning of the McCarran-Ferguson Act. The Court declined to decide the first factor, the risk spreading factor, because the remaining two factors were clearly satisfied. However, with respect to the “risk spreading” factor, the Court acknowledged, but did not adopt, the argument forwarded by the United States as *amicus curiae*.⁸⁴ In its brief, the United States noted that the notice-prejudice rule “shifts risk” to the extent that the risk of late notice and stale evidence is shifted from the insured to the insurer and may result in higher premiums and spreading risk among policyholders.⁸⁵ The second factor is satisfied because the notice prejudice rule dictates the terms of the insurance contract by requiring that the insurer prove prejudice before enforcing a timeliness of claim provision in the contract.⁸⁶ The third factor is also satisfied because the notice prejudice rule has more than a passing impact on the insurance industry—it is aimed at it.⁸⁷

The Court specifically rejected UNUM’s arguments that the notice-prejudice rule conflicted with ERISA. UNUM asserted that the notice-prejudice rule conflicted with ERISA’s requirement in §504 (a)(1)(D) that requires fiduciaries to act in accordance with plan documents. The Court points out that, under this argument, ERISA §504 preempts any state law contrary to a written plan term, an outcome that “makes scant sense”⁸⁸ and would “virtually read the saving clause out of ERISA.”⁸⁹ The Court, citing *Metropolitan Life*⁹⁰ and *FMC Corp*⁹¹ points out that the Court has repeatedly held that state laws mandating insurance contract terms are saved from preemption under §514(b)(2)(A).⁹²

UNUM also attempted to convince the Court that ERISA’s civil remedies preempt any action for plan benefits brought under state rules. The Court summarily disposed of this argument by pointing out that the cause of action in this case was brought pursuant to ERISA § 502(a)(1)(B). However, the Court specifically acknowledged in a footnote the United States’ argument as *amicus curiae* that,

⁸⁴ *Id.* at 374.

⁸⁵ *Id.* citing United States as *Amicus Curiae* 14.

⁸⁶ *Id.* at 374 – 375.

⁸⁷ *Id.* at 375 (citations omitted).

⁸⁸ *Id.*

⁸⁹ *Id.* at 376.

⁹⁰ 471 U.S. at 758

⁹¹ 498 U.S. at 64

⁹² *Id.* at 375 - 376.

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notwithstanding *Pilot Life*, a state law that “regulates insurance” within the meaning of the saving clause is saved from preemption even if it provides a state law cause of action or remedy.⁹³

The Court rejected the Ninth Circuit’s conclusion that the *Elfstrom* rule does not “relate to” an ERISA plan and, therefore, was not preempted. The Court pointed out that the *Elfstrom* rule, by “deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration.”⁹⁴ Therefore, the *Elfstrom* rule “relates to” an ERISA plan and is preempted.

**RUSH PRUDENTIAL HMO, INC. v. MORAN,
536 U.S. 355 (2002)**

In *Rush Prudential HMO, Inc. v. Moran*, the Court held that Illinois’s independent review law was not preempted as a law that “relates to” an ERISA plan because it “regulates insurance” within the meaning of ERISA’s saving clause.

The Court explained that there is a presumption against preemption that informs the saving clause analysis. According to the Court, the “unhelpful drafting” of ERISA’s preemption and saving clauses require that the ordinary meaning of these “antiphonal phrases” be qualified by the assumption that “the historic police powers of the states were not meant to be superseded unless it was the clear and manifest purpose of Congress.”⁹⁵

The Court stated that the Illinois independent review law “related to” an ERISA plan because it “bears indirectly but substantially on all insured benefit plans (citation omitted) by requiring them to submit to an extra layer of review for certain benefit denials”⁹⁶ and would be preempted unless it “regulates insurance” within the meaning of the saving clause.

The Court held that an HMO is both a health care provider and an insurer.⁹⁷ By underwriting and spreading the risk of treatment costs among the HMO participants, the HMO performs a traditional insurance function. The fact that an HMO may also provide medical services or that it may transfer some of its risk to the providers does not take the HMO out of the insurance business.⁹⁸ The Court also recognized that Congress intended for state insurance laws to apply to HMOs and that most state insurance departments are primarily responsible for the regulation of HMOs.⁹⁹ The Court stated that the

Comment [tp4]: Correct spelling to "superseded"

Comment [T5]: For consistency with other citation revisions/formatting, should be edited to: 536 U.S. 355, 364-366 (citations omitted)

⁹³ *Id.* at 376 n.7. As discussed below, the Court later resolved this question in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), reaffirming that the *Pilot Life* doctrine preempts a state insurance law establishing a private cause of action against health insurance carriers, as applied to insurance that provides ERISA benefits.

⁹⁴ *Id.* at 379.

⁹⁵ 122 S.Ct. 2151, 2158-2159 (citations omitted).

⁹⁶ *Id.* at ~~2159~~365.

⁹⁷ *Id.* at ~~2160~~367.

⁹⁸ *Id.*

⁹⁹ *Id.* at ~~367-369~~2160-2161.

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application of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.¹⁰⁰

The Court applied the three McCarran-Ferguson factors,¹⁰¹ pointing out that a All three factors are not required in order for a law to regulate insurance within the meaning of the saving clause.¹⁰² The Court confirmed its “common sense” conclusion by observing that the statute met at least two of the three factors: (i) it regulated an integral part of the policy relationship between the insured and insurer by providing “a legal right to the insured, enforceable against the HMO, to obtain an authoritative determination of the HMOs medical obligations”¹⁰³ and (ii) the statute was aimed at a practice limited to entities within the insurance industry for the same reasons it satisfied the common sense test.¹⁰⁴

The Court then addressed the Pilot Life doctrine, observing that the HMO “does not give up. It argues for preemption anyway, emphasizing that the question is ultimately one of congressional intent, which sometimes is so clear that it overrides a statutory provision designed to save state law from being preempted.”¹⁰⁵ While acknowledging the “extraordinarily preemptive power” of ERISA’s exclusive remedy,¹⁰⁶ tThe Court explained that the Illinois law does not “supplemen[t] or supplan[t] the federal scheme by allowing beneficiaries to obtain remedies under state law that Congress rejected in ERISA”¹⁰⁷ because the Illinois law “provides no new cause of action under state law and authorizes no new form of ultimate relief.”¹⁰⁸

The Court made clear that even though deferential review is “highly prized by benefit plans,” ERISA does not require that a plan’s benefit determinations be discretionary or receive deferential review.¹⁰⁹ The Court stated that the Illinois law effectively “prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract’s terms” and in this way, “is no different from the types of substantive state regulation of insurance contracts we have in the past permitted to survive preemption.”¹¹⁰ The Court observed further that external review under the Illinois law is limited to the single issue of medical necessity, and in contrast to a traditional arbitration proceeding, it “does not give the independent reviewer a free-ranging power to construe contract terms.”¹¹¹

The Moran. Therefore, the Court ruled that the Illinois independent review law is not preempted. However, external review laws were relatively new and still evolving at the time, so the Court left open

¹⁰⁰ *Id.* at 216371–372.

¹⁰¹ See discussion of *Metropolitan Life v. Massachusetts*.

¹⁰² 536 U.S. *Id.* at 216373.

¹⁰³ *Id.* at 2164373–374.

¹⁰⁴ *Id.* at 216374–2164.

¹⁰⁵ *Id.* at 375.

¹⁰⁶ *Id.* at 376.

¹⁰⁷ *Id.* at 2166378.

¹⁰⁸ *Id.* at 3792167.

¹⁰⁹ *Id.* at 3842169–3872171.

¹¹⁰ *Id.* at 2170386.

¹¹¹ *Id.* at 383.

Comment [T6]: Suggest editing to read: “and consistent with *Unum*, that all three...”

Further, suggest editing the corresponding footnote to read: “536 U.S.373 (citing *Unum* 458 U.S. 119 at 129)”

As drafted, the statement is correct, but the Court was proceeding on the basis of its finding in the *Unum* case; a case discussed in the handbook’s preceding section. This edit would lend a consistency among summaries, while accurately reflecting the Court’s analysis.

Comment [T7]: Suggest editing to read: “The Court then examined whether the Illinois law establishing an independent review procedure worked to create an additional claim or remedy that supplemented or supplanted remedies available under ERISA, and would therefore otherwise be saved from preemption under the Court’s previously enumerated *Pilot Life* doctrine.”

As drafted, the statement is drawing from dicta that is the least flattering to plans. This stylistic approach doesn’t fit with the handbook’s otherwise black letter analytical style. Further, the excerpted statement does not accurately reflect the legal argument and resulting legal holdings which centered around fact-specific issues unique to the Illinois independent review procedure law in question.

Comment [T8]: Suggest editing to read: “civil enforcement provisions”

The proposed edit reflects the exact language used by the Court in the cited provision. See *Rush Prudential* at 376. Otherwise, as drafted, it would appear to apply too broad of a description of what the Court states.

Comment [T9]: Suggest striking this statement.

Similar to comments noted above, this selects dicta that is the least flattering to plans. This particular dicta merely states a truism of any party to a legal proceeding whose decision making is subject to judicial review, not merely benefit plans (i.e. any such party would prefer deferential review). Accordingly, its inclusion isn’t necessary to understand or elaborate on the Court’s holding.

Comment [T10]: Suggest editing to read: “The Court found that rather than give an independent reviewer “free-ranging power to construe contract terms”, the Illinois law instead established an independent review process that relied on a qualified professional’s determination of medical necessity that wasn’t adjudicatory in nature (i.e. wasn’t akin to evidentiary proceedings in arbitration or judicial settings).”

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the possibility that ~~a some other~~ state independent review scheme might conflict sufficiently with ERISA to be preempted; for example, ~~—Moran involved a state review process that resolves only disputes concerning application of medical judgment. Also the Court mentioned that a state law would be preempted if it imposed “procedures so elaborate, and burdens so onerous that they might undermine [ERISA’s civil enforcement provisions].”¹¹² However~~On the other hand, ~~this concession is made only after the Court stated its view that state independent review laws, made clear while entailing that the mere use of different procedures in different states would not impose unacceptable administrative burdens so as to be preempted.~~¹¹³ The Court explained that disuniformities are the inevitable result of the congressional decision to save state insurance laws and that HMOs have to establish procedures for conforming with local laws in any event.¹¹⁴ Since that time, external review requirements have become a standard health insurance consumer protection, and in the Affordable Care Act, Congress not only mandated that insurers comply with applicable state external review laws, incorporating them by reference into federal law,¹¹⁵ but established a federal external program for self-funded ERISA plans and for insured health plans in states that did not have external review laws consistent with the NAIC Uniform External Review Model Act.¹¹⁶

KENTUCKY ASSOCIATION OF HEALTH PLANS v. MILLER
123 S.Ct. 1471 (2003)

In *Kentucky Association of Health Plans v. Miller* the Court held that Kentucky’s “any willing provider (AWP)” laws were not preempted under ERISA because they “regulated insurance” within the meaning of ERISA’s saving clause, §514(b)(2)(A). In reaching this conclusion, the Court announced a new test for determining whether a state law regulates insurance, and in so doing, announced a clean break from over 15 years of saving clause precedent.

At issue were two Kentucky AWP laws: one requiring that health insurers include in their networks all providers willing to agree to the terms of the contract; and another requiring that insurers offering chiropractic benefits include in their networks all chiropractors willing to accept the terms of the contract.

In determining that Kentucky’s AWP laws regulated insurance, the Court announced a new two-part test for determining whether a state law regulates insurance.¹¹⁷ The first part of the new test requires that the state law be “specifically directed towards entities engaged in insurance.”¹¹⁸ To explain this test, the Court refers to its previous opinions in *Pilot Life, Rush Prudential* and *FMC Corp.*¹¹⁹ In order for a state law to be “specifically directed toward” the insurance industry, the state law must be more than a law of

¹¹² *Id.* at 381 n.11.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ PHSA § 2719(b)(1).

¹¹⁶ *Id.* § 2719(b)(2).

¹¹⁷ 123 S.Ct. 1471, 1479.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 1475.

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general application with some bearing on insurers.¹²⁰ But even a law specifically directed at the insurance industry must regulate an insurer with respect to the insurer's insurance practices.¹²¹

Further, the Court makes clear that a state law's impact on non-insurers is not inconsistent with the requirement that a law be "specifically directed toward" the insurance industry and does not take the law the outside the scope of ERISA's saving clause.¹²² The Kentucky Association of Health Plans argued that Kentucky's AWP laws were not specifically directed at the insurance industry because of: (1) their impact on providers;¹²³ and (2) their application to "self-insurer or multiple employer arrangements not exempt from state regulation by ERISA"¹²⁴ and HMOs that provide administrative services only to self-insured plans.¹²⁵ The Court rejected these arguments.

The Court observed that all laws that regulate insurers will have some impact on entities that have relationships with those insurers, including laws the Court held regulated insurance in *FMC Corp.* and *Rush Prudential*.¹²⁶ With respect to the scope of the Kentucky AWP laws, the court pointed out that ERISA's saving clause requires that a state law "regulate insurance," not "insurance companies" or the "business of insurance."¹²⁷ Therefore, the fact that Kentucky's AWP laws apply to self-insurers and multiple employer welfare arrangements, which are entities engaged in the same kind of risk-spreading activities as are insurance companies, does not forfeit the laws' status as laws regulating insurance within the meaning of the saving clause.¹²⁸ ERISA's deemer clause¹²⁹ prevents states from regulating self-funded ERISA plans that they could otherwise regulate.¹³⁰

The Court employs this same analysis to explain that Kentucky's AWP laws are "specifically directed towards" the insurance industry, even though they apply to HMOs administering self-insured plans. The Court expresses the opinion that the activity of administering a self-insured plan, which the Court already explained engages in risk-spreading functions identical to insurers, is sufficient to bring the HMO within the activity of insurance for the purposes of ERISA's saving clause, even though the deemer clause would prevent a state from applying the law to a self-funded plan.¹³¹ Further, the Court in *Rush Prudential* explained that Congress did not intend for overbreadth in the application of a state law to remove a state law entirely from the category of state regulation saved from preemption.¹³²

¹²⁰ *Id.* citing *Pilot Life v. Dedeaux*, 481 U.S. 41, 50; *Rush Prudential v. Moran*, 536 U.S.355, 366; *FMC Corp v. Holliday*, 498 U.S. 52, 61.

¹²¹ 123 S. Ct. at 1474 citing *Rush Prudential v. Moran*, 536 U.S. 366.

¹²² 123 S.Ct. at 1476.

¹²³ *Id.* at 1475-1476.

¹²⁴ *Id.* at 1476 n.1.

¹²⁵ *Id.*

¹²⁶ *Id.* at 1475.

¹²⁷ *Id.* at 1476 n.1.

¹²⁸ *Id.*

¹²⁹ ERISA §514(b)(2)(B).

¹³⁰ 123 S.Ct. at 1476 n.1.

¹³¹ *Id.*

¹³² *Id.*

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The second part of the new saving clause analysis requires that the state law “substantially affect the risk pooling arrangement between the insurer and the insured.” This new test is a “clean break from the McCarran-Ferguson factors”¹³³ and does not require that the state law actually “spread risk,”¹³⁴ or “alter or control the actual terms of insurance policies” in order to regulate insurance within the meaning of the saving clause.¹³⁵ The Court explained that Kentucky’s AWP laws meet the second part of the new test by “alter[ing] the scope of permissible bargains between insurers and insureds in a manner similar to the mandated benefit laws [] upheld in *Metropolitan Life*, the notice prejudice rule [] sustained in *UNUM*, and the independent review provisions [] approved in *Rush Prudential*.”¹³⁶

The practical effect of the Court’s new two-part test on state laws remains to be seen. Perhaps the fact that the McCarran-Ferguson factors are no longer a part of the preemption analysis will result in more laws being considered laws that regulate insurance within the meaning of the saving clause. On the other hand, the McCarran-Ferguson factors were only guideposts used to reinforce the common-sense understanding of whether a law regulated insurance and the risk-spreading factor in particular was set aside by the Court in *UNUM* and *Rush Prudential*. No one can know the true impact of this new preemption test until a new round of cases work their way through the federal courts and ultimately is applied by the Supreme Court.

**AETNA HEALTH INC. v. DAVILA,
542 U.S. 200 (2004)**

In *Aetna Health Inc. v. Davila*, the Supreme Court revisited the question first raised in *Pilot Life*, and reaffirmed that ERISA’s exclusive remedy preempts conflicting state laws even if the law is a statute expressly directed toward the insurance industry. Although the Court has still never squarely held that any state law actually falls within the *Pilot Life* exception to the Saving Clause, it made clear that if any law providing an alternative remedy for ERISA plan participants were found someday to regulate the business of insurance, it would nevertheless be preempted.¹³⁷

In 1997, the Texas Legislature enacted a provision in its Civil Practice and Remedies Code establishing that a health insurance carrier, HMO, or other managed care entity has a duty to exercise ordinary care when making health care treatment decisions, and creating a private cause of action for insureds and enrollees who claim to be harmed by a carrier’s negligence.¹³⁸ Juan Davila filed suit against Aetna, his employer’s insurer, alleging that he suffered a severe reaction to a pain medication he had taken because Aetna required “step therapy” and refused to cover a safer medication that his doctor had prescribed.

¹³³ *Id.* at 1479.

¹³⁴ *Id.* at 1478 n.3.

¹³⁵ *Id.* at 1477.

¹³⁶ *Id.* at 1477-1478.

¹³⁷ *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), decided together with *CIGNA HealthCare of Texas, Inc. v. Calad*, involving an action brought under the same Texas statute by a CIGNA enrollee.

¹³⁸ Tex. Civ. Prac. & Rem. Code § 88.002. (2014) In response to *Davila*, Tex. Civ. Prac. & Rem. Code § 88.0015 was added in 2005, making Chapter 88 inapplicable to ERISA plans. Although the Texas law is part of its civil practice code, some states include similar provisions within their insurance codes. See, e.g., Maine Health Plan Improvement Act at 24-A Me. Rev. Stat. Ann. § 4313 (2015).

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Aetna removed the case to federal court, but the Fifth Circuit remanded it to state court,¹³⁹ ruling that the claim denial was not an ERISA fiduciary decision and that the tort remedy under Texas law had no counterpart in ERISA and therefore did not conflict with ERISA's exclusive remedy.

The Supreme Court reversed, holding that by its nature, an ERISA benefit determination is a fiduciary act, and the "fact that a benefits determination is infused with medical judgments does not alter this result."¹⁴⁰ Rejecting the plaintiffs' argument that "ordinary care" was a separate statutory duty under state law that was independent of the benefit determination,¹⁴¹ the Court concluded that the Texas law "related to" an ERISA plan and was preempted because it conflicted with "Congress' intent to make the ERISA civil enforcement mechanism exclusive."¹⁴² The Court did not decide whether the law "regulated insurance" within the meaning of the saving clause. Instead, after noting that the plaintiffs had not made that argument in the lower courts, the Court held that even if the Texas law could "arguably be characterized as 'regulating insurance,'" the exclusive remedy clause would still control over the saving clause.¹⁴³ The Court cited *Rush Prudential* for the proposition that "a comprehensive remedial scheme can demonstrate an 'overpowering federal policy' that determines the interpretation of a statutory provision designed to save state law from being pre-empted. ERISA's civil enforcement provision is one such example."¹⁴⁴ Although the Court was unanimous, Justice Ginsburg issued a concurring opinion, joined by Justice Breyer, urging Congressional action to correct "an unjust and increasingly tangled ERISA regime" leaving "a regulatory vacuum" in which "virtually all state law remedies are preempted but very few federal substitutes are provided."¹⁴⁵

**METROPOLITAN LIFE INS. CO. v. GLENN,
554 U.S. 105 (2008)**

In *Metropolitan Life Ins. Co. v. Glenn*, the Supreme Court held that the principles set forth in *Firestone* still apply when the benefit plan is fully insured, but clarified that even if the insurer is granted valid discretionary authority, it is only entitled to limited deference under *Firestone* because it has an inherent conflict of interest.

Wanda Glenn filed a claim under her employer's group long-term disability policy, issued by Metropolitan Life. The insurer found her to be unable to perform her job duties and awarded benefits for two years, but once the policy's two-year "own-occupation" period had expired, she was required to prove that she was unable to perform "the material duties of any gainful occupation for which [she was]

¹³⁹ *Roark v. Humana, Inc.*, 307 F.3d 298 (2002). The *Roark* companion case did not reach the Supreme Court with *Davila* and *Calad* because the Fifth Circuit upheld removal on the ground that the complaint also included a count for breach of contract, which was completely preempted by ERISA, giving rise to federal jurisdiction over the entire case (a warning for practitioners). A fourth companion case involved a governmental plan, so ERISA did not apply.

¹⁴⁰ 542 U.S. at 219.

¹⁴¹ *Id.* at 215.

¹⁴² *Id.* at 216.

¹⁴³ *Id.* at 217-218.

¹⁴⁴ *Id.* at 217. (citations omitted) See discussion of *Rush Prudential v. Moran*.

¹⁴⁵ *Id.* at 222 (Ginsburg, J., concurring) (citations and internal punctuation omitted)

Comment [T11]: Suggest striking "(a warning for practitioners)" appearing as a parenthetical in the corresponding footnote. It seems out of place in the handbook.

Comment [T12]: Suggest editing to read: "is generally a fiduciary act"

This reflects the actual language employed by the Court, which wrote: "A benefit determination under ERISA, though, is generally a fiduciary act." *Aetna* at 218 (emphasis added).

This implies there may be exceptions, and should probably remain so qualified when discussing the express holding of the case.

Comment [tp13]: As a general comment, *Glenn*'s central takeaway would appear to be less about "what" standard of review should apply (the Court was clear it was the standard enumerated in *Firestone*), but rather "how" the *Firestone* standard should be applied when a conflict of interest is implicated. The current summary appears to overemphasize the former at the expense of the latter.

Glenn addressed two central questions: 1) whether a plan administrator that both evaluates and pays claims operates under a conflict of interest when making discretionary benefit determinations; and 2) "how" any such conflict of interest should be taken into account on judicial review of such discretionary benefit determinations.

As to #1, the Court held that when an administrator determines eligibility and pays benefits out of its own pocket, it does create a conflict of interest.

However characterizing that conflict of interest as "inherent" risks overstating the relative impact such conflicts may have. The decision expressly provides that any such "conflict" may in fact be so outweighed by other factors (or itself entirely mitigated to the point of vanishing entirely), that it has little to no bearing in determining the lawfulness of a benefits determination. *Glenn* at 112, 117. May consider referring to them as "apparent" conflicts of interest, where "apparent" (i.e. "seemingly true but possibly not true") seems to better reflect the Court's view in terms of the relative impact any such conflict may actually have from a judicial point of view.

As to #2, the Court held that a nuanced, fact-specific inquiry was required, which considered all relevant factors - of which the existence of a conflict is but one factor among many to be considered, and whose weight is relative to the other factors considered and the specific facts of the case.

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reasonably qualified” in order to continue receiving benefits.¹⁴⁶ At the insurer’s request, Glenn had applied for Social Security disability benefits,¹⁴⁷ which are also based on an “any occupation” standard, and the Administrative Law Judge found her eligible, ruling that she was disabled “from performing any jobs [for which she could qualify,] existing in significant numbers in the national economy.”¹⁴⁸ Nevertheless, the insurer conducted an independent review, decided that Glenn was insufficiently disabled, and denied benefits. After Glenn’s internal appeals were denied, she filed suit under ERISA.¹⁴⁹

Pursuant to a discretionary clause, the insurer was designated as Claim Fiduciary and was granted “discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.”¹⁵⁰ The insurer argued that its self-interest in the outcome of claim disputes should not diminish the deference that administrators with discretionary authority are granted under *Firestone*, because the employer had approved the terms under which the Plan would be administered by the same company that was paying the benefits.¹⁵¹ It argued further that when claim decisions are made by a professional insurance company, paying claims is its business and the market provides strong incentives to make accurate claim decisions.¹⁵²

The Court agreed that the insurer was entitled to deference under *Firestone*, and that its self-interest in the outcome did not require *de novo* review of its claim denials.¹⁵³ It did not consider the possibility that a *Firestone* “discretionary trust” analysis might not be the best way to decide whether an insurer has complied with its contractual obligations under an insurance policy,¹⁵⁴ when the insurer is not merely the administrator of the contract but one of the parties. However, the Court held that there is an inherent conflict of interest when “a plan administrator both evaluates claims for benefits and pays benefits claims,” and that conflict “must be weighed as a factor in determining whether there is an abuse of discretion.”¹⁵⁵

¹⁴⁶ *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 109 (2008).

¹⁴⁷ Disability policies contain offset clauses, so that when the beneficiary is eligible for Social Security disability benefits, what the insurance provides is income enhancement from the level provided by Social Security to the level guaranteed by the policy. The policies require beneficiaries to apply for Social Security when it is available.

¹⁴⁸ 554 U.S. at 109.

¹⁴⁹ *Id.*

¹⁵⁰ Brief of Petitioner at 3. The NAIC *Prohibition on the Use of Discretionary Clauses Model Act* (Model No. 42) was amended in 2004 to include disability policies within its scope, but some states either permit discretionary clauses or prohibit them only for medical insurance policies. Challenges to the validity of laws prohibiting discretionary clauses are discussed below in the FAQ, at Page .----

¹⁵¹ 554 U.S. at 112.

¹⁵² *Id.* at 114.

¹⁵³ *Id.* at 116.

¹⁵⁴ See Brief of *Amicus Curiae* NAIC at 20–21. The only time the Justices used any form of the word “contract” was in a string citation in a dissenting opinion, describing one of the cited cases as involving a “pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.” 554 U.S. at 123 (Roberts, C.J., dissenting in part and concurring in the judgment).

¹⁵⁵ 554 U.S. at 111–112 (*internal punctuation and citations omitted*).

Comment [tp14]: Accurate, though contextually out of place when discussing the Court’s analysis of an appropriate standard of review. These arguments were raised to advance an argument that there was no conflict of interest, which the Court found unavailing.

These arguments were not raised in connection with determining how to apply an appropriate standard of review (i.e. “how” to determine the impact any conflict of interest may have on the lawfulness of a benefits determination as a factor enumerated under *Firestone*).

Including these in the summary (as currently drafted) risks confusing that contextual point.

Comment [tp15]: This, on initial read, appears inconsistent with the reference to “limited deference” in the opening sentence. Emphasizing the earlier point on perhaps clarifying “limited deference” or omitting it.

Comment [tp16]: Suggest moving this point to a corresponding footnote. Appears to have no bearing on explaining the actual decision.

Comment [tp17]: See earlier comment. Stating that such conflicts of interest are “inherent” risks overstating their relative impact in determining the lawfulness of a benefits determination (which is the fundamental point of the decision).

May consider referring to them as “apparent” conflicts of interest, where “apparent” (i.e. “seemingly true but possibly not true”) seems to better reflect the Court’s view in terms of the relative impact any such conflict may actually have from a judicial point of view.

The Court expressly provides that any such “conflict” may in fact be so outweighed by other factors (or itself entirely mitigated to the point of vanishing entirely), that it has little to no bearing in determining the lawfulness of a benefits determination. *Glenn* at 117

Stating in relevant part: “The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccur...

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Applying that standard, the Court affirmed the Sixth Circuit's ruling that Glenn was entitled to reinstatement of her benefits. When it enumerated the various factors it had weighed, the Court gave particular emphasis to "the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then ignored the agency's finding."¹⁵⁶

**GOBEILLE v. LIBERTY MUTUAL INS. CO.,
577 U.S. ---, (2016)**

In *Gobeille v. Liberty Mutual Ins. Co.*, the Court held that states cannot require self-insured employers or their third-party administrators to participate in all-payer claims databases, which provide a comprehensive resource intended to track substantially all health care expenditures in the state.

Vermont's law was challenged by two insurance companies, but neither of them was acting in its capacity as an insurer. The plaintiff, Liberty Mutual, provided a self-funded employee health plan for its 80,000 U.S. employees. Fewer than 200 were located in Vermont, so Liberty Mutual was below the mandatory reporting threshold. However, the plan was administered by Blue Cross Blue Shield of Massachusetts (BCBSMA), which had enough TPA activity in Vermont that it was required to report claims to the database on behalf of all of its Vermont clients.¹⁵⁷ Liberty Mutual instructed BCBSMA not to report any information from the Liberty Mutual plan, and sought a declaratory judgment that the statute was preempted by ERISA.

Vermont asserted that the statute was a public health law rather than an employee benefit law, and that it did not impose any material costs on employers, so that its incidental impact on employee benefit plans did not "relate to" ERISA plans as the Court had interpreted that term in *Travelers*.¹⁵⁸ The Court, however, described reporting as a core obligation under ERISA, particularly so because ERISA's regulatory scheme relies on recordkeeping and disclosure rather than on imposing substantive requirements on benefit plans.¹⁵⁹ Therefore, the Court held that preemption "is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans."¹⁶⁰ and because federal authority occupies the field, it is preemption does not require any inquiry into whether a particular state requirement is in fact novel, inconsistent or burdensome.¹⁶¹ Although ERISA reporting concentrates on financial matters, that does not mean reporting of health data is reserved for the states to regulate; the Court held that it is sufficient that USDOL has the authority to require reporting of health data and has chosen not to do so.¹⁶²

¹⁵⁶ *Id.* at 118.

¹⁵⁷ *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. ---, slip op. at 4.

¹⁵⁸ *Id.* at 10–11. *See supra* pp. -----.

¹⁵⁹ *Id.* at 7–9. While this is an accurate description of the traditional ERISA approach, the Affordable Care Act has now included self-insured ERISA plans within the scope of many of its substantive protections. *See* ERISA § 715, enacted by PPACA § 1563(e).

¹⁶⁰ *Id.* at 10.

¹⁶¹ *Id.* at 11.

¹⁶² *Id.* at 10–11.

Comment [tp18]: This statement is contrary to the actual holding of the case, where the Court directs a nuanced, fact-specific, multi-factor based judicial review of discretionary benefits determinations - and specifically "how" to take into account in such a review any identified conflicts of interest.

In doing so, the Court merely recounted what the lower Appellate Court had previously considered and weighed, and agreed that this specific factor - as well as several other "serious concerns" - when "taken together" with "some degree" of conflicting interests found to exist on the insurer's part - all combined to lead that lower court to set aside the insurer's discretionary decision. It wasn't this one factor alone - or necessarily an emphasis of this one factor - that the Supreme Court found compelling. Rather it was merely illustrative of the multi-factor inquiry and balancing the Court directed should be undertaken.

For example, the insurer had also: 1) emphasized a certain medical report that favored a denial of benefits; 2) had deemphasized certain other reports that suggested a contrary conclusion; and 3) had failed to provide its independent vocational and medical experts with all of the relevant evidence.

Compounding this, the insurer failed to develop a detailed appellate record demonstrating efforts it undertook to ensure accurate claims assessments. Efforts the Court states earlier in the decision that could render the existence of any identified conflict of interest less impactful when considering and balancing all the relevant factors present in any one case. *Glenn* at 117-118

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Justice Breyer wrote a separate concurrence to note that USDOL's authority to prescribe reporting requirements included the ability to collect this data for the states or to mandate compliance with state reporting requirements.¹⁶³

Justice Ginsburg dissented, joined by Justice Sotomayor. She interpreted *Travelers, Dillingham and DeBuono* as having "reined in" the "relate to" clause "so that it would no longer operate as a 'super-preemption' provision."¹⁶⁴ She observed that seventeen states already had similar laws, which "serve compelling interests, including identification of reforms effective to drive down health care costs, evaluation of relative utility of different treatment options, and detection of instances of discrimination in the provision of care."¹⁶⁵ She criticized the focus on "the sheer number of data entries that must be reported to Vermont.... Entirely overlooked in that enumeration is the technological capacity for efficient computer-based data storage, formatting, and submission" of this information, which any insurer or plan administrator generates in the ordinary course of business.¹⁶⁶ She concluded that the law should not be preempted because it is a law that "applies to all health care payers and does not home in on ERISA plans,"¹⁶⁷ and does not relate to or interfere with ERISA's exclusive regulation of the management and solvency of ERISA plans or address relationships between entities that are subject to ERISA.¹⁶⁸

¹⁶³ *Id.*, Breyer concurrence. Justice Thomas also concurred separately, agreeing with the majority's interpretation of ERISA but questioning whether ERISA was constitutional. *Id.*, Thomas concurrence.

¹⁶⁴ *Id.* at 16. See *supra* pp. -----.

¹⁶⁵ *Id.* dissent at 2.

¹⁶⁶ *Id.* at 12.

¹⁶⁷ *Id.* at 7.

¹⁶⁸ *Id.* at 9.