Employment Law - Employee Retirement Income Security Act - Preemption of State Law

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EMPLOYMENT LAW—EMPLOYEE RETIREMENT INCOME SECURITY ACT—PREEMPTION OF STATE LAW—The United State Supreme Court held that state hospital rate-setting statutes which impose a significant indirect burden on Employee Retirement Income Security Act plans do not "relate to" the plans sufficiently to invoke preemption of state laws.


Hospital rates in the State of New York are governed by principles\(^1\) that consider the identity of a health insurance payor as a factor in determining the amount a hospital may bill for a patient's inpatient hospital stay.\(^2\) For example, if a patient is enrolled in a Blue Cross/Blue Shield ("Blue Cross") plan, Medicaid, or certain Health Maintenance Organizations ("HMO's"), that patient's hospital stay is billed at a rate based on the patient's diagnosis.\(^3\) Patient diagnoses are categorized into one of 794 Diagnostic Related Groups ("DRG's").\(^4\) The DRG-based reimbursement system figures the average cost to treat each of the 794 diagnoses.\(^5\) Thus, all patients with a specific diagnosis, regardless of the actual cost of treatment incurred,


\(^2\) New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. "Unique among the states, however, New York provides that the amount charged to a patient is then increased by a 'payer factor,' depending solely upon the type of health care coverage protecting the patient." Brief for Respondents, The Travelers Insurance Company, et al., at 3, New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. 1671 (Nos. 93-1408, 94-1414, 93-1415).

\(^3\) New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. Diagnosis is defined as "the discovery of the source of a patient's illness or the determination of the nature of his disease from a study of its symptoms." BLACK'S LAW DICTIONARY 453-54 (6th ed. 1990).

\(^4\) New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. The DRG system adopted by New York is based on the DRG system established under Medicare. See N.Y. PUB. HEALTH LAW § 2807-c(3)(a) (McKinney 1993).

\(^5\) New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674.
are generally billed at the same rate under the DRG-based system.6

The impetus behind New York State Conference of Blue Cross & Blue Shield Plans was the fact that some health insurance payors were being charged the applicable DRG rate, plus one or more of several surcharges imposed under New York law,7 of which three were at issue.8 The first surcharge allowed a hospital to bill for a patient’s hospital stay at the applicable DRG rate plus a thirteen percent surcharge.9 Even though state law imposed the first surcharge, the hospital could keep any proceeds the surcharge generated.10 Payors upon whom this surcharge was imposed included commercial insurance carriers other than Blue Cross,11 self-insurance funds, and motor vehicle insurance funds.12

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6. Id. The concept of DRG’s is explained as follows:

[All] patient illnesses and injuries resulting in admission to a hospital are classified into different groups, termed diagnosis-related groups (DRG’s), that are clinically coherent and relatively homogeneous with respect to resources used by a hospital. . . . Using this classification system, Medicare has developed a system of payments to hospitals under which each DRG (i.e., each type of injury or illness) will be paid at a set rate. If a hospital’s costs are less than that rate, the hospital keeps the difference; if the hospital’s costs are more than the set rate, the hospital incurs the loss.


8. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. The three surcharges at issue were applied at the rates of 13%, 11% and 9%. Id.

9. Id. See N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993).

10. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993). The law directs hospitals to use funds obtained as a result of the surcharge “for patient care purposes.” Id.

11. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1673. See Brief for Petitioner, New York State Conference of Blue Cross & Blue Shield Plans, at 3, New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. 1671 (1995) (Nos. 93-1408, 93-1414, 93-1415). The principal reason that Blue Cross was not subjected to the surcharges was because the preferential treatment assisted Blue Cross “in shouldering the burden of open enrollment for individuals and small groups (that is insuring all applicants without regard to age, occupation or physical condition) on a community rated basis as well as other publicly responsible activities.” Id.

12. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(1)(b) (McKinney 1993). Commercial insurance is defined as “[i]ndemnity agreements . . . whereby parties to commercial contracts are to a designated extent guaranteed against loss by reason of a breach of contractual obligations on the part of the other contracting party.” BLACK'S LAW
The second surcharge at issue allowed a hospital to bill for a patient's hospital stay at the applicable DRG rate plus an eleven percent surcharge.\textsuperscript{13} The second surcharge was collected by the hospital, and the hospital then remitted the surcharge to the State of New York.\textsuperscript{14} The second surcharge was imposed upon commercial insurance carriers (other than Blue Cross)\textsuperscript{15} and only applied to discharges occurring between April 1, 1992 and March 31, 1993.\textsuperscript{16} For this one-year period, some commercial insurance carriers were actually subjected to both the thirteen percent surcharge and the eleven percent surcharge—thus incurring hospital claims twenty-four percent higher than those payors not subjected to the surcharges.\textsuperscript{17}

The third surcharge was imposed on certain HMO’s.\textsuperscript{18} Depending upon the number of Medicaid patients an HMO

\textsuperscript{13} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(11)(i) (McKinney 1993).

\textsuperscript{14} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 712 (2d Cir. 1993), rev’d sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995). The funds collected pursuant to the surcharge were ultimately deposited into New York’s general fund. Id.

\textsuperscript{15} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1673. See supra note 11.


\textsuperscript{17} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(11)(i) (McKinney 1993). The statute acknowledges that the 13% surcharge may also apply, and it refers to the 11% surcharge as a “supplementary payment rate conversion factor” that yields a “total conversion factor of 24%.” Id.

\textsuperscript{18} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(2-a)(c)(i) (McKinney Supp. 1995). An HMO will not be subject to this surcharge if it reaches its “Medicaid target” as calculated by the state. N.Y. PUB. HEALTH LAW § 2807-c(2-a)(c)(i) (McKinney Supp. 1995).

An HMO is defined as a "health care system, operating within a specific geographical area, in which an organization hires medical professionals to provide a wide range of specified medical services for their prepaid subscribers." WEBSTER’S NEW WORLD DICTIONARY 621 (3d college ed. 1988).

The “Medicaid target” is generally calculated under the New York statute by multiplying the number of subscribers in an HMO by the number of Medicaid-eligible persons in an HMO’s geographical area divided by the total population in the HMO’s area (subject to an adjustment factor). N.Y. PUB. HEALTH LAW § 2807-c(2-a)(a)(iv)(A), (v)(A) (McKinney Supp. 1995).
enrolled, the surcharge could have been imposed at its maximum level, nine percent, or it could have been reduced pursuant to the statute.\textsuperscript{19} The state received the surcharge directly from the HMO's.\textsuperscript{20}

The state, through the imposition of the three surcharges, effectively raised the cost of health care insurance provided through commercial insurers other than Blue Cross.\textsuperscript{21} Suit was initiated by commercial insurers\textsuperscript{22} in their role as fiduciaries for those plans affected by the surcharges in an attempt to invalidate the surcharges.\textsuperscript{23}

The Southern District Court of New York, on cross-motions for summary judgment and motion to stay pending appeal, invalidated the surcharges because the surcharges were preempted\textsuperscript{24} under Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA").\textsuperscript{25} The district court,

\begin{itemize}
  \item \textsuperscript{19} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(2-a)(c)(ii) (McKinney Supp. 1995). If an HMO reaches 25% of its Medicaid target, the 9% surcharge is reduced by 25%; if it reaches 50% of its Medicaid target, the surcharge is reduced by 50%; if it reaches 75% of its Medicaid target, the surcharge is reduced by 75%. Id.
  \item \textsuperscript{20} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1674. See N.Y. PUB. HEALTH LAW § 2807-c(2-a)(c)(i) (McKinney Supp. 1995). The funds are ultimately deposited in the state's general fund. Id.
  \item \textsuperscript{23} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1675.
  \item \textsuperscript{25} Travelers Ins., 813 F. Supp. at 1012. The district court also found that neither the Tax Injunction Act nor the doctrine of laches barred plaintiffs' claim; two
through a broad reading of the preemption clause, noted that the requisite relationship between New York State law and the ERISA plans existed based on several factors. The surcharges would, at least indirectly, increase costs for the ERISA plans. Also, the plans could pass along the increase to their customers, who may ultimately switch insurance companies and select Blue Cross coverage because Blue Cross is not subject to the surcharges and need not reflect them in its cost of coverage. ERISA's savings clause did not save the surcharges from preemption because the surcharges merely altered the competitiveness of the insurance carriers, which in the court's opinion did not rise to the level of insurance regulation.

The State of New York and the New York Conference of Blue Cross & Blue Shield Plans appealed the decision of the district court to the United States Court of Appeals for the Second Circuit, which substantially affirmed the decision below. Supporting a broad interpretation of the ERISA preemption clause, the Second Circuit concluded that the surcharges related to employee benefit plans as contemplated under ERISA, even though the impact of the surcharges on employee benefit plans might be deemed indirect. The Second Circuit opined that the requisite connection of the surcharges to ERISA plans stemmed from the "significant economic burden" that the surcharges were preempted by the Federal Employee Health Benefit Act; and parts of an Actuarial Information Letter issued by the Department of Insurance were preempted under ERISA. Defendants' motion to stay pending appeal was granted in part and denied in part. Plaintiffs subject to the 13% surcharge were ordered to continue to pay the surcharge, but any amounts owing pursuant to the other surcharges did not have to be remitted but were to be deposited into an escrow account pending issue resolution.

Section 514(a) of ERISA states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988).

27. Id. at 1003.
28. Id. The district court further supported its conclusion that preemption applies by noting that a plan could lower the level of insurance benefits provided, as an alternative to raising costs, thus affecting the operation of the plan itself. Id. at 1004. The court also pointed out that should a plan lower benefit levels, plan administration would no longer be consistent from state to state. Id. at 1004-05.
29. Id. at 1008. The savings clause under ERISA provides that "[e]xcept as provided . . . nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (1988).
31. Travelers Ins., 14 F.3d at 719.
placed on the plans.\textsuperscript{32} Recognizing that a recent United States Court of Appeals for the Third Circuit case, United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital\textsuperscript{33} addressed the same issue, the Second Circuit acknowledged the conflict between its decision and the narrower interpretation of ERISA's preemption clause set forth by the Third Circuit.\textsuperscript{34} The surcharges were ultimately held to be preempted, according to the court, upon its determination that the surcharges did not fall within the narrow exception to ERISA preemption offered by the savings clause because the surcharges were not intended to regulate the business of insurance.\textsuperscript{35}

The United States Supreme Court granted certiorari\textsuperscript{36} to resolve the split of authority between the Second and Third Circuits over the proper scope of the ERISA preemption clause with respect to rate-setting statutes where the impact on employee benefit plans is only indirect.\textsuperscript{37} Justice Souter delivered the opinion of the Court\textsuperscript{38} which considered whether the New York surcharges that increased hospital inpatient rates charged to certain insurance payors related to employee benefit plans to the extent that they were invalidated by ERISA's

\begin{itemize}
  \item \textsuperscript{32} Id. at 721.
  \item \textsuperscript{33} 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993).
  \item \textsuperscript{34} Travelers Ins., 14 F.3d at 721. The Third Circuit held that New Jersey's hospital rate-setting statutes were not preempted by ERISA. United Wire, Metal & Machine Health & Welfare Fund, 995 F.2d at 1196. The court commented that Congress did not intend "to frustrate the efforts of a state, under its police power, to regulate health care costs." Id. According to the Second Circuit, the Third Circuit's narrow view of preemption was based on a case that rejected preemption unless the state law involved regulated "the terms and conditions of employee benefit plans." Travelers Ins., 14 F.3d at 719, 721. The narrowness of that interpretation was later rejected by the Supreme Court of the United States. Id.
  \item \textsuperscript{35} The Second Circuit relied on the Supreme Court's decision in Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990), to support its conclusion. Travelers Ins., 14 F.3d at 719. In Ingersoll-Rand, the Supreme Court noted that Congress did not intend "to restrict ERISA's pre-emptive effect to state laws purporting to regulate plan terms and conditions." Ingersoll-Rand, 498 U.S. at 141. See infra notes 136-44 and the accompanying text for a discussion of Ingersoll-Rand.
  \item \textsuperscript{36} New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 305 (1994) (granting certiorari). Certiorari is defined as a "writ of common law origin issued by a superior to an inferior court requiring the latter to produce a certified record of a particular case tried therein." BLACK'S LAW DICTIONARY 228 (6th ed. 1990). The Supreme Court "uses the writ of certiorari as a discretionary device to choose the cases it wishes to hear." Id.
  \item \textsuperscript{37} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1676.
  \item \textsuperscript{38} Id. at 1673.
\end{itemize}
preemption clause.\textsuperscript{39}

The Supreme Court reversed the judgment of the district court and the court of appeals.\textsuperscript{40} The Court's analysis considered the language of ERISA in an attempt to define whether a state law "relates to" an employee benefit plan.\textsuperscript{41} Acknowledging that a reading of the statute alone could lead to unrestrained interpretations due to the potential vastness of the statutory language, the Court shifted its focus to the congressional intent behind ERISA legislation—the development of uniform and consistent employee benefits law.\textsuperscript{42}

To establish a baseline for analytical comparison, the Court stated that preemption under ERISA should clearly apply if a state law has a direct effect on the administration of an employee benefit plan or on the benefits offered by such a plan.\textsuperscript{43} Exploring the motivation behind the New York surcharges, the Court determined that the surcharges were imposed on commercial insurers other than Blue Cross, primarily because Blue Cross incurred additional costs by enrolling many persons considered uninsurable by other commercial plans.\textsuperscript{44} The resultant economic effect on ERISA

\textsuperscript{39} Id. at 1676.
\textsuperscript{40} Id.
\textsuperscript{41} Id. at 1677. An "employee benefit plan" is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(3) (1988). An "employee welfare benefit plan" is defined as:

\begin{quote}
[An]y plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).
\end{quote}


An "employee pension benefit plan" is defined as:

\begin{quote}
[An]y plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that . . . such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond.
\end{quote}


\textsuperscript{42} New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1677.
\textsuperscript{43} Id. at 1678.
\textsuperscript{44} Id.
plans was considered to be merely indirect. While the New York surcharges admittedly affected an employee benefit plan's cost of providing health insurance, the Court opined that such surcharges did not mandate the choice of one particular health insurer. The Court reasoned that the surcharges were not inconsistent with the congressional intent behind the enactment of ERISA because, notwithstanding any effect on the cost of providing coverage, the surcharges did not adversely affect uniformity of plan administration or benefit provision.

The Court then described several common situations in which state regulations that indirectly affected employee benefit plans were permitted to stand despite an effect on the overall cost of the plan. For example, the Court noted that a state may impose quality control standards on health care services provided pursuant to an ERISA plan without invalidation under ERISA, even though the imposition of such standards would raise the costs of the plan.

The Court also looked to the rules of statutory construction in an effort to lend further support to its analysis of ERISA's preemptive scope. Because the ERISA statute requires a state law to "relate to" a benefit plan before it will be preempted by ERISA, the Court reasoned that there is clearly some restriction intended to apply to the reach of preemption. According to the Court, too broad an interpretation of ERISA's preemption provision would effectively negate the restriction and would run counter to proper statutory interpretation that implies that once any such restriction is set forth, it is intended to have some substantive meaning.

Thus, the Court concluded that if it invalidated the New York surcharges solely on the basis that the surcharges had an indirect effect on ERISA plans, then it would effectively have

45. Id. at 1679.
46. Id.
47. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1679.
48. Id. The Court specifically referred to state regulation of quality control standards and employment conditions. Id.
49. Id.
50. Id. Statutory construction is defined as a "judicial function required when a statute is invoked and different interpretations are in contention." BLACK'S LAW DICTIONARY 1412 (6th ed. 1990).
51. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1679. The Court reasoned that too broad an interpretation of ERISA's preemption provision would "effectively read the limiting language in § 514(a) out of the statute." Id.
52. Id.
invalidated a multitude of existing state regulations that also have such indirect effects. The Court recognized that ERISA was not meant to interfere with general health, safety, and welfare regulations traditionally legislated at the local level. Also, since the New York Legislature’s objective in applying the surcharges was cost-uniformity, and in light of the fact that the surcharges only had an indirect effect on ERISA plans, the Court was unable to justify ERISA preemption. According to the Court, the situation dealt with in New York State Conference of Blue Cross & Blue Shield Plans did not rise to a level consistent with the congressional intent behind the passage of ERISA. Thus, the Court pointed out that the effect of the surcharges was that ERISA plans would have another factor to consider when picking and choosing a health insurance carrier. The Court ultimately determined that this indirect interference with employee benefit plans, however, did not “relate to” the plans in a manner that necessitated preemption.

In further support of its conclusion, the Court explored the scope of Mackey v. Lanier Collection Agency & Service, Inc. which upheld a state law imposing additional costs on an ERISA plan by allowing garnishment of plan assets. The Court

53. Id. The Court commented that the larger the body of legislation that would have to be invalidated under the reading accorded the statutory language, the more likely it is that the reading is too broad. Id.
54. Id. at 1680. See Hillsborough County v. Automated Medical Lab., Inc., 471 U.S. 707, 719 (1985) (holding that “the regulation of health and safety matters is primarily, and historically, a matter of local concern.”).
55. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1678. The court of appeals commented that the purpose of the 13% surcharge was to “level [the] playing field” between Blue Cross and its competitors. Travelers Ins. Co. v. Cuomo, 14 F.3d 708, 712 (2d Cir. 1993), rev’d sub nom. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S.Ct. 1671 (1995). The Second Circuit further stated that the purpose of the 11% surcharge was to give Blue Cross a competitive advantage, and that the purpose of the 9% surcharge was to encourage Medicaid enrollment in HMO plans. Id.
56. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1679.
57. Id. at 1680.
58. Id.
59. Id.
60. Id.
62. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1680. Garnishment is defined as “[s]atisfaction of an indebtedness out of property or credits of debtor in possession of, or owing by, a third person.” BLACK’S LAW DICTIONARY 680 (6th ed. 1990).
63. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1680 (citing Mackey). In Mackey, the Court considered whether a Georgia gar-
reasoned that if a state could impose such costs on an ERISA plan, albeit indirect costs, then it should certainly be permitted to subject an ERISA plan to economic influence, such influence being less of a burden on an ERISA plan than imposition of actual costs.64

The Court failed to accept the commercial insurers' argument that the New York surcharges should be preempted unless application of the savings clause was found.65 The Court reasoned that New York State Conference of Blue Cross & Blue Shield Plans did not require a savings clause analysis because the requisite burden on the ERISA plan was not sufficient to trigger preemption.66 According to the Court, if the result of the surcharges would have limited the selection of commercial insurers to Blue Cross only, then such an argument may have been more plausible.67

Finally, the Court emphasized that finding preemption applicable to such an indirect effect on ERISA plans would necessitate further invalidation of similar state laws that indirectly affected such plans.68 To support this point, the Court set forth numerous examples of state hospital rate regulation that were already in place when ERISA was enacted.69 The Court noted that the legislative history of ERISA did not

nishment statute was invalidated insofar as garnishment proceedings were brought against an ERISA plan participant. Mackey, 486 U.S. at 831. Acknowledging that creditors had to have some way to enforce their judgments, the Court ultimately rejected the contention of the plan's trustees that the state law "relates to" the ERISA plan sufficiently to trigger preemption even though the plan incurred substantial administrative costs as a result of the garnishment proceedings. Id. at 831-34. See infra notes 118-22 and accompanying text for a discussion of Mackey.

64. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1680.

65. Id. The commercial insurers relied on Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985). In Metropolitan Life, the Court briefly addressed the issue of whether a Massachusetts law that mandated the provision of mental health benefits by certain employee benefit plans was preempted by ERISA. Metropolitan Life, 471 U.S. at 739. In Metropolitan Life, the state did not dispute the fact that the law "related to" the plans, but instead argued that preemption under ERISA was precluded by the savings clause. Id. at 738-39. See infra notes 105-09 and accompanying text for a discussion of Metropolitan Life.

66. New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1681.

67. Id.

68. Id.

69. Id. The Court cited laws from numerous states that regulated hospital charges "to one degree or another" when ERISA was enacted. Id. (citing CAL. INS. CODE ANN. § 11505 (West 1972), COLO. REV. STAT. §§ 10-16-130, 10-17-108(2)-108(3), 10-17-119(1)(b) (1973), CONN. GEN. STAT. §§ 33-166, 33-172, 33-179k (1975) and NEW YORK PUB. HEALTH LAW § 2807 (McKinney 1971)).
mention invalidation of such existing state legislation. Also, with respect to federal legislation, the Court stated that the same Congress that passed ERISA also passed the National Health Planning and Resources Development Act of 1974 (the "NHPRDA"). The Court stated that the NHPRDA effectively encourages state involvement in rate regulation of the health care industry by providing funding incentives to those states that comply. According to the Court, Congress would not pass ERISA, and then subsequently pass the NHPRDA if the two statutes could not be reconciled. The Court concluded that Congress would not pass ERISA intending that state rate regulation of employee benefit plans would be preempted, and then subsequently pass the NHPRDA, which encouraged such state rate regulation.

Thus, the Court held that the New York surcharges were valid and not subject to ERISA preemption. Emphasizing that there may be state laws that indirectly affect ERISA plans that could be subject to preemption, the Court clarified that its holding does not imply that only a state law that directly affects an ERISA plan can be invalidated. The Court determined that the indirect effects on ERISA plans caused by the surcharges did not rise to the level contemplated by ERISA to invoke preemption. Therefore, the decision of the Second Circuit was reversed and the case remanded.

ERISA was enacted in 1974 to protect employees and beneficiaries from unscrupulous practices regarding employer-
established benefit plans.\textsuperscript{80} A fundamental concept of the statute allows federal law to supersede or preempt state law in the event that a state law "relates to" an ERISA plan.\textsuperscript{81} The purpose behind preemption is to maintain uniformity in employee benefits law.\textsuperscript{82} There are three primary sections of ERISA that deal with preemption—the preemption clause, the savings clause, and the deemer clause.\textsuperscript{83} The preemption clause is broadly construed, and it mandates the preemption of any state law that "relates to" an employee benefit plan.\textsuperscript{84} Because the exact breadth of the preemption clause is somewhat unclear, it is the subject of much litigation.\textsuperscript{85} The savings clause limits Section 514(a) of ERISA in that it allows states to retain the power to regulate insurance.\textsuperscript{86} The savings clause is qualified by ERISA's deemer clause\textsuperscript{87} in that the deemer clause specifies what types of entities are "deemed" appropriate subjects of state insurance regulation.\textsuperscript{88}

The Supreme Court first considered the scope of ERISA's preemption clause in\textit{Alessi v. Raybestos-Manhattan, Inc.}\textsuperscript{89} In\textit{Alessi}, the Court addressed the issue of whether the ERISA preemption clause invalidated a New Jersey law that prohibited an ERISA plan from using a recipient's workers' compensation benefits to offset pension benefits payable by the plan.\textsuperscript{90} The
Court began by reviewing principles of federalism to acknowledge the proper respect due to state laws facing preemption under federal standards. Then, looking to congressional intent behind ERISA legislation, the Court emphasized that Congress' intent was to have federal law control employee benefit plan regulation. Based on the express language of the ERISA statute, the Court held that the state law did "relate to" pension plans because the law encroached on the actual calculation of pension benefits and disallowed a federally approved benefit calculation method. The Court was careful to limit the scope of its holding by emphasizing that such an impact on a benefit calculation method as seen in this case so clearly affects the ERISA plan, that the Court believed it did not have to define the outer scope of ERISA's preemption clause in threshold situations. Acknowledging, however, that the state law in Alessi was not specifically targeted toward pension plans, but rather was a workers' compensation law with an indirect effect on pension plans, the Court maintained that preemption may still apply even when a state law impact on an ERISA plan is indirect.

The Supreme Court opened the door to a broader scope of ERISA's preemption clause in Shaw v. Delta Air Lines, Inc. In Shaw, the Court addressed the issue of whether New York legislation that prohibited discrimination by an employee benefit plan based on pregnancy, and that mandated certain pregnancy benefits, had the requisite relationship with ERISA plans to trigger preemption. The plain language of ERISA guided the Court's understanding that a state law "relates to" an ERISA

(1) Alessi, 451 U.S. at 522. The Court stated that preemption of state law by federal law is not to be presumed unless the nature of the subject matter necessitates federal preemption or it is the clear intent of Congress. Id.

(2) Id. at 522-23.

(3) Id. at 524-25. The benefit calculation method that allows the plan to offset any pension benefits payable with such funds as workers' compensation is known as integration. Id. Whether integration with workers' compensation benefits is a permissible benefit calculation method under ERISA is not specifically addressed in ERISA legislation. Id. at 517. However, ERISA permits a plan to integrate pension funds with certain Social Security and Railroad Retirement benefits. Id. at 516.

(4) Id. at 525.

(5) Id.


Acknowledging that this was a broad interpretation of the statutory language, the Court found that ERISA's legislative history supported such an interpretation. The Court held that the New York legislation clearly related to the ERISA plan involved because it affected how the plan was structured and what benefits the plan paid. The Court noted that the structure of the plan was affected because the plan had to assure that it did not discriminate on the basis of pregnancy. The Court also noted that the benefits provided under the plan were affected because the plan was required to offer sick leave benefits during pregnancy. The Court acknowledged that its broad interpretation of the phrase "relates to" has limits and that a state law may affect an ERISA plan in a fashion too remote to trigger preemption. Reluctant to explore those limits, though, the Court was satisfied that the laws at issue were clearly within the scope of preemption, and it did not express an opinion as to how broad the phrase "relates to" could ultimately be interpreted.

In Metropolitan Life Insurance Co. v. Massachusetts, the Court was able to work within the boundaries of its previous decisions to decide whether a state law "related to" an ERISA plan sufficiently for preemption to be possible. Specifically, the issue presented was whether a Massachusetts law that mandated the provision of mental health benefits by certain employee benefit plans was preempted by ERISA. In holding

98. Shaw, 463 U.S. at 96-97.
99. Id. at 98-99. For example, the Court quoted Senator Williams:
It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute 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. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.
Id. at 99 (citing 120 Cong. Rec. 29197 (1974)).
100. Id. at 97. After finding that both laws "relate to" an employee benefit plan, the Court considered whether any other ERISA provisions save the laws from preemption. Id. at 100.
101. Id. at 97.
102. Id.
103. Shaw, 463 U.S. at 100 n.21.
104. Id.
106. Metropolitan Life, 471 U.S. at 739.
107. Id. at 738. The Court briefly addressed the issue of whether the Massachusetts law related to ERISA plans in a fashion that would trigger preemption because the Commonwealth of Massachusetts did not dispute that the requisite rela-
that the Massachusetts law clearly "related to" ERISA plans so as to trigger preemption, the Court reiterated the broad scope of ERISA's preemption clause and clarified that even when a state law is consistent with ERISA directives, preemption of the state law can occur. The Court characterized the impact on the ERISA plan as indirect but noted that such impact may nonetheless invoke preemption.

The first case in which the Supreme Court limited the increasingly broad reach of ERISA's preemption clause was *Fort Halifax Packing Co. v. Coyne.* In *Fort Halifax,* the Court addressed the issue of whether a Maine statute that required employers to make a severance payment to employees upon relocation or termination of the employer's business was preempted by ERISA. When the Fort Halifax Packing Company ("Fort Halifax") closed its plant in 1981, employees sued for severance pay as set forth in the Maine statute. Fort Halifax argued that because the state statute affected an "employee benefit," it was preempted by ERISA. The Court held that preemption did not apply because the Maine statute affected an "employee benefit" and not an "employee benefit plan." The Court reasoned that the express language of ERISA does not refer to state regulation of employee benefits, but to state regulation of "employee benefit plan[s]." The Court also held that the underlying purpose of ERISA...
preemption, the creation of national uniformity in employee benefits law to facilitate plan administration, was not violated by the Maine statute because it did not require an employer to establish or maintain a benefit plan, and any administrative burden placed on an employer forced to pay the one-time payment was de minimis.116 Finally, the Court opined that the underlying purpose of ERISA itself, the protection of employees and beneficiaries from unscrupulous administrative practices of an employee benefit plan that jeopardize their right to receive benefits, was not contravened by the Maine statute because the administrative activity required to comply with the statute did not rise to the level of an activated plan.117

One year later, the Court again limited ERISA's preemption clause in Mackey v. Lanier Collection Agency & Service, Inc.118 The issue before the Court in Mackey was whether a Georgia garnishment statute was invalidated insofar as garnishment proceedings were brought against an ERISA plan participant.119 The Court held that the garnishment statute was not preempted by ERISA because ERISA plans can lawfully be sued and creditors must have some way to enforce their judgments.120 Trustees of an ERISA plan facing garnishment proceedings maintained that garnishment of the assets of an

116. Fort Halifax, 482 U.S. at 8-12. The Court pointed out that an employer may never be burdened by the Maine statute because it only applies when a plant closes or relocates. Id. at 12. In the event that an employer is subject to the statute, the Court noted that "[t]o do little more than write a check hardly constitutes the operation of a benefit plan." Id.

In his dissenting opinion, Justice White maintained that an employee benefit plan was created under the Maine statute, regardless of whether an "administrative scheme" was required for an employer to comply with the law. Id. at 24 (White, J., dissenting).

117. Fort Halifax, 482 U.S. at 15-16.
119. Mackey, 486 U.S. at 831. Mackey involved two Georgia statutes. Id. at 829-31. The first statute exempted ERISA plans from garnishment proceedings if the proceedings did not relate to collection of alimony or child support. See Ga. Code Ann. § 18-4-22.1 (1982). The Court held that this statute was preempted by ERISA because it expressly referred to ERISA plans in its language. Mackey, 486 U.S. at 830. The second statute was the general garnishment statute in the State of Georgia. See Ga. Code Ann. § 18-4-20 (Supp. 1987).

The Court rejected the trustees' argument that for preemption purposes garnishment of plan funds by creditors of a plan is not necessarily treated the same as garnishment of plan funds by creditors of a plan participant. Mackey, 486 U.S. at 835-36.

120. Mackey, 486 U.S. at 834. Section 502 of the ERISA statute permits an ERISA plan to "sue or be sued." 29 U.S.C. § 1132(d)(1) (1988). Also, ERISA plans can be sued for such state claims as "unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan." Mackey, 486 U.S. at 833.
ERISA plan was precluded under ERISA. However, the Court rejected the trustees' contention that the state law "relates to" the ERISA plan sufficiently to trigger preemption even though the plan incurred substantial administrative costs as a result of the garnishment proceedings.

The Supreme Court further limited ERISA's preemptive scope in Massachusetts v. Morash. In Morash, the Court was called on to decide whether ERISA preempted a Massachusetts criminal statute that prohibited employers from withholding accrued vacation pay upon an employee's discharge. The Court rejected the employer's argument that ERISA preempted the statute because vacation pay procedures constituted an "employee welfare benefit plan" under ERISA. The Court reasoned that, similar to the regulation of the payment of wages, regulation of vacation pay would not further ERISA's legislative purposes. Clarifying the scope of its holding, the Court noted that if the vacation benefits would have been accrued or only conditionally payable, then the vacation benefits may have constituted an "employee welfare benefit plan" because the administrative function necessary to provide the benefits would have been more prevalent. The Court noted that, while the payment of the vacation benefits from the employer's general assets did not require ERISA intervention, the existence of a separate asset fund for vacation pay purposes could pose the requisite risk to employees that would afford ERISA's protection.

121. Mackey, 486 U.S. at 831.
122. Id. at 831-32. The Court's focus was primarily on the need for a state to have an enforcement mechanism to collect judgments rather than on incidental costs that would fall upon an employee benefit plan as a result of garnishment proceedings. Id. at 834.

In his dissenting opinion, Justice Kennedy asserted that the substantial administrative costs incurred by a plan when it acts as a garnishee fulfills the requisite connection between a state law and an ERISA plan to trigger preemption. Id. at 842 (Kennedy, J., dissenting).

126. Id. at 115. See supra note 41 for the definition of an "employee welfare benefit plan."
127. Morash, 490 U.S. at 115. The Court emphasized that ERISA does not involve the regulation of employee wages. Id. The Court stated that the legislative intent behind the enactment of ERISA was "to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." Id. at 112.
128. Id. at 115-16.
129. Id. at 120.
In *FMC Corp. v. Holliday*, the Court addressed the question of whether ERISA preempted a Pennsylvania law that precluded an ERISA plan from seeking reimbursement from a participant for medical expenses when the participant recovered the same expenses in a tort action. Relying on prior broad interpretations of the preemption clause, the Court held that the Pennsylvania law did "relate to" an employee benefit plan and thus triggered preemption. The Court established the existence of the requisite relationship by noting that not only did the Pennsylvania law specifically refer to ERISA plans, but it subjected them to regulations that varied from state to state. The Court was satisfied that preemption was essential to preserving the uniformity of benefits law that ERISA was enacted to maintain.

With the broad scope of ERISA's preemption clause holding strong in the Rehnquist Court, the issue of preemption was addressed again in *Ingersoll-Rand Co. v. McClendon*. The Court considered whether ERISA preempted a Texas common law claim that an Ingersoll-Rand employee was discharged solely for the purpose of precluding the vesting of his pension. Initially, the Court reiterated the broad reach of the preemption clause that is evidenced by Congress' intent and by prior decisions. Two established limitations to the

131. *FMC Corp.*, 498 U.S. at 54. The relevant section of the Pennsylvania Motor Vehicle Financial Responsibility Law provides that:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

Section 1719 of the law states that "[a]ny program, group contract or other arrangement for payment of benefits . . . shall be construed to contain a provision that all benefits provided therein shall be in excess of and not in duplication of any valid and collectible first party benefits provided." 75 PA. CONS. STAT. § 1719 (1987).

132. *FMC Corp.*, 498 U.S. at 58-59. The Court considered ERISA's savings clause and deemer clause. Id. at 60-61.

133. Id. at 59. The Court referred to § 1719 of the Pennsylvania law that made reference to "[a]ny program, group contract or other arrangement for payment of benefits." Id. See supra note 131 for text of § 1719.

134. *FMC Corp.*, 498 U.S. at 60.
135. Id.
137. *Ingersoll-Rand*, 498 U.S. at 135.
138. Id. at 138. The Court noted that ERISA's preemption clause is so broad that "our task of discerning congressional intent is considerably simplified." Id.
139. Id. at 138-39. See, e.g., *FMC Corp.*; Metropolitan Life Ins. Co. v. Massa-
preemption clause were acknowledged by the Court. First, an indirect administrative burden placed on a benefit plan pursuant to a state law does not necessarily trigger preemption. Second, preemption applies only to state laws that affect ongoing benefit plans. Because neither limitation applied to the case at hand, and because the employee benefit plan was fundamental to the employee’s action against Ingersoll-Rand, the Court found that the requisite relationship existed for preemption to apply. The Court noted that this result is consistent with the congressional intent behind ERISA preemption, which is primarily to maintain national uniformity in employee benefits law.

Perhaps the broadest interpretation of the phrase “relates to” was set forth in District of Columbia v. Greater Washington Board of Trade. The issue in Greater Washington was whether ERISA preempted a District of Columbia statute that required employers to provide health care coverage to employees receiving workers’ compensation benefits. The Court reiterated the broad reach of ERISA’s preemption clause, noting that preemption of a state law can apply even though the impact on an ERISA plan is indirect and the state law parallels ERISA directives. The Court held that the District of Columbia statute was preempted by ERISA. The primary basis for the Court’s conclusion was that existing benefit levels were used as a benchmark to measure benefits due under the statute, and therefore, to the extent that the existing benefit levels were used as...
derived from an ERISA plan, the statute was preempted.\textsuperscript{150} Thus, the Court held it was primarily this reference by implication to an ERISA plan that established the requisite relationship for preemption.\textsuperscript{151}

In his dissenting opinion, Justice Stevens stated that the Court entered "uncharted territory" by finding preemption primarily because the statute referred to an ERISA plan.\textsuperscript{152} According to Justice Stevens, the statute neither affected plan administration nor imposed any regulations upon the plan itself.\textsuperscript{153} Justice Stevens suggested that the Court should have looked at the case in light of the evils that ERISA was designed to prevent.\textsuperscript{154}

The history of ERISA's preemption clause is unique in that the Court's interpretation of the clause has oscillated between a very broad interpretation and a narrow interpretation. Historically, the clause had been read very broadly.\textsuperscript{155} Between 1987 and 1989, however, the Supreme Court set forth limitations on the scope of the preemption clause.\textsuperscript{156} For example, a state law is not preempted by ERISA if the state law "relates to" an employee benefit, but not to an employee benefit plan.\textsuperscript{157} Also, the fact that a state law places an indirect burden on an ERISA plan does not necessarily command

\textsuperscript{150} Greater Washington, 113 S. Ct. at 583-84.
\textsuperscript{151} Id. at 584. The Court noted that to the extent that the statute refers to an ERISA plan, "any state law imposing requirements by reference to such covered programs must yield to ERISA." Id.
\textsuperscript{152} Id. at 587-88 (Stevens, J., dissenting).
\textsuperscript{153} Id. at 587.
\textsuperscript{154} Id. at 588. In his dissent, Justice Stevens stated that "the Court should pause to consider, first, the wisdom of the basic rule disfavoring federal pre-emption of state laws, and second, the specific concerns identified in the legislative history as the basis for federal pre-emption." Id. Justice Stevens believed that by undergoing this type of analysis, the Court would not have found preemption. Id. Justice Stevens commented: "Where that holding will ultimately lead, I do not venture to predict." Id.
\textsuperscript{155} See, e.g., Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983). In Shaw, the Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Shaw, 463 U.S. at 96-97.
\textsuperscript{156} See, e.g., Ingersoll-Rand, 498 U.S. at 139. The Court recognized that the preemption clause is interpreted broadly; however, the Court reviewed prior cases that placed limits on the phrase. Id.
\textsuperscript{157} Fort Halifax, 482 U.S. at 8. The Court held that a state law mandating a one-time severance payment to employees upon the closing of a plant did not constitute or relate to an employee benefit plan and thus was not preempted by ERISA. Id. at 8.

In Morash, the Court held that a state law mandating the payment to employees of accrued vacation pay did not constitute or relate to an employee benefit plan and thus was not preempted by ERISA. Morash, 490 U.S. at 114.
preemption. 158 Demonstrating that the previous limitations placed on the clause did not establish a jurisprudential trend toward further restriction of the clause, the Court rendered one of its broadest interpretations of preemption in 1992 in Greater Washington. The mere reference to an ERISA plan in a state law was the key factor that triggered preemption in Greater Washington. 159 However, in its most recent look at ERISA's preemption clause, the Court backed away from such a sweeping interpretation and restricted its scope once again by allowing a state law that placed an indirect, yet significant, burden on ERISA plans to stand. A closer look at the Court's seemingly inconsistent interpretation of the clause in New York State Conference of Blue Cross & Blue Shield Plans may explain the result.

While ideally the Court should strive to devise some consistent, objective interpretation of the phrase "relates to" in order to make application of ERISA more uniform, it cannot look at the scope of the phrase in a vacuum. 160 Each case has the potential to create far-reaching implications, and those implications play a significant role in ERISA preemption analysis.

In New York State Conference of Blue Cross & Blue Shield Plans there were three primary aspects of the Court's decision. 161 First, the Court acknowledged that statutory language alone did not provide a sufficient basis to render a decision. 162 Second, the Court determined that preemption of New York's surcharges was not necessitated by congressional intent regarding ERISA legislation. 163 Third, the Court was deeply concerned with the far-reaching implications of the decision if the New York surcharges were displaced. 164

One must ponder whether it was perhaps the far-reaching

158. Mackey, 486 U.S. at 831-32.
159. Greater Washington, 115 S. Ct. at 583.
160. Id. at 588 (Stevens, J., dissenting). Justice Stevens commented that the Court should look beyond "dictionary definitions of the word 'relate'" and consider basic principles of federalism and congressional intent in ERISA preemption analysis. Id.
161. See New York State Conference of Blue Cross & Blue Shield Plans, 115 S. Ct. at 1677.
162. Id. The Court referred to the language of ERISA as "unhelpful text." Id.
163. Id. at 1680. The Court believed that Congress was most concerned with national uniformity in employee benefits law. Id. at 1677. The Court did not believe that Congress envisioned federal preemption of "general health care regulation." Id. at 1680.
164. Id. at 1681. The Supreme Court stated that "any conclusion other than the one we draw would bar any state regulation of hospital costs." Id. The Court referred to such an outcome as "an unsettling result." Id.
implications that an adverse decision would have had on the petitioners that ultimately persuaded the Court. The Court faced the consequences of squelching not only one state's efforts to set hospital rates, but many such efforts by various states. Justice Souter reviewed the multitude of state regulations that were in effect when ERISA was enacted. He recognized that should a reading of the preemption clause be so broad as to invalidate a large amount of existing state regulations, the reading is most likely too broad and has surpassed the intended scope of ERISA legislation.

Even more significant was the possible effect of the decision, not only on states' existing legislation, but on contemplated health care reform initiatives. Perhaps no preemption case has posed the threat of such serious implications of a broad interpretation of the clause as New York State Conference of Blue Cross & Blue Shield Plans because of the possible impact on health care reform. Until national health care reform measures are passed by Congress, states must confront spiraling health care costs and shortfalls in the funding of indigent care. If New York's surcharges would have been preempted, hospitals in New York would have lost a significant source of revenue that...
is used to fund indigent care for its residents.\textsuperscript{170} Thus, there is a strong argument that it was ultimately the long-term ramifications of this decision that guided the Court in its decision.

It cannot be said with certainty to what extent this decision effectively restricted the scope of the preemption clause for subsequent cases. Should the Court be faced with a case today that poses significantly less ramifications than those posed by \textit{New York State Conference of Blue Cross \& Blue Shield Plans}, the Court may very well return to a broader definition of preemption. However, to the extent a state law coincides with health care reform objectives, this case may have started a trend toward allowing such a state law to stand.\textsuperscript{171}

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\textsuperscript{170} Karen Pallarito, \textit{High Court Backs Some Patient Rate Surcharges—States Allowed to Add Surcharges to Hospital Patient Rates Covered By Employee Care Plans}, \textit{MODERN HEALTHCARE}, May 1, 1995. “By rejecting the ERISA pre-emption argument, the high court prevented hospitals from losing $200 million a year paid by commercially insured patients.” \textit{Id.}

\textsuperscript{171} See Robert L. Roth, \textit{U.S. Supreme Court's Decision in New York State Conference of Blue Cross \& Blue Shield Plans v. Travelers Insurance Co.: Perhaps Less than Meets the Eye}, \textit{HEALTH LAW DIGEST}, June 1995, at 7. “[T]he case law relating to ERISA pre-emption of state health reform initiatives is still developing.” \textit{Id.}