

August 31, 2002

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Maine Health Data Organization
102 State House Station
Augusta, ME 04333-0102

Re: ERISA preemption

Dear Alan:

In my capacity as legal advisor to the Maine Health Data Organization (“MHDO”), you have inquired whether the recently adopted rules of the MHDO pertaining to assessments and health data obligations of third party administrators are precluded by the so-called ERISA preemption. At the outset, please be advised this correspondence should not be construed as a formal opinion of the Attorney General¹. Rather, this correspondence reflects my research and views on this matter and does not necessarily reflect the formal position of the Attorney General. In order to determine whether the ERISA preemption prohibits the imposition of assessments or collection of health data from third party administrators², it is appropriate to briefly review the purposes and objectives of both the MHDO and the ERISA preemption clause.

Maine Health Data Organization

The Maine Health Data Organization was established by the Legislature to gather clinical, financial, and hospital restructuring data from health care facilities, providers, and payers. *P.L. 1995, C. 653*.³ The Legislative purpose in establishing the MHDO was as follows:

It is the intent of the Legislature that uniform systems of

¹ The Attorney General is authorized to issue written opinions upon questions of law submitted to him or her by the Governor, state departments or agencies, either branch of the Legislature, or by any member of the Legislature on legislative matters. *5 M.R.S.A. § 195*.

² For purposes of this correspondence, the term “third party administrator” refers both to third party administrators and carriers which provide administrative services only for plan sponsors.

³ The statute has been codified at 22 M.R.S.A. Ch.1683, §§ 8701-8711.

reporting health care information be established; that all providers and payers who are required to file reports do so in a manner consistent with these systems; and that, using the least restrictive means practicable for the protection of privileged health information, public access to those reports be ensured.⁴

The MHDO was established to create and maintain an objective, reliable, and comprehensive health information database to enhance the delivery of health services in Maine. The organization is accorded broad statutory authority to collect, process, store and analyze a broad array of clinical, financial and restructuring data from health care providers, payers and third party administrators. 22 M.R.S.A. §§ 8704(1), 8704 (10), 8708, 8710 & 8711.

Although the MHDO has had the authority to impose assessments⁵ and gather health data⁶ from third party administrators since its inception, it has only recently exercised its authority in this regard. In the past year, the MHDO adopted a revised *Determination of Assessments, 90-590 CMR Ch. 10* and a new *Uniform Reporting System for Health Care Claims Data Sets, 90-590 CMR Ch. 243*. As a result third party administrators were subject to an MHDO assessment calculated by the percentage of health care claims paid or processed by the TPA in relationship to the entirety of claims paid or processed by TPAs in Maine.⁷ Furthermore, TPAs were required to submit to the MHDO health care claims data sets consisting of member eligibility files, medical claims files, pharmacy claims files and dental claims files.⁸ Consequently, this is the initial opportunity for the MHDO to address the issue of whether the imposition of assessments or mandated collection of health care data from third party administrators licensed in Maine is precluded as a result of the ERISA preemption clause.

ERISA Preemption

The Employee Retirement Income Security Act of 1974 (“ERISA”)⁹ is a comprehensive statutory scheme which governs employee benefit plans. The statute was enacted in response to growing concerns about “the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds”. See *Carpenters Local Union v. United States Fidelity & Guaranty*, 215 F.3d 136 (1st Cir. 2000), quoting *Massachusetts v. Morash*, 490 U.S.107, 115, 104 L.Ed. 98, 109 S.Ct.1668 (U.S. 1989). Section 514 (a) of ERISA¹⁰ provides that the Act “shall supercede any and all State laws insofar as they...relate to any employee benefit

⁴ 22 M.R.S.A. § 8701.

⁵ 22 M.R.S.A. §8706(2)(C)(2).

⁶ 22 M.R.S.A. §§ 8708 & 8711.

⁷ See *Maine Health Data Organization Rule on Determination of Assessments, 90-590 CMR Ch. 10, §2 (D)*.

⁸ See *Maine Health Data Organization Rules Relating to Uniform Reporting System for All Health Care Claims Data Sets, 90-590 CMR Ch.243, §2*.

⁹ ERISA is codified at 29 U.S.C. §§ 1001-1461.

¹⁰ Section 514(a) has been codified at 29 U.S.C. 1144(a).

plan” covered by the statute. Nevertheless, the ERISA pre-emption of state legislation does not apply to “any law of any State which regulates insurance”. 29 U.S.C. § 1144(b)(2)(A).

The Supreme Court has determined that Congress intended Section 514 to establish the regulation of employee welfare benefit plans “as exclusively a federal concern” *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, 68 L.Ed. 402, 101 S.Ct. 1895 (U.S.1981). In providing for the preemption of state legislation relating to ERISA governed employee benefit plans, the Congress intended:

to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government...[and to prevent] the potential for conflict in substantive law...requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 141, 112 L.Ed. 2d 474, 111 S.Ct. 478 (U.S. 1990).

The comprehensive regulation of employee welfare and pension benefit plans under ERISA extends to those which provide “medical, surgical, or hospital care or benefits” for plan participants or their beneficiaries through the purchase of insurance or otherwise. *See* 29 U.S.C. § 1002(1). Accordingly, the Act controls the administration of benefit plans by imposing reporting and disclosure requirements, 29 U.S.C. §§ 101-111; participation and vesting requirements, §§ 201-211; funding standards, §§ 301-308; and fiduciary responsibilities for plan administrators, §§ 401-414.

Initially, the courts interpreted the ERISA preemption clause rather broadly. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 77 L.Ed. 490, 103 S.Ct. 2890 (U.S. 1983); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 121 L.Ed. 2d 513, 113 S.Ct.580 (U.S. 1990). In *Shaw* the Supreme Court interpreted the phrase “a law ‘relates to’ an employee benefit plan” to mean “if it has a connection with or reference to such a plan” and held state statutes meeting this standard to be preempted by ERISA. 463 U.S. 85 at 96-97.

But in recent years, the Supreme Court has adopted a more deferential position with respect to state statutes of general application which indirectly relate to the administration of employee benefit plans governed by ERISA. In *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed. 2d 695 (U.S. 1995) the Supreme Court rejected an ERISA pre-emption challenge to a state hospital regulatory statute which imposed surcharges upon commercially insured patients and health maintenance organizations. New York State had adopted a hospital rate setting mechanism under which rates for in-patient care were based upon a standard rate which reflected the average cost of treating the specific medical condition rather than the cost of the actual individual care. The State thereafter

adopted a hospital surcharge applicable to commercial insurers and HMOs designed to foster hospital cost containment and promote health care for the uninsured and underinsured. An ERISA governed employee benefit plan which operated hospitals subject to the statutory surcharge challenged the statute on the grounds the surcharge would increase the costs of insuring hospital services for plan members, thus triggering the ERISA pre-emption, under the rationale the increased hospital charges interfered with the health plan's ability to select coverage for its members. While observing "the basic thrust of the preemption clause was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans", the Court found the New York statute did not "relate to" the employee benefit plan within the meaning of Section 514 (a). Reasoning that the New York statute establishing charge differentials between the Blues and commercial insurers recognized that the Blues covered many persons commercial carriers would reject, the Court observed the statute had only an indirect economic influence on choices made by insurance purchasers, including ERISA plans. The Court found an indirect economic influence does not bind plan administrators to any particular choice or preclude uniform administrative practice or the provision of a uniform interstate benefit package. Rather, it simply bears on the costs of benefits and the relative costs of competing insurance available to such plans. In concluding the ERISA preemption was not designed to promote cost uniformity amongst health plans, the Court ruled:

...to read the preemption as displacing all state laws affecting costs and charges on the theory that they indirectly relate to ERISA plans that purchase insurance policies or HMO memberships that would cover such services would effectively read the limiting language in § 514 (a) out of the statute, a conclusion that would violate basic principles of statutory interpretation and could not be squared with our prior pronouncement that "preemption does not occur if the state law has only a tenuous, remote or peripheral connection with covered plans, as is the case with many laws of general applicability."
Travelers, 514 U.S. 645, 661.

The recent jurisprudence according the ERISA preemption a more narrow construction is based, to a significant extent, upon a more deferential approach to subject areas which have" been traditionally occupied by the States." See, e.g. *Jones v. Rath Packing Co.*, 430 U.S.519, 525, 51 L.Ed. 604, 97 S.Ct. 1305 (U.S. 1977). In addition to the express exception to the ERISA preemption for state legislation regulating insurance, the courts have also recognized the historic police powers of the States to regulate matters of health and safety. *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 91 L.Ed. 2d 1447, 67 S.Ct. 1146 (U.S. 1947) ("[w]here federal law is said to bar state action in fields of traditional state regulation...we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress); *Hillsborough County v. Automated Medical*

Laboratories, Inc., 471 U.S. 707, 85 L.Ed. 2d 714, 105 S.Ct. 2371 (U.S. 1985). Hence, unless Congress has clearly manifested an intent to preempt an area of state legislation regulating an area “traditionally occupied by the States”, state statutes which have only an indirect affect upon an ERISA plan will generally survive an ERISA preemption challenge.

In *De Bueno v. NYS-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1787, 138 L.Ed. 2d 21 (U.S. 1997), the Supreme Court, rejecting an ERISA challenge to a New York statute which imposed a gross receipts tax upon ERISA funded medical centers, eschewed a mechanistic application of the ERISA preemption clause in favor of an approach which compared the objectives of ERISA preemption with the specific purpose of the state regulatory statute, stating:

In our earlier ERISA preemption cases, it had not been necessary to rely on the expansive character of ERISA’s literal language in order to find preemption because the state laws at issue in those cases had a clear “connection with or relation to” ...ERISA benefit plans. But in *Travelers* we confronted directly the question whether ERISA’s “relates to” language was intended to modify “the starting presumption that Congress does not intend to supplant state law”... We unequivocally concluded that it did not, and we acknowledged “that our prior attempts to construe the phrase ‘relate to’ do not give us much help drawing the line here”. In order to evaluate whether the normal presumption against preemption has been overcome in a particular case, we concluded that “we must go beyond the unhelpful text and the frustrating difficulty of defining the key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive. 520 U.S. 806, 813-814.

In *De Bueno* the Court concluded there was nothing in the operation of the New York statute, which imposed a tax on gross receipts for patient services upon diagnostic and treatment centers, *inter alia*, to suggest it was the type of statute the Congress intended to preempt under the ERISA act. The Court determined the New York Legislature, faced with the choice of either curtailing its Medicaid program or generating additional revenue to reduce a projected operating budget, chose to impose the gross receipts tax at the patient services level pursuant to a statute of general application. Since the purpose of the statute was not to regulate any aspect of ERISA governed plans, and the statute did not expressly refer to ERISA or ERISA governed plans, the Court concluded the impact of the tax upon ERISA plans was only indirect and, hence, not subject to the ERISA preemption clause. *De Bueno*, 520 U.S.806 at 816. Of particular relevance to our inquiry

regarding the application of the MHDO statutes and rules to TPAs supporting ERISA plans, the Court observed:

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. 520 U.S. 806 at 816 (emphasis added).

In the aftermath of *Travelers* and *De Bueno*, the First Circuit Court of Appeals has adopted a more deferential standard of ERISA preemption review. In *Carpenters Local Union United Brotherhood of Carpernters & Joiners of America v. U.S. Fidelity & Guaranty Co.*, 215 F. 3d 136 (1st Cir. 2000), the Court observed:

Travelers plainly signaled a significant analytic shift in regard to the “connection with” portion of the ERISA preemption inquiry, abandoning strict textualism in favor of a more nuanced approach. 215 F.3d 136, 140.

While cautioning that “even under the new regime...state laws which furnish alternative enforcement mechanisms threaten the uniformity that Congress labored to achieve and thus are preempted by ERISA”, the Court concluded the Massachusetts bond statute under challenge neither singled out ERISA plans for special treatment nor depended upon their existence as an essential part of its operation. Rather, the statute was “indifferent to ERISA coverage”, and “one of a ‘myriad of state laws’ of general applicability that impose some burdens on the administration of ERISA plans...but nevertheless do not ‘relate to’ them within the meaning of “ the ERISA statute”. *Carpenters*, 215 F.3d 136, 145.

MHDO Assessment and Data Requirements

The MHDO statutes and rules authorizing the imposition of assessments upon and requiring the reporting of clinical, financial and other health care claims information by health providers and payers constitute state regulatory law of general applicability. The MHDO statutes and rules neither single out ERISA governed plans, refer to ERISA or depend upon the ERISA regulatory framework for their operation or application. Indeed, the MHDO statutes and rules are “indifferent to ERISA coverage” and apply to a wide range of health care payers and plan administrators, regardless of whether they administer or support ERISA plans. The purpose of the MHDO statutes and rules is totally unrelated to the objectives of the Congress in establishing the ERISA preemption. Whereas Congress sought to promote a regulatory climate which “permit[ted] the nationally uniform administration of employee benefit plans, *Travelers*, 514 U.S. 645 at 657 by adopting the ERISA preemption, the MHDO statute sought to facilitate the creation of “ a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens.” 22 M.R.S.A. §§ 8701 & 8703(1).

The MHDO statutes and rules under consideration are an expression of the exercise of traditional police powers vested in the Maine Legislature to promote the health and well being of Maine residents. The MHDO sought to impose its assessment authority upon third party administrators in order to facilitate the development of a nonprofit health data processing center.¹¹ The organization adopted its *Rules Relating to the Uniform Reporting System for Health Care Data Sets* in order to satisfy its legislative mandate to compile and maintain a comprehensive health information database to improve health care for the people of Maine. 22 M.R.S.A. § 8703(1). There is nothing in the enabling legislation, nor the rules adopted by the MHDO, to suggest this is the type of state activity the Congress intended to supercede via the aegis of the ERISA preemption. Although the imposition of an assessment or mandated claims reporting requirements upon a TPA which administers ERISA governed employee benefit plans may have some incremental affect upon the cost of plan administration, it is apparent the reference legislation and rules only have an incidental and indirect impact upon such TPAs and the plans they administer. Accordingly, it is my view that the MHDO statutes and rules which subject third party administrators servicing ERISA governed employee benefit plans to assessments and mandatory health claim reporting requirements do not contravene the ERISA preemption, nor are they superceded by ERISA.

Very sincerely yours,

(Original signed)

N. Paul Gauvreau
Assistant Attorney General

NPG/s

¹¹ In 2001 the 120th Maine Legislature enacted L.D.1304, “An Act to Create the Maine Health Data Processing Center. *See P.L. 2001, Ch. 456*. In order to allow the MHDO to finance the new processing center, the Legislature increased the amount of revenues the organization could raise via its assessment authority from \$750,000 to \$1,346 million.