WHAT'S AT STAKE WITH ERISA CASE

C. Scott Litch, Cheryl A. Cameron, and Cheryl H. DeVore

INTRODUCTION AND BACKGROUND

It is important that health care provider associations advocate for state laws that protect patients and providers from abusive insurer practices. However, opportunities from past successes and future initiatives could change if a federal law exemption of state law is too broadly interrupted.

The Employment Retirement Income Security Act of 1974 (ERISA)[1] generally set standards for private-sector health plans and exempts self-funded plans from state insurance laws.[2] These plans are usually operated by very large corporations. As a brief overview of ERISA and the rationale for what is called the ERISA preemption:

> " . . . Congress sought to provide national standards for employee benefit plans, including reporting, disclosures, fiduciary responsibilities, claims/appeals and remedies for noncompliance. To minimize the potential patchwork effect of each state enacting their own laws regulating employee benefits, Congress included a broad preemption of state laws that could interfere with the uniform administration of ERISA plans."
>
> "ERISA . . . generally preempts "any and all state laws" to the extent they "relate to" employee benefit plans, but a complex body of court decisions and federal guidance surrounds this issue. Only federal courts can ultimately determine whether ERISA preemption applies, though the Department of Labor (DOL) has issued its own preemption guidance from time to time." [3]

BASIC ISSUE AND RECENT LEGAL CHALLENGE

How far does the ERISA exemption extend relative to state efforts to regulate health insurer practices, including dental insurance plans? Dental insurance plans have often claimed that the federal ERISA law allows them to avoid complying with state laws impacting dental coverage if the plans are operating as administrators for an employer's self-funded plan.

While there has been much case law on the matter over many decades, the 2020 U.S. Supreme Court decision in *Rutledge v. Pharm. Care Mgmt. Ass'n* provided needed clarity in unanimously holding that an Arkansas statute regulating the relationship between pharmacy benefit managers (PBMs) and pharmacies is not preempted by ERISA.[4] A 2021 U.S. 8th Circuit Court of Appeals ruling applied the principles in Rutledge to reject an ERISA preemption challenge to a North Dakota law regulating PBMs (*Pharm. Care Mgmt. Ass'n v. Wehbi*). [3,5]

Unfortunately, in 2023, with a holding contrary to the protections from state law preemption that had been provided in the *Rutledge* and *Pharm. Care Mgmt Ass'n* cases, the U.S. 10th Circuit Court of Appeals held in *Pharm. Care Mgmt. Assoc. v. Mulready* that ERISA preempts provisions of an Oklahoma law regulating pharmacy benefit managers, who manage prescription drug benefits on behalf of health plans by negotiating prices with drug manufacturers and contracting with pharmacies.[6] This decision's interpretation of the ERISA preemption arguably conflicts with the 2020 Supreme Court decision described above.

REQUEST FOR SUPREME COURT TO CLARIFY LIMITS ON ERISA PREEMPTION

An *Amicus Curiae* (Latin for "friends of the court") legal brief was filed on June 12, 2024, requesting that the U.S. Supreme Court hear a case to clarify/elucidate that the ERISA preemption of state insurance laws/regulations is limited. The brief was filed by the American Dental Association (ADA), American Optometric Association, American Association of Orthodontics, the **American Academy of Pediatric Dentistry**, Association of Dental Support Organizations and American Association of Oral and Maxillofacial Surgeons in support of the petition for a writ of certiorari (request for review) in *Mulready v. Pharmaceutical Care Management Association (PCMA)*.[7] The amica curaie also included the American Academy of Oral & Maxillofacial Pathology, American Association of Endodontists, Academy of General Dentistry, and American Academy of Periodontology.[8]

The amicus brief advocates that most state laws, particularly those that protect patients and dentists from abuse by dental insurers, can be applied to all carriers, including those administering self-funded dental plans for employers. It emphasizes that the case has significance far beyond the relationships between PBMs and pharmacies, a context that has dominated recent ERISA preemption cases. The brief explains how the U.S. 10th Circuit Court of Appeals decision in *Mulready* with its overly broad application of ERISA preemption raises a more fundamental question: whether states retain their traditional authority to enact and enforce laws governing health care and insurance.

Among other issues, the amicus brief argues that state insurance laws such as medical loss ratio (MLR) and dental loss ratio (DLR) should not be preempted by ERISA. If the decision in *Mulready* is reversed, it will enable (that is, prevent ERISA preemption of) other state insurance reform laws (in addition to MLR/DLR legislation) that the ADA is pursuing, and which are supported by the AAPD. This includes promoting states' adoption of the *Transpar-*

ency in Dental Benefits Contracting Model Act adopted by the National Council of Insurance Legislators. This model law addresses several key issues: fair and transparent network contracting (allows dentists to accept or refuse contracts to which they would otherwise be obliged); virtual credit cards (not limiting payments to such method); and prior authorization (hold dental insurers to pay what was promised in the authorization).[9]

It is important to highlight that what has traditionally held to be preempted by ERISA are state laws that would mandate certain benefits. This means that the current legal effort—even if successful—would not eliminate the ERISA preemption of self-funded plans from state insurance mandate laws, such as general anesthesia coverage for dental cases. That is why the AAPD supports amendments to both ERISA and the Affordable Care Act in order to address current gaps in coverage.[10]

SUBSTANTIVE ARGUMENTS FOR LIMITING PREEMPTION

The amicus brief begins by explaining why the medical and dental communities care about this issue. It describes how health care provider associations advocate for state laws that protect patients and providers from abusive insurer practices. It provides examples of patient and provider-friendly laws that provider associations have advocated. It describes some of the challenges faced because of misunderstandings or overbroad misapplications of the ERISA preemption, such as push-back from legislative counsel and reluctance by insurance commissioners and other law enforcement agencies to enforce provider-friendly laws against the insurance companies that administer health plans.

Some specific examples are cited below:

> "For example, amici advocate for laws requiring third-party payors to honor assignments of benefits, including in states within the Tenth Circuit. See, e.g., Colo. Rev. Stat. § 10-16-106.7; N.M. Stat. Ann. § 13-7-42; and Okla. Stat. tit. 36, § 6055(F). Such laws require payors to pay providers directly for health-care services provided to patients. Without this protection, many patients would forgo needed health care because they cannot afford to pay up-front for services."
>
> "Amici similarly advocate for laws that require third-party payors to honor prior authorizations. . . . When payors issue a prior authorization, providers and patients rely on that promise of payment. These laws prevent payors from later denying payment after the authorized service has been performed. Such laws protect patients from surprise bills they may not have the resources to pay and ensure that providers get paid for their services." *Emphasis added.*

The amicus brief moves on to address why the Supreme Court should grant review. It describes how the Supreme Court provided much needed clarity in *Rutledge v. PCMA*, and the cases leading up to it, by focusing ERISA preemption on only those state laws that interfere with "central matters of plan administration." As argued in the brief:

> "Rutledge established a clear two-step approach for determining whether a state law has a "connection with" ERISA plans that triggers preemption. First, courts should ask whether the state law directly regulates "a central matter of plan administration," such as laws that require specific benefits or rules for determining beneficiary status. Id. at 86-87. Second, courts should ask whether a state law produces indirect economic effects that are so "acute" that they "force an ERISA plan to adopt a certain scheme of coverage."
>
> "This Court also made clear that state laws can affect an ERISA plan without triggering ERISA preemption:
>
> 'Crucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs.' "

The amicus brief then explains how the Tenth Circuit's decision in *Mulready* undermines that clarity in three significant ways:

- First, *Mulready* significantly expands ERISA preemption from applying just to state laws that regulate benefit *plans* to encompassing all state laws that regulate *benefits*. Because virtually every health-care service can be characterized as a benefit, every state health care law becomes a target for preemption. Quoting from the brief:

  > "The Court of Appeals' principal error was conflating state laws that regulate benefits—i.e., how healthcare is provided and paid for—with state laws that regulate benefit plan administration. See *Mulready*, 78 F.4th at 1198. It held that any state law that restricts how a plan provides benefits triggers ERISA preemption because it "forbids an element of benefit design." Id. It reasoned that "forbidding something is itself a requirement that the PBM do the opposite of what is forbidden." Id. at n.11. It then exacerbated its error by holding that even de minimis interference with how a plan can choose to deliver benefits, such as "eliminating the choice of one method of structuring benefits," triggers preemption. Id. at 1198, 1202-1203."

- Second, the Tenth Circuit in *Mulready* gave little weight to *Rutledge* and other similar cases, dismissing them as "rate regulation cases." As a result, *Mulready* calls into question whether the clarity that *Rutledge* provided even applies to a substantial portion of ERISA preemption cases. *Emphasis added*.

- Third, *Mulready* explicitly expands ERISA preemption into subject matters that ERISA itself does not address. As a result, the decision creates regulatory vacuums that Congress never intended, and it exposes patients and providers to abusive practices by insurance companies and large employers with no possibility of government oversight or accountability. As summarized in the brief:

  "The regulatory vacuum created by the decision below on vital issues regarding how health care is delivered—issues on which ERISA itself has nothing to say—would render those beneficiaries vulnerable to abusive practices. Insurance companies and large employers would dictate what health care citizens receive with no government oversight or accountability. There is no evidence that Congress understood that it was usurping traditional state power to regulate health care, much less creating an untouchable regulatory vacuum in such an important area of the law. As this Court held in *Travelers*, "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." 514 U.S. at 661. *Emphasis added*.

CONCLUSION

Properly constraining the scope of ERISA preemption is vital to preserving the capability of health professions associations to advocate for their members and members' patients via state laws regulating health care. This issue must continue to be monitored and action taken when opportunity allows. The Supreme Court's ruling on the petition for writ of certiorari will likely be handed down this fall. In October, the Supreme Court invited the Solicitor General (the federal government 's chief lawyer to the high court) to file a brief in this case, which indicates the court's interest in potentially granting certiorari.

C. Scott Litch, M.A., J.D., is the AAPD 's Chief Operating Officer and General Counsel. For further information contact Mr. Litch at (773) 938-4759 or slitch@aapd.org.

Cheryl A. Cameron, Ph.D., J.D., is Professor, Oral Health Sciences, School of Dentistry, Virginia and Prentice Bloedel University Professor, and Vice Provost Emeritus, University of Washington.

Cheryl H. DeVore, M.S., J.D,. is the senior partner at Thomas Law Group, and Faculty Emeritus of The Ohio State University's College of Dentistry (where she retired as the Associate Dean of Academic Affairs).

This column presents a general informational overview of legal issues. It is intended as general guidance rather than legal advice. It is not a substitute for consultation with your own attorney concerning specific circumstances in your dental practice. Mr. Litch does not provide legal representation to individual AAPD members.

References

1. 29 U.S.C. §1003 (2024).
2. 29 U.S.C. §1144 (2024).
3. Stamm C, Calloway M, Glass R (2022, Mar. 22) A primer on ERISA's preemption of state laws. Mercer. https://www.mercer.com/insights/law-and-policy/a-primer-on-erisas-preemption-of-state-laws/ (accessed July 24, 2024).
4. Rutledge v. Pharm. Care Mgmt. Ass'n, 592 U.S. 80 (2020).
5. Pharm. Care Mgmt. Ass'n v. Wehbi, 18 F.4th 959 (8th Cir. 2021).
6. Pharm. Care Mgmt. Ass'n v. Mulready, 78 F.4th 1183 (10th Cir. 2023).
7. Pharm. Care Mgmt. Ass'n v. Mulready, petition for cert. filed (U.S. May 10, 2024) (No. 23-1213).
8. Pharm. Care Mgmt. Ass'n v. Mulready. Brief amicus curiae of American Dental Association and Eight Health-Care Provider Associations. 12 June, 2024. https://www.supremecourt.gov/DocketPDF/23/23-1213/314807/20240612114858877_23-1213%20ADA%20Amicus%20Brief%20Final.pdf.
9. Burger D. (2021, Sept. 30) ADA, National Council of Insurance Legislators push for transparency in dental insurance bills. ADA News. https://adanews.ada.org/ada-news/2021/september/national-council-of-insurance-legislators-push-for-transparency-in-dental-insurance-bills (accessed September 12, 2024).
10. Technical Report 2-2012 (2012, May) An essential health benefit: General anesthesia for treatment of early childhood caries. AAPD. https://www.aapd.org/assets/1/7/POHRPCTechBrief2.pdf (accessed September 5, 2024).