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Interview: Benefits Attorney Cynthia M. Stamer
This month’s interview, with an attorney who specializes in employee benefits, focuses on the implications of the U.S. Supreme Court’s ruling in Travelers Insurance Company v. Cuomo, and other related cases, with particular attention to the impact on not-for-profit managed care entities.

Have Tax-Exempt Managed Care Entities Been Given Competitive Advantage By High Court?

Cynthia Marcotte Stamer practices employee benefits and health care law as a partner in the Dallas, Texas-based law firm of Akin, Gump, Strauss, Hauer & Feld. Ms. Stamer serves on the board of directors of the Southwest Benefits Association and chairs its continuing education committee. She also is a member of the employee benefits committee of the tax section of the American Bar Association. In this interview with EBPR editor Seymour LaRocK, Ms. Stamer discusses the implications of the U.S. Supreme Court’s decision in Travelers Insurance Company v. Cuomo, and other related developments, particularly with respect to managed care operations.

Q: The U.S. Supreme Court, in Travelers Insurance Company v. Cuomo (No. 93-108; see EBPR, May 1995, p. 14) held that a hospital surcharge imposed under New York law was not preempted by provisions in ERISA that preempt state laws that “relate to” employee benefit plans. Given the Court’s decision that the law did not relate to an employee benefit plan, isn’t the question of ERISA preemption largely irrelevant?

A: Reports of the demise of ERISA preemption are greatly exaggerated. While a number of recent decisions, including Travelers, address the limits of its reach, ERISA preemption continues to provide vital and vibrant protection to employee benefit plans and their sponsors and administrators.

Of course, Congress’ addition to the Tax Code of Sec. 162(n), which prohibits employers from deducting any health plan contributions if the plan does not pay the New York surcharge, renders ERISA preemption practically irrelevant as applied to the New York statute. Additionally, the growing popularity and use of capitated arrangements and other “risk-shifting” or insurance-type arrangements also undermine the practical importance of the distinction between fully insured versus self-insured plans created by the “savings clause” of ERISA Sec. 514.

However, the precedent regarding ERISA preemption remains largely intact.

Q: The NYSA-ILA welfare fund involved in Chassin v. NYSA-ILA Medical and Clinical Services Fund (No. 94-745; see EBPR, June 1995, p. 16) is, without question, an ERISA plan. The Second Circuit U.S. Court of Appeals ruled that ERISA did, indeed, preempt the New York law because the tax directly related to the fund. However, on remand, the Second Circuit found no statutory basis for treating self-insured plans differently than insured plans for purposes of ERISA preemption. Isn’t that a 180-degree reversal?

A: The Second Circuit’s finding of no statutory basis for distinguishing self-insured plans is difficult to explain. The Supreme Court in Travelers suggested that self-insured plans might qualify for different treatment by expressly excluding those programs from its Traveler’s holding. On the other hand, the court in Travelers unequivocally rejected the rationale adopted by the Second Circuit in its original decision.
Unfortunately, the Supreme Court did not choose to share its rationale for vacating and remanding Chassin. As a result, we, like the Second Circuit, had to look to the Travelers decision for guidance about the motivations behind the Court’s decision to vacate Chassin.

Both Travelers and Chassin address the question of whether a state law taxing health care services that has the effect of increasing the cost of medical services provided or reimbursed by an employee benefit plan sufficiently “relates to” an employee benefit plan to fall subject to preemption. The Supreme Court’s decision to vacate and remand Chassin might better be explained as an undertaking to allow the Second Circuit to reform the rationale of its decision in light of Travelers. Therefore, the Second Circuit’s subsequent decision in Chassin should be viewed as an expansion of Travelers, rather than a mere reformation of its rationale.

Q: In Cigna Healthplan of Louisiana v. Louisiana (U.S. District Court for the Middle District of Louisiana, No. 94-885; see EBPR, August 1995, p. 51), the court voided Louisiana’s any-willing-provider statute on the grounds of ERISA preemption. In so ruling, the court appears to have a much better understanding of what managed care is than does the Supreme Court. From the standpoint of ERISA preemption, however, is the district court’s opinion reconcilable with the Supreme Court’s construction of the scope of laws that “relate to” employee benefit plans, as seen in Travelers?

A: The Travelers decision addresses the circumstances under which ERISA would preempt a law of general application, when the law makes no reference to and is not intended to directly regulate or to affect ERISA plans. Because the district court in Cigna Healthplan of Louisiana v. Louisiana found that the any-willing-provider statute expressly referenced and was designed to regulate ERISA plans, it was not absolutely necessary for it to evaluate the law under the standards established in Travelers. Nevertheless, the district court also found that the any-willing-provider statute affects the structure and administration of ERISA plans and impacts the employers’ or plan sponsors’ distinction as to how health benefits may be structured under their employee benefit plans. The Supreme Court in Travelers identified findings such as these as supporting a finding of preemption. Accordingly, the district court’s findings also are consistent with the standards established under Travelers.

Q: In today’s health care marketplace, there appears to be little difference whether HMOs, PPOs, and other managed care systems are operated by for-profit or not-for-profit entities. That being the case, could it not have been argued that New York’s surcharge gives an unconstitutionally competitive advantage to the already tax-exempt Blue Cross/Blue Shield organization? In other words, hasn’t New York created an uneven playing field?

A: Unquestionably, the New York surcharge operates to benefit the Blues. However, state insurance laws—and even the Internal Revenue Code—long have granted special preferences to Blue Cross/Blue Shield organizations. However, because Congress has delegated to the states significant power to regulate insurance and, under the McCarran-Ferguson Act, carved the business of insurance out of the reach of many federal antitrust laws, it is questionable whether the extension of these preferences to the Blues is permissible.

Q: IRC Sec. 501(m)(1) states that if providing commercial-type insurance constitutes a “substantial part” of a Sec. 501(c)(3) organization’s activities, the organization will no longer qualify for tax exemption. The Internal Revenue Service has taken the position that the tax-exempt status of nonprofit HMOs conducting point-of-service (POS) operations may be jeopardized. If the IRS pulled the tax exemption of, for example, a New York State Blue Cross/Blue Shield plan on that account, could the Blue Cross plan argue that it was protected from such adverse action under Travelers?

A: No. Travelers governs the effect of ERISA on the enforceability of state tax and
other laws. As a federal law, the Internal Revenue Code is outside the scope of ERISA preemption, as well as the Supreme Court's opinion in Travelers.

Q: In Announcement 95-25, I.R.B. 1995-14, the IRS indicates that it is troubled by the recruitment practices of tax-exempt hospitals. It provides examples of various inducements and incentives for physicians to "sign on," including professional practice income guarantees. Managed care organizations regularly offer financial incentives to physicians to induce them to "sign on." Could the provisions of Announcement 95-25 extend to tax-exempt managed care providers?

A: Announcement 95-25, by its terms, clearly states that it applies only to hospitals. While many of these same issues probably would arise in one form or another in evaluating a managed care provider's tax exemption application, the applicable legal requirements, purposes, and operations of hospitals and managed care organizations differ. Accordingly, application of Section 501(c)(3) to a PPO or other managed care organization's tax exemption application might yield different results from some of those illustrated in Announcement 95-25. Rulings on requests seeking tax-exemptions for integrated delivery systems probably provide somewhat better insight into application of the requirements for tax exemption for PPOs or other managed care organizations.

Q: Managed care is supposed to bring competition into the marketplace. While PPO networks and other managed care providers do offer financial incentives as a means of recruiting providers, physicians and other providers frequently cite the threat of financial losses as a result of nonparticipation or exclusion from important networks as a motivation for joining. Do you think that a nonsignatory doctor could successfully raise an anti-competitive issue before the Federal Trade Commission? After all, ERISA does not preempt federal laws.

A: Physicians frequently seek to challenge network activities using antitrust laws. Occasionally, physicians are successful in challenging the contracting actions of PPOs or other managed care providers on antitrust grounds. Because of the fact-specific nature of antitrust analysis, however, the likelihood of success that a particular physician might expect would depend on his or her particular circumstances. Most of the time, however, under the principles adopted by the FTC, physicians are not successful in their efforts to challenge their exclusion from a PPO or other managed care provider panel on antitrust grounds. There also is a U.S. Supreme Court decision involving exclusive contracts, *Jefferson Parish Hospital District No. 2 v. Hyde*, that is not encouraging for such physician challenges.

[Ed. Note: Subsequent to this interview, three groups of anesthesiologists filed an antitrust suit against the Aetna Health Plan of New York in the U.S. District Court for the Southern District of New York, as *Ambrose, et. al. v. Aetna Health Plan, et. al.* (No. 95-CIV-6631). The physicians charged that they had been coerced into signing inequitable contracts. The plan, according to the suit, threatened to cut off from future business the hospitals where the anesthesiologists were based, unless the doctors signed up.]

Q: Finally, it seems to many observers that the Supreme Court in *Travelers* and *Chassin* has violently disrupted the fairly consistent case law developed over the past 20 years with regards to ERISA preemption, leaving us suddenly without guidance in this area, like Alice trying to decipher the words of Humpty Dumpty. What are your thoughts?

A: The *Travelers* decision clarifies, rather than rejects, the long-standing precedent regarding ERISA preemption. Under *Travelers*, a generally applicable state law will not be preempted based solely on the law's indirect effect on plan costs. Instead, the Supreme Court's decision makes clear that a preemption finding is conditional on a finding that the law binds plan administrators or sponsors to a particular choice, precludes uniform administration of the provision of a uniform interstate benefit package, conflicts with ERISA, or otherwise affects an employee benefit plan in some other impermissible manner.