STATE COVERAGE INITIATIVES
Issue Brief

A National Initiative of
The Robert Wood Johnson Foundation

August 2000

ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High Risk

by Pat Butler

Because under the Employee Retirement Income Security Act of 1974 (ERISA) states cannot directly regulate employee-sponsored health plans, ERISA raises multiple issues for states seeking to expand access to individual insurance for people with high-risk medical conditions. The most common approach to financing such access is the creation of "high-risk pools" that permit people who are unable to obtain health insurance due to past or present medical conditions to buy coverage.

High-risk pools were first developed 25 years ago and now exist in 28 states. Many of these states use the high-risk pools to provide access to health coverage for people leaving the group insurance market as required by HIPAA (the 1996 Health Insurance Portability and Accountability Act). Alternatively, a few states either require individual insurance carriers to accept all applicants regardless of health status ("guaranteed issue") and limit the premium they can charge or use open-enrollment Blue Cross plans as insurers of last resort.[1]

The costs of high-risk pools routinely exceed the premiums paid by subscribers (which states cap between 125 and 200 percent of the individual market premium). Traditionally health insurers operating in the state have shared these costs. In states with "guaranteed issue" laws and rating limits in the individual market, some insurers may draw unusually large numbers of high-risk subscribers. A few of these states have enacted mechanisms to reallocate the excess cost of high-risk subscribers across all carriers in the individual market, and sometimes also the group market.

With the growth of self-insurance in the 1980s,[2] state assessments and other risk-spreading mechanisms have fallen on insurers as they cover a declining number of lives, leading states to seek alternative sources of financing to spread the costs more broadly. ERISA permits states to tax insurers but limits some state financing options; for example, it prohibits direct assessments on employer-sponsored health plans.

The purposes of this Issue Brief are to outline ERISA's purposes and analytical framework[3] and to examine ERISA implications for various financing mechanisms that states might use to finance individual insurance market risk-spreading initiatives. Although there has been relatively little ERISA litigation challenging state insurance risk adjustment mechanisms, most court decisions have upheld state taxation of insurers and health care providers for this purpose. This paper does not discuss the policy wisdom of the various financing approaches. Detailed information about state high risk pools, including their financing mechanisms and an outline of their policy advantages and disadvantages, is available from other sources.[4]

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ERISA Background and Purpose

ERISA was enacted by Congress to remedy pension plan fraud and mismanagement, but it applies to other types of private employer- or union-sponsored "welfare benefit programs," including health coverage.[5] Although states can generally regulate in areas touched by federal law as long as state law does not directly conflict with federal law, ERISA contains a broad preemption clause providing that ERISA supercedes state laws that "relate to any employee benefit plan." This preemption provision contains several exceptions, including one for state laws regulating insurance. But ERISA also explicitly provides that states may not consider an employer-sponsored plan to be an insurer. Consequently, states cannot directly regulate *employer-sponsored health plans* but can regulate *health insurers* that sell products to employer plans. These provisions lead to the distinction between "self-insured" employer plans, which bear their own insurance risk and which states cannot regulate at all, and "insured" employer plans, over which states can exert influence by regulating the insurers selling policies to those plans. Nevertheless, both types of plans are "ERISA plans."

Congress constructed ERISA's preemption clause very broadly, prohibiting states from regulating even in areas where federal law was silent. Its objective was to facilitate the administration of nationally uniform employee benefit plans by avoiding the "threat" of states enacting conflicting and inconsistent laws.

Analytical Framework of ERISA's Preemption Clause

Federal courts, which interpret ERISA's preemption clause, use a two-step framework in deciding whether ERISA preempts a state law. First, they examine whether the state law "relates to" ERISA (i.e., private employer-sponsored) plans. If so, they explore whether the state law is "saved" because it regulates insurance. Courts will hold that a state law relates to ERISA plans if it: 1) directly refers to ERISA plans (for example, by imposing obligations on them or treating them differently or by using the ERISA plan's benefits as a way to calculate other benefits[6]); 2) regulates the same areas as ERISA (such as reporting, disclosure, or remedies); 3) regulates an ERISA plan's benefits, structure, or administration; or 4) imposes substantial costs on ERISA plans.

The courts have interpreted ERISA's preemption clause very broadly to preempt state laws with only an indirect impact on private-sector employer-sponsored plans. Yet several cases in recent years (including the Supreme Court's 1995 *Travelers Insurance* and 1997 *De Buono* decisions) have narrowed the sweep of ERISA preemption.[7] These and other recent ERISA cases make clear that ERISA does not preempt all types of state health care legislation, but it does prohibit state laws directly aimed at private-sector employer-sponsored plans. Still, the impact of ERISA preemption on many types of state health care access initiatives remains unclear because the courts have decided so few directly relevant cases.

If a court holds that a state law relates to ERISA plans, it then must decide whether the law regulates insurance. A state law may regulate insurance if it is generally directed at the insurance industry and it regulates activities that: 1) spread risk across a broad population; 2) integrally involve the relationship between the insurer and insured persons; and/or 3) are limited to entities in the insurance industry.[8] In 1999 the Supreme Court held that a state law need not meet all three of these latter criteria, but the Court did not clarify which criteria must be met.[9]

ERISA Implications for State Individual Insurance Access Financing Strategies

States can use various financing strategies to fund the costs of high risk pools in excess of subscriber premiums or reallocate the costs of excess insurer risks. These strategies include insurer assessments/taxes, health care provider taxes, and other more general revenue sources. While many of these strategies present no ERISA problem, some may raise ERISA preemption issues.

Prohibited Assessments

Despite recent cases narrowing the reach of ERISA's preemption provisions, states cannot directly tax private employer-sponsored plans. This is clear from several older cases[10] and entirely consistent with language in the Supreme Court's *Travelers Insurance* opinion that ERISA preempts any state financial assessment or administrative obligation directed at ERISA (private-sector employer-sponsored) plans. For example, as discussed below, Louisiana's risk pool tax applying to self-insured employer-sponsored plans was held to be preempted.[11]

Potential Revenue Sources

Several types of strategies to spread risk in the individual insurance market are unlikely to run afoul of ERISA. A few states use general revenues, including general fund taxes or earmarked assessments from tobacco taxes or lottery funds, to support their high risk pools. Other states allow insurers to credit risk pool assessments against income or other state tax liabilities, an indirect means to finance risk pool costs from general revenues (to the extent that the assessed insurers have taxable income). Regardless of their cost impact on ERISA plans, such generally applicable laws (that do not single out ERISA plans) should not raise ERISA preemption issues.[12]

Provider Taxes

The *Travelers Insurance* case and several

federal court decisions following it[13] provide strong precedent for taxing health care providers to finance health insurance for high risk individuals, even though the incidence of the tax may fall on ERISA plans and other health care purchasers (as long as ERISA plans are not singled out or treated differently).[14] In 1997, Minnesota used a portion of its two-percent tax on hospitals and other health care providers to fund its high risk pool; this tax had previously been upheld against an ERISA challenge.[15]

On the other hand, a federal district court in Louisiana held that ERISA preempted the state's high risk pool assessment, which explicitly attempted to require self-insured plans (as well as insurers and patients) to pay a tax on hospital and ambulatory surgery services.[16] Because this case preceded *Travelers Insurance* (which involved a different but analogous method of redistributing the health insurance costs of high risk people[17]), however, it is not sound precedent for challenging a state provider tax that *does not* single out ERISA plans. A state should be able to defend against an ERISA challenge a generally applicable provider tax, regardless of its cost impact on ERISA plans.[18]

Insurer Taxes

The states use various insurance assessment approaches to defray the cost of high risk pools or reallocate the excess costs of guaranteed issue for high risk individual insurance subscribers. Most states assess such costs on the basis of the premium revenues generated by all insurers doing business in the state, but a few states base the assessment on amounts of claims paid or the number of covered lives. The assessment amounts can be capped or open-ended and can be assessed at the end of the risk pool's budget year or prospectively.[19]

ERISA's insurance regulation "savings clause" has been interpreted to authorize states to regulate insurers. In non-ERISA cases the Supreme Court has included taxation as one of the state's traditional insurance regulation functions.[20] A federal district court held that ERISA did not preempt New York's system of redistributing the excess costs of high-cost subscribers in the individual insurance market as part of its guaranteed issue and community rating laws.[21] The Court held that the law did not relate to ERISA plans because although the law was likely to raise the plans' costs, these effects were indirect. Even if the court had held that the assessment relates to ERISA plans, however, this redistribution process would undoubtedly have been held to be permissible state insurance regulation. Apparently no other state laws imposing risk pool assessments on primary health insurers have been challenged under ERISA.

As the base of traditionally insured health plans has declined, states have wanted to tax other insurers, for example, "stop-loss" or "excess loss" insurers that protect self-insured employer-sponsored plans against high total or individual claims costs. There is legal precedent supporting taxation of stop-loss insurers, but the boundaries of state jurisdiction remain unclear because few of these cases have been litigated. It might be argued that some types or amounts of stop-loss insurer taxes affect the self-insured plan itself, which ERISA prohibits. (For example, courts have held that states cannot regulate stop-loss insurers in a way that is designed to influence the underlying self-insured plan, such as by mandating benefits.[22]) But the *Travelers Insurance* decision makes clear that cost impacts alone do not cause preemption.

Wisconsin is one state that taxes the premium income of stop-loss insurers (along with those of regular health insurers) to finance the state's high risk pool. The Seventh Circuit Court of Appeals upheld Wisconsin's law, holding that taxing insurers' stop-loss premiums does not relate to ERISA plans (despite imposing costs on them) because the tax law does not affect the plans' structure or administration.[23] Inasmuch as states appear to be well within their traditional authority to tax an insurer's premiums, this case exemplifies one of the most easily defensible types of stop-loss insurer tax — a tax on the premium income from stop-loss policies.

An older decision by the Ninth Circuit Court of Appeals upheld California's general insurance premium tax on not only the insurers' stop-loss premiums but also the value of the health benefits paid by self-insured plans.[24] The Court held that this tax *does* relate to ERISA plans because it is computed on the basis of the ERISA plan's own payments.[25] But the Court then held that the tax is saved as insurance regulation because it is assessed on the insurer only; the law did not mention ERISA plans even though it affected their costs.[26] Relying on this Ninth Circuit opinion, a federal district court in Oregon subsequently upheld that state's high risk pool assessment against stop-loss insurers.[27] Oregon's tax is based on the number of covered lives insured by both primary health insurers and stop-loss insurers.[28]

The California and Oregon cases are the only decisions involving stop-loss insurer taxation that has been decided under ERISA's insurance savings clause.[29] They suggest that at least states under the jurisdiction of the Ninth Circuit Court of Appeals (Arizona, California, Hawaii, Idaho, Nevada, Oregon, and Washington) may impose a tax based on the claims payments of the self-insured plans that the stop-loss carriers protect. Whether other courts would accept this holding is unclear, but it certainly offers support for narrower types of state taxes on stop-loss insurers that bear part of a self-insured ERISA plan's risk. For example, Washington state has revised its risk pool financing to assess insurers based on the number of covered lives. Stop-loss

insurers are assessed on the basis of 1/10 of the lives in the plans their policies cover. Not only does Washington have the benefit of the Ninth Circuit precedent holding state stop loss insurer taxes to be saved as insurance regulation, the particular calculus in Washington's tax arguably approximates the relative share of insurance risk that stop-loss insurers bear. Thus it is easily defensible as not relating to ERISA plans under the rationale in the Seventh Circuit Wisconsin case.

It may be easier for stop-loss insurers to administer assessments based on premium revenues (routine financial information) rather than on covered lives (which stop-loss insurers might have to identify from their policy holders). But both types of assessment basis are equally defensible under ERISA, as the Wisconsin and Oregon cases demonstrate. While a state law explicitly imposing burdens on ERISA plans (such as reporting to state agencies about their coverage) is likely to be preempted because it relates to ERISA plans, a requirement that *insurers* report revenues or covered lives is within state jurisdiction to regulate the business of insurance and consequently should be exempt from ERISA preemption.

Stop-loss insurer assessments may be hard to enforce if states do not collect complete and accurate data on insurers' stop-loss business. If information on stop-loss business is not routinely reported to state insurance regulators, it may be difficult to know which insurers to assess and how much they owe for this line of business. Wisconsin requires stop-loss insurers to report their stop-loss premiums; other states planning to assess stop-loss insurers should develop similar reporting requirements to identify this line of business.[30]

Third-Party Administrator (TPA) Taxes

It is far less clear whether states can tax TPAs or other organizations that administer ERISA health plans. The Fifth Circuit Court of Appeals struck down a Texas law imposing an administrative service tax on TPAs and other administrators of employer-sponsored health plans. The tax was based on the value of all payments made under the plan and was imposed directly on self-insured health plan sponsors, which challenged the law on ERISA preemption grounds.[31] The court held that the tax related to ERISA plans because of its impact on them and, moreover, that the law was not saved as insurance regulation because ERISA prohibits states from considering ERISA plans to be insurers. While the court's decision seems sound regarding taxing the employer sponsors directly (the specific issue in this case), it might be possible to tax independent organizations that do not sponsor but merely *administer* ERISA plans. But such a tax would need to be a tax of general applicability (such as a general business, gross receipts, or similar tax imposed on many types of businesses or services) that could not reasonably be argued to be directed at ERISA plans. Because TPA's do not bear risk, state laws regulating or taxing them cannot be saved as insurance regulation.[32]

Summary and Conclusion

States have a variety of options to finance the costs of programs to make individual market insurance products more accessible and affordable to people with high risk medical conditions. While states cannot directly tax or regulate self-insured ERISA plans, they can impose several types of taxes that may have an impact on those plans, for example:

- general revenue taxes (even when they raise ERISA plan costs)
- provider taxes (even when they may be passed along to ERISA plans)
- health insurer taxes (on premiums, numbers of covered lives, or other bases)
- stop-loss insurer taxes (on premiums or other bases)
- general business taxes on organizations including TPAs that do business with ERISA plans (as long as TPAs or other administrators are not treated differently from other service providers).

In states other than those within the Ninth Circuit's jurisdiction, it is less clear whether stop-loss insurers can be taxed on the basis of the self-insured plan's claims that they administer (as TPAs) or do not administer (as in the California case).

States can minimize the likelihood of an ERISA suit by drafting their tax laws and other risk-spreading laws to avoid easy challenges. For example, states risk an ERISA challenge if their laws explicitly refer to ERISA plans or self-insured employer plans (as did the Louisiana law invalidated by the district court). Some courts have held that ERISA preempts only laws that refer to ERISA plans and have an impermissible impact on them.[33] Other courts, however, are more literal in their interpretation of this test, holding that ERISA preempts state laws that refer to ERISA plans even when the state law does not impose burdens on ERISA plans but, for example, exempts them from the state law's jurisdiction.[34]

The states' methods for financing risk pools and other risk-spreading strategies by taxing primary health insurers are generally easily defended against an ERISA challenge. But other sources of revenue are available. Based on the holding in *Travelers Insurance*, for example, provider taxes are a secure financing source. Likewise, states can certainly assess stop-loss insurer taxes on premium revenues and other bases, such as the numbers of covered lives. While ERISA implications of a broader tax on stop-loss insurers (like that in California) have not been tested elsewhere, many financing strategies should withstand ERISA challenges, suggesting that many states might safely expand their sources of revenue to fund individual health insurance access initiatives.

Endnotes

1. Communicating for Agriculture. 1999. *Comprehensive Health Insurance for High-Risk Individuals.* Fergus Falls, MN: Communicating for Agriculture.

2. Although it is difficult to quantify precisely the number of employees in self-insured ERISA plans, estimates range from 33 to 50 percent of workers in private employer-sponsored plans. Marquis, S. and S. Long. 1999. "Recent Trends in Self-Insured Employer Health Plans." *Health Affairs* 18(2):161-166; Jensen, G.A. and M.A. Morrisey. 1999. "Employer-Sponsored Health Insurance and Mandated Benefit Laws." *Milbank Quarterly* 77(4): 425-459.

3. A detailed discussion of ERISA's background, court interpretations, and implications for a variety of state health policy initiatives is provided in Butler, P. 2000 *ERISA Preemption Manual for State Health Policy Makers.* Portland, ME: National Academy for State Health Policy and Washington, DC Alpha Center.

4. *Comprehensive Health Insurance for High-Risk Individuals.*

5. Plans operated by churches are exempt from ERISA, as are plans operated by state, local, and the federal governments.

6. *District of Columbia v. Greater Washington Board of Trade,* 506 U.S. 125 (1992).

7. *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.,* 514 U.S. 645 (1995); *De Buono v. NYSA-ILA Medical and Clinical Services Fund,* 520 U.S. 806 (1997).

8. *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 at 740 (1985).

9. *UNUM Life Ins. Co. v. Ward,* 119 S. Ct. 1380 (1999).

10. Courts have held that ERISA preempts state attempts to assess private employer-sponsored plans to fund high risk pools: *Electrical Workers' Welfare Fund v. Markham,* 490 F. Supp. 931 (D. Minn. 1980); *General Split Corp. v. Mitchell,* 523 F. Supp. 427 (D. Wis. 1981). Courts also have held that ERISA preempts other types of state taxes imposed specifically on employer-sponsored benefit plans, *National Carriers Conference Committee v. Heffernan,* 454 F. Supp. 914 (D. Conn. 1978).

11. Louisiana's risk pool law defined "insurance arrangement" as "any plan, program, contract or any other arrangement under which [organizations] provide to their employees or participants ... health care services or benefits other than through an insurer" including a "self-insurer," defined as a person or organization that provides health care services or reimbursement for all or any part of the costs of health care for its employees or participants in this state other than through an insurer." Louisiana Insurance Code, Revised Statutes 22:232 (10) and (17). This law was held preempted in *Bricklayers Local No. 1 v. Louisiana Health Ins. Assoc.,* 771 F. Supp. 771 (E.D. La. 1991).

12. The Sixth Circuit Court of Appeals held that ERISA does not preempt a local income tax, even when it taxes the value of some ERISA plan benefits (employee income contributed to a non-tax-advantaged health care savings account), *Firestone Tire & Rubber Co. v. Neusser,* 810 F. 2d 550 (6th Cir. 1987). The same Court of Appeals later held that ERISA does not preempt a state gross business tax that includes in the taxable assets the value of employee compensation and benefit plans, *Thiokol Corp., Morton Int'l, Inc. v. Roberts,* 76 F. 3d 751 (6th Cir. 1996), cert. denied., 117 S. Ct. 2448.

13. *Boyle v. Anderson,* 68 F.3d 1093 (8th Cir. 1995), *cert. denied,* 516 U.S. 1173 (1996); *New England Health Care Employees Union v. Mount Sinai Hospital,* 65 F.3d 1024 (2d Cir. 1995); *Connecticut Hosp. Assoc. v. Weltman,* 66 F.3d 413 (2d Cir. 1995).

14. The Supreme Court in *Travelers Insurance* did suggest that very high taxes might begin to affect ERISA health plan administration, but even the 24 percent hospital taxes at issue in that case were not viewed as excessive, 514 U.S. at 664.

15. *Boyle v. Anderson.* The Minnesota tax rate is currently 1.5 percent and is not currently used to fund the state's high risk pool.

16. *Bricklayers Local No. 1 v. Louisiana Health Ins. Assoc.* The reference to employer-sponsored self-insured plans in the Louisiana law is cited in endnote 11.

17. To minimize the burden on Blue Cross, which accepted high risk people, New York required insurers other than Blue Cross to pay surcharges on hospital bills.

18. As drafted, the Louisiana law, 22:239, still raises ERISA problems because the legislature designated the provider tax a "mandated benefit," which arguably makes it "relate to" ERISA plans in a way that a general tax does not (see *Metropolitan Life Ins. Co. v. Massachusetts*).

19. *Comprehensive Health Insurance for High-Risk Individuals.*

20. *Prudential Ins. Co. v. Benjamin,* 328 U.S. 408, 429 (1946); *Group Life & Health Ins. Co. v. Royal Drug Co.,* 440 U.S. 205 (1979). These cases involved the McCarran-Ferguson Act's authority for states to regulate insurance, but since the courts apply the McCarran-Ferguson Act analysis in ERISA cases (see *Metropolitan Life Ins. Co. v. Massachusetts*), state tax laws should be viewed as insurance regulation for purposes of ERISA.

21. *N.Y.S. HMO Conference v. Curiale,* 64 F. 3d 794 (2d Cir. 1995), was based on the *Travelers Insurance* rationale. The particulars of New York's law changed in 1996 (Hall, M.A. 2000. "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy & Law* 25(1):71-100) but the redistribution approach should still survive an ERISA challenge.

22. *Brown v. Granatelli,* 897 F.2d 1351 (5th Cir. 1990), *cert. denied,* 498 U.S. 848 (1990). Courts also have held that states cannot define at what point a self-insured plan bears so little risk (due to generous stop-loss coverage) that the plan is no longer self-insured and the stop-loss insurer is a primary health insurer because this type of regulation impermissibly "deems" self-insured ERISA plans to be insurers, American Med. Sec. v. Bartlett, 111 F.3d 358 (4th Cir. 1997), cert. denied, 118 S. Ct. 2340 (1998)). The Fourth Circuit Court of Appeals noted, however, that states can regulate stop-loss insurance policies themselves, arguably including taxing them. For more discussion of state stop-loss carrier regulation, see *ERISA Preemption Manual.*

23. *Safeco Life Ins. Co. v. Musser,* 65 F. 3d 647 (7th Cir. 1995). This case relied on *Travelers Insurance* to hold that the state law did not relate to ERISA plans because it did not regulate health plan structure or administration.

24. *General Motors Corporation v. Cal. State Board of Equalization,* 815 F. 2d 1305 (9th Cir. 1987). The court accepted the California law's definition (earlier upheld by the state supreme court, *Metropolitan Life Ins. Co. v. State Bd. of Equalization,* 186 Cal. Rptr. 578 (Cal. 1982)) of an insurer's "gross premiums" to include the benefits paid out by the self-insured plan as well as premiums collected from it. The reasoning of this case as to why the law relates to ERISA plans is consistent with the Supreme Court's later decision in *Greater Washington Board of Trade.*

25. The case precedes *Travelers Insurance* and so its analysis might be somewhat different today, but because the state tax was calculated based on the ERISA plan's benefits payments, it seems likely that it would still be held to relate to ERISA plans under the general language in *Travelers Insurance* and the specific holding in *Washington Board of Trade.*

26. In this case, the self-insured plans were contractually obligated to pay any taxes imposed on the insurer, but this was not the result of the state tax law and therefore irrelevant to ERISA analysis. The Court also held that the state law did not "deem" self-insured plans to be insurers, in violation of ERISA, because the tax was directed only at licensed stop-loss insurers.

27. *Safeco Life Ins. Co. v. Oregon Medical Insurance Pool,* Civ. No. 920331-MA and 92-512-MA, D. Ore. Sept. 1, 1992.

28. States taxing stop loss carriers on the basis of covered lives, as does Oregon, might want to avoid "double" taxation of insured plans that pay assessments directly and also use stop-loss insurance. For example, Oregon's program requires the stop-loss carriers to report only the number of covered lives covered by stop-loss policies that have not already been reported by primary health insurers.

29. The Supreme Court has never decided an ERISA preemption case involving state insurer taxes.

30. To avoid an argument that a stop-loss insurer reporting requirement unduly burdens ERISA plans (for example, by effectively requiring these plans to report data to their stop-loss insurers), states should consider requiring stop-loss insurers to report to the state information that they routinely collect as part of their stop-loss business operations.

31. *E-Systems, Inc. v. Pogue,* 929 F. 2d 1100 (5th Cir. 1991). The 2.5 percent tax was imposed on individuals and organizations receiving administrative service fees for providing services to "employer-employee, multiple employer-employee, self-insurance group, member," or other health plans, but excluding insured plans otherwise taxed under state insurance law (Texas Insurance Code art. 4.11A section 1).

32. *Insurance Bd. of Bethlehem Steel Corp. v. Muir,* 819 F.2d 408 (3d Cir. 1987); *Powell v. Chesapeake & Potomac Telephone Co. of Va.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 476 U.S. 1170 (1986).

33. The court in *Thiokol Corp., Morton Int'l, Inc.* analyzed this issue in detail and held that a statutory reference to ERISA plans should cause preemption only when the law has a burdensome effect on ERISA plans. The court in *N.Y.S. HMO Conference v. Curiale* held that the reference was irrelevant because the law could be enforced without it. See also, *Washington Physicians Service Assoc. v. Gregoire,* 147 F.3d 1039 (9th Cir. 1998), *cert. denied,* 119 S. Ct. 1033 (1999), where the Ninth Circuit ignored an exemption for ERISA plans in the state's law.

34. In *Mackey v. Lanier Collection Agency,* 486 U.S. 825 (1988), and *Prudential Insurance Co. v. National Park Medical Center,* 154 F.3d 812 (8th Cir. 1998), the state law exemption for ERISA plans caused preemption. In *Greater Washington Board of Trade,* the fact that a workers' compensation law based its requirements on the existence of an employer's health insurance benefit caused preemption because the state workers' compensation calculation was premised on the existence of an ERISA plan.

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