



Empowering and Protecting Consumers: ERISA Thwarts State Innovation

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The national debate over the future of the ACA includes considerable discussion about increasing consumer engagement, in part by expanding the use of health savings accounts and high deductible health plans as strategies to provide consumers more choices and to reduce health care costs. These policy objectives require accurate, available, comprehensive and consumer-friendly information. “Transparency” is often the watchword in these discussions, but there are serious questions about how consumers, policymakers, purchasers, and payers will access the information necessary for consumer-driven policies to work.

States have pursued an array of policies to improve transparency in health care for consumers, regulators, and purchasers. These health care transparency measures include: building price transparency tools using data from state all-payer claims databases (APCDs), increasing provider network transparency, curbing surprise medical bills from out-of-network providers that were not disclosed to the patient, and requiring pharmacy benefit managers to report drug markups and pricing methodologies.

While transparency laws are not a silver bullet to reign in health care costs, they are necessary components for consumer protection and for states to understand their own health care markets. Despite robust and valuable state innovation in health care transparency, the federal Employee Retirement Income Security Act (ERISA) often prevents these state laws from benefitting a growing preponderance of health care consumers. More than [60 percent](#) of all workers with private, employer-based health insurance are in self-funded plans and these plans are beyond the reach of state law, accountable only to the federal Department of Labor, which administers ERISA. Without that data, transparency efforts are, at best, incomplete.

How ERISA Thwarts State Health Care Transparency Efforts

All-Payer Claims Databases. State [APCDs](#) are the foundation of the most robust tools for health care price- and quality- transparency.¹ APCDs collect provider-specific data on the notoriously opaque *amounts paid* by various payers, as opposed to the *amounts charged*, which are less meaningful to consumers. APCDs aim to promote transparency as a [cost-containment tool](#), while managing the risks of collusion and price increases from unfettered price transparency.

In 2016, however, the Supreme Court dealt a substantial blow to state APCDs in [Gobeille v. Liberty Mutual Ins. Co.](#), holding that ERISA preempts Vermont’s APCD reporting law with respect to private, self-funded employee health plans.² The Court [reasoned](#) that “preemption is necessary to prevent States from imposing novel, inconsistent and burdensome reporting requirements” on ERISA plans, favoring instead a “single uniform national scheme for the administration of ERISA plans.”³ As a result, state health care transparency efforts built on APCDs could be missing information about a large segment of privately insured individuals.

State APCDs have recently addressed the issue of burden to self-funded plans by creating a [common data layout](#), assuring consistent data reporting across the states. But without action from the federal government (either Department of Labor or Congress), states will still be unable to mandate cost data from private, self-funded employer plans. Today states are providing price and quality information to consumers through easily accessible websites that provide searchable, statewide comparison tools about costs of procedures, by insurer. [Maine](#) and [New Hampshire](#)'s consumer tools were recently [cited](#) by Consumer Reports for effectively providing the kind of information consumers need to be informed purchasers. Unfortunately, the *Gobeille* decision undercuts the utility of these price transparency tools by limiting them to providing only partial data.

Provider Network Transparency & Surprise Medical Bills. A similar dynamic impedes states' efforts to improve the transparency of provider networks and limit surprise medical bills. [Surprise medical bills](#) are the charges that arise when an insured patient involuntarily and inadvertently receives care from an out-of-network provider, which often occurs when the facility is in-network, but physicians are not. Several states have enacted laws to increase the transparency and [accuracy of provider network directories](#), which are important to consumers as provider networks continue to narrow. A [few states](#), including California, Connecticut, Florida, and New York, go further to shield patients from surprise bills, through a combination of disclosure and consent, limits on charges, dispute resolution mechanisms, and requirements that plans protect patients from having to pay additional costs for surprise bills.⁴ Several more states are considering similar legislation. Despite these promising developments, ERISA preempts provisions of provider network transparency and surprise billing laws that impose requirements on self-funded ERISA plans.

Drug Price Transparency from PBMs. As prescription drug prices soar, states are pursuing policies to shine a light on the factors contributing to consumers' drug costs, including markups and rebates for pharmacy benefit managers (PBMs) and others along the pharmaceutical supply chain.⁵ However, because PBMs may administer drug benefits for self-funded employee health plans, the familiar ERISA preemption argument arises, and the Eighth Circuit recently struck down Iowa's drug pricing transparency law as applied to PBMs acting as third-party administrators for ERISA plans.⁶ Citing *Gobeille*, the court reasoned that a state law requiring disclosure from PBMs for ERISA plans is preempted because it "intrudes upon a matter central to plan administration and interferes with nationally uniform plan administration."⁷ This significantly limits the state's capacity to address drug pricing.

In sum, after *Gobeille* declared that ERISA preempts state reporting requirements for ERISA plans, including their third-party administrators, all manner of state transparency laws that seek disclosure from health plans are inapplicable to a large and growing segment of the privately insured population.

Overcoming the ERISA Barrier for State Health Care Transparency

The expanding scope of ERISA preemption significantly limits the ability of consumers and purchasers to have all the information they need to be active and effective purchasers. States cannot protect their citizen-consumers and oversee rising health care costs without health care transparency laws that provide information about *all* the payers in the system, not just some. There are a few steps states can take to promote health care transparency on their own. However, for state transparency efforts to achieve their maximal effect, changes are required at the [federal level](#).

What States Can Do to Promote Transparency. States can take steps to avoid ERISA preemption of their health care transparency efforts. The first strategy for states is to promulgate measures that rely upon disclosure and participation from non-ERISA entities, such as health care providers or drug manufacturers. Second, states can continue to require transparency of plans other than self-insured ERISA plans, including fully insured plans, state employee health plans, non-group plans, and Medicaid plans. Third, states can encourage voluntary participation by self-funded ERISA plans by demonstrating to employers and plan sponsors the benefits of transparency for more value-based provision of health care for their members.

State Capacity to Finance Health Reforms. [High risk pools](#) are one strategy being discussed at the federal level to provide health coverage to high cost, high need consumers. Historically, states have financed such pools through assessments on payers. States also use taxes on payers to finance their health care programs, such as Medicaid. A recent court decision held that such assessments on employer-based plans are *not* preempted by ERISA, and that incidental reporting of data pursuant to a tax on health plans would be permitted.⁸ While this Sixth Circuit decision preserves states' ability to levy taxes on payers, including ERISA plans, to finance health programs, groups representing these plans are mounting challenges to see if they can use ERISA preemption to curtail this critical state effort.

A Federal Solution Is Needed. The growing sweep of ERISA preemption means that a federal solution is necessary. A federal solution could take many forms. The Department of Labor and other federal agencies could provide guidance or rulemaking to establish [federal standards](#) on health care transparency applicable to ERISA plans or, better yet, work with states in a [hybrid approach](#). Congress could take steps to open the doors to health care transparency to enable market forces to work and allow states to take responsibility for their health care systems by carving state transparency efforts from ERISA's preemptive reach. Although federal action may be necessary for health care transparency efforts to reach all consumers, such a policy should be crafted to preserve state flexibility and innovation.

Health care transparency is critical as states and consumers are increasingly responsible for their own health care spending. Yet ERISA preemption prevents state transparency measures from reaching a large and growing proportion of their privately insured citizens. States will continue to be the sources of innovation and legislative reforms in health care, but a federal solution is needed to overcome the barriers to transparency posed by ERISA.

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Endnotes

1. See CO Medical Price Compare, <https://www.comedprice.org/#/home>; COMPAREMAINE: HEALTH COSTS & QUALITY, <http://www.comparemaine.org/>; *Health Costs for Consumer*, N.H. HEALTHCOST, <http://nhhealthcost.nh.gov/health-costs-consumers>; OREGON HOSPITAL GUIDE, <http://oregonhospitalguide.org/>.
2. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936 (2016). The ruling does not affect the ability of states to require data from public self-funded plans, such as state employee health plans.
3. *Gobeille*, 136 S. Ct. at 945, 947.
4. N.Y. Ins. Law § 3241(c); N.Y. Fin. Servs. Law Art. 6. Conn. Gen. Stat. 38a-591a; § 20-7f. A Cal. Health & Safety Code § 1371.71; Cal. Ins. Code § 10112.82; Fla. Stat. § 627.64194; Tex. Ins. Code Ann. § 1467.051.
5. Ameet Sarpatwari, Jerry Avorn, Aaron Kesselheim. *State Initiatives to control medication costs—can transparency legislation help?* 374 *New Engl. J. Med.* 2301 (2016).
6. *Pharm. Care Mgmt. Ass'n v. Gerhart*, ___ F.3d ___ (8th Cir. 2017).
7. *Gerhart*, ___ F.3d at *5. In two separate pre-*Gobeille* cases, courts concluded that state drug price disclosure laws applicable to PBMs were not preempted by ERISA. The D.C. Circuit held that the DC's drug price transparency and "pass-back" laws were not preempted by ERISA, but only because they were voluntary/waivable for the ERISA plan sponsor and therefore did not burden plan administration. *Pharm. Care Mgmt. Ass'n v. D.C.*, 613 F.3d 179 (D.C. Cir. 2010). The First Circuit has held that Maine's drug pricing disclosure laws, though mandatory for PBMs, was not preempted by ERISA because reporting requirements imposed on PBMs did not affect the freedom of ERISA plan sponsors to administer their plans. *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005).
8. See *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549 (6th Cir. 2016), cert. denied, No. 16-593, 2017 WL 69264 (U.S. Jan. 9, 2017).

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