No. 13-10349

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

Ralph T. Hudgens, in high official capacity as Georgia Insurance and Safety Fire Commissioner,
Defendant-Appellant,
v.
America's Health Insurance Plans,
Plaintiff-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA

BRIEF OF AMICI CURIAE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AND THE GEORGIA CHAMBER OF COMMERCE IN SUPPORT OF AFFIRMANCE

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America's Health Insurance Plans v. Hudgens

Docket No. 13-10349-FF

CERTIFICATE OF INTERESTED PARTIES AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, neither *Amicus Curiae* the Chamber of Commerce of the United States of America nor *Amicus Curiae* the Georgia Chamber of Commerce has a parent corporation, and no publicly held corporation owns 10% or more of their stock.

In addition to persons and entities listed in the certificates filed by Defendant-Appellant, Plaintiff-Appellee, and other *amici*, the undersigned counsel certifies, pursuant to 11th Cir. R. 26.1-1, that the following additional persons and entities have an interest in the outcome of this appeal.

1. Chamber of Commerce of the United States of America, *amicus curiae*
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STATEMENT OF THE ISSUE

Whether the district court correctly held that the Insurance Delivery Enhancement Act of 2011 ("IDEA") is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq*. ("ERISA").

INTEREST OF THE AMICI[1]

The Chamber of Commerce of the United States of America (the "U.S. Chamber") is the world's largest business federation, representing 300,000 direct members and indirectly representing the interests of three million businesses and professional organizations of every size, in every industry sector, and from every region of the country. The U.S. Chamber regularly advocates on issues of vital concern to the business community, and has frequently participated as *amicus curiae* before this Court and numerous others, including the United States Supreme Court. A majority of the U.S. Chamber's members provide health benefits for their employees.

The Georgia Chamber of Commerce (the "Georgia Chamber," and together with the U.S. Chamber, the "Chamber *Amici*") serves the unified interests of its thousands of members – including small businesses and Fortune 500 corporations

[1] All parties have consented to the filing of this brief *amici curiae*. *See* Fed. R. App. Pro. 29(a). This brief was not authored in whole or in part by any party's counsel, and no entity or person, aside from *amici*, their members, and their counsel, made any monetary contribution intended to fund the preparation or submission of this brief. *See* Fed. R. App. Pro. 29(c)(5).

– that employ millions of Georgians in a diverse range of industries across all 159 counties of the state. A particularly important function of the Georgia Chamber is to advocate for its members. In this case, that advocacy is against IDEA, which undermines Georgia's ability to attract and maintain successful businesses. The Georgia Chamber has long opposed attempts to weaken the mandate of uniformity in the administration of employee benefits contained in ERISA – a position that is born from members' experience with ERISA's reduction of the administrative burdens that would otherwise arise from trying to create and maintain employee benefit plans that comply with the fluid laws and regulations of all fifty states.

The availability and cost of health care in this country is a matter of critical national importance. Some 149 million Americans receive their health benefits through their employment, which is the leading source of health benefits for nonelderly people. Over 60% of employers offer health benefits to their workers, and a majority of American workers receive these benefits from self-funded plans, the type of plan at issue in this case. As a consequence, employers have an enormous interest in the regulation of employee health benefits, and particularly those provided through self-funded plans.

This case involves an issue that is crucial to employers: whether a state can impose unique time limitations (and associated fines and penalties) on self-funded plans for processing and paying claims, over and above – and different from –

those required by ERISA, the federal law that governs all employee benefit plans. The answer to this question will have far-reaching consequences for all sponsors of self-funded plans, including many members of these *amici*, as well as their employees. The Chamber *Amici* file this brief *amici curiae* to aid the Court in its understanding of the nature of self-funded health benefit plans, the importance of the question to be decided, and the deleterious impact that a reversal of the district court's decision could have on employers that sponsor self-funded plans and their employees.

SUMMARY OF ARGUMENT

A majority of workers with employer-provided health benefits are in self-funded plans that cover employees in many different states. It is critical that these plans remain free from state regulation in order to continuing providing employees with efficient, cost-effective coverage.

ERISA preempts state laws, like IDEA, that frustrate Congress's goal of uniformity in plan administration. To require self-funded plans to comply with a multitude of different, and conflicting, rules governing the processing and payment of benefit claims would result in gross inefficiencies and increased administrative costs. These increased costs, in turn, would lead to reduced health benefits for employees, which is the very result Congress intended to avoid in enacting ERISA's express preemption provision.

ARGUMENT[2]

I. Preservation of National Uniformity for Self-Funded Health Care Plans Is Crucial to Their Continued Viability.

There are two main kinds of plans that employers use to provide health benefits to their employees: insured plans and self-funded (or self-insured) plans. A company with an insured health plan ordinarily enters into a contract with a health insurance company for a fixed cost; the employer pays the price of that coverage, with the employees sometimes sharing the cost through premiums deducted from their pay. The insurance company processes the employees' health care claims, using its own assets to pay claims covered by the plan, minus any annual deductibles and co-payments owed by the employees. The insurance company bears the ultimate risk that the magnitude of covered claims will exceed the fixed cost.

In self-insured plans, by contrast, the employer pays covered health care claims from its own assets.[3] As with insured plans, employees may share the cost through premiums deducted from their pay, and the employer may impose deductibles and co-payments, but the employer, rather than an insurance company,

[2] The reasons why the district court's decision is correct are explained in detail in the Brief for Appellee. All defined terms used by Appellee are used in this brief with the same meanings.

[3] Some self-funded plans are only partially self-insured – the employer may limit its exposure by purchasing stop-loss or excess-loss insurance to protect the employer against very large claims.

bears the ultimate financial risk with regard to the health care claims incurred by its employees.

Employers with self-insured health plans often contract with third parties – called third-party administrators ("TPAs") – to perform various administrative duties for the plan, such as processing and paying claims and keeping records. Employers pay TPAs for these services through administrative fees; thus, the employers still bear the costs of administering these plans even though they are outsourcing certain plan administration functions to TPAs.

Some TPAs are also health insurance companies; others are solely in the business of serving as third party administrators and do not offer insurance. Occasionally, employers with self-funded plans perform the administrative duties themselves – typically through a plan committee composed of employees of the company. But, for most companies with a self-funded plan, it is more efficient to have a TPA administer the plan than it is to devote company employees and resources to claims processing and other administrative tasks that have nothing to do with the company's core business. Because TPAs allow these companies to focus on their core businesses, it is critically important that the same nationwide standards under ERISA—and the same protections from state regulation, through preemption doctrines—apply to TPAs as are applied to the underlying plans themselves. Application of consistent standards and preemption principles to self-

funded plans *and* their TPAs therefore serves ERISA's goals by ensuring consistent application of company policies to employees nationwide, and by allowing these plans to choose whether to process claims themselves or to hire a TPA to perform these administrative functions.

Regardless of who administers the plan, a self-funded plan must be implemented and administered in accordance with the employer's policies and procedures, as reflected in the plan. For self-insured plans, those policies typically are plan-specific, depending on that employer's needs, and they often are designed to apply uniformly to employees in multiple states. Thus, the rules applied by TPAs for a particular self-funded plan may be different from the policies and procedures used by the TPA for other plans, particularly as compared to insured plans that may be subject to a particular state's insurance laws.

Participants in both insured and self-funded plans often assign to their health care providers the right to make a claim for payment directly to the insurance company (in an insured plan) or to the TPA or plan committee (in a self-funded plan). Alternatively, the employee may pay the health care provider himself, and then submit the claim to the insurance company, TPA, or plan committee. In either case, before a claim is paid, it must be processed. Each claim is different and can require a range of determinations before any payments are made, including: whether the patient is a *bona fide* participant or beneficiary in the plan (which may

require the TPA to obtain information about dates of employment and the like from the employer plan sponsor), whether the plan covers the medical procedures for the patient's condition (which may require application of the plan's terms, plus consideration of clinical factors for a particular condition or treatment), and the amount the plan will pay for a covered medical procedure (which may also require analysis of plan provisions).

Under ERISA, an entity or individual who exercises discretion with regard to plan administration is a fiduciary. *See* 29 U.S.C. § 3(21). Exercising discretion as to whether a benefit claim is covered by the plan and is therefore eligible to be paid, and in what amount, is a fiduciary function. Some self-funded plans grant this discretion to the TPA; in other plans, the plan committee retains the discretion to make these decisions, and the TPA has only ministerial authority. Thus, contrary to Appellant's contention, while some TPAs are not fiduciaries, others plainly are.

Self-insured plans have been gaining in popularity. In 1999, only 44% of covered workers were in self-funded plans; today, 60% of employees with health benefits are covered by self-funded plans. Kaiser Family Found., *2012 Annual Survey: Plan Funding*, at 161. The larger a company is, the more likely it is to use a self-funded plan to provide its employees with health benefits. *Id.* at 160, 161. In 2012, 78% of employees who worked for companies with more than 1,000

employees were covered by self-insured plans; that figure rose to 93% of employees who worked for businesses with more than 5,000 employees. *Id.* Most of these large employers are national companies, with employees in many different states.

Employers provide health benefits to their employees through a self-funded plan rather than through an insured plan for a variety of reasons. Chief among these is that a self-funded plan offers an employer more control: more control over the cash flow needed to cover its workers' health costs, more control over its ability to design a health plan to address its own needs and the needs of its workforce, and more control over the plan's administration and overall cost. Employers are able to retain more control over the design and administration of self-funded plans for one principal reason – these plans, unlike insured plans, are not subject to regulation by the states. This dichotomy stems from the fact that, notwithstanding ERISA's broad preemption of state laws, the statute specifically allows states to regulate the business of insurance and, therefore, permits the states indirectly to regulate insured plans. *See* 29 U.S.C. § 1144(b)(2)(A). Self-funded plans, however, may not be deemed insurance companies for this purpose, *see* 29 U.S.C. § 1144(b)(2)(B), and accordingly, are not subject to state regulation.

The uniformity that is available as a result of being free from state regulation is extremely important for large national companies that have employees spread

across the country and could, therefore, be subject to unique, and often conflicting, regulations by numerous different states. Having to tailor employee health benefit programs to comply with a patchwork of regulations on a state-by-state basis would be extremely burdensome and expensive. The employer plan sponsor, as the entity that is ultimately responsible for the plan, would bear these burdens and costs whether states seek to impose these requirements on the plans themselves or on the TPAs that act on behalf of the plans in processing claims. Faced with onerous and costly regulatory requirements flowing from state regulation, many employers could be expected to decrease the benefits they provide to their employees. Others would increase the share of the cost that the employees themselves would bear, and yet others would eliminate employer-provided health care benefits altogether. Consequently, the preservation of the uniformity for self-funded health care plans is crucial to their continued viability.

II. IDEA Is Preempted Because its Direct and Significant Effect on Self-Funded Plans Is Contrary to Core ERISA Objectives.

ERISA's broad preemption provision indicates Congress's intent to establish the regulation of employee welfare benefit plans, such as the self-funded plans at issue in this case, "as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). 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 . . . 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, 142 (1990). "The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995).

To that end, a state law is preempted, and cannot be applied to an ERISA-covered plan if, among other things, it "has an impermissible 'connection with' [such] a plan." *Boggs v. Boggs*, 520 U.S. 833, 841, 860 (1997) (citation omitted). Whether a particular state law has an impermissible connection with ERISA-covered plans is based, in turn, on "the objectives of the ERISA statute" and "the effect of the state law on ERISA plans." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997) (quotation omitted); *see also Boggs*, 520 U.S. at 841 (holding preempted a state law that "operates to frustrate [ERISA's] objectives"); *Morstein v. National Ins. Servs., Inc.*, 93 F.3d 715, 723 (11th Cir. 1996) (noting that a preemption analysis involves evaluating "Congress's purpose for ERISA").

A state law imposing direct, significant, and unique claims processing and payment obligations on self-funded plans and their TPAs, like IDEA in this case, would frustrate several of ERISA's key, interrelated objectives.

First, the law is directly contrary to ERISA's central aim of having a nationally uniform system of administration for covered plans. It has long been recognized that one of Congress's principal goals in enacting ERISA was to establish one overall scheme to deal with covered plans "so that employers would not have to 'administer their plans differently in each State in which they have employees.'" *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (quoting *Shaw v, Delta Airlines, Inc.*, 463 U.S. 85, 105 (1983)); *see also Ingersoll-Rand*, 498 U.S. at 142 (same); *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1140 (11th Cir. 2001) (noting that one of ERISA's "two central goals" is "uniformity in the administration of employee benefit plans"). Requiring a large, national plan to process and pay claims according to state-specific, conflicting time deadlines, for the many different states in which it has employees, would be extremely onerous. This is shown vividly in the district court's recitation of the hodgepodge of widely-varying state prompt pay laws for non-ERISA and insured plans, on the books in 2007:

> Three states, including Georgia, have strict provisions requiring that insurers pay claims in as little as 15 days, while South Carolina stands alone in allowing up to 60 days. However, 18 states and the District of Columbia require that "clean" claims be paid within 30 days, while ten states demand that payment be made within 45 days. Seven states distinguish between electronically submitted claims, which must be paid within 45 days, and paper claims, which must be paid within 30 days. Virginia provides 40 days, and West Virginia allows 40 days upon manual submission of a claim and 30 days on an electronic claim, while Hawaii permits 30 days for paper claims and 15 days for electronic claims. Tennessee provides 30 days for paper claims and 21 days for electronic claims. New Hampshire gives 45 days for a paper claim and 15 days on electronic claims, and Louisiana allows 45 days for in-network claims if submitted within 45 days of rendering service, 60 days for in network claims submitted after 45 days from the time of service, 30 days for out of network claims and 25 days for electronic claims. New Jersey and Rhode Island provide 30 days on paper claims and 40 days on electronic claims. Mississippi provides 25 days on electronic claims and 35 days on paper claims.

(R. 46, at pp. 38-39, n. 25 (citation omitted)). The Commissioner's argument in this case arguably would permit these states to expand their disparate laws to self-funded plans and their TPAs. Thus, to conclude that it would be contrary to ERISA's goal of uniformity in plan administration to subject a self-funded plan to all these different state requirements would, in the words of the district court, be "an understatement." *Id.*

ERISA itself requires that every employee benefit plan include a claims procedure, pursuant to which a participant or beneficiary must be notified if his claim for benefits has been denied, and afforded an opportunity for a full and fair review of the decision by a fiduciary of the plan. 29 U.S.C. § 503. The

Department of Labor has promulgated extensive and detailed regulations under this provision. *See generally* 29 C.F.R. § 2650.503-1. Briefly, these regulations require that every employee benefit plan establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. 29 C.F.R. § 2650.503-1(b). Additional, and more rigorous, requirements apply to the claims procedures of a group health plan. *See* 29 C.F.R. § 2650.503-1(c). Generally, if a health benefit claim is denied, these ERISA regulations require that the plan provide notice of the denial within thirty days of receiving the claim, a time period that can be extended for an additional fifteen days under specified circumstances. *See* 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).[4] Claimants must be provided at least 180 days thereafter within which to appeal an adverse decision, 29 C.F.R. § 2560.503-1(h)(3)(i), and the plan must then issue a decision, generally within sixty days of receiving the appeal, a time period that can be extended for an additional sixty days under specified circumstances. 29 C.F.R. § 2560.503-1(i)(2)(iii).

If each state were permitted to overlay these detailed and comprehensive *federal* procedures with its own unique and very different state claims processing requirements, the administrative burden on self-insured plans would increase

[4] Much shorter time periods apply in certain circumstances, *e.g.*, in the case of a "pre-service claim," 29 C.F.R. § 2560.3-1(f)(2)(iii)(A), or an "urgent care claim," 29 C.F.R. § 2560.3-1(f)(2)(i).

tremendously, in direct contravention of ERISA's goals. ***For each individual claim that it receives***, the TPA (or plan committee) would have to, among other things: (1) identify which state the affected employee or dependent resides, where the plan or employer is located, and/or where the medical services were rendered, as well as applicable choice-of-law rules—all of which may be necessary just to determine which state's rules apply to a claim under a nationwide plan; (2) determine whether the applicable state has a deadline or other rules for processing and paying the claim; (3) identify the specific requirements for that particular state and that specific claim (*e.g.*, what triggers the relevant deadlines, whether the claim was submitted electronically or by paper, whether the health care provider was in-network or out-of-network, all of which could impact the relevant timelines); (4) take all necessary steps to ensure that it processes that claim within the state's deadline, which could require allocating additional resources, or moving a claim ahead in the queue of claims to be processed from various states; and (5) calculate applicable interest payments (which likely would also vary by state) for claims that are deemed untimely under that state's rules. Clearly, allowing states to impose their own individual time deadlines for processing claims on self-insured plans runs directly counter to the ERISA-central goal of giving plans the benefit of "nationally uniform plan administration." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 148 (2001).

Imposing these significant administrative burdens on plans is also contrary to a second, related goal of ERISA: to keep plan administration efficient and cost-effective. "Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators . . . . " *Egelhoff*, 532 U.S. at 149-50 (alterations in original); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) (noting that one goal of ERISA preemption is to avoid the inefficiencies stemming from "require[ing] plan providers to design their programs in an environment of differing state regulations"); *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2d Cir. 2006) (noting that ERISA preemption aimed to "minimize[] the administrative and financial burdens of complying with conflicting directives from the states").

Allowing individual states to impose unique claims processing requirements on self-insured plans that operate in many different states would lead to obvious inefficiencies. Instead of having in place one uniform system that applies to all claims, such as a rule by which a TPA processes claims in the order in which they are received, the administrator would have to set up a complicated system to keep track of the various states' requirements, when a claim was received and in what form, and when it needs to be processed and paid. Indeed, to comply with these time limits, a TPA might have to interrupt its processing of one claim – not subject

to a state deadline or subject to a longer one – in order to prioritize another claim that is subject to an earlier deadline. The resulting inefficiencies would not only greatly increase costs to the detriment of both employer and employees, but could also unfairly prejudice those employees who reside in states without prompt pay laws, or that have such laws but allow more time to process claims, because their reimbursement claims could be subject to additional delays as TPAs work to meet the deadlines mandated by states that have strict prompt payment laws.

Employers have a finite amount of money to cover employment costs. The increased expense of providing employee health benefits due to the additional cost of complying with different states' claims processing requirements will result in reductions in other employment costs, such as lower wages, reduced pension benefits, or, more likely, decreased health benefits. And some employers may decide not to offer health benefits to its employees at all. This all flies in the face of ERISA's most basic goal: "to protect . . . the interests of employees and other beneficiaries of employee benefit plans." *Morstein*, 93 F.3d at 724 (citing *Shaw*, 463 U.S. at 90). In fact, the probability that the imposition of a hodgepodge of state regulations on plans would cause a reduction in employee benefits in the long run was a main reason why Congress included ERISA's preemption provision in the first place:

> In enacting this [preemption] provision, Congress sought principally to address concerns that lack of uniformity and the administrative and financial burdens of compliance with conflicting state laws might work to the detriment of plan beneficiaries, and reduce the willingness of employer to adopt such plans, or lead to a reduction in the level of benefits furnished.

Plumbing Indus. Bd. v. E.W. Howell Co, Inc., 126 F.3d 61, 66 (2d Cir. 1997); *see also Fort Halifax*, 482 U.S. at 11 (noting that subjecting a plan to regulation by the states "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them"). In short, Congress intended to preempt state laws that would divert money now being used to cover employee benefits to pay for additional administrative costs necessary to comply with those laws.

CONCLUSION

Allowing states to impose their own unique time deadlines for claims processing on self-funded ERISA plans would lead to gross inefficiencies, increased costs, and reduced benefits for employees. These are the very results Congress sought to avoid when it included in the statute the broad preemption provision. The district court's decision should be affirmed.

Dated: April 29, 2013

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify, pursuant to Fed. R. App. P. 32(a)(7)(C), that this Brief of *Amici Curiae* the Chamber of Commerce of the United States of America and the George Chamber of Commerce complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B)(i) because it contains 4,056 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman font.

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