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MEMORANDUM

TO: Marcia Salkin

FROM: Robert H. Myers, Jr.
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DATE: April 29, 2005

SUBJECT: ERISA Preemption of State Laws Relating to Employee Benefit Plans

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I. INTRODUCTION AND SUMMARY

Just over 30 years ago, Congress enacted the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq., with the purpose of creating a uniform federal scheme governing the operation and administration of private employee benefit plans. One of Congress's principal goals in enacting ERISA was to encourage the formation and maintenance of employee benefit plans by avoiding a "multiplicity of regulation" and "conflict... in law" between state and federal regulatory systems. *National Conference of Blue Cross-Blue Shield Plans v. Travelers Ins. Co*, 514 U.S. 645, 656-57 (1995) (citation omitted). In so doing, Congress sought to "minimiz[e] the administrative and financial burdens" on unions and employers sponsoring benefit plans, recognizing that such burdens ultimately would be borne by beneficiaries. *Englehoff v. Englehoff*, 532 U.S. 141, 149-50 (2001).

In enacting ERISA Congress was "acutely aware" that in a voluntary system of employee benefits, the cost of financing benefit plans is "an important factor in determining whether they will be adopted." Remarks by Sen. Nelson, 120 *Cong. Rec.* 29,952, 29,953 (1974). For this reason, Congress sought to avoid a "patch-work scheme of regulation [that] would introduce considerable inefficiencies in benefit program operation... ." *Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987). Congress recognized that if it did not address regulatory inefficiencies, they would lead to increased costs for plans and a corresponding reduction in benefits—or no benefits at all. *Id.*

Consistent with the goal of establishing uniform national standards for private employee benefit plans, Congress included in ERISA a broad preemption of state laws regulating such plans. Thus, ERISA states that it preempts any state law that "relates to" a private employee benefit plan. Congress, however, also included in ERISA a "savings clause" that shields state laws regulating insurance, banking, and securities from preemption. The interaction between ERISA's general preemption clause and the savings clause causes the scope of ERISA's preemptive force to vary drastically depending on whether an employee benefit plan is self-insured[1] or provides benefits through the purchase of insurance.

With respect to self-insured plans, the courts have recognized an extremely broad preemption of state law under ERISA. Subject to fairly narrow legal limitations, self-insured, private employee benefit plans are generally considered exempt from state regulation. Thus, for example, a state may not mandate that private, self-insured employee benefit plans include certain types of benefits or that such plans offer beneficiaries the right to a third-party "external review" of benefit decisions. The broad scope of ERISA's preemption is the same regardless of whether the plan is sponsored by a private employer or a union or established under collective bargaining agreements negotiated between unions and employers.

Employee benefit plans that finance benefits through commercial insurance are treated very differently. Applying ERISA's "savings clause," the courts have consistently recognized the authority of states to regulate such plans indirectly, but nonetheless extensively, by regulating the commercial insurance they rely upon. There seems to be very little that a state cannot require of such plans by regulating the plan's insurer. For example, it is well established that a state may require insured employee benefit plans to provide mandated health benefits simply by requiring any insurer offering group coverage to include specified benefits in the offered coverage. Similarly, the Supreme Court has upheld the authority of the states to require HMOs providing employee benefits to guarantee the right to third-party "external review" for all benefit determinations.

Attached to this memo is a chart describing the types of laws typically adopted by the states to regulate group health insurance. These laws place an indirect but substantial burden on insured employee benefit plans, even to the point of defining the types of benefits they must offer. All of these laws either have been upheld by the courts or would likely be upheld if they were challenged on the basis of ERISA preemption.

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[1] Self-insured plans sometimes are referred to as "self-funded" plans.

There is, however, at least one significant limitation on state authority over insured employee benefit plans. The Supreme Court has held that ERISA's civil enforcement provisions constitute the exclusive legal remedy where a beneficiary of an employee benefit plan seeks to bring suit based on wrongful denial of benefits. Although the cases involving this circumstance have involved self-insured plans, the Supreme Court has stated that this preemption applies regardless of whether the benefits are self-insured or insured.

ERISA establishes special rules regarding the application of state law to multiple employer welfare arrangements ("MEWAs"). Generally speaking, the states are free to regulate self-insured MEWAs the same way they regulate licensed, commercial insurance companies. In addition, states may regulate MEWAs that provide benefits through the purchase of insurance indirectly through the regulation of commercial insurers, just as they do with other insured employee benefit plans. States also are permitted to exercise direct regulation over certain aspects of insured MEWAs.

II. SCOPE OF ERISA

ERISA applies to "employee benefit plans," which includes pension, health, and other benefit plans established by private-sector employers and employee organizations such as unions. 29 U.S.C. § 1003(a). Certain types of plans providing benefits for employees are expressly excluded from regulation under ERISA. These include plans established by federal, state, or local governmental entities and plans established by churches. *See* 29 U.S.C. § 1003(b).[2] Because such plans are excluded from ERISA's scope, ERISA does not preempt state laws regulating them.

ERISA applies to employee benefit plans regardless of whether they are self-insured by the sponsor or provide benefits through the purchase of commercial insurance. Thus, even if a plan provides benefits solely through a state-licensed insurer or HMO, it is fully subject to the federal requirements established by ERISA. Although the federal regulatory scheme established by ERISA applies equally to self-insured and insured plans, the distinction between self-insured and insured becomes critical in determining ERISA's preemptive effect on state law.

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[2] Plans maintained solely to comply with applicable workers' compensation, unemployment compensation, and disability insurance laws, plans maintained outside the United States primarily for the benefit of non-resident aliens, and excess benefit plans as defined in 29 U.S.C. 1002(36) also are not covered by ERISA. 29 U.S.C. 1003(b).

III. PREEMPTION OF STATE LAW

As discussed above, one of Congress's primary goals in enacting ERISA was to establish uniform national standards for private employee benefit plans. In keeping with this objective, Congress included in ERISA a broad preemption of state and local laws regulating such plans. Thus, ERISA states that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan... ." 29 U.S.C. § 1144(a).[3] This broad preemptive language, however, is substantially limited by a "savings clause" that shields certain types of state laws from preemption. The savings clause states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A).[4]

The tension between the "antiphonal" clauses of ERISA's preemption provision has been the subject of considerable litigation over the years. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364 (2002). The result has been radically different outcomes regarding the scope of federal preemption as it applies to self-insured employee benefit plans versus plans that provide benefits through commercial insurance.

The discussion below regarding self-insured and insured employee benefit plans deals with single-employer plans, union plans, and certain multi-employer plans established under collective bargaining agreements. It does not apply to MEWAs, which are subject to special rules permitting the states to regulate these plans directly. MEWAs are discussed in a separate section below. Multi-employer plans established pursuant to collective bargaining agreements, which are commonly referred to as "Taft-Hartley" plans, are not considered MEWAs. 29 U.S.C. § 1002(40)(A)(i).

A. Self-Insured Plans

With respect to self-insured ERISA plans, the principal issue to be decided in determining whether a state law is preempted by ERISA is whether the law "relates to" employee benefit plans. In making this determination, the Supreme Court has held that ERISA should be interpreted to preempt not only state laws dealing with subjects specifically covered by ERISA—e.g., financial reporting, disclosure, and fiduciary

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[3] The term "State laws" includes all state and local laws, decisions, rules, regulations and other actions having the effect of law. 29 U.S.C. § 1144(c). Thus, ERISA's preemptive force applies to all state and local laws. For ease of reference, this memo refers to state and local law collectively as "state law."

[4] ERISA's preemption provision also contains a "deemer" clause that forbids states from regulating self-insured plans by deeming them to be insurers. 29 U.S.C. § 1144(b)(2)(B).

duties—but more broadly any state law that "has a connection with or reference to..." an employee benefit plan. *Shaw v. Delta Airlines* 463 U.S. 85, 96-98 (1983).

Applying *Shaw* and later Supreme Court cases in the same vein, the courts have given an expansive reading to the "relates to" language found in ERISA's preemption provision. Thus, for example, ERISA preempts state laws:

- Mandating that private, self-insured plans include certain health benefits;[5]
- Requiring third-party "external review" of benefit decisions made by private, self-insured plan;[6]
- Establishing the legal remedies available to beneficiaries who seeks to contest benefit determinations made by private, self-insured plans;[7]
- Establishing financial standards for private, self-insured plans;[8]
- Directly taxing private, self-insured plans.[9]

The broad scope of ERISA's preemption provision means that most, if not all, state laws regulating insurance would likely be preempted if a state were to attempt to apply such laws to private, self-insured plans. An outline of the types of laws typically adopted by states to regulate insurance is attached to this memorandum. All of these laws would likely be preempted if they were applied to private, self-insured employee benefit plans.

Notwithstanding the broad application given to ERISA's preemption clause, the Supreme Court has recognized certain limits on its scope. In the landmark case *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Court examined a New York state law that required hospitals to collect a surcharge from patients covered by commercial insurers and that imposed a hospital surcharge on certain HMOs. Although the state law at issue in *Travelers* involved insured employee benefit plans, the decision is important to self-insured plans because it

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[5] *See, e.g., Children's Hospital .v Whitcomb,* 778 F.2d 239 (5th Cir. 1985) (state law requiring that mental illness benefits be equal to physical illness benefits in employee benefit plans is preempted by ERISA insofar as it relates to self-insured plans). *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (recognizing that state law mandating minimum mental health benefits in insurance contracts "relates to" employee benefit plans and would be preempted by ERISA if not for the insurance saving clause).

[6] *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. at 372 n. 6 9 (noting that Illinois' external review law would not be saved from preemption to the extent it applied to self-insured plans).

[7] *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004).

[8] *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

[9] *Id.*

defines the limits of the "relates to" language contained in ERISA's preemption provision.

In *Travelers*, a group of insurers brought suit against the state of New York on behalf of the employee benefit plans they administered, claiming that the state law was preempted because it impermissibly "related to" employee benefit plans by driving up the cost of benefits. The Supreme Court rejected this argument, holding that the surcharges did not bear the requisite "connection with" ERISA plans to trigger preemption. 514 U.S. at 662. The Court found that the law requiring the surcharges had "only an indirect effect on the relative cost of various health insurance packages" available to employee benefits plans, and did not impose substantive coverage requirements on plans, as was the case in an earlier case in which a state law mandating the coverage of certain benefits was found to "relate to" employee benefit plans. 514 U.S. at 664.[10] The Court concluded that nothing in the language of ERISA or the context of its passage indicated that Congress intended to displace laws, like the New York hospital surcharge requirement, that involve general health care regulation. 514 U.S. at 661.

The *Travelers* decision places an outer limit on ERISA's preemption provision, leaving room for state laws of general applicability that have an indirect effect on self-insured plans. Nevertheless, the decision leaves intact the essential breadth of ERISA's preemption of state laws that purport to regulate self-insured plans.

Some lower federal courts have permitted the states to regulate self-insured employee benefit plans indirectly through the regulation of third-party administrators ("TPAs") that administer such plans. For example, in *Benefax Corp. v. Wright,* 757 F.Supp. 800 (W.D. Ky. 1990), a federal district court in Kentucky held that a state statute requiring TPAs to maintain state licenses and comply with certain financial responsibility standards was not preempted ERISA. More recently, a federal district court in Maine held that ERISA does not preempt a Maine law requiring TPAs and other entities to report certain health care claims information. *Patient Advocates, LLC v. Prysunka*, Civ. No. 03-118-P-H, March 24, 2004. Laws regulating TPAs place an indirect burden on self-insured employee benefit plans by increasing the cost of administrative services. Other courts, however, have struck down such laws as preempted by ERISA. *See, e.g., NGS American, Inc. v. Barnes*, (5th Cir. 1993) (Texas statute regulating TPAs is preempted); *Self-Insurance Institute of America v. Gallagher*, 1989 U.S. Dist. LEXIS 13942 (N.D. Fla. 1989) (Florida statutes imposing administrative requirements on TPAs and regulating their relationship with employee benefit plans are preempted by ERISA).

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[10] That law ultimately was found to be saved from preemption, as it imposed mandated benefits only on insurance. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

In addition, some courts have held that the purchase of stop-loss insurance[11] by an otherwise self-insured employee benefit plan may remove it from the protection of ERISA preemption by bringing the plan within ERISA's insurance savings clause. *See, e.g., Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986). Courts holding this view, however, are a distinct minority. Most courts have held that maintaining stop-loss insurance does not bring an otherwise self-insured plan within the authority of state law. *See, e.g., American Medical Security v. Bartlett*, 111 F.3d 358 (4th Cir. 1997), *cert. denied*, 524 U.S. 936 (1998); *Travelers Ins. v. Cuomo*, 14 F.3d 708 (2d Cir. 1993), *rev'd in part*, 514 U.S. 645 (1995); *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986); *Minnesota Chamber of Commerce & Industry v. Hatch*, 672 F.Supp. 393 (D. Minn. 1987).

B. Insured Plans

ERISA's savings clause creates a safe harbor under which any state law "which regulates insurance" is exempt from preemption. 29 U.S.C. 1144(b)(2)(A). Although the particulars of the legal test applied by the Supreme Court in determining whether a law falls within the savings clause have evolved over time, the Court has consistently found that state laws regulating insurance are exempt from preemption, even when such laws substantially affect employee benefit plans that provide benefits through insurance.

Under the Court's current test for determining whether a state law is saved from preemption, a law must satisfy two requirements to fall within the saving clause. First, the law must be "specifically directed towards entities engaged in insurance." *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2002) (citations omitted). Second, the law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* Under this test and an earlier form of analysis employed by the Supreme Court,[12] the states have been permitted to regulate insured employee benefit

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[11] Stop-loss insurance is excess insurance purchased to cover losses incurred by a plan above a specified level.

[12] The current test is a refinement of an earlier test employed by the Court that involved examining three factors in determining whether a law came within the insurance savings clause. These factors, which were described as "guideposts" rather than hard-and-fast criteria, were articulated as follows: First, whether the practice regulated by the law "has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." 538 U.S. at 339-41. In *Miller* the Court expressly abandoned this test in favor of the current approach because it had led to confusion and inconsistency among the lower courts. 538 U.S. at 342.

plans extensively by regulating their insurance benefits. For example, under ERISA case law, states either can or likely can:

- Require insurers and HMOs to include certain mandated benefits in the plans they offer to employers and unions;[13]
- Require insurers and HMOs to make available third-party "external review" for insureds who wish to contest a benefit determination;[14]
- Tax and assess the insurance premiums paid by employers and unions sponsoring insured plans;
- Regulate the rates paid by employers for insurance so as to force the spreading of risk among small employers.
- Define the terms under which insured plans must accept individuals for coverage.
- Require plans to pay for temporary "continuation" coverage for employees who leave or are terminated and, indirectly, subsidize permanent "conversion" coverage for employees who leave or are terminated and wish to maintain coverage on an individual basis.[15]

This is just a partial list of the types of state regulation of insurance purchased by employee benefit plans that either has been upheld by the courts or would likely be upheld if the law were ever challenged. The description of typical state insurance laws attached to this memo provides a more comprehensive view of regulation in this area. All of the laws included in the chart would likely survive an ERISA preemption challenge.

C. ERISA's Civil Enforcement Provisions

The Supreme Court has recognized certain limitations on the scope of ERISA's insurance savings clause. Even if a state law regulates insurance, it may nonetheless be preempted by ERISA if conflicts with ERISA's exclusive civil enforcement provisions. In *Pilot Life Ins. Co v. Dedeaux*, 481 U.S. 41 (1987), the Supreme Court held that ERISA preempted a Mississippi law that authorized certain legal remedies against the administrator of an employee benefit plan for the improper denial of a claim for benefits. The Court first found that the state law in question did not "regulate insurance" so as to come within the insurance savings clause. 481 U.S. at 51. Yet the Court did not base its decision solely on this finding. The Court also found that the Mississippi law conflicted with the detailed civil enforcement scheme established by ERISA. 481 U.S. at 57. The Court found that Congress intended ERISA's enforcement scheme to be the exclusive

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[13] *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

[14] *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

[15] *See, e.g., Cuttle v. Federal Employees Metal Trades Council*,623 F. Supp. 1154 (D. Me. 1985).

means by which beneficiaries could seek redress for improper denial of benefits under an employee benefit plan. On this ground and the separate ground that the law did not regulate insurance, the Court found that the law was preempted by ERISA. *Id.*[16]

The Supreme Court recently reaffirmed its holding in *Pilot Life*. In *Aetna Health, Inc. v. Davila*, 124 S.Ct. 2488 (2004), the Court examined a Texas law authorizing beneficiaries to bring suit in state court to obtain damages for wrongful denial of benefits under an employee benefit plan. As with the state law at issue in *Pilot Life*, the Court found that the Texas statute was preempted by ERISA's civil enforcement provisions, which establish the exclusive remedies for beneficiaries seeking to contest a benefit determination by an employee benefit plan. 124 S.Ct. at 2502. In reaching this conclusion, the Court expressly noted that "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 124 S.Ct. at 2500.

D. MEWAs

ERISA establishes a special rule under which the states are permitted to apply their insurance laws to self-insured MEWAs. Thus, unlike other self-insured employee benefit plans, a self-insured MEWA is fully subject to state law. In addition, the states are permitted to regulate some aspects of MEWAs that purchase commercial insurance. This latter authority is in addition to the general authority of the states to regulate insured MEWAs indirectly by regulating the insurance they purchase.

A MEWA is an employee health benefit plan established by two or more unrelated employers. 29 U.S.C. § 1002(40).[17] Like other benefit plans, a MEWA may be self-insured or it may provide benefits through insurance purchased through a commercial insurer.

In the case of self-insured MEWAs, ERISA provides that the states may apply their insurance laws to such plans, so long as the state laws so applied are not inconsistent with the requirements generally imposed on employee benefit plans by ERISA. 29 U.S.C. § 1144(b)(6)(A)(ii). In effect, this means that the states may regulate self-insured MEWAs as if they were commercial insurers. *See Atlantic Health Care Trust v. Googins*, 2 F.3d 1, 5 (2d Cir. 1993), *cert. denied*, 510 U.S. 1043 (1994). The

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[16] *Accord Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990).

[17] A few limited types of plans are excluded from the definition of a MEWA and therefore not subject to ERISA's special rules for such plans—for example, as discussed above, a multi-employer plan established under a collective bargaining agreement is not a MEWA. 29 U.S.C. § 1002(40)(A)(i). A plans maintained by two or more employers under common control also is not a MEWA. 29 U.S.C. § 1002(40)(B)(i).

only limitation on this authority is that the states may not create requirements for self-insured MEWAs that directly conflict with ERISA's requirements for employee benefit plans. For example, a state could not establish a requirement for a self-insured MEWA that would cause fiduciaries of the plan to violate their fiduciary duties under ERISA. A state could, however, require a self-insured MEWA to comply with claims processing standards that are more stringent than, but otherwise consistent with, ERISA's claim processing requirements.

In the case of MEWAs that purchase commercial insurance, the states may regulate such plans indirectly the same way they regulate other employee benefit plans that purchase insurance. As discussed above, this type of regulation, though indirect, may be extensive in scope and practical effect. In addition, to the extent that an insured MEWA is "fully insured"—i.e., funds benefits solely through commercial insurance—the states may apply their insurance laws directly to the plan to require the plan to maintain specified levels of reserves and collect specified contributions. 29 U.S.C. § 1144(b)(6)(A)(i). ERISA provides that the Department of Labor may grant fully insured MEWAs a special exemption from direct state regulation. 29 U.S.C. § 1144(b)(6)(B). To date, the Department has never granted such an exemption.

Representative State Laws Affecting Employer Health Insurance

Type of State Regulation	Explanation
Advertising	Advertisements for health coverage must conform to certain requirements for form and content. Advertising materials must be submitted to regulators for review and approval prior to use.
Any willing provider	Requires health plans* with "preferred provider" networks to accept any doctor, hospital, or other health care provider into the network if the provider is willing to abide by the terms of participation. Limits the ability of health plans to negotiate provider discounts by promising a certain volume of patients in return for lower fees.
Continuation coverage	Health plans must offer temporary "continuation" coverage to employees who are terminated or leave their job ("mini COBRA").
Conversion coverage	Health plans must offer employees who are terminated or leave their job the opportunity to purchase "conversion" coverage on an individual basis and may not charge more than a certain amount above what the employee paid for group coverage.
Coordination of benefits	Health plans must "coordinate benefits"—i.e., determine which plan will pay in the case of overlapping coverage—according to certain rules establishing priority.
Discontinuance and replacement	When an employer discontinues coverage with one health plan and replaces it with coverage from another, the former plan and the present plan must cover employees and their dependents according to certain rules.

* The term "health plans" refers to health insurers, HMOs and other state-licensed providers health coverage.

Type of State Regulation	Explanation
External review	Health plans must give members the right to third party review of determinations regarding whether a benefit is medically necessary or appropriate.
Financial requirements	
Accounting standards	Health plans must follow statutory accounting rules.
Custodial accounts	Health plans must maintain certain custodial accounts for monies held in a fiduciary capacity.
Financial examination	Health plans must submit to examination for financial solvency by state regulators.
Financial reporting	Health plans must provide annual and quarterly financial reports to regulators.
Investments	Health plans may invest only in certain types of investments.
Material transaction disclosure and approval	Health plans must disclose certain "material transactions" and may need to obtain regulatory approval.
Minimum capital and surplus	Health plans must maintain certain minimum amounts of unimpaired capital.
Reserves	Health plans must maintain and provide actuarial certification of cash reserves to pay anticipated claims.
Statutory deposits	Health plans must maintain certain statutory deposits of cash or securities to be held by regulators for the benefit of policyholders in case of failure to pay claims.
Fraud	Health plans that become aware of provider or policyholder fraud must report such activity to the department of insurance. Health plans also may be required to implement anti-fraud programs.

Type of State Regulation	Explanation
Internal grievance procedures	Health plans must maintain internal procedures for resolving member grievances, including contested benefit determinations.
Issuance and renewal of coverage	
Guaranteed issue	Health plans offering coverage to small employers (2-50 employees) must accept all small employers who apply.†
Preexisting conditions and portability	Generally, health plans may not exclude coverage for preexisting conditions for more than 12 months. Prior, continuous "creditable coverage" must be credited toward and reduce any preexisting condition exclusion period.†
Guaranteed renewal	Coverage may not be terminated except for nonpayment of premiums or certain other reasons.†
Licensing	Health plans must be licensed by state regulators.
Mandated benefits	Health plans must include certain mandated health care benefits in all coverage offered to employer groups. For example, health plans may be required to cover experimental cancer treatments.
Mandated providers	Health plan must permit covered services to be performed by certain types of health care providers—for example, chiropractors.
Market conduct examinations	Health plans must submit to, and pay for, onsite examinations by regulators for compliance with state law requirements.

† Federal law—i.e., HIPAA—requires this, but states may impose more stringent requirements.

Type of State Regulation	Explanation
Network standards	Health plans with "preferred provider" networks must conform to certain standards regarding the types, geographical distribution, qualifications, and availability of providers in the network.
Premium rate regulation	
Prior review and approval of premium rates	Premium rates must be filed with the department of insurance and receive approval before they may be used.
Rate restrictions	Premium rates for small employers (2-50 employees) may be based only on certain demographic factors of group members, such as age and gender, to a limited extent, health factors. Variation in rates from employer to employer based on health status of the group is limited.
Limitations on renewal rates	Premium rate for any small employer group may be increased only by a certain amount upon renewal.
Minimum loss ratio	For small employer coverage, the ratio of benefit payments to administrative expenses, including profit, may not be less than a certain minimum.
Privacy	Health plans must maintain the privacy of customer information, must provide annual privacy notices, may disclose personal information only in certain circumstances, and must give customers the right to access their information and request modification of inaccurate or incomplete information.‡

‡ The HIPAA Privacy Rule also requires this, but states may adopt more stringent measures.

Type of State Regulation	Explanation
Prompt payment of claims	Health plans must pay "clean claims" with in a certain period of time.
Security	Health plans must maintain a written information security program.‡
Taxes and assessments	
Premium tax	Insurers must pay annual state premium taxes.
Guaranty fund assessments	Insurers must pay assessments levied by the state life and health guaranty fund in case of insurer insolvency.
High-risk pool assessments	Health plans must pay annual assessments to fund state high-risk pool, which provides coverage for individuals who cannot obtain private coverage.
Unfair Trade Practices	Health plans must not engage in certain "unfair trade practices," which include misrepresentations or dissemination of misleading material, unfair competition, making false statements to public officials, permitting unfair discrimination, giving certain rebates, failing to maintain adequate business records, and engaging in unfair complaint handling.
Utilization review	Health plans must conform to certain standards for benefit determinations involving medical necessity and appropriateness of care, including the adoption of utilization review procedures, contracting requirements, requirements for clinical standards, procedures for appealing benefit determinations, and prior authorization of emergency services.

‡ The HIPAA Privacy Rule also requires this, but states may adopt more stringent measures.