Whereas, The Employee Retirement Income Security Act (ERISA) of 1974 was initially intended as a protection for workers’ pension plans with employer-based health plans a secondary late add-on; and

Whereas, When ERISA was first implemented, a very low percentage of the population was covered by employer-based health plans, but today employer-based health insurance is the single largest segment of the U.S. health insurance market; and

Whereas, The provisions of ERISA protect the majority of employer-based health care plans from state level regulation and legal proceedings at the state level; and

Whereas, Although ERISA requires plans to establish a grievance and appeals process for participants to get benefits from their plans and gives participants the right to sue for benefits and breaches of fiduciary duty, contending against care decisions under employer-based health plans has such severe restrictions in the scope and penalties for mismanaged care in retrospect that most attorneys are not qualified to take on such cases; and

Whereas, Actions against ERISA-protected employer-based health care plans cannot be brought in state courts but must be brought in special federal courts; and

Whereas, ERISA-protected plans may only be sued for actual monetary damages and not pain or suffering, nor loss of wages etc.; and

Whereas, After initial filing against an ERISA-protected plan, new information is not admissible going forward; and

Whereas, In the past, suits against ERISA-protected plans largely failed, with one such decision at the United States Supreme Court evoking a dissenting opinion by Justice Ruth Bader Ginsberg, who stated that this was an unfair law and a bad law because it restricts individual rights excessively and should be replaced by a better law, states, many attorneys and even the AMA shied away from attempting to eliminate or change ERISA; and

Whereas, Justice Ginsberg said ERISA is a “candidate for the most inscrutable legislation Congress ever passed” in a 2004 Supreme Court case that held that negligence claims against employer-sponsored health plans are preempted by ERISA, suggesting that congressional action amending ERISA may be the only mechanism available to provide patients with adequate compensation for damages incurred as a result of coverage decisions made by employer-sponsored health plans; and
Whereas, In December 2020, *Rutledge v. PCMA* determined that ERISA does not prevent states from enacting laws regulating the abuse of payment practices of pharmacy benefit managers (PBMs), the middlemen that manage prescription drug benefits for health insurers, Medicare Part D drug plans, and large employers. The suit was brought by the Attorney General of Arkansas defending a state law in that regard and, among others, the American Medical Association filed an amicus curae brief. The Court rejected the argument that ERISA made simple enforcement mechanism “impermissible” because PBMs administered benefits on behalf of ERISA plans. Justice Sotomayor explained however that the enforcement mechanisms “do not require ERISA plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies” of PBMs; and

Whereas, There is now an argument that may weaken the total protection ERISA plans have had in the state arena, and if so, may open ERISA plans to more substantive scrutiny at the state level that could lead to limiting abuses of some of those plans, improving healthcare and patient rights; and

Whereas, the prevailing tide in some federal legislative circles is that the federal government should leave more jurisdiction to the states, leaving open the possibility that ERISA itself could be substantially amended at this time; therefore be it

Resolved, That our American Medical Association study the implication of the Supreme Court decision in *Rutledge v. PCMA*, and any other relevant legal decisions of the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 when the quality of care or healthcare outcomes are questioned, reporting back to the House of Delegates by I-24 (Directive to Take Action); and be it further

Resolved, That our AMA review the contemporary political temperament and consider renewing efforts to amend The Employee Retirement Income Security Act of 1974 to allow for more patient rights in actions to redress adverse healthcare decisions, including allowing states more rights to regulate employer-sponsored health plans currently shielded by ERISA (Directive to Take Action).

Fiscal Note: TBD

Received: 10/1/2023

References:


RELEVANT AMA POLICY

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.


ERISA and Managed Care Oversight D-383.984

Our AMA will develop, propose, and actively support (1) federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; (2) federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and (3) federal and state legislation prohibiting "all products" clauses or linking participation in one product to participation in other products ("tied") administered or offered by third party payers or their affiliates.

Citation: Res 915, I-06; Reaffirmed: Res. 223, I-10; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: BOT Rep. 9, A-22
ERISA Preemption and State Prompt Pay Laws D-385.984

(1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws.

(2) Our AMA Advocacy Resource Center disseminate information to the Federation regarding the issue of Employee Retirement Income Security Act preemption and state prompt pay laws, including specific guidance for drafting legislation to best avoid preemption.

(3) Our AMA continue to seek legal avenues for advancing the case against ERISA preemption of state prompt pay laws.

(4) Our AMA monitor developments with regard to implementation of the U.S. Department of Labor claims processing regulation and provide information to the federation on any significant developments.

Citation: BOT Rep. 16, I-02; Reaffirmed: A-10; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: A-14; Reaffirmed in lieu of: Res. 235, A-17

ERISA and Health Plan Related Legislation D-190.996

Our AMA will continue to urge state medical associations to undertake surveys of their members regarding payment delays by health plans so that physicians will be aware of plans that are delaying payment and that may be financially weak.

Citation: BOT Rep. 7, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

ERISA Plans and the United States Department of Labor D-385.973

1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.

2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor.

Citation: Res. 213, A-07; Reaffirmed: A-10; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: A-14; Reaffirmed in lieu of: Res. 235, A-17
Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975

Our AMA:

(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;

(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;

(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.

(4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;

(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and

(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

Citation: Sub. Res. 805, I-95; Appended: Res. 117, A-98; Reaffirmed: A-99; Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00; Reaffirmed: I-01; Reaffirmed and Appended: Res. 704, A-03; Reaffirmed: I-04; Reaffirmed: A-08; Reaffirmed: A-08; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: A-14