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CHIROPRACTIC FUTURE STRATEGIC PLAN

May 23, 2025

Formal Comments to the U.S. Department of Justice
Re: Misuse of ERISA to Enable Anticompetitive Practices
Submitted by Chiropractic Future

I. Introduction

Chiropractic Future, a not-for-profit advocacy group advancing healthcare through collaboration, improved patient access, and equitable policy, respectfully submits these comments in response to the U.S. Department of Justice Anticompetitive Regulations Task Force's request for information on laws and regulations that create anticompetitive conditions in healthcare markets. We commend the Department's initiative in addressing this important issue.

Chiropractic Future asserts that insurers and administrators of self-funded employer-sponsored health plans are increasingly and erroneously asserting that ERISA fully supersedes all state regulation of the health care provider-health network relationship. Health plans have used this unsupported argument to suppress provider competition, insulate discriminatory benefit designs, and deny patients access to lower-cost, conservative care. We urge the Task Force to examine the impact of this practice. We believe the result is a distorted healthcare marketplace where certain provider types, including chiropractors, are systematically disadvantaged, despite licensure and clinical efficacy, as we detail below.

II. Anticompetitive Practices Enabled by ERISA Preemption

In general, federal law overrides conflicting state law. However, where federal law is silent, states may legislate. Additionally, when a state law contains requirements more stringent than a federal law, state law will take priority.

ERISA was intended to regulate the relationship between employees and their employers and employer health plans. However, we believe ERISA was not designed to regulate the relationship between health care providers and health care networks or insurers. ERISA's broad preemption clause (29 U.S.C. § 1144(a)) was intended to protect uniformity in plan administration, but it leaves to the states the regulation of the business of insurance. Thus, state legislatures have enacted laws to protect health plan members (patients) and health care providers (who have little or no negotiating power with the network) in their contractual relationship with health networks.

However, many insurers and third-party administrators (TPAs) now exploit the ERISA preemption provision to avoid state-level protections of chiropractors and their patients, thereby:

- Reimbursing chiropractors at substantially lower rates for identical services,
- Imposing arbitrary visit caps and benefit exclusions,
- Denying coverage for services explicitly allowed under state scope-of-practice laws,
- Recouping payments retroactively, even when errors are insurer-caused,
- Using offsets from unrelated claim payments to unilaterally recover disputed payments.

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Insurers and third-party administrators argue that these tactics are protected from state oversight solely by virtue of ERISA preemption, not because they serve beneficiaries. This creates systemic market distortion, consolidates insurer power, and narrows patient provider choice.

III. Anticompetitive Effects on Provider Markets and Consumer Access

Insurers are leveraging ERISA preemption not to fulfill fiduciary responsibilities, but to shield benefit design strategies that entrench anticompetitive market control. Under 29 U.S.C. § 1104(a)(1), ERISA fiduciaries are required to act "solely in the interest of the participants and beneficiaries" and "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use." Rather than meeting this standard, insurers assert ERISA preemption to circumvent state-level competition rules, sidestep enforcement of due process protections, and apply discriminatory plan structures that favor dominant provider types.

These practices impose economic and competitive penalties on disfavored provider classes, most notably chiropractors, and burden patients with higher out-of-pocket costs, narrower provider access, and delayed or denied care. The cumulative effect distorts the provider marketplace and inappropriately prioritizes insurer control over competition, innovation, and value.

A. Competitive Suppression Through Structural Exclusion

By inappropriately invoking ERISA to preempt state fair-pay laws and scope-of-practice protections, insurers construct plan structures that suppress chiropractic participation through arbitrary caps, exclusions, and reimbursement disparities. These design features are not based on medical necessity, cost-efficiency, or patient outcomes; instead, they reflect administrative preferences that consolidate market power among select provider types.

Such actions are inconsistent with ERISA fiduciary obligations. As emphasized in Varity Corp. v. Howe, 516 U.S. 489 (1996), fiduciaries must act with undivided loyalty toward beneficiaries. Discriminatory tiering based on licensure, without legitimate justification, undermines the diversity and availability of lower-cost care alternatives and insulates incumbent providers from meaningful competition.

B. Asymmetric Enforcement via Recoupments and Offsets

Insurers sometimes assert ERISA preemption to justify taking back claim payments years after they are paid, often contrary to their fiduciary duty to plan beneficiaries, even when the overpayment resulted from the insurer's own administrative error. These recoupments often occur outside state-imposed timeframes and without appeal rights, shifting all financial responsibility to the provider who, despite having provided a valuable service years earlier, is now forced to attempt collection from the plan beneficiary. Equally egregious are "cross-plan offsets," where insurers unilaterally take back money from providers out of wholly unrelated future claim payments to the provider

The Department of Labor has warned against such practices, noting in its October 2023 enforcement action against EmblemHealth that using assets from one plan to resolve issues in another violates plan fiduciaries' duties. Courts have also emphasized that fiduciaries must act with prudence and fairness under prevailing circumstances (Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)).

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By overreaching their administrative discretion and recoupment authority, under the guise of preemption, insurers suppress non-aligned providers, discourage plan participation, and undermine patient continuity of care—all while sidestepping accountability under the guise of ERISA preemption.

C. Market Foreclosure Through Network and Administrative Barriers

By erecting administrative, financial, and structural barriers to chiropractic participation in networks, insurers restrict competition by eliminating providers that offer high-value, lower-cost care. This results in concentrated market control, where a small number of insurers dictate both pricing and access, contrary to the competitive goals of ERISA-regulated benefit plans and broader antitrust policy.

IV. Legal Context and Misuse of Fiduciary Authority

Insurers increasingly assert fiduciary authority under ERISA not to protect participants, but to rationalize plan design and payment practices that serve their own financial and administrative interests. In this way, insurers misuse fiduciary power as a mechanism to seize control over access and pricing. When preemption is used to block provider participation, deny medically-necessary covered services, or implement self-serving reimbursement practices, fiduciary discretion morphs into a tool of vertical market control.

Importantly, this misuse of preemption runs contrary to the Supreme Court's reasoning in *Rutledge v. Pharmaceutical Care Management Association (PCMA)*, 592 U.S. 80 (2020). There, the Court held that ERISA does not preempt state laws that regulate healthcare costs and access unless such laws directly interfere with plan administration. Additionally, the court signaled concern over this breadth of asserted preemption that allows plans to sidestep otherwise enforceable state laws designed to promote transparency, fairness, and market balance. These assertions stretch ERISA far beyond its role as a shield for uniform plan administration and transform it into a sword for competitive suppression. This contravenes fiduciary standards under 29 U.S.C. § 1104(a)(1) and undermines the Court's clear signal that ERISA is not meant to preclude fair state regulation of provider markets.

These dynamics create a dual-sided distortion of the healthcare market: monopolistic in terms of market control and limiting patient access, and monopsonistic in suppressing provider compensation. By consolidating control under the guise of fiduciary responsibility, insurers not only diminish competition, they also drive systemic cost inflation by displacing lower-cost care options and eliminating price pressure. This exploitation of ERISA's fiduciary structure fundamentally undermines both the statutory purpose of the Act and its competitive neutrality.

V. Recommendations to the Task Force

We urge the Department of Justice to:

1. **Investigate insurer misuse and over-assertion of ERISA preemption** to shield discriminatory benefit structures and suppress participation of lawful provider types, particularly in self-funded employer plans.
2. **Affirm through guidance or a joint DOJ/FTC statement** that health benefit plans that restrict access or suppress reimbursement based solely on provider licensure, absent empirical justification, may constitute anticompetitive conduct under federal law.

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3. **Refer and coordinate with the Department of Labor** to pursue fiduciary enforcement where cross-plan offsets, retroactive recoupments, or exclusionary reimbursement tactics violate 29 U.S.C. § 1104(a)(1), particularly when such practices suppress provider participation, inflate patient costs, and contribute to anticompetitive market conditions that distort price signals and reduce care options.
4. **Support targeted rulemaking** clarifying the limits of ERISA preemption in benefit design and network composition, and establishing clear criteria to prohibit exclusionary practices that suppress provider competition, restrict access to qualified providers, and undermine the duty of undivided loyalty owed to beneficiaries.

VI. Conclusion

This is not a call for special treatment of one provider category. Rather, we call for competitive fairness for all categories of qualified health care providers.

The unchecked use of ERISA preemption to implement discriminatory benefit designs undermines patient choice, inflates costs, and weakens healthcare market diversity. When plan fiduciaries prioritize administrative convenience or financial control over beneficiary welfare, they violate both the intent and obligations of ERISA.

We urge the Department of Justice to address these distortions through investigation, guidance, and enforcement.

Respectfully submitted,
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