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ERISA Pre-emption: Implications for Health Reform and Coverage

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- **ERISA pre-emption of state health insurance regulation**—This *Issue Brief* provides an overview of the issues relating to the Employee Retirement Income Security Act of 1974 (ERISA) and state and local attempts at comprehensive health insurance reform. It reviews the statute and its history, major case law relating to the interaction of ERISA and state law, and the implications of ERISA's pre-emption of state laws governing health insurance. It also presents the latest data on the number of health plan participants in both insured and self-insured ERISA-governed plans, and the trends related to self-insurance.
- **Both federal and state laws govern health benefits**—Under ERISA, the regulation of employment-based health benefit plans has evolved into a system in which both federal and state laws play important roles. As a result of a series of Supreme Court decisions, health benefit plans that purchase coverage from insurance companies are subject to regulation directly at the federal level and indirectly at the state level, while self-insured plans are regulated exclusively at the federal level.
- **Federal pre-emption of state insurance law was deliberate**—Although some argue the original decision by Congress to pre-empt was casually made, historical evidence suggests it was deliberate and essential to the enactment of ERISA.
- **ERISA-covered health plan participants**—EBRI estimates of the Current Population Survey (CPS) indicate that there were 132.8 million persons covered by ERISA plans (both self-insured and fully insured) in 2006. This population includes workers in private-sector firms and their dependents; workers employed in the public sector with health insurance in their own name and dependents of persons employed in the public sector were excluded from the estimate.
- **Self-insured health plans**—Overall, 45 percent of workers were covered by a fully insured health plan and 55 percent were covered by a self-insured health plan. Self-insurance has been growing over the years, but it remains much more prevalent in larger firms. In firms with 5,000 or more employees, 89 percent of workers were covered by self-insured arrangements in 2006, up from 62 percent in 1999.
- **Massachusetts and California cases**—Massachusetts has implemented a comprehensive program aimed at insuring all residents of the state, funded in part by mandatory employer contributions. California appears to be moving toward adopting a similar system. So far, neither program has been subject to a court challenge on ERISA pre-emption grounds.
- **"Fair share" laws are being struck down**—Several cases brought in federal court on ERISA pre-emption grounds have resulted in state and local "fair share" laws being overturned. Such laws generally require employers to pay into a state fund if they pay less than a specified percentage of payroll toward health benefits or do not provide health insurance coverage at all. The state of Maryland, Suffolk County, NY, and the city of San Francisco have passed such laws. Federal courts have struck down all of them on ERISA pre-emption grounds, although San Francisco's law has been upheld by the Ninth Circuit Court of Appeals and appears destined for a Supreme Court challenge.

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Introduction

The primary federal law governing employment-based retirement and health benefits in the private sector is the Employee Retirement Income Security Act of 1974, known as ERISA. In drafting the law, Congress initially focused on retirement benefits (hence the “R” in ERISA), but ultimately decided to bring most private-sector health benefit plans under the jurisdiction of ERISA as well.

Among the many complications of ERISA’s application to health benefits (as opposed to retirement benefits) is that insurance products—such as employment-based health insurance—are subject to partial state regulation. To prevent employers from having to deal with a costly and confusing welter of both individual state and national regulation of their health plans (especially for large employers operating in multiple states) Congress included a provision in ERISA that generally “pre-empts” the state regulation of privately insured health benefit plans.

Over the 35 years since its enactment, ERISA has been amended in various ways, and today ERISA is once again central to the health policy debate—in particular, ERISA’s pre-emption provisions. This is not the first time ERISA has been at the center of a health policy debate: In the late 1990s, ERISA was criticized as providing inadequate legal remedies to participants in employment-based health plans. Going back further, the scope of ERISA’s pre-emption of state law was attacked during comprehensive national health insurance reform efforts in the late 1980s and early 1990s.

The debate, this time, focuses on ERISA’s pre-emption of certain provisions in state health care reform plans. Those who want to change ERISA argue that the pre-emption provisions of ERISA prevent state and local governments from regulating employment-based group health plans, thereby preventing comprehensive health insurance reform at the state and local levels. On the other side of the debate, however, are employers who argue that ERISA’s pre-emption is necessary to provide equal benefits to all of their employees regardless of where they work or live. This *Issue Brief* explores the history of how the law was enacted and shaped over time by court decisions, the issues surrounding ERISA’s pre-emption of state law, and the scope of the ERISA-covered population. It also discusses the positive aspects of the law and its effects on health insurance coverage in the United States.

ERISA Overview

Most individuals under age 65 (mostly workers and their families), approximately 162 million, have employment-based health insurance coverage, and a majority of this coverage is provided by private-sector employers (Fronstin, 2007). Because no other nation relies on employment-based coverage to the extent the United States does, the question bears asking: Why is the existing system as successful as it is in covering workers and their families? Many employers, especially large ones, maintain that the answer lies in ERISA’s pre-emption of state law.

ERISA provides a legal framework for the uniform provision of benefits by employers doing business anywhere in the country. This uniformity allows multistate companies that self-insure to offer consistent benefit packages wherever they happen to be located, which results in ease of administration and lower expenses. For self-insured plans, freedom from state benefit mandates (for example, requirements that health insurers cover services provided by certain medical specialties or cover treatments for specific diseases) also allows plan sponsors to design benefit packages that meet the needs and desires of their employees, as well as to effectively promote wellness and control health costs. All plans, both insured and self-insured, benefit from ERISA’s uniform regulations governing plan information, fiduciary standards for persons responsible for plan management, and reporting and disclosure requirements. ERISA pre-emption also provides consistent legal rights and remedies for participating employees and their dependents.

ERISA History

Prior to ERISA's enactment, employee pension and health benefit plans were subject to preferential federal tax treatment along with relatively weak disclosure requirements under the Welfare and Pension Plan Disclosure Act of 1958 (WPPDA). Under WPPDA, there were no civil enforcement provisions or federally enforceable rights to vested benefits. State common law and regulations generally governed where federal law was silent. Although a few self-funded health plans were in existence, mainly in the unionized work force, most employment-based health benefits were provided through insurance contracts, which were regulated by the states.

During the 1950s and 1960s, the lack of legal protections afforded pension plan participants resulted in retirees in some well-publicized cases receiving much smaller retirement benefits (or in some cases no benefits) than what was promised. One of the most significant cases was the bankruptcy of the Studebaker automobile company in the early 1960s, which left thousands of long-tenured workers with only a fraction of their promised pension benefits. The Studebaker collapse led directly to the congressional hearings that culminated in the enactment of ERISA.

Although the security of health and other types of employee benefit plans was clearly not as central as pension funding in its formation, ERISA was drafted to cover *all* employee benefit plans, including health benefits (Employee Benefit Research Institute, 1984; Shay, 1993; Butler, 1994; Gordon, 1993 and 2007). This inclusion was no oversight.

Despite claims that ERISA's broad pre-emption was inadvertent, the official legislative history supports the scope of pre-emption. At least two specific references to broad pre-emption were cited in the *Congressional Record* during the debates preceding its final passage. Rep. John Dent (D-PA) characterized the "reservation to Federal authority the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement" (U.S. Congress, 1974a). Furthermore, Sen. Harrison Williams (D-NJ) said about employee benefit plans: "It should be stressed with narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to pre-empt the field for Federal Regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State and local governments, or any instrumentality thereof, which have the force or effect of law" (U.S. Congress, 1974b).

Because there is not much in ERISA's legislative history specifically enumerating health benefits, valuable perspective can be gained from individuals who helped create it. Michael S. Gordon, who served under the late Sen. Jacob Javits (R-NY) from 1970–1975 as minority counsel for pensions on the Senate Labor and Public Welfare Committee, was a key congressional staff member involved in the drafting and enactment of ERISA. As Gordon discusses in the following excerpt (EBRI, 1993, 2007), the scope of ERISA's pre-emption was determined to a large extent by political considerations of the day.

The fact is that the key legislators involved in enacting ERISA's all-inclusive pre-emption provision did realize and understand its essentially adverse effect on state regulation of health plans. Some of them, like former Sen. Jacob Javits, the foremost architect of ERISA, but also an impassioned advocate of national health insurance, not only knew and understood, but were exceedingly troubled by the implications of ERISA's broad pre-emptive scope.

In order to appreciate what troubled many ERISA legislators, like former Sen. Javits, but which, nonetheless, led to the much criticized pre-emption provision that we confront today, it is necessary to turn the clock briefly back to the situation that existed at the time of the Senate-House conference on ERISA in 1974. The Senate and House passed versions of pre-emption that prevented the states from legislating about the matters regulated by the law. Since, in contrast to the extensive regulation imposed on pension plans, the then-pending legislation imposed only fiduciary and disclosure requirements on health and welfare plans, this meant that states were generally free to legislate content requirements for such plans—

exactly the situation that proponents of state health plan reforms currently regard as preferable.

However, during the ERISA conference, three dramatic instances of state action affecting health and welfare plan development in a potentially injurious way were brought to the attention of the conferees...[t]he three problem areas (not necessarily listed in the order of their importance) were (a) the Monsanto decision, (b) Hawaii's prepaid Health Care Act and California's threatened imitation of that model, and (c) pending state restrictions on prepaid legal services plans.

In the Monsanto decision, a Missouri lower court had held that the Monsanto company's noninsured health plan for its employees, a portion of which was collectively bargained, could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri. Business and organized labor groups objected to the notion that a state could treat such a noninsured health plan trust fund as if it were an insurance company subject to the regulation of commercial insurers under the supervision of the state's insurance commissioner. The case was perceived by them as a prelude to a revenue grab by Missouri so as to rationalize the imposition of a premium tax on employer contributions to noninsured employee benefit trusts. It was also perceived as having the collateral purpose of inducing such trusts to switch their operations to commercial insurers.

Moreover, that segment of the labor movement that operated joint labor-management multi-employer health plans, the so-called Taft-Hartley plans, feared that if the Monsanto decision was embraced by other state courts, it would put the Taft-Hartley plans out of business. After all, what was the point of having a noninsured trust fund if the practical effect was to obliterate the distinction between insured and noninsured plans and treat the latter as if they were for-profit insurance companies? Thus, both business and labor concluded that if the pre-conference version of ERISA's pre-emption clause permitted states to adopt the Monsanto approach, then such a clause had to be modified to short-circuit such a development. Parenthetically, the Monsanto decision was reversed after ERISA's enactment. Similarly, just prior to ERISA's enactment, Hawaii had passed its Prepaid Health Act and California was threatening to do something along the same lines. While Hawaii's labor unions had supported the Hawaii health law, the AFL-CIO feared (as did big business) that a series of state laws with varying health plan requirements would impose impossible compliance burdens on large multistate plans.

Moreover, in the case of collectively bargained plans, allowing states to determine the appropriate health benefits, instead of the collective-bargaining parties, appeared to intrude on a critical federal labor law principle that labor unions had struggled for decades to vindicate. At the time, it was understood that from the perspective of many multistate unions, only a federal program of national health insurance justified the modification of that principle.

The last of the triumvirate of concerns that led to sweeping pre-emption had to do with prepaid legal services plans. A number of labor unions had invested heavily in the establishment of collectively bargained prepaid legal services plans, but there was an acrimonious dispute between the AFL-CIO and American Bar Association over whether the panel of lawyers available to provide their services under these plans should be open or closed. The American Bar Association was lobbying state legislatures to enact laws forbidding the type of legal services plans the AFL-CIO favored, which were closed panels.

Employer-union prepaid legal services plans were a type of welfare plan that fell under ERISA's jurisdiction. However, since the pre-conference version of ERISA would have permitted states to prohibit the AFL-CIO-favored legal services plan, the AFL-CIO insisted on the modification of the pre-emption clause to assure the survival of its approach. In my view, it should be clearly understood that the failure to modify pre-emption to deal with all the concerns I have just described would have resulted in a failure to enact ERISA altogether.

Finally, it is worth noting that Hawaii did not secure a legislative exemption from ERISA pre-emption until 1983. Indeed, the provision granting this exemption contained a warning that other states should not consider this a precedent for future exemption (Gordon, 1993; Mariner, 1992), and there is no procedural language in ERISA that provides an avenue for other states to obtain a waiver or exemption from pre-emption.

Structure of ERISA

ERISA established the federal government as the primary regulator of private-sector employee benefit plans. Most of ERISA's substantive provisions primarily address the private employment-based pension system. The act set financial standards for pension plans, such as the requirement that plan assets be held in trust, fiduciary standards (the "backbone" of ERISA) for plan administrators and service providers, and rules on reporting and disclosure, participation, and vesting. It also provided plan participants with the remedy of recovery of improperly denied benefits plus attorneys' fees. Through ERISA, Congress created the Pension Benefit Guaranty Corporation (PBGC) to insure benefits for "defined benefit" pension plan participants. The act assigned jurisdiction over reporting, disclosure, and fiduciary standards to the Department of Labor's (DOL) Employee Benefits Security Administration, and gave jurisdiction over eligibility, funding, and vesting to the Department of the Treasury.

Despite the fact that most of ERISA's requirements focus on pensions, the framework established in the act applies to *all* employee benefit plans, including health benefit plans and other welfare benefit plans such as disability coverage, group life insurance, etc.

Fiduciary Issues

Fiduciary standards are of primary importance under ERISA's enforcement scheme. Under ERISA, fiduciaries by definition are those persons who exercise control or discretion in the management of plan assets, provide investment advice to a plan, or have discretionary authority in administering a benefit plan. ERISA mandates that a fiduciary's duty is to act in the "sole interest" of plan participants and beneficiaries. Specifically, a fiduciary must act with the "care, skill, prudence, and diligence" of a "prudent man" (Sec. 404(a)(1)(B)). A fiduciary is expected to be familiar with matters pertaining to employee benefit plans; hence, the so-called "prudent man" is actually a "prudent expert" standard for determining proper fiduciary conduct. Fiduciaries are personally liable for any losses to a plan resulting from a breach of fiduciary duty and can be barred from continuing in such capacity if the breach is grossly negligent.

The Savings and Deemer Clauses

ERISA not only sets national standards for employee benefit plans, but, most importantly, pre-empts *all* state laws that "relate to" employee benefit plans (Sec. 514(a)). Within this broad pre-emption, however, the act specifically preserves the states' right to regulate the business of insurance under what is commonly called the "savings" clause (Sec. 514(b)(2)(A)). This clause effectively reinforces the states' authority to regulate insurance under the McCarran-Ferguson Act (1945). Finally, to protect self-insured plans from the full reach of state regulation, ERISA includes another provision commonly called the "deemer" clause (Sec. 514(b)(2)(B)) that prevents states from deeming employee welfare benefit plans to be in the business of insurance.

This language was drafted in the knowledge that some benefit plans purchase coverage from insurance companies while others “self-insure” by paying claims out of their own assets or trust accounts. While ERISA governs plans in both instances, in practice this results in the ability of the states to regulate certain aspects of the insurance products sold to welfare benefit plans, but no ability of the states to directly regulate self-insured arrangements. In essence, with insured plans the states may regulate in areas that are not governed by ERISA—they might require health insurance contracts to offer certain mandated benefits, for example—but ERISA will continue to govern participants’ remedies, reporting, disclosure, and fiduciary requirements. It is this distinction between insured and self-insured plans and the scope of state regulation that can reach them that will be explored in the court cases discussed below.

Key ERISA Supreme Court Cases

Over the years, the Supreme Court has examined the scope of ERISA’s pre-emption in several cases. It should be noted at the outset that this section is intended to provide a brief overview of the cases relating to ERISA pre-emption; it is not intended to be a complete examination of ERISA case law and should not be cited as a legal authority.

- **Shaw v. Delta**—In a key case, *Shaw v. Delta Airlines, Inc.* (463 U.S. 85, 1983), the Supreme Court attempted to define the meaning of the words “relates to” or, in other words, which state laws were pre-empted by ERISA. The Court stated that “relates to” in Sec. 514 of ERISA means “having a connection with or referring to” an employee benefit plan, a sweeping albeit ambiguous standard. Furthermore, the Court noted that the clause was “conspicuous in its breadth.” The Supreme Court in this case did suggest that some state laws that have an impact on an employee benefit plan would not be pre-empted because the impact is “too tenuous, remote, or peripheral,” a point that the court would address again in subsequent cases.
- **DC v. Washington Board of Trade**—In *District of Columbia v. Greater Washington Board of Trade* (506 U.S. 125, 1992), the Supreme Court addressed a workers’ compensation statute, and for guidance turned to the “having a connection with or referring to” language. The law in question would have required any employer that provided health insurance coverage to an employee to continue to provide the existing coverage or its equivalent after the employee had an injury causing a workers’ compensation claim. The Court found the District law was pre-empted under what many observers considered a broad interpretation of the “relates to” language.
- **New York Blue Cross & Blue Shield v. Travelers**—While it appeared for a time that the Court was developing a broad view of ERISA pre-emption, more recent cases indicate a change in direction. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (514 U.S. 645, 1995), the Supreme Court found that the impact of the hospital surcharges imposed by New York state on an employee benefit plan were too attenuated to be pre-empted under ERISA. This case was the first Supreme Court ruling that seemed to narrow the previously broad interpretation of the “relates to” clause, leading some observers to suggest that the states will have more flexibility to impose laws of general applicability even if they have an impact on employee benefit plans, whether self-insured or insured (Liston and Patterson, 1996; U.S. General Accounting Office, 1995).
- **DeBuono v. NYSA-ILA Medical Services**—While *Travelers* helped set some boundaries around the scope of pre-emption, it did not provide a “bright-line” test as to when a state law will be considered “too tenuous, remote, or peripheral” or when it will be pre-empted. Another case that appears to have narrowed the scope of pre-emption is *DeBuono v. NYSA-ILA Medical Services Fund* (520 U.S. 806, 1997). In this case, the Supreme Court held that a New York State gross receipts tax on medical providers applied to a hospital owned and operated by a self-insured ERISA plan, in this case a union-sponsored plan. The court rejected the lower court’s “expansive and literal interpretation” of ERISA pre-emption, holding that the tax was one of general applicability and did not affect ERISA’s objectives.

In both *DeBuono* and *Travelers*, the Court moved from the broad expansive and literal interpretation of ERISA pre-emption to a more narrow view of what Congress’ objectives were when

it passed ERISA. Thus, it appears that if the law in question does not have an explicit reference to an ERISA plan such as in *Greater Washington Board of Trade*, it may not be pre-empted even if the law has an impact on employee benefit plans.

Without an explicit reference to employee benefit plans, the Court appears to be leaning toward using what it describes as the objectives of the ERISA statute as a guide to determine which state laws will survive a pre-emption challenge. In both *Travelers* and *DeBuono*, the Court determined that the laws in question pertained to matters (health and safety) that states typically regulated, and that there is no hint in ERISA's legislative history suggesting that Congress intended to stop states from regulating these types of matters. Consequently, a law of general applicability that imposes burdens of administration on ERISA plans but is not the type of state law that Congress intended ERISA to supersede may survive ERISA pre-emption.

- ***Boggs v. Boggs***—In another Supreme Court case, *Boggs v. Boggs* (117 SCt 1754, 1997), the Court held that ERISA pre-empted Louisiana's community property law. The issue before the Court in *Boggs* was the ability of a deceased wife to leave her interest in her husband's pension to their children. The husband later remarried, and after his death, the children by his first wife brought suit against his second wife who now received his survivor's benefit. The children claimed that their mother had the right to the pension under Louisiana law, and that they should collect under her will. In making its ruling, the Court did not rely on ERISA's statutory language, but rather turned to one of the statute's purposes—to ensure an income stream to a surviving spouse. Because the children's claim under Louisiana's community property law conflicted with ERISA and frustrated its purposes, the law was held to be pre-empted. While at first glance this case might seem to go against the rulings in *Travelers* and *DeBuono*, the circumstances are different because the claim in question was determined to undermine a particular objective of ERISA.
- ***MetLife v. Massachusetts***—In addition to the ambiguities of Sec. 514, the Supreme Court has also had to interpret the "savings" and "deemer" clauses in order to help define the limits of ERISA pre-emption. *Metropolitan Life Insurance v. Massachusetts* (471 U.S. 724, 1985) was the defining case regarding the "savings clause." In this case, the Supreme Court considered a Massachusetts mental health benefit mandate for group health policies. The Court held that the mandate did "relate to" employee benefit plans, but the law regulated the terms of an insurance contract. Consequently, the law was exempt from pre-emption under the savings clause. In coming to this conclusion, the Court used the three-prong test developed in *Union Labor Life Ins. v. Pireno* to determine whether an activity or practice constituted the "business of insurance." The activity in question must spread risk, the relationship between insured and insurer must be an integral part of the activity, and it must be limited to entities in the traditional insurance industry (*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 1982). Under this test, the Court concluded that the Massachusetts mandate and mandated benefits in general met all three criteria. Thus, mandated benefit laws are exempt from pre-emption. In reaching its decision, the Court acknowledged that its ruling created a distinction between plans that are insured and "uninsured" (self-insured), because the deemer clause would immunize an uninsured plan from state-mandated benefit laws.
- ***FMC Corp. v. Holliday***—The Supreme Court specifically ruled on the application of the deemer clause to self-insured ERISA plans in *FMC Corporation v. Holliday* (498 U.S. 52, 1990). This case dealt with the issue of whether a state's "antisubrogation" law was saved from pre-emption as insurance regulation on self-insured plans. The Court stated that the law did come under the savings clause as a law that regulated the "business of insurance," but the Court further ruled that state insurance laws "do not reach self-insured employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." Thus, the Court applied a broad interpretation of the deemer clause, exempting self-insured ERISA plans from direct and indirect state regulation.
- ***Pilot Life v. Dedeaux***—The Supreme Court went on to refine its analysis of the "savings" clause in *Pilot Life Ins. v. Dedeaux* (481 U.S. 41, 1987). In *Pilot Life*, an injured employee who was denied permanent disability benefits under an employee welfare plan sued the insurer of the plan for breach of contract (alleging bad faith) and other state common-law causes of action. In arguments before the

Supreme Court, the plaintiff contended that the bad faith claim under Mississippi law was saved from pre-emption, because it applies to insurance. However, the Court ruled that the Mississippi law of bad faith was not saved from pre-emption based on its reading of the language of the “savings” clause and the overall scheme of ERISA. The Court determined that implicit within the language of the “savings” clause is the requirement that “in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.” Because the bad faith law had general applicability, not specific applicability to the insurance industry, it did not meet the test. As to the overall scheme of ERISA, the Court concluded that the civil enforcement provisions of ERISA were intended to be the “exclusive vehicle for action by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits.” Consequently, the Court found that ERISA’s purpose would be undermined if the savings clause were applied to allow causes of action that might vary from state to state, something Congress explicitly rejected when drafting the statute. Under this interpretation, a state law that does not directly regulate the business of insurance is pre-empted by ERISA for both insured and self-insured plans.

- ***Kentucky Association of Health Plans v. Miller***—The most recent Supreme Court pre-emption case is *Kentucky Association of Health Plans v. Miller* (538 U.S. 329, 2003). At issue in this case was a Kentucky “any willing provider” (AWP) law, which required health insurers and managed care organizations to reimburse all licensed physicians or health professionals as long as they were willing and qualified to participate in the insurer’s network (regardless of whether an insurer actually had a contractual relationship with them). A trade association of health insurers and managed care organizations sued in 1997, claiming the law was pre-empted by ERISA. After the U.S. District Court ruled in favor of the defendants, the plaintiffs appealed. The Sixth Circuit affirmed in a split decision. The majority held that the AWP laws relate to employee benefit plans under ERISA Sec. 514(a), but that Sec. 514(b) saved the law from pre-emption, as it applied only to directly insured plans. The dissent argued that Sec. 514(b) did not apply because the AWP laws were not directed against “insurance” in the ordinary understanding of that term. In essence, under the McCarran-Ferguson Act and the three-prong test articulated in *Pirino*, the law in question did not regulate insurance. Following this ruling, the plaintiffs appealed to the Supreme Court, which upheld the law, stating that it was making a “clean break” from the three-prong test. Under the Court’s holding, a state law is deemed to regulate insurance under Sec. 514(b) if it (1) is specifically directed toward entities engaged in insurance and (2) substantially affects the risk pooling arrangement between the insured and the insurer. The court found that the laws in question met both tests, and were therefore not pre-empted.

In summary, it is clear that ERISA’s pre-emption of state law remains broad, despite the holdings in *Travelers*, *DeBuono*, and *Miller*. As is obvious from this brief overview, the case law has tended to be fact-specific and is subject to continuing evolution.

The Scope of the ERISA-Covered Population

ERISA covers a large portion of Americans with health insurance. However, not all persons with health insurance are covered by the act.

First, ERISA specifically exempts coverage offered by religious organizations (commonly called “church plans”) and coverage offered to employees and dependents by federal, state, and local government employers. Second, ERISA does not apply to the market for individual health insurance coverage; this nongroup market is regulated at the state level. Finally, ERISA does not apply to government-run plans, such as Medicare, Medicaid, or the State Children’s Health Insurance Program (S-CHIP).

Employment-based health benefits remain by far the most common form of health coverage in the United States, consistently covering roughly two-thirds of the nonelderly population, or 161.7 million individuals in 2006 (Figure 1). To get a picture of the ERISA-covered population within this universe,

Figure 1
Nonelderly Population With Selected Sources of Health Insurance Coverage, 1994–2006

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total	229.9	231.9	234.1	236.2	238.6	242.6	244.8	247.5	250.8	252.7	255.1	257.4	260.0
Employment-Based Coverage	148.1	149.7	151.7	156.9	160.4	164.7	167.5	166.1	164.9	162.9	161.0	161.3	161.7
Own name	76.3	76.9	78.0	78.5	80.2	82.2	84.6	84.1	82.5	81.5	81.6	82.3	82.9
Dependent coverage	71.9	72.8	73.7	78.4	80.2	82.4	82.9	82.0	82.4	81.5	79.4	79.0	78.8
Individually Purchased	17.3	16.8	16.8	17.1	16.5	16.4	16.0	16.0	16.6	16.7	18.0	17.9	17.7
Public	39.4	38.8	37.8	35.3	34.6	34.8	35.8	37.9	40.0	42.5	45.1	45.5	45.5
Medicare	3.7	4.1	4.6	4.7	4.8	4.9	5.4	5.6	5.8	6.2	6.3	6.4	6.5
Medicaid	29.1	29.4	28.6	26.4	25.2	25.5	26.2	28.3	29.9	32.4	34.6	34.7	34.9
Tricare/CHAMPVA ^a	8.7	7.5	6.9	6.6	6.9	6.6	6.8	6.6	6.9	6.9	7.4	7.7	7.1
No Health Insurance	36.5	37.3	38.3	38.9	39.4	38.5	38.2	39.5	41.8	43.1	43.0	44.4	46.5
	(millions)												
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Coverage	64.4	64.6	64.8	66.4	67.2	67.9	68.4	67.1	65.7	64.5	63.1	62.7	62.2
Own name	33.2	33.2	33.3	33.2	33.6	33.9	34.6	34.0	32.9	32.2	32.0	32.0	31.9
Dependent coverage	31.3	31.4	31.5	33.2	33.6	34.0	33.8	33.1	32.8	32.2	31.1	30.7	30.3
Individually Purchased	7.5	7.2	7.2	7.2	6.9	6.8	6.5	6.5	6.6	6.6	7.1	7.0	6.8
Public	17.1	16.7	16.2	15.0	14.5	14.3	14.6	15.3	15.9	16.8	17.7	17.7	17.5
Medicare	1.6	1.8	2.0	2.0	2.0	2.0	2.2	2.3	2.3	2.5	2.5	2.5	2.5
Medicaid	12.7	12.7	12.2	11.2	10.6	10.5	10.7	11.4	11.9	12.8	13.6	13.5	13.4
Tricare/CHAMPVA ^a	3.8	3.2	2.9	2.8	2.9	2.7	2.8	2.7	2.8	2.7	2.9	3.0	2.7
No Health Insurance	15.9	16.1	16.4	16.5	16.5	15.9	15.6	16.0	16.6	17.1	16.9	17.2	17.9
	(percentage)												

Source: Employee Benefit Research Institute estimates of the Current Population Survey, March 1995–2007 Supplements.

Note: Details may not add to totals because individuals may receive coverage from more than one source.

^a TRICARE (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Figure 2
Percentage of Workers With Health Insurance in Partially
or Completely Self-Funded Plans, by Firm Size, 1999–2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total	44%	49%	49%	49%	52%	54%	54%	55%	55%
3–199	13	15	17	13	10	10	13	13	12
200–999	51	53	52	48	50	50	53	53	53
1,000–4,999	62	69	66	67	71	78	78	77	76
5,000 or more	62	72	70	72	79	80	82	89	86

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2007.

Note: includes public-sector plans not governed by ERISA.

data were examined from Current Population Survey (CPS), a survey conducted by the U.S. Census Bureau.¹ According to CPS data, there were 132.8 million persons covered by ERISA plans in 2006, or 82 percent of the population with employment-based health benefits. The ERISA population includes workers in private-sector firms and their dependents; workers employed in the public sector with health insurance in their own name and dependents of persons employed in the public sector were excluded from the estimate. However, the 132.8 million estimate may slightly overstate the ERISA population because persons covered by church plans were not excluded because of data limitations in identifying this population.

The ERISA population can be divided into two groups—those covered by self-insured plans and those covered by fully insured plans. Overall, 55 percent of workers were covered by a self-insured health plan. Self-insurance has been growing over the years, but it remains much more prevalent in larger firms. In firms with 5,000 or more employees, 89 percent of workers were covered by self-insured arrangements in 2006, up from 62 percent in 1999 (Figure 2). Note, however, that the prevalence of self-insurance is much lower among smaller plans, with only 13 percent of workers in self-insured plans in firms with fewer than 200 participants.

Assuming that the 55 percent of workers covered by self-insured arrangements applies to dependents as well, it can be assumed that, of the 132.8 million individuals in ERISA plans, 73 million were covered by self-insured plans. Workers employed in the public sector may also be in self-insured arrangements but they will not be covered by ERISA. According to one estimate, 58 percent of workers in state and local government plans are in self-insured arrangements.²

The prevalence of self-insurance in large employers is due to a variety of factors. First, larger employers have the resources to employ the staff necessary to administer self-insured plans, and, second, they have the financial resources to pay claims. In addition, as noted at the beginning of this report, self-insurance allows plan sponsors to design benefit packages to fit the needs of their work forces. When a plan self-insures, it can spell out which services it will cover, make arrangements with doctors and hospitals to provide coverage at favorably negotiated rates, and design financial incentives, such as deductible and co-payment structures, that encourage wise use of health benefits. The ability to do all of this via self-insurance can give large employers a distinct and significant cost advantage over firms opting to purchase insurance.

Even for those small firms able to pay for health insurance, many simply could not afford the potential liability that can arise when a complex and costly illness occurs with a covered employee or dependent—meaning these firms cannot afford to take on the risk of self-insuring. Purchasing stop-loss insurance can mitigate this risk, but even this action requires administrative acumen and overhead that is often lacking in small firms.

A more fundamental problem for small firms is the cost of health insurance coverage generally. Many small firms find it difficult, if not impossible, to afford health coverage for their employees, which results in lower levels of coverage. Indeed, more than 35 percent of workers in private-sector firms with fewer than 10 employees were uninsured, compared with only 13.0 percent of workers in private-sector firms with 1,000 or more employees (Fronstin, 2007).

One of the factors that disproportionately affects small firms is the cost of mandated benefits. As shown by Jensen and Morrissey (1999) mandated benefits cause reductions in coverage owing to small firms' greater sensitivity to price. Jensen and Morrissey modeled the effects of state mandates, as well as other insurance

regulations, on the decision by small firms (fewer than 50 workers) to offer health insurance over a period of several years. According to their findings, each additional mandate significantly lowered the small firm's probability of offering health insurance. Extrapolating from their findings, roughly 18 percent of businesses that are currently without coverage would likely sponsor coverage but for mandates. Because benefit mandates can apply only to insured coverage, larger employers can immunize themselves from these cost-drivers by self-insuring.

State Reform Efforts and the Impact of ERISA

With the failure of comprehensive health insurance reform at the national level in 1993–1994, the states have increasingly begun to try to deal with the issue of the uninsured. Over the past decade, several states and local jurisdictions have considered and adopted so-called “fair share” laws that apply only to employers that pay less than a specified percentage of their payrolls toward health care costs, or do not provide health benefits at all. Such employers would be required either to increase their health care spending or pay a percentage of their covered payroll to the state, county, or city, ostensibly to help offset the cost of state-provided public coverage.

In recent years, the state of Maryland, Suffolk County, NY, and the city of San Francisco have passed such laws. Federal courts have struck down all of them on ERISA pre-emption grounds. In the Maryland case, the U.S. Court of Appeals found that the law ran afoul of ERISA’s requirement for nationwide uniformity by having a direct impact on plan design. In essence, the only way an employer could comply with the law was to increase spending on its plan in one state, thereby running afoul of ERISA’s standard of nationwide uniformity. In the Suffolk County case, the U.S. District Court held that the law in question was pre-empted for the same reasons. Most recently, the U.S. District Court for the Northern District of California held that San Francisco’s Health Care Security Ordinance is pre-empted by ERISA. The ordinance would have required private employers with 20 or more workers to make health care expenditures of specific amounts per hours of work. In *Golden Gate Restaurant Assoc. v. San Francisco*, the court granted summary judgment on the grounds that (1) the ordinance had an impermissible connection with employee benefit plans and (2) its expenditure requirements made unlawful reference to employee benefit plans. Note that as of this writing, the U.S. Court of Appeals for the Ninth Circuit has upheld the ordinance, although an appeal is expected which would take the case to the Supreme Court.

Prior to the states taking up “fair share” laws, the state of Maryland attempted to regulate self-insured plans through regulating the stop-loss coverage that many such plans buy. The state insurance commissioner issued a rule holding that the purchase of stop-loss indemnity coverage below a relatively high “attachment point” (i.e., the amount of loss at which the coverage takes affect), would result in that coverage being treated as health insurance coverage. Such coverage would then be subject to the mandated benefits otherwise required of insured plans in Maryland. Both the U.S. District Court and the Court of Appeals found the law pre-empted on grounds that it interfered with the right of self-insured plans to design their own benefit packages.

Two of the most recent statewide comprehensive reform efforts, in Massachusetts and California, have not yet been subject to a court challenge on ERISA pre-emption grounds. As noted below, at this writing the California plan has been subject to revisions and has not yet been implemented. The Massachusetts plan, however, went into effect in 2007.

The Massachusetts plan, signed into law by Gov. Mitt Romney, requires all residents of the Commonwealth to have health insurance. It does this via an individual and employer mandate, funded in part by employer subsidies. Under the Massachusetts plan, the employment-based system is intended to continue to provide the bulk of coverage of the nonelderly population, supplemented by public coverage and individual coverage. Under the law, by July 1, 2007, employers with 11 or more employees are required to provide health insurance coverage or pay a “fair share” contribution to the state of up to \$295 annually per employee. Employers are also required to offer a Sec. 125 “cafeteria plan” that permits workers to purchase health care with pre-tax dollars or face a “free-rider surcharge” if employees make excessive use of

uncompensated care. The individual and small-group markets are to be merged, which presumably will help reduce premium rates for individuals.

A similar system is under consideration in California, where Gov. Arnold Schwarzenegger and the legislature have been offering counterproposals. After the governor proposed a “fair share” style plan early in 2007, the legislature passed its own more ambitious version of health reform, which the governor vetoed. At this writing, it appears that the governor and the speaker of the House have agreed on a compromise bill, but the state Senate has yet to approve it. Once approved by the legislature and signed by the governor, California voters will still need to approve an initiative to provide funding for the program. This revised proposal is based on an individual mandate funded in part by employer subsidies. Employers would be required to contribute between 1 percent and 6.5 percent of Social Security-eligible wages toward employee health insurance coverage, or pay the equivalent into a state trust fund, which would fund public coverage. The percentage of the assessment would be based on a sliding scale tied to the size of the firm. This proposal is expected to cover approximately 70 percent of uninsured Californians.

Conclusion

It is clear from the case law discussed above that ERISA puts limits on the states’ ability to carry out health insurance reforms. ERISA pre-emption has prevented individual states and localities from mandating a minimum level of coverage for employment-based plans, and, so far, appears to prevent the states from mandating that employers provide health benefits. For employers operating in multiple states, this is exactly what ERISA was supposed to do—prevent multi-state employers from having to meet potentially 50 different sets of regulations. In addition, states have been limited in their ability to fund health insurance subsidy arrangements for low-income persons through taxes on self-insured plans. Employers argue that taxing voluntary private-sector benefits is an inappropriate source of funds for providing mandatory public-sector coverage for the uninsured, and that a more generally applicable tax would be more appropriate, since taxing benefits only discourages the voluntary provision of benefits. On this point, it should be noted that Massachusetts and California are imposing contributions not linked directly to employee benefit plans, clearly hoping to avoid a pre-emption challenge on that issue.

Given the current pre-emption structure, as states continue to pass incremental regulations and benefit mandates on insured plans, it seems clear that more employers will be forced to consider self-insuring their health benefit plans, simply as a response to the significantly growing regulatory costs. And, as the cost of insured coverage rises, smaller employers may consider dropping coverage entirely.

As the administration of President George W. Bush comes to an end, and the fiscal demands on a deficit-plagued federal government continue to increase, it seems clear that political prospects are slim that the next president and the next Congress will enact a publicly funded universal-care health care system covering all Americans. But the alternative—greater state regulation of employment-based health care, which remains the bedrock of the current system—could ultimately prove to be self-defeating if employers decide to get out of the game.

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Endnotes

¹ See Fronstin (2007) for more information about the Current Population Survey.

² See <http://www.kff.org/insurance/7672/index.cfm>.

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