

# Implications of ERISA for Health Benefits and the Number of Self-Funded ERISA Plans

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Issue Brief

- This *Issue Brief* provides an overview of the issues relating to the Employee Retirement Income Security Act of 1974 (ERISA) and health benefit plans, the major case law relating to ERISA and health plans, and the implications of the preemption of state regulations for health plan sponsors and participants. It also presents the latest data on the number of health plan participants in self-funded ERISA plans. Finally, it presents a summary of current legislative proposals that would attempt to amend ERISA.
- Under the framework ERISA established for employee benefit plans, the regulation of employment-based health benefit plans has evolved into a two-tiered system in which both federal and state laws play important roles. The Supreme Court has interpreted ERISA's "savings" and "deemer" clauses to mean that insured plans are subject to regulations directly at the federal level and indirectly at the state level, while self-funded plans are regulated exclusively at the federal level.
- The ERISA statute and the courts' interpretations of the Act have created a sharp controversy over how employee health benefit plans are provided and administered, with state regulators and consumer advocates on one side of the debate and plan sponsors (e.g., employers and unions) on the other. State regulators and consumer advocates tend to favor more regulation, and in many instances greater regulation at the state level, which they argue would provide more protections for consumers. However, employers and unions (or any plan sponsors) think ERISA preemption is very important to their ability to provide innovative and cost-effective health benefits for their employees, and assert that ERISA's present structure should be preserved.
- The U.S. General Accounting Office (GAO) found that 44 million individuals (39 percent of those in ERISA plans) were enrolled in self-funded ERISA plans in 1993, up from 39 million (33 percent of those in ERISA plans) in 1989. The Employee Benefit Research Institute (EBRI), using the same methodology as GAO with 1995 data, estimated that 48 million individuals (39 percent of those in ERISA plans) were enrolled in self-funded ERISA plans in 1995.
- When policymakers look to amend ERISA, they should consider whether the change to ERISA will produce a higher level of quality for consumers than is being provided under the present system and will continue to do so in the future. Policymakers must also decide whether quality of care is better enhanced by health plans' greater exposure to liability or by market forces. If policymakers decide that increased exposure to liability is the route to go, will consumers be able to enjoy any potential improvement in quality or will more individuals end up uninsured because of increased costs and not be able to get any care regardless of the quality?

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## Introduction

In recent years, the Employee Retirement Income Security Act of 1974 (ERISA) has

come under increasing scrutiny from critics who believe that it denies adequate legal remedies to participants in employment-based health plans. Under ERISA, the remedies available limit the dollar damages to the value of denied benefits plus attorneys' fees, not the lost income, pain and suffering, or disability that could occur in claims arising out of denied benefits. Furthermore, ERISA supersedes (or "preempts") all state laws that "relate to" employee benefits, including state tort and contract laws. In addition to the limited legal remedies, critics also claim ERISA provides inadequate consumer protections for participants in those private employment-based health plans that are immune from state insurance regulation.

Some advocates insist that health plans and health plan sponsors should be subject to greater monetary remedies, especially state law-based tort claims, in order to deter health plans from indifferent or possibly negligent behavior toward enrollees. Policymakers on Capitol Hill have cited instances of individuals who have found themselves without the desired legal recourse under ERISA after having health services denied. Several bills have been introduced in the 105<sup>th</sup> Congress that would amend ERISA to create new rights and remedies for alleged mistreatment of patients by health plans.

In addition, legislative attempts to add various mandated benefits, stricter disclosure requirements, and other regulations on health plans at the federal level have drawn attention to ERISA. (Only federal legislation can reach all employment-based health plans.) Indeed, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry focused on ERISA as it crafted a health care consumer's "bill of rights."

However, ERISA still has strong support from employers, unions, other health plan sponsors, and health plans that contend that criticism of ERISA is based on anecdotal evidence. Its proponents also believe that the statute provides an excellent foundation for the voluntary employment-based health care system in the United States to be innovative and cost effective. In particular, employers rely on ERISA's broad preemption of state laws to provide nationally uniform benefit plans, allowing them to offer the benefits that are preferred by their work forces. In addition, ERISA proponents argue that much of the success in maintaining the employment-based health care system can be attributed to the framework that ERISA established for the provision of health benefit plans. Furthermore, proponents believe that ERISA protects plan participants by means of the fiduciary obligations it imposes on the sponsors and administrators of health benefit plans and its "full and fair" review process for resolving complaints about claims decisions.

This *Issue Brief* provides an overview of these and other issues relating to ERISA, the major case law relating to ERISA and health plans, and the implications of the preemption of state regulations for health plan sponsors and participants. It also presents the latest data on the number of health plan participants in self-funded ERISA plans. Finally, it presents a summary of current legislative proposals that would attempt to amend ERISA.

## ERISA Preemption

ERISA established the federal government as the primary regulator of

private-sector employee benefit plans. Prior to ERISA's enactment, employee benefit plans were regulated mainly at the state level, although they were subject to preferential federal tax treatment. Oversight of employee benefits varied considerably from state to state. Some

*ERISA mandates  
that a fiduciary's  
duty is to act solely  
in the interest of  
plan participants  
and beneficiaries.*

states had weak funding requirements and protections for participants in pension plans, while others had stricter regulations. Employee health benefit plans generally fell under state insurance regulation. Due to the lack of consistent legal protections these state regulations afforded pension plans, retirees in some well-publicized cases received fewer retirement benefits than anticipated.<sup>1</sup> Congressional concern about the solvency and security of employment-based pension plans from such incidents was the primary force behind the passage of ERISA (Employee Benefit Research Institute, 1979). Even though the security of health and other employee benefit plans was not as central as pension issues in the formation of the Act, ERISA was drafted to cover all employee benefit plans, including health benefit plans (Employee Benefit Research Institute, 1984a; Shay, 1993; Butler, 1994).

As originally passed, ERISA contained several provisions primarily addressing the private employment-based pension system. It set financial standards for pension plans (including the requirement that plan assets be held in trust); fiduciary standards for plan administrators; and rules on 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 guarantee benefits for private pension plan participants.<sup>2</sup> Additionally, ERISA authorized the creation of individual retirement accounts (IRAs) (Employee Benefit Research Institute, 1984b). The statute assigned jurisdiction over reporting, disclosure, and fiduciary standards to the Department of Labor's (DOL) Pension and Welfare Benefits Administration, and gave jurisdiction over eligibility, funding, and vesting to the Department of the Treasury.

Yet, the framework established in ERISA applies to all employee benefit plans, including health benefit plans. Specifically, it sets forth standards on reporting and information disclosure, claims appeal procedures,

remedies for wrongfully denied benefits, and fiduciary standards—the “backbone” of ERISA. Under ERISA, fiduciaries by definition are those who exercise control or discretion in the management of plan assets, provide investment advice to a plan, and have discretionary authority in administering a benefit plan (Employee Benefit Research Institute, 1979). ERISA mandates that a fiduciary's duty is to act solely in the 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)). The fiduciary is expected to be familiar with matters pertaining to employee benefit plans; hence, the so-called “prudent expert” standard is applied in determining proper fiduciary duties. Fiduciaries are also 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.

ERISA not only specifies certain standards for employee benefit plans, but also preempts *all* state laws that “relate to” employee benefit plans<sup>3</sup> (sec. 514(a)), although the statute did specifically preserve the states' right to regulate the “business of insurance” under what is commonly called the “savings” clause (sec. 514(b)(2)(A)). This clause reinforced the states' authority to regulate insurance that the McCarran-Ferguson Act (1945) had established earlier. However, ERISA includes another provision (commonly called the “deemer” clause (sec. 514(b)(2)(B)) that prevents states from deeming employee welfare plans<sup>4</sup> to be in the business of insurance so that the states can regulate them. Not surprisingly, the interpretation of these clauses has

<sup>1</sup> For example, in the early 1960s, when the Studebaker automobile company collapsed, thousands of vested workers too young to retire were left with substantially reduced pension benefits.

<sup>2</sup> There are some exceptions. For an exhaustive list of plans specifically excluded from coverage by PBGC, see pages 278–279 of Allen et al., 1997.

<sup>3</sup> Government and church plans are exempted from ERISA regulation.

<sup>4</sup> Welfare plans is the term ERISA uses for nonpension benefit plans.

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caused much judicial reflection as to the meaning of “relates to” and what is reserved to the states under the “business of insurance.”

A debate still continues over why and how ERISA was drafted to cover all employee benefit plans. Some believe that ERISA’s broad preemption was inadvertent as the official legislative history is largely silent on nonpension matters. However, at least two specific references to the broad preemption 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 preempt 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). In addition, another strong supporter of the ERISA legislation during its passage, Rep. John Erlenborn (R-IL), wrote in 1995 that “key to the passage of this landmark legislation [ERISA] was the inclusion of a clause that reserved to the federal government, to the exclusion of the states, the right to regulate ‘employee benefit plans’” (Erlenborn, 1995). Moreover, two congressional staff members, Michael Gordon and Vance Anderson,<sup>5</sup> both agree that broad preemption was not inadvertent and

that members of Conference Committee knew that the regulation of health plans as well as other welfare plans would fall under federal regulation.

Further supporting the view that broad preemption was intentional is the fact that the State of Hawaii, which was in the process of implementing its Prepaid Health Plan at the time ERISA was enacted, did not secure a limited specific exemption from ERISA preemption until 1983. In addition, the provision granting this exemption contained a warning that other states should not consider this a precedent for future exemption (Gordon, 1993; Mariner, 1992). Indeed, there is no language in ERISA that provides a process for states to obtain a waiver or exemptions from ERISA preemption. Consequently, whether or not it was clear to every member of Congress, it is obvious that the individuals who worked on ERISA clearly understood that health benefit plans as well as all welfare plans would be included in this legislation.

## Health Benefit Plan Regulation

Under the framework of ERISA, the regulation of employment-based health benefit plans has evolved into a two-tiered system in which both federal and state laws play important roles. Because of the Supreme Court’s interpretation of ERISA’s “savings” and “deemer” clauses in *Metropolitan Life Insurance v. Massachusetts* (471 U.S. 724, 1985) and *FMC Corporation v. Holliday* (498 U.S. 52, 1990), insured plans are subject to regulations directly at the federal level and indirectly at the state level, while self-funded plans are regulated exclusively at the federal level. A self-funded (self-insured) health benefit plan is one in which an employer pays for the health care claims of its participants directly out of its own income or assets. Such plans are usually funded on a pay-as-you-go basis, with claims paid by the employer as they arise. However, a third-party administrator (TPA), an insurance company, or other claims processing organization typically administers these plans, and there are a relatively small number of self-administered plans.

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<sup>5</sup> Michael Gordon served under the late Sen. Jacob Javits (R-NY) from 1970–1975 as minority counsel for pensions on the Senate Labor and Welfare Committee and assisted in the drafting and enactment of ERISA. Vance Anderson was the Chief Counsel of the House Education and Labor Committee during the passage of ERISA. Gordon has expressed his views in a few written pieces such as Gordon (1993), and Anderson’s views were obtained through the authors’ conversation with him.



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On the other hand, an insured plan is one in which an employer pays premiums to purchase a health insurance contract (or a health maintenance organization (HMO) contract) from an insurer (HMO) to cover the claims of the plan's participants. In this distinction between self-funded plans and insured plans, it is important to understand the difference between a "health benefit plan" and a "health plan." A health benefit plan is one of many employee benefit plans that an employer or union may offer or sponsor, which is the domain of ERISA, while a health plan is the content of the health benefit plan that is offered. State regulation arises in the regulation of a health plan only to the extent that the health plan is offered through an insured product, since the insurer is regulated directly by states.

Because both types of plans originate from a health benefit plan, they are regulated at the federal level under ERISA for reporting and information disclosure, claims appeal procedures, fiduciary standards, and remedies for wrongfully denied benefits. (It is important to note that *all* private-sector, nonchurch-based employee benefit plans are ERISA plans. Employee benefit plans sponsored by government entities are not governed by ERISA.) By virtue of their ability to regulate the business of insurance, states are able to regulate the content of insurance contracts purchased by benefit plans,<sup>6</sup> such as mandating certain benefits, and they are able to regulate the insurance companies themselves. But states are preempted from regulating the content of self-funded (self-insured) plans, so employers that self-fund are not subject to state benefit mandates, other state health insurance regulations, and direct taxes on insurance premiums.

## Major Court Cases

Over the years, the Supreme Court has examined the scope of ERISA's preemption in various cases.<sup>7</sup> 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 preempted 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 preempted because the impact is "too tenuous, remote, or peripheral," a point that the court would address again in subsequent cases.

In *District of Columbia v. Greater Washington Board of Trade* (113 S Ct 580, 1992), the Supreme Court addressed a workers' compensation statute and turned to the "having a connection with or referring to" language for guidance. 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 preempted under what many observers considered a broad interpretation of the "relates to" language.

While it appeared that the Court held a broad view of ERISA preemption, some recent cases indicate a change in direction. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (115 S Ct 1671, 1995), the Supreme Court found that the impact of the hospital surcharges imposed by New York state were too attenuated on an employee benefit plan to be preempted under ERISA. This case was the first Supreme Court ruling that seemed to narrow the previ-

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<sup>6</sup> Recent court rulings appear to have placed a limit on the states' ability to completely regulate the design of an insured health plan. For instance, the Supreme Court recently declined to review the case, *Texas Pharmacy Association v. Prudential Insurance Company*, where the Fifth Circuit Court of Appeals ruled that an any willing provider law was preempted by ERISA.

<sup>7</sup> This section is only intended to provide a brief overview of the major court cases relating to ERISA and health benefit plans. It is not intended to be a complete examination of ERISA case law and should not be cited as an authority.

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ously 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, self-funded or insured (Liston and Patterson, 1996; U.S. General Accounting Office, 1995). While *Travelers* helped set some boundaries around the scope of preemption, 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 preempted.

Another case that appears to have narrowed the scope of preemption is *DeBuono v. NYSA-ILA Medical Services Fund* 138 L. Ed. 2d. 21 (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-funded ERISA plan, in this case a union-operated plan. The court rejected the lower court’s “expansive and literal interpretation” of ERISA preemption, 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 preemption 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 preempted 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 preemption 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 preemption.

In another recent Supreme Court case, *Boggs v. Boggs* (117 SCt 1754, 1997), the Court held that ERISA preempts 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 preempted. 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.

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 preemption. *Metropolitan Life Insurance v. Massachusetts* (471 U.S. 724, 1985) was the defining case on 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 preemption under the savings clause. In coming to this conclusion, the Court used the three-part test developed in *Union Labor Life Ins. v. Pireno*<sup>8</sup> to determine whether an

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<sup>8</sup> The test contained the following three parts: the activity must spread risk, the relationship between insured and insurer must be an integral part of the activity, and it is limited to entities in the traditional insurance industry (*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 1982).

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activity or practice constituted the “business of insurance.” 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 preemption. However, the Court acknowledged that its ruling created a distinction between plans that are insured and “uninsured” (self-funded), because the deemer clause would immunize an uninsured plan from state mandated benefit laws.

The Supreme Court specifically ruled on the application of the deemer clause to self-funded 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 preemption as insurance regulation on self-funded 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-funded 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-funded ERISA plans from direct and indirect state regulation.

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 preemption, because it applies to insurance. However, the Court ruled that the Mississippi law of bad faith was not saved from preemption 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 the scheme of ERISA 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. Thus, under this interpretation, a state law that does not directly regulate the business of insurance is preempted by ERISA for both insured and self-funded plans.

In summary, it is clear that ERISA’s preemption of state law remains broad, despite the holdings in *Travelers* and *DeBuono*. In an attempt to generalize, it appears that state laws of general applicability that do not single out employee benefit plans can avoid being preempted by ERISA if the courts find the connection tenuous or remote, while those that do single out employee benefit plans will most likely be preempted. As is obvious from this brief overview, the case law has tended to be fact-specific and is subject to continuing evolution.

## Preemption Issues

The ERISA statute and the courts’ interpretations of the Act have created a sharp

controversy over how employee health benefit plans are provided and administered. The two sides of the debate fall into two relatively distinct groups, with state regulators and consumer advocates on one side and plan sponsors (e.g., employers and unions) on the other. State regulators and consumer advocates tend to favor more regulation, and in many instances greater regulation at



*ERISA preemption has prevented the states from mandating a minimum level of coverage for self-funded plans, and also prevents them from specifically mandating that employers provide health benefits.*

the state level. Thus, they would prefer a more narrow interpretation of ERISA's preemption of state laws or the elimination of ERISA preemption altogether. In particular, the opponents of ERISA would prefer self-funded plans to be subject to the same regulations as insured plans. However, employers and unions (or any plan sponsors<sup>9</sup>) think ERISA preemption is very important to their ability to provide innovative and cost-effective health benefits for their employees, and feel strongly that the present structure of ERISA should be preserved. The remainder of this section will discuss the reasons that state regulators and consumer advocates feel that ERISA provides inadequate or uneven regulations and why employers and unions feel that the framework established under ERISA is a superior method for the cost-effective provision of health benefit plans.

## State Mandates Compared with ERISA for Provision and Administration

Whatever your position on ERISA preemption, it became clear during the push for health care "reform" in 1993–1994 that ERISA limits the states' ability to carry out systemwide health care regulation, because states cannot regulate self-funded plans. ERISA preemption has prevented the states from mandating a minimum level of coverage for self-funded plans, and also prevents them from specifically mandating that employers provide health benefits.<sup>10</sup> Employers and unions counter that this is exactly what ERISA was supposed to do, in order to prevent multistate employers from having to meet potentially 50 different sets of regulations. In addition, states have been limited in their ability to create insurance pools for the uninsured through premium taxes, because the direct levying of premium taxes on self-funded plans would be preempted. However, employers and unions argue that the taxation of benefits is an inappropriate source of funds for providing 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 by employers (Atkins and Bass, 1995). In fact, states have begun to use general provider taxes; an example is

New York State, which was the subject of the *Travelers* case. Furthermore, under the present structure, as states continue to pass incremental regulations and benefit mandates on insured plans, more employers will consider self-funding their health benefit plans or even dropping coverage entirely to avoid the higher cost and loss of flexibility they believe these mandates would entail (Atkins and Bass, 1995). Thus, implementation of greater regulation of the health care marketplace by states could become self-defeating (McDonnell, Anzick, and Custer; 1992).

Consumer advocates are concerned that employers who self-fund can alter coverage in their plans at any time, leaving participants without coverage for a previously covered condition. *McGann/Greenberg v. H&H Music Company* (113 S Ct 482, 1992) is an often cited example of this practice. In this case, an employer dropped a health insurance policy that provided health benefits up to \$1 million for all conditions shortly after medical claims for AIDS-related conditions were submitted. According to the employer, due to substantially increased premiums for the insured plan after the submission of these claims, it could only afford to offer a self-funded plan that had a specific \$5,000 maximum coverage for AIDS-related conditions. Because the employer still wanted to provide some health care coverage for its employees, the employer concluded it had no other choice but to settle for this plan, even though

<sup>9</sup> This report uses employers and unions as generic terms for plan sponsors. However, they are not the only plan sponsors that are concerned about these issues.

<sup>10</sup> Some believe that other schemes to get employers to provide health benefits such as a "pay or play" system could survive a preemption challenge (Butler, 1994; Atkins and Bass, 1995).

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employees with AIDS would be without coverage for their condition after reaching the \$5,000 maximum (*Benefits Quarterly*, 1993; Snider, 1992).<sup>11</sup> The Fifth Circuit Court of Appeals held that the employer was free to change the policy at any time if the plan allowed for amendments and termination, and the Supreme Court did not accept the case on appeal (Gostin and Widiss, 1993). Under this precedent, employers with self-funded plans are allowed to change coverage at any time to any level, if the plan allows for amendments. However, this is an issue not only for self-funded ERISA plans but also for insured plans. An employer with an insured plan can also alter its plan to stop covering a specific condition unless a state mandates that a specific condition be covered. However, plans that use an insurance contract have less flexibility in altering policies than self-funded plans due to state mandates and the need for negotiation with insurance issuers. Furthermore, because there is no federal or state mandate that requires employers to provide coverage, an employer can drop coverage for any reason, including if it feels the cost has become too high.

Subsequent to the *McGann* case, the Americans with Disabilities Act (ADA) went into effect, requiring that individuals with disabilities be treated the same as those without disabilities. Some analysts believe that the ADA will provide a guarantee of coverage for certain diseases considered to be disabilities in self-funded and insured plans. However, others argue that the ADA will not guarantee that self-funded plans will cover certain conditions considered to be disabilities, because the Act sanctions changes to health plans based on valid actuarial data (Snider, 1992; Gostin and Widiss, 1993).

Court decisions concerning the ADA seem to support the position that the circumstances in *McGann* would now be held as a violation of the ADA, as long as the condition that has limited benefits is considered a

disability. In *World Ins. Co. v. Branch* (966 F.Supp. 1203, 1997), a \$5,000 maximum on medical benefits for AIDS care was held to be a violation of the ADA, because the insurer did not demonstrate, using sound actuarial principles, that the underwriting risks for AIDS-related conditions were substantially different from those for other catastrophic illnesses. This was the typical direction in which the courts were headed until *Parker v. Metropolitan Life Ins. Co.* (24 BPR 1877 6<sup>th</sup> Cir., 1997), where the court ruled on the ability of insurers to limit disability benefits for participants with mental health disabilities relative to physical disabilities. The court concluded that “the ADA simply does not mandate equality between individuals with different disabilities.” Consequently, the court upheld the lower benefits for participants with mental conditions. Thus, the courts now seem to be unsettled over whether insurers can provide different coverage levels for different conditions. However, some believe that employers would be taking a significant risk of violating the ADA if they treat individuals with different types of disabilities differently, given the present state of court rulings on the ADA.

Critics say that, in addition to being able to alter coverage at any time (except for the limitations imposed by the ADA), self-funded plans provide participants a different scope of benefits than insured plan participants receive. They contend that, prior to 1996, ERISA imposed “essentially no benefit requirements on employee health plans and prohibits states from defining benefits for employee health benefit plans” (Butler and Polzer, 1996). However, a study of self-funded plans by Acs et al. (1996) found that self-funded plans offer virtually identical coverage in actuarial value as fully insured indemnity plans but somewhat less coverage than HMOs. In addition, Acs et al. found that the premiums and employee contributions were similar for self-funded, fully insured, and HMO plans. Other reports have found that many self-funded plans place limits on some benefits that are covered more extensively by state mandates, in particular, mental health benefits (U.S. General Accounting Office, 1996; Butler and Polzer, 1996).

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<sup>11</sup> It is interesting to note that if the employer had decided to drop coverage entirely for all employees after being faced with the increased premiums, the employer would have been totally within its rights, because ERISA provides no mandate to provide health benefits.

*Even though self-funded plans are not subject to state regulations, they are either directly or indirectly subject to significant federal regulations.*

Even though self-funded plans are not subject to state regulations, they are either directly or indirectly subject to significant federal regulations. First, ERISA was specifically amended in 1996 to require certain benefits through the Newborns and Mothers Health Protection Act, the Mental Health Parity Act, and the Health Insurance Portability and Accountability Act (HIPAA), which respectively require coverage for minimum lengths of stay for the mother of a newborn and the newborn, the same lifetime limits for mental health benefits as those for medical and surgical health benefits, and the maximum length of preexisting condition exclusions to be 12 months,<sup>12</sup> respectively. ERISA health plans are also subject to other federal legislation, in particular, the Pregnancy Discrimination Act, which requires coverage for pregnancy, the ADA as previously discussed, as well as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA provides participants of ERISA health plans the ability to continue coverage under that plan for up to 18 months when they terminate employment. In addition, ERISA health plans are affected by the following legislation or regulations: the Federal HMO Act, the Internal Revenue Code nondiscrimination rules, the Age Discrimination in Employment Act, and the regulations governing Medicare as a secondary payer.

The framework established under ERISA for providing employee benefit plans is viewed as an important ingredient in employers' and unions' ability to provide health benefits. Employers and unions argue that by not having to follow state-by-state regulation, they are able to tailor benefits to their participants'

needs, not to what individual state legislatures deem to be appropriate

for everyone. This is particularly important for benefit decisions that are negotiated between employers and unions or workers, where tradeoffs between health benefits, other benefits, and compensation are determined through the negotiation process. In addition, employers and unions are able to experiment and allow benefits to evolve as changes occur in the treatment of various conditions.<sup>13</sup> Furthermore, employers and unions are able to undertake innovative measures to enhance quality and control costs in order to provide more individuals access to health care.<sup>14</sup> Employers and unions contend that, under the ERISA framework, health benefit plans can use more resources to pay health care claims and spend less on administrative expenses in complying with various state regulations (Atkins and Bass, 1995). Thus, employers and unions are able to offer greater monetary compensation or require less cost sharing for their health benefit plans.

## Solvency Requirements

Critics of ERISA preemption also cite the statute's lack of solvency requirements. They argue that an employer who inadequately funds its self-funded plan has opened itself up to the risk of being forced to drop coverage or possibly go out of business, if the plan experiences unusually large claims. Thus, all employees in the company could be left without health benefits and no way to continue coverage under the present plan (Polzer and Butler, 1997). However, if the employer had purchased an insurance contract, the insurance company

<sup>12</sup> HIPAA further reduces preexisting condition exclusions for individuals previously enrolled in a health plan as long as there was not a significant break in coverage. It also contains numerous other provisions, many of which are focused on regulations of insurers, not group health plans. Although HIPAA does include nondiscrimination provisions for group health plans regarding eligibility, premiums, and contributions based on health-related factors, it does not prohibit plans from establishing differing lifetime limits on specific benefits. Other provisions of HIPAA that relate to group health plans are discussed in later sections.

<sup>13</sup> Employers argue that by not being forced to meet state mandates for a specified number of visits for mental health benefits, they can set limits in other ways that allow for flexibility in finding the proper treatment for each participant's circumstances.

<sup>14</sup> See the GAO report (1997b) for a general perspective of management techniques employers use in the design of their health benefit plans. For specific corporate initiatives, see the Business Roundtable statement before the President's Advisory Commission on Consumer Protection and Quality.

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would be responsible for the unusually large claims. Therefore, the employer would not be faced with this additional financial risk. Moreover, the states operate “guaranty funds or associations” to pay the claims of participants in an insured plan if the insurer goes out of business while the policy is in effect, whereas these associations are not open to participants of self-funded plans.

However, employers argue that the Internal Revenue Service (IRS) currently restricts the amount of pre-tax funds that an employer can hold in reserve for the payment of health benefits. Furthermore, employers contend that state “guaranty funds or associations” are of limited value if a substantially large insurer were to go out of business due to the associations’ limited funding. In addition, employers point out that sometimes employers are forced to alter or drop health benefits if their employees experience unusually large claims, because insurance companies tend to increase premiums to recoup these large claims. In general, employers worry that solvency standards would restrict their ability to reallocate assets to other uses within the business and consider rigid solvency standards to be unnecessary, because they can purchase stop-loss coverage for their self-funded plans.<sup>15</sup> In fact, there have been no significant problems with self-funded plan failures across all firm sizes (U.S. General Accounting Office, 1995).

Aside from the financial risk of inadequate funds in a self-funded plan, participants in both self-funded and insured plans are in similar positions if an employer terminates coverage or goes out of business. If an employer terminates coverage under a self-funded or insured plan, the employee is ineligible for COBRA coverage, because his or her employment status is unchanged. If an employer goes out of business, neither a self-funded nor an insured plan would continue to exist. Therefore, continued coverage under the plan would be impossible. A state-based mechanism does not exist to provide coverage for employees after employers either cease operations or terminate plans. This issue actually relates to the voluntary nature of the employment-based

system. HIPAA provides some relief for individuals in this situation, but does not eliminate the issue.

## Disclosure Rules

Critics also question the adequacy of ERISA’s disclosure rules. ERISA requires that each participant receive a summary plan description (SPD) that must include information on the name and type of administration of the plan with addresses, requirements for eligibility, explanations of situations that may result in denial or loss of benefits, source of the financing of the plan, and methods of presenting claims and remedies available to redress denied claims. In addition, the SPD must contain a statement of participants’ rights under ERISA and of the plans administrator’s fiduciary duty to administer the plan prudently and in the sole interests of the plan’s participants. Furthermore, DOL regulations require that the SPD contain a description of benefits. Moreover, under HIPAA an ERISA group health plan sponsor has up to 60 days or at regular intervals of not more than 90 days after any “material reductions in covered services or benefits” to provide participants with a summary description of the reduction. However, critics argue that participants do not understand the SPD, many states require greater information on the operation of insured plans, and changes are not immediately required to be disclosed. Although the SPD must be filed with DOL, it is not reviewed for compliance (Polzer and Butler, 1997).<sup>16</sup> Employers claim that the information provided is thorough, that explanations are provided to employees when they enroll, and that administrators are available to answer questions.

The extent of the fiduciary obligations imposed by ERISA in relation to disclosure by a plan was the

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<sup>15</sup> However, stop-loss coverage is not necessarily a guarantee against plan insolvency. These plans lack guaranteed renewability, have payment limits, and face less regulatory oversight than other insurance products.

<sup>16</sup> The 1997 Balanced Budget Act no longer requires that DOL receive a copy of the SPD. However, participants must still receive a copy and employers must provide it to DOL on request.



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subject of a recent court case denied review by the U.S. Supreme Court (*Shea v. Esensten*, US SupCt, No. 97-225, 10/14/97). In *Shea*, a participant of an employment-based health plan that contracted with an HMO was denied referral to a cardiologist by his HMO's primary care doctor after experiencing symptoms of heart problems. The participant subsequently died of heart failure. The lawsuit alleged that the HMO breached its fiduciary duties by not disclosing the physician compensation arrangements, which if the participant had known, he allegedly would have sought care at his own expense. The U.S. Court of Appeals for the Eighth Circuit remanded the case for further proceedings on whether the HMO breached its fiduciary duties by not disclosing the HMO's financial incentives for physicians. However, the state tort claims against the HMO for not disclosing this information were ruled to be preempted by ERISA.

## ERISA's Remedies

Under traditional indemnity plans, the most prevalent type of plan at the time ERISA was enacted, the denial of a claim is typically not as critical as it is in a managed care setting, because claims are generally paid or denied after the treatment has taken place. In a managed care setting, the dominant form of health plan enrollment today, most claims decisions are made prospectively through the utilization review process. This leads many to believe that a denial of coverage by a plan is the denial of care. Consequently, ERISA critics think that the appeals procedures for ERISA health benefit plans need to be expedited and involve the use of an outside review board. Currently, a decision of an appealed claim must ordinarily be made within 60 days after the request for a review to the appropriate fiduciary or designee and, under special circumstances, up to 120 days.<sup>17</sup> (For health benefit plans that use an insured plan, these plans must also adhere to the state law appeal rules.) However, a fiduciary potentially could have a conflict of interest in that the sponsor of the plan could gain from denied benefits, and the sponsor is generally the

fiduciary's employer. Therefore, ERISA critics say 60 days is entirely too long for urgent situations, and the use of an outside review board would mitigate the possibility of a conflict of interest. DOL is now considering changing the regulations on the appeals process for ERISA plans to address these issues. Employers contend that a nationally uniform appeals procedure is vital to multistate employers for the administration of benefits in a cost-effective manner. Furthermore, since a fiduciary is personally liable for any negligent decisions, employers believe that a fiduciary would only act prudently and in the sole interest of the participants of the plan. Thus, an outside review board would only increase costs and make fewer resources available for providing actual health benefits.

Despite the fiduciary standards established for ERISA plans, critics believe that ERISA's limited remedies and its preemption of state tort and contract laws in cases such as *Shea* constitute the absence of a major deterrent to health plan<sup>18</sup> negligence: the potential for punitive and compensatory damages. The case that ERISA critics point to is *Corcoran v. United Health Care, Inc.* (965 F. 2d 1321, 5<sup>th</sup> Cir. 1992). In *Corcoran*, a woman sued her health plan's utilization review company for the wrongful death of her fetus, when the utilization review company denied preauthorization for hospitalization to monitor her pregnancy. The court determined that malpractice laws are laws of general applicability that "relate to" an employee benefit plan

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<sup>17</sup> ERISA allows for the use of an injunction (sec. 502 (a)(3)), but it is rarely used because it is costly and is not a final decision.

<sup>18</sup> Currently, insured (indemnity and managed care) plans and self-funded plans are immune from state tort and contract law under ERISA for benefit determination and administration decisions. In addition, administrators or administrative companies to these plans such as utilization review companies are also immune as well as plan sponsors (employers, unions). Thus, any legislation that opens up health plans to greater liability will most likely make the other groups liable also, especially employers who self-fund plans, or increase the costs of providing health benefits at the very minimum. Consequently, when this report discusses opening up health plans to greater liability, it is generically referring to all of these groups. When the term employers is used to express the argument against increased liability, it is also generically referring to all these groups.



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and therefore are preempted by ERISA. The court went on to find that the utilization review company did make medical decisions but only in the context of benefit determination. Consequently, the only legal remedies available are those specified in ERISA, which do not include remedies for emotional distress or loss of consortium. Therefore, the court concluded that the utilization review company was not liable for any punitive or compensatory damages.

The key issue in the court ruling in the *Corcoran* case is that the utilization review company made a benefit determination, while the *Shea* case dealt with the administration of benefits. The courts appear to rule consistently that state tort laws are preempted when a plan's decision relates to a benefit determination or administration (Butler and Polzer, 1996; Association of Private Pension and Welfare Plans, 1997). However, when the issue becomes something outside of the determination or administration of benefits, state malpractice (tort) claims have been increasingly held to be not preempted by ERISA. For instance, in *Dukes v. U.S. Healthcare Inc.*, *Visconti v. U.S. Healthcare, Inc* (57 F. 3d 350 3d Cir. 1995), a hospital allegedly refused to perform a blood test on a patient who later died, and a patient's condition allegedly was allowed to deteriorate over a series of prenatal visits, resulting in a stillbirth of a fetus. In this case, the court ruled that malpractice claims were not preempted, because they were not claims to recover benefits due or to enforce the rights of a beneficiary under sec. 502 of ERISA. In addition, the court concluded that the quality of benefits is an area that has traditionally been occupied by state regulation, and Congress' silence on the issue led the court to believe that Congress intended it to remain as such.<sup>19</sup> However, in an earlier case, *Butler v. Wu* (853 F.Supp. 125, 1994) malpractice claims against an HMO were held to be preempted by ERISA. Thus, there appears to be a distinction evolving in the courts between a benefit determination and administration (preempted) and a medical decision outside of a benefit determination (increasingly not preempted), although the courts have

not settled this issue.

In addition to ERISA's limited remedies' alleged lack of a deterrent effect, critics believe that participants in ERISA health plans should have open to them all remedies available under state tort and contract laws for other reasons. Since many of these critics believe that the denial of coverage is the denial of care, they believe administrators of plans make medical decisions and thus should be held responsible for those decisions through malpractice liability. Once health plans are held liable, critics argue that the quality of care they provide will improve. Furthermore, if a participant is harmed by a decision of a health plan, the participant could secure damages other than merely the lost benefit, and ERISA critics think that the participants should be able to fully recover these additional damages. Moreover, they argue that when remedies are limited to the value of lost benefits, many attorneys will not take cases that involve potentially wrongfully denied benefits because the costs are too high relative to the potential reward.

Employers counter that when a health plan makes a benefit determination, it is interpreting a contract between the health plan and the participant on what benefits are covered under that contract.<sup>20</sup> The health plan is not preventing that participant from receiving the care or telling the participant not to get the care but simply stating whether the contract covers the benefit. Therefore, malpractice law would not apply. In addition, employers contend that opening up health plans to more remedies will substantially increase costs, while quality will not improve. With more remedies available, more litigation would result, including frivolous lawsuits. Consequently, costs for the plans would

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<sup>19</sup> The courts have come to the same conclusion in other cases. For example, in *Pacificare of Oklahoma Inc. v. Burrage* (59 F.3d 151 10<sup>th</sup> Cir. 1995), the court ruled the malpractice claim did not encompass a determination of benefits by the plan. See also *Kearney v. U.S. Healthcare, Inc.* (859 F.Supp. 182, 1994). In addition, DOL supports the claim that malpractice claims are not preempted if they are not administration or determination of benefits. See *Amicus Briefs Filed by the Secretary of Labor*.

<sup>20</sup> This is not unique to ERISA benefit plans; all health plans (public and private) have limits and exclusions. Therefore, interpretation of any plan's benefits must be made for circumstances that are not clear.

increase to cover litigation expenses, possibly forcing employers to increase cost sharing of premiums with participants or stop offering health benefits entirely. This has serious implications for the number of uninsured, as shown by a recent study by Cooper and Schone (1997). They found that as cost sharing has increased in the last decade, the take-up rate for health benefits by eligible participants of health benefit plans has significantly decreased. For those who still receive health benefits, employers argue the quality of care would not improve and might decrease, since the courts do not have the expertise to reach the appropriate decisions in specific cases. In addition, innovation could be stifled because health plans will be reluctant to cover anything other than what is required due to the fear of large judgments against them if they deviate from the standards established by state laws. Furthermore, employers believe that the marketplace—with the freedom to innovate—will provide the best quality of care at affordable costs, and employers and health plans are actively pursuing enhancements in quality under ERISA preemption that they suggest would not be possible if liability is increased.

## Estimates of Self-Funding<sup>21</sup>

achieving better control over the costs of providing and designing health benefits, and the levying of taxes on health insurance premiums by states are the various factors that have led employers to self-fund health benefits over the years. Each factor has had varying importance over time, but it appears that self-funding was on the rise during the beginning half of the 1990s and subsequently has held relatively stable during the mid-1990s. However, because data on employers that self-fund are limited, it is difficult to determine exactly how many employers are self-funding. The remainder of

Increasing health care costs, growing numbers and varying levels of state mandates,

Table 1  
Percentage of Full-Time Employees  
in a Self-Funded ERISA<sup>a</sup> Plan

	Medium and Large Establishments			
	1988	1991	1993	1995
Total	34	39	46	47
Fee-for-service	31	33	30	26
Preferred provider organization	3	6	16	21
	Small Establishments			
	1990	1992	1994	
Total	28	32	31	
Fee-for-service	25	27	23	
Preferred provider organization	3	5	8	

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments*, 1991, 1993, and 1995 (Washington, DC: U.S. Government Printing Office, 1993, 1995, and 1996); *Employee Benefits in Medium and Large Firms*, 1988 and 1989 (Washington, DC: U.S. Government Printing Office, 1989 and 1990); *Employee Benefits in Small Private Establishments*, 1990, 1992, and 1994 (Washington, DC: 1992, 1994, and 1996).

<sup>a</sup>Employee Retirement Income Security Act of 1994.

this section will provide a summary of the best available data on the percentage and number of people in self-funded ERISA health plans and the percentage of employers offering a self-funded plan.

## Employees in Self-Funded Plans

One of the data sets that includes information on the self-funding of health plans is the Bureau of Labor Statistics (BLS) employee benefits survey. This survey collects data on employee benefits of full-time employees. The BLS survey found that for medium and large private establishments (100 or more employees), the percentage of full-time employees in self-funded ERISA plans<sup>22</sup> grew from 34 percent in 1988 to 47 percent in 1995 (table 1). However, for small private establishments, the BLS reports the percentage went from 28 percent in 1990 to 32 percent in 1992, with a slight decline in 1994 to 31 percent. The percentage of full-time workers in self-funded traditional fee-for-service ERISA plans declined, while the percentage of full-time workers in self-funded preferred provider organization (PPO) ERISA plans increased between 1988 and 1995, which is consistent with the general movement into managed care. This is true for both small and medium and large establishments (table 1).

<sup>21</sup> In this section, where the year-to-year changes are small, the changes may be statistically insignificant. Thus, caution should be used when trying to interpret the trend for these changes.

<sup>22</sup> Again, ERISA health plans are all health plans offered by employers (insured and self-funded) except for government (federal, state, and local) employee plans and plans offered by churches to their employees.

KPMG Peat Marwick conducts an annual survey of health benefits of employers with 200 or more employees who offer health benefits. In their 1997 survey, they found a general decline in the percentage of employees covered by a self-funded plan of each plan type except for PPOs. In particular, the percentage of employees covered by self-funded HMOs and point-of-service plans (POSS) both significantly declined in 1997 from 1996. However, the increase in the percentage of employees covered by a self-funded PPO increased only slightly. The overall enrollment in PPOs grew significantly, while the enrollment in HMOs and POSS was virtually unchanged. Consequently, the overall percentage of employees working for employers with 200 or more employees covered by a self-funded plan fell from 65 percent in 1996 to 60 percent in 1997 (table 2).

In an analysis of KPMG Peat Marwick's small and large employer surveys of health benefits, Gabel, Ginsburg, and Hunt (1997) found that the percentage of workers in self-funded plans was virtually unchanged between 1993 and 1996 for both small and large employers. They reported that 34 percent of the workers in small employers were in self-funded plans in 1993, with the percentage increasing slightly to 35 percent in 1996. For large employers, they determined that the percentage of workers in self-funded plans had increased from 64 percent in 1993 to 66 percent in 1996. Furthermore, they discovered an increasing trend in the use of self-insurance with managed care plans for both small and large employers. However, this trend appears to be reversing at least for large employers, as described previously in the 1997 KPMG Peat Marwick survey.

Other surveys have allowed for the calculation of the percentage of employees in self-funded health plans. Acs et al. (1996) analyzed three surveys and found that between 32 percent and 42 percent of employees were covered under a self-funded plan. The surveys were conducted in different years and represented different types of employees. The Health Insurance Association of America estimates that 44 percent of all health benefits were paid under self-funded plans in 1992 (Butler, 1994).

Table 2  
Estimates of the Percentage of Employees in Self-funded Plans in Employers with 200 or More Employees

Year	Conventional	HMO <sup>a</sup>	PPO <sup>b</sup>	POS <sup>c</sup>
Percentage of Employees Enrolled in Each Plan Type				
1996	26%	33%	25%	16%
1997	18	33	31	17
Percentage of Employees in a Self-Funded Plan for Each Plan Type				
1996	90	21	82	86
1997	87	14	86	77
Total Percentage of Employees in a Self-Funded Plan				
1996				65
1997				60

Source: KPMG Peat Marwick, *Health Benefits in 1997* (Washington, DC: KPMG Peat Marwick, 1997).

<sup>a</sup>Health maintenance organization.

<sup>b</sup>Preferred provider organization.

<sup>c</sup>Point-of-service plan.

Liston and Patterson (1996) found that 60 percent of all workers were in some form of self-funded health plan in 1993, but this percentage fell to 51 percent in 1995. Thus, the estimates of the percentage of employees in self-funded plans vary over a relatively large range, possibly due to the scope of the surveys. However, the trend toward an increasing percentage of individuals covered by a self-funded health plan appears to have ended, with the proportion holding stable or possibly declining.

## Employers Offering Self-Funded Plans

Besides looking at employees who are covered by self-funded plans, it is important to look at the percentage of employers offering a self-funded plan. According to surveys conducted by Foster Higgins of employers that offer health benefits, the percentage of employers with 10 or more employees offering a self-funded indemnity plan decreased from 11 percent in 1993 to 9 percent in 1996 (Foster Higgins, 1994, 1995, 1996, 1997). In contrast, the percentage of employers with 10 or more employees offering a self-funded PPO increased from 1 percent to 11 percent from 1993 to 1996. In addition, self-funding of POS plans fell from 4 percent in 1994 to 3 percent in 1996, while the percentage of employers offering a self-funded HMO fell from 3 percent in 1994 to 2 percent in 1996.<sup>23</sup> However, the 1996 percentages for

<sup>23</sup> These numbers are consistent with those of Uccello (1996), who found that 13 percent of employers (with 2 or more employees) who offered health benefits self-funded in 1992.

the two latter groups did show an increase from 1995 (table 3).<sup>24</sup> The survey is limited in that it does not report the percentage of employers that offer any kind of a self-funded plan. This is due to the fact that an employer may offer a self-funded indemnity plan and a self-funded PPO along with an insured HMO. Consequently, the employer would be included in both the percentage of employers that offer a self-funded PPO and the percentage that offer a self-funded indemnity plan. The percentages for each plan type are not mutually exclusive, so they cannot be added up to get a total percentage. Therefore, it cannot be determined from this survey what the exact overall absolute trend is for employers offering a self-funded plan, but it does appear that a higher percentage of employers offered a self-funded plan in 1996 than in 1995, after a slight decline in 1995 from 1994 (table 3).

Employer size is an important factor in determining whether an employer offers a self-funded health plan. The Foster Higgins surveys' breakdowns for large employers show that these employers are more likely to self-fund health benefit plans (table 3). For instance, 42 percent of employers with 500 or more employees offer a self-funded PPO, while 50 percent of employers with 5,000–9,999 employees offer a self-funded PPO. The same trend emerges for each plan type.<sup>25</sup>

## Total Number of Participants in Self-Funded Plans

The surveys described above are limited in that they only look at the number of full-time employees covered by a self-funded plan, the percentage of employers that self-fund a certain type of plan, or the percentage of employees covered by a self-funded plan for only larger employers. This does not allow determination of the total number of people who are covered by self-funded ERISA plans. Therefore, the U.S. General Accounting Office (1995) developed a process to estimate the total number of individuals covered by self-funded ERISA plans. GAO first estimated the total percentage of full-time workers

Table 3  
Percentage of Employers Offering  
a Self-Funded Plan,  
by Plan Type and Employer Size, 1993–1996

Plan Type	1993	1994	1995	1996
10 or More Employees				
Fee-for-Service	11%	9%	7%	9%
Preferred Provider Organization	1	6	9	11
Point-of-Service Plan	n/a	4	2	3
Health Maintenance Organization	n/a	3	1	2
500 or More Employees				
Fee-for-Service	43	44	38	36
Preferred Provider Organization	22	31	35	42
Point-of-Service Plan	n/a	15	14	19
Health Maintenance Organization	n/a	4	6	3
5,000–9,999 Employees				
Fee-for-Service	54	46	54	49
Preferred Provider Organization	41	43	47	50
Point-of-Service Plan	n/a	20	25	34
Health Maintenance Organization	n/a	10	11	8

Source: A. Foster Higgins & Co., Inc., *National Survey of Employer-Sponsored Health Plans*, 1993, 1994, 1995, and 1996 (Princeton, NJ: A. Foster Higgins & Co., Inc., 1994–1997).

covered by self-funded ERISA plans by using the weighted-average of the percentage of employees covered by a self-funded ERISA plan in small employers from the 1992 BLS employee benefits survey and the percentage of employees covered by a self-funded ERISA plan in medium and large employers from the 1993 BLS employee benefits survey. They determined that about 39 percent of all full-time employees were covered by a self-funded ERISA plan, up from 33 percent during the period covered by the 1989 and 1990 surveys.

Using the Bureau of the Census Current Population Survey (CPS) data, GAO then estimated the total number of participants covered by ERISA health plans (insured and self-insured) to be 113.5 million. (This figure includes dependents and other employees with coverage.) Therefore, GAO concluded that 44 million individuals<sup>26</sup> (17 percent of the U.S. population) were

<sup>24</sup> Among employers offering an HMO, the percentage that self-fund increased from 3 percent to 7 percent from 1995 to 1996. Among those offering a POS, the percentage that self-fund increased from 13 percent to 16 percent from 1995 to 1996. The overall percentage (the number above in the text) of those offering a self-funded plan of each type may be significantly small, but the percentage (number in this footnote) that self-fund within each plan type is becoming increasingly significant.

<sup>25</sup> This corresponds with surveys from KPMG Peat Marwick that show employees of larger employers are more likely to be covered by a self-funded plan than employees of smaller employers.

<sup>26</sup> GAO assumed that the percentage of all individuals covered by ERISA plans is equivalent to the percentage of full-time workers covered by ERISA plans. Therefore, the 44 million participants is derived from the 113.5 million participants covered by ERISA plans times the 39 percent of full-time workers covered by self-funded ERISA plans. EBRI uses the same assumption for 1995 to get numbers comparable with the GAO result.



enrolled in self-funded ERISA plans in 1993, up from 39 million in 1989. The Employee Benefit Research Institute (EBRI), using the same methodology as GAO with 1995 data, estimated that 48 million individuals in 1995 (18 percent of the U.S. population) were enrolled in self-funded ERISA plans. This still represents about 39 percent of the individuals covered by ERISA plans in 1995. Thus, the number of participants in self-funded ERISA plans appears to have held relatively stable in 1995 after a significant increase in 1993, using this method (table 4).

## Stop-Loss Insurance

Another important factor in the number of self-funded plans is an employer's ability to use stop-loss insurance with self-funded plans. A stop-loss plan is an insurance plan that self-funded plans use to protect the company from unusually large claims. If the employer's claims surpass a certain dollar limit, the stop-loss insurer will assume liability for any claims above that amount. The dollar limits could be either on a per person basis or on a total claim basis. The surveys conducted by Foster Higgins show significant growth in self-funded plans with stop-loss coverage from 1995 to 1996. In addition, KPMG's annual surveys show an upward trend in the number of employees covered by a self-funded plan with stop-loss insurance from 1996 to 1997.

Employers see the use of stop-loss insurance as an important safety value for health benefit plans. In addition, they contend that stop-loss coverage is insurance for the plan, not for each participant's health care claims. The use of this insurance reduces the health benefit plan's risk of being unable to meet its obligations. However, some state regulators are concerned that the line between stop-loss coverage and full insurance is sometimes blurred, especially in situations where there are relatively low maximum payments that an employer must cover before the stop-loss insurer assumes liability (Butler and Polzer, 1996). Currently, states have very limited ability to regulate when stop-loss coverage

Table 4  
Estimates of the Number of Participants  
in Self-Funded ERISA<sup>a</sup> Plans

Survey Year	Breakdown by Survey		
	Full-Time Employment Size	Employees with Coverage	Percentage in Self-Funded ERISA <sup>a</sup> Plans
1989	Medium and Large	29.8 million	36
1990	Small	22.8 million	28
1992	Small	24.4 million	32
1993	Medium and Large	23.5 million	46
1994	Small	23.5 million	31
1995	Medium and Large	25.5 million	47
Overall Estimates of Participants in Self-Funded ERISA <sup>a</sup> Plans			
Year	Weighted Average Percentage in Self-Funded Plans	Participants in Employment-Based ERISA <sup>a</sup> Plans	Participants in Self-Funded ERISA <sup>a</sup> Plans
1989	33	117 million	39 million
1993	39	113.5 million	44 million
1995	39	124 million	48 million

Source: U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments*, 1991, 1993, and 1995 (Washington, DC: U.S. Government Printing Office, 1993, 1995, and 1996); and *Employee Benefits in Small Private Establishments*, 1990, 1992, and 1994 (Washington, DC: U.S. Government Printing Office, 1991, 1994, and 1996). For 1989 and 1993, U.S. General Accounting Office, *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA*, GAO/HEHS-95-167 (Washington, DC: U.S. General Accounting Office, 1995) provided these estimates of Bureau of Labor Statistics (BLS) data and Current Population Survey (CPS) data. For 1995, Employee Benefit Research Institute estimates of BLS and CPS data.

<sup>a</sup>Employee Retirement Income Security Act of 1974.

becomes primary insurance due to the rulings thus far by the courts regarding ERISA and stop-loss coverage.<sup>27</sup>

The most recent case on stop-loss coverage is *American Medical Security, Inc. v. Bartlett* (No. 96-1376, 1997). The Fourth Circuit U.S. Court of Appeals affirmed a lower court's ruling that Maryland's regulation prohibiting the issuance of stop-loss health insurance policies with an attachment point<sup>28</sup> below \$10,000 was preempted by ERISA. In another case, the Fifth Circuit Court of Appeals ruled in *Brown v. Granatelli* (897 F. 2d 1351, 1990) that a Texas-mandated benefits law was preempted by ERISA for a stop-loss insurer if the insurer was truly insuring against catastrophic costs (above \$30,000). However, the court did suggest in dicta that at a sufficiently low (e.g., \$500) deductible, a self-funded plan might be considered an insured plan, and the stop-

<sup>27</sup> States are able to regulate the solvency and other aspects of stop-loss insurers but cannot mandate health benefits for stop-loss insurance plans.

<sup>28</sup> An attachment point is the maximum amount a self-funded plan must pay per employee per benefit year before the stop-loss insurer assumes liability.



loss plan would be subject to state mandates (Butler, 1994). Hence, there may be a point where the courts will determine that a stop-loss plan is actually a primary insurer. However, some recent court rulings, including *American Medical Security, Inc.*, have rejected the idea that such a low attachment point exists that would turn stop-loss coverage into full insurance, since by doing so would be to treat self-funded plans as insurers, which would be a violation of the deemer clause in ERISA. As long as the employer maintains a relatively high attachment point on its stop-loss insurance plan, the employer's self-funded plan will apparently be considered immune from state regulation (Employee Benefit Research Institute, 1995; Liston and Patterson, 1996).

The use of self-funding health benefits increased from 1989 to 1993 and appears to have held stable since that time. There has been some discussion of increased use of self-funding, particularly by small employers as a result of the greater availability of stop-loss insurance products (Gabel et al., 1997). Furthermore, the creation of creative risk arrangements, especially among managed care plans, could lead to increases in self-funding. However, the data available show that the percentage of participants in self-funded plans is holding stable.

## Proposed Legislation

This section outlines the more prominent bills proposed in the 105th Congress to amend ERISA.

The bills range from very comprehensive to single issue measures. Most of the proposed legislation focuses on what consumer advocates call "consumer protection initiatives" or what health plan sponsors and health plans call "anti-managed care" bills or "provider protection" measures. The bill sponsors say their legislation would protect consumers from alleged abusive practices of managed care plans. Consequently, they say consumers would have greater protections from and recourses

against health plans. However, health plans and health plan sponsors contend that the legislation really addresses provider protections and would limit their flexibility in plan design and increase plan costs. Thus, the cost of health insurance would increase for consumers, placing a larger burden on individuals to finance their health insurance and potentially increasing the number of uninsured.

## Patient Access to Responsible Care Act of 1997 (PARCA) (S.644/H.R.1415)

PARCA was introduced by Rep. Charles Norwood (R-GA) in the House and Sen. Alfonse D'Amato (R-NY) in the Senate. It is a comprehensive measure that would impose numerous federal regulations on all health plans but in some cases only on managed care plans, not fee-for-service plans.

First, the bill would ban "gag rules or clauses"<sup>29</sup> (provisions in provider contracts that limit what providers can say about a plan or about what treatment options are available<sup>30</sup>) and potentially a wide range of utilization review requirements in providers' contracts. Second, it prohibits plans from requiring preauthorization for emergency room care, requires them to make emergency services available at all times, and mandates review and a determination of coverage within 30 minutes for claims of "urgent" care. Third, patients would be guaranteed plan coverage for a specialist when recommended by a treating health professional. Fourth, the bill would require all network-based health plans to offer a point-of-

<sup>29</sup> There is some disagreement concerning what meets the test of a gag rule. Some say that it only limits discussion of the treatment options available meets the test, while others would also include anti-disparagement clauses. PARCA covers only medical communications.

<sup>30</sup> A recent GAO report (GAO, 1997a) found no evidence that explicit gag clauses were used by health plans in the contracts they examined. However, the study relied on each HMO to submit a typical contract and did not examine any other written or oral communications between physicians and HMOs that could limit discussions of patient treatments. Therefore, the report did not rule out the possibility that HMOs use other measures to restrict medical communications.

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service (POS) option to enrollees at the time of enrollment, with restrictions on the premiums that could be charged for this benefit. Fifth, it requires all health plans to have a standard for due process for both participants and providers. Sixth, the bill would prohibit health plans from discriminating in any activity against individuals on the basis of health status or anticipated need for health services, which would effectively eliminate underwriting or rating differences. Seventh, the bill would limit much of the discretion that health plans have in structuring their provider networks. Eighth, an external review process would be required for the appeal of denied claims.

In addition to the various provisions above, PARCA contains the very hotly debated provision that would make “any person that provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits” explicitly liable for damages under state law for personal injury or wrongful death. Currently, the courts appear to rule consistently that state tort laws are preempted when a plan’s decision relates to a benefit determination or administration (Butler and Polzer, 1996; Association of Private Pension and Welfare Plans, 1997). However, when the issue becomes something outside of the determination and administration of benefits, state malpractice (tort) claims have increasingly been found not preempted by ERISA.<sup>31</sup> Despite the courts’ movement toward state-based remedies for malpractice claims outside of benefit determinations, this bill would guarantee a health plan’s participants who have allegedly been harmed by a plan’s decision (medical or benefit determination) full access to remedies available under state tort laws.

Proponents of this provision argue that ERISA currently prevents participants in health plans from the guarantee of receiving historical legal protections and remedies available under state laws. In addition, proponents argue that increased liability for health plans will

force the plans to improve the quality of care they provide. However, opponents of the bill point out that the bill could lead to a substantial number of lawsuits, including frivolous suits, and open up liability not just to health plans but also to health plan sponsors (e.g., employers) and health plan administrators. The threat of this increased liability could lead to weakened utilization controls, while health plan sponsors would be faced with potentially significant cost increases. Thus, ultimately some employers might drop health benefits, leading to reduced access to health insurance for some consumers as well as decreases in innovation by health plans and employers due to the threat of a lawsuit if they experiment. Furthermore, by opening up ERISA health plans to liability under state tort laws, national uniformity of employee benefit plans would effectively be eliminated. This inconsistent applicability of regulations could result because each state could pass laws that would require plans to conduct certain actions or be held liable for not performing the required actions under state tort laws. In response to criticisms of PARCA from employers, Rep. Norwood has recently introduced a new bill, Responsibility in Managed Care Act (H.R. 2960), that explicitly exempts employers from liability for a health plan’s decision unless employers are involved in the administration of the plan.

## Health Insurance Bill of Rights of 1997 (S.373/H.R.820)

Introduced by Sen. Edward Kennedy (D-MA) and Rep. John Dingell (D-MI), this bill would establish federal regulations that would be applicable to all health insurance and health benefit plans (insured or self-funded). The bill includes many of the same regulations on health plans as PARCA, but does not include the provision that allows participants to recover punitive and compensatory damages from health plans.

In addition to the regulations that the bill outlines, it would allow states to enact standards that are “at least as stringent” as the federal standards

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<sup>31</sup> See the discussion on ERISA’s remedies in the section on Preemption Issues.

*Another factor shaping future legislation is the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.*

except for those addressing emergency services. This bill, as well as PARCA, could lead to increased costs for employers either through higher premiums for health insurance or increased costs for self-funded plans as a result of the additional restrictions or increased coverage mandates. Furthermore, employers would have less flexibility to define the benefits that their particular employees want, while the health benefit plans of participants in self-funded plans and in states with less regulation would be subject to more regulations.

### **Managed Care Plan Accountability Act of 1997 (H.R.1749)**

This bill would make a group health plan or a health insurance issuer that uses managed care liable for compensatory and punitive damages if the policies of a managed care plan deny medically necessary coverage to participants. Introduced by Rep. Pete Stark (D-CA) in the House, it is similar to the provision in PARCA in that it makes additional entities explicitly liable for compensatory and punitive damages deriving from the decisions of a managed care plan. However, this bill focuses on any "medically inappropriate decision or determination" resulting from a cost containment technique or a policy "which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients."

### **Other Proposed Legislation**

Various other bills that mandate specific regulations for health plans have been introduced. Required coverage for a minimum length of stay for mastectomies and coverage of diagnostic mammography and pap smears are being proposed as federal mandates (i.e., H.R.616/S.249 and H.R.760/S.727). In addition, guaranteed access to emergency medical services is proposed in a bill (S.356) as well as bans on "gag rules" (H.R.586/S.449). Mandates to require dependent coverage for children and

controls on lifetime aggregate limits imposed by health plans have also been introduced (H.R.1854 and H.R.1807).

### **Anticipated Legislation**

Sen. James Jeffords (R-VT) is expected to introduce The Health Care Quality and Consumer Protection Act in early 1998. The bill would establish quality standards that private health plans must meet and maintain to receive the required accreditation. In addition, the act would include stricter disclosure requirements for plans on benefits, funding arrangements, and plan grievance and appeal procedures. The bill is also expected to contain many of the regulations on health plans that were discussed in PARCA. However, it will not provide legal remedies based on state tort law.

Another factor shaping future legislation is the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The commission was established to advise the President on changes taking place in the health care system. It is also supposed to recommend policies that may be necessary "to promote and assure health care quality and value, and protect consumers and workers in the health care system." A preliminary report outlining the commission's recommendations was delivered to the President in late November 1997, and the final report on its recommendations is due by March 30, 1998.

The preliminary report contains seven proposed consumer "rights" and one recommendation for consumer "responsibilities." The "rights" proposed include topics on information disclosure, choice of providers and plans, access to emergency services, participation in treatment decision, respect and nondiscrimination, confidentiality of health information, and complaints and appeals. However, the report does not recommend how to implement these "rights," or whether they should be voluntarily provided or mandated.

President Clinton intends to turn the report into legislation in 1998. In addition, ERISA preemption was a

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heavily debated topic in the recent hearings conducted by Sen. Jeffords. Consequently, important legislation directed toward ERISA is likely to result from Sen. Jeffords' bill and the President's bill, based on the commission's report.

### Expansion of Portability and Health Insurance Coverage Act of 1997 (EPHIC) (S.729/H.R.1515)

This bill, introduced by Rep. Harris Fawell (R-IL) in the House and Sen. Tim Hutchinson (R-AR) in the Senate, would create a new class of multiple employer welfare arrangements (MEWAs)<sup>32</sup> called association health plans (AHPs). AHPs would allow small businesses and individuals to band together to purchase health insurance through bona fide associations established for reasons other than the provision of insurance. Once the AHP enrolled a sufficient number of participants, the plans would be allowed to self-fund under ERISA and would be protected from state mandates and regulations. Under this bill, state regulation pertaining to MEWAs would be preempted from applying to qualified AHPs, while state regulation for all other MEWAs would be strengthened.

The goal in creating AHPs is to lower the costs of purchasing health insurance for small employers by giving them access to more market power and economies of scale in the purchase of health insurance. Preemption of state laws for AHPs would provide an incentive for small employers to join them and purchase health insurance, because it would give them the advantages of self-funding. Small employers would then have flexibility in the health benefits they offer as well as better control over the costs of their health benefits. Proponents claim AHPs could increase portability for employees who belong to these associations. Thus, an employee who changed jobs between two employers that were part of the same association would be able to continue under the same plan without any change in providers.

However, critics of this bill argue that allowing AHPs that self-fund to be exempt from state regulation could destabilize the market for small group health insurance. Employers would be drawn to these self-funded associations, because the association plan could offer less than the state-mandated benefits and be less costly. Thus, healthy groups would be particularly attracted to these associations, forcing the rates up in the state-regulated market for small group insurance. Consequently, if an AHP had significant claims and had to raise premiums, some employers might drop out, leaving the AHP without sufficient income to pay claims. This outcome could result in the remaining employers not having health coverage for their employees or facing substantially higher costs. Since the AHP would be exempt from state mandates and direct state taxation, it would not be part of the states' guaranty pools. Therefore, some participants or employers could be stuck with the responsibility for some claims that should have been covered under the plan. Opponents of this measure believe that there are not enough protections in this bill to prevent this occurrence. The group health insurance market could become unstable as a result of employers' ability to move in and out of associations as costs change and the potential reduction in the number of group insurance policy providers caused by competition among association health plans. Thus, fewer individuals could have access to health benefits or insurance than do now. Proponents counter that many practices of health insurers that occur in the small group market, such as increasing premiums when a group has a dramatic increase in claims and reducing risk by selecting the most favorable groups, create instability in the small

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<sup>32</sup> Currently, fully insured MEWAs are subject to only the solvency requirements of the state, while the insurers who issue policies to these MEWAs are subject to the full range of state insurance regulation. For self-insured MEWAs, the full range of state insurance regulations apply except for those that conflict with the provisions of ERISA. In addition, these MEWAs are still subject to ERISA reporting, disclosure, and fiduciary standards (Atkins and Bass, 1995).

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group market that could be alleviated by allowing small employers to band together.<sup>33</sup> Therefore, AHPs would place small employers on the same level as large employers in their purchase of insurance, giving individuals who work for small businesses more access to health insurance. Nevertheless, critics of this bill argue that there is no need to expend scarce government resources to create a new, federal level regulatory framework for MEWAs, when the states already have regulations and manpower for the enforcement of these regulations in place.

## Conclusion

Despite the sometimes confusing interplay between ERISA and state law, employers and

unions have found ERISA to be crucial to their ability to provide employee health benefits. ERISA allows multistate employers and unions to provide uniform coverage across all states instead of having to meet different state regulations, which these employers find critical to their ability to provide health benefits cost effectively. Employers and unions are able to offer the same benefits to all employees, which allows employees who transfer to continue coverage under the same plan. This uniformity reduces problems with employee relations, reduces the administrative costs of having to conform to many different state regulations, and allows for national collective bargaining<sup>34</sup> (U.S. General Accounting Office, 1995). Therefore, employers and unions or workers can negotiate over the level of health benefits relative to other benefits and wages, instead of having a mandated health benefit package. Furthermore, employers and unions that self-fund find that ERISA preemption allows them to better control their costs.<sup>35</sup> Employers and unions are able to negotiate with specific providers and be flexible with the type of coverage they offer. Thus, the employer is able to identify

more efficient providers and ensure that they meet certain quality standards. In addition, employers and unions are not subject to direct state excise taxes on insurance premiums (Employee Benefit Research Institute, 1984a). Some employers argue that if it were not for this ability to control or limit costs and the flexibility to define their own health benefits under ERISA's framework, they might provide much less generous benefits or none at all.

Employers, unions, and health plans fear that amending ERISA to allow punitive and compensatory damages will lead to a proliferation of costly lawsuits, with no resulting increase in quality. Employers and unions particularly believe that quality will not improve because of ERISA's fiduciary standards that require health benefit plan fiduciaries to act in the sole interest of plan participants and beneficiaries. If litigation reaches a significant level, employers may drop health insurance coverage because of the rising expense or out of fear of a large judgment against them. On the other hand, proponents of increased liability for ERISA health plans argue that participants who have been harmed by the decision of an ERISA health plan should have full access to all state tort and contract law remedies for recourse against the plans. In addition, the proponents of increased liability contend that health plans will not make great strides in increasing the quality of care until they are exposed to large judgments.

In addition to advocating increased liability for

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<sup>33</sup> HIPAA places significant restrictions on these practices by insurers.

<sup>34</sup> Unions consider this to be important in that unions are able to bargain for certain benefits without being constrained by differing state regulations on required benefit levels.

<sup>35</sup> There appears to be no solid data on the average cost-savings for employers who self-fund health benefits. However, a 1996 study by GAO looked at the costs of various state mandates. They concluded that mandates do increase costs, but many self-funded plans provide the mandated benefits. Thus, the cost savings may not be that great. The GAO did point out that, on average, self-funded plans save 2 percent by not having to pay premium taxes. Thus, the GAO concludes that cost savings are gained by self-funding since mandates do increase cost, but in some cases the savings is small because self-funded plans already provide the mandated benefits.



health plans, ERISA critics believe that there is inadequate regulation in ERISA for self-funded ERISA plans, creating uneven regulations for participants in insured plans and self-funded plans. The critics maintain that this is unfair and that participants of self-funded plans are at risk for harm under ERISA's present structure. They assert that participants in self-funded ERISA plans do not have the protections of solvency standards for their plan, do not have the specific benefit mandates and protections against managed care practices that those in insured plans have, and do not receive the information and assistance with complaints that those in insured plans receive. Furthermore, ERISA critics argue that state governments should be able to fully regulate health care in their jurisdictions.

As this *Issue Brief* suggests, there are strong arguments for both altering and preserving ERISA. Thus, when policymakers look to amend ERISA, they should consider whether any change to ERISA will provide a higher level of quality for consumers than is being provided under the present system and will continue to do so in the future. Policymakers must also decide whether quality of care is better enhanced by health plans' greater exposure to liability or by market forces. If policymakers decide that increased exposure to liability is the route to go, will consumers be able to enjoy any potential improvement in quality or will more individuals end up uninsured because of increased costs and not be able to get any care regardless of the quality? It is clear that additional mandates and regulations on health plans will increase costs, but it is not known by how much.<sup>36</sup> Hence, it is impossible to predict the extent

of which employers and unions would stop providing benefits if faced with more regulations. In addition, many so-called consumer protection initiatives being proposed could be interpreted as provider protections. If these initiatives are only provider protections, will the result be improved quality or only increased costs? Can the present marketplace force a higher quality of care, or will regulation better serve consumers of health care? If regulation is chosen, will many potential innovative ways to finance health care be lost, as employers assert, because strict regulations limit experimentation?

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<sup>36</sup> The impact has been estimated to be relatively negligible to substantial, depending on the interpretation of the mandates and assumptions from that interpretation. Despite the wide range, any increases in costs for health benefits could have potentially serious implications for the likelihood of small businesses offering health benefits. For instance, Feldman et al. (1997) estimated that for small establishments (with fewer than 50 employees) in the state of Minnesota, an increase of \$1 in monthly premiums would lead to approximately a 2 percent reduction in the proportion of small establishments offering health insurance. Consequently, if these regulations raise the costs of health insurance significantly, a potentially significant number of individuals could be without health insurance, especially employees of small businesses.

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