

# ERISA and Health Plans

**EBRI**  
**EMPLOYEE**  
**BENEFIT**  
**RESEARCH**  
**INSTITUTE®**

*Special Report*

*Issue Brief Number 167*

- This *Issue Brief* is designed to provide a basic understanding of the relationship of the Employee Retirement Income Security Act of 1974 (ERISA) to health plans. It is based, in part, on an Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) educational briefing held in March 1995. This report includes a section by Peter Schmidt of Arnold & Porter; a section about multiemployer plans written by Judy Mazo of The Segal Company; and a section about ERISA and state health reform written by Kala Ladenheim of the Intergovernmental Health Policy Project.
- Starting in the late 1980s, three trends converged to make ERISA a critical factor in state health reforms: increasingly comprehensive state health policy experimentation; changes in the makeup of the insurance market (including the rise in self-insurance and the growth of managed care); and increasingly expansive interpretations of ERISA by federal courts. The changing interpretations of ERISA's relationship to three categories of state health initiatives—insurance mandates, medical high risk pools, and uncompensated care pools—illustrate how these forces are playing out today.
- ERISA does have a very broad preemptive effect. Federal statutes do not need to say anything about preemption in order to preempt state law. For example, if there is a direct conflict, it would be quite clear under the Supremacy Clause [of the U.S. Constitution] that ERISA, or any federal statute, would preempt a directly conflicting state statute.
- States can indirectly regulate health care plans that provide benefits through insurance contracts by establishing the terms of the contract. And they also raise money by imposing premium taxes. But they cannot do the same with respect to self-funded plans. That is one of the factors that has caused a great rise in the number of self-funded plans.
- State regulation [of employee benefits] can create three kinds of problems: cost of taxes, fees, or other charges; cost of dealing with substantive, possibly inconsistent, benefit standards; and cost of identifying, understanding, and complying with the regulations themselves.

## Table of Contents

I. The Basics of ERISA as It Relates to Health Plans ...	2
Peter Schmidt, Esq., Arnold & Porter	
Introduction .....	2
ERISA Preemption .....	3
Insured and Self-Insured Plans .....	4
Discussion on States and Preemption .....	6
Multiemployer Plans and Preemption .....	7
MEWAs Versus Multiemployer Plans .....	7
Discussion about Multiemployer Plans and MEWAs .....	9
General Discussion .....	9
Managed Care .....	9
Stop Loss .....	10
Payment Rate Setting .....	11
Self-Insurance .....	12
ERISA Waivers .....	13
ERISA Damages .....	13
II. ERISA Preemption: Significance to Employers and Multiemployer Plans .....	15
Judy Mazo, The Segal Company	
Introduction .....	15
State and Local Revenue Raising .....	15
Substantive Rules and Standards .....	16
Compliance Costs .....	16
III. ERISA and State Health Reform .....	17
Kala Ladenheim, Intergovernmental Health Policy Project	
Introduction .....	17
Insurance Mandates .....	17
Medical High Risk Pools .....	18
Uncompensated Care Rules .....	18
Other State Initiatives .....	19

# Part I. The Basics of ERISA as It Relates to Health Plans

By Peter Schmidt, Esq.  
Arnold & Porter

## Introduction

I am going to start at a very basic level by asking the question, what is preemption?

To a lawyer, the concept of federal preemption has its origin in the U.S. Constitution. The Constitution includes the Supremacy Clause, which basically says that federal law is supreme. If there's a conflict between state law and federal law, federal law will take precedence.

The Supremacy Clause and this doctrine of law do not require a direct conflict in order for preemption to occur. In other words, you can imagine a federal law that says you must do X and a state law that says you must do Y. Where the two are inconsistent and you obviously can't comply with both of them, the federal law under the Supremacy Clause would be predominant. And you would do X.

But the Supreme Court, in construing the Supremacy Clause, does not require a direct conflict of that type. There are areas in which Congress has acted in a way that the Supreme Court says "occupies the field," meaning that Congress intended federal regulation to be the only regulation in that area. This doctrine is argued in all kinds of areas. For example, you may have seen the cigarette manufacturers arguing that the warning labels that Congress required on cigarette cartons and advertising some years ago precluded state regulation of cigarette advertising and other aspects of cigarette smoking and the damages that might result.

---

## ERISA Preemption

Let's turn to ERISA preemption, the basic topic, and again start at

the first level. What does ERISA mean?

It stands for the Employee Retirement Income Security Act of 1974. ERISA applies to virtually all private-sector employee benefit plans. The term *employee benefit plan* means an employee welfare benefit plan, an employee pension benefit plan, or a plan that is both. The terms *welfare benefit plan* and *benefit plan* are extremely broad: employee welfare benefit plans cover virtually any kind of plan you can think of, including any private-sector health plan that is offered by an employer whether it is insured or not insured.

**ERISA itself is a complicated statute containing a good deal of substantive regulation. Most of this regulation applies to pension plans, not to welfare or health benefit plans.** For example, ERISA requires that, after a period of years, a pension benefit that you've been earning becomes vested and is nonforfeitable. It can't be taken away from you.

There is no comparable provision with respect to health plans. In one respect that's perfectly understandable. If you work for years trying to earn a pension and then it's taken away the year before you retire, the inequity is obvious. In contrast, with a health plan, the benefit is used as the need arises. As you work, you're receiving coverage. If you get sick, you take advantage of it.

However, one area in the health plan segment that is similar to pension plans is retiree health. Some employers promise retiree health coverage, and this coverage has become very expensive for a number of employers for a variety of reasons. Health care itself, of course, has become very expensive. Some industries that have promised retiree health benefits have been shrinking, so there are many retirees and not many active workers to support the benefit anymore. Therefore,

employers have been cutting back.

There have been a number of court battles about these cutbacks. **One thing is clear: there is no right to vesting in health benefits under ERISA. Instead, the courts apply contract rights created under federal law. Sometimes courts tell employers they can't cut back on retiree health benefits and other times they say they can cut back. But, unlike the situation with pension benefits, ERISA itself has very little in the way of substantive regulation of health care benefits.**

There are disclosure rules that apply to health benefit plans requiring employers to make plan documents available to their workers. There are fiduciary rules that govern the conduct of the managers of these plans and sometimes can be used as a means to sue an employer who is denying a worker a benefit. And there are consequences under the fiduciary rules that are more severe with respect to liability for breaching these fiduciary rules than for a simple breach of contract claim. That has some relevance in this area. But these are the exceptions rather than the rule in ERISA. There is very little substantive regulation of health plans in ERISA.

**There is, for example, nothing in ERISA about many of the issues on which so-called health care reform in the last several years has focused, for example, preexisting condition limitations, universal coverage (or any coverage for that matter), portability, or managed care. ERISA does not regulate any of these issues in a direct way and only regulates them indirectly to a small extent.**

Nonetheless, ERISA does have a very broad preemptive effect. Federal statutes do not need to say anything about preemption in order to preempt state law. For example, if there is a direct conflict, it would be quite clear under the Supremacy Clause that ERISA, or any federal statute, would preempt a directly conflicting state statute. There may be a question as to whether the federal statute is constitutional, i.e., whether this is an area in which Congress really belongs. But assuming

*For a while it was rare for ERISA cases to go to the Supreme Court, but it is happening more frequently now.*

that it is constitutional, it quite clearly would override a conflicting state law.

Some laws, though, and ERISA is one, have explicit preemption clauses in the statute itself. The text of the ERISA statute says, with a significant but not overwhelming exception that I will mention later, “The provisions of this title, and Title IV” (meaning titles of ERISA) “shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.”

“Relate to” is obviously a loose term with a potentially broad sweep. The legislative history of ERISA from 1973 and 1974 makes clear that Congress in fact intended a very broad sweeping preemptive effect.

For a while it was rare for ERISA cases to go to the Supreme Court, but it is happening more frequently now. My theory is that the statute is maturing. People are seeing the ambiguities and the potential for lawsuits, but the increase in ERISA litigation also has to do with our aging population. Nonetheless, preemption has been a hot issue in the Supreme Court almost from the outset. And when the Supreme Court decides a preemption case, it doesn’t necessarily establish bright lines that end the controversy. Many cases go to the Supreme Court and, after the Court says this is the law, that’s the end of the matter. However, ERISA preemption is such a difficult issue, at least at the margins, that it has been the subject of many cases, and I’m sure there will be a number in the future. In fact, there’s one before the Supreme Court right now, the Travelers case, which deals with a New York statute that I’ll discuss later.<sup>1</sup>

Preemption applies not only with respect to pension plans where, as I’ve indicated, there is substantive regulation but also to health care plans and welfare benefit plans in general. So, you have what some think is an anomalous situation where, on the one hand, the ERISA statute says the states cannot regulate this area and, on the other hand, the statute doesn’t provide any

substantive regulation itself. If you want to change that situation, what can you do?

First, ERISA preemption is not an impediment to *federal* legislation. The comprehensive health care reform that was discussed last year, incremental health care reform, or any kind of health care legislation that’s done at the federal level will not be affected or impeded in any way by ERISA preemption. Nothing has to be done with ERISA to change the rules at the federal level.

However, with one exception that I will discuss relating to state insurance regulation, **ERISA does preclude regulation by the states. In other words, if you want to change that rule, you’ll have to change the ERISA preemption provisions. ERISA currently has no provision for “waivers.” People sometimes ask me how to get an ERISA waiver. Where is the provision for an ERISA waiver? There isn’t any.** The only way to get an ERISA waiver is to pass a law, and have the President sign it, that says ERISA preemption does not apply, for example, to the prepaid health care act of Hawaii. (For a variety of reasons the statute actually says that with respect to Hawaii.)

So, ERISA preemption does not apply with respect to Hawaii health care regulation of a particular kind. Other states have asked for similar kinds of provisions. You may think that’s good or bad. We’ll come in a minute to some of the pros and cons. But it requires a federal law, a piece of federal legislation if you want to do it.

## *Insured and Self-Insured Plans*

An important distinction that confuses people sometimes

is the effect of ERISA preemption on insured health plans on the one hand and self-funded or self-insured health plans on the other. Insured health plans and self-funded or self-insured health plans can be thought of as

<sup>1</sup> See the box, “The Travelers Case,” for an explanation of the ruling that was handed down on April 26, 1995 in this case.

---

occupying opposite ends of a spectrum (with hybrid plans in between). In its simplest form, an insured plan is one where the employer purchases health care coverage from an insurance company and simply pays a premium each year for that coverage.

A self-funded plan, on the other hand, is one where the employer puts money directly into a plan, which then pays the benefits itself (rather than buying insurance coverage). Or, it can be thought of that way because it may be funded on a pay-as-you-go basis. But, in effect, what happens is when the employees make claims under the health care plan, the employer pays them with money that's been put aside in this plan and not given to an insurance company. There's no insurance element except for the notion that the employer is insuring itself.

Why are these plans affected differently by preemption? The answer is that ERISA's preemption clause, which has three basic sections, includes an exception. The first section states the basic preemption rule referred to earlier, 514(a), is called the ERISA preemption clause. The second section, called the "savings clause," in effect says that ERISA does not impede the state's ability to regulate insurance. **Insurance regulation is a traditional state regulatory activity as opposed to a federal activity, and Congress recognized that there was, in the health care area and even in the pension area, some potential overlap between insurance on the one hand and employer benefit plans on the other.** The third section, called the "deemer" clause, says in essence that states cannot avoid preemption by simply calling benefit plan regulation insurance regulation.

The Supreme Court has said that, even in the case of an employee benefit plan, if the states regulate insurance contracts, then it is permitted to have an effect on a plan that buys insurance contracts. Thus, the state may dictate that only certain insurance contracts are legal. You have to have a certain level of mental health coverage. You have to have chiropractic treatment as an alternative. You have to have this. You have to have

that. You have to have certain reserves to maintain financial stability, etc. That clearly has an effect on an insured plan because the contracts the plan buys can no longer exclude mental health benefits if the state requires mental health coverage in every health insurance contract. The state is indirectly requiring the plan to have that kind of coverage. So mandated benefits legislation can affect insured employer health plans in this indirect fashion.

**However, the Supreme Court has said that states cannot regulate employee benefit health care plans that don't buy insurance contracts.**

Because the exception to ERISA preemption is one that says states can regulate *insurance*, let's look at a plan that clearly doesn't have anything to do with insurance. This type of plan provides certain benefits, and when an employee incurs a claim, the plan pays that benefit out of its own assets. In that circumstance, ERISA preemption precludes state regulation. Thus, under the current state of the law, states can't have generally applicable mandated benefit legislation.

The result of this is that states can indirectly regulate health care plans that provide benefits through insurance contracts by establishing the terms of the contract. And they also raise money by imposing premium taxes. But they cannot do the same with respect to self-funded plans. That is one of the factors that has caused a great rise in the number of self-funded plans.

But let me come to the currently pending Supreme Court case, *Travelers*,<sup>2</sup> which concerns a New York state statute that the U.S. Court of Appeals for the Second Circuit in New York said was preempted by ERISA. This 1993 decision conflicted with a Third Circuit decision upholding a similar New Jersey law called *United Wire*, that was decided in 1992. (The Supreme Court doesn't take all cases that people appeal, but it is likely to accept cases where there's a conflict between the lower courts, the Courts of Appeal.)

The *Travelers*' case involves a New York law

---

<sup>2</sup> *Ibid.*

### The Traveler's Case

On April 26, 1995, after the EBRI-ERF briefing on ERISA was held, the Supreme Court handed down its decision in *New York Blue Cross v. Travelers Ins.*, \_ U.S. \_, 131 L.Ed. 2d 695. In that decision, the Court upheld the hospital surcharges imposed by New York law, declining to hold that state statute preempted by ERISA. The Court saw the law's indirect economic effect on employee benefit plans as too attenuated to support a finding of congressional intention to preempt such regulation. The Court did say that an indirect economic effect could, at least theoretically, rise to a level of substantively regulating employee benefit plans, and therefore be preempted. The decision, however, provides no "bright-line" test on this score and may well be destined to take its place in a long line of ad hoc Supreme Court decisions on ERISA preemption. Although these decisions have at least the veneer of analytic complexity, they are arguably best categorized under the "I know it when I see it" strain of judicial rationalizing.

providing that hospital rate surcharges were payable by some users

of hospital services, including self-funded plans, but not by all users. An avowed purpose of one such surcharge was to get more people to use the Blue Cross/Blue Shield plans. These plans have their own problems in a free market situation where they traditionally have been the insurer of last resort, accepting everybody. They were sort of community rated except that in a free market situation a plan that accepts everybody ends up with only the unhealthiest persons. Plans that primarily cover healthy people can charge a lower premium, so the healthy people enroll in plans that insure only healthy people instead of plans that pool all the risks and require them to pay for some portion of the unhealthy people also.

Such plans, including Blue Cross/Blue Shield, traditionally have had a problem competing, and this statute was in part designed to deal with that. Similarly, the New Jersey law involved hospital surcharges meant to fund uncompensated care, i.e., care for people who go to emergency rooms needing treatment and are not turned away but don't have any insurance or any assets.

These laws were challenged on several bases, but a principal basis of challenge was the notion that, for a self-funded plan this statute was preempted by ERISA—that ERISA preempts any state law that relates to an employee benefit plan. And it clearly involves a law that relates to an employee benefit plan when someone from the self-insured ERISA plans shows up at the hospital and is in effect taxed, i.e., the self-funded plan is taxed to pay for uncompensated care for people who are not members of the health plan in question.

If you take the term *relates to* very literally, and the Supreme Court has read this quite broadly in general, you would think that's the right conclusion. You can see, however, that this is a relatively close call. The

Third Circuit came out one way, the Second the other. There has to

be some limit to the notion of *relate to*. For example, if a health benefit plan rents space from a landlord and then doesn't pay its rent, and the landlord sues the plan for rent, can the plan come in and say, sorry, that's preempted by ERISA and ERISA doesn't say anything about our having to pay rent so we're not going to pay?

There is a point, and the Supreme Court has said this in several cases, where ERISA does *not* preempt the state law when its relation to employee benefit plans is too attenuated. It does have some effect on the plan, but the law wasn't meant to regulate a plan or tax a plan. And the effect that it admittedly has on a plan is regarded as too remote to trigger ERISA preemption. Part of the reason the Supreme Court has had a hard time establishing bright lines is because in some respects it's kind of a common sense test. These things have to be decided on a case-by-case basis.

## Discussion on States and Preemption

**QUESTIONER:** In New York, where the hospital rate setting law gives an advantage to Blue Cross, those ERISA plans that are working through Blue Cross are regulated by the law. Were ERISA self-insured plans disadvantaged?

**PETER SCHMIDT:** Yes. And in fact, one of the aims of the statute was to make Blue Cross/Blue Shield more attractive to all consumers, including ERISA plans.

You might ask why should there be any ERISA preemption in this area when the statute itself has very little in the way of substantive regulation. And in fact, proponents of changes to ERISA preemption ask that very question. They say in the context of health care reform efforts, "let's let the states experiment." There are

---

50 of them. We're going to try different models and somebody's going to find out what works best and then, if it's appropriate to do that at the federal level, we can. But why handcuff the states with ERISA preemption, particularly when the federal government doesn't regulate these things itself?

That question is certainly legitimate. The answer, i.e., the rationale for preemption in this area, is usually focused on national or multistate health care plans. There are, for example, large manufacturers in the industrial sector and elsewhere with workers in different states. If you have a patchwork quilt of regulation, you would likely have conflicting mandated benefit laws requiring, for example, chiropractic coverage, a certain amount of mental health coverage, and so forth. There are in fact over a thousand such laws on the books right now in the 50 states. It's been thought that people who operate on a national level, or even in a number of states, would in effect have to take their single plan—which was designed to provide the same coverage to all their workers—and break it into as many as 50 different plans, with different terms, in order to meet the requirements of the various states.

## *Multiemployer Plans and Preemption*

requirements in different states. Another entity that has this concern is the multiemployer plan. I've done a lot of work with multiemployer plans over my career, and I've found both on Capitol Hill and also in the courts in other contexts that many people don't have any idea what a multiemployer plan is. It is defined in the statute as a plan that is collectively bargained and to which more than one employer contributes. Two conditions must be

I mentioned large companies, large industrial companies, as having this concern about meeting different

met in order to be a multiemployer plan. The first condition is quite important in distinguishing multiemployer plans from multiple employer welfare arrangements (MEWAs). MEWAs are noncollectively bargained plans maintained to benefit employees of two or more employers that are not under common control.

Where do multiemployer plans come from? They got their start in industries in which individuals work for more than one employer; the most extreme illustration, for example, is the West Coast longshore industry, where stevedores come to a dispatch hall every day and are sent to various employers in the port to unload ships that day. There are rules, at least in some segments of this industry, that if you worked yesterday and there's somebody in the dispatch hall who didn't work yesterday, he goes out and you don't. If you worked for employer X yesterday and there's work available at employer Y, you are sent to Y rather than back to X. So people work for different employers every day. And in that circumstance, they don't have enough continuity with a single employer to earn, for example, a traditional pension benefit. Employers have never paid pensions to people who worked for one day for them, or even for one year.

The multiemployer plan developed in these industries. The industry itself became for this purpose the employer. And the plan gave credit for service with any of the employers in the industry. If you work 1,000 total hours during the year for five different employers, you earn 1,000 hours of credit under your multiemployer pension plan. If you work enough hours to have eligibility for a health benefit under the multiemployer health plan, you get a health benefit. These plans have spread to other industries, but generally they're industries where people move from one employer to another. The needle trades and the construction trades are other examples.

## MEWAs Versus Multiemployer Plans

**MEWA, the acronym for multiemployer welfare arrangement, is a term that's in ERISA. In fact, it's**

---

**on the page with the preemption clause of ERISA because there are special ERISA preemption rules with respect to MEWAs.** Some MEWAs, like the kind that were featured on “60 Minutes,” are bad apples.

It doesn't follow that an arrangement of this kind has to be a bad apple. It may well make sense in certain circumstances. But MEWAs are in part a creature of this preemption anomaly that I talked about before, i.e., where ERISA preempts other regulation but provides no substantive regulation of its own. In effect, preemption provides interstices in which bad apples can sit. And by bad apple, let me give you an illustration of a simple case.

I'm a bad apple. I set up an entity and call it an insurance company or something else. I go to employers and say, I'm going to provide you health coverage for one-half of what you're paying now. The employer says it's a good deal. He signs up and starts paying me monthly premiums. I don't set up any reserves. In fact, my arrangement is never going to be able to pay the benefits that I'm promising. How do I survive?

The answer is in the long run, I don't. But for a while, particularly if I'm signing up new employers, I've got enough cash coming in to pay benefits, and employers who were concerned about me can call these other employers whose name I'll give them. And they'll say, it seems fine so far. They're very polite, they pay the benefits, etc. In effect, it's a Ponzi scheme. Eventually it has to collapse, and when it collapses is usually when the phone stops being answered. “60 Minutes” shows up and the place is boarded up and nobody can find anybody. A number of these operations have been set up.

What does ERISA or ERISA preemption have to do with this? The answer is, states normally regulate this kind of business. But when I first opened my MEWA and the regulators said okay, we like new employers in our community but we want to make sure that you've got adequate reserves, that you're financially stable, etc. I said I'm an employee benefit plan, and I'm not subject to state regulations. So I'm really not inclined to show you any of my books or to try and meet any of

your requirements.

That worked for a while with some people. At least there was a fight about whether it worked or not. So, Congress changed the law to say that, in effect, if you are a MEWA, you are subject to state insurance regulation. However, if you're a multiemployer plan (not a MEWA), preemption works as described above.

This is where people get confused because a MEWA, like a multiemployer plan, has more than one employer contributing to it. Remember, I said a multiemployer plan had two conditions: it is collectively bargained and more than one employer contributes. And incidentally, in a multiemployer plan, there's usually a common bond as in the stevedoring industry, the Ladies Garment Workers Union in New York, and the carpenters' union.

A MEWA, on the other hand, has different kinds of people in it: different kinds of employers whose link may be nothing more than that they all contribute to this particular plan. And they're not collectively bargained because they are not generally a result of negotiations of any kind on the labor side but are simply retail commercial transactions.

**MEWAs under ERISA are now basically subject to state insurance regulation. If a plan is fully self-insured, then the state regulation is a bit limited, covering only financial stability and related conditions that the state imposes. But if a MEWA is not fully insured, then it's subject to the full range of state insurance regulations under ERISA.**

So that's a thumbnail sketch both of ERISA preemption and multiemployer plans. People need to understand multiemployer plans because even though they look very much like other kinds of plans, their structure makes it impractical for them to comply with certain conditions with which single-employer plans can easily comply.

This impracticality results from a number of factors. For example, multiemployer plans have to be funded by a contribution rate based on units of produc-

---

tion. For example, so many cents per hour would go to fund the health care plan, the pension plan, or any other kind of multiemployer plan. In a single-employer plan, like the one operated by General Motors or U.S. Steel, the company simply puts in enough money during the year to pay the health care plan's claims. Managers can wait and see what ERISA requires in terms of pension funding and put in that amount of money. A multiemployer plan can't do that. It can't come to the end of the year and see then if the employers can be found and forced to put in the money. There has to be a separate entity of some kind that is funded by reference to units of production. Funding in this fashion could, without special provisions, run afoul of administrative rules on full funding, etc.

Moreover, these plans don't have the records that the employers maintaining single employer plans have. For example, in the pension area, if nondiscrimination rules require access to the compensation levels of an employer's other workers, a multiemployer plan wouldn't have these records.

## Discussion about Multiemployer Plans and MEWAs

**QUESTIONER:** Is multiemployer plan an interchangeable term for Taft-Hartley or is Taft-Hartley just one of them?

**PETER SCHMIDT:** Essentially it's an interchangeable term. Taft-Hartley has a requirement that says it's a felony for an employer to give money or anything of value to a union official. If a plan is administered in part by union officials, as most multiemployer plans are, then it would be a violation of Taft-Hartley unless it qualifies for one of the exceptions in sec. 301(c)(5). One exception says that it is not in violation of Taft-Hartley law if it's a trust that provides an employee benefit, is jointly administered, and includes an equal number of employer and employee representatives.

Theoretically, you could have an arrangement

outside the multiemployer universe that qualifies as a Taft-Hartley plan. But as a practical matter, you don't. That's where it shows up all the time, and the terms are thus used interchangeably.

These plans, which are not to be confused with so-called "MEWAs," have on occasion joined with the National Association of Manufacturers, the ERISA Industry Committee (ERIC), and others who normally don't support the same legislation as unions do. But on ERISA preemption, in fact, they have seen eye-to-eye generally. And the Chamber of Commerce, at least in 1980, took the same position.

## General Discussion

### Managed Care

**QUESTIONER:** I have a

question about managed care and ERISA. I've heard that states that are trying to regulate managed care insurance are running into problems.

**PETER SCHMIDT:** That's a real issue. When I mentioned the three clauses of ERISA preemption, I didn't spend much time on the third one, which has special relevance here. The first section is the preemption clause itself. The second section is called the savings clause, which says ERISA preemption doesn't apply to state regulation of insurance. And the third one is sometimes called the "deemer" clause. Essentially it says, just because you call it insurance regulation doesn't mean we're going to treat it as insurance regulation.

**State regulation may still be preempted by ERISA even if it's expressed in the guise of insurance regulation.** In the Travelers' case, the New York state insurance regulators issued some rules. I said there's a spectrum of health care plans from fully insured at one end to completely self-insured at the other. Not too many people sit right at those ends. They're somewhere in between. And what's closest to

---

*Normal stop loss is insurance and states are permitted to regulate it, despite ERISA preemption. What you're buying is something that I think spreads the risk in the normal way.*

self-insured is a situation where you basically self-insure but you have stop loss insurance in case your claims go berserk.

The insurance regulators in New York issued some rules that said you can't sell stop loss insurance to a plan unless that plan has mental health coverage and a whole gamut of things that they clearly couldn't require as a direct law applicable to self-funded plans. The Second Circuit said no, that's not insurance regulation, it's an attempt to regulate ERISA plans in a way that's not permitted by ERISA.

This is one of the gray areas that is still being sorted out.

DALLAS SALISBURY: The principle issue that relates to managed care concerns some state efforts regarding so-called any willing provider legislation that would require managed care organizations essentially to allow any doctor who wanted to be part of the organization to join.

QUESTIONER: There are other issues: utilization review standards, due process standards, and the whole issue of consumers being able to sue the current system. That hasn't been discussed. The fact is that if you're in an ERISA plan, you can only get the cost of the care that wasn't provided.

PETER SCHMIDT: And attorneys' fees. But you're right. Only those two things. You can't get extra contractual damages, punitive damages, consequential damages. You can't get any of that. And this applies to any employer plan regardless of whether it's self-insured or not.

## Stop Loss

**QUESTIONER: Could you tell me about stop loss? There's a debate now whether stop loss is insurance and whether it should be regulated by the state.**

PETER SCHMIDT: My sense is that normal stop loss is insurance and states are permitted to regulate it, despite ERISA preemption. What you're buying is something that I think

spreads the risk in the normal way. Stop loss is something where you don't normally expect to have a claim against the coverage. Just like the fire insurance on your house, you don't expect to have a claim. You pay something as do hundreds of other people. And then when one in a hundred has a house burn down, it's paid for. And in that sense, I think it's clearly insurance. But when a state says, if you have stop loss insurance, you must have certain levels of health benefits, is that regulation of insurance or of employee benefit plans? To take, for purposes of illustration, a more absurd example, suppose a state passes a law saying that, if you have stop loss, you're not allowed to stand up and read the Constitution. That's not regulation of insurance and would be a violation of the First Amendment. If a state says, we can add on any kind of regulation we want to "regulation" of a stop loss policy without worrying about ERISA preemption, I don't think that works as a concept.

Then the question becomes, is there a bright line here? Does what New York tried to do fall beyond the line? The Second Circuit said yes. Can you do anything with respect to stop loss? I think you can provide some kinds of standards in line with more traditional insurance regulation. And there's going to be a gray area somewhere in the middle.

QUESTIONER: The states can tax the premiums for stop loss, can't they?

PETER SCHMIDT: My understanding is that states can charge premiums on insurance generally.

QUESTIONER: Even though it's a self-insured plan?

PETER SCHMIDT: It's not self-insured to the extent that it has stop loss. I mean, a pure self-insured plan

---

wouldn't have stop loss. I don't know if there has been litigation on that particular issue.

QUESTIONER: I know it is happening. There are states that tax.

PETER SCHMIDT: Yes, my immediate reaction would be you ought to be able to tax it without running afoul of ERISA preemption. But it's conceivable courts have said otherwise; I just don't know.

DALLAS SALISBURY: The tax applies to the premium on the stop loss coverage, not on the cash flow within the health plan itself.

PETER SCHMIDT: Right. I think if you put in a tax, a so-called premium tax, on stop loss insurance and it was measured in the way Dallas says, that would probably be held preempted in the same way that the New York courts said you're not regulating the stop loss, you're trying to regulate the benefits that the plan provides.

QUESTIONER: Is there a definition of what stop loss insurance actually is? If you have a per person deductible of \$5,000 and buy stop loss insurance above that, my understanding is you still qualify as self-insured, and the state can't control you.

PETER SCHMIDT: You're talking about something that's kind of transparent from the other end, trying to make yourself seem self-insured where you're not. A more extreme example may be to say, what if you have a \$200 deductible and then you buy stop loss insurance to cover everything over that. That looks like a traditional health insurance contract, and I think courts would say you can regulate that. ERISA itself doesn't use the term stop loss.

QUESTIONER: Do you have a sense of whether there are economic or legal limits to expansion of stop loss coverage?

DALLAS SALISBURY: **There is a question of whether there are economic or legal limits to the expansion of stop loss coverage. During the health reform debate reinsurers expressed concern about the absence of attention to the dynamics of that market. They view themselves as fully subject to state regulation.**

At the very small end of the employment spectrum, they're concerned about small businesses with a narrow set of benefits that try to bring stop loss reinsurance down to a low level. The issue is whether limits should be set so that in order to be considered self-insured, an employer would have to pay claims of, for instance, up to \$3,000 per capita in an aggregate cost sense. None of the bills that I have seen try to determine that number.

## Payment Rate Setting

QUESTIONER: Maryland has a payment rate setting system similar to New York's in some ways. Their hospitals adopted this system in 1974. Does that mean that it's safe from ERISA suits since the system went in before ERISA?

PETER SCHMIDT: No, there's no grandfathering of that kind. I don't know the Maryland system, and I don't know whether there have been any challenges to it under ERISA, whether it passes muster or doesn't. But there's no grandfathering of that kind.

DALLAS SALISBURY: My understanding of the Maryland system is that it is not an issue of regulating the plan or regulating insurance but of establishing a payment rate system for all insurers.

QUESTIONER: You're right. The Maryland payment rate setting system could potentially be subject to an ERISA challenge. It has not been subject to one in the state because it worked. It was put in place through the Social Security Act, through Medicare.

---

PETER SCHMIDT: Both the New York and the New Jersey statutes had diagnosis related group bases that were not challenged. It was the surcharges and the changes after that that were challenged in those cases. I'm not familiar with Maryland's system and I don't know if it's distinguishable in that regard or not.

## Self-Insurance

QUESTIONER: What are some of the advantages to companies that self-insure; what is their argument in favor of self-insurance in terms of being more economical and uniform nationally?

DALLAS SALISBURY: The first advantage was gained by large companies, and it was the ability, by self-insuring, to avoid paying insurance companies a lot of money that they could then hold in reserve and collect the investment earnings. In the early structures, pre-1974, the companies were never able to recoup the losses from those forgone earnings.

The second advantage was nonfinancial: it was the companies' ability to provide an identical health plan to workers wherever they were working so that there was no variation in the employee benefit package as they moved from place to place. In the days when companies were fully insured, there would be variations from state to state as a result of the state insurance regulation of the fully insured program. And companies would end up with something being covered in one state that was not covered in a different state or something they didn't want to do that was mandated in a particular state.

**In the last 10 years, when state health insurance reforms became far more frequent and aggressive in terms of underwriting standards as well as benefit mandates, the size of the employers that are self-insuring has dropped dramatically.** Whereas in the early days it was principally large employers that were motivated by their multistate status as well as by financial considerations, now the growth of self-insurance is being driven much more by a desire

simply not to be under that more extensive state regulation.

For example, if one looks at the current discussion on Capitol Hill of insurance market reforms that might be put into federal legislation, and one were to put those bills on a continuum relative to the state of California and assign a 10 to what California now has in the law as its insurance underwriting standards for fully insured plans, most of the bills now being discussed on Capitol Hill would be down at maybe a 4.

**At least one-half of the states have more aggressive standards for preexisting conditions and underwriting and guarantees of renewability, etc., than what is being contemplated in Congress. And so very small businesses are concerned about costs. State mandates can multiply the cost of a plan relative to what it could provide through a self-insured approach. The cost would be lower not because of lower claims experience per se, but because the plan would be able to have different deductible structures and longer waiting periods, etc.**

PETER SCHMIDT: I think to some extent, too, you can look at it as the pressure coming from the other side. In terms of the employers' perception, why should they pay these premiums when they're big enough to have a pool to spread the risk across without joining with others. They might as well capture the insurance company profits for themselves.

**Insurance companies have moved further and further away from the traditional concept of insurance by experience rating and risk selection techniques. So that in effect, an employer ends up covering its own risks anyway.** If it's going to have to pay a different premium each year, depending on its claims experience, then eventually it may say, I'm there anyway. I have, in effect, stop loss insurance. But other than that, I seem to be paying everything out of my pocket anyway so why not self-insure and not pass profits to other people?

---

And to some extent, I think insurance companies have been happy with this result because they end up in a situation where they say, we are administering these programs anyway. Let's charge a fee for administering the program and let the employer's assets fund the plan and then there isn't a risk for us, either.

## ERISA Waivers

QUESTIONER: I was wondering if you could possibly provide some background on how Hawaii was successful in getting the ERISA waivers?

DALLAS SALISBURY: I wouldn't describe it as successful in getting an ERISA waiver because the waiver was incorporated into ERISA. Its inclusion was related to the fact that they had already done something and also to the fact that the senior senator from the state of Hawaii was threatening to keep other legislation from being enacted if the provision did not get into the bill. According to the legislative history, he was the only senator who felt strongly enough about the preemption clause to make an either "do this or there will be no legislation" type of threat.

Since that time, the numbers make clear that if others had wanted waivers at that point, there probably would not have been tremendous resistance to it. The market has changed so fundamentally since ERISA was enacted that it now becomes a far different political issue than it was back then because not only do major corporations now self-insure but self-insurance goes very far down the scale.

## ERISA Damages

QUESTIONER: Would you discuss extra contractual damages in ERISA, including the legislative history and how that affects plans?

PETER SCHMIDT: I'm not sure if there's legislative history on this point. From a technical/legal standpoint,

it comes from a couple of things in ERISA, but not an explicit statement, that you can't get extra contractual damages.

The Supreme Court has said more clearly in the last year or two than it had said previously that you can only get equitable relief under ERISA for certain things that are specified, such as benefits. There's a provision that says this is the section you sue under. It says you can get the benefits that you're promised and other appropriate equitable relief.

For the nonlawyers, equity on the one hand and law on the other stem from the English tradition on which our jurisprudence is largely based. In England, courts of equity simply "did the fair thing"—a practice stemming from the traditional right to seek a "boon" from the king. Courts of law had more formal and rigid procedures. Our system follows this tradition, but it has merged the two courts. However, equitable relief traditionally does not include what we would think of as damages. Some things get close; for example, restitution is an equitable remedy. So, if something's been taken away, you can make the person give it back.

Restitution may be a lot like damages in a lot of fact patterns, but consequential damages, not an equitable relief. The Supreme Court said early on in one of its first ERISA cases that you can't get what it calls extra contractual damages under ERISA. There has been a minority effort—a vocal minority—for some time to change the law in that regard.

QUESTIONER: Does that significantly influence health benefits?

PETER SCHMIDT: The people who are trying to make the case in the starkest terms for changing that rule would say there are some bad apples out there who try to avoid paying the promised benefit and just say, sue me. When they are sued, they can only be sued under ERISA because of ERISA preemption. And, under ERISA, they can't be held liable for any extra contractual damages. So all they have to do in the end is pay what they were

---

supposed to pay in the first place. What's the down side for bad apples in acting that way?

The people on the other side would say, that may be true for the bad apples but there are a lot of good apples out there, too. These are tough decisions sometimes, involving issues such as autologous bone marrow transplants and similar procedures that some plans don't cover because they are experimental, cost hundreds of thousands of dollars, and may or may not be effective. Then, if a court says you should have paid, you may owe much more than the contested benefit because the person lost his or her job and house and experienced pain and suffering.

Under ERISA, this person can sue the fiduciaries. As mentioned earlier, there are some things you can get under interpretations of the fiduciary rules (although not extra contractual damages) that you wouldn't get under normal breach of contract. One of the scary things for people who run any kind of plan, the fiduciaries of the plan, is that they're personally liable for breaches of fiduciary responsibility. In benefit claim situations, it really doesn't make sense to make them personally liable, and most courts don't. But I've seen decisions where courts get confused, too, and order the fiduciary to pay.

Many ERISA lawyers, at least in this town, marvel that anybody serves as a fiduciary under the current law. In fact, I was at a meeting where we talked about this and somebody said, you'd have to be a lunatic to be a fiduciary if a plan couldn't cover your legal costs when you were sued, at least under the circumstance where you'd pay back the legal costs if you lost. This is common in the corporate situation. The problem I found with this discussion was that most of us in the room believed you'd have to be a lunatic to do it *with the coverage*.

There does come a point where even people who are not thinking about this all the time, and aren't as risk averse as lawyers tend to be, are not going to serve as fiduciaries. And from a policy standpoint, that wouldn't be a good result.

QUESTIONER: Isn't there an insurance that covers certain risks that fiduciaries are subject to?

PETER SCHMIDT: Yes, it's a tricky area in itself. ERISA precludes plans from paying for insurance for their fiduciaries unless the policy has a right of recourse against the fiduciary. In other words, the plan can buy coverage to protect itself, but whoever pays it can then go after the fiduciary. That doesn't cover the fiduciary.

Fiduciaries can buy insurance for themselves, but they have to pay the premium. Questions have been raised about the fact that the basic insurance is sold to the plan and then there is what is called a nonrecourse rider that the fiduciaries pay for. And they pay some arguably nominal amount for the rider. I have heard it questioned whether that itself is a violation of ERISA because in effect the plan itself is really paying for the coverage. The bottom line is that it's a hard problem to solve fully just with the notion of getting insurance under the current state of the law.

QUESTIONER: Has anyone raised a concern that the personal insurance that the fiduciaries take out make them less responsible?

PETER SCHMIDT: I don't know. I guess it could be argued that way. I tend to come at it from the other end of the spectrum where I think, you are seriously exposing yourself to do this in the first place. And if you do do it, you have to be very careful and should be able to secure insurance coverage. But I'm not a fiduciary. And I'm always very careful not to be because it's a functional definition under ERISA and you could become a fiduciary even if you didn't have a title like trustee of the plan or whatever.

---

# Part II. ERISA Preemption: Signifi- cance to Employers and Multiemployer Plans

By Judy Mazo

The Segal Company

## *Introduction*

**In recent years, ERISA preemption has tended to draw the most atten-**

**tion in connection with health plans. This is largely because states have been particularly active in attempting to regulate—and tax—health coverage, and these efforts have generally been rebuffed by the federal courts when applied to ERISA plans.** Also, since ERISA does not regulate health plans with the same types of detailed, exacting standards that it imposes on pension plans, critics of ERISA preemption sometimes charge that ERISA health plans are “unregulated.” (Not only does this overlook the extensive and growing web of federal laws governing health plan design and operations, it implies that there is something inherently undesirable about leaving any activity unregulated.) Of course, retirement and deferred compensation plans also come under the ERISA preemption shield, but health plans offer the clearest illustrations of plan sponsor concerns.

Why is this so important to plan sponsors? Is it

more than a wish to avoid another level of regulation and accountability?

At the core is a fairly self-evident principle. **Plan sponsors *don't* want benefits to be subjected to state regulation for the same reasons that states want to regulate them: because they have become so significant in the lives of the employees, the operations of the sponsoring businesses, the groups that deliver benefits or covered services, and the broader economy. To compete globally, American businesses do not want to be forced to shape and price their benefit programs according to rules that can change abruptly at a state line.** This is as true for employers contributing to, and unions cosponsoring, multiemployer plans under the Taft-Hartley Act as it is for individual companies.

State regulation can create three kinds of problems: cost of taxes, fees, or other charges; cost of dealing with substantive, possibly inconsistent, benefit standards; and cost of identifying, understanding, and complying with the regulations themselves.

## *State and Local Revenue Raising*

With the intense hostility to general tax increases that has

become a political fact of life in recent years, states and localities have had to search out other revenue sources. Some charges that have been tried, but blocked by ERISA preemption, include fees or service taxes for specialized professionals who provide services to ERISA plans, such as actuaries or claims administrators; a tax on the cash-flow of self-funded health plans, similar to insurance premium taxes; and taxes or surcharges on benefit plan activities (e.g., a real estate transfer tax applied to pension fund asset transactions).

These types of charges are politically attractive to state and local governments because they are “invisible”—hidden increases in plan sponsor costs, along with

---

the other costs of doing business. When they can be targeted to larger, interstate corporations and union groups, which are more likely to incur high service charges and maintain self-insured programs, the political impact can be defused even more. Employees, of course, bear the brunt of these charges when they are paid less or have their coverage reduced to compensate for the higher cost, but that can be “blamed” on the employer or the union that determines wages. By contrast, a local or state sales or income tax increase reminds the citizenry, each time they buy something or receive a paycheck, of the money that their elected representatives are making them pay.

In light of the U.S. Supreme Court’s 1995 decision in *Pataki v. Travelers Ins. Co.*, upholding New York State’s system of selective surcharges on hospital bills, this is an area of concern from which even ERISA may not protect employee benefit plans.

## *Substantive Rules and Standards*

These could take any of a myriad of forms: benefit

mandates, such as required inclusion in health plans of coverage for selected conditions or services (e.g., infertility services, pastoral counseling, acupuncture, etc.); *bans* on certain coverages (e.g., abortion) or even a requirement for universal employer-paid health coverage (as in Hawaii); rules for the manner in which benefit plans are operated (e.g., claims review procedures, special nondiscrimination rules—sexual orientation, marital status, youth, standards for plan enrollment and election procedures); rules governing basic plan design and administration (e.g., any-willing-provider, mandatory point-of-service and other anti-managed care laws, minimum and/or maximum reserve requirements for health plans); state law causes of action and damages remedies, including punitive damages.

Obviously, all of these types of rules have direct

costs. But this is compounded by the direct and indirect costs of trying to deal with different rules in different states. **Balkanizing plans’ designs would weaken plan sponsors’ negotiating positions with providers and impair the economies of scale achievable through integrated benefits programs.** It could seriously undermine administrative quality-control efforts, as it would be difficult for all concerned to keep track of the correct rules and procedures if they vary from office to office. More than that, it would undermine coherent benefit and compensation planning by forcing employers and collectively bargained groups to provide different benefits to similarly situated employees depending on where they live or, perhaps, where they work. The irrationality would become most evident in metropolitan areas that span state lines, such as New York, Philadelphia, Washington, Chicago, Charlotte, St. Louis, and Kansas City.

## *Compliance Costs*

Too often the frictional costs of regulation—paying people to

monitor the various state and local requirements in order to determine whether they require any substantive action—are overlooked. However, considering that this regulation means keeping abreast of laws, rules, and court decisions of more than 50 jurisdictions (including the District of Columbia) that can affect benefit plans directly as well as indirectly, the costs can be substantial. Similarly, state registration and reporting requirements can entail costly systems modifications even if they do not lead to positive mandates. And, given the range and complexity of the various rules, the potential for inadvertent violations is magnified by the number of jurisdictions involved.

---

# PART III. ERISA And State Health Reform

By Kala Ladenheim  
Intergovernmental Health Policy Project

## *Introduction*

For better or worse, ERISA has shaped state health reform for two decades.

Unlike Hawaii, where a unique ERISA exemption was granted by Congress for an employer mandate enacted a few months before ERISA was passed, states that seek to assure coverage for all their residents are barred by ERISA from requiring employers to insure their workers. **If it were not for ERISA, employer mandates would be a likely vehicle for comprehensive access reforms, since most of the medically uninsured have work force connections and most private health insurance is obtained through employment.** Even more modest state efforts to expand coverage for the working poor are dampened by states' inability to demand that employers continue current coverage and concomitant fears of further erosion of coverage among the near poor.

In the late 1980s and early 1990s, first in response to apparent federal indifference, then in anticipation of expected national health reforms, a number of states began to explore ways of assuring coverage for all. Two states (Massachusetts and Oregon) enacted laws—never implemented—that use a combination of taxes and credits for health insurance known as employer play or pay. There will probably never be a test of whether these constructs would have withstood an ERISA challenge although, with the Travelers' decision, they seem more viable today than they have for some

time. Washington state chose to gamble on changes in federal ERISA law and enacted a straightforward employer mandate: the federal changes never came, and the mandate was repealed this year. Minnesota took what looked like a safer route around ERISA and proposed individual mandates, but even these were repealed when it became apparent that the state would be alone in experimenting with universal coverage.

In the first decade after enactment, ERISA's influence on state health policy was not particularly contentious. Expansions of coverage for the indigent, elderly, and disabled as well as state programs to control the shape and costs in the delivery system while supporting hospitals with a high burden of indigent care seemed unaffected by ERISA. **However, starting in the late 1980s, three trends converged to make ERISA a critical factor in state health reforms: increasingly comprehensive state health policy experimentation; changes in the makeup of the insurance market (including the rise in self-insurance and the growth of managed care); and increasingly expansive interpretations of ERISA by federal courts. The changing interpretations of ERISA's relationship to three categories of state health initiatives—insurance mandates, medical high risk pools, and uncompensated care pools—illustrate how these forces are playing out today.**

## *Insurance Mandates*

ERISA has been interpreted consistently as preempting

**insurance mandates for self-insured plans while allowing states to place them on insurance. Mandates may require that coverage for certain benefits (e.g., hospice care, mental health care) be provided or offered; specific providers be put on a par with others (osteopaths, psychologists) or specific groups of persons (dependent students,**

**newborns**). Every state has some mandated requirements, ranging from a low of 6 in Idaho to 30 in California,<sup>3</sup> and many are not controversial. However, in response to criticism of the proliferation of mandates and concern that these were driving firms to self-insure, a number of states instituted procedures for studying and evaluating proposed new mandates in the 1980s.

Lately, narrow clinically defined mandates have become more common: requirements that insurers cover a particular test or procedure such as mammography or autologous bone marrow transplants, for example. This reach of mandates into clinical specifics has most recently taken the form of requirements that managed care plans permit new mothers to remain in the hospital for 48 hours after delivery or provide home nursing. Such laws highlight the ambiguity of ERISA in the area of managed care. Depending on how the requirement is worded, the regulations may be laws related to insurance (permitted for non-ERISA plans), medicine (possibly applicable to all plans, given the ruling on Travelers), or on an entity whose status under ERISA depends on whether and how various plans are defined within a state's insurance code.

## Medical High Risk Pools

Medical high risk pools for the 1 percent to 3 percent of the population that is

likely to experience difficulty in finding coverage in the insurance market due to preexisting medical conditions, often called comprehensive health insurance pools, originated in Minnesota and Connecticut in the 1970s. By the late 1980s, about one-half of the states had some sort of product available. The earliest pools were funded through premium taxes, and courts were swift to rule

that these could not be levied on employer plans because of the deemer clause in ERISA. Later pools tended to rely on general fund revenues; these were seen as immune to ERISA challenge until the rulings in New Jersey and New York that suggested that a variety of health-related taxes could be challenged under a sweeping interpretation of preemption and fiduciary responsibility.

While a few states—Indiana, for one example—encouraged employers to place high risk workers in its pool, most states sought to discourage participation by employers that were not sharing the financial risks. However, since direct prohibition on self-insured plans participating in these pools would violate ERISA, barriers to separating high risk employees from self-insured groups were constructed through individual eligibility determination geared to the availability of other coverage. Recent state insurance reforms adopted by almost all the states, requiring carriers to guarantee issue and renewal of policies for small groups (and in some cases individuals) and limit or prohibit medical underwriting and extended waiting periods, have the effect of creating a wider risk pool. However, the same problems remain for persons moving between plans covered by the state laws and plans that are immune from them. Because of ERISA, states alone cannot establish reciprocal portability for eligibility, underwriting, and preexisting condition waiting periods for persons moving from self-insured to insured plans and vice versa.

## Uncompensated Care Rules

In the first decade after ERISA, a number of states experimented

with rate regulation and all-payer systems that set hospital payment rates for all groups. These required federal waivers for both Medicaid and Medicare, and in several cases they were formed in conjunction with a system that equalized expenditures among, as well as

<sup>3</sup> Gretchen Babcock, Susan Laudicina, and Brice Oakley, State Legislative Health Care and Insurance Issues; 1994 Survey of Plans (Washington, DC: Blue Cross Blue Shield Association, 1994). Appendix-unnumbered table: State Mandated Benefits and Providers.

*Given the variety of state laws, the fluidity of the contracting entities, and lack of guidance from the courts to date, it may take more than one case to determine the applicability of ERISA.*

within, hospitals by taxing receipts or revenues to fund an uncompensated care pool. This strategy of rate regulation and pooling risks generally fell out of favor as states began to pursue more competition-oriented strategies in the 1980s, but it had in any case never seemed to be within the domain of ERISA. This changed in the early 1990s, when the loss of the Medicare waiver in New Jersey and the sudden leap in the assessment on other providers was a triggering event for the lawsuit (*United Wire et al.*) that led the way in broad interpretations of ERISA in the second and third circuit courts in the early 1990s.

While few states were still regulating hospitals rates, 26 states were taxing providers in the 1990s, often in order to take advantage of an anomaly in the federal Medicaid law that allowed states to tax providers, use the funds to draw down federal matching funds at a rate that varied from 1:1 to 4:1, and then return the money to the hospital in the form of “disproportionate share hospital” reimbursements. Because new limits sharply curtailed states’ ability to guarantee that hospitals would have their funds restored just as some circuit courts were ruling such taxes might be subject to ERISA, the fate of state provider taxes was uncertain for several years. However, the Travelers’ decision seems to confirm states’ ability to set such levies.

## *Other State Initiatives*

categories of incremental reforms adopted in many states in the penumbra of national reform in the 1990s. These activities, which had once seemed innocuous in terms of ERISA, were increasingly being questioned on ERISA grounds in light of expansive court rulings. These activities included the use of standardized and electronic

The Travelers’ decision has apparently cleared the way for some other

claims, data collection activities, and other planning and administrative simplification strategies.

ERISA’s place in other areas remains unclear. While state insurance reforms have been clearly targeted to groups too small to self-

insure, both states and insurers have muddied the boundaries of these reforms. Some insurers offer reinsurance at low attachment points that make it indistinguishable from insurance products, while some states have been exploring ways of using mandates or tax incentives to force third party administrators or reinsurers to structure benefits in a way that mirrors insurance regulation.

Managed care is a term now loosely used to cover a plethora of arrangements from loose provider networks that assume only a minimum of risk to indemnity insurance with a utilization review component. The extent to which such arrangements constitute insurance, medical practice arrangements, or something else, is rarely codified. Some states—Minnesota is a leader here—have begun to develop unified codes across the spectrum of entities. Any willing provider laws and patient protection acts—laws that impose conditions related to provider contracting, consumer access to providers, and conditions for rejecting claims and providers—are active areas of state health lawmaking today. Given the variety of state laws, the fluidity of the contracting entities, and lack of guidance from the courts to date, it may take more than one case to determine the applicability of ERISA. Indeed, barring an update of ERISA in regard to health, the effect of ERISA on state health reforms is likely to continue to be important but ambiguous as legislative initiatives, the market, and legal doctrine continue to evolve.

---

**EBRI****EMPLOYEE****BENEFIT****RESEARCH****INSTITUTE®**

# Special Report

*Issue Brief Number 167*

© 1995.  
Employee  
Benefit  
Research  
Institute-  
Education  
and  
Research  
Fund.  
All rights  
reserved.

---

The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan public policy research organization based in Washington, DC. Established in 1978, EBRI provides educational and research materials to employers, employees, retired workers, public officials, members of the press, academics, and the general public. The Employee Benefit Research Institute Education and Research Fund (EBRI-ERF) is a nonprofit, nonpartisan education and research organization established by EBRI in 1979. EBRI-ERF produces and distributes a wide range of educational publications concerning health, welfare, and retirement policies. Through its books, policy forums, and monthly subscription service, EBRI-ERF contributes to the formulation of effective and responsible health, welfare, and retirement policies. EBRI and EBRI-ERF have—and seek—a broad base of support among interested individuals and organizations with interests in employee benefits education, research, and public policy.

**EBRI Issue Briefs** provide expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. **EBRI Notes** provides up-to-date information on a variety of employee benefit topics. **EBRI's Benefit Outlook** provides a comprehensive legislative bill chart coupled with observations on the likelihood for passage of employee benefits-related legislation. **EBRI's Quarterly Pension Investment Report (QPIR)** provides historical data on net contributions to pension plans and investment allocation by plan type, total plan assets and their investment mix by plan type, and short- and long-term earnings. **EBRI's Washington Bulletin** provides sponsors with short, timely updates on major developments in Washington in employee benefits.

EBRI also publishes EBRI/Gallup public opinion surveys, special reports, studies, and books.

**For information on subscribing to EBRI publications or on becoming a member of EBRI, call or write to EBRI at 2121 K Street, NW, Suite 600, Washington, DC 20037-1896, (202) 659-0670.**

Nothing herein is to be construed as necessarily reflecting the views of the Employee Benefit Research Institute or the Employee Benefit Research Institute Education and Research Fund or as an attempt to aid or hinder the passage of any bill pending before Congress.

EBRI Issue Brief is registered in the U.S. Patent and Trademark Office  
ISSN: 0887-137X 0887-1388/90 \$ .50 + .50 .  
e-mail: publications @ EBRI.org