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EMPLOYER-BASED HEALTH PLANS

Issues, Trends, and Challenges Posed by ERISA



**Health, Education, and
Human Services Division**

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Congressional Requesters

As the movement for comprehensive federal health care reform has faded, the focus of reform has shifted to the states and private market. States remain concerned about the growing number of individuals lacking health coverage and about financing health plans for low-income individuals. Employers have become increasingly aggressive in managing their health plans and have adopted a wide variety of managed care plans and innovative funding arrangements. Despite the recent moderation of health care cost increases, both states and employers continue to seek approaches that will enable them to more effectively provide health care coverage to their respective constituencies.

Much of the debate on this subject centers on the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides a federal framework for regulating employer-based¹ pension and welfare benefit plans, including health plans. Most Americans receive health care coverage through employment, and most of these health plans are subject to ERISA requirements. ERISA preemption effectively blocks states from directly regulating most employer-based health plans, but it permits states to regulate health insurers. Because the distinction between prohibiting states from directly regulating employer health coverage and allowing them to regulate health insurers is sometimes obscure, the courts have had to determine many of the actual implications of ERISA preemption.

Because employer health plans are generally beyond the scope of state authority, states consider ERISA a major obstacle to their ability to effectively manage their health care markets. Although states seek changes in ERISA to give them more flexibility to increase access to health care and lower health costs, only Hawaii has received a statutory exception from ERISA. The business community, however, notes that, by specifically preventing states from regulating employers' voluntary provision of health coverage, ERISA promotes more effective provision of such coverage. Business leaders maintain that ERISA is the lynchpin of their efforts to effectively manage the cost and quality of the health care plans they offer their employees.

¹Such plans may be established or maintained by employers, employee organizations (such as unions), or both.

To assist the Congress in its decision-making on this issue, you asked us to provide information on (1) ERISA's relationship to the current system of employer-based health coverage, (2) the implications of the trend toward employer self-funding on the oversight of employees' health care coverage, (3) the kinds of state actions preempted by ERISA, and (4) the advantages of ERISA preemption to employers that offer health care coverage to their workers.

To develop this information, we interviewed officials representing the following entities: state associations; the states of Massachusetts, Oregon, Washington, and North Carolina; large multistate employers; business associations; and the Department of Labor. To a lesser extent, we also contacted several insurers, managed care plans, unions, providers, consumer advocates, and their national representatives. Although individual members of each of these interest groups have differing views, in this report we generally use "states" or "employers" to refer to the predominant perspectives of each group.

We also reviewed the legislative history, court decisions, and research on ERISA. To analyze the financing and provision of health care coverage, we examined data from the Bureau of Labor Statistics (BLS) Employee Benefits Surveys and the Bureau of the Census Current Population Survey (CPS).

Our review was conducted between November 1994 and May 1995 in accordance with generally accepted government auditing standards.

We have also begun examining other related issues, including the implications of small employers' self-funding on states' small group reforms, for a forthcoming report.

Results in Brief

Although ERISA preemption effectively blocks states from regulating most employer-based health plans, it permits states to regulate health insurers. We estimate that roughly 114 million individuals (44 percent of the U.S. population) are covered by ERISA health plans. In most of these ERISA plans, the employer purchases health care coverage from a third-party insurer that is subject to state insurance regulation and insurance premium taxation. But for nearly 40 percent of these plans, covering about

44 million people, the employer chooses to self-fund² and retain the risk for its health plan. Because these self-funded plans are not deemed to be insurance, ERISA preempts them from state regulation and premium taxation. All ERISA health plans, including self-funded ones, are subject to federal fiduciary and reporting standards.

Available data suggest that self-funding is increasing, particularly among smaller firms. For example, one survey indicates that between 1990 and 1992 the percent of participants covered by self-funded plans in private establishments with fewer than 100 employees increased from 28 percent to 32 percent. Accurately assessing such trends, however, is difficult given the dynamic nature of the health market and the increasingly blurred distinction between self-funded and insured plans. In many cases, employees do not know whether their employer-based health plan is self-funded or purchased through an insurer. This results partly because employers are increasingly adopting funding arrangements that are neither fully insured nor fully self-funded. These arrangements include increased use of stop-loss coverage to moderate the employer's risk and alternative arrangements with managed care plans that share risk among the plan, providers, and the employer. Currently available data sources do not provide sufficient detail to accurately gauge such trends, in part because ERISA preempts states from requiring health plans to report such data and federal data collection efforts have been limited.

The growth of self-funding poses concerns for the states because fewer individuals are insured by health plans that states oversee. States view ERISA as an impediment to ensuring adequate consumer protections for all individuals with employer-based health care coverage as well as for enacting administrative simplification or cost reduction reforms that would improve the efficiency, equity, and efficacy of their health care markets. States maintain that they should have the right to uniformly tax all participants with health coverage without ERISA's shielding a group of employers. States also believe that some of the emerging self-funded health plans with extensive stop-loss coverage closely resemble more traditional health insurance and are trying to regulate these plans.

²Although both the terms "self-insured" and "self-funded" are commonly used to describe employer health plans that are less than fully insured, neither is completely accurate. Insurance is a contractual arrangement in which financial risk from one party (the "insured") is transferred to another party (the "insurer"). In this report, we refer to firms that bear a large portion of the risk for employee health claims as self-funded rather than self-insured because no insurance arrangement covers this risk. Even the term "self-funded" may not be entirely accurate because, in most cases, employers do not set aside separate funds to finance their health plans but pay for incurred health costs through general assets. A more accurate but too awkward term may be "less than fully insured" because many employers with self-funded plans purchase stop-loss insurance to mitigate their potential losses or purchase prepaid health care contracts for some employees.

Employers, on the other hand, believe that, by providing the underlying framework for voluntary health care coverage, ERISA has been integral to their efforts to contain health care costs and design plans tailored to their employees' needs. They are concerned that any modification to ERISA will jeopardize their recent cost containment gains and, worse yet, may impose an additional burden on employers voluntarily providing coverage. They maintain that if the costs associated with state regulation following an ERISA amendment are too high, they may have to reevaluate how they voluntarily offer health benefits.

To date, the courts have played a key role in defining the extent to which ERISA preempts state attempts to regulate or tax employer health plans. Earlier decisions appeared to interpret ERISA as restricting a broad range of state provisions that may relate to employer health plans. But the most recent Supreme Court decision noted that "nothing in the language of the Act . . . indicates that Congress chose to displace general health care regulation." Evaluating the state response to this ruling is premature, but it may suggest greater flexibility for states, which will probably lead to further litigation.

ERISA's effect on the ability of states and employers to influence the health care system's impact on their constituents remains ambiguous and is subject to further interpretation. Better information on the participants in self-funded plans and state regulation's effect on these plans is currently missing.

Background

The current ERISA debate stems primarily from the act's preemption of state laws that "relate to" employer- or union-sponsored health plans, which provide coverage for about 140 million Americans. In general, ERISA prevents states from regulating employer health plans but allows them to regulate the terms and conditions of health insurance sold in the state. Thus, for example, states cannot require employers to provide health care coverage, but they can require that all health insurance policies sold in the state include specific benefits (for example, mental health benefits). This results in a very different regulatory framework depending on whether the employer purchases its health care coverage from an insurer, which the state regulates, or self-funds its health plan, avoiding many state regulations.

Although ERISA prevents states from directly regulating employer health plans, it does impose certain federal requirements on all health plans. These include

- reporting requirements providing, for example, that information about each plan be reported annually to the Department of Labor;
- disclosure requirements ensuring that plan participants and beneficiaries have access to information about the plan;
- fiduciary obligations prohibiting conflicts of interest and imposing certain fund management and investment practices; and
- plan claims filing procedures including, for example, a process for appealing claim denials.³

ERISA does not, however, require employers to provide or maintain a minimum level of health benefits nor to set aside funds to pay for expected health claims.

ERISA requirements apply to all private employer-based health plans, whether fully insured through a third party or self-funded.⁴ In a self-funded health plan, an employer directly holds much of the financial risk associated with its employees' health care costs. Often, an employer that self-funds simplifies its administrative burden by contracting with an insurance company or other organization to perform administrative services.⁵ In addition, an employer that self-funds often purchases stop-loss insurance that moderates its risk by capping the amount of claims it will pay directly for either an individual or the group.

Effect on Health Plans Changing as Courts Continue to Interpret ERISA Preemption

Court decisions on the scope of ERISA preemption continue to affect the nature and structure of employer-based health plans. ERISA was initially passed primarily in response to concerns about the solvency and security of employer-based pension plans, but its preemption clause made it possible for employers to provide all employee benefits—including health plans—largely free from state regulation. The impact of ERISA has become

³In addition, the 1986 Consolidated Omnibus Budget Reconciliation Act amended ERISA to add provisions requiring group health plans covering over 20 employees to continue health coverage for 18 to 36 months following a termination of employment and certain other conditions (29 U.S.C. 1161 et seq.).

⁴Governmental plans—those offered by local, state, or federal governments—and church plans are generally excepted from ERISA requirements.

⁵These are typically called “administrative services only” contracts and are performed by “third-party administrators.”

increasingly significant as the number of self-funded health plans has grown.

Court Decisions Lead to Sharp Distinction in Regulating Self-Funded and Fully Insured Plans

The original ERISA preemption language was sufficiently ambiguous that courts have had to elaborate on its scope.⁶ Courts have tried to delineate how closely state laws must relate to employer health plans to be preempted. In *Metropolitan Life Ins. Co. v. Massachusetts*,⁷ a unanimous Supreme Court identified a crucial distinction under ERISA between the treatment afforded health plans that are self-funded and those that are fully insured. The Court's decision permitted states to generally enforce laws that apply to insurers even though this would impact the employee health plans that they insure.

In effect, this decision has produced a divided regulatory system: the federal government retains the sole authority under ERISA to regulate employer-based health plans but not health policies sold by insurance companies; states can regulate health insurance companies and their policies but not the plans provided by employers.⁸ Thus, insured health plans are subject to specific consumer protections, state-mandated benefit laws, premium taxes, any-willing-provider laws, and participation in community-rated or high-risk pools; self-funded health plans are not.

The distinction between self-funded and fully insured health plans does not, however, extend to health care coverage offered by federal, state, and local governments. For example, health plans offered through the Federal Employees Health Benefits Program (FEHBP), although not self-funded, are not subject to many state regulations such as insurance premium taxes and mandated benefits. Similarly, some state health plans are legally exempt from compliance with state requirements, although these plans often do comply or, in some instances, have legal requirements that apply only to state employee health plans.

⁶For example, the Supreme Court noted that ERISA's preemption clauses "perhaps are not a model of legislative drafting" (*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)), and they have been characterized as "a veritable Sargasso Sea of obfuscation" (*Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 717 (2d Cir. 1993)).

⁷471 U.S. 724 (1985).

⁸The McCarran-Ferguson Act, enacted in 1945, provides that federal laws are not to be construed to apply to the insurance industry unless they explicitly so state (15 U.S.C. 1012(b) (1988)). The result has been that regulating the insurance industry has been left largely to the states. In addition, both the federal and state governments share responsibility for regulating health plans that are multiple employer welfare arrangements (29 U.S.C. 1144(b)(6)).

Table 1 categorizes and summarizes regulatory differences among employer-based health plans.

Table 1: Regulatory Status of Employer-Based Health Insurance

Type of employer-based health plan	ERISA plans		ERISA exempt ^a	
	Self-funded	Fully insured	Federal Employees Health Benefits Program	State/local government employees
Risk bearer	Employer ^b	Insurer	Insurer ^c	Insurer or government
State premium taxation	Exempt	Insurer pays	Exempt (since 1990)	State determines
Regulation	Exempt from state regulation and mandated benefits	Insurer subject to state regulation and mandated benefits	Exempt from state regulation and mandated benefits (since 1978)	State determines
	Department of Labor administers fiduciary, reporting, and disclosure requirements	Department of Labor administers fiduciary, reporting, and disclosure requirements	Administered by Office of Personnel Management (OPM) laws	No significant federal role
Rights and remedies for denied claims	Appeals reviewed internally by employer	Appeals reviewed internally by insurer	OPM reviews appeals	Determined by state law
	Employer not subject to punitive or compensatory damages	Employer and insurer not subject to punitive or compensatory damages	Law exempts from punitive or compensatory damages	Damages determined by state law

^aChurch plans are also exempt from ERISA.

^bMany employers may pass on some risk to a stop-loss insurance carrier.

^cThe FEHBP operates much like a self-funded health plan, however, because the risk to insurers is minimal. Those insurers with cumulative operational losses adjust premiums upward to recoup losses. Plans receive a separate negotiated profit regardless of whether they experience operating losses or gains. See Federal Compensation: Premium Taxes Paid by the Health Benefits Program (GAO/GGD-89-102, Aug. 8, 1989).

The courts continue to delineate what state actions are allowed or preempted under ERISA. Recently, the Supreme Court issued its decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.⁹ This decision did not delineate fully between state actions that are preempted and those that are not but indicated that courts may approve state actions that do not conflict with ERISA's underlying objectives or impact too greatly on employee benefit plans. In the wake of the Court's ruling in Travelers, states are likely to perceive that they have more options and greater flexibility than previously recognized. In particular, the decision permits New York and other states to adopt hospital rate setting systems and may permit states to tax providers. The

⁹115 S. Ct. 1671 (1995).

case suggests that state laws affecting employee health plans will have to be judged individually on the facts and circumstances in each case. The nature and magnitude of the impact on employee benefit plans of each state law at issue will determine the outcome. In cases in which the state law does not conflict with ERISA's objectives, it should survive legal challenge. The Travelers case leaves substantial questions unresolved about ERISA preemption that may need to be resolved through further litigation.¹⁰

Employers Adopt Funding Methods That Blur Distinction Between Self-Funded and Fully Insured

Although ERISA and court decisions have produced a sharp distinction in the regulatory status of self-funded and insured health plans, most employer plans can be categorized as ranging from full insurance to complete self-funding. Clearly distinguishing between self-funded and fully insured plans is growing more difficult as the health market changes. Among factors contributing to the confusion are more extensive use of stop-loss coverage and innovative risk-sharing arrangements between employers and managed care organizations.

The level of stop-loss coverage that a self-funded employer purchases is one factor that influences where an employer's plan fits within this range: A plan with a low stop-loss threshold self-funds a smaller share of its risk than a plan with a high stop-loss threshold. Particularly among smaller employers, some health plans have stop-loss coverage beginning at a relatively low level of health claims. In addition, many employers that offer self-funded health plans also provide insured coverage to some employees. For instance, many employers that provide a self-funded plan also offer their employees a choice of one or more health maintenance organizations (HMO) that may not be self-funded. Some employers, however, are beginning to adopt alternative financing arrangements with managed care plans that place some financial risk with the employer as well as the plan and its providers. Some employers may also provide coverage for specific conditions, such as cancer or mental health care, through a separate plan that may be either insured or self-funded. In many cases, employees will not know whether their employer-based health plan is self-funded or purchased through an insurer, especially since commercial insurers often provide administrative services for self-funded health plans.

¹⁰In appendix I, we further discuss ERISA's provisions relating to health plans and the courts' major decisions on ERISA preemption.

Data Are Limited but Indicate That Employers Are Increasingly Self-Funding

Data on the number and characteristics of self-funded ERISA plans are scant largely because efforts to collect this information on the federal level have been limited. The incomplete data that do exist, however, indicate that self-funding has increased recently, both among small and large firms. Employers have increasingly self-funded to better manage their costs, through greater control over their health benefits and plan assets, as well as to maintain uniformity in health plans that cross state borders.

The federal government is the only entity that can collect complete data on the number and characteristics of self-funded plans because ERISA preempts state efforts to require employers to provide health plan data. Because (1) the current federal reporting requirements focus on pension plans rather than health plans, (2) health plans with fewer than 100 participants are generally exempt from reporting, and (3) inconsistencies exist among the data reported for health plans, the current data are of little value in assessing the number or characteristics of employers that self-fund their health plans. Furthermore, the Department of Labor is currently considering revisions, but whether this would enhance or reduce the information available on self-funded health plans is unclear.¹¹

The lack of a clear distinction between self-funded and insured health plans also contributes to the difficulty in estimating the number of individuals enrolled in self-funded plans. Particularly as the distinction between self-funded and fully insured plans has blurred due to the increased use of stop-loss coverage and alternative funding arrangements with HMOs, surveys and employers inconsistently report whether a plan is self-funded or fully insured.¹²

Despite incomplete data, our analysis of employer benefits surveys shows that in 1993 approximately 44 million individuals, or 17 percent of the U.S. population, were enrolled in self-funded ERISA health plans (see fig. 1).¹³ An additional 27 percent of the population, or about 69 million individuals,

¹¹See appendix II for a discussion of the Department of Labor's regulation of ERISA plans.

¹²For example, several recent surveys we examined (including those conducted by Foster Higgins, Peat Marwick, and BLS) did not determine whether HMO plans offered by an employer were partially self-funded. However, although perhaps still infrequent, several large employers we contacted have established alternative funding arrangements with HMOs that include the employer's retaining some risk. A 1989 survey by Foster Higgins reported that about 4 percent of employers' HMO plans were self-funded, but more recent Foster Higgins surveys have not discussed self-funding among HMOs.

¹³This may understate the percentage of the U.S. population enrolled in self-funded plans and thus fully exempt from state regulation. A BLS survey found that 27 percent of participants covered by state and local governments were enrolled in self-funded plans. However, as previously stated, it is unclear how many employer health plans sponsored by governments, either self-funded or fully insured, would have to comply with the state requirements that would apply if they were ERISA fully insured plans.

were enrolled in insured plans that are also subject to ERISA. Thus, a total of nearly 114 million Americans were enrolled in ERISA plans. The remainder of the population either had coverage from a government or church employer (27 million), Medicare (31 million),¹⁴ Medicaid (24 million),¹⁵ individual insurance (20 million), or Department of Veterans Affairs (VA) or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) health plans (5 million);¹⁶ 40 million individuals were uninsured.¹⁷

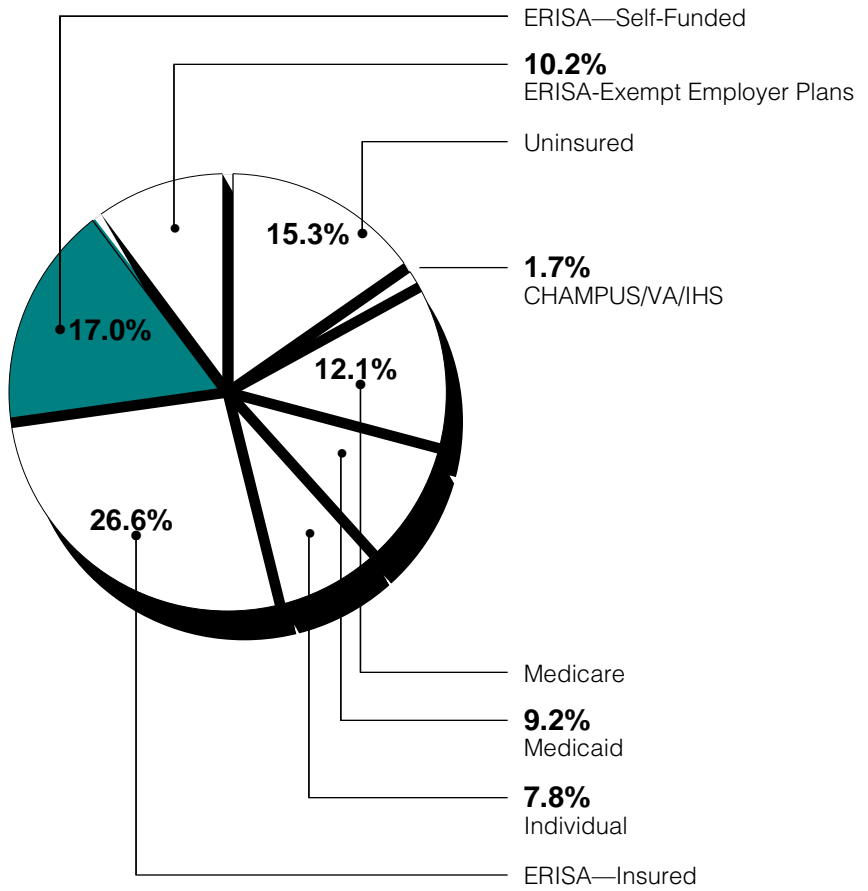
¹⁴To avoid double counting, this number does not include individuals who also received employer-based coverage and who were working (1.7 million individuals). For these individuals, Medicare would be a secondary payer to the primary employer-based coverage. This number does include 8.3 million individuals who received employer-based coverage but did not indicate that they were working. In these cases, we assumed that Medicare was the primary payer and that the employer-based plan was Medicare supplemental (Medigap) coverage. The Health Care Financing Administration (HCFA) reported that 35.6 million individuals were enrolled in Medicare in 1992.

¹⁵To avoid double counting, this number includes only those individuals who did not also have either Medicare or employer-based coverage during 1993. If these individuals were included, Medicaid enrollment would total 32 million individuals. HCFA reports that 31.2 million individuals were enrolled in Medicaid in 1992.

¹⁶To avoid double counting, this number does not include 5 million individuals who also received employer-based coverage, Medicare, or Medicaid during 1993.

¹⁷Appendix III further describes our approach for estimating the number of individuals in self-funded plans.

Figure 1: Health Coverage by Source, 1993



Self-Funded ERISA Plans

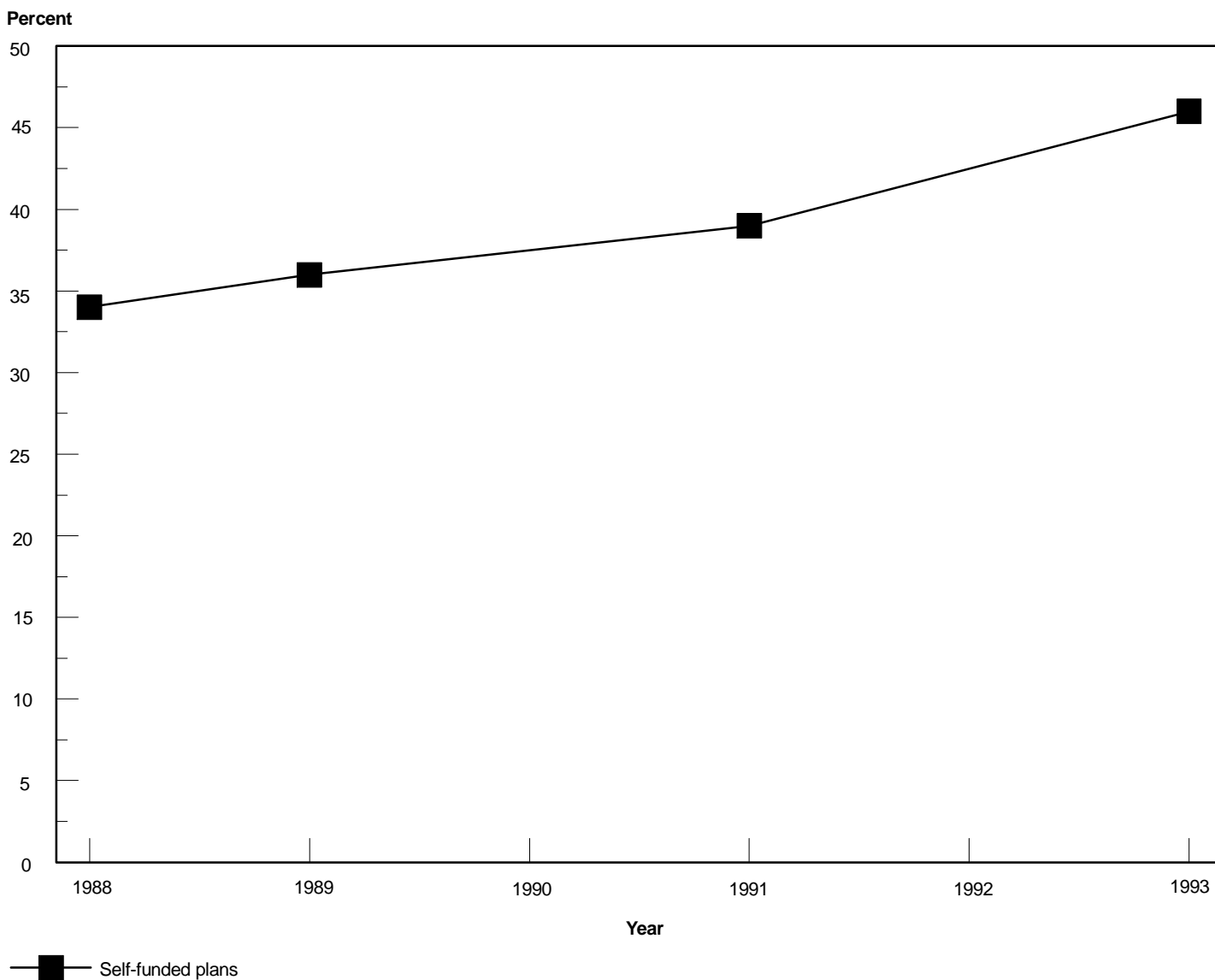
Notes: ERISA-exempt includes employer health plans sponsored by governments and churches. IHS stands for Indian Health Service.

Source: GAO calculations based on Bureau of the Census and BLS data.

The number of individuals enrolled in self-funded plans appears to be growing. On the basis of calculations we made from existing data sources, the total number of individuals enrolled in self-funded plans increased by nearly 6 million from 1989 to 1993. This growth is occurring in firms of all sizes.¹⁸ As shown in figure 2, the percentage of plan participants enrolled in self-funded health plans has increased from about 28 percent in 1986 to about 46 percent in 1993 in medium sized and large private establishments (those with at least 100 employees).

¹⁸Self-funding is most prevalent among large firms. A survey by Foster Higgins found that 78 percent of firms with 1,000 or more employees and 89 percent of firms with 20,000 or more employees were self-funded in 1993.

Figure 2: Growth in Self-Funding in Medium and Large Private Establishments, 1988 to 1993



Note: Includes establishments with 100 or more employees only.

Source: BLS Employee Benefits Surveys, 1988-1993.

Growth in self-funding appears to be occurring in small firms as well. In 1992, 32 percent of plan participants covered by private establishments with fewer than 100 employees were in self-funded plans;¹⁹ in 1990, 28 percent of plan participants in such firms were in self-funded plans. Limited evidence shows that even smaller firms—those with fewer than 50 employees—are beginning to self-fund. For example, a trade association representing self-funded plan interests provided examples of employers with as few as 13 employees that chose to self-fund. One third-party administrator we contacted has rapidly expanded its business among small self-funded employers. By 1994, this firm had contracts with more than 2,300 self-funded firms with 50 or fewer employees, including 132 firms with fewer than 10 employees.

The growth in self-funding in small and large firms reflects employers' recognition that self-funding employee health benefits offers several advantages. Employers believe that self-funding allows them to directly gain from their cost-containment efforts by having plan design flexibility, control of premium assets, and reduced administrative costs. In addition, employers' self-funding allows them to avoid potentially costly state regulation, including premium taxes, reserved funding requirements, benefit mandates, any-willing-provider laws, and participation in community-rated or high-risk pools. Employers also indicate that the ability to maintain national uniformity in plan design and benefits through self-funding enhances employee relations.

States Claim ERISA Limits Their Ability to Reform Their Health Care Systems

As self-funding has grown, states have lost regulatory oversight over a growing portion of the health market. Between 1989 and 1993, we estimate that the number of self-funded plan enrollees increased by about 6 million individuals, and the number of privately insured individuals that state insurance commissioners regulate declined even further as more individuals became uninsured or enrolled in Medicaid or Medicare. With these changes, states are concerned that they cannot provide consumer protections to self-funded health plan participants and that their ability to tax and collect data on health plans is eroding.

¹⁹This number may overstate the actual percentage of participants enrolled in self-funded health plans in small firms. The number of participants in firms with fewer than 100 employees may be lower because the data are collected by establishment rather than by firm; that is, many establishments are part of a larger firm that enrolls its employees in a self-funded health plan. It is also noteworthy that many small employers do not offer health coverage.

More broadly, states view ERISA preemption as an obstacle to their adopting a wide range of health care reform strategies.²⁰ Given the improbability of federal reforms to achieve universal coverage in the near future, many state governors and legislators are seeking an active role in expanding the number of individuals covered and in controlling health care costs. The response to the 1994 national health care reform debate and the views of recently elected governors and state legislators may have increased opposition to comprehensive reform in some states, but the impetus for incremental changes remains strong.

States Concerned That Consumers in Self-Funded Plans Have Inadequate Protection

States believe that ensuring adequate consumer protections will become increasingly difficult as more firms self-fund, exempting them from state insurance regulation. Our analysis of CPS data indicates that the number of individuals under state insurance commission oversight (that is, those with insured health plans offered through employers or purchased individually) declined by nearly 8 million between 1989 and 1993. Much of this decline was attributable to growth in the uninsured population and Medicare and Medicaid enrollment. However, enrollment in self-funded health plans increased by nearly 6 million during this time, also contributing to the decline in the number of insured health plan participants under state oversight.²¹ Although little evidence exists to substantiate self-funding's adverse effect on plan participants, state regulators are concerned that federal fiduciary standards and their enforcement may not provide sufficient consumer protections for these participants.²²

State regulators are particularly troubled that firms that they believe cannot adequately absorb the costs of self-funding will nonetheless choose this option. Although only anecdotal evidence exists of the difficulties facing small firms if they self-fund, in part because states do not have access to this information, some regulators contend that firms with fewer than 500 employees should not be completely self-funded. However, the

²⁰For a more thorough discussion of the state perspective on ERISA, see Patricia A. Butler, *Roadblock to Reform: ERISA Implications for State Health Care Initiatives*, National Governors' Association (Washington, D.C.: 1994).

²¹While the number of individuals in fully insured ERISA plans decreased by 9.2 million between 1989 and 1993, the number of enrollees with individual coverage increased by 1.7 million. The net effect is that the states lost regulatory authority over 7.5 million enrollees in the private market. In addition to the growth of enrollment in self-funded plans (5.7 million individuals), Medicare grew by nearly 2 million individuals, Medicaid increased by more than 8 million individuals, and more than 6 million more individuals were uninsured.

²²For further discussion of states' concerns about the need for stronger consumer protections for beneficiaries of self-funded plans, see *ERISA: A Call for Reform: Recommendations of the NAIC ERISA Working Group*, National Association of Insurance Commissioners (Washington, D.C.: 1994).

size of firm that can adequately bear risk is subject to debate, especially since small firms can purchase stop-loss coverage to moderate their exposure to large, unexpected losses.²³ In addition, disagreement exists about whether a firm's size should be the measure of its ability to self-fund rather than its wage structure or financial condition. For example, some believe that even very small firms with relatively large assets can self-fund safely with adequate stop-loss coverage.

Of more concern to state regulators than small firms' purchase of traditional stop-loss coverage, however, are new stop-loss insurance products that more closely resemble traditional health insurance products with a high deductible. These products allow small firms to self-fund, avoiding state regulation, while only bearing a small portion of the risk. To address this issue, the National Association of Insurance Commissioners (NAIC) is developing a model act that would define minimum stop-loss coverage levels, preventing the sale of products that are merely a subterfuge for traditional health insurance.²⁴ New York, Oregon, and North Carolina have already tried to address this issue by prohibiting or limiting the sale of stop-loss coverage to small firms.²⁵

ERISA Restricts State Efforts Regarding Employer Health Plans

In addition to states' concerns about the loss of regulatory oversight due to the increase in self-funded plans, states view ERISA as an obstacle to enacting comprehensive reforms and to adopting the more modest administrative simplification and insurance regulation proposals on which many states are focusing. ERISA clearly preempts state laws that mandate employers to offer or contribute to coverage. In addition, according to a report of the National Governors' Association (NGA), the following are potential state actions prohibited due to judicial interpretations of ERISA:²⁶

- “establishing minimum guaranteed benefits packages for all employers;

²³Even with stop-loss coverage, some believe that small firms, for example, those with fewer than 50 employees, cannot safely self-fund.

²⁴An NAIC draft model act would define stop-loss plans as those exceeding an established threshold of claims, whereas plans that have a lower threshold are regulated by the states as traditional health insurance. For example, this model act would set thresholds of \$20,000 per individual or 120 percent of expected claims for stop-loss coverage.

²⁵In Oregon, this law applies to firms with 3 to 25 employees, while New York's law applies to firms with 3 to 50 employees and North Carolina's law applies to firms with 1 to 49 employees. Whether these laws are shielded from ERISA challenge because they regulate stop-loss insurers rather than health plans is not fully resolved.

²⁶See NGA Policy: Health Care Reform, National Governors' Association (Washington, D.C.: 1995).

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- developing standard data collection systems applicable to all . . . health plans;
 - developing uniform administrative processes, including standardized claim forms;
 - establishing all-payer rate-setting systems;²⁷
 - establishing a statewide employer mandate;
 - imposing a level playing field through premium taxes on self-[funded] plans; and
 - imposing a level playing field through provider taxes where the tax is interpreted as having an impermissible direct or indirect impact on self-[funded] plans.”

The Supreme Court’s recent decision in Travelers, however, may have provided states more flexibility in some areas, particularly rate setting and provider taxes, than reflected in the NGA list.

Because several states have passed comprehensive reform legislation that would likely be preempted by ERISA, some states have petitioned their congressional delegations to propose legislation granting broad exemptions from ERISA.²⁸ Only Hawaii has succeeded in obtaining a statutory exemption from ERISA, enabling the state to mandate employers to provide health care coverage. Other states that have not tackled comprehensive reform have sought more limited ERISA exemptions for specific regulatory or tax initiatives. For example, before the Supreme Court ruling earlier this year, New York sought to amend ERISA to allow the state to continue taxing hospital services. Finally, to balance state desires for additional regulatory authority over self-funded health plans with business concerns, some state representatives have proposed establishing additional federal standards to apply to all health plans.²⁹

²⁷For example, Maryland sets hospital rates for all payers, including Medicare, Medicaid, and both self-funded and fully insured health plans. Other states, such as New York, also set hospital rates for some payers but not for Medicare.

²⁸Current law provides for states to request and be granted a Medicaid waiver, which essentially permits them to disregard selected Medicaid requirements that would otherwise apply. Some states would like ERISA amended to establish a similar mechanism for granting so-called ERISA waivers.

²⁹For example, the federal government could establish a minimum benefits package and data collection requirements. States may or may not be allowed to go beyond these national requirements.

State Support for Employer Mandates Is Fading

Several states have passed comprehensive health care reform legislation, including employer-mandated coverage or play-or-pay³⁰ systems, that would likely be preempted without an exemption from ERISA. Although several states continue to seek waivers, these states' commitment to their enacted reforms is fading. Indeed, implementation has been delayed in most states in part because of concerns about an ERISA challenge but also because of several other key factors. These factors include changes in governors and state legislative representatives, constrained state budgets, difficulty in passing necessary financing measures, and the opposition of small businesses.

For example, Massachusetts has delayed the implementation of a play-or-pay system several times since its enactment in 1988, and the current governor seeks its repeal. In 1995 Washington repealed the employer-mandated health care coverage passed in 1994 because the newly elected legislature opposed it. Opponents of the employer mandate in Oregon anticipate that a sunset clause in the legislation will obviate the need for an outright repeal.³¹

States Believe That ERISA Preemption Also Undermines Incremental Initiatives

Although several states have retreated from comprehensive health care reforms, many continue to seek narrower reforms, including taxing authority and data collection, that ERISA may also preempt. States maintain that they should have the right to apply taxes uniformly to all participants in the health care market without ERISA's shielding a group of employers. Because self-funded plans are shielded from premium and other taxes, as well as participation in high-risk pools, a disproportionate share of the cost of state programs to improve access or expand coverage could fall on insured plan participants.³²

States would also like to collect data to adequately assess characteristics of their health care market and the effectiveness of their small group reforms.³³ States would like data partly because they fear that increased self-funding in small firms will lead to only the high-risk and high-cost

³⁰This approach would require employers to either provide health care coverage to their employees or pay a tax to subsidize state-sponsored health care coverage.

³¹The sunset clause requires Oregon to receive necessary ERISA waivers by January 1996, or relevant sections of the reform act become invalid.

³²Further information on the taxes that states assess on health plans appears in appendix IV.

³³For information on the types of small group reforms that states have enacted, see Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

groups remaining in the small group insurance market.³⁴ For example, although Massachusetts officials no longer seek an ERISA waiver to implement their play-or-pay provision, they would like some narrower changes to ERISA to allow them to collect information on self-funded health plans to measure the success of their small group reforms.

Employers View ERISA as Critical to Their Ability to Efficiently Provide Health Care Coverage

Many employers, particularly larger self-funded firms, view ERISA preemption of state regulation of employer health plans very differently from the states: they view it as a fundamental strength of a voluntary employer-based health care system.³⁵ They note that preemption was designed to provide uniform rules for all employers and to prevent states from imposing 50 different regulatory approaches to health care. In general, they view private market decisions as a more effective tool in managing the nation's health care system than a government-sponsored system or state regulation.

Although employers focus on different aspects of the ERISA debate, they are generally opposed to granting the states greater flexibility. They believe that any change in ERISA may lead to state requirements that would hinder their ability to manage the cost and quality of their employees' health care. Also, employers are concerned that greater state flexibility will mean higher costs for them, either through additional administrative burden, taxes, or increased litigation resulting from changes in the ERISA appeals process. They have expressed concerns that if changes to ERISA significantly raise their costs, they may have to reevaluate their voluntary provision of health benefits.³⁶

Employers Concerned That ERISA Changes May Reduce Their Cost-Containment Ability

Employers maintain that ERISA preemption provides the framework for them to manage the cost of their employees' health care coverage. They cite several recent studies and reports, as well as their own experience, as evidence of their initiatives' effectiveness. For example, employer surveys by Foster Higgins, an employer benefits consulting firm, indicate that average costs for employer-based health coverage decreased 1.1 percent

³⁴This may be particularly the case in states that have passed laws providing for tight rating restrictions, narrowing the range in premiums that health plans are allowed to charge, and for guaranteed issue, requiring health plans to offer coverage to any individual.

³⁵See G. Lawrence Atkins and Kristin Bass, *ERISA Preemption: The Key to Market Innovation in Health Care*, Corporate Health Care Coalition (Washington, D.C.: 1995).

³⁶In fact, many employers have already dropped retiree health benefits, though not because of any ERISA modifications. See *Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System* (GAO/HRD-93-125, July 9, 1993).

between 1993 and 1994. They are concerned that changes to ERISA that either grant greater state flexibility or impose federal standards may severely hamper their cost-containment efforts. Employers point to current state-mandated benefits, any-willing-provider laws, and risk pooling in the insured market as examples of state actions that would undermine their recent cost-containment and quality enhancement strides.

Employers argue that benefit mandates, if applied to self-funded plans, may limit their ability to alter benefits offerings to control costs. For example, employers cite that their ability to change mental health benefits from a limited number of inpatient and outpatient days to a more flexible case management system has saved money and improved quality of care. They believe that a mandated mental health benefit as adopted in some states for insured plans would restrict benefit design and not allow this innovation.³⁷

Employers are also concerned that states' any-willing-provider laws may severely impact employers' cost-containment efforts.³⁸ They believe that their increased reliance on managed care has been integral to lowering their health care costs.³⁹ Because the basic tenets of managed care are to limit choice of provider to control utilization and ensure adequate patient volume and provider quality, employers argue that if the law requires managed care plans to accept all providers meeting certain criteria, managed care will lose its ability to control health costs. Although the courts are deciding the scope and extent of any-willing-provider laws, these laws have not been applied to arrangements between self-funded plans and managed care providers. Employers oppose any amendments to ERISA that would extend the reach of these laws.

In addition, employers generally oppose amendments to ERISA that would allow states to include self-funded plans in community-rated pools. In community-rated pools, health costs are spread more evenly among the participants in the pool without reflecting the employer's actual claims experience. Thus, an employer with previously higher than average health

³⁷See appendix V for a list of state-mandated benefits and a discussion of their potential costs.

³⁸Any-willing-provider laws require a health plan to include in its managed care network any provider that meets the plan's terms. According to the Group Health Association of America, of the states with any-willing-provider laws, 10 have laws that apply to all providers, 14 have laws that apply to pharmacists, 3 have laws that apply to physicians, and 4 have laws that apply to nonphysician providers. However, in most states the laws are limited because they do not apply to HMOs or apply only to particular types of managed care plans.

³⁹A survey by KPMG Peat Marwick indicates that in 1994 nearly two-thirds of individuals with employer-based insurance were enrolled in network-based managed care.

care costs would see those costs reduced, and one with lower than average costs would see them increased. Employers argue that community rating removes nearly all incentives for them to innovate to control costs because the savings do not accrue to the employer but to the whole community.

Employers Contend That ERISA Changes Could Increase Their Costs

Employers are concerned that amendments to ERISA that increase state flexibility will result in higher administrative costs and higher taxes, either directly or through an employer mandate. Also, they believe that ERISA changes may cause them to lose other advantages of self-funding, such as control over plan assets, and expose them to expensive lawsuits arising from health care claim denials.

Employers oppose ERISA amendments that would grant states regulatory authority over self-funded plans. Large and small firms with workers in many states view the prospect of different state reform initiatives and regulatory systems as cumbersome, costly, and unnecessary. The administrative burden may be especially acute in the 41 U.S. metropolitan areas that cross state boundaries.⁴⁰ However, measuring the potential cost of compliance with differing state administrative requirements would depend largely upon the variance in regulations that states adopt as well as how employers design and administer their plans.

Multistate employers maintain that compliance with multiple systems or requirements will hinder their ability to preserve nationwide uniformity in their health plans, harming employee relations and weakening cost-control initiatives. By maintaining a uniform benefits plan, employers can provide equitable benefits to employees in different geographic locations, transfer employees without disrupting benefit coverage, and collectively bargain on a nationwide basis.⁴¹ For these reasons, to the extent that employers support health care reforms, they prefer uniform national standards to varying state standards.

⁴⁰See *Health Care Alliances: Issues Relating to Geographic Boundaries* (GAO/HEHS-94-139, Apr. 8, 1994).

⁴¹Despite the value to employers of a nationally uniform plan, employers also often contract with managed care plans that vary substantially in benefit structure and operation in different geographic regions. In this case, the lower costs of managed care plans may compensate for reduced uniformity.

Employers are concerned that ERISA may be modified to permit states to directly or indirectly tax employer health plans.⁴² Employers contend that many states that are experiencing severe financial constraints, in part due to rapidly increasing Medicaid costs, may seek the authority to tax employers who already provide health coverage. Employer groups maintain that they do not necessarily oppose state programs to improve access but believe that states should fund their initiatives through generally applicable taxes clearly within the scope of their authority, even if politically unpopular. This would more fairly distribute the burden of providing health care coverage to the uninsured rather than create an incentive for employers to not offer coverage.

To illustrate their point, employers point to state taxes, even typical ones like premium taxes of 2 to 3 percent, that may create significant costs as health care costs become an increasing share of total employee compensation. For example, these taxes would cost between \$10 million to \$15 million if applied to some Fortune 100 firms that spend more than \$500 million on their employees' health coverage. Moreover, employers note that states may more easily increase these taxes if states are not restrained by firms' ability to easily exit the insured market. Furthermore, the costs that employers incur from state taxation may increase as more states turn to provider taxes as a financing source, especially after the Supreme Court's recent ruling upholding states' ability to impose comprehensive rate-setting schemes that essentially function like provider taxes.

Employers have also expressed concerns that state solvency standards requiring the establishment of reserves will force them to restrict a portion of their plan assets that could be used for other purposes. This loss of control could amount to an increase in their overall costs, particularly when interest rates are high. Moreover, employers believe that solvency standards for self-funded plans are unnecessary because few plan failures have occurred, even in smaller firms with stop-loss coverage.

Finally, employers—whether they self-fund or purchase insurance—fear that they may lose ERISA protections from potentially exorbitant damages stemming from disputes over denied health claims. Employers believe that ERISA's requirement for an internal appeal adequately ensures that employees' grievances are fairly represented, although some maintain that

⁴²The recent U.S. Supreme Court ruling in the *Travelers* case may have implications for states' ability to levy provider taxes, which may relieve state pressure for ERISA amendments granting them more explicit taxing authority over ERISA plans. However, it is likely that additional litigation will be needed to further clarify the issue.

it is burdensome. In return for establishing an appeals system, employers receive immunity from what they perceive as tort system excesses.⁴³ In particular, employers are not subject to punitive or compensatory damages resulting from inappropriately denied claims. Employers view liability for denied claims as a potentially expensive issue that could force them to discontinue their health plans if ERISA is amended.

Conclusion

ERISA's role in health care is poorly understood. In large part, confusion over ERISA stems from a lack of well-developed data and information to assess conflicting contentions about the potential costs and benefits of ERISA as it relates to health care. Indeed, both states and employers argue that they must play a more active role in managing the quality and costs of health care, yet their beliefs are largely based on strongly held philosophical arguments. Key elements of these arguments include the appropriate role for government, the appropriate distribution of health care costs, the primacy of the private market, and the division of responsibilities between federal and state governments. Due to these arguments, ERISA reform promises to be a challenging issue for the Congress.

Agency Comments

Department of Labor officials provided us with comments on a draft of this report. (See app. VI.) They pointed out that the perspectives of participants and beneficiaries were addressed only to a limited extent and that more information would be useful. However, our primary focus, as agreed to with our requesters, was the perspectives of states and employers on ERISA preemption. We acknowledge that the perspectives of participants and beneficiaries are also important, but they are more diffuse and difficult to categorize.

Labor officials also stated that the Pension and Welfare Benefits Administration provides more technical assistance to participants, beneficiaries, and the general public, and we changed the report to include that information. Labor officials also provided technical comments, which we incorporated where appropriate.

⁴³Employers often cite *Fox v. Health Net of California*, in which a woman's estate was awarded \$89 million in damages after being denied coverage for an autologous bone marrow transplant on the grounds that it was considered an experimental treatment for her condition. Ultimately, the two parties settled the case for an undisclosed sum. In this case, ERISA did not limit the remedies available because the woman received health care coverage from her husband's employer, which was exempted from ERISA because it was a county government.

Please call me on (202) 512-7119 if you or your staffs have any questions about this report. This report was prepared under the direction of Mark V. Nadel, Associate Director of National and Public Health Issues. Other major contributors are listed in appendix VII.

A handwritten signature in black ink that reads "Sarah F. Jaggard". The signature is written in a cursive style with a long, sweeping underline that extends to the left.

Sarah F. Jaggard
Director, Health Financing and
Public Health Issues

List of Requesters

The Honorable James M. Jeffords
The Honorable Paul Wellstone
The Honorable John H. Chafee
The Honorable William S. Cohen
The Honorable Kent Conrad
The Honorable Christopher J. Dodd
The Honorable Russell D. Feingold
The Honorable Dianne Feinstein
The Honorable Bob Graham
The Honorable Mark O. Hatfield
The Honorable J. Robert Kerrey
The Honorable Patrick J. Leahy
The Honorable Joseph I. Lieberman
The Honorable Carol Moseley-Braun
The Honorable Paul Simon
The Honorable Olympia J. Snowe
The Honorable Arlen Specter
United States Senate

The Honorable Benjamin L. Cardin
The Honorable Major R. Owens
The Honorable Nydia Velasquez
The Honorable Pat Williams
House of Representatives

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Abbreviations

BLS	Bureau of Labor Statistics
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
	Services
CPS	Current Population Survey
ERISA	Employee Retirement Income Security Act of 1974
FEHBP	Federal Employees Health Benefits Plan
HCFA	Health Care Financing Administration
HMO	health maintenance organization
IRS	U.S. Internal Revenue Service
MEWA	multiple-employer welfare association
NAIC	National Association of Insurance Commissioners
NGA	National Governors' Association
OPM	Office of Personnel Management
PPO	preferred provider organization
PWBA	Pension and Welfare Benefits Administration
SPD	summary plan document
VA	Department of Veterans Affairs
WPPDA	Welfare and Pension Plans Disclosure Act

ERISA History and Court Interpretations

The Employee Retirement Income Security Act of 1974 (ERISA)⁴⁴ and its implications for health plans are often misunderstood. Much of this confusion results from the act's focus on pension plans rather than health plans and the ambiguity of some of the legislative language, which has been interpreted in a variety of lower federal and Supreme Court decisions.

Initial ERISA Legislation Focused on Pension Plans

ERISA was passed primarily in response to concerns about the solvency and security of employer-based pension plans.⁴⁵ These concerns arose because many retirees did not receive anticipated retirement benefits in several well-publicized cases.⁴⁶ ERISA imposed minimum vesting requirements on employer pension plans to guarantee that employees receive a right to such benefits within a reasonable time after beginning their employment. It also established funding requirements, providing that employers reserve funds to ensure that they are available to pay those benefits when the employee retires, and established a system of plan termination insurance to provide for benefit payments even if an employer terminates a defined-benefit plan.

ERISA Requirements Relating to Health Plans

In addition to pension plans, ERISA regulates “employee welfare benefit plans,” which include employer health plans.⁴⁷ Therefore, although only a limited discussion occurred during the Congress’ initial consideration of ERISA regarding its impact on employee health plans, all health plans established and maintained by an employer are covered by ERISA.⁴⁸ Because the Congress was principally concerned with pension plan reform when ERISA was enacted, ERISA established stricter requirements for

⁴⁴Public Law 93-406, 88 Stat. 829 (classified as amended at 29 U.S.C. 1161 et seq.) (1988).

⁴⁵ERISA’s predecessor was the Welfare and Pension Plans Disclosure Act (WPPDA), passed in 1958 (P.L. 85-836, 72 Stat. 997) (previously classified as amended at 29 U.S.C. 301 et seq.) (1970). The WPPDA established a federal role in protecting interstate commerce and the interests of participants in employee benefit plans through the imposition of disclosure and reporting requirements for such plans. Each plan was required to provide the Department of Labor and plan participants with a plan summary and an annual report. In contrast to ERISA, the WPPDA expressly provided that state laws affecting the operation or administration of such plans were not preempted. In response to cases of malfeasance on the part of pension administrators, the WPPDA was amended in 1962 to make federal crimes of certain improper actions taken in connection with an employee benefit plan.

⁴⁶In the early sixties, for example, Studebaker, which had been a major automobile manufacturer, closed its Fort Wayne, Indiana, assembly plant; thousands of employees and former employees were left with greatly reduced pension benefits.

⁴⁷As described in ERISA, a welfare benefit plan generally provides for hospital, medical, surgical, sickness, accident, disability, death, unemployment, severance, or similar benefits.

⁴⁸Governmental and church plans are generally exempted from ERISA requirements.

pension plans than for welfare benefit plans. For example, health plans are not subject to the participation, vesting, and funding requirements that pensions are. However, health and other welfare benefit plans must comply with ERISA's reporting and disclosure procedures, fiduciary standards, and claims appeal requirements.

Reporting and Disclosure

ERISA requires all covered employer-based health plans to file Forms 5500 (Annual Return/Report of Employee Benefit Plan) for the Department of Labor. These reports provide periodic information on plan participants and finances. ERISA also requires plans to give plan participants and beneficiaries a summary plan description (SPD). The SPD is the basic document that gives the plan beneficiary the plan's details and describes, in understandable terms, their rights, benefits, and responsibilities under the plan. A copy of the SPD and a statement of ERISA rights must be furnished to participants and beneficiaries within 90 days after participation begins; and, generally, within 120 days after the plan is subject to the act, it must be filed with the Department.

Fiduciary Standards

ERISA established fiduciary standards to protect employee benefit plan participants and beneficiaries from plan mismanagement. The act defines a fiduciary as anyone who exercises discretionary control or authority over the management of a plan or renders investment advice to a plan. Generally, these standards require fiduciaries to act with care, skill, prudence, and diligence in investing plan assets and to manage plan assets solely in the interest of plan participants and beneficiaries. Although health plans are not required to reserve sufficient funds to pay benefits as prescribed by ERISA's funding standards for pension plans, and self-funded plans are not directly impacted by funding requirements states impose on insurers, plan fiduciaries are required to manage plan assets, including employee contributions, in the best interest of the participants and beneficiaries.

Claims Procedures

ERISA's administration and enforcement provisions describe the remedies available to participants and beneficiaries for violations of the act's requirements. Welfare benefit plans covered under the law must have established written procedures for filing a claim, and the beneficiary must be informed of these procedures. When a claim is denied, employee benefit plans are required to provide participants and beneficiaries written notice setting forth the specific reason for the denial and to afford them a

reasonable opportunity for a full and fair review by the fiduciary of the decision denying the claim. If the beneficiary disagrees with the final decision, ERISA allows him or her to sue in the federal courts.

ERISA Preemption of State Regulation Relating to Employer Benefits

The current debate concerning ERISA and health benefit plans stems primarily from ERISA's preemption clause. This provision makes it possible for employers to provide employee benefits largely free from potentially burdensome and conflicting state regulation. Because ERISA left regulating the insurance industry to the states, however, its impact achieved great significance only as the result of the growth of self-funded health plans.

The relevant ERISA language has been recognized as among the most complex and confusing in the federal code.⁴⁹ It includes three significant clauses: the preemption clause, the saving clause, and the deemer clause. The preemption clause provides that ERISA supersedes any and all state laws that "relate to" any employee benefit plan. The saving clause, consistent with long-standing national policy,⁵⁰ provides nonetheless that ERISA will not be construed to exempt or relieve any person from any state law regulating insurance. Therefore, a state insurance law may relate to employee benefit plans but nonetheless not be preempted by ERISA. Finally, the deemer clause narrows the possible scope of the saving clause by providing that no employee benefit plan will be deemed an insurer or in the insurance business for the purpose of any state law purporting to regulate insurance. The result is to restrict the extent to which state insurance regulation can affect, or serve as a pretext for regulating, employee benefit plans.

As discussed more fully below, the phrase "relate to" has been the source of much legal dispute in part because of the lack of a clear legislative record on congressional intent. Original versions of the legislation passed by the House and the Senate did not include this sweeping preemption language. Instead, both the House and Senate versions had preemption language that would have limited state regulation related only to the specific provisions of the respective bills.⁵¹ The conference report

⁴⁹See, for example, *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 424, 740 n. 16 (1985).

⁵⁰Passed in 1945, the McCarran-Ferguson Act (P.L. 79-15, 59 Stat. 33) provides that federal laws are not to be construed to apply to the insurance industry unless they explicitly so state (15 U.S.C. 1012 (1988)). The result is that regulating the insurance industry has been left largely to the states. See *Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources* (GAO/HRD-94-26, Dec. 27, 1993).

⁵¹*Shaw v. Delta Air Lines, Inc.*, 463 U.S. 84, 96 (1983).

provides little guidance on interpreting the final language.⁵² Given the sparse discussion in the conference report, particularly with the evolution of employee benefits plans since ERISA's passage, courts have played a major role in defining the scope and extent of ERISA preemption.

Although many states have tried to narrow the scope of ERISA preemption to gain more flexibility in regulating employer health plans, Hawaii is the only state that has received an exemption from ERISA. This exemption, enacted in 1983, has allowed Hawaii to enforce a mandate requiring all employers to provide employees a standard health package and pay for 75 percent of the premium. However, congressional approval of Hawaii's ERISA exemption was due in part to the fact that Hawaii had enacted comprehensive health care reform concurrently with the original federal passage of ERISA.⁵³ The conference report explicitly stated that the Hawaii exemption was not to "be considered a precedent with respect to extending such amendment to any other state law," and the Congress has not approved any state ERISA exemption requests since Hawaii's.⁵⁴

Courts Have Played a Key Role in Defining the Scope and Extent of ERISA

The original ERISA preemption language was sufficiently ambiguous that the courts have had to define its scope. To a large degree, these court cases have attempted to delineate how closely state laws must relate to employer health plans to be preempted. Other major court decisions have addressed the ERISA appeals requirements for denied claims and the ability of employers to reduce benefits that are covered in their health plan.

In its seminal case, *Shaw v. Delta Airlines*,⁵⁵ a unanimous Supreme Court relied on the dictionary meaning of "relate" and ERISA's legislative history to hold that a law relates to an employee benefit plan "if it has a connection with or reference to such a plan."⁵⁶ However, the Court indicated that "[s]ome state actions may affect employee benefit plans in

⁵²H.R. Conf. Rep. No. 1280, 93d Cong., 3d Sess., 383 (1974); reprinted in 1974 U.S.C.C.A.N. 5038, 5162.

⁵³Hawaii officials have unsuccessfully sought additional flexibility under ERISA to amend its 1974 reforms, particularly to be able to mandate employer coverage of dependents.

⁵⁴As described later in this section, the Congress also amended ERISA in 1983 to allow states to regulate health plans sponsored by "multiple employer welfare arrangements." In addition, the House of Representatives included 2-year ERISA waivers for four states (New York, Hawaii, Maryland, and Minnesota) in its version of the 1993 budget act, but this provision was not included in the final version. The tax code was amended, however, to temporarily require employers to pay New York hospital surcharges to receive federal tax deductions for health plan contributions.

⁵⁵463 U.S. 85 (1983).

⁵⁶463 U.S. 85, 97 (1983).

too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."⁵⁷ By way of example, the Court cited a 1979 case upholding garnishment of a spouse's income to pay child support but expressly refused to indicate where to draw the line between state actions that are preempted and those that are not.

Two years later, in Metropolitan Life Ins. Co. v. Massachusetts,⁵⁸ a unanimous Supreme Court identified a crucial distinction under ERISA between the treatment afforded employee benefit plans that are self-funded and those that are insured. At issue in the Metropolitan case was the effect of ERISA on a so-called mandatory benefit law under which Massachusetts required health insurance in the state to include certain minimum coverage for mental illness. Noting the dearth of discussion about the saving clause in the legislative history, the Court observed that the wording of the saving clause did not change during the conference, although its prominence was certainly enhanced when the preemption clause was significantly broadened.

The Court went on to construe the saving clause broadly to permit states to enforce such laws against insurers even though this would impact the employee benefit plans that they insure. The Court noted that its holding resulted in a distinction between insured and self-funded plans, with the former being indirectly subject to state regulation, such as mandated benefit laws, and the latter escaping such regulation.⁵⁹ This distinction provides an incentive for employers, particularly those operating in more than one state, to self-fund because it frees them from state laws that would otherwise affect them.

Two years later, in Pilot Life Ins. Co. v. Dedeaux,⁶⁰ a unanimous Supreme Court explained that although the saving clause was to be interpreted broadly, it could not save from preemption state laws that conflict with substantive provisions of ERISA. The effect was that common law tort and contract causes of action seeking damages for improper processing of an employee benefit plan claim are preempted. In Pilot Life, an employee sought to recover damages from the insurer that had, on the behalf of his employer, denied him benefits under an employee welfare benefit plan. The employee based his claims on state law, and the Court held that the

⁵⁷463 U.S. 85, 101, n. 21 (1983).

⁵⁸471 U.S. 724 (1985).

⁵⁹471 U.S. 724, 747 (1985).

⁶⁰481 U.S. 41 (1987).

civil enforcement provisions of ERISA were the exclusive means for employees to seek such recoveries. Because the state law claims conflicted with ERISA's civil enforcement provisions, they were not saved from preemption by the saving clause.

Relying on Pilot Life, ERISA has been held to protect third parties in addition to insurers from tort liability and other state claims when they are performing services on behalf of an employee benefit plan. For example, in Corcoran v. United Healthcare, Inc.,⁶¹ a utilization control organization disagreed with a pregnant employee's attending physician and indicated that, if she remained in the hospital as her physician advised, her health plan would not cover the costs.⁶² Although the employee could have remained in the hospital at her expense, she left the hospital to receive nursing care at home, which the utilization control organization indicated would be covered. While the employee was at home when the nurse was not present, the fetus went into distress and died.

In response, the employee brought a wrongful death action against the utilization control organization. While mindful that its interpretation left a gap in the remedies for protecting plan participants and beneficiaries, the Court held that the case was controlled by Pilot Life, and the wrongful death claim was preempted. The Court noted that fundamental changes in employee benefit plans since ERISA's passage may indicate a need to reevaluate protections but acknowledged that such a task falls to the Congress and not the courts.

Most recently, the Supreme Court issued its decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.⁶³ This decision did not delineate fully between state actions that are preempted and those that are not but indicated that courts may approve state actions that do not conflict with ERISA's underlying objectives or impact too greatly on employee benefit plans. The case reached the Supreme Court as a result of a conflict between federal circuits over the extent to which states can impose hospital surcharges on employee benefit plans. The Third Circuit had upheld a New Jersey hospital tax used to compensate hospitals

⁶¹965 F.2d 1321 (5th Cir. 1992).

⁶²Unknown to the employee and her attending physician, the utilization control organization had obtained an independent second opinion from another physician who also indicated that the employee would be at considerable risk if not hospitalized (965 F.2d 1322 (5th Cir. 1992)).

⁶³115 S. Ct. 1671 (1995).

with higher shares of indigent and Medicaid patients;⁶⁴ the Second Circuit had rejected New York's system of imposing hospital surcharges on the basis of whether the care was financed by commercial insurers, HMOs, or Blue Cross & Blue Shield plans as a violation of ERISA.⁶⁵ Reversing the Second Circuit in a unanimous decision, the Supreme Court elaborated upon its holding in Shaw that "relate to" means "has a connection with or reference to" and held that New York's hospital surcharge system was not preempted by ERISA. Because New York's law was not directed specifically at employee benefit plans, the Court concluded that its hospital rate system had no reference to ERISA. Acknowledging that "connection with" was no more helpful than "relate to" in defining ERISA preemption, the Court reviewed the legislative history and ERISA objectives. The Court found that its basic thrust was to permit the nationally uniform administration of employee benefit plans by eliminating conflicting state regulation and reiterated that state laws mandating benefits or otherwise directly regulating the content or administration of plans are preempted. However, the Court distinguished New York's system from these preempted state laws because the New York law's purpose was to assist Blue Cross & Blue Shield rather than to regulate the content or administration of employee benefit plans.⁶⁶ While conceding that economic impacts alone could in some cases sufficiently trigger ERISA preemption, the Court held that New York's hospital surcharges had only an indirect economic influence on employee benefit plans and therefore was not preempted.

In the wake of the Court's ruling in Travelers, states are likely to perceive that they have more options and greater flexibility than previously recognized. The case suggests that state laws affecting employee benefit plans will have to be judged individually on each instance's facts and circumstances. The nature and magnitude of the impact on employee benefit plans of each state law at issue will determine the outcome. Where the state law does not conflict with ERISA objectives, it should survive legal challenge.

⁶⁴United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1179 (3d Cir.), cert. denied, 114 S. Ct. 382 (1993).

⁶⁵Travelers Ins. Co. v. Cuomo, 14 F.3d 708 (2d Cir. 1994) (subsequent history omitted).

⁶⁶The Court noted that the state decision to assist Blue Cross & Blue Shield plans was based on its ability to pay hospitals more promptly and its long history of open enrollment.

Administration and Enforcement of ERISA

The Department of Labor and the Internal Revenue Service (IRS) have primary responsibility for enforcing ERISA requirements. Labor's Pension and Welfare Benefits Administration (PWBA) enforces ERISA's fiduciary requirements, which ensure that private pension and welfare benefit plans operate in the best interests of plan participants and beneficiaries, and reporting and disclosure requirements, which ensure that plans provide financial and other information to the federal government and plan participants and beneficiaries. IRS enforces ERISA's participation, vesting, and funding requirements for pension plans.

Since December 1986, PWBA's ERISA enforcement strategy has focused on investigating "significant issue" cases with a high potential for fiduciary violations or other imprudent management practices. Although PWBA has also emphasized investigations of multiple employer welfare arrangements (MEWA), it has focused less on single employers that self-fund their health benefit plans.

PWBA's Enforcement Strategy

The goal of PWBA's enforcement strategy is to achieve the greatest possible ERISA compliance by using resources effectively. PWBA believes that investigations of significant issue cases have a broader impact than investigations of individual cases because they focus on financial institutions and service providers that usually serve many plans and many participants. Thus, when a fiduciary violation by a financial institution or service provider is corrected, dollar recoveries and the number of plans and participants involved are typically larger than when a violation by an individual plan is corrected.

As of May 1994, PWBA had about 400 enforcement staff working on investigations of employee benefit plans (both pension and welfare benefit plans) covered by ERISA. At that time, over 720,000 private pension plans and 4.5 million welfare benefit plans were subject to title I of ERISA and Labor regulation. These plans had about \$2.5 trillion in assets and covered about 200 million participants. PWBA allocates at least 50 percent of its enforcement resources to significant issue cases, with no less than 20 percent spent on either financial institution or service provider cases. PWBA devotes the remaining resources to investigating general cases. PWBA officials could not estimate the number of enforcement staff positions dedicated specifically to health benefit plan activities.

PWBA's 1994 guidance to its 10 area offices required them to balance types and sizes of plans selected for general investigations, with a general rule

that no more than 5 percent of all such cases involve plans with fewer than 50 participants. PWBA uses several methods to identify financial institutions, service providers, and pension and welfare plans for investigation. The methods include referrals from IRS and other agencies, complaints from participants and beneficiaries, manual review of financial and other information on plans' annual Form 5500 series reports, spin-offs from other investigations, special area office projects, and computer targeting. The computer targeting programs search automated Form 5500 series report information for characteristics that PWBA believes indicate a high potential for ERISA violations. Generally, the targeting programs are used to identify pension and welfare plans for investigation, although some programs can be used to identify financial institutions and service providers.

In addition, the Department told us that PWBA provides technical assistance to beneficiaries and the general public. For example, PWBA may determine that an individual contacting the Administration is inappropriately being denied health benefits to which he or she is entitled and has attempted to obtain. In these situations, PWBA may intervene to assist the individual in obtaining coverage or payment of a specific benefit. PWBA also ensures compliance with provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986⁶⁷ that provides for the continuation of group health coverage for employees and family members whose coverage would otherwise be discontinued in cases of terminated employment, death of an employee, or divorce from a covered employee.

Focus on MEWAs

PWBA officials told us that although they have been concerned with single employers that offer self-funded health plans for several years, they have placed more emphasis on investigating MEWAs.⁶⁸ A MEWA is an ERISA welfare benefit plan or other arrangement established or maintained to provide benefit coverage to the employees of two or more employers. Their promoters often represent to employers and state regulators that MEWAs are employee benefit plans covered by ERISA and as such are exempt from state insurance regulation under ERISA's preemption provision.

By avoiding state insurance reserve, contribution, and other requirements applicable to insurance companies, MEWAs can often market insurance

⁶⁷29 U.S.C. 1161 et seq.

⁶⁸See *Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation*, U.S. Department of Labor, Pension and Welfare Benefits Administration (Washington, D.C.: 1992).

coverage at substantially lower rates. This makes MEWAS an attractive alternative for small businesses that find it difficult to get affordable employee health care coverage. In practice, some MEWAS have been unable to pay claims due to insufficient funding and inadequate reserves, or, in the worst situations, they were operated by people who drained a MEWA's assets through excessive fees and embezzlement. In 1992, we reported that these problems were widespread.⁶⁹ According to state insurance officials, between 1988 and 1990, MEWAS left at least 398,000 participants and their beneficiaries with over \$123 million in unpaid claims and many other participants without insurance. Further, over 600 MEWAS failed to comply with state insurance laws, and some violated criminal statutes.

Recognizing that it was both appropriate and necessary for states to establish, apply, and enforce state insurance laws concerning MEWAS, the Congress amended ERISA in 1983 to provide an exemption to ERISA's broad preemption provision for regulating MEWAS under state insurance laws. Since the late 1980s, Labor has acted to alleviate MEWA problems. In May 1990, the Secretary of Labor announced a program to improve MEWA enforcement efforts. The program included distributing to each state, on a quarterly basis, copies of Labor's advisory opinions; training state and federal officials; sharing information on investigations; and developing technical assistance material and reviewing information reported by plans to the IRS to determine the feasibility of providing the states a list of MEWAS. Labor also increased its investigations of MEWAS, from 30 in December 1989 to 86 in September 1991.

Recently, PWBA officials told us that about 40 percent of their current health benefit investigations involved MEWAS. PWBA data on MEWA investigations showed a total of 91 MEWA investigations pending (70 civil cases and 21 criminal cases), and PWBA had recovered from MEWA cases about \$3.9 million in prohibited transactions reversed and plan assets restored in fiscal year 1994. This total has declined considerably from MEWA investigative efforts in 1993, when PWBA recovered about \$6.3 million. Statistics on PWBA's investigations of single-employer self-funded health plans are unavailable.

Civil Enforcement and Criminal Penalties

When PWBA identifies violations, ERISA authorizes the Department of Labor to assess penalties against the violators. Labor may assess a penalty of up to \$1,000 per day against a plan administrator who fails or refuses to file a

⁶⁹Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (GAO/HRD-92-40, Mar. 10, 1992).

Form 5500 series report or whose report is rejected for lack of material information.

When PWBA finds that welfare or pension plans that do not qualify for tax exemption have violated ERISA's prohibited transaction requirements, Labor may assess parties in interest (such as fiduciaries, employees, persons who provide plan services, employers or employee organizations whose members are covered by a plan, or others) a penalty up to 5 percent of the prohibited transaction and up to 100 percent if the transaction is not corrected within 90 days. Labor must, with certain exceptions, assess a penalty against a fiduciary or any person who knowingly participated in a fiduciary breach that occurred or continued after December 19, 1989. The fiduciary penalty is equal to 20 percent of the recovery amount agreed to in a settlement with Labor or contained in a court order.

In addition, Labor investigates criminal charges for willful violations of ERISA reporting and disclosure provisions. Upon conviction, a person can be fined a maximum of \$5,000 or imprisoned for up to 1 year or both; except that, in the case of such violation by a corporate entity, the fine imposed upon the person is not to exceed \$100,000.

Forms 5500 Are of Limited Value for Assessing the Number and Characteristics of Self-Funded Health Plans

The Department of Labor obtains information on the number and characteristics of self-funded health plans from the annual Form 5500 returns that employee benefit plans file with the IRS. However, PWBA officials told us that the Forms 5500 are a poor source of data on self-funded plans because they do not clearly define self-funded plans and the data contain many errors. Further, Labor officials question the accuracy of other sources of information on the number of self-funded plans.

How Do Labor's ERISA Enforcement Activities Compare With Those Performed by State Insurance Departments?

The McCarran-Ferguson Act, passed in 1945, established a statutory framework whereby responsibility for regulating the insurance industry was left largely to the states. ERISA's preemption provision is consistent with this arrangement. The Supreme Court has recognized, however, that this effectively creates a dual system, with states regulating fully insured plans indirectly through their regulation of insurance but not self-funded plans.

State insurance departments use different enforcement activities to regulate the insurance industry than the Department of Labor uses to

enforce ERISA's requirements on self-funded employer health benefit plans. The major responsibilities of state insurance departments typically include

- licensing insurance companies and the agents who sell insurance to ensure that companies are financially sound and reputable and that agents are qualified;
- setting standards for and monitoring the financial operations of insurers to determine whether they have adequate reserves to pay policyholders' claims;
- reviewing and approving rates to ensure that they are both reasonable for consumers and sufficient to maintain solvency of insurance companies;
- reviewing and approving insurance policies to ensure that they are not vague or misleading and meet state requirements, such as mandatory benefit provisions; and
- monitoring insurers' actions to ensure that they are not engaging in unfair business practices or otherwise taking advantage of consumers and assisting consumers by investigating their complaints, answering questions, and conducting educational programs.

As previously noted, under ERISA, only the fiduciary and reporting and disclosure standards apply to welfare benefit plans, including health plans. The participation, vesting, and funding requirements apply only to pension plans. Major differences in Labor's and states' enforcement activities are in financial regulation of employer health plans, reporting and disclosure requirements, and the handling of consumer complaints.

Financial Regulation

The principal responsibility of all state insurance departments is to protect consumers by ensuring that insurance companies comply with minimum solvency standards. ERISA, however, does not require health benefit plans to satisfy any solvency standards. According to the National Association of Insurance Commissioners (NAIC), ERISA does not set standards to regulate the continued solvency of health plans once they begin operation. As a result, NAIC believes that employees covered under self-funded health plans are vulnerable to plan mismanagement and a plan's intentional abuse of its discretion because state solvency standards are preempted for self-funded plans.

NAIC also points out that while ERISA provides termination insurance for defined benefit pension plans, no similar insurance exists for health plans. Generally, insured health plans are protected by state guaranty funds, but single-employer, self-funded health plans are not. NAIC states that, as a

consequence, participants and beneficiaries of self-funded health plans have few avenues of redress against an insolvent plan other than to join the bankrupt employer's other creditors to pursue the firm's remaining assets.⁷⁰

Further, NAIC contends that participants in an insured single-employer health plan enjoy the benefits of solvency oversight and insolvency protection. NAIC believes this disparity likely is the unintended consequence of ERISA's failure to regulate the content of employer benefit plans and the fact that ERISA exempts the insurance industry from state purview. NAIC concluded that if an employer offers its employees an insured health benefit plan, the plan's contents are subject to the requirements of state law, including solvency requirements. However, employees covered by a self-funded plan would not be subject to these requirements.

Reporting and Disclosure Requirements

ERISA does not require administrators of single-employer self-funded health plans to submit plan disclosure documents to any administrative agency for review, according to NAIC. Moreover, ERISA allows the plan administrator to distribute a summary of material modifications to participants and beneficiaries 210 days after the end of the plan year in which the changes were adopted. In contrast, according to the NAIC, state insurance laws typically require that single-employer insured health plans submit plan policy forms to the state insurance departments for review and approval. Most states also require insured health plans to promptly notify participants and beneficiaries of changes to the plan.

Consumer Complaints

Another significant difference in state insurance department enforcement activities and Labor's is in handling consumer complaints. Labor's approach to assisting individual participants with health plan complaints involves informing participants and beneficiaries of their rights under ERISA and providing general information about how the law may apply to their situations. Generally, Labor's investigations of employer health plans are broader in scope than individual consumer complaints and involve financial institutions and service providers. In contrast, state insurance departments actively investigate consumers' complaints of high-pressure sales practices, improperly denied claims, unfair discrimination, and improper denial of coverage. Also, most states perform market conduct

⁷⁰ERISA: A Call for Reform: Recommendations of the NAIC ERISA Working Group, NAIC (Washington, D.C.: 1994).

exams to review the marketing, underwriting, rating, and claims payment practices of health insurers.

In addition, according to NAIC, ERISA does not ensure participants and beneficiaries in health benefit plans an unbiased and independent review process. Although ERISA requires that all single-employer health plans, whether self-funded or insured, provide a mechanism to permit participants and beneficiaries to appeal a plan's denial of a claim, the review may be based upon the written record and conducted by the same plan administrator who denied the claim. In comparison, NAIC states that participants and beneficiaries of single-employer insured health plans have access to state insurance departments in which participants and beneficiaries can obtain an independent and informal review of their complaints. For example, NAIC reported that in the first 9 months of 1993 the Wisconsin insurance department handled 2,438 complaints relating to insured single-employer health plans and recovered \$485,580.

Estimation of Enrollment in Self-Funded Health Plans

Although disparate sources of federal government information characterize components of the U.S. health care market, no database accurately portrays the number of individuals enrolled in ERISA plans or the number of individuals enrolled in self-funded plans. Therefore, we estimated these numbers using several data sources. This required (1) estimating the number of individuals with employer-based health coverage, (2) estimating the number of individuals enrolled in ERISA health plans (subtracting coverage provided by government and church employers from total employer-based coverage), and (3) incorporating data from other sources to estimate how many individuals are enrolled in self-funded ERISA health plans.

Thus, on the basis of different assumptions, we estimate that between 106 and 114 million Americans are enrolled in ERISA health plans. Of these, between 41 million and 47 million individuals, representing 16 to 18 percent of the U.S. population, are enrolled in self-funded health plans. Our estimate is that 44 million individuals, 17 percent of the population, are enrolled in self-funded ERISA plans.

Number of Individuals With Employer-Based Health Coverage

The Bureau of the Census' Current Population Survey (CPS) provides data on the source of health insurance coverage, or lack thereof, for all Americans. The survey asks questions about health insurance coverage at any time during the previous year. For the March 1994 survey, Census scientifically selected about 57,000 households and weighted the results to represent the whole nation. As shown in table III.1, most Americans receive coverage through their employment or from government programs like Medicare and Medicaid.⁷¹

⁷¹Some individuals may receive coverage from several sources (for example, retirees who are Medicare eligible but also receive supplemental coverage from their former employer). To avoid double counting, we prioritized the source of coverage reported by the CPS. For our analysis, employer coverage is considered primary to other sources of coverage, except for 8.3 million individuals who also received Medicare and did not indicate that they were employed by the private sector or governments. For these individuals, we assume that Medicare was the primary payer and that the employer-based plan was Medicare supplemental coverage.

**Appendix III
Estimation of Enrollment in Self-Funded
Health Plans**

Table III.1: CPS Estimates of Health Care Coverage Source, 1993

Source of coverage	Individuals (in millions)	Percent of population
Employment ^a	140.0	53.9
Medicare	31.4 ^b	12.1
Medicaid	23.9 ^c	9.2
CHAMPUS/VA/military	4.5 ^d	1.7
Individual	20.2	7.8
Uninsured	39.7	15.3
Total (U.S. population)	259.8	100.0

^aAlso includes union-sponsored coverage.

^bTo avoid double counting, this number does not include individuals who also received employer-based coverage and who are working (1.7 million individuals). For these individuals, we assumed that Medicare would be a secondary payer to the primary, employer-based coverage. HCFA reports that, in 1992, 35.6 million individuals (13.7 percent of the population) were enrolled in Medicare.

^cTo avoid double counting, this number includes only those individuals who did not also have either Medicare or employer-based coverage during 1993. If these individuals were included, Medicaid enrollment would total 31.7 million individuals. HCFA reports that, in 1992, 31.2 million individuals were enrolled in Medicaid.

^dTo avoid double counting, this number does not include 5.1 million individuals who also received employer-based coverage, Medicare, or Medicaid during 1993.

Number of Individuals Enrolled in ERISA Health Plans

Because government- and church-sponsored employee plans are not ERISA plans, the number of individuals enrolled in ERISA plans is a subset of those who have employer-based coverage. Therefore, to estimate the number of individuals enrolled in ERISA plans, we used the number of individuals receiving health coverage through private-sector employers and government or church employers.

Of the 140 million individuals with employer health coverage in 1993, the CPS reported that nearly 73 million individuals worked for a private employer, 16 million worked for a government employer, and 51 million did not indicate a category of employment. Most of these 51 million unclassified individuals (82 percent) were children or spouses of workers with employer coverage. We allocated these individuals to the related worker's employment category. The remaining 9 million individuals were simply allocated proportionately to either private or government coverage.⁷² As shown in table III.2, we estimate that nearly 114 million individuals received health coverage through a private-sector employer.

⁷²That is, 81 percent of these 9 million individuals were allocated to the private sector and 19 percent were allocated to government.

**Appendix III
Estimation of Enrollment in Self-Funded
Health Plans**

**Table III.2: Distribution of Individuals
With Employer-Based Health Care
Coverage**

	Private	Government	Unclassified
Initial CPS data (before allocation of unclassified individuals)	72.6 (82 percent)	16.0 (18 percent)	51.2
Estimates (after allocation of unclassified individuals)	113.9 (81 percent)	26.0 (19 percent)	0

In some cases, individuals may have been employed under one category but received coverage under another category. For example, a person may work for a private firm but receive family coverage through a spouse who is employed by the government. If government benefits are more generous, then it is likely that many spouses may elect the government-sponsored coverage rather than their own private-sector coverage. However, the CPS data do not allow us to determine when this situation occurs.

Comparing the CPS data with other sources, our estimate of employer-based health coverage offered by governments is lower than expected. On the basis of enrollment in the Federal Employees Health Benefits Program (FEHBP) and employment by state and local governments, the CPS data may underestimate government-sponsored health coverage by as much as 8 million individuals.⁷³ If our estimate of enrollment in government-sponsored health plans is low, then our number of individuals covered through private-sector health plans is high. In our final estimates for self-funded health plans, therefore, we tested the sensitivity of our analysis to different assumptions of employer-based coverage offered by private-sector and government employers.

In addition to health plans offered by government employers, health plans sponsored by churches are also exempt from ERISA. To estimate the number of participants in church-sponsored health plans, we analyzed the CPS data to identify about 250,000 individuals who were clergy or religious workers and who received employer-based health coverage. We estimate that about 500,000 individuals and dependents receive employer coverage through church-sponsored health plans. However, this may be an

⁷³In 1993, FEHBP enrollment was about 9 million individuals, including 2.4 million employees, 1.7 million retirees, and approximately 5 million dependents. However, most FEHBP enrollees who are retirees of the federal government would also have Medicare as their primary coverage. Thus, we estimate that about 6 million individuals receive FEHBP as their primary source of coverage. The Bureau of Labor Statistics (BLS) reported that about 15.4 million individuals were employed by state and local governments in 1992, with 90 percent of full-time state and local government employees participating in their employers' health plans. Using these data, we estimate that roughly 28 million individuals (including dependents) would be covered by employer health plans sponsored by local and state governments. Thus, government-sponsored coverage estimated from these sources would be about 34 million individuals, compared with the 26 million individuals we estimated from the CPS data.

**Appendix III
Estimation of Enrollment in Self-Funded
Health Plans**

underestimate because many church workers would be classified in administrative or other occupations and cannot be separately identified as church employees. Because of the relatively small number of people receiving employer coverage through church-sponsored health plans, this number is unlikely to significantly affect our final estimates of the number of individuals in ERISA self-funded plans.

Thus, of the nearly 140 million individuals that the CPS reported receive employer-based health coverage, we estimate that about 114 million are enrolled in ERISA health plans, as summarized in table III.3.

**Table III.3: Participants With
Employer-Based Health Care Coverage
Overseen by ERISA**

	Number of participants (in millions)
Employer-based coverage	140.0
Government-sponsored coverage	26.0
Church-sponsored coverage	0.5
ERISA health plans	113.5

Using a similar approach with the March 1990 CPS, we estimate that of the 144 million individuals with employer-based health coverage in 1989, approximately 117 million were in ERISA health plans.

**Number of Individuals
Enrolled in
Self-Funded Health
Plans**

Employer benefits surveys that BLS has produced indicate the percentage of plan participants with employer-based health care coverage that are enrolled in self-funded plans. A difficulty with these data, however, is that they are collected in alternating years for establishments with fewer than 100 employees and for establishments with 100 or more employees.⁷⁴ To generate a rate for the number of individuals enrolled in self-funded plans for establishments of all sizes, we blended the results of survey years 1992 and 1993, as shown in table III.4.

⁷⁴See *Employee Benefits in Medium and Large Private Establishments, 1993*, U.S. Department of Labor, BLS (Washington, D.C.: Nov. 1994), and *Employee Benefits in Small Private Establishments, 1992*, U.S. Department of Labor, BLS (Washington, D.C.: May 1994).

**Appendix III
Estimation of Enrollment in Self-Funded
Health Plans**

Table III.4: BLS Estimates of the Number of Full-Time Participants in Self-Funded Health Plans in 1992 and 1993

Survey year	Establishment size (number of employees)	Full-time employees represented by survey	Full-time employees with coverage	Participants in self-funded plans (percent)
1992	Fewer than 100	34.4 million	24.4 million	32
1993	100 or more	28.7 million	23.5 million	46

The overall percentage of participants enrolled in self-funded plans, 39 percent, is the weighted average of the BLS data representing all full-time employees with health coverage.

To examine the trend in enrollment in self-funded plans, we also calculated a blended self-funded rate from BLS' survey for years 1989 and 1990. On the basis of this calculation, the percentage of participants enrolled in self-funded health plans in 1989 and 1990 was 33 percent. (See table III.5.)

Table III.5: BLS Estimates of the Number of Full-Time Participants in Self-Funded Health Plans in 1989 and 1990

Survey year	Establishment size (number of employees)	Full-time employees represented by survey	Full-time employees with coverage	Participants in self-funded plans (percent)
1990	Fewer than 100	32.5 million	22.8 million	28
1989	100 or more	32.4 million	29.8 million	36

Other Sources of Data on Prevalence of Self-Funding

To verify the accuracy of our results, we compared the BLS survey findings with other potential sources of data on the prevalence of self-funding. These included reports that health plans are required to submit to the Department of Labor as well as private employer benefit surveys. However, in most cases, these sources were incomplete or error prone. Few sources provide data for employers of all sizes, including small employers that tend less to self-fund.

All employers with at least 100 employees that provide employee benefits are required to report to the Department of Labor, using a Form 5500.⁷⁵ Unfortunately, the Department of Labor acknowledges that the data from this form are of limited value in estimating the number of self-funded health plan participants because the form is primarily designed for pension plans, the data are not reported consistently, and the data may be

⁷⁵Employers with fewer than 100 employees are not required to file a Form 5500 unless they self-fund their benefits and pay from a trust fund (rather than from general assets).

prone to filer errors and errors introduced in the data processing.⁷⁶ Despite these limitations, an analysis of the Form 5500 filings by Mathematica Policy Research, Inc., for the Congressional Research Service estimated that, for employers with more than 100 employees in 1991, 42 percent of participants were in fully insured plans, 26 percent of participants were in partly self-funded plans, and 32 percent of participants were in fully self-insured plans. Mathematica excluded firms with 100 or fewer employees because the data were too incomplete.

A 1994 survey in 10 states conducted by Rand, Inc., for the Robert Wood Johnson Foundation and the Department of Labor found results very similar to the BLS survey we used.⁷⁷ In the 10 states it surveyed, Rand found that 41 percent of participants were enrolled in self-funded health plans. Like the BLS survey, these results included health plans of all sizes, including those with fewer than 100 employees. However, it is limited to the states included in the survey. The National Center for Health Statistics is currently using a similar survey nationwide; the results of its employer benefit survey are expected in fall 1995.

Finally, several private employer benefits consulting firms have estimated the proportion of health plans offered by employers of different size categories that are self-funded. In 1993, Foster Higgins reported that, among employers with more than 500 employees, 64 percent of indemnity plans were self-funded and 62 percent of preferred provider organization (PPO) plans were self-funded. For employers with fewer than 500 employees, only 17 percent of indemnity plans were self-funded and 4 percent of PPO plans were self-funded. Similarly, KPMG Peat Marwick's 1994 survey of employers with at least 200 employees found that 62 percent of conventional (indemnity) plans were self-funded, 63 percent of PPOs were self-funded, and 58 percent of point-of-service plans were self-funded. Peat Marwick did not survey firms with fewer than 200 employees. In both cases, these surveys only reported the percentage of plans that are self-funded, not the percentage of individuals enrolled in self-funded health plans.

Because the BLS survey is the only one of these sources that reports national percentages of participants in self-funded health plans in firms of all sizes, we used this source in our final estimates of the number of

⁷⁶For example, some employers report multiple Forms 5500 for each health plan they provide, whereas others report a single Form 5500 for all of their health plans. It is also difficult to determine whether the health plan is a single-employer plan or a multiemployer plan.

⁷⁷The states surveyed include Colorado, Florida, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington.

Americans enrolled in self-funded health plans. Since the Rand survey also included all firm sizes (although only 10 states were surveyed), we used its slightly higher percentage of participants in self-funded health plans to examine the sensitivity of our results.

Number of Individuals in Self-Funded Health Plans

We estimate that about 44 million participants (17 percent of the U.S. population) were enrolled in self-funded ERISA health plans in 1993.⁷⁸ This estimate is calculated by multiplying the percentage of participants in self-funded plans (39 percent) in 1992-93 by the number of participants in ERISA health plans in 1993 (113.5 million). Using the same approach, we estimate that approximately 39 million participants were enrolled in self-funded ERISA health plans in 1989.

Because of uncertainties in the number of enrollees in employer health plans sponsored by governments or churches, we tested the sensitivity of our estimate using a lower number of participants in ERISA health plans. By estimating that 106 million individuals participated in ERISA health plans (rather than 114 million), we calculated approximately 41 million enrollees in self-funded ERISA health plans in 1993 rather than 44 million enrollees. This represents about 16 percent of the U.S. population.

We also tested our estimates using a higher percentage of participants in self-funded plans. On the basis of the 10-state survey conducted by Rand, we assumed that 41 percent of participants were in self-funded health plans (rather than the 39 percent estimated by BLS). Thus, using this assumption, we estimate 47 million enrollees in self-funded ERISA health plans (nearly 18 percent of the population) rather than 44 million enrollees.

⁷⁸Some state and local governments also self-fund their health plans. In 1992, a BLS survey found that 27 percent of participants receiving health care coverage from state and local government employers were in self-funded plans. Our analysis of the 1993 CPS survey estimates that about 20.9 million Americans receive coverage from state and local government employer health plans. Thus, about 5.7 million of these state and local government workers and dependents are in self-funded plans.

State Taxes Assessed on Health Plans

One of the most direct and quantifiable advantages that firms receive from self-funding their health plans is their exemption from state premium taxes and some other assessments paid by health insurers and HMOs. Most insurers and HMOs will pass on the costs of these taxes to their customers through higher premiums. However, their ability to do so, as well as the overall impact on an employer, depends on factors such as the competitiveness of the market, size of the employer, and insurer's marketing strategy.

As shown in table IV.1, premium taxes on commercial health insurers range from less than 1 percent to over 4 percent, with most states having premium tax rates of about 2 or 3 percent. Many states also provide exemptions or discounted tax rates for Blue Cross & Blue Shield Plans, HMOs, and locally based insurers.

Table IV.1: State Health Insurance Premium Tax Rates

Numbers in percent

	Health insurers	Blue Cross & Blue Shield plans	HMOs
Alabama	1-4 ^a	1-4 ^a	1 ^b
Alaska	2.7	6 ^c	2.7
Arizona	2	2	2 ^d
Arkansas	2.5	1	2.5 ^e
California	2.35	0	0
Colorado	2.25	5¢ per enrollee ^f	0 ^g
Connecticut	1.75 ^h	2 ^h	1.75 ^h
Delaware	2	0	0
District of Columbia	2.25	0	0
Florida	1.75	1.75	0
Georgia	2.25	2.25	2.25 ⁱ
Hawaii	4.265	0	0
Idaho	1.4-2.75 ^j	1.4-2.75 ^j	.04¢ per enrollee ^f
Illinois	2 ^k	0	0
Indiana	2	0	0
Iowa	2	2	0-2 ^l
Kansas	1-2 ^a	1-2 ^a	0.5-1 ^l
Kentucky	2	2 ^m	2 ^m
Louisiana	2-2.25 ⁿ	2-2.25 ⁿ	2-2.25 ⁿ
Maine	2	0.015	0
Maryland	2	0	0 ^o
Massachusetts	2-2.28 ^p	0	0

(continued)

Appendix IV
State Taxes Assessed on Health Plans

Numbers in percent

	Health insurers	Blue Cross & Blue Shield plans	HMOs
Michigan	0 ^q	0	0
Minnesota	2	0	0
Mississippi	3	0	0
Missouri	2	0	0
Montana	2.75 ^r	0	0
Nebraska	0.5	1	1
Nevada	3.5	3.5	3.5
New Hampshire	2 ^s	0	2 ^s
New Jersey	1.05	2¢ per subscriber	0
New Mexico	0.9-3 ⁱ	0.9-3 ⁱ	3
New York	1	0	0
North Carolina	1.9	0.5	0
North Dakota	1.75	1.75	1.75 ^t
Ohio	2.5 ^u	2.5 ^u	0
Oklahoma	2.25	2.25	2.25 ^v
Oregon	2.25 ^w	0	0
Pennsylvania	2	0	2 ^x
Rhode Island	2	0	0
South Carolina	1.25	1.25	0 ^y
South Dakota	2.5	2.5	2.5 ^b
Tennessee	2.5	2.5	2
Texas	1.75	0	1.75 ^z
Utah	0	0	0
Vermont	2	0	0
Virginia	2.25	0.75 ^{aa}	0 ^{bb}
Washington	2 ^{cc}	2 ^{cc}	2 ^{cc}
West Virginia	3	0	0
Wisconsin	2	0	0 ^{dd}
Wyoming	0.75	0.75	0.75

Note: Premium taxes expressed as percentage rate assessed on gross premiums unless otherwise noted.

^aDomestic (state-based) insurers pay lower rate.

^bCredit for HMOs with state home office.

^cTax based on gross premium less claims paid.

^dTax assessed on net charges.

Appendix IV
State Taxes Assessed on Health Plans

^eCredit for HMOs with state home office and local salaries and wages.

^fPer month.

^gFee collected on the basis of premium volume.

^hTax collected on the basis of net direct premiums.

ⁱCredit for HMO city license fee.

^lLower rate applies to insurers investing in state securities.

^kDomestic insurers meeting certain requirements are tax exempt.

^lHMOs less than 6 years old pay the lower rate.

^mAdditional tax of \$0.25 per outpatient pharmaceutical drug if tax is not paid by pharmacist.

ⁿTax set as \$140 for \$7,000 or less in premiums received and \$225 for each additional \$10,000 in premiums received.

^oHMOs are tax exempt except where HMO benefits are offered by a for-profit commercial insurer. HMOs offered by nonprofit insurer are tax exempt.

^pLower rate is paid by insurer if also licensed as life insurance company. PPOs taxed at 2 percent.

^qInsurers pay business tax.

^rHealth insurers also pay \$0.70 per Montana resident to fund genetics program.

^sMinimum payment of \$200.

^tHMO credits for exam fees and state home office.

^uDomestic insurers pay lesser of 2.5 percent of franchise tax.

^vFederal payments (Medicare and Medicaid) to HMOs are tax exempt; HMOs get a credit if invested in state securities; credit for HMO state home office.

^wDomestic insurers pay income tax instead.

^xNonprofit or benevolent HMOs are tax exempt.

^yTaxed as a corporation at 5 percent; also have a license tax.

^zFor first \$450,000 of gross reserves collected, HMO tax rate is 0.875 percent. HMOs receive a credit for Texas investments not to exceed \$2 per enrollee.

^{aa}Tax assessed on subscriber fees.

^{bb}Pay insurance commission maintenance assessment of no more than 0.1 percent of premium, with a minimum of \$300.

^{cc}Additional fee assessed for Department of Insurance operations, not to exceed 0.125 percent of receipts.

^{dd}HMOs pay franchise tax of 7.9 percent.

Source: NAIC, 1995.

Health insurers are also liable for paying other miscellaneous assessments collected by the states.⁷⁹ For instance, all states maintain guaranty funds to pay outstanding claims in cases of an insurer's failure. Every state except New York retroactively assesses insurers to finance these guaranty funds. That is, in years that moneys are drawn from the guaranty funds because of an insurance failure, insurers are assessed a fee on the basis of their market share within the state to pay for the guaranty fund expenses. States cap the maximum rate insurers may be assessed in a year, typically at about 2 percent of gross premiums. However, except in a few states where a large insurer failed, actual assessments are much lower than the maximum rate. For example, in 1990, actual assessments against life and health insurers for guaranty funds averaged about 0.15 percent. That year, 20 states (including Puerto Rico) either made no assessments or made refunds for surpluses in life and health insurance guaranty funds; guaranty fund assessments exceeded 1 percent of premiums in only three states.

Another significant cost for health plans in some states results from taxes assessed on providers, such as hospitals. A 1994 survey by the American Public Welfare Association found that about half of the states have adopted provider revenue taxes. Many states have tax rates ranging from 1 to 7 percent, although New York imposes a 13-percent tax on hospital services paid by commercial insurers.⁸⁰ In many states, these funds are popular because they can be used to receive federal matching funds for Medicaid.⁸¹ In other states, such as Massachusetts, these taxes are redistributed to hospitals to reimburse for uncompensated care costs. Finally, New York has used these taxes for hospital rate-setting programs

⁷⁹State regulations also require health insurers to maintain reserves to protect the insurer's financial solvency. Although not directly a tax, reserve standards require the insurer to maintain and account for these funds in a specified way and may result in an opportunity cost to the insurer. This opportunity cost results from the insurer not having the flexibility to use the funds in other ways that may have a higher rate of return. In contrast, self-funded health plans do not have reserve requirements. It is impossible to accurately estimate the costs saved by self-funded health funds from the lack of reserve requirements because (1) the extent to which self-funded plans voluntarily reserve assets for paying future health claims is unknown; (2) in the absence of state regulations, insured plans could invest the funds currently maintained in reserve in many ways; and (3) how fully insurers pass on the associated costs of reserve requirements (or a tax) to employers through higher premiums is unclear. Because solvency standards would require a self-funded employer to set aside funds to pay for future health care claims, the employer could encounter an opportunity cost by losing the flexibility to invest the funds at a higher rate of return.

⁸⁰Hospital services provided to Blue Cross & Blue Shield enrollees are exempt from the surcharge, and HMO enrollees pay from 0 to 9 percent depending on the share of Medicaid enrollees in the HMO. Until 1993, commercial insurers also were required to pay an additional 11 percent surcharge on hospital revenues.

⁸¹See *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government* (GAO/HEHS-94-133, Aug. 1, 1994). In 1991, the Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 to severely restrict the use of provider-specific taxes and donations as a source of state Medicaid matching funds.

and to provide a competitive advantage to Empire Blue Cross & Blue Shield because the insurer has maintained a policy of open enrollment and has thereby insured higher risk and costly individuals.

Even though these taxes are imposed on providers rather than directly on health plans, they have an indirect effect on health plan costs. Hospital services provided to enrollees in self-funded health plans as well as those provided to fully insured health plan enrollees have been taxed.⁸² Because of this indirect effect on health plans, several states, including New York and New Jersey, have had their provider taxes challenged under ERISA. However, the Supreme Court ruled in the Travelers case that the New York system of hospital surcharges, which is essentially a provider tax, has too indirect an effect on health plans to be preempted by ERISA. Thus, pending further litigation, states appear to have the ability to impose general provider taxes without violating ERISA.

⁸²To some extent, a hospital tax may not proportionately affect all payers equally. For example, even though a state may impose a 10-percent tax on hospital charges, a large insurer or self-funded health plan may negotiate an additional 10-percent discount from hospital services and nullify the effect of the tax on its health plan costs.

State-Mandated Benefits

State governments require, or mandate, that companies selling health insurance cover specified health services or the services provided by specified providers.⁸³ Mandates are typically narrowly defined provisions and may be applied to commercial insurance companies, Blue Cross & Blue Shield plans, and HMOs.

Mandates are often classified as treatment mandates, provider mandates, and special-population mandates. Treatment mandates require insurance companies to cover treatment for specific conditions, such as alcoholism and mental health problems, or for specific procedures, such as in vitro fertilization services. Provider mandates require payment for covered services from specific types of providers, such as chiropractors, psychologists, or optometrists. Special-population mandates require insurance coverage for defined groups, such as newborns, adopted children, or handicapped dependents.

Mandated benefits are often debated, the debate usually centering on the value of mandated benefits relative to their cost. Proponents of mandates, including many consumer groups and health care providers, argue that they may (1) provide equal access to necessary services; (2) pay for themselves in the long run, especially preventive care services; (3) make certain benefits available to those who are likely to become uninsured or uninsurable; and (4) prevent some insurers from experiencing substantial adverse selection, that is, attracting individuals who have costly health conditions or are more likely to incur high health costs. Opponents, including many business groups and insurers, argue that mandates may (1) raise total health care costs and thus premiums, (2) cause employers to self-fund or discontinue their health plans, (3) interfere in the voluntary contract between insurers and employers, (4) result from political pressure from special interest groups and providers, and (5) create administrative burdens for insurers or employers operating in many states.

States Usually Mandate Benefits for Select Types of Coverage

The number and type of benefits mandates vary by state. Although analyses have shown that the total number of mandates adopted by the states exceeds 700, this overstates the scope of mandated benefits because many states have identical or similar requirements.

States most frequently mandate coverage for preventive treatments like mammograms and pap smears or for treatment of mental illness or alcohol

⁸³States' ability to require insurers to sell insurance policies to employee welfare benefit plans containing specified benefit or provider provisions was upheld in *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985). See appendix I for a more detailed discussion of this case.

**Appendix V
State-Mandated Benefits**

and substance abuse. In addition, states often require coverage for more common alternative providers like chiropractors and optometrists and for special populations like newborns and the handicapped. A small number of states requires coverage for more specific conditions or treatments, such as congenital defects like cleft palate or hair loss due to specific medical conditions or treatment. Table V.1 shows the number of states with specific mandated benefits as identified by NAIC and Blue Cross & Blue Shield of America.⁸⁴ States typically mandate that insurers cover specific benefits in all plans sold, whereas some states merely mandate that insurers offer specific benefits but the insurer may also offer other plans without these benefits. In some cases, the mandates are limited to particular plans, such as HMOs or group insurance plans.

Table V.1: Number of States With Specific Mandates

	Cover ^a	Offer ^b	Total
Treatment mandates			
Mammography screening	41	4	45
Mental illness	15	16	31
Alcoholism treatment	24	16	40
Drug abuse treatment	15	8	23
Pap smear	19	0	19
Well child care	14	4	18
Infertility treatment/in vitro fertilization	11	3	14
Temporomandibular joint disease treatment	10	3	13
Maternity care	11	2	13
Breast reconstruction following mastectomy	9	2	11
Phenylketonuria	7	1	8
Cleft palate	6	0	6
Prostate cancer screening	4	1	5
Bone marrow transplant	3	1	4
Scalp hair prosthesis (for alopecia areata)	2	0	2
Provider mandates			
Psychologists	40	1	41
Chiropractors	39	2	41
Optometrists	35	2	37
Podiatrists	30	0	30

(continued)

⁸⁴We used data from NAIC for treatment mandates because this source refers to specific state laws that require mandates, whereas Blue Cross & Blue Shield data are based on a survey of Blue Cross & Blue Shield plans, which may be less consistent in identifying mandates. However, NAIC does not report provider or special population mandates, and therefore we reported the data from Blue Cross & Blue Shield. In general, the two sources are similar, although Blue Cross & Blue Shield reported somewhat more states with treatment mandates.

Appendix V
State-Mandated Benefits

	Cover^a	Offer^b	Total
Nurse midwives	28	2	30
Social workers	21	3	24
Nurse practitioners	17	2	19
Psychiatric nurses	15	0	15
Osteopaths	13	1	14
Physical therapists	10	0	10
Nurse anesthetists	10	1	11
Professional counselors	9	1	10
Speech/hearing therapists	5	5	10
Occupational therapists	6	1	7
Acupuncturists	5	1	6
Special-population mandates			
Newborns	48	1	49
Handicapped dependents	35	0	35
Continuation of coverage for dependents	32	1	33
Dependent students	7	0	7

^aStates require specified benefit to be covered in health insurance plans sold.

^bStates require insurers to offer specified benefit, generally at a higher cost, although insurers may also sell plans without specified benefit.

Source: For treatment mandates, NAIC State Positions: Mandated Benefits, 1994.

For provider and special-population mandates, State Legislative Health Care and Insurance Issues: 1994 Survey of Plans (Dec. 1994).

In addition to treatment, provider, and special-population mandates, states have increasingly considered any-willing-provider laws that require managed care plans to accept health care providers in their networks that meet the terms and standards of the plan. According to the Group Health Association of America, of the states with any-willing-provider laws, 10 have laws that apply to all providers, 14 have laws that apply to pharmacists, 3 have laws that apply to physicians, and 4 have laws that apply to nonphysician providers. However, in most states the laws are limited because they do not apply to HMOs or to only particular types of managed care plans.

Mandates Increase Cost of Health Insurance Premiums, but Overall Cost Effect Is Unclear

The limited research on state benefit mandates indicates that they increase health care claims costs. The effect of mandates on costs is not uniform, however, since coverage for select benefits like mental health and substance abuse often accounts for a large percentage of increased claims costs.⁸⁵

Determining the effect of a specific health insurance mandate on premiums can be difficult, in part because it is hard to assess a mandate's effect on the overall increase in health claims and the attendant impact on health insurance premiums. Also, a mandate's cost effect on an employer can vary sharply depending on the demographics and health needs of the employee population. In addition, it is difficult to assess the true impact of mandates when a large percentage of employer plans, both fully insured and self-funded, offer benefits similar to the more costly state mandates.

Studies Show That Mandates Increase Health Care Claims Costs

Studies in several states have found that benefit mandates generally increase claims costs by 5 to 22 percent. These analyses have aggregated insurance company claims data and determined payments for mandated benefits as a percentage of total medical benefits paid. Table V.2 summarizes various state studies that have estimated the increased claims costs from mandated benefits.

Table V.2: Costs of Mandated Treatment Benefits, Selected States

State	Year	Total costs (percent)
Iowa	1987	5.4
Maryland	1988	22.0
Massachusetts	1990	18.0
Oregon	1989	8.1
Virginia	1989	22.0
Wisconsin ^a	1989	7.1

^aIncludes five mandated benefits: mental health (including substance abuse), chiropractic, diabetes, home health care, and skilled nursing care.

Sources: Jonathon Gruber, "State-Mandated Benefits and Employer-Provided Health Insurance," *Journal of Public Economics*, Vol. 55 (1994), pp. 433-464; Michael L. Hand and G. Marc Choate, "The Cost of State-Mandated Health Care Benefits in the State of Oregon," unpublished, 1991; Gail Jensen and Jon Gabel, "Price of State Mandated Benefits," *Inquiry*, Vol. 26 (1989), pp. 419-431; and Gregory Krohm and Mary H. Grossman, "Mandated Benefits in Health Insurance Policies," *Benefits Quarterly*, Vol. VI, No. 4 (1990), pp. 51-60.

⁸⁵Another mandate often cited as imposing a significant health claims cost is continuation of health insurance benefits for terminated employees. State laws requiring this coverage were largely superseded with the passage of federal requirements in 1986 (29 U.S.C. 1161 et seq.).

However, the results of these studies should not necessarily be generalized to all states, even to states with identical mandates. The reason for this is that many factors that are difficult to account for, such as provider charges and practice patterns and policy deductibles and copayment rates, may influence claims costs in each state.

Impact of Mandates on Claims Costs Is Not Uniform

While the limited research generally shows that state benefit mandates increase costs, it suggests that some mandates have a greater impact on claims than others. Studies have shown that mental health, substance abuse, dental care, and maternity and neonatal care mandates are among the highest cost mandates. For example, a summary of five state studies estimated that mental health benefits added between 2.6 and 6.5 percent to health care claims. Mandates determined not to add significantly to health insurance costs include services for in vitro fertilization, acupuncture, and cleft palate, as well as services provided by chiropractors and home health nurses. It is these low-cost mandates, however, that are often cited by employers as examples of the added wasteful expense mandates cause them. Whereas the added claims costs caused by mandates may affect small businesses' decisions on whether to offer health care coverage, larger businesses, many of which offer more comprehensive benefits regardless of mandates, tend to express concern about the added compliance costs resulting from varying mandates and limited flexibility to design their own benefit packages. However, these costs would be even more difficult to measure than the claims costs incurred by mandates.

Problems With Study Approaches May Make Their Results Less Conclusive

In addition to the difficulty of generalizing studies of benefit mandates to all states, the methodological problems inherent in existing studies obscure the entire cost impact of benefit mandates. These studies clearly show that benefit mandates increase claims costs to some extent, in part because the availability of insurance coverage for specific treatments will undoubtedly result in claims for those treatments. The extent of the overall increase in health claims and the attendant impact on health insurance premiums is unclear, however.

Some of these methodological problems follow:

- Many mandate studies were conducted in the 1980s and may not reflect the trend of more individuals being enrolled in managed care plans that attempt to manage utilization of health care services.

- Studies may understate actual utilization due to a mandate because other related health services, although not themselves mandated, may also be provided. For example, some analysts have noted that conditions such as alcoholism may cause other medical problems such as malnutrition. Treatment for these related conditions would not be provided under the mandate and, therefore, costs related to the treatment of alcoholism may be understated.⁸⁶
- Studies may also overstate the increase in use of services. This could occur if services provided under the mandate substitute for services formerly provided through traditional coverage. In addition, many health plans may offer benefits similar to those mandated before its enactment. Thus, attributing the use of services to a mandate would overstate the mandate's effect.
- Studies may not capture overall lower health care utilization if coverage is required for services delivered by a lower cost provider.
- Claims-based studies rely on accurate treatment coding by the provider and an insurer's ability to isolate claims through its claims paying system. This may be difficult, especially in the case of multiple diagnoses.
- Studies traditionally focus on the costs of mandates, not on the benefits. Although a cost-benefit analysis would be difficult, if not impossible, to undertake, a truly rigorous analysis of state mandates would track health care utilization of a specific population over time to determine if medical interventions based on state mandates ultimately improved overall health status and avoided more costly medical interventions later on.

In addition to these methodological problems, mandate studies have not conclusively shown that benefit mandates are a large burden to employers that would cause them to self-fund or not seek coverage. Many employers currently offer coverage similar to state mandates, and, for those that self-fund, mandates are commonly not a factor or are only one of several factors affecting that decision.

⁸⁶Krohm and Grossman, p. 54.

Comments From the Department of Labor

U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210



JUL 10 1995

Mark V. Nadel
Associate Director of National
and Public Health Issues
Health, Education, and
Human Services Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Nadel:

In reply to your letter of June 26, 1995, to Secretary Reich requesting comments on the draft GAO report entitled "The Employee Retirement Income Security Act of 1974: Issues, Trends, and Challenges for Employer-Sponsored Health Plans," the Department's response is enclosed.

I would like to take this opportunity to offer a few general comments in addition to the more detailed comments we have enclosed.


First, the body of the document compares only the positions of employers and the states on ERISA preemption issues. The report would benefit from also including the perspective of participants and beneficiaries of these benefits. While this is done to a limited extent in Appendix II, the main section is silent in this regard. For example, ERISA bars state remedies for wrongful denial of health benefit claims (for both insured and self-funded plans) that might be available to participants in health plans not covered by ERISA.

Second, PWBA provides considerably more technical assistance to participants, beneficiaries, and the general public than is described in Appendix II. We may determine that a correspondent or caller is inappropriately being denied health benefits to which he or she is entitled and for which he or she has made direct attempts to obtain. In these situations, PWBA may intervene to assist the person in obtaining coverage or payment of a specific benefit. PWBA plays a major role in ensuring compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a complex law which guarantees, among other things, the continuation of group health insurance for employees and/or their family members in certain situations. Among these situations are termination of employment, death of an employee, and divorce or legal separation from a covered employee.

Appendix VI
Comments From the Department of Labor

The Department appreciates the opportunity to comment on this report.

Sincerely,


Olena Berg
Assistant Secretary

Enclosure

GAO Contacts and Acknowledgments

Contacts

Michael Gutowski, Assistant Director, (202) 512-7128
John Dicken, Senior Evaluator, (202) 512-7135
Rafe Forland, Senior Evaluator
Craig Winslow, Senior Attorney, (202) 512-8225

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