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EMPLOYER-BASED
HEALTH PLANS

Issues, Trends, and Challenges
Posed by ERISA

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Madam Chairman and Members of the Committee:

I am pleased to be here today as the Committee continues its deliberations on health insurance reforms. Much of the emerging debate on the appropriate role in health reform for the private market, the federal government, and state governments has focused on the Employee Retirement Income Security Act of 1974 (ERISA). More specifically, ERISA preemption effectively blocks states from directly regulating most employer-based health plans, but it permits states to regulate health insurers.

At the request of a bipartisan group of Senators and Representatives, including Senators Jeffords, Wellstone, Dodd, and Simon of this Committee, we are releasing a report that addresses ERISA's role in the current system of employer-based health care coverage.¹ My testimony today will focus on (1) the proportion of workers in self-funded plans, (2) the kinds of state actions preempted by ERISA, and (3) the advantages of ERISA preemption to employers that offer health care coverage to their employees.

In brief, our analysis showed that nearly 40 percent of enrollees in employer-based health plans, about 44 million people, are in self-funded plans. The divided federal and state framework for regulating health plans produces a complex set of trade-offs. Self-funded plans, which are exempt from state regulation under ERISA, provide employers greater flexibility to design a health benefits package that may have been less feasible to provide under state regulation. At the same time, however, states are unable to extend regulations, such as solvency standards, preexisting condition clause limits, and guaranteed issue and renewal requirements, even indirectly, to enrollees in these self-funded plans.

We developed our information on the basis of interviews with officials representing states, employers, and other health industry groups; a review of ERISA court cases and other literature; and an analysis of data from the Bureau of Labor Statistics and the Bureau of the Census.

BACKGROUND

The statutory language on ERISA preemption has been characterized as among the most complex and confusing language in the federal code.² ERISA provides a federal framework for

¹Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

²See, for example, Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 424, 740 n. 16 (1985).

regulating employer-based³ pension and welfare benefit plans, including health plans. Most Americans receive health care coverage through employment, and most of these plans are subject to ERISA's requirements. ERISA's language, however, leaves open to interpretation the prohibition of states from directly regulating employer health care coverage while allowing them to regulate health insurers. The result has been that the courts have had to provide guidance on many implications of ERISA preemption.

The division of regulatory responsibilities between federal and state governments results in differing treatment of self-funded and insured plans.⁴ For example, recent state initiatives to provide for guaranteed issue, guaranteed renewability, and portability of insurance coverage apply only to fully insured health plans.⁵ S. 1028, introduced by you and Senator Kennedy, and legislation proposed by Senator Jeffords would amend ERISA to provide additional national requirements for all private health plans--both self-funded and insured. S. 1028 would include provisions that limit exclusions for preexisting conditions, guarantee availability and renewability, ensure portability, and encourage group purchasing.⁶ Senator Jeffords' proposal would also add federal requirements for ERISA health plans, including provisions that define self-funded plans, require disclosure of the funding status to participants, establish plan termination coverage and rules, and clarify nondiscrimination rules and the regulation

³Such plans may be established or maintained by employers, employee organizations (such as unions), or both.

⁴Insurance is a contractual arrangement in which financial risk from one party (the "insured") is transferred to another party (the "insurer"). 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 this term 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.

⁵See Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

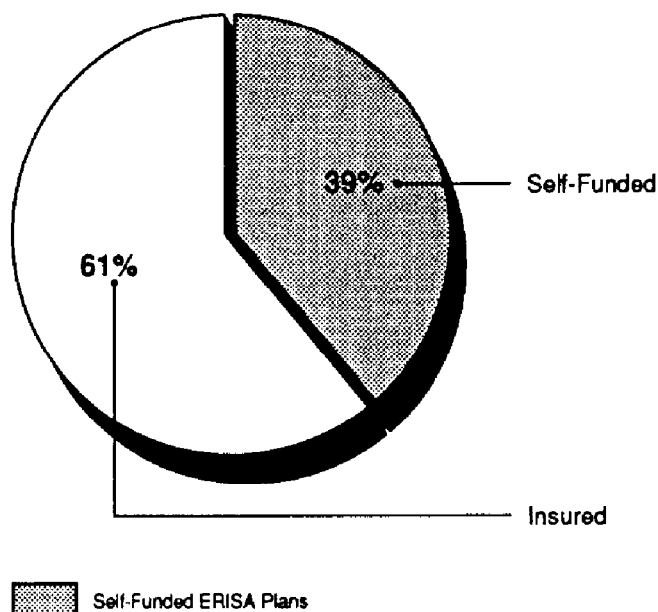
⁶See Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (GAO/T-HEHS-95-205, July 18, 1995).

of multiple employer welfare arrangements. These bills attempt to clarify the uncertainty that currently results from ERISA preemption and the divided regulatory system.

A LARGE SHARE OF AMERICANS ARE ENROLLED IN SELF-FUNDED HEALTH PLANS

No definitive data exist on the number and characteristics of self-funded ERISA plans because efforts to collect this information at the federal level have been limited, and ERISA preempts states from doing so. The lack of a clear distinction between many self-funded and insured health plans also contributes to the difficulty in estimating the number of individuals enrolled in self-funded plans. Although data are incomplete, we examined existing data reported by the Bureau of Labor Statistics and the Bureau of the Census to estimate the extent of self-funding among all firm sizes and health plan types. Our analysis indicates that nearly 40 percent of enrollees in private employer-based health plans, about 44 million people, are in self-funded plans in which the employer chooses to retain all or part of the risk of its health costs. (See fig. 1.) Because these self-funded plans are not deemed to be insurance, ERISA preempts them from state regulation and premium taxation.

Figure 1: Private-Employer Health Care Coverage, 1993



In most private employer-based health plans, the employer purchases health care coverage from a third-party insurer subject to state insurance regulation and insurance premium taxation.⁷ Including both self-funded and insured health plans, 114 million people (44 percent of the U.S. population) are in health plans covered by ERISA requirements. The remainder of the population either have coverage from a government or church employer (27 million), Medicare (31 million),⁸ Medicaid (24 million),⁹ individual insurance (20 million), or Department of Veterans Affairs or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) health plans (5 million);¹⁰ 40 million individuals were uninsured. (See fig. 2.)

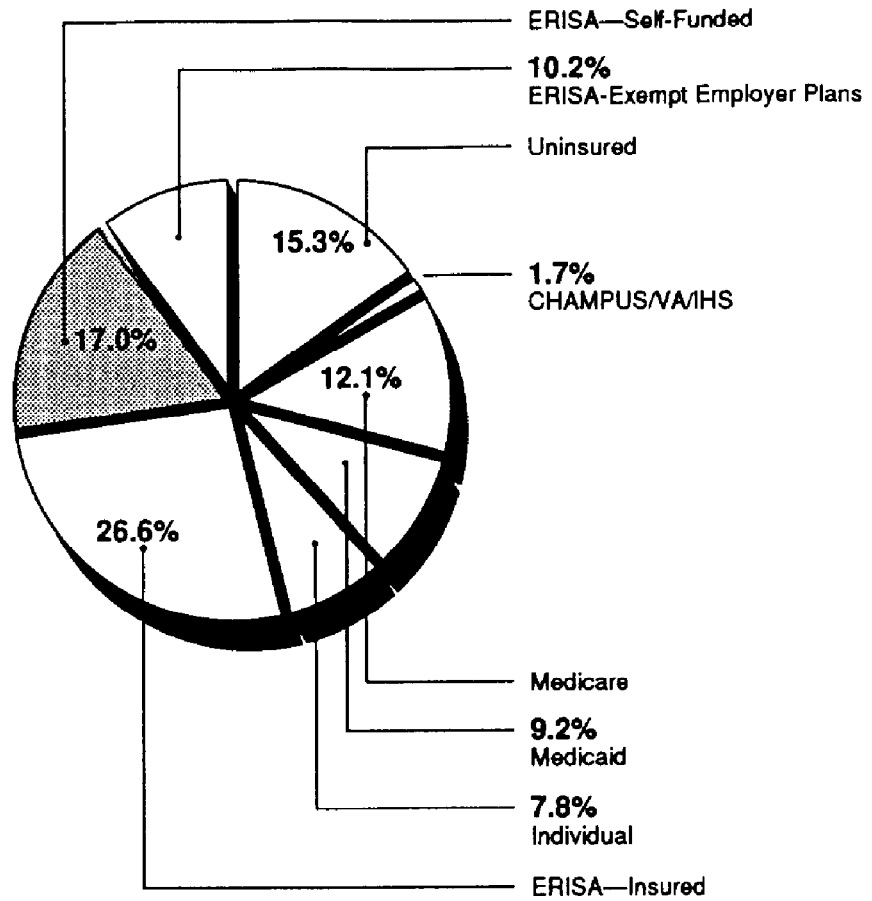
⁷Although the term "ERISA health plans" is sometimes mistakenly used to refer only to self-funded health plans, ERISA requirements apply to all private employer-based health plans, whether fully insured through a third party or self-funded. Governmental plans--those employee health plans offered by local, state, or federal governments--and church plans are generally excepted from ERISA requirements.

⁸To avoid double counting, this number does not include individuals who also received employer-based coverage and who are working (1.7 million people). For these people, Medicare would be a secondary payer to the primary employer-based coverage. This number does include 8.3 million people 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 people were enrolled in Medicare in 1992.

⁹To avoid double counting, this number includes only those people who did not also have either Medicare or employer-based coverage during 1993. If these people were included, Medicaid enrollment would total 32 million people. HCFA reported that 31.2 million people were enrolled in Medicaid in 1992.

¹⁰To avoid double counting, this number does not include 5 million people who also received employer-based coverage, Medicare, or Medicaid during 1993.

Figure 2: Health Care Coverage by Source, 1993



Self-funded ERISA plans

SELF-FUNDING APPEARS TO BE INCREASING

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.¹¹ 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 a health plan is self-funded or insured. 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.

STATES CLAIM THAT 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 people. In addition, the number of privately insured individuals that state insurance commissions 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 shrinking.¹²

States maintain that they should have the right to have uniform taxes and regulatory standards for all health plans 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

¹¹This 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.

¹²For 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).

and are trying to regulate these arrangements. Finally, although previously several states had wanted exemptions from ERISA to implement comprehensive health care reforms, including employer mandates, the momentum for such reforms has largely dissipated. However, the impetus for incremental changes, such as taxes and data collection, remains strong.

EMPLOYERS VIEW ERISA AS CRITICAL TO THEIR ABILITY TO EFFICIENTLY PROVIDE HEALTH CARE COVERAGE

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.¹³ They note that preemption was designed to provide uniform rules for all employers and to prevent states from imposing many different regulatory approaches to health care.

Employers also believe that changing ERISA may lead to state requirements that would hinder their ability to manage the cost and quality of their employees' health care. They 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. 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 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.¹⁴

EFFECT ON HEALTH PLANS CHANGING AS COURTS CONTINUE TO REINTERPRET ERISA PREEMPTION

To date, the courts have played a key role in delineating 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

¹³See G. Lawrence Atkins and Kristin Bass, ERISA Preemption: The Key to Market Innovation in Health Care, Corporate Health Care Coalition (Washington, D.C.: 1995).

¹⁴In fact, this trend may already be evident with retiree health benefits, though not because of any ERISA modifications. See Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (HRD-93-125, July 9, 1993).

regulation."¹⁵ Evaluating the response to this ruling is premature, but it may suggest greater flexibility for states, which will inevitably lead to further litigation.

CONCLUSION

In summary, 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 on ERISA's potential costs and benefits relating to health care. Both states and employers argue that they must play a more active role in managing health care quality and costs. Key elements of their positions 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. To date, court interpretations have been the primary guidance on the implications of ERISA preemption. Ultimately, a legislative resolution, though challenging, may be the only clear solution to the current dilemmas.

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Madam Chairman, this concludes my statement. I would be happy to answer any questions.

For more information on this testimony, please call Mark Nadel, Associate Director for National and Public Health Issues, at (202) 512-7125 or Michael Gutowski, Assistant Director, at (202) 512-7128. Other major contributors include John Dicken, Senior Evaluator, and Craig Winslow, Senior Attorney.

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¹⁵See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. (115 S. Ct 1671 (1995)).

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