

# Report

## **ERISA Health Plans: Key Structural Variations and their Effect on Liability**

**By**

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# Health Plans: Key Structural Variations and their Effect on Liability

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*What do policymakers need to know about the “anatomy” of health plans regulated by ERISA in order to make informed legislative decisions?*

## Executive Summary

In fashioning legislative and regulatory responses to consumer and plan sponsor concerns about our current health care system, policymakers increasingly find themselves dealing with questions involving the Employee Retirement Income Security Act of 1974 (ERISA) and its relationship to employer-sponsored group health plans. Although ERISA establishes uniform minimum standards for group health plans in a variety of areas,<sup>2</sup> the application of these standards and the liability for those charged with carrying out the standards may vary widely, depending on the way the plan sponsor has structured its employee benefit plan.

ERISA health plans vary based on many factors, including:

- (1) the type of plan sponsor:
  - a “single-employer plan” is a group health plan established or maintained by a single company or a group of related companies (such as a parent and its subsidiary corporations) that provides health benefits for the employees of that company or group;

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<sup>2</sup> These areas include standards regarding reporting to the government, disclosure to participants and beneficiaries, fiduciary responsibility, the right to continue coverage after an individual loses coverage as a result of certain qualifying events, limitations on the applicability of preexisting condition exclusions, and other benefit-related mandates. In addition, ERISA establishes certain enforcement mechanisms for participants and beneficiaries when they believe their rights under the Act have been violated, such as procedures for benefit claims and appeals, the right to sue and remedies for violations of the Act.

- a “multiemployer plan” is a collectively bargained group health plan covering employees of more than one employer all of whom are signatory to a collective bargaining agreement with the same local, national or international union;
  - a “multiple employer welfare arrangement” or MEWA is a group purchasing arrangement covering employees of more than one employer, usually employers who belong to the same business or trade association but who have no legal or contractual connection to each other (as distinguished from multiemployer plans described above where participating employers are linked to the group health plan through the legally enforceable collective bargaining agreement);
- (2) the level of plan sponsor involvement in plan operations;
- (3) the extent to which plan sponsors retain insurance risk; for example, a group health plan may be:
- “fully insured,” where the insurance risk is transferred to an insurer; or
  - “self-insured,” where the insurance risk is retained by the plan sponsor (although, in some cases, the plan sponsor may share the risk through the purchase of stop-loss insurance or other forms of reinsurance); or
  - a combination of both insured and self-insured features, where the plan sponsor has determined that it will bear the insurance risk for some types of benefits or benefit structures and it will purchase insurance for other types of benefits;
- (4) the administrative variation among self-insured plans, such as:
- “self-administration,” a decision by the plan sponsor to appoint a plan administrator (e.g., either the company itself or an employee or agent of the company) to retain fiduciary obligations for administering the plan under ERISA); or
  - outsourced administration, in which the plan sponsor hires one or more third-party administrators (TPAs) (typically either a firm that specializes in such services or an insurer or HMO with which the plan sponsor contracts for “administrative services only” (ASO)); to the extent that the TPA exercises control over plan administration, it assumes fiduciary obligations under

ERISA, although in some cases the ERISA fiduciary duties may be shared by the plan administrator and one or more TPAs as co-fiduciaries;

- (5) number and type of group health plans, such as:
  - a package of comprehensive health benefits provided under a single group health plan; or
  - discrete stand-alone plans for different benefits (e.g., major medical, dental, vision, prescription drug, behavioral health);
- (6) the form of the plan and the nature of the employer subsidy, such as:
  - a traditional comprehensive medical plan offered with shared financing of the cost of benefits through co-insurance, co-payments and/or deductibles;
  - a cafeteria plan, established under §125 of the Internal Revenue Code and offered in connection with an employer-sponsored group health plan, in which employees may choose between cash or tax-favored benefits, using their own pre-tax dollars (accomplished through salary reduction) which may be supplemented by employer contributions;
  - a medical flexible savings account (FSA), a salary-reduction pre-tax cash account, offered in connection with an employer-sponsored group health plan; may be supplemented by employer contributions;
  - a medical savings account (MSA), a cash account funded by employer contributions and offered in connection with a high-deductible (i.e., catastrophic) health plan; only certain employers and individuals may establish MSAs;
  - a health reimbursement arrangement (HRA), a non-salary reduction cash account to which an employer contributes on a defined contribution basis, but with no employee contributions permitted;
  - a defined contribution health plan that combines some or all of the above features but emphasizes consumer choice (sometimes called a “consumer-driven health plan”);
- (7) the methods by which benefits are delivered, such as:

- the level of employee choice may differ, for instance:
    - the employer may offer a single plan or choice of plans;
    - the employer's plan allows access to in-network providers only
    - employee's are offered a point-of-service option (i.e., the plan establishes financial incentives favoring use of in-network providers, but patients can be treated by non-network providers at additional out-of-pocket cost);
  - the delivery mechanism may differ, for instance:
    - fee-for-service;
    - HMOs;
    - PPOs or similar arrangements;
    - combination of above;
- (8) the funding arrangement for self-insured plans may vary:
- funds may be set aside to pay claims in a tax-exempt trust (usually a "voluntary employees' benefit association" or VEBA; claims paid from trust assets;
  - no funds are set aside to pay claims; claims paid from the general assets of the employer.

The structural variation among plans drives the allocation of fiduciary responsibility and ultimate liability under ERISA of the persons involved in plan administration. The Issue Brief discusses in detail these sources of variation and the fiduciary and liability implications that flow from employer design choices.

Employers and other plan sponsors believe that the substantial flexibility they have in designing a group health plan is a significant incentive for them to provide health care coverage. They consider their ability under ERISA to make structural choices, as well as benefit design choices, essential because these options provide mechanisms to tailor their plans not only to the benefit needs of their workforce but to their own needs as well.

But this diversity in structure among ERISA health plans and the ability of employers to alter these structures in response to changing legal, financial and workplace conditions clearly impact the capacity of policymakers to respond to emerging consumer concerns in a reasonable and effective fashion.

If policymakers want to assure that their regulatory and legislative proposals achieve the goals for which they are intended, they need to be aware of the main sources of structural

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variation, as well as the legal principles, that will affect accountability and liability of plan sponsors, fiduciaries, and others providing services to the group health plan.

Recently, Congress has moved to consider reforms to ERISA that would alter the current liability rules in a way that may be more favorable to participants in ERISA plans. At the same time, ERISA's shield against liability for medical treatment decisions which has operated to protect HMOs and insurers from liability under state malpractice and tort laws has eroded through court decisions. Regardless of what changes may be made, if any, to ERISA's fiduciary and liability rules, policymakers can benefit from understanding how the current liability structure works.

## Background

Although not well understood by policymakers and many employers themselves, the Employee Retirement Income Security Act of 1974 (ERISA) has a profound impact on approximately 130 million Americans that receive their health coverage through the private-sector employee health plans that it regulates. Understanding the basic legal underpinnings of ERISA, as well as the anatomy of ERISA health plans, including their wide-ranging structural variations, is valuable to both plan sponsors and policymakers who are currently engaged in debates over several issues that could have important impacts on the health system. Whether policymakers are attempting to expand plans' legal liability for injuries caused through their managed care cost-containment practices or attempting to reduce the number of the uninsured, it is important to understand how ERISA health plans are structured, who is responsible for sponsoring and operating them, and how these structures might vary.

Some of these differences may be caused by ERISA's statutory framework and flow from a plan sponsor's initial decision regarding how involved in plan administration it wants to be. Other structural differences may reflect the interplay of ERISA with state laws regulating insurance. A common misconception about ERISA is that it covers only self-insured health plans. However, regardless of whether the plan sponsor chooses to purchase insurance to deliver the promised health benefits or to self-fund them, the employer-sponsored group health plan is covered by ERISA. But the insurance product that the plan sponsor purchases in a fully insured context will also be subject to state insurance regulation.

Some of the variation among group health plans simply reflects the tremendous diversity of private-sector entities sponsoring them as well as constantly evolving employer strategies to purchase health care benefits more effectively. From a plan sponsor's point of view, this flexibility is one of the hallmarks and strengths of the employer-sponsored health plan system.

Regardless of its impetus, the diversity in structure among ERISA health plans and the ability of employers to alter these structures in response to changing legal, financial and

workplace conditions clearly affect the capacity of policymakers to respond to emerging consumer concerns in a reasonable and effective fashion.

Beginning in the fall of 2001, supported by a grant by the Robert Wood Johnson's Changes in Health Care Financing and Organization National Initiative, researchers at the Center for Health Services Research and Policy at the School of Public Health and Health Services at The George Washington University Medical Center interviewed a series of experts on ERISA plans, including representatives of employers, benefit plan consultants, and lawyers who advise ERISA health plans and their sponsoring employers to identify the primary sources of variation in the structure of ERISA-covered plans. The purpose of this Issue Brief is to summarize these variations, describe the basic ERISA fiduciary and liability rules and illustrate how these structural variations may affect liability under ERISA.

## What is an ERISA “plan”?

One fundamental area of confusion for policymakers and others has been appreciating how expansive the term “ERISA plan” is and how an “ERISA plan” differs from other entities in the marketplace. Whether an arrangement to provide health benefits to a group of employees is an ERISA plan or not depends on two main factors: (1) whether the arrangement is a “plan” under ERISA, and (2) whether the “plan” has been established or maintained by a plan sponsor (or employer) that is subject to ERISA.

When an employer covered by ERISA (typically a private-sector employer) compensates its employees by providing employee benefits, such as health coverage, in most cases the employer has established an ERISA plan. This may be true even if the employer does not observe all the formalities that ERISA requires for establishing a plan (such as memorializing the benefit promise through a written document) or even if the employer does not realize that its practices and operations reflect the adoption of a plan (for instance, the employer who decides to simply reimburse employees for the purchase of insurance coverage). The courts have concluded that as long as one can identify in general terms the promised benefits, the intended beneficiaries, the source of financing and the procedure that a beneficiary might follow to obtain the promised benefits, an ERISA plan exists.<sup>3</sup>

Under ERISA, an employee benefit plan is “any plan, fund, or program” established or maintained by an employer, an employee organization, or both, to provide participants and

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<sup>3</sup> Most courts have followed this description of a “plan” first articulated in *Donovan v. Dillingham*, 688 F.2d 1367 (11<sup>th</sup> Cir. 1982)(en banc). For a more extensive discussion of when an ERISA plan is formed, see “First, Ya’ Gotta’ Have a Plan,” a paper by Ronald Dean, published by the American Bar Association in the two-volume text from the 16<sup>th</sup> Annual National Institute on ERISA Basics, June, 2002.

beneficiaries with certain specified benefits.<sup>4</sup> Employee benefit plans may be either “employee pension benefit plans” or “employee welfare benefit plans.”

Under employee welfare benefit plans, employers provide:

... **through the purchase of insurance or otherwise** [emphasis added]: A) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability, death, unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302 (c) of the Labor Management Relations Act of 1947 (other than pensions on retirement or death, and insurance to provide such pensions).<sup>5</sup>

Group health plans comprise the largest group of welfare plans covered under ERISA.

Under this definition, an “employer” refers to not just an individual employer, but also a group or association of employers. Under some circumstances, the term “employer” may include all entities under common corporate control (such as a wholly owned subsidiary of a company). An employer also includes a group or association of employers.<sup>6</sup>

But not all employers are subject to ERISA’s requirements, even if they do sponsor employee benefit plans for their employees. Exempt employers include governments (state, local, and Federal) and churches (including church-related agencies).<sup>7</sup> For instance, ERISA applies to employee benefit plans sponsored by The George Washington University for its staff, but not to employee benefit plans sponsored by the Veterans Administration or the State of California for its employees (governmental plans).

An ERISA plan is a legal entity in its own right, separate and apart from its plan sponsor. It may sue and be sued in its own name.<sup>8</sup> Any money judgment against the ERISA plan is enforceable

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<sup>4</sup> Section 3(3) of ERISA, 29 U.S.C. §1003(3).

<sup>5</sup> ERISA § 3(1), 29 U.S.C. § 1003(1).

<sup>6</sup> Although the matter is not entirely clear, under ERISA, the term “employee” has been held to exclude independent contractors, sole proprietors (unless they have at least one common law employee) and, in some jurisdictions, partners and their spouses.

<sup>7</sup> Although their plans meet the definition of an employee benefit plan, plans of these employers are excluded from ERISA under §4(b). Note, however, that although not covered under Title I of ERISA, governmental and church plans are not completely immune from Federal regulation, since they are subject to many requirements of the Internal Revenue Code (“the Code” or “IRC”). Some provisions of the Public Health Service Act may also apply to certain government health plans (“non-Federal governmental plans”).

<sup>8</sup> ERISA §502(d)(1).



only against the plan itself and not against anyone else, unless, of course, liability against that person is separately established.<sup>9</sup> For instance, an injured plaintiff would have to sue and establish liability against the plan's fiduciaries, not just the ERISA plan, if recovery is sought from those persons.

## Major Sources of Variation in ERISA Plans

ERISA plans are structured in a remarkably wide variety of ways. However, this Issue Brief focuses on the most significant distinctions among employer-sponsored health plans that may affect liability. The two most obvious differences among ERISA health plans are (1) the kinds of benefits that are offered (e.g., comprehensive medical, vision, dental, prescription drug, etc.) and (2) the generosity and comprehensiveness of the benefit package itself. However, the liability implications for these types of differences are also obvious. Other sources of variation regarding group health plans are less apparent to plan participants and beneficiaries (as well as policymakers), but ultimately these differences may have a far more significant impact under ERISA on who may be liable for harm to covered individuals and for what may these persons be held accountable. These variations include, for example, differences based on the type of plan sponsor, the amount of insurance risk that the plan sponsor retains, the financing mechanisms used to provide benefits, the methods by which benefits are delivered, and the degree to which the plan sponsor assumes fiduciary obligations for carrying out plan administration and other plan duties. Liability under ERISA or other Federal or state laws may differ substantially based on the way the ERISA plan is structured. A chart summarizing the major structural variables described in this Issue Brief can be found as Appendix I.

### 1. Variation based on the type of plan sponsor

One way to categorize ERISA group health plans is by the kind of entity that sponsors the plan. Most ERISA plans are sponsored by one employer and cover only the employees of that employer. In some cases, the "employer" may include other members of a larger corporate entity, called a "controlled group" of companies, as defined under the Internal Revenue Code.<sup>10</sup> Typically under ERISA, these plans are called "single-employer" or "corporate" plans.<sup>11</sup> Single-employer plans are generally established unilaterally by employers, although in some cases, the plans may be the product of collective bargaining. If they are, the bargaining agreement may be one of several documents that affect the rights of participants and beneficiaries covered under the plan but, under ERISA, the written plan document itself is the primary document that controls benefit entitlement and plan operations.

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<sup>9</sup> ERISA §502(d)(2).

<sup>10</sup> For instance, under §105(h)(8) of the Code, in determining whether the benefits provided under a self-insured group health plan discriminate in favor of highly-compensated employees, the employer must consider the health benefits provided to all employees of related firms, not just the employees of that particular establishment.

<sup>11</sup> The definition of "single-employer plan" is found in ERISA § 4001(a)(15).

In contrast, multiemployer plans<sup>12</sup> are always the direct product of collective bargaining. Multiemployer plans are collectively bargained plans established or maintained by more than one employer (often within the same or related industries) and, by law,<sup>13</sup> must be administered by a joint board of trustees consisting of an equal number of representatives of labor and management. These plans are sometimes referred to as “Taft-Hartley plans” because contributions to such a jointly-administered plan are authorized under section 302 of the federal Taft-Hartley Act.<sup>14</sup>

A third type of ERISA health plan based on plan sponsorship is also recognized under ERISA. These plans are called multiple employer welfare arrangements or MEWAs.<sup>15</sup> A MEWA typically involves two or more unrelated employers<sup>16</sup> often belonging to the same business or trade association that come together to offer health insurance to the employees of association members. Sometimes these plans are confused with multiemployer plans because of their similar names, but they are clearly different. For instance, in a multiemployer plan, all of the contributing employers are signatory to a collective bargaining agreement with the same local, national or international union. Participation in the multiemployer health plan is required under the collective bargaining agreement and therefore an enforceable contractual agreement exists between the union and the employer to provide benefits for unionized employees.

In contrast, MEWAs are mechanisms to bring together otherwise unrelated employers to provide benefits usually through an association in which the employer participates but with no legally binding commitment under a collective bargaining agreement to do so. Because of important legal and structural differences, the application of ERISA’s standards to employers who provide health insurance through a MEWA differs in some respects from the application of those standards to employers providing benefits through a multiemployer plan. The most significant difference is the fact that in certain instances (as described below) state law may apply to MEWAs, even if they are self-insured.

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<sup>12</sup> The definition of “multiemployer plan” is found in ERISA §§ 3(37) and 4001(a)(3).

<sup>13</sup> This is a requirement of Federal labor law, not ERISA. Section 302(c) of the Taft-Hartley Act requires joint administration.

<sup>14</sup> Often these plans are mistakenly described as “union” plans, despite the fact that their governing structure requires joint administration by representatives of labor and management. As previously noted, under ERISA §3(16)(B)(3), the joint board of trustees is the plan sponsor of a multiemployer plan.

<sup>15</sup> ERISA §3(40). MEWAs are arrangements established or maintained to offer any benefit described in ERISA §3(1) to the employees of two or more employers (including one or more self-employed individuals). Plans or arrangements established or maintained pursuant to bona fide collective bargaining agreements are not MEWAs. Nor are plans or arrangements established or maintained by rural electric or telephone cooperatives or single employers.

<sup>16</sup> These employers are “unrelated” because they are neither signatories to collective bargaining agreements with the same union (as are employers who contribute to multiemployer plans) nor “related” in the tax sense (i.e., part of the same controlled group of companies).

Further adding to the confusion, MEWAs are not always themselves considered “plans” under ERISA. In some cases, a MEWA may act as a fiscal intermediary to negotiate with providers or perform administrative functions for the members of the association. If the MEWA itself is not an ERISA plan, it is subject to the full range of state regulation.<sup>17</sup> For liability purposes under ERISA, however, each employer that participates in a MEWA is considered to have established its own ERISA-covered plan. However, it is possible that the MEWA may also be considered an ERISA plan too. In that case, both the MEWA and each participating employer must comply with ERISA’s rules.

## **2. Variation based on the level of plan sponsor involvement in plan operations**

When an employer decides to provide health benefits for its employees, one of the most critical decisions it must make is how much it wants to be involved in the actual operation of the health plan. Employer involvement varies considerably and may change substantially over time in response to external forces, such as changes in the law, regulation, business and economic conditions, employee preferences, costs and other developments in the health care marketplace. As discussed below, this decision usually is closely linked to the decision regarding whether to purchase insurance to deliver promised benefits or whether to retain the insurance risk themselves.

## **3. Variation based on the level of plan sponsor retention of insurance risk**

For most employers, the first decision they must make after determining to offer health insurance to employees is whether to purchase a fully insured product or to self-insure the benefits. By purchasing a fully insured product, the employer shifts the insurance risk completely and limits

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<sup>17</sup> In the past, the question of whether Federal or state law should apply to MEWAs has been a source of controversy and confusion. In 1983, Congress amended ERISA to clarify that (1) to the extent that a MEWA is not a plan covered under ERISA, states have full authority under their insurance powers to regulate MEWAs, (2) even if the MEWA is an ERISA plan, if the MEWA is fully insured, the state may regulate it for solvency and may adopt provisions to enforce the solvency requirements, and (3) if the MEWA is not fully insured, provisions of state insurance law may apply to it “to the extent not inconsistent with the preceding sections of this title [Title I of ERISA].”

Both before and after 1983, treatment of MEWAs by the states has not been uniform. Most states do not try to regulate self-insured MEWAs, but rather treat them as unlicensed insurance companies; a few states have adopted regulatory schemes applicable to self-insured MEWAs, often based on the National Association of Insurance Commissioners (NAIC) Model Act, imposing licensing requirements similar to those of HMOs. Yet enforcement problems continue to exist, as some MEWA entrepreneurs try to operate beyond the reach of state law, and both state and Federal regulators struggle with some fundamental definitional questions that go to the heart of the dispute over which level of government has the ultimate legal and regulatory authority for MEWAs. For example, when a state tries to investigate a self-insured MEWA, the MEWA may claim immunity from state law because it alleges it is a bona fide collectively bargained plan. Whether this claim is true or not will govern which law applies, since only genuine collectively bargained plans are exempt from state law.

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its liability to simply paying the applicable premium to the insurer. At the same time, however, the employer exposes itself to the premium underwriting practices of the insurer.

If the employer decides to self-insure the health benefits, it retains the risk of paying for the health care services used by its employees itself and exposes itself to potentially greater total liability. Some of this risk may be shared, however, through the use of reinsurance or stop-loss insurance and most employers who self-insure benefits do use these techniques to minimize their actual insurance risk.

Employers often offer a mixture of fully insured and self-insured benefits, opting, for example, to self-insure the basic medical benefit package and to fully insure ancillary benefits, such as vision or dental care, or other types of welfare benefits, such as long-term disability. To further confuse matters, there are also a variety of products, such as minimum premium arrangements, offering a blend of insurance and self-insurance to employer plans.

A common misconception about ERISA is that it covers only self-insured health plans. However, regardless of whether the plan sponsor chooses to purchase insurance to deliver the promised health benefits or self-fund them, the employer-sponsored group health plan is covered by ERISA. But the insurance product that the plan sponsor purchases in a fully insured context will also be subject to state insurance regulation. So although the ERISA plan itself cannot be directly regulated by the states (regardless of whether it is insured or self-insured), by regulating the insurance product purchased by ERISA plans, states can influence the benefit practices of a fully insured ERISA plan.

This distinction between insured and self-insured ERISA plans can dramatically affect consumer protections available to participants, in part due to the inapplicability of state consumer protection laws and insurance regulation to self-insured ERISA plans and the limited indirect influence that these state regulatory mechanisms applicable to insurers have on fully-insured ERISA plans.<sup>18</sup>

#### **4. Administrative variation among self-insured plans**

Self-insured ERISA plans vary in their administrative structure. Some plan sponsors choose to administer the promised benefits by handling the claims administration functions in-house. Others choose to hire outside administrators – typically contracting with one or more third-party administrators (TPAs) (including HMOs or insurers acting as TPAs) to provide claims administration. Sometimes employers use different TPAs for different benefits. For example, an

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<sup>18</sup> For a fuller discussion of this issue, see K. Polzer and P. Butler, “Employee Health Protections Under ERISA,” *Health Affairs* (September/October 1997):93-102; Patricia A. Butler and Karl Polzer, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, Oakland, CA: California HealthCare Foundation, April 2002, available at <http://www.chcf.org>.

employer may have one TPA to administer its health plan, but may use a pharmacy benefits manager (PBM) to administer its prescription drug benefits. Some employers use a combination of self-administration and outside administration. For instance, an employer may use a TPA to administer its medical benefits, but self-administer its cafeteria plan or health flexible spending accounts.

Using an HMO as a TPA to administer the self-insured ERISA plan's health benefits (and not as an insurer) sometimes results in a mistaken belief by participants and beneficiaries that the HMO is actually underwriting or bearing the risk for the payment of benefits. Instead, if all the HMO or insurer is doing is providing claims administration services, then the typical arrangement is described as an "administrative services only" or "ASO" agreement. If the HMO or TPA has not agreed to assume liability as a claims fiduciary (and some TPAs do assume fiduciary liability for claims decisions), the participant must look to the named fiduciary if benefits are not properly paid. This variation in plan administration affects the legal liability that may arise from improperly processed or denied claims because liability for failure to pay claims flows under ERISA to the person who has the fiduciary responsibility to pay them.

For instance, if a TPA is operating under an ASO contract and does not either agree to assume or actually exercise ultimate decision-making authority (i.e., fiduciary responsibility) over claims decisions under the plan, generally the TPA will not be liable for injuries caused by a decision made by the plan's fiduciary. But if the TPA is the claims fiduciary, it will be subject to fiduciary liability under ERISA, either on its own or as a co-fiduciary with any other fiduciary who under the terms of the ERISA plan shares decision-making authority for benefit claims.

## **5. Variation based on number or type of ERISA plans**

Although ERISA and the Internal Revenue Code describe the types of benefits that can be offered on a tax-favored basis through a group health plan,<sup>19</sup> neither law requires that these benefits all be provided through the same group health plan. That decision rests with employers and other plan sponsors, although given the tremendous variety of coordinated arrangements that employers use to deliver benefits, it is often difficult even for them to determine whether they have established one or more ERISA plans. Unless the plan documents provide otherwise, under ERISA, the existence of a single plan is assumed if the plan sponsor files only one Form 5500 with the government that covers all the health benefits it provides.<sup>20</sup>

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<sup>19</sup> The tax treatment of medical benefits is circumscribed primarily by IRC §§ 105 and 106, and the definition of "medical care expenses" can be found in IRC §213.

<sup>20</sup> The Form 5500 is the annual financial report required under ERISA. In general, ERISA requires that plan administrators file this form for each employee benefit plan established or maintained by the plan sponsor, although welfare plans (including group health plans) with fewer than 100 participants are exempt. ERISA §103, 29 U.S.C. §1023.

Most employers provide all promised medical benefits under the same ERISA plan. Usually a single ERISA plan will cover a broad group of benefits, including inpatient and outpatient care, mental health and substance abuse, vision care, dental, and prescription drug benefits.

Other employers may establish separate ERISA plans for one or more of these benefits (i.e., a stand-alone for mental health benefits, for vision, for dental or for prescription drug benefits). An employer may sponsor one ERISA health plan even though it contains multiple benefits options or offers a mixture of fully insured and self-insured benefits. For instance, some large employers have one ERISA plan, but carve out their mental health benefits and contract with a managed behavioral health care provider on a fully insured basis, even though they may provide the other medical benefits on a self-insured basis.

In crafting legislation or regulations, it is important for policymakers to consider a whether a proposed bill or rule should apply to all group health plans, or just to certain kinds of health plans or specific benefits. For example, in the Health Insurance Portability and Accountability Act of 1996, certain categories of benefits were exempted if they were not part of the employer's general medical plan (e.g., limited-scope dental or vision benefits if they are provided under a separate policy, certificate, or contract of insurance and are not an integral part of the plan).<sup>21</sup>

## **6. Variation based on the nature of employer subsidy and the form of the plan**

Employer plans differ in the nature and amount of the subsidy they promise employees. Most employers provide comprehensive health benefits for their employees, with some form of shared financing of the cost of the benefits between the employer and the employees. If costs go up, some employers may either absorb those costs themselves, or, more likely, on an ad hoc basis will pass on some or all of the increase to employees through increased cost-sharing. In either case, the employer has promised to provide the comprehensive benefits, rather than agreeing only to contribute a fixed amount toward coverage. This is more akin to the defined benefit approach for pension plans. In communicating the availability of group health plan coverage, other employers limit the amount of money they will contribute up front by declaring that they will pay only X% or \$Y toward the cost of coverage. Fixing the contribution in advance limits the employer promise to the subsidy, rather than to the benefit package itself. This type of arrangement may be considered a “defined contribution” approach to providing health benefits.

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<sup>21</sup> Benefits are not considered “integral” if the participant can elect not to receive the benefits, and if the participant who does elect the benefits, is responsible for paying an additional premium or contribution for the coverage.



In addition to their group health plans, some employers also establish “cafeteria plans” under Section 125 of the Internal Revenue Code in order to give their employees a tax-favored choice between cash and one or more additional medical or other benefits. In conjunction with cafeteria plans, a growing number of employers also offer “health flexible spending accounts” (FSAs) which allow employees on a pre-tax basis to set aside money to offset tax-deductible medical expenses incurred during the plan year, but not otherwise covered under the employer plan, such as co-payments, deductibles, infertility treatment, lasik surgery, etc..<sup>22</sup> At the end of the plan year, unused amounts in an FSA are forfeited. These mechanisms are also considered “defined contribution” approaches to providing health benefits.

Other types of employer-sponsored plans may include more limited arrangements for providing medical benefits, such as medical savings accounts (MSAs) which combine a high-deductible health plan<sup>23</sup> with a cash account from which non-covered medical expenses can be paid.<sup>24</sup> Only self-employed individuals and small employers (generally those with fewer than 51 employees during a specified time period) may establish MSAs. The main advantage to a MSA over a traditional FSA is that unused amounts in the MSA at the end of the plan year can be rolled over and used in succeeding years.

## **7. Variation based on methods by which benefits are delivered**

As previously noted, ERISA plans vary in the way that promised benefits are delivered to participants and beneficiaries. A fully-insured ERISA-covered health plan may contract with one or more HMOs or health insurers. A self-insured ERISA plan may contract with one or more HMOs, insurers, PPOs, POS plans, or other service providers in the marketplace in order to deliver the promised benefits. In each of these cases, the employer or the ERISA plan has contracted with one or more “health plans.”

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<sup>22</sup> Some employers are beginning to offer other types of health plan arrangements, sometimes called “consumer-driven health plans.” Although a full discussion of this trend is beyond the scope of this Issue Brief, this approach is worth mentioning as an illustration of yet another source of variation for employer-sponsored plans. One feature of some of these plans is a personal care account, similar to an FSA. Key tax and ERISA questions had arisen around these arrangements, but recently some of these questions were clarified. On June 26, 2002, the IRS issued Notice 2002-45 and Rev. Rul. 2002-41 which provide guidance on arrangements called “employer-provided health reimbursement arrangements” or “HRAs.” An HRA is similar to an FSA, but with two significant differences: the arrangements must be funded by employers and not by employees through salary reduction arrangements or other cafeteria plan contributions and unused funds in the account may be carried over from year to year. HRAs can also be used in conjunction with FSAs, according to the IRS. If HRAs meet the requirements described in the guidance, both contributions made by the employer and the benefits received by the participants are excludable from the participants’ gross income under IRC §§105 and 106.

<sup>23</sup> A high-deductible health plan is one providing for individual coverage with a deductible of \$1,500 to \$2,250 and a maximum out-of-pocket limitation of \$3,000 or family coverage with a deductible of \$3,000 to \$4,500 and a maximum out-of-pocket limitation of \$5,500.

<sup>24</sup> MSAs are governed by IRC §220.

Use of these similar terms for two distinctly different entities is terribly confusing to policymakers, courts, and to covered individuals. Many people fail to distinguish between the ERISA plan itself and the vendors that provide services to the plan, such as an HMO. This may be due to the use of the generic term “health plan” to mean the vendor through which participants receive their medical care.<sup>25</sup> Policymakers need to be mindful of this difference as they design legislation or regulations. Use of the term “health plan” to signify an HMO or other MCO will inevitably raise concerns among plan sponsors that that term will be construed to mean “ERISA-covered health plan” and implicate them, not just the HMO. Conversely, if policymakers really mean to cover ERISA plans and their fiduciaries under their proposals, they should do so explicitly.

Typically medium or large employers sponsor a single ERISA-covered group health plan with multiple benefit delivery options (e.g., an HMO, a preferred provider organization (PPO) and a PPO with a point-of service (POS) option). Most plans sponsored by larger employers provide participants with a choice of benefit delivery options (i.e., a choice of “health plans”), although current data confirm that small firms are much less likely to offer employees choice.<sup>26</sup> This data also illustrates that during the period of 1988 through 2001, more than half the employees were offered two or more health plans.<sup>27</sup> Plans offered by small employers typically offer only one option. Most recently, about \_ of all employees with employment-based health coverage had access to the types of plans that offered the greater flexibility regarding providers (i.e., a conventional health plan or a PPO).<sup>28</sup>

In some cases, the ERISA plan may directly contract with providers or establish its own provider networks. In most cases, however, the plan contracts with HMOs, PPOs or other managed care organizations and participants are expected to use the preestablished networks provided by these entities.

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<sup>25</sup> Recognizing this confusion, Justice David Souter, in a recent Supreme Court opinion, defined an ERISA “plan” as: “a scheme compris[ing] a set of rules that define the rights of a beneficiary and provide for their enforcement. Rules governing collection of premiums, definition of benefits, submission of claims and resolution of disagreements over entitlement to services are the sorts of provisions that constitute a plan. [citations omitted] Thus, when employers contract with an HMO to provide benefits to employees subject to ERISA, the provisions of documents that set up the HMO are not, as such, an ERISA plan but the agreement between an HMO and an employer who pays the premiums may, ... provide elements of a plan by setting out rules under which beneficiaries will be entitled to care.” *Pegram v. Herdrich*, 120 S.Ct. 2143, 2151 (2000).

<sup>26</sup> T. Rice, J. Gabel, L. Levitt and S. Hawkins, “Workers and their Health Plans: Free to Choose?” *Health Affairs* (January/February 2001):184. B. Schone and P. Cooper, “Assessing the Impact of Health Plan Choice,” *Health Affairs* (January/February 2001): 273.

<sup>27</sup> T. Rice, et al, at 184-187.

<sup>28</sup> *Id.*



Because of the substantial flexibility that employers have to design their benefit plans, it is not easy to generalize regarding how employer-sponsored ERISA plans are structured. However, each of these structural variations may affect the allocation of fiduciary responsibility under ERISA. This, in turn, affects the liability under ERISA that flows from those allocations.

## **8. Variation based on financing mechanisms**

Plan sponsors who provide health benefits through a self-insured group health plan may, but are not required to, set aside assets to fund those benefits.<sup>29</sup> In contrast, ERISA requires advance funding for pension plans, including a mandate that pension plan assets be placed in a trust administered by trustees who are fully subject to ERISA's fiduciary standards. Thus another source of variation among ERISA health plans is the funding status of the plan.

If the employer decides to fund its self-insured plan, it would typically establish a tax-exempt trust from which the benefits would be paid.<sup>30</sup> Otherwise, claims and expenses in connection with the self-insured ERISA plan are paid out of the employer's general assets. Regardless of its funding status, however, the health plan remains governed by ERISA.

### **Structural variation drives legal liability**

The key to understanding how these variations in structure may affect the plan sponsors' legal liability is a firm grounding in ERISA's fiduciary responsibility principles, because the degree to which the plan sponsor assumes fiduciary obligations for carrying out plan administration and other plan duties is the basis for assessing liability under ERISA.

### **Key ERISA plan actors**

Every ERISA plan must be established or maintained by a plan sponsor, a term that is defined more broadly than "employer." A "plan sponsor" under ERISA §3(16)(B) includes (1) the employer, in the case of a plan established or maintained by a single employer, (2) the

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<sup>29</sup> Funding is not an issue for fully insured plans. Premiums are simply paid out of the employer's general assets. However, if an employer uses a payroll deduction mechanism to collect employee premiums under a self-insured plan, those assets are plan assets and must be used only to pay benefits or reasonable expenses of plan administration. As a practical matter, the cash flow generated by these after-tax employee premiums on a pay period basis usually is less than the amount needed to pay benefits during that period, so the question of whether these amounts need to be held in trust never arises. In the case of a cafeteria plan which receives pre-tax employee contributions through salary reduction, however, the Department of Labor has maintained a "non-enforcement" policy regarding the ERISA requirement that plan assets be held in trust. See ERISA Tech. Release 92-01 (57 Fed. Reg. 23,272 (June 2, 1992)).

<sup>30</sup> These trusts are called "voluntary employees' beneficiary associations" or VEBAs and are established under IRC §501(c)(9) to provide life, sickness, accident or similar welfare benefits to employees, retirees and their dependents.

employee organization, in the case of a plan established or maintained by an employee organization, or (3) the joint board of trustees (or similar group of representatives), in the case of a multiemployer plan. As previously noted, “employer” includes associations or groups of employers.

In addition, ERISA requires that every plan be in writing and have a “named fiduciary” who has the overall responsibility for making sure the plan is run correctly.<sup>31</sup> A named fiduciary can be an individual, a committee, a corporation or any other entity, including the plan sponsor. The named fiduciary has the authority to control and manage the operation and administration of the plan and invest its assets. In a typical single-employer plan, the company itself is often the named fiduciary, in addition to being the plan sponsor. In a typical multiemployer plan, the joint board of trustees is both the plan sponsor and the named fiduciary. In addition to the named fiduciary, others involved with the group health plan may also be fiduciaries. With two narrow exceptions, ERISA’s fiduciary rules apply to all types of employee benefit plans regardless of structure or size, including pension and welfare plans, regardless of whether they are insured or self-insured, funded or unfunded.<sup>32</sup>

## Fiduciary status under ERISA

Other persons may act as fiduciaries of an ERISA plan besides the named fiduciary. In general, ERISA adopts a functional test to determine fiduciary status. Under ERISA, a person is a fiduciary “to the extent” that the person: (1) exercises any discretionary authority or control over the management of the plan or the management or disposition of its assets, (2) renders investment advice regarding plan assets for a fee or other direct or indirect compensation, or has the authority or responsibility to do so, or (3) has any discretionary authority or control over plan administration.<sup>33</sup> The use of the term “person” in ERISA may also cause confusion because the term means an individual, a committee, a corporation or any other entity. It is not limited to a natural person (i.e., an individual human being). Normally because of the duties they perform, certain individuals (such a plan administrator<sup>34</sup> or trustee) will be fiduciaries.<sup>35</sup>

<sup>31</sup> ERISA §402(a).

<sup>32</sup> The only exceptions are so-called “top-hat plans” - unfunded plans maintained primarily to provide deferred compensation to a select group of management or highly compensated employees – and certain arrangements providing payments to a retired partner or a deceased partners’ successor-in-interest. ERISA §401(a).

<sup>33</sup> ERISA §3(21)(A).

<sup>34</sup> An administrator is the person specifically designated by the terms of the plan, or if the plan fails to designate someone, the plan sponsor is considered the administrator. If an administrator is not named and a plan sponsor cannot be identified, the Secretary of Labor has the authority by regulation to establish a procedure to prescribe one. ERISA § 3(16)(A). Typically in most self-insured single-employer plans, the plan sponsor is also the administrator.

<sup>35</sup> If a funded plan uses an investment manager (as defined in ERISA §3(38)), the manager is required to acknowledge fiduciary status in writing.

Other persons, particularly those who provide advice to the plan, are not normally considered fiduciaries, but if, in fact, they exercise discretion or control over a fiduciary function (such as an aspect of plan administration), they will be fiduciaries under ERISA's functional test.

For group health plans, a fiduciary is any person who exercises discretion or control over plan administration and management or, in the case of a funded health plan,<sup>36</sup> who exercises discretion or control over plan assets. Determining if one is a fiduciary under ERISA requires an assessment of the facts and circumstances of each particular situation. So whether fiduciary liability flows to those who provide administrative services to the plan (including in-house administrative staff, TPAs, health insurers, HMOs, and insurers with administrative-services-only (ASO) contracts, pre-certification and utilization review organizations (UROs)) depends on the nature of their duties. Some plan fiduciaries also assign responsibility for certain distinct functions to various vendors (such as pharmacy benefit managers or PBMs), but retain general administrative functions themselves. Other fiduciaries may contract out only a portion of the administrative responsibility, such as providing the notices and election forms for health insurance continuation administration under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) or furnishing of certificates of creditable coverage under HIPAA (the Health Insurance Portability and Accountability Act of 1996). In each case, the determination of whether the person to whom the function has been assigned is a fiduciary must be made by carefully examining the actual duties the person is performing.

The key to this determination is whether the service provider makes discretionary decisions regarding the plan administration or management. It is often difficult to assess the nature and extent of a service provider's discretion. For instance, if the plan documents or a contract gives a TPA or insurer discretionary authority to grant or deny claims for the plan, that person acts in a fiduciary capacity when it decides claims. However, if the decision of the TPA or insurer is only a non-binding recommendation to the named fiduciary and the ultimate discretion to grant or deny claims is retained by the named fiduciary (or another fiduciary), the TPA or insurer may not be a fiduciary. As a practical matter, however, if the named fiduciary always rubber stamps the recommendation of the TPA or insurer, a court could find that the TPA or insurer is a fiduciary based on its examination of the pattern of conduct regarding decision-making that the named fiduciary has followed.

Some group health plans use a hybrid or tiered claims decision-making process. The TPA or insurer may have the discretion to grant or deny claims at the initial submission level, but

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<sup>36</sup> Unlike pension plans, welfare plans under ERISA do not have to be funded. Thus a plan sponsor may choose to provide benefits through a fully insured arrangement (i.e., one in which the total risk for claims payment is shifted totally to a health insurance issuer) or a self-insured arrangement (i.e., one in which the plan sponsor retains the risk itself). Self-insured arrangements may be funded (i.e., contributions are made by the plan sponsor to a trust (usually one set up under IRC §501(c)(9) – a voluntary employees' beneficiary association or VEBA) or unfunded (i.e., claims paid out of the general assets of the employer)).

the named fiduciary may retain authority to review appeals. In that case, both will have fiduciary duties, but the TPA or insurer will be a fiduciary to the extent it exercises discretion, while the named fiduciary is a fiduciary regarding matters over which it exercises discretion.

More difficult calls regarding fiduciary status occur with UR entities or TPAs who, in the context of the coverage decision-making process, exercise judgment as to whether or not a particular treatment is medically necessary or appropriate, experimental or investigational. An emerging trend in the case law is to distinguish between coverage decisions (e.g., whether a particular treatment is covered or not excluded under the plan) and medical or treatment decisions (e.g., decisions involving medical judgments, including those involving mixed coverage and treatment decisions).<sup>37</sup> Although these entities will be fiduciaries under ERISA if they exercise discretion over fiduciary activities, given the current case law, some of their decisions may be fiduciary decisions and others may not be.

Other types of recordkeepers, including those involved in COBRA administration or in issuing HIPAA certificates of creditable coverage, may simply be performing ministerial functions at the direction of a fiduciary and not making discretionary decisions themselves. If that is the case, they will not be fiduciaries. Also independent medical consultants hired by the plan to review cases involving medical judgment are probably not fiduciaries, since they typically make non-binding recommendations to the ultimate decision-makers.

If the group health plan documents specifically permit it, the named fiduciary may allocate or delegate fiduciary responsibility to other fiduciaries in the operation or administration of the plan.<sup>38</sup> If there has been a proper delegation of authority to another fiduciary under the plan documents, the delegating fiduciary is generally only liable for the prudent selection and monitoring of the conduct of other fiduciary, not for the other fiduciary's substantive activity. For instance, if the plan permits the named fiduciary to delegate claims administration, once the named fiduciary prudently selects a claims fiduciary, if in carrying out its delegated duties, the claims fiduciary commits a fiduciary breach, it is solely liable for the breach (or liable to the extent that its contractual liability does not provide for indemnification by the plan). The named fiduciary is not also liable (unless it is a co-fiduciary, as discussed below).

In addition, if the plan documents permit, fiduciaries may hire professional advisors to help them carry out their duties under ERISA and the plan. Unlike the delegation situation

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<sup>37</sup> For a discussion of the case law regarding this coverage v. treatment distinction, see Borzi, Phyllis C. *Distinguishing Between Coverage and Treatment Decisions: What's Left of ERISA Preemption?*, 49 U.BUFF.L.R. 1219 (2001). Broader discussions of the relationship between state law and ERISA can be found in Butler, Patricia A. and Polzer, Karl, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, Oakland, CA: California HealthCare Foundation, April 2002, available at <http://www.chcf.org>; Butler, Patricia A. 2000 *ERISA Preemption Manual for State Health Policy Makers*. National Academy for State Health Policy (Portland, ME) and Alpha Center (Washington, D.C.).

<sup>38</sup> ERISA §402(b)(2).

[www.gwhealthpolicy.org](http://www.gwhealthpolicy.org)

described above, however, even if the selection and hiring of the advisor is prudent, the fiduciary retains fiduciary liability for the advisors' actions.

Finally, nothing in ERISA prohibits persons acting as fiduciaries from serving in more than one capacity with respect to the plan (e.g., as both the plan sponsor and a fiduciary), as long as the plan documents permit this practice.<sup>39</sup> This is a departure from the common law of trusts under which the same person cannot play multiple roles, even sequentially, because of the potential for a conflict of interest. But it is quite common for the plan sponsor to play several roles, including named fiduciary and plan administrator.

## **Fiduciary conduct under ERISA**

ERISA §404 describes the basic duties of ERISA plan fiduciaries. These rules establish a standard of conduct that applies to all fiduciary activities with respect to the plan.

In general, ERISA requires fiduciaries to discharge their duties “solely in the interest of” participants and beneficiaries and for “the exclusive purpose” of paying benefits and defraying “reasonable” administrative expenses.<sup>40</sup>

ERISA fiduciaries are subject to the so-called “prudent expert” standard, requiring them to act “with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.” Although extensive case law can be found under ERISA addressing what the prudent person standard means in the context of a pension plan, it is not entirely clear whether this requirement has special meaning in a group health plan context.

In addition, if plan assets are held in trust,<sup>41</sup> fiduciaries are generally required to diversify assets to minimize large losses unless it is prudent not to do so. Fiduciaries must also follow the plan documents to the extent the documents are consistent with ERISA and other Federal laws.

Under ERISA, a person is a fiduciary only “to the extent” that he or she performs fiduciary functions, so a person may be a fiduciary for one purpose but not for another. For instance, if a group health plan is self-insured, a TPA or HMO acting as claims fiduciary does not automatically become a fiduciary with respect to any other duties a fiduciary of the plan

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<sup>39</sup> As Justice Souter noted, this practice differs from the common law rule of trusts requiring that trustees must wear only one hat - a fiduciary one - when they take any actions affecting beneficiaries of the trust. Said Justice Souter wryly: “ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions.” *Pegram v. Herdrich*, 120 S.Ct. 2143, 2152 (2000)

<sup>40</sup> ERISA §404.

<sup>41</sup> Since not all group health plans are funded, this requirement may have limited application to health plans.

might have. Similarly, if a TPA or HMO, acting as a claims fiduciary, breaches its fiduciary duties, other fiduciaries of the plan are generally not liable for the claims fiduciary's actions.<sup>42</sup> In addition, fiduciary liability only arises for actions taken while the person is a fiduciary, not prior or subsequent actions.<sup>43</sup> Under ERISA, the plan document may also allocate fiduciary duties among fiduciaries<sup>44</sup>

However, the claims fiduciary and other fiduciaries may be "co-fiduciaries." Under ERISA §405, a co-fiduciary may become liable for the fiduciary breach of another fiduciary. This can occur when a fiduciary (1) "participates knowingly" or "knowingly tries to conceal" an act or omission of another fiduciary (if the act or omission would constitute a breach of fiduciary duty); (2) breaches his or her own fiduciary duties in a manner that enables a co-fiduciary to commit a breach; or (3) knows about a co-fiduciary's breach and fails to take reasonable steps to correct the breach.

As a practical matter, the primary way that a fiduciary can demonstrate that its actions are prudent under ERISA is by showing that fiduciary duties have been carried out in a procedurally prudent fashion (i.e., by demonstrating "procedural prudence").<sup>45</sup> Generally this means that a reasonable procedure must be established and followed for making fiduciary decisions.

## Plan Sponsor (Settlor) functions

Under ERISA, the plan sponsor is the person who establishes or maintains the plan. Generally this will be the employer. However, the plan sponsor could also be the jointly administered labor/management board of trustees in the case of a multiemployer plan, described above.<sup>46</sup> In a typical case, the plan sponsor serves in more than one capacity with respect to the

<sup>42</sup> However, the named fiduciary (or other fiduciary) that selects the claims fiduciary is responsible for the prudent selection and monitoring of the claims fiduciary. See DOL Reg. §2509.75-8, Q & A D-4 and D-17, 29 C.F.R. §2509.75-8, Q& A D-4 and D-17.

<sup>43</sup> ERISA §409(b). But a newly appointed fiduciary cannot permit continuing breaches of fiduciary duties to occur, even though he or she may not be responsible for the original breach. If the fiduciary discovers a prior fiduciary violation, the fiduciary may have a duty to take action to cure the violation if taking action could prevent or reduce a loss. See, e.g., *Silverman v. Mutual Benefit Life Insurance Co.*, 138 F.3d 98 (2<sup>nd</sup> Cir. 1998) (no liability for successor if plaintiff could not prove that pension plan losses would have been prevented if successor took action against prior trustee).

<sup>44</sup> See ERISA §405(c).

<sup>45</sup> This principle has evolved through case law. For instance, in *Donovan v. Mazzola*, 716 F.2d 1226, 1232 (9<sup>th</sup> Cir. 1983), the court measured whether the fiduciaries acted prudently by looking at whether or not they used the appropriate methods to investigate the merits and structure of the investment, not whether the investment ultimately was a good one. This procedural approach has evolved during the past two decades since it is so difficult to measure whether a fiduciary's conduct was prudent from a substantive point of view at the time that the decision was made, knowing what the fiduciary knew then, not what one in retrospect thinks would have been prudent. In other words, a fiduciary who took all the necessary procedural steps to make a prudent decision at the time will not be held liable if the decision turns out to be less successful than originally thought.

<sup>46</sup> ERISA §3(16)(B).



plan: it will be the entity that decides to adopt a plan in the first place and determines what benefits will be provided (the “settlor” in the vernacular of the common law of trusts) and, once the plan is established, it will direct the plan activities as the named fiduciary or serve as the plan administrator. However, when the employer wears multiple hats, it may be difficult to determine the capacity in which it functioning when it takes action (i.e., whether it is acting as plan sponsor or fiduciary).

This is particularly true since not all decisions that affect a plan are fiduciary actions. Courts have described some of them as “settlor” or “plan sponsor” functions and have refused to hold the plan sponsor responsible as a fiduciary for those actions and their consequences. A number of cases under ERISA have focused on where one draws the line between settlor and fiduciary functions. For instance, establishing or amending a plan or deciding to modify or terminate an employee benefit plan are considered to be settlor functions.<sup>47</sup> However, the implementation of a settlor decision may involve fiduciary functions.

The line between “fiduciary” and “settlor” functions is often hard to draw. This is particularly true when the plan sponsor also acts as a fiduciary of the plan (this is usually called “wearing two hats”). The first step is to determine which hat the person is wearing when actions affecting employee benefit plans are taken. Some of the most difficult cases under ERISA concern instances when the employer/plan administrator is communicating information to participants and beneficiaries.<sup>48</sup>

As a practical matter, it is quite important to determine which hat the plan sponsor is wearing when it takes action, since there is a significant difference in legal exposure for a person,

<sup>47</sup>See, e.g., *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73 (1995) (even though an employer acts as a fiduciary when it administers a welfare plan, it is not acting in a fiduciary capacity when it decides to create, amend or terminate such a plan) and *Lockeed Corp. v. Sprink*, 517 U.S. 882 (1996) (same result regarding pension plans). Although this is clearly the rule for single-employer ERISA plans, it may not be the rule for actions taken by a joint Board of Trustees of an ERISA-covered multiemployer plan. See, e.g., *Deak v. Masters, Mates & Pilots Pension Plan*, 821 F.2d 572 (11th Cir. 1987), *cert. denied*, 484 U.S. 1005 (1988) (amending the plan is a fiduciary function). *But see*, *Walling v. Brady*, 125 F.3d 114 (3<sup>rd</sup> Cir. 1997) (amending the plan is not a fiduciary function, even when amendments are adopted by multiemployer plan trustees).

<sup>48</sup> One of the most important cases in this area is the 1996 Supreme Court case, *Varity Corp. v. Howe*, 516 U.S. 489 (1996). In *Varity*, the Court considered three legal questions: (1) Was the employer acting in its capacity as an ERISA “fiduciary” when it significantly and deliberately misled the beneficiaries, (2) In misleading the beneficiaries, did the employer violate the fiduciary obligations that ERISA §404 imposes upon plan administrators, and (3) Does ERISA §502(a)(3) authorize ERISA plan beneficiaries to bring suit that seeks relief for individual beneficiaries harmed by an administrator’s breach of fiduciary obligations? Although the facts are complicated, the basic problem facing the Supreme Court was deciding which hat the employer representatives wore when they induced employees to transfer to a new company by knowingly false assurances that the new company had a bright future, and that it was financially sound. In addition, they deliberately chose not to inform employees of certain information about their employee benefits and presented other information in an incomplete way so as to not raise concerns among the employees. Ultimately, the Court concluded that communicating about employee benefit plans is a fiduciary function because it involves plan management and administration. Even if the person doing the communicating wears more than one hat, when communicating to employees about benefits, the person is acting as a fiduciary.

depending on whether the plan sponsor is acting as a “fiduciary” or “settlor.” Participants and beneficiaries may sue under ERISA §502(a)(2) or (3) for breach of fiduciary duty. But if the person responsible for the action that resulted in harm to the plan or the individual was acting as a settlor, not a fiduciary, the person cannot be held liable for a fiduciary breach. Thus, settlor activities are generally immune from liability under ERISA.

## Nature of Fiduciary Duties

Although ERISA’s statutory requirements apply to fiduciaries of both pension and health plans, fiduciary law has largely developed in the pension area. Most of the core statutory requirements presume the existence of a trust from which benefits will be paid, reflecting the influence of the common law of trusts on many of ERISA’s rules. But as previously noted, ERISA does not require group health plans to be funded. If the employer decides to fund the health plan by establishing a trust, however, ERISA’s fiduciary duties are applicable to any persons with discretion or control over those plan assets. That would include anyone who makes payments from that trust. However, ERISA’s fiduciary rules also clearly govern conduct related to how the plan is administered, not just how the assets are managed and invested. Therefore, ERISA’s functional test regarding who is a fiduciary must be carefully applied determining liability for fiduciary breaches related to administrative functions of the plan.

In the managed care context, this is an important principle. Many HMOs, health insurance issuers, TPAs, or utilization review organizations (UROs) state explicitly in their contracts with employers that they are not ERISA fiduciaries. However, if the HMO, issuer, TPA, or URO makes discretionary decisions over certain aspects of plan administration (such as determining medical necessity or making other coverage determinations), then a court, in examining the facts and circumstances of a particular case, could find the entity to be a fiduciary, despite its written statement that it is not.<sup>49</sup> Employers appear to respond to contract provisions proposed by service providers that would absolve those vendors from fiduciary liability in several ways. Some employers simply refuse to sign the contract until the question of fiduciary responsibility is satisfactorily resolved. Others sign, but may blithely assume that if later sued by a participant who has been injured by the action of the HMO, a court will conclude that the HMO was a fiduciary, despite the contract language. Still others reach impasse over the issue and may simply operate as if the contract is in effect but never actually sign it.

Determining whether an HMO, TPA or other service provider is an ERISA fiduciary and whether the acts it performs are fiduciary acts is directly relevant to questions of liability under ERISA and state law. Typically HMOs and other risk-bearing entities are subject to state law.

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<sup>49</sup> In *Reich v. Lancaster*, 55 F.3d 1034 (5<sup>th</sup> Cir. 1995), the court held that an insurance consultant/TPA that was hired by the plan to provide claims administration and insurance services was a fiduciary because the TPA had the authority and discretion to investigate and approve claims and pay benefits. *Id.* at 1047.



ERISA plans are not.<sup>50</sup> Yet HMOs often try to argue they are immune from a particular state law because it is preempted by ERISA. On one hand, if an HMO, issuer, TPA, or URO wants to escape state regulation, it will argue that it is an ERISA plan fiduciary engaged in plan administration activities. If the conduct the state is attempting to regulate is an act of plan administration related to an ERISA plan, the state law should be preempted by ERISA. On the other hand, if the HMO or other entity is engaged in an act of plan administration, it should be a fiduciary with respect to that act, and therefore subject to ERISA's fiduciary rules.

In weighing whether it is worse to be an ERISA fiduciary than to be subject to state regulation, in essence, the HMO or other entity is evaluating the financial risk of potential personal liability for a fiduciary breach under ERISA (but with damages for the improper coverage decision limited only to the value of the denied claim) against exposure to the full range of penalties the state may provide (including the possibility of compensatory (non-economic) damages, and in about half the states, punitive damages).<sup>51</sup>

Of course, some HMOs have successfully had it both ways: acknowledging fiduciary status both in suits they bring to preclude the application of state law and in suits where they are defending against enforcement of state laws, but denying fiduciary status in private lawsuits brought against them under ERISA by aggrieved participants and beneficiaries.

## Special fiduciary issues regarding group health plans

Since most of the case law concerning fiduciary duties under ERISA has developed in the pension plan context, a threshold question has arisen about whether ERISA's fiduciary rules apply in the same way to group health plans. Because the statute makes no distinction among types of employee benefit plans, the fiduciary rules apply to all plans. Interestingly enough, however, certain practices that clearly have fiduciary ramifications for pension plan fiduciaries at first blush may be regarded differently when applied to health plans. For instance, ERISA experts generally agree that choosing a particular vendor to provide investment options for a

<sup>50</sup> Section 514(a) of ERISA broadly preempts any state law that "relates to" an employee benefit plan, unless the state law falls within the "savings" clause. State laws that escape preemption through the savings clause include state insurance, banking, and securities laws, as well as generally applicable criminal laws. However, under the so-called "deemer" clause, states cannot define employee benefit plans as insurance companies in order to use the state insurance law exception to circumvent the general prohibition on state regulation of plans. As a result, all employee benefit plans covered under ERISA are subject to Federal regulation under ERISA (regardless of whether the plan is insured or self-insured) and immune from direct state regulation. However, ERISA-covered group health plans may be affected indirectly by state insurance regulation of the products sold to ERISA plans.

<sup>51</sup> The distinction between being a fiduciary under ERISA and therefore immune from state law for fiduciary conduct or not being a fiduciary subject to ERISA and therefore subject to state law may not be as clear in the future. Some believe that the Supreme Court in *Pegram v. Herdrich*, 120 S.Ct. 2143 (2000) was signaling in dicta that it is possible to be an ERISA fiduciary and subject to state law for "mixed treatment and coverage decisions." However, the Court has not yet reached that question.

company's section 401(k) plan is a fiduciary, not a settlor, decision. Yet some practitioners question whether the selection of a health care vendor is a fiduciary decision or is part of the settlor design decision. In both cases, the decision to establish a plan is a settlor decision, as are any decisions regarding the design of the plan (e.g., how many investment choices participants will have or how many health benefit delivery options participants will have). But implementing those decisions (e.g., whether to use Fidelity or Vanguard or whether to offer Aetna US Healthcare or Blue Cross) involves fiduciary decision-making.

In the context of choosing a health care vendor or any other service provider to the group health plan (including a TPA, insurer or URO) and monitoring its performance, questions have also arisen about how ERISA's fiduciary rules are to be applied. In the only specific guidance on this issue, in 1998 the Department of Labor (which administers ERISA) replied to a letter from the Service Employees' International Union asking whether a fiduciary must always select the lowest bidder for health care delivery services. Although noting that the cost of the services must be reasonable, the Department said that fiduciaries have a duty to take the quality of services into account in the selection process and that failure to do so would result in a fiduciary breach.<sup>52</sup>

Other common, but unanswered, fiduciary questions are: Can a plan sponsor take its own financial condition into account in selecting a health care vendor or must it select only the highest quality service provider or the HMO with the most comprehensive benefits or the PPO with the widest possible network, regardless of cost? In the context of its duty to monitor performance, at what point would a fiduciary be required to change vendors due to poor service? Put another way, how poor would service have to be from a vendor for the fiduciary to be required to seek another vendor? How would that duty be measured against the disruption in health care treatment that employees might suffer were the fiduciary to change vendors? In fact, if changing vendors meant a change in the basic structure of a plan (e.g., moving from an HMO to a PPO or POS plan), would the decision to change vendors be a fiduciary or settlor decision? In keeping with ERISA's "prudent expert" standard, what level of knowledge would the fiduciary be required to have to identify and seek out vendors that provide "quality" health care? Does ERISA require the fiduciary to either engage in provider credentialing or profiling (or hire someone to do it) to determine the medical competence of physicians and other medical professionals in the provider networks employees use? Does the fiduciary have a higher duty to ascertain competence of providers if the plan offered provides for a more limited participant choice of providers? What does the "prudent expert" requirement mean when health plan decision-making is undertaken?

## **Who is liable for failures to carry out these plan responsibilities?**

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<sup>52</sup> DOL Info. Letter from Bette J. Briggs to Diana O. Ceresi (Feb, 19, 1998). This letter can be found on the DOL website at: <http://www.dol.gov/pwba/programs/ori/advisory98/seiu5ltr.htm>.

When a failure to carry out a statutory obligation occurs (such as failing to offer qualified beneficiaries the opportunity to elect COBRA health insurance continuation coverage after a qualifying event takes place) or when a breach of fiduciary duty occurs, liability is assessed against the person who had the obligation or duty but failed to carry it out. Under ERISA, most of the reporting and disclosure obligations fall on the shoulders of the plan administrator and, of course, the fiduciary duties fall on the plan's fiduciaries. ERISA sets out what injured participants can recover for such failures.<sup>53</sup> However, if the injury alleged results from conduct that is not actionable under ERISA, other types of liability may arise. The two primary types of non-ERISA liability that are commonly alleged are contract liability (i.e., when the injury results from violating the terms of a contract)<sup>54</sup> and tort liability (i.e., when the injury results from deliberate acts or negligence in carrying out one's duties). A discussion of these non-ERISA liabilities is beyond the scope of this Issue Brief.

## **What rights do participants and beneficiaries currently have to sue under ERISA?**

Although the casual observer to the current political debate in Congress over HMO liability might conclude that participants have no right to sue their health plans under ERISA when they are injured, the right to bring a lawsuit under ERISA is well established. In fact, ERISA's civil enforcement provisions are very detailed. The circumstances under which a civil action may be brought are enumerated in ERISA §502 as are the remedies to which participants are entitled if their rights are violated.

### **Who can sue?**

Section 502(a) of ERISA specifically describes the persons who can sue under ERISA: participants, beneficiaries, fiduciaries and, under certain circumstances, the Secretary of Labor. Others, such as employers, unions, health care providers, non-fiduciary service providers and the plan itself are generally precluded from bringing an ERISA action because they lack "standing" (i.e., are not authorized under the statute to bring suit).<sup>55</sup>

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<sup>53</sup> See ERISA §502.

<sup>54</sup> If the employee benefit plan is collectively bargained, non-ERISA duties may arise under the bargaining agreement with respect to employee benefit plans. For instance, ERISA does not require health plans to be funded. However, if a company agrees in its collective bargaining agreement with the union to establish a trust and prefund retiree health benefits (consistent with the current tax rules) but fails to do so, it can be sued for breach of contract, but not under ERISA.

<sup>55</sup> From time to time courts have been called upon to tackle the issue of whether someone other than these specific entities should be given standing to sue under ERISA. Generally, the courts have interpreted the language of §502(a) narrowly. See, e.g., *Franchise Tax Board of California v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983) (suggesting that the list of plaintiffs in §502(a) is exclusive); *New Jersey AFL-CIO v. New Jersey*, 747

## What court hears the suit?

ERISA claims are usually heard in Federal courts. Section 502(e)(1) of ERISA generally requires that all lawsuits brought by plan participants, beneficiaries, fiduciaries or the Secretary of Labor under Title I of ERISA be heard in Federal courts. The only exception is when a participant or beneficiary brings a claim for benefits. In that case, either state or Federal court may hear the claim.<sup>56</sup> This “concurrent jurisdiction” question has been a source of great confusion for plaintiffs, their lawyers, and sometimes policymakers, because the choice of venue (i.e., where the lawsuit is heard) really has no bearing on which law is applied. Regardless of which court hears the case, Federal law is always applied because these benefit claims arise under ERISA. However, if the participant brings a benefit claims case in state court and the case involves a statutory question (rather than a question of interpretation of the plan’s terms), the defendant has the right to remove the case to Federal court.<sup>57</sup> Most defendants (the ERISA plan and/or its fiduciaries when a participant challenges a benefit claim decision) exercise this right and force the suit to be heard in Federal court. As a practical matter, however, if both plaintiff and defendant agree that the suit involves a claim for benefits, the outcome of the benefit claims case should be the same regardless of the court that hears the case because Federal ERISA law always applies.

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F.2d. 891 (3<sup>rd</sup> Cir. 1984) (union lacks standing); *Tuvia Convalescent Center, Inc. v Hospital Employees*, 717 F.2d 726 (2<sup>nd</sup> Cir. 1983) (employer lacks standing).

A few courts have opened the door to independent standing for other entities, such as employers, not specifically referenced in §502(a), but generally, other entities must rely on derivative standing, if they are to have standing at all. Compare, *Fentron Industries v. National Shopmen Pension Fund*, 674 F.2d. 1300 (9<sup>th</sup> Cir. 1982) (certain non-enumerated parties (employers) have standing to sue based on a three-part test for determining an implied authority to sue based on analysis of whether Congressional intended to prevent other parties from suing) with *Pressroom Unions Printers League Income Security Fund. V. Continental Assurance Co.*, 700 F.2d 889 (2<sup>nd</sup> Cir. 1983) (*Fentron* court applied wrong test: question is one of intent to grant subject matter jurisdiction, not intent to prevent legal actions by employers or others).

Under the general case law described above, health care providers lack independent standing to sue ERISA plans. See, e.g., *Psychiatric Institute v. Connecticut General Life Ins. Co.*, 780 F. Supp. 24 (D.D.C. 1992). There appears to be only one case holding otherwise. *Cameron Manor, Inc. v. United Mine Workers of America*, 575 F. Supp. 1243 (W.D. Pa. 1983). However, under some circumstances, providers may be able to sue ERISA plans in a derivative capacity. Under ERISA §206(d), 29 U.S.C. §1056(d), benefits under pension plans may not be assigned. But no such statutory prohibition applies to non-pension benefits, including health benefits. Often patients assign their right to payment for covered medical services under their health plans to providers. Generally the courts recognize these assignments if properly executed and permit suits under ERISA to go forward.

<sup>56</sup> ERISA §502(e)(1).

<sup>57</sup> If a claim arises under Federal law, the Federal courts have exclusive jurisdiction over it, even if the plaintiff properly filed the claim in state court based on ERISA’s concurrent jurisdiction provision. 28 U.S.C. §1441(b). Actions by a participant to enforce his or her rights under the statutory language of ERISA are brought under §502(a)(2)(B)(ii) and, even under ERISA, these cases may only be heard in Federal courts. Often a participant’s suit will involve claims under both this section and §502(a)(1)(B), but once the statutory claim is brought, the suit must be heard in Federal court.

## Coverage v. treatment disputes: Does state law apply?

In many of the lawsuits that are currently filed in health care cases, disputes arise over the fundamental nature of the claim. Usually the defendant HMO or health plan will argue that the case involves a challenge to a coverage decision made under ERISA and therefore should be decided by applying Federal law. The plaintiff typically disagrees, arguing that the case really is a dispute about the quality of care that has been received, rather than coverage or eligibility for benefits, and therefore state malpractice or tort law should be applied.

As previously noted, some courts have distinguished between coverage cases under ERISA and quality or treatment cases in which state law regarding the standard of medical practice would be applied. This is an extremely important distinction for injured plaintiffs. If the court decides that the case is a “coverage” case under ERISA, then only ERISA remedies are available and courts have generally limited ERISA remedies to receipt of the benefit that has been improperly denied, not money damages to compensate the injured plaintiff. But if the court considers the case a “treatment” (or “quality of care”) case, state malpractice or tort law will apply. Under these state laws, injured plaintiffs can receive money damages to compensate them for injuries they may have received, and, in some states, may be eligible for punitive damages as well. In addition, under state law, the plaintiff will be entitled to a jury trial, which is not available under ERISA. Thus the stakes are quite high for plaintiffs whose objective is to influence the way courts characterize the fundamental nature of the dispute.

Although the factual issues can get quite complicated, the courts have generally analyzed disputes by first honing in on two key questions: (1) what act of the defendant allegedly caused the plaintiff’s injury, and (2) whether the defendant was a fiduciary engaged in plan administration duties on behalf of the ERISA plan when it performed the act that supposedly caused the plaintiff’s injury.

The latter question can only be answered by examining the way the plan is structured.

### 1. Benefit claims suits

ERISA authorizes participants and beneficiaries to sue under the terms of the plan to recover benefits, enforce their plan rights, or to clarify rights to future benefits.<sup>58</sup> These claims for benefits are generally filed against the plan and its fiduciaries. In lawsuits involving a group health plan, unless the participant understands the structure of the plan and the legal responsibilities of the plan actors that flow from that structure, it may be difficult to correctly identify the proper defendants. And plaintiffs who sue the wrong defendants generally lose.

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<sup>58</sup> ERISA §502 (a)(1)(B)

For example, if the plaintiff alleges that he or she has been harmed either because the plan improperly denied benefits or because the plan’s delay or inaction regarding the claim for benefits caused injury, liability under ERISA for those actions can only be placed on the fiduciary whose actions caused the alleged harm (i.e., the person with discretion to decide claims). Under ERISA, if the plaintiff sues a TPA (or an HMO acting as a TPA) who only has the authority to make a non-binding recommendation to the plan’s fiduciary and is not ultimately the decision-maker, the plaintiff will not be successful because he or she has sued the wrong person.<sup>59</sup> On the other hand, if the plaintiff sues a TPA or HMO who is a plan fiduciary with discretion to decide claims, the plaintiff may not win, but at least the plaintiff has sued the person with the ultimate responsibility under ERISA for the act that allegedly caused his or her injury.

## 2. Treatment suits

An injured plaintiff can always sue the provider who caused his or her injury under state malpractice laws, even if the injury occurred as a result of treatment he or she received through an ERISA plan. However, in some cases, suits for negligence under state law against HMOs have also been permitted, even though the HMO was delivering benefits under an ERISA plan. This is because some courts recognize that HMOs make both coverage and treatment decisions (or “mixed treatment and eligibility decisions,” the terminology used by the Supreme Court in the recent case of *Pegram v. Herdrich*<sup>60</sup>). In these cases, the courts have focused on the dual roles that HMOs play for ERISA plans as providers of medical services as well as claims administrators. Despite the fact that under the plan structure, the HMO may perform fiduciary functions when it determines eligibility for benefits and administers claims, the court may conclude that the dispute is not about the HMO carrying out those duties, but rather involves the issue of whether the treatment provided by the HMO under the ERISA plan was substandard.<sup>61</sup> In other words, under the plan structure, if the HMO allegedly caused the injury wearing its provider hat (as opposed to its fiduciary hat), the court may decide that state law applies, not ERISA.

<sup>59</sup> Even if the plaintiff is successful, recovery under ERISA is limited. Sometimes plaintiffs seek compensatory and punitive damages in connection with a claim for benefits. However, the Supreme Court has held that a successful plaintiff in an ERISA benefit claim case is only entitled to “contractual damages” (i.e., the benefit he or she was improperly denied under the plan). According to the Supreme Court, money damages or other forms of compensatory damages, such as compensation for pain and suffering, and punitive damages are not available in these cases. In *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), the Supreme Court said that the term “equitable relief” included only traditional equitable remedies such as injunction, mandamus and restitution. The Supreme Court also ruled out tort-like remedies, such as compensatory damages, as a form of restitution under ERISA §502(a)(3).

<sup>60</sup> *Pegram v. Herdrich*, 120 S.Ct. 2143, 2151 (2000).

<sup>61</sup> See Borzi, Phyllis C., *Distinguishing Between Coverage and Treatment Decisions: What’s Left of ERISA Preemption?* 49 U.BUFF.L.R. 1219 (2001).



This relatively new phenomenon in which HMOs may be subject to state law for treatment decisions (or perhaps for mixed eligibility and treatment decisions as well) comes at a time in which a number of states have adopted liability laws specifically directed at HMOs in their provider capacity.<sup>62</sup> Even though the case law in some jurisdictions is moving in that direction, it is not clear whether HMOs can always be held liable under state law for treatment decisions, because the extent to which state right-to-sue laws may be enforced against entities providing benefits to ERISA plans will depend on whether they are preempted by ERISA.<sup>63</sup>

## Conclusion

Employers and other plan sponsors believe that the substantial flexibility they have in designing a group health plan is a significant incentive for them to provide health care coverage. They consider their ability under ERISA to make structural choices, as well as benefit design choices, essential because these options provide mechanisms to tailor their plans not only to the benefit needs of their workforce but to their own needs as well. Significantly, an employer's ability to decide the extent to which it wants to become involved in assuming insurance risk (i.e., the basic choice between insuring and self-insuring the promised benefits) and handing administrative operations in a self-insured plan (i.e., the choice between self-administration and engaging the services of a TPA to administer some or all of the benefits), give plan sponsors the ability to decide just how much they want to be exposed to ERISA liability. If an employer wants to simply write a check each month to an insurer or HMO and shift all the responsibility for providing benefits and administering the plan to vendors, it can do that. If the plan sponsor wants to exercise greater fiduciary control over the administration and operation of its health plan, it can do that too, because the structural choices employers have allow them to consider a continuum of involvement. Most importantly, plan sponsors can constantly reevaluate those choices and make necessary adjustments to reflect changing times and external influences.

From a policymaker's point of view, plan sponsor flexibility to restructure health plan operations may pose certain challenges. In designing and evaluating legislative proposals, policymakers and others need to be mindful of the expansive structural options that employers have at their disposal and the effect that an employer's decision to structure its health plan may have on its ERISA and other liability.

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<sup>62</sup> As of the summer of 2001, the list of states that have enacted laws giving consumers expanded rights to sue their managed care plans included nine states – Arizona, California, Georgia, Louisiana, Maine, Oklahoma, Tennessee, Texas, and Washington. For more information on these laws, see “Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience,” a report prepared by Patricia Butler for the Kaiser Family Foundation and available on the Foundation's website at <http://www.kkf.org/content/2001/3155>.

<sup>63</sup> The U.S. Court of Appeals for the Fifth Circuit, for instance, concluded that ERISA did not preempt the Texas HMO Act. *Corporate Health Ins. Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 *reh'g and reh'g en banc den.* 220 F.3d 641 (5th Cir.), *cert. granted, vacated and remanded sub nom, Montemayor v. Corporate Health Ins.*, 122 S.Ct. 2617(mem)(2002).

ERISA's fiduciary rules are the heart of the law. Drawing their roots from the long-established body of law governing trusts, ERISA's fiduciary responsibility requirements establish the rules of behavior for those responsible for carrying out the activities necessary to deliver on the benefit promise made by plan sponsors to participants. ERISA's fiduciary rules are structured to balance the competing interests of plan sponsors and plan participants. On the one hand, they hold fiduciaries accountable for operating the plan solely in the interest of the participants, while on the other hand, they define and limit plan and fiduciary liability within the policy and legal structure of a voluntary system of providing benefits. The bottom line is simply this: acting as an ERISA fiduciary carries legal liabilities but also provides legal protections.

At the same time, ERISA's remedial scheme also contains mechanisms for individual participants to challenge fiduciary decision-making regarding both benefit eligibility and plan management. The core of the current Congressional debate over patients' rights is whether the various legal mechanisms currently in place through ERISA provide an adequate and appropriate balancing of the competing interests of plan sponsors who voluntarily promise benefits, plan fiduciaries who must assure the delivery of promised benefits through prudent plan management, and individual participants who have relied on both those promises and the activities of fiduciaries who manage the plan on their behalf.

ERISA sets out the parameters of legal liability and protection for plan sponsors and fiduciaries involved in establishing and operating group health plans. For nearly 30 years, this structure has provided HMOs, insurers, ERISA plans and employers direct or indirect immunity from the consequences of several types of medical decision-making activities either undertaken by them or on their behalf under ERISA plans. Recently, Congress has moved to consider reforms to ERISA that would alter the current liability rules in a way that may be more favorable to participants in ERISA plans. At the same time, as previously noted, ERISA's shield against liability for medical treatment decisions has eroded through court decisions.

Regardless of what changes may be made, if any, to ERISA's fiduciary and liability rules, policymakers can benefit from understanding how the current liability structure works. Because ERISA's rules are extremely complex and not generally well understood, without a greater understanding of how ERISA currently holds various parties accountable for plan operations and decision-making, the chances that new legislation or regulation will have unintended consequences and unanticipated market responses will only increase.



## APPENDIX I – Summary of primary sources of variation

Among the primary sources of variation in ERISA-covered group health plans are:

- *the type of plan sponsor*
  - single-employer plan (one company (or a controlled group of companies) providing benefits for its own employees)
  - multiemployer plan (collectively bargained plan covering employees of a single local, national, or international union with contributions by two or more employers signatory to that union's collective bargaining agreement)
  - multiple employer welfare arrangement (MEWA) (plan covering employees of more than one employer; usually all employers members of the same business or trade association; no contractual connection between employers as in multiemployer plan described above)
- *the level of plan sponsor involvement in plan operations*
- *the extent to which plan sponsors retain insurance risk*
  - fully insured group health plan (risk transferred to insurer)
  - self-insured group health plan (risk retained by plan sponsor)
  - combination group health plan (some benefits insured, some self-insured)
- *the administrative variation among self-insured plans*
  - self-administration (plan administrator retains fiduciary obligations under ERISA)
  - outsourced administration (plan hires one or more third-party administrators (TPAs) (TPA may or may not assume fiduciary obligations under ERISA; if not, plan administrator retains them; alternatively plan administrator and TPA may be co-fiduciaries)
- *number and type of group health plans*
  - number of group health plans
    - single plan
    - multiple plans
  - type of group health plan
    - comprehensive (medical plus dental, vision, prescription drug, etc.)
    - medical only
    - separate plans for different benefits (e.g., medical, dental, vision, prescription drug, etc.)

- *the nature of the employer subsidy and the form of the plan*
  - traditional package of benefits offered, shared financing of cost through copayments and/or deductibles; employer subsidizes some or all the cost of benefit package
  - cafeteria plans (established under §125 of Internal Revenue Code; offers employees choice between cash or tax favored benefits through salary reduction); may or may not have defined contribution employer subsidy)
  - flexible savings account (FSA) (salary reduction cash account)
  - medical savings accounts (MSA) (high-deductible health plan with cash account that may or may not have defined contribution employer subsidy)
  - health reimbursement arrangement (HRA)(non-salary reduction cash account subsidized on a defined contribution basis)
  
- *the methods by which benefits are delivered*
  - level of employee choice
    - single or multiple health plans offered
    - in-network providers only
    - point-of-service (financial incentives favoring in-network provider selection, but patients can chose non-network providers with additional out-of-pocket contribution)
  - delivery mechanism
    - fee-for service
    - one or more HMOs
    - one or more PPOs or other arrangements
    - combination of above
  
- *the financing arrangement for self-insured plans*
  - funded through tax exempt trust (voluntary employees' benefit association (VEBA)); claims paid through trust
  - claims paid from general assets of employer