Order Code RS20315
Updated June 18, 2001

ERISA Regulation of Health Plans: Fact Sheet

Hinda Ripps Chaikind
Specialist in Social Legislation
Domestic Social Policy Division

The Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) places the regulation of employee benefit plans (including health plans) primarily under federal jurisdiction for about 124 million people. ERISA's treatment of health plans is both complicated and confusing. ERISA has been interpreted as dividing health plans into two groups regulated differently under the law: about 54 million people are covered by self-insured plans for which the employer, rather than an insurer, assumes the risk for paying for covered services and about 70 million people are covered by purchased insurance (according to 2000 information from the Census Bureau and the Department of Labor). ERISA also distinguishes between the regulation of health plans and the business of insurance, for purposes of determining federal and state regulatory authority. However, these distinctions are not as clear cut as they seem and ERISA has been the subject of many court cases since its enactment.

How does ERISA distinguish between federal and state authority? In short, only ERISA applies to self-insured health plans, while both ERISA and state authority (for the business of insurance) apply to insured health plans. Three sections of ERISA are key in defining the federal and state roles. First, §514(a) states that federal law "preempts", or overrides, state laws as they "relate to" employee benefit plans. This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states. However, the wording "relates to" is not precise, and as a result, the courts continue to define this term, case by case. Second, §514(b)(2)(A), the "savings" clause, retains state authority over the business of insurance. The business of insurance typically refers to the regulation of plan solvency, marketing, information disclosure, consumer grievances and may also include mandating benefits, taxing insurance premiums, and mandating participation in state risk pools and uncompensated care plans. Finally §514(b)(2)(B), the "deemer" clause, does not allow states to deem an employee benefit plan to be in the business of insurance. The effect of this clause is that self-insured plans are not subject to state rules governing the business of insurance.

Why is the distinction between federal and state roles important? The distinction is important because federal laws governing health plans are different from state laws in areas such as compensation in courts, access to care, and mandated coverage. Thus, whether the plan falls under federal or state authority has very different implications for health plans and their beneficiaries. Generally, individuals wrongfully denied service under ERISA-covered plans may only sue under federal law exclusively for the cost of the

benefits they were denied and legal fees. They can't recover punitive damages, pain and suffering, or lost income, as these remedies are available only under state law. Also, federal law has minimal requirements for access or coverage, with few exceptions such as those included in the Health Insurance Portability and Accountability Act of 1996, and its amendments. State regulations can also include mandated benefits and review processes not covered under federal statute.

When does state law apply to ERISA plans? Self-insured plans are preempted from state law; therefore covered only by ERISA. For all other ERISA health plans (government and church employee plans are exempt), federal law preempts state law for issues that "relate to" employee benefit plans, and state law applies for issues involving the business of insurance. The line between self-insured and insured becomes blurred when employers buy stop-loss insurance to guard against catastrophic costs (costs above a certain level). Further, the boundaries for both the business of insurance and issues that "relate to" health plans have been subject to widespread interpretation. Courts have traditionally favored preempting state law for most employee benefit situations, although that is changing. In 1995, in *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*, the Supreme Court found that state-wide rate setting was allowable because it did not specifically relate to the plan; rather it included all insurance offered within the state. Then in 2000, in *Pegram V. Herdrich*, the Supreme Court's ruling limited the role of ERISA in a claim against an HMO physician. While some attorneys think this decision provides an opportunity for more state claims, the issue will continue to be debated in the courts.

What are the most controversial issues? The most controversial issues are the right to sue under state law, standards for appeals, access to and choice of providers, and mandated coverage. The right to sue under state law has become increasingly important with the rise in managed care plans and enrollment. Managed care, because of pre-authorization requirements, has shifted court battles from who will pay to whether or not a service will be delivered at all. Treatment delays can result in lost wages, increased illness, or even death. When managed care organizations are brought to court, they prefer ERISA for its limited redress. An adjunct issue to the right to sue is internal (within plan) or external (independent) review. ERISA does not require external review, so that without this source of redress, the only option for beneficiaries denied coverage is the court. Guaranteed access to care and mandated coverage of certain services are also regulated by states and subject to only limited federal statutes.

How is Congress addressing these issues? Comprehensive patient protection bills have been introduced in the 107th Congress to expand access, establish an appeals process, and address the limited remedies available under ERISA. S. 6 is identical to the 106th Congress' House-passed bill (H.R. 2990). This bill would allow state law causes of action to proceed, by eliminating the ERISA preemption. S. 1052, similar to H.R. 526, would distinguish between types of claims, allowing some claims to go forward in states while expanding federal remedies for individuals wrongfully denied services. S. 889 would expand federal remedies, but would not amend ERISA's preemption language to allow any new causes of action to be brought in state courts. (See CRS Issue Brief IB98017, *Patient Protection and Managed Care: Legislation in the 107th Congress*, for more detail.)