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Employee Health Plan Protections Under ERISA

How well are consumers protected under managed care and “self-insured” employer insurance plans?

by Karl Polzer and Patricia A. Butler

Despite much-publicized consumer concerns about managed care plans, remarkably little attention has focused on a more fundamental issue: Federal law governing private-sector health plans offers little or no assistance to employees who encounter problems with health benefits. Although some managed care plan enrollees worry that plans discourage doctors from communicating openly with patients, referring patients to specialists, or using appropriate technology, they are likely to be unaware of the limited government regulation and legal remedies that govern their health benefits. In this Commentary we argue that the interaction between the federal Employee Retirement Income Security Act of 1974 (ERISA) and state laws over health insurance has produced limited and uneven consumer protections that legislators should address as part of the current national debate over managed care as well as any future “reforms” to expand access to care.

ERISA And Health Plan Regulation

ERISA was designed to establish uniform federal standards for pension and employee “welfare benefit” plans, including health plans offered through private-sector employers and unions (“ERISA plans”). In part because federal health plan standards are more limited than those in most states, the 114 million Americans who are covered through private employers may be making several false assumptions about the security of their benefits. For example, they may assume that their health plans will cover all serious illnesses, that promised coverage cannot be withdrawn, that they have been informed about major coverage changes, that employers have put aside enough money to pay for needed treatments, that government regulators will assist them if a major problem arises, and that if a problem cannot be resolved, they can pursue remedies in the courts.

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Yet this confidence is unwarranted because ERISA limits federal and state oversight of health plans as well as judicial remedies previously available to insurance subscribers.

ERISA preempts state laws that attempt to regulate most types of private-sector health plans but permits states to regulate the business of insurance (while prohibiting them from considering employee plans to be insurers). The courts have held that states can regulate employee health plans indirectly by regulating health insurers but cannot regulate “self-insured” plans. Although ERISA has enhanced regulation of pension plans, it has substantially deregulated employee health plans, both because of its lack of substantive requirements in the health area and the growth of self-insurance (where the plan assumes all or part of the insurance risk that total employee health costs will exceed an expected budget). Gregory Acs and colleagues estimated that about 40 percent of private-sector employees and their dependents are covered by self-insured plans.

**ERISA’s Limits On Health Plan Protections**

Although many policy analysts have examined ERISA’s constraints on state authority to craft health system reforms, little information has been published about ERISA’s limits on employee health plan protections. To provide background for future public discussion of these issues, we undertook a study to describe how consumer protections governing private-sector employee medical benefits vary between state and federal government authority and among states. Our research included analysis of ERISA and its interpretation by the courts, discussions with staff of the U.S. Department of Labor, review of insurance statutes and regulations, and interviews with regulators in six states regarding their regulatory policy, experience overseeing health coverage, and observations about consumers’ concerns. Although we also spoke with representatives of various stakeholders, such as employers, health plans, and the actuarial profession, we were unable to identify any consumer advocacy organizations focusing on ERISA health plan issues (although several work on managed care problems).

Our study revealed wide variation in the level of consumer protection afforded members of private-sector employee health plans, especially between those in self-insured plans (subject only to federal law) and insured plans (where state insurance laws may apply) but also from state to state. Confounding analysis of these issues is the limited information about the extent of self-insurance, the actual content and practice of self-insured plans, and consumers’ experience with plan information and grievance resolution processes.
Our key findings are summarized below.

**Solvency.** ERISA contains no financial standards for health plans, whereas almost all states actively regulate the solvency of commercial insurers and health maintenance organizations (HMOs). In contrast to pension plan requirements, there are neither federal health plan solvency standards nor a federal guarantee fund to assist employees if a plan fails. Data from a 1993 employer survey in ten states reveal that many small firms self-insure but carry no stop-loss coverage, thus exposing employees to financial risk. Insurance regulators in Oklahoma, for example, described the case of a self-insured firm’s employee who was left facing more than $100,000 in medical bills when the firm declared bankruptcy. Although the business resumed under a new name, state regulators were powerless to help the former employee.

**Benefits requirements.** Concern over state insurance benefits mandates was a major reason that large businesses sought federal preemption of state regulation over health plans when ERISA was enacted in 1974. Many employers continue to point to the number of and interstate variation in such mandates to explain their preference for self-insurance. Until 1996, when it imposed certain insurance market reforms, obstetrical length-of-stay standards, and limited mental health parity requirements, Congress imposed no benefits requirements on employee health plans other than continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Limited data on self-insured plans suggest that the categories of benefits they cover and their actuarial value are similar to those of indemnity plans, though less generous than those of HMOs, and that some restrict the amount of care within categories of services such as mental health. Many states prohibit such limits on insurance products and regulate other insurance practices, such as managed care activities and limits on exclusions for experimental services. These standards cannot apply to self-insured plans.

**Information.** State regulators report that most consumers generally do not read or understand health plan documents and insurance contracts, particularly the meaning and implications of being enrolled in a self-insured plan. ERISA requires that basic health plan information in a “summary plan description” be provided to plan enrollees and filed with the U.S. Department of Labor. But the department does not review plan documents for compliance with the law. Furthermore, at the time we conducted our research, summary plan descriptions did not have to inform participants about whether a plan was self-insured (partly because a definition of what constitutes self-insurance has never been articulated in federal policy).
Recent amendments to ERISA may provide participants in some types of plans with information concerning whether the plan is insured or not, but it remains unclear how many participants will receive this information, exactly how the information will be communicated, and whether they might understand the significance of self-insurance in terms of their future access to consumer protections. ERISA plans also are not required to notify participants in advance of significant plan changes. Several state laws prescribe more detailed consumer information requirements, particularly regarding managed care plan policies. And some states have attempted to help consumers understand what it means to be in a self-insured plan.

Assistance with consumer complaints. Insurance regulators in our six study states, which we believe are typical of most insurance departments, act as consumer advocates and actively investigate complaints of employees in insured health plans. But they have no jurisdiction over self-insured plans, although some regulators in some of the study states reported attempting to resolve disputes involving self-insured plans (especially if administered by a licensed insurer acting as a third-party administrator) through informal persuasion. If unsuccessful, however, state officials can only refer these complaints to Labor Department officials, who reported to us that they have neither the mandate nor the resources to investigate complaints involving benefit disputes between plans and individuals. The department limits its consumer advocacy to problems that threaten a health plan’s aggregate membership.

Legal remedies. In many areas of consumer protection, ERISA’s preemption of state law has led to divergent standards for self-insured and insured health plans. With regard to legal remedies available to plan participants, however, the law has produced uniformity between enrollees in self-insured and insured plans, but at a level not favorable to consumers. The U.S. Supreme Court has interpreted ERISA to say that a challenge to either an insured or a self-insured private employee plan’s coverage decision is limited to payment for the actual cost incurred for the benefit in dispute. Remedies such as consequential damages (for lost wages or pain and suffering) or punitive damages (to punish outrageous conduct) that are traditionally available to insurance consumers in non-ERISA plans (such as individual policies or government-sponsored plans) are not available in ERISA plans. ERISA’s limitations on damages make it difficult for aggrieved plan participants to find legal representation, and they provide an incentive for insurers to deny coverage because plan participants may not appeal.

Managed care practices. No consumer issues today are more
contentious than concerns that managed care plans may limit access to care by restricting provider networks, imposing cumbersome utilization review requirements, refusing to cover high-cost services, narrowly defining treatment protocols, paying physicians in ways that encourage restricting services, and/or limiting physician discussion of payment arrangements or treatment options.\(^{18}\) Except for the 1996 federal mandates that required both insured and self-insured plans to cover certain minimum hospital maternity stays and to provide limited parity in mental health coverage, there are no federal standards for managed care employee plans.

ERISA’s limited remedies for injuries can be more damaging to consumers when a managed care plan refuses coverage than when an indemnity plan refuses payment because managed care plan denials occur before treatment, whereas indemnity plan disputes typically occur after care has been rendered. A federal court held that an employee health plan participant, who alleged that denial of hospital care during a high-risk pregnancy resulted in fetal death, had no legal remedy for her injuries.\(^ {19}\) There is now a dispute in the courts over whether enrollees can sue managed care organizations for malpractice.\(^ {20}\) In contrast to these limited federal standards, several states have enacted laws to require managed care plans to provide consumer information about how to use the plan, permit women to choose their gynecologist as their primary care physician, define emergency visits more broadly, or establish more specific rules than ERISA for appeal mechanisms.\(^ {21}\)

- **Defining self-insurance.** In choosing a health plan, healthy employees are unlikely to think about the need for legal and administrative remedies for potential disputes over coverage. They may discover the relevance of these legal details only after becoming ill and being denied an expensive treatment. To understand their legal protections, employees must know whether they are covered by an insured or a self-insured plan, but for several reasons, that may be difficult to determine. First, neither the ERISA statute, Labor Department policy, nor the Supreme Court (in distinguishing between insured and self-insured plans) has defined self-insurance explicitly. Second, many firms offer both fully insured and self-insured plans. Furthermore, self-insured plans often are administered by licensed insurers acting only as third-party administrators, which can confuse participants. Finally, many health plans are financed through complex risk-sharing arrangements that plan sponsors may variously characterize as health insurance, “self-insurance” backed up by a stop-loss contract, a fee-for-service contract with a provider group or HMO with some risk-sharing features that do not transfer enough risk to constitute insurance, or other “creative” arrangements.\(^ {22}\)
The use of stop-loss coverage, a long-standing form of risk sharing for self-insured plans, raises a dilemma for state insurance regulators. Their authority to regulate stop-loss insurers is compromised by recent court decisions that limit their ability to determine the point at which an employee plan transfers so little risk to an insurer that it arguably is no longer really self-insured.23 State regulators interviewed in our study reported that an increasing number of small businesses are ostensibly self-insuring while also purchasing stop-loss policies covering individual claims exceeding $500 or $1,000. Viewing such arrangements as a subterfuge to avoid insurance taxes, benefit mandates, and consumer protections, several states have adopted a model stop-loss act developed by the National Association of Insurance Commissioners, but a federal court of appeals recently held that it violates ERISA.24

State regulators also are concerned about losing control over ERISA plans that contract directly with risk-bearing provider networks.25 Many are disturbed by a trend toward unregulated physician/hospital organizations and medical groups that assume varying levels of risk from ERISA plans, HMOs, and other organizations.

According to a recent employer survey, 21 percent of workers receiving care from HMOs are in self-insured plans, up from 15 percent in 1995.26 In these arrangements, ERISA plans purport to retain the risk and contract to use an HMO's provider network, but regulators worry about the amount of risk actually transferred to providers and the potential for insolvencies.

**Limits on state regulation of insurance.** State authority over health coverage is limited not only by employers' tendency to self-insure but also by recent court opinions narrowing the definition of what constitutes “the business of insurance” left to states under ERISA. For example, several courts have held that HMOs are not insurers.27 Another court held that ERISA preempts a state law mandating that health carriers permit all categories of providers to render covered services.28 These cases suggest that many of the laws that states recently have enacted to address managed care plan policies not only do not apply to self-insured plans but may be preempted as applied to HMOs and other managed care plans. If such judicial interpretations continue, there is likely to be more demand for Congress either to regulate managed care itself or to clarify state regulatory authority.29

**Discussion**

By deciding whether to self-insure, employers and other health plan sponsors, whether knowingly or not, determine to a great extent the degree of regulatory protection available to employees and their
dependents. A policy question not raised in the current debates over managed care and quality issues is how similar or different are the interests of plan sponsors and participants? For example, would a plan sponsor be willing to expose an employee to more risk than the employee would choose with full knowledge of the potential ramifications of the entire health coverage transaction? If so, to what degree should government intervene to protect consumer interests, while not unduly interfering with plan sponsors’ ability to design cost-effective plans and negotiate with insurers and providers?

ERISA’s preemption clause has protected employee benefit plans from conflicting state rules (although not from conflicting court opinions); it shields employee health plans from meeting substantive standards for solvency and imposes only minimal information disclosure and benefits requirements. Because Congress could not have anticipated in 1974 the many changes in health care financing and delivery that would occur over the succeeding twenty-three years, two fundamental questions merit reexamination: First, what standards should apply to all private employee health benefits? And second, what level of government should establish and enforce employee health plan standards?

Although attempts to amend ERISA to authorize specific state health care reform initiatives over the past five years were unsuccessful, in 1996 Congress amended ERISA to impose two specific types of standards on both insured and self-insured plans. The Health Insurance Portability and Accountability Act limits all employee health plan use of preexisting condition exclusion periods and plan applicant health status information. The 1997 appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development imposes minimum lengths of hospital maternity stays and limits certain differences in coverage between mental and physical health services. In both cases, Congress permitted states to enforce federal standards or adopt stricter laws to govern insurance products.

Congress is now entertaining several other proposals to regulate managed care, such as inpatient mastectomy requirements and gag-clause prohibitions. How this continued push for individual mandates might influence the development of broader consumer protections for enrollees in private-sector employee health plans remains unclear, since the consumer protection issues we have outlined here have not been part of the national managed care policy debate. Although current political pressures could be channeled into an effort to adopt a comprehensive and balanced set of protections for all employee health plan consumers, without a broadened public discussion of fundamental issues, they are perhaps just as likely to lead...
to more consumer confusion and employer expense. Provider lobbying, resisted by employers and unions that sponsor health plans, could result in the adoption of a limited and eclectic set of benefit and treatment mandates without a careful effort to construct a system of consumer protections that balance the needs of individuals against those of plans.

As these policy debates unfold, a key issue from the consumer viewpoint ought to be to what degree the federal government (itself, or by delegation to state agencies) ensures that health benefits are adequate, available, and protected, regardless of the financing arrangement or type of insurance contract a plan sponsor happens to choose, particularly as employers and insurers intensify efforts to manage health care costs by managing care.

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NOTES

1. On ERISA preemption, see 29 U.S. Code 1144(a)(1988). Public-employee plans, such as those operated by state or local governments, and a few private-sector plans, such as those operated by churches, are not subject to ERISA. U.S. General Accounting Office, Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA, GAO/HEHS 95-167 (Washington: GAO, July 1995). On state regulation of insurance, see 29 U.S. Code 1144(b)(2)(B). In the 1983 ERISA amendments, Congress permitted states to regulate “multiple employer welfare arrangements” (MEWAs) to respond to problems of insolvency and consumer misrepresentation by these types of plans. On the status of employer plans as insurers, see 29 U.S. Code 1144(b)(3).

2. Although this distinction may not appear particularly logical, it was sanctioned by the U.S. Supreme Court in Metropolitan Life Ins. Co. v Massachusetts, 471 U.S. 724 (1985), in holding that a state can mandate that insurers, but not self-insured plans, cover mental health benefits.


6. The six states—California, Colorado, Florida, Minnesota, Ohio, and Oklahoma—were chosen not necessarily to be representative of the nation but rather to illustrate variation in insurance and managed care markets, agencies with regulatory jurisdiction, and historical problems with health coverage insolvencies as well as four (Colorado, Florida, Minnesota, and Oklahoma) of the ten states participating in the 1993 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey that provided data on self-insuring firms. Acs et al., “Self-Insured Employer Health Plans.”

7. One should not assume, however, that state standards for insurers are necessarily appropriate for self-insured employee benefit plans. If Congress were to contemplate developing solvency standards for self-insured ERISA health
plans, for example, an important question would be how stringent those standards should be. Some ERISA experts argue that single-employer ERISA health plans expose consumers to less risk than commercial insurer plans, which are one step further removed from plan participants. Furthermore, they argue, whereas insurers have an incentive to assume business risk to expand, ERISA plans are formed solely for the purpose of providing benefits to employees. On the other hand, because the solvency of ERISA plans is related to the financial condition of the firm providing benefits, employee coverage may be jeopardized by the risk-taking behavior of the employer. ERISA plans that cover aggregations of employer groups (such as MEWAs) tend to be less financially stable than single-employer plans.

8. RAND tabulations of the 1993 RWJF Employer Health Insurance Survey of ten states. Absent some form of insurance to pool risk with other small groups, the variability of employees’ health care costs is large enough to jeopardize the solvency of many small-firm health plans. (This contrasts with the greater ability of a large firm to predict and budget for overall employee medical costs.) It is not difficult to see how a medical treatment costing thousands of dollars might threaten the solvency of a small firm’s self-insured plan. Yet under current law, self-insured plans face no federal financial standards and cannot be regulated by states.


11. COBRA entitles former employees and their dependents in firms with twenty or more employees to remain covered through the employee health plan for specific time periods. The Americans with Disabilities Act (ADA) offers some protections to employees in firms with fifteen or more workers from discrimination in coverage of certain illnesses.


13. *Federal Register* (8 April 1997): 16979. Interim rules, effective 1 June 1997 implementing parts of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require summary plan descriptions of group health plans to include information indicating whether a “health insurance issuer” (defined as insurers and HMOs licensed under state law) is responsible for the “financing or administration” of the plan. Self-insured plans administered by third-party administrators that are not health insurance issuers or administered in-house would not have to disclose funding arrangements and their implications regarding consumer protections to participants.

14. Until HIPAA, plans were required to notify participants about “material modifications” to a plan only within 210 days of the end of the plan year. This meant that an employer could drop coverage of a benefit or conversion option *(Kytle v Steward Title Co., 788 F. Supp. 321 [S.D. Tex. 1992])* and not inform employees for up to 575 days thereafter. HIPAA requires notice no later than sixty days after a “material reduction” in covered services or benefits but still does not require advance notice.


16. For example, see Ohio Department of Insurance, *Ohio Consumer’s Guide to Health Insurance* (Columbus: Ohio Department of Insurance, July 1995).

17. ERISA does permit a plan participant to seek an injunction to obtain benefits, but this is rarely practical in view of the cost of the litigation and need for timely treatment. Consequently, it occurs only in cases of very expensive treatment in life-threatening situations.

19. In Corcoran v United Health Care, Inc., 965 F. 2d 1321 (5th Cir., 1992), a federal court of appeals held that although ERISA permits suits over the denial of treatment, no meaningful damages could be awarded because ERISA does not permit damages for emotional distress, pain, or suffering and because equitable relief, such as an injunction, would have been meaningless once the fetus died.


22. For example, the Buyers Health Care Action Group in Minnesota has constructed contracts that transfer some risk to providers while attempting to avoid state characterization of an insurance arrangement subjecting providers to HMO regulation. S. Wetzell, “Consumer Clout,” Minnesota Medicine (February 1996): 15–19.

23. Both the structure of a stop-loss contract and the amount of risk that a health plan passes on to a commercial insurer through it are factors in disputes over whether such an arrangement is stop-loss insurance or health insurance per se. Under a group health insurance contract, according to many insurance industry representatives and some regulators, the employer is the master policyholder, while plan participants hold certificates giving them the right to receive health care under the master contract (Ohio Department of Insurance). A stop-loss contract, in contrast, involves only the employer and not the plan participants, even though the stop-loss payments to the plan may be contingent on an individual participant’s claim experience.


27. These decisions are usually based on the fact that HMOs agree to provide or arrange for services and, often, the fact that state HMO licensure laws define them as not insurers. Compare O’Reilly v Cueleers, 912 F. 2d 1383 (11th Cir., 1990) and Dearmas v Av-Med, Inc., 814 F. Supp. 1103 (E.D. Fla., 1993) with Physicians Health Plan, Inc. v Citizens’ Ins. Co. of America, 673 F. Supp. 903 (W.D. Mich., 1987).

28. Washington Physicians Service Association v Gregoire, No. C96-5850FDB (2 May 1997). This case involves a provider mandate (in contrast to the benefit mandate upheld in Metropolitan Life) applied to all health carriers and so is different from “any-willing-provider laws” applied to managed care plans, which also have been preempted by ERISA. Cigna Health Plan of Louisiana v Ieyoub, 82 F. 3d 642 (5th Cir., 1996).

29. For example, although the notion that HMOs are not insurers because they perform both insurance and health care delivery functions seems illogical, ERISA’s legislative history is not helpful in determining what kinds of arrangements Congress intended states to be able to regulate in view of the relatively small role played by HMOs, much less other types of managed care plans, in 1974.