Congressional Research Service

Report RS20315

ERISA Regulation of Health Plans: Fact Sheet

Hinda Chaikind, Domestic Social Policy Division

October 3, 2007

Abstract. The Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) places the regulation of private sector employee benefit plans (including health benefits) primarily under federal jurisdiction for about 177 million people. While ERISA does not require an employer to offer health benefits, it does mandate compliance if such benefits are offered.

ERISA Regulation of Health Plans: Fact Sheet

Hinda Chaikind
Specialist in Health Care Financing

October 3, 2007

Congressional Research Service
7-5700
www.crs.gov
RS20315

CRS Report for Congress
Prepared for Members and Committees of Congress

Contents

Contacts

The Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) places the regulation of private sector employee benefit plans (including health benefits) primarily under federal jurisdiction for about 177 million people. While ERISA does not require an employer to offer health benefits, it does mandate compliance if such benefits are offered. Employers can offer health insurance by either purchasing a health insurance product or they can self-insure, where they rather than an insurer assume the risk for paying for covered services. ERISA has been *interpreted* as dividing health plans into these two groups, which is important because they are regulated differently under the law: about 82 million people are covered by purchased insurance, and about 95 million people are covered by self-insured plans (according to information derived from the enhanced March 2006 Current Population Survey). ERISA's regulation of health plans has been the subject of many court cases.

How does ERISA distinguish between federal and state authority?

In short, ERISA applies to all private sector employer-sponsored health plans, whereas state insurance laws additionally apply to purchased 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 the courts continue to define this term case by case. Second, § 514(b)(2)(A), ERISA's "savings" clause, retains state authority over the business of insurance. State laws relating to the business of insurance typically include the regulation of plan solvency, marketing, information disclosure, and 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 and state laws governing health plans are different in areas such as remedies in courts, access to care, and mandated coverage. Whether a plan falls under federal only or both federal and state authority has very different implications for health plans and beneficiaries. Generally, individuals wrongfully denied services under ERISA-only covered plans may sue under federal law only for the cost of the denied benefits and legal fees. They cannot recover punitive damages, pain and suffering, or lost income—remedies 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.

The line between self-insured and insured becomes blurred even further when employers providing self-insured health plans also 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 there are notable exceptions. In 1995, in *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*, the Supreme Court found that statewide rate setting was allowable

because it did not specifically relate to the plan; rather, it included all insurance offered within the state.[1]

What are the most controversial issues?

The most controversial issues are the right to sue health plans under state law, standards for appeals, access to and choice of providers, and mandated coverage. The right to sue under state law became more important with the rise in managed-care plans and enrollment. Managed care, because of preauthorization requirements, has shifted court battles from who will pay to whether or not, or even when or where, a service will be provided. 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 only to limited federal statutes. Some plans claim that state laws are too costly, creating apparent inequities between plans regulated solely by federal law and plans regulated by both federal and state laws. The 110th Congress has introduced bills aimed at reducing the regulatory burden that state insurance laws impose on health plans, thereby reducing some of the inequities.

What are the state activities?

Most states have legislation and/or regulation in place providing for independent review of health plan benefit denials. The courts are providing a critical role in determining whether or not ERISA preemptions applies. In *Rush Prudential HMO Inc. v. Moran*, the Supreme Court determined that ERISA did not preempt the Illinois HMO external review law (requiring physician review for disagreements about medical necessity of covered services). Following that decision, on remand from the Supreme Court, the Fifth Circuit U.S. Court of Appeals ruled that ERISA did not preempt a similar Texas HMO external review law.

Author Contact Information

Hinda Chaikind
Specialist in Health Care Financing
hchaikind@crs.loc.gov, 7-7569

[1] For a more detailed description of ERISA and relevant court cases, see CRS Report 98-286, *ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans*, by Jon O. Shimabukuro.