

Regulation of ERISA Plans:
The Interplay of ERISA and California Law

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*Prepared for the
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by*

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I. Introduction

Overview

In recent years, no set of health policy issues has been more challenging to both federal and state officials than how to regulate the managed health care industry. During the past decade, employers, government agencies, and other purchasers of health care increasingly opted for managed health care products in order to constrain the growth of health care spending. Resulting consumer discontent and health care provider backlash have prompted a new round of legislative and regulatory activity. As policymakers continue to struggle to find a balance in protecting the interests of patients, providers, and health care purchasers, such as employer-sponsored health plans, the patchwork of laws protecting consumers has become increasingly complex, both in California and the rest of the nation.

As the policy debates continue, this report attempts to map the variation in consumer protections under federal and state law for Californians enrolled in private-sector employee benefit plans. Like most Americans, the majority of the state's residents under age 65 receive health coverage through employment—either through their jobs or the jobs of family members.¹ Most residents with job-based health coverage work for private-sector employers. This report will explore the variation in private-sector employee consumer protections under state and federal law along a number of dimensions including rules concerning health plan solvency, mandated benefits, required information, managed care standards, appeals of denied claims and subsequent legal remedies, and coverage portability. (The coverage and consumer protections for people working for public-sector employers and churches fall under different combinations of federal and state laws than those documented in this report.)

ERISA and State Law: The Regulatory Divide

Health benefits provided by private-sector firms are regulated under a checkerboard of federal and state laws that can leave consumers bewildered should an issue arise concerning payment for or coverage of services or continued access to coverage. The principal federal statute governing private-sector health plans is ERISA—the Employee Retirement Income Security Act of 1974. Under this law, a legal entity called a “plan” is created when an employer or union promises to

compensate employees in the form of health benefits. ERISA is basically a law of fiduciaries and trusts. Among its main purposes is to make sure that plan sponsors follow through on promises to provide pensions and other benefits, including health coverage, while facilitating the voluntary provision of employee benefits. ERISA's notion of a "health plan" (a distinct legal entity created when an employer promises to provide and pay for employee health benefits) is often confusing to people, including policymakers, who are more used to thinking of health plans as organizations like indemnity insurers and HMOs that compete in the marketplace to provide health insurance and health care services. (In this report we often refer to health care service plans as HMOs.)

Under ERISA, states are forbidden from enforcing laws relating to private-sector employee health benefit plans but allowed to regulate indemnity insurers and managed health care companies contracting with ERISA plans. (Under ERISA, states can regulate "the business of insurance.") As a result, when issues arise with their health coverage, residents of California, like those in other states, may or may not have recourse to state regulatory agencies, depending on whether their employers have purchased fully insured products or have decided to "self-insure" the firm's health coverage. If the employer has purchased a fully insured product, there is another wrinkle. Different California agencies license and oversee different types of health insurance and managed care products.

Research Approach

Our research is based on analysis of state and federal statutes, regulations, and policy statements, court opinions, and interviews in late 2001 and early 2002 with state and federal regulators, representatives of the Governor's office and legislative staff, spokespeople for employers and the insurance and managed care industries, and consumer advocates. (See the Appendix for a list of people interviewed.)

Organization of this Report

This report begins by outlining the history, purpose, and court interpretations of ERISA along with its provisions that preempt state law and set out responsibilities for employer-sponsored health plans. The third chapter outlines the regulatory setting and health coverage landscape in California. Each following chapter discusses how state and federal regulation protects health coverage consumers on issues of: health plan solvency, health plan benefits and managed care standards, information disclosure, dispute resolution, and coverage continuation, portability, and access rules.

II. ERISA: Background, Purpose, and Employer Plan and DOL Responsibilities

The ERISA Statute

ERISA was enacted by Congress in 1974 primarily to remedy pension fraud and mismanagement.² The law prescribes a comprehensive scheme to regulate employee pension programs.³ It applies to employee benefit plans (established by employers or employee organizations, usually joint labor/management boards sponsoring collectively bargained plans), including both pension plans and “welfare benefit plans,” such as arrangements to provide medical care “through the purchase of insurance or otherwise.”⁴ The term “ERISA plan” means all such private-sector employee plans (except those operated by churches), whether they are insured or self-insured.⁵ Plans offered by state and local governments or sold in the individual market are not subject to ERISA.⁶ ERISA is administered and enforced by the U.S. Department of Labor (DOL).

In contrast to its detailed provisions regarding pension programs, ERISA originally imposed few standards on welfare benefit plans like health plans. It required only that employee health plans disclose certain information to covered individuals and DOL, meet fiduciary duty standards, and provide a procedure to resolve disputes with the plan (including a limited right to sue in federal court to recover costs of denied services). Over the years, Congress has amended ERISA several times and currently is considering adding managed care standards and expanded appeals procedures and civil litigation options against health plans, requirements that are discussed in more detail in later sections of this report. There remain, however, no federal standards for health plan solvency, eligibility, or vesting of benefits. For employee health plans, federal standards for information disclosure to participants, mandated benefits, and remedies for injuries due to health plan coverage disputes are generally less prescriptive than the insurance standards and common law that exist in virtually all states, including California.

Under the federal supremacy doctrine of the U.S. Constitution, when a state law directly conflicts with federal law, federal law prevails.⁷ But while Congress typically allows states to regulate in areas where federal law is silent, ERISA generally supercedes such state legislation

through its preemption clause⁸ While some ERISA preemption opponents assert that the breadth of congressional preemption was “inadvertent,”⁹ others argue persuasively that, while the provision was not “deeply considered” and there was no independent analysis of its long-term implications, Congress intended broad preemption in 1974.¹⁰ As this report will discuss, several recent congressional ERISA amendments craft different, more limited, types of preemption of state law. For example, in 1996 Congress mandated ERISA plans to cover a minimum number of hours of post-delivery maternity and newborn hospitalization, while allowing stricter (but not more lenient) state insurance laws on maternity hospital benefits.¹¹

State laws that regulate the business of insurance are explicitly “saved” from preemption under ERISA’s so-called “savings clause,” section 514(b), which exempts from preemption several types of state law: those regulating insurance, banking, and securities; criminal law; the Hawaii Prepaid Health Care Act; certain laws regulating multiple employer welfare arrangements; Medicaid secondary payer laws; and qualified domestic relations orders.¹² Congress left state insurance regulation—a federal responsibility when it occurs in interstate commerce¹³—to states in the 1945 McCarran-Ferguson Act.¹⁴ While state laws regulating health insurers are thus saved from preemption, in its “deemer clause” ERISA forbids a state to consider an employee benefit plan to be an insurer in order to bring it under state jurisdiction.¹⁵ In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which amended ERISA, Congress imposed specific requirements on both employee health plans and insurers and managed care companies contracting with them. HIPAA creates a federal regulatory “floor” for certain insurance market practices but permits states to supplement the federal standards in certain explicit respects. Federal laws requiring health plans to provide postnatal hospital care and post-mastectomy care and to cover any mental health benefits offered similarly to other medical conditions and their preemption provisions are discussed in Chapter 5.

Read together, these ERISA preemption provisions permit states to regulate health insurers (with which ERISA plans contract) but not to regulate self-insured ERISA plans themselves. (States can regulate self-insured plans that are not ERISA plans, that is, those offered by churches and state or local governments, as well as insurance products sold in the individual market.) Neither the ERISA statute nor DOL regulations, however, clarify what is meant by self-insurance.¹⁶ Often employee health plan enrollees are not aware whether or not a plan is fully insured.¹⁷

Interpreting ERISA’s Preemption Clause

As arbiters of the meaning of federal law, the federal courts are responsible to interpret ERISA’s preemption provisions (including the “savings” and “deemer” clauses) and have decided thousands of ERISA preemption cases. Because these provisions are not especially clear, ERISA will continue to raise questions regarding state health policy that only the courts can resolve. The discussion below briefly summarizes the approach courts take in analyzing an ERISA preemption case.¹⁸

Under the guidance of the U.S. Supreme Court, lower federal courts apply a two-step analysis to decide if ERISA preempts a state law: (1) does the state law “relate to” an ERISA (private-sector employee) plan? And (2) if so, is it “saved” from preemption because it regulates the business of insurance? Although the Supreme Court had interpreted ERISA’s preemption clause very broadly for many years, in the 1995 *Travelers Insurance* case, the Court narrowed the reach

of ERISA preemption when it held that a New York hospital rate-setting law did not “relate to” ERISA plans (even though it increased their costs) because it did not directly regulate employee health plans and, furthermore, involved traditional state public health authority.¹⁹ What remains clear from the Supreme Court opinions, however, is that states cannot tax or directly regulate ERISA plan benefits, structure, or administration.²⁰ Courts have held that ERISA’s preemption provision supercedes state laws attempting to impose directly on self-insured employee plans premium taxes, risk pool assessments, benefits mandates, solvency standards, and managed care rules.²¹

The federal courts also have examined state laws to determine whether they escape preemption under ERISA’s savings clause. (Of course, any state insurance laws that directly conflicted with federal law would be preempted on the basis of the Constitution’s supremacy clause.) The courts analyze state laws to see whether they are generally directed at the insurance industry and, if so, whether the activity regulated under the law meets criteria for being insurance—spreading risk, involving the relationship between the insurer and insured person, and/or being limited to insuring entities.²² Although some lower courts held that ERISA preempts state laws that fail to meet all three of these standards, in its 1999 *UNUM Life* decision,²³ the Supreme Court held that not all these three criteria need to be met. The Court’s opinion provides lower courts greater flexibility to find that a state insurance or managed health care law can survive ERISA preemption, but it leaves to the lower federal courts responsibility to determine when a state law regulates insurance. The significant role of courts in interpreting ERISA’s preemption clause and savings clause makes it difficult to predict with certainty whether ERISA will preempt a particular state law.

Employer-Sponsored Health Plan Responsibilities under ERISA

ERISA imposes several responsibilities on employer-sponsored health plans, whether insured or self-insured. Among other duties, they must:

- establish procedures for claims review consistent with federal standards
- disclose specific information about the plan to plan participants
- permit departing employees and their dependents to remain in the group health plan up to 36 months under prescribed circumstances upon payment of up to 102 percent of the group premium
- impose similar annual and lifetime limits on mental health coverage as those imposed on physical health coverage
- provide a minimum amount of post-delivery hospital care for mothers and newborns
- cover reconstructive surgery for mastectomy patients
- provide minimum pre-existing condition exclusion periods.
- report certain plan information to the Secretary of DOL

- operate the plan as a fiduciary would administer a trust
- comply with child support orders
- treat Medicaid as a secondary payer
- provide departing employees certificates indicating they had qualifying coverage that allows them to enroll in COBRA or HIPAA plans²⁴

The first seven standards, designed to protect ERISA health plan consumers, are discussed in subsequent sections of this report. Here, we briefly discuss the DOL reporting and plan sponsor fiduciary responsibilities.

ERISA Plan Sponsor Reporting Requirements

With respect to welfare benefit plans (such as employee health plans²⁵) covering 100 or more participants, federal law requires plan sponsors to file an annual report with the DOL on the financial condition of the plan and expenditures during the year.²⁶ This annual report contains information on (1) insurance contracts, (2) reimbursement to actuaries and accountants, (3) participation in certain investment arrangements, loans, or leases, (4) assets, liabilities, income and expenses, and (5) an accountant's report.²⁷ DOL must make these reports available for the public to view or obtain copies. Welfare benefit plans with fewer than 100 participants that use insurance and/or pay benefits directly out of their assets (i.e., do not "fund" their plan or receive employee contributions) are exempt from filing these reports.

ERISA Plan Fiduciary Duties

Because it was designed to overcome pension plan mismanagement, ERISA was founded on the law of trusts, embodying the precept that plan assets are held in trust and a plan fiduciary must operate the plan in the sole interest of plan participants in providing benefits and incurring reasonable administrative costs.²⁸ This fiduciary duty has been interpreted to prohibit misuse of funds, financial self-dealing by plan sponsors and their contractors, and misrepresentation of a plan's financial soundness and to require providing information to participants and actively managing plan assets. In the case of employee health plans, wrongfully denying a claim for medical benefits even when acting in bad faith is not necessarily a breach of fiduciary duty,²⁹ but a federal court recently held that a self-insured ERISA plan sponsor violated its fiduciary duty when it refused to cover hospitalization related to pregnancy in violation of explicit plan terms.³⁰ Organizations other than the plan sponsor that administer a health plan (such as third party administrators or HMOs) can be fiduciaries subject to ERISA's fiduciary duty requirements.³¹

U.S. DOL Responsibilities

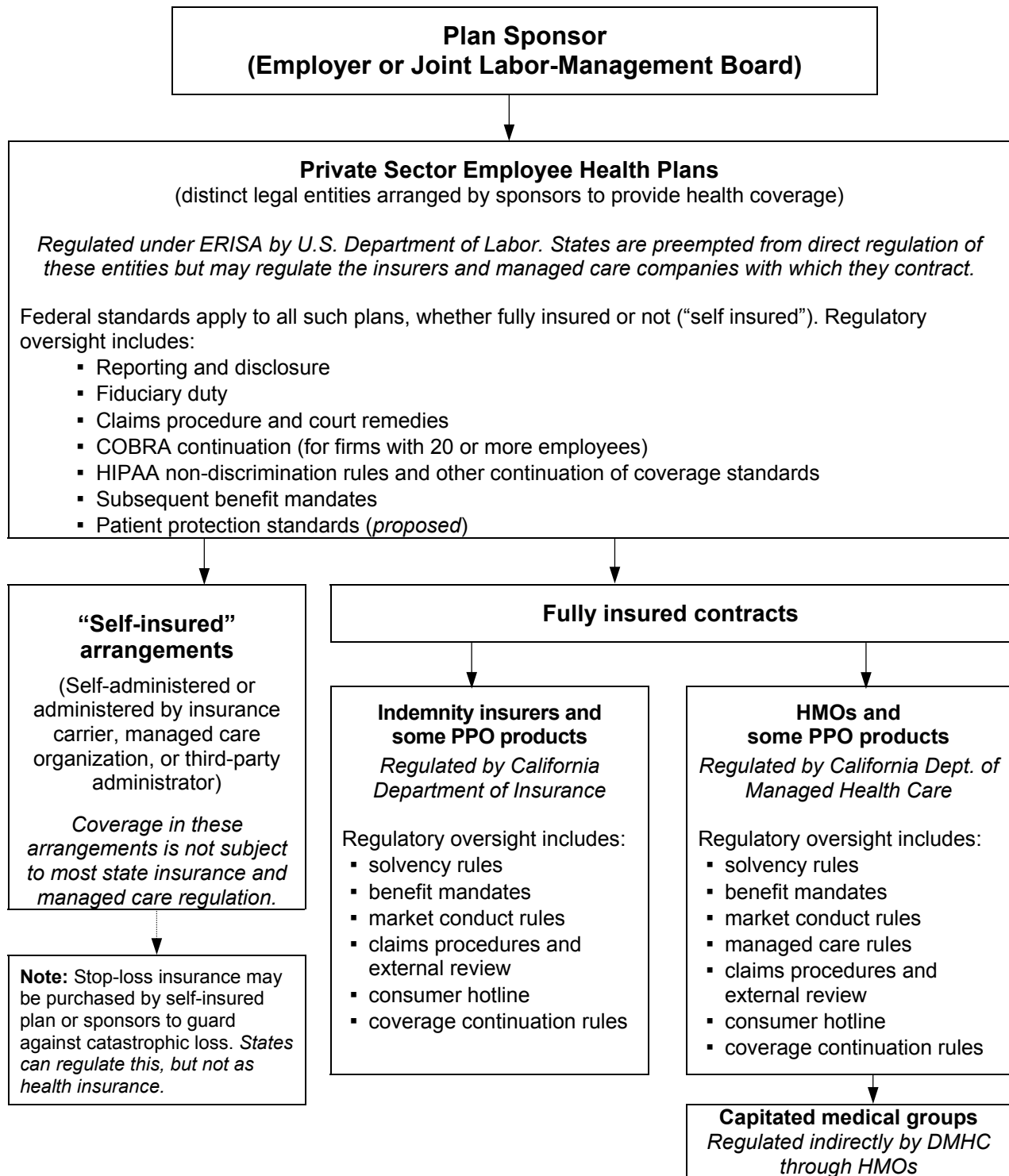
In its responsibility to administer ERISA, the Pension and Welfare Benefits Administration (PWBA) of the DOL: (1) interprets the statute by issuing regulations, opinion letters, and other policy statements, (2) collects information from ERISA pension and welfare plan administrators, (3) conducts and supports research on ERISA pension and welfare plan characteristics, and (4) enforces ERISA by bringing actions against ERISA plan administrators for violating ERISA's requirements and employers for failing to notify beneficiaries about their rights to COBRA continuation benefits in violation of federal law. The DOL views its ERISA enforcement

responsibility primarily to safeguard the collective rights of employee pension and welfare plan participants from misconduct by plan administrators. The central office in Washington, D.C. establishes policy and coordinates enforcement efforts through ten regional offices (one in Los Angeles and one in San Francisco) and five additional district offices.

The DOL has undertaken several initiatives to educate employers, insurers, and insurance plan participants and beneficiaries about new rights and responsibilities under HIPAA. The agency has published a reference booklet on these amendments and provided public service announcements to the radio and print media.³² In the fall of 1998, the DOL began a health plan consumer education initiative (the “Health Benefits Education Campaign”) in partnership with several government agencies, unions, employers, insurers, health care providers, and consumer advocates. Three DOL publications, which also appear on its Web site, provide information to health coverage consumers about considerations in choosing plans, legal rights under COBRA and HIPAA, and consumer protections.³³ These documents link to other resources and publications available by mail or on the Internet.

With regard to the private-sector employee health plans, ERISA standards provide a legal framework that overlays state regulation of insurance and managed care and in most instances trumps conflicting state laws (see Figure 1).

Figure 1. Regulation of Private-sector Employee Health Plans and Group Health Insurance under California and Federal Law (ERISA)



III. The California Health Coverage Industry and Regulatory Structure

Regulation of California Health Insurers and HMOs

In California, two state agencies split the task of regulating the health insurance industry. The California Department of Managed Health Care (DMHC) focuses on managed health care products licensed under the Knox-Keene Act and regulates “health care service plans” that provide both health insurance and medical services to more than 20 million state residents. Licensees include HMOs and some insurance products using preferred provider organizations (PPOs). The other agency, the California Department of Insurance (CDI), is responsible for overseeing a wide range of insurers including traditional life and health insurance carriers. It regulates health insurers through its jurisdiction over “disability plans.” An estimated 1.5 to 2 million state residents are covered through indemnity health insurance companies and other health insurance products under the CDI supervision. Most of these health insurers contract with PPOs. CDI also licenses MEWAs (Multiple Employer Welfare Arrangements). In recent years, state policymakers have discussed the idea of merging CDI’s regulation of health insurance into the DMHC, but while speculation continues, many informants interviewed said that jurisdiction seems likely to remain in both agencies, at least in the near future.

The divided regulation of managed care and health insurance in California creates an added layer of potential confusion for consumers. Many regulators and industry representatives interviewed in preparing this report said that the two regulatory agencies have fundamentally different missions. For health care service plans, the DMHC regulates both insurance functions and the provision of health care services; the CDI does not regulate health care services because the products under its jurisdiction involve only the transfer of insurance risk and do not directly provide health care services. Despite this general description of their jurisdictional differences, which seems to hold true in most cases, there is considerable overlap between the agencies with regard to regulating less intensely managed health insurance products, which can be licensed by either agency. (Such managed care products include those using PPO networks and utilization review.) An executive for one major carrier with a large HMO business that is licensed under the

DMHC said that the company decides where to seek licensure of its PPO products on a product-by-product basis.

Insurers weighing which regulatory regime to choose face some trade-offs. CDI regulation generally is considered to be far less restrictive in many ways, including its oversight of network adequacy and the flexibility given to employers and insurers to design benefit packages. On the other side of the ledger, CDI licensure is more costly, the agency has higher capital requirements, and carriers must participate in a guarantee fund that is tapped to cover claims costs when a carrier becomes insolvent.

Prevalence of Self-insurance

A widely used term, “self-insurance” refers to a variety of arrangements in which a plan sponsor purchases health coverage for employees while retaining most or all of the risk of claims cost fluctuation within the ERISA health plan. (As noted below, many employers that self-insure their health benefits reduce their risk through stop-loss insurance purchased by either the employer or the ERISA health plan.) In 2001, on a national level, 47 percent of covered employees were in self-insured plans while in California about 27 percent of covered workers (approximately 3 million) were in self-insured plans, according to a survey by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust (HRET) (Table 1).³⁴ States cannot regulate self-insured arrangements as health insurers but can regulate the health insurance and managed health care companies under contract with fully insured ERISA health plans. Although it is widely used by large employers in the state, self-insurance is less prevalent in California than in the nation as a whole in part because of the high penetration of standardized managed care products that are more likely to fall under state regulation. For example, with the exception of one contract with a large multi-state employer, Kaiser Permanente, the state’s largest managed health care plan, offers only fully insured products in California. Many health insurers in the state, however, do provide administrative services to self-insured employee health plans. As cost pressures grow, more employers currently purchasing fully insured products, including HMO coverage, are reported to be considering switching to self-insurance.

For both the nation and California, the proportion of employees in self-insured plans is lowest among those enrolled in HMOs or point-of-service (POS) plans. For the nation, 29 percent of HMO-covered workers were in self-insured plans compared with 40 percent in POS plans, 62 percent in PPO plans, and 68 percent in traditional health insurance plans, according to the Kaiser/HRET data. However, the study noted that the percentage of HMO enrollees in self-insured employee plans increased nationally from 19 percent in 1999 to 29 percent in 2001. The California portion of the Kaiser/HRET survey showed that, in 2001, 18 percent of HMO-covered workers, 15 percent of POS-covered workers, and 53 percent of PPO-covered workers were in self-insured plans (Tables 2, 3, and 4). The California survey estimated that less than one percent of covered workers were enrolled in traditional indemnity plans, either insured or self-insured. Among a total of about 11.2 million covered workers in the state, about 5.4 million were enrolled in HMOs, 2.8 million in POS plans, and 2.9 million in PPO plans.

Table 1. Percentage of Covered Workers in Self-insured^a and Insured Health Plans in California and the United States in 2001^b

	Self-insured		Insured	
	California	U.S.	California	U.S.
Total	27%	47%	71%	52%
Small firms (<200 workers)	14	21	83	78
Large firms (200+ workers)	36	60	63	40

Source: *Employer Health Benefits 2001 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, and Kaiser/HRET 2001 California Employer Health Benefits Survey.

^a In the survey, employers were asked whether their coverage was underwritten by an insurer, whether it was self-insured, or whether they did not know. Because some said they did not know, percentages do not always add up to 100%.

^b The national data include state and local government plans (which are not subject to ERISA) while the California figures do not include state and local government plans.

Table 2. Percentage of HMO-Covered Workers in Self-insured And Insured Health Plans in California and the United States, 2001^a

	Self-insured		Insured	
	California	U.S.	California	U.S.
Total	18%	29%	79%	70%
Small firms (<200 workers)	11	19	85	80
Large firms (200+ workers)	23	32	76	67

Source: *Employer Health Benefits 2001 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, and Kaiser/HRET 2001 California Employer Health Benefits Survey.

^a Percentages do not add up to 100% because some respondents said that they did not know whether their plans were insured or self-insured.

Table 3. Percentage of PPO-Covered Workers in Self-insured and Insured Health Plans in California and the United States, 2001^a

	Self-insured		Insured	
	California	U.S.	California	U.S.
Total	53%	62%	46%	37%
Small firms (<200 workers)	21	30	77	69
Large firms (200+ workers)	80	78	19	22

Source: *Employer Health Benefits 2001 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, and Kaiser/HRET 2001 California Employer Health Benefits Survey.

^a Percentages do not add up to 100% because some respondents said that they did not know whether their plans were insured or self-insured.

Table 4. Percentage of POS-Covered Workers in Self-insured and Insured Health Plans in California and the United States, 2001^a

	Self-insured		Insured	
	California	U.S.	California	U.S.
Total	15%	40%	84%	57%
Small firms (<200 workers)	13	9	87	90
Large firms (200+ workers)	17	63	83	32

Source: Employer Health Benefits 2001 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust, and Kaiser/HRET 2001 California Employer Health Benefits Survey.

^a Percentages do not add up to 100% because some respondents said that they did not know whether their plans were insured or self-insured.

In California, as in the nation, the larger the employer offering a health plan, the more likely the plan will be self-insured (Table 1). In California, in 2001, 36 percent of covered workers in firms with 200 or more workers were in self-insured plans compared with 14 percent of covered workers in firms with fewer than 200 workers. In the country as a whole, in 2001, 60 percent of covered workers in firms with 200 or more workers were in self-insured plans compared with 21 percent in firms with fewer than 200 workers.

In part because state insurance regulation imposes additional costs and reduces employer flexibility in designing benefit packages, ERISA's strong preemption of state law led to the growth of self-insured plans, especially those sponsored by large employers operating across state lines. When the law was enacted more than 25 years ago, almost all employee health plans were fully insured. In the years after ERISA's passage, aided by a series of court decisions broadly interpreting ERISA's preemption of state law, most of the larger ERISA health plans opted to self-insure at least some of their employee health coverage, thereby unilaterally deregulating a large part of the market.

Sponsors of employee health plans moved away from fully insured products for a variety of reasons. Besides eliminating insurance fees and improving cash flow, they could segregate their plans from state-regulated risk pools and various state-imposed subsidies that might be built into insurance rates. They also could escape state regulations, such as capital and reserve requirements, benefit mandates, and contributions to guarantee associations. By the end of the 1980s, most large employers offered self-insured plans to at least some of their employees. The smaller a plan's size, the greater the risk posed by self-insurance. Because of the added risk that self-insuring may entail, most small employers have remained in the state-regulated insurance market. Yet many small employers do self-insure and, as noted below, data show that many that self-insure do not back up their plans with stop-loss insurance.

Insurance regulators in many states have noted that they often receive complaints from consumers in self-insured health plans whom they are powerless to assist because of ERISA preemption of state law.³⁵ Sometimes, the most poignant cases are those in which a small firm has self-insured benefits that it cannot deliver if one large claim occurs. (Large firms are more likely to have employee benefit departments that may resolve complaints at an early stage as well as the financial wherewithal to cover the cost of large claims.) While regulators in both of

California's regulatory agencies said they receive complaints from consumers in self-insured plans that they refer to DOL, neither state agency reported a particular pattern of problems caused by the use of self-insured products, either among large or small groups. (In fact, as discussed in Chapter 7, complaint data analyzed by the authors from the Health Rights Hotline, which is operated by a nonprofit organization, suggest that people in the Sacramento area enrolled in self-insured and insured health plans raise similar types of problems.) Staff in charge of the DMHC's consumer hotline said that less than one percent of the 15,000 calls received each month involved potential referral to DOL. In a written statement, however, the CDI did report that it receives "numerous complaints about losing coverage, payment issues, and various other issues involving self-insured plans."

Self-insurance is heavily used by large employers in California. According to the president of the Pacific Business Group on Health (PBGH), which represents 40 of the state's largest employers and other large purchasers, "self-funding" allows large employers many advantages including greater flexibility in benefit design and avoiding payment of the mark-up for an insured product. Despite the possibility that the passage of federal patients' rights legislation might level the playing field somewhat between insured and self-insured products, he noted that the surge in premium costs in recent years is prompting more employers to consider self-insuring. This is, in part, because many employers perceive that they might have more control over the cost and quality of provider networks with which they contract. The typical member of the PBGH offers employees a self-insured PPO arrangement along with Kaiser Permanente and a couple of other HMOs on an insured basis. Some PBGH members have contracted with HMOs on a self-insured basis. Many employers want more flexibility in benefit design with HMOs and other plans under the supervision of the DMHC.

Concerns about rekindled health care inflation; employee complaints about managed care; and increased regulatory and legal costs have led many large employers across the country to consider experimenting with a health benefit design that would shift significantly more financial risk and decision-making to employees. These new products are often referred to as "defined contribution" or "consumer-driven" approaches.³⁶ PBGH, for example, recently announced that in 2002 it would begin offering members a plan option that it describes as putting consumers in more direct control of their care and moving away from the managed care model.³⁷ Companies that opt for its new "Breakthrough Plan" would set up personal care accounts for workers and their families with no referral or pre-authorization requirements or other administrative hurdles. Once an employee hit a chosen account limit and also met a chosen deductible amount, coverage then could be provided through a PPO or other plan arrangement. Typically, with these types of plan designs, there is a significant gap between the amount of money put in the employee's personal account and where the plan deductible is set. Employees would have to cover medical expenses falling in this gap. Consumer advocates have expressed concerns that "defined contribution" benefit designs such as these would expose many consumers to increased financial risk, especially people with medical conditions and lower incomes.

It is hard to gauge exactly the prevalence of self-insurance among California's smaller employers. Many parties interviewed, including government officials and several insurance and managed care industry executives, said that brokers arrange for and insurance carriers offer administrative services to companies with 50 or more lives seeking to buy self-insured coverage. From many accounts, however, self-insurance is not viable for groups with 50 or fewer lives,

due to both the extremely high risk that it poses and the success of California's small-group-market reform law, which took effect in 1993. Both federal and state laws require insurers to guarantee issue products to groups with 50 or fewer lives. California also forbids rates for groups of this size to vary by more than 20 percentage points based on a group's health status (not more than 10 percent above or below the standard rate).³⁸ Though often under attack from elements of the insurance industry, this fairly tight rating band has served to help keep sicker small groups from being priced out of the small-group insurance market. This segment of the market also is reported to be relatively competitive and is dominated by managed health care products. Before the small-group reforms were passed, many small firms had trouble gaining access to insurance.

Although many experts interviewed said that they knew of few, if any, firms with fewer than 50 employees that self-insure their health plans, two sources of information suggest the contrary. First, the 2001 Kaiser/HRET survey of California employers reports that about 11 percent with 3–49 workers said they had self-insured health plans.³⁹ (It is possible that some of these firms might purchase coverage through larger groups such as association plans or multiple employer welfare arrangements, discussed later, or that some employers interviewed do not understand the meaning of self-insurance.) Second, the The Health Rights Hotline, an independent consumer assistance program that serves four counties surrounding Sacramento, reported receiving several inquiries and complaints from participants in self-insured plans of firms with 20–49 workers during the 12 months beginning July 1, 2000.⁴⁰

When insured products are not available at affordable rates, the pressure to self-insure increases. Groups with more than 50 lives do not fall under the small-group reforms and may be denied coverage or offered a higher range of prices based on medical underwriting. One executive of a purchasing cooperative in the state reported increased pressure in the segment of the small group market just above groups of 50. For example, he recently was contacted by an employer with about 100 workers whose coverage had been lost when an insurance carrier had gone out of business and who subsequently could not get a rate quote from another insurer. One insurance industry representative asserted that if the state adds benefit mandates and increases regulatory burdens, it will put more pressure on employers to self-insure their health benefits. A recent Los Angeles Times article reported that more small firms nationwide were considering switching to self-insurance, including HMO coverage.⁴¹

A financial examiner for the DMHC noted that some of the health care service plans licensed by the agency, especially the larger ones, have affiliates or components that contract with self-insured employer plans. There are many variations in how this might be done. Sometimes risk is split; for example, the licensed health care service plan might be at risk for providing professional medical services while the employer plan might retain the risk for hospital inpatient care. (In such an instance, the licensed health care service plan might also administer the inpatient care and process claims on behalf of the employer plan.) In some arrangements, an affiliated insurance company may act as a third-party administrator for an employee plan and rent the use of a medical network from an HMO. The DMHC official reported that renting medical provider networks seems to be most prevalent in contracts specifically geared to provide mental health benefits. Some of these arrangements are under review by the DMHC to determine which entity is actually bearing insurance risk and whether entities involved are operating as unlicensed health care service plans. Because an organization providing services to a self-insured employer plan may carry the same label as a state-regulated entity carrying insurance risk, it can

be very difficult for consumers to determine which government agency they should call if a problem arises with their medical benefits.

Regulation of Self-insured Plans in California

In California, as in other states, consumers in self-insured private-sector employee plans must contact the U.S. Department of Labor (DOL), which enforces ERISA, for assistance when problems arise. State regulators typically have no authority to help them. Regulation of health care under ERISA health benefit plans is generally far less intense (and imposes fewer regulatory costs) than state regulation of indemnity insurers and managed health care companies.

Consumers in fully insured ERISA plans can, of course, call the DOL if they experience an ERISA issue with their employee health benefits. More typically, the issues that arise in insured plans involve the organization under contract to provide their health coverage. In those cases, consumers would contact the state agency regulating that organization.

Sometimes people charged with administering an ERISA health plan are not sure whether the plan is self-insured. As noted earlier, one area of confusion for consumers and regulators is the role of “stop-loss” insurance, which some ERISA plans purchase to protect the plan from very high cost cases. Some of these ERISA health plans call themselves self-insured while, in the view of state insurance regulators, they are using stop-loss insurance as a way to avoid state insurance regulation of plan benefits and taxes. Unlike plans that purchase stop-loss to cover costs above a high threshold, such as \$10,000 or more per individual case or \$100,000 for the entire group, some ERISA health plans claim to be self-insured with stop-loss that covers health care costs over only a few hundred dollars. Some states have attempted to consider such plans to be insured and subject to regulation, but two courts have held that ERISA preempts this type of state regulation.⁴² Many similar state laws, however, including some that define low-threshold stop-loss insurance policies as health insurance policies or outlaw stop-loss policies with low thresholds, have not been challenged. California does not attempt to regulate or limit the use of stop-loss insurance by self-insured health plans.

Health Insurance and HMO Industry Composition in California

Perhaps more than in any other state, the health insurance market in California is dominated by managed care. Almost two-thirds of the state residents receive health benefits from health care service plans regulated by the DMHC. While one analyst has observed that the state’s HMO industry stopped growing in 2000 and a recently-released survey notes a drop in HMO membership,⁴³ the state association representing managed health care plans recently reported that managed care enrollment has continued to grow in recent years but at a slower pace. According to the California Association of Health Plans, managed care plan enrollment increased by almost 3 percent, from 21.5 million to 22.1 million, between September 1999 and June 2001.⁴⁴ During the same period, the association also reported a five-percentage point shift from enrollment in PPOs to enrollment in HMOs. This would indicate a shift toward a more intense form of managed care, a movement contrary to nationally reported trends in recent years. Among the managed care enrollees, 78 percent were in HMOs in 2001, up from 73 percent in 1999; sixteen percent were in PPOs in 2001, down from 21 percent in 1999. (The remaining 5.5 percent were in point of service plans in both years.) However, survey results released February 19, 2002 by the Kaiser Family Foundation and the Health Research and Educational Trust found that the first

time in at least eight years, the percentage of Californians enrolled in HMOs had decreased, dropping below 50 percent in 2001.⁴⁵

In 2001, five health plans accounted for 77 percent of the managed care market in the state: Kaiser Permanente (with 27 percent); Blue Cross (19 percent); Health Net (12 percent); PacifiCare (10 percent); and Blue Shield (9 percent). According to the industry report, about three-quarters of the state's managed care enrollees are in plans sponsored by their employers. About 12 million are in groups of 50 or more employees and another 2.7 million in groups with fewer than 50 workers. About two million people subscribe to managed health care plans on an individual basis.

It is harder to estimate the number of Californians enrolled in PPOs under the jurisdiction of the CDI because neither the CDI nor the state's life and health insurance industry has had a way to tabulate enrollment. The CDI is currently conducting a survey of enrollment in health carriers under its jurisdiction. (As noted above, an industry representative estimated that roughly 1.5 million to 2 million Californians were enrolled in plans licensed by the CDI.)

Financial Difficulties

After the failure of several HMOs and many more capitated medical groups, the solvency of California's managed care industry, as well as the state's efforts to respond to its financial woes and provide stability for consumers, are among the most salient and difficult issues facing state health policymakers.

In the early 1990s, many California HMOs transferred risk to provider organizations (medical groups) through capitation arrangements, often in response to market pressure applied by employers and other purchasers demanding better value. Under these arrangements, the HMO retained responsibility for marketing and was licensed by the state, while functions such as medical management and claims processing typically were delegated to the provider organizations along with the financial risk.⁴⁶ These delegated arrangements have reportedly become somewhat less prevalent after several medical groups found they lost money and went bankrupt, but the delegated model is still widely used.

Broadly speaking, HMOs were shifting risk below the radar screen of state regulators. Independent medical groups bearing insurance risk are not required to obtain a license from either the DMHC or CDI in order to operate and received little regulatory scrutiny for many years. In part because medical groups were not regulated by either agency, many took on too much risk and became insolvent. After two large publicly traded physician group companies, FPA Medical Management and MedPartners Providers Network, filed for bankruptcy, public pressure led to the passage of legislation in 1999 designed to increase the state's ability to maintain the solvency of medical groups, primarily through monitoring their financial status. The California Legislature created the Financial Solvency Standards Board within the DMHC to begin regulating risk-bearing medical groups indirectly by requiring managed care plans to meet certain standards in their contracts with the medical groups. As discussed below in Chapter 4, which addresses solvency standards, the effectiveness of the state's new regulatory approach—as well as the viability of the delegated model of managed care remain open questions.

Although more than 360 organized physician groups are reported to operate in California, the largest ten of these together with Kaiser Permanente's medical groups provide care for almost 80 percent of the state's managed care enrollees.⁴⁷ While Kaiser Permanente's medical delivery system is largely self-contained, most of California's HMOs contract with several medical groups. The larger HMOs typically have contracts with more than 200 medical groups. Often a medical group may contract with many or most of the HMOs serving an area.

The California Association of Health Plans 2001 annual report notes that over the past few years "there has been a disturbing growth in tensions between plans and their provider partners."⁴⁸ One regulator interviewed described a sense of immense distrust pervading relations between HMOs and medical groups, referring to the current business environment as "poisonous." These observations reflect the increased amount of financial pressure that has been brought to bear on the managed care industry in California.

IV. Solvency Standards

The degree to which people with private-sector employee health benefits are protected from the financial insolvency of the health insurance and managed care organizations serving them varies widely. This variation hinges in large part on the financial stability of the firms sponsoring the coverage but also depends on whether employee health coverage is provided through contracts under state financial supervision.

Employers provide workers and their dependents with health care benefits on a voluntary basis, either unilaterally or as a result of collective bargaining. By promising to provide employees with health coverage as part of their compensation, employers take on a number of financial and other risks. A principal risk is uncertainty about how much employee health care may cost over a given time period. The smaller the employee group, the greater this risk becomes. For well-capitalized firms with large numbers of employees, the risk of plan insolvency due to fluctuations in medical claims is usually relatively small. The risk is greater, however, for smaller firms and for companies in fragile financial condition. Catastrophic medical costs could easily put a small firm out of business if it attempted to honor its promise to provide medical coverage without pooling risk with other firms through an insurance contract.

Under federal law, employers sponsoring health plans are free to terminate them at any time. This feature of federal law may give employers a safety valve to protect their businesses should the cost of health coverage exceed a firm's capacity to finance it. But the voluntary nature of the employment-based health system also may leave employees without a source of medical care and facing huge medical bills if an employer terminates coverage due to financial stress.

Insuring Risk

In order to reduce the uncertainty of future medical costs, most medium-size and smaller employers contract with commercial insurers, Blue Cross and Blue Shield companies, or managed health care organizations and pass all or most of the financial risk on to them. Likewise, many employers that are self-insured (that is, that do not buy group health insurance per se) back up their plans by buying stop-loss policies. These stop-loss policies typically protect the employer-sponsored health plan or the employer, itself, from financial losses due to

catastrophic health claims rather than providing health insurance to the individuals covered under the health benefits plan. However, data show that some smaller firms do self-insure, and many of these self-insured employers do not buy stop-loss policies, potentially leaving their employees vulnerable to losing their coverage should a catastrophic illness strike one or a few of them.

According to 1997 survey data, 63 percent of self-insured California business establishments that were part of firms with fewer than 500 workers reported that they did not buy stop-loss insurance. Among self-insured California business establishments that were part of firms with 500 or more workers, 41 percent of those surveyed did not buy stop-loss coverage.⁴⁹

Just as many self-insured employee health plans buy stop-loss policies, many insurers and HMOs cede part of the risk they assume from employee health plans to reinsurers. A failure of any link in this chain of entities that have assumed risk for financing health care—employers, health insurers, stop-loss insurers, or reinsurers—can have negative consequences for covered employees. Mismanagement, bad luck, or fraud may leave employees without coverage and facing steep medical bills. If benefits are lost, even healthy workers may have trouble finding an alternative source of coverage. If an alternative source is available, having to change plans may mean switching physicians or disrupting a course of treatment.

Federal Law

Unlike its treatment of defined-benefit pension plans, ERISA does not contain specific solvency standards for employee health plans.⁵⁰ Therefore, the DOL is not authorized to directly regulate employee health benefit plan solvency even if it desired to do so. On occasions, the DOL can and does take legal action to enforce the broad duty of fiduciary responsibility that ERISA imposes on plan administrators and other parties with discretionary authority over plan assets. DOL might intervene, for example, if a fiduciary or other party diverted funds for purposes other than for providing benefits under a health plan.

States, including California, traditionally have served as watchdogs on behalf of consumers in regulating the financial solvency of insurers, Blue Cross and Blue Shield companies, and HMOs. While states can apply solvency standards to licensed insurers and managed care plans, ERISA prevents them from directly regulating employee health benefit plans (that is, private-sector health plans).

California Solvency Standards

The two state agencies that regulate health insurers and managed care organizations, respectively, take distinctly different approaches toward ensuring the solvency of these entities. And not all organizations bearing medical insurance risk come under their direct control. The recent solvency problems of the state's managed care industry have landed on the DMHC's plate.

Solvency regulation involves two general functions: monitoring and corrective action. Regulators routinely monitor companies' financial conditions. When a carrier fails, or seems to be heading into financial trouble, regulators may intervene to try to find a way to restore it to financial health. Finally, should the company go under, systems are put in place to minimize harm to consumers.⁵¹

DMHC Approach

DMHC takes a number of steps to protect consumers and health care providers from disruptions caused by insolvencies. The agency conducts examinations of health care service plans, reviewing items such as cash flow, premium receivables, intercompany transactions, and medical liabilities. Regulators consider whether regulated firms in compliance with minimum capital standards and claims paid requirements. They also check to see whether managed care companies have appropriate insurance⁵² and procedures to monitor the financial viability of capitated medical groups that contract to assume insurance risk from managed care organizations.

Under California law, the DMHC takes a more traditional approach to ensuring that regulated entities have sufficient levels of capital than the CDI, which uses a risk-based capital system, described below. The DMHC is authorized to enforce solvency rules requiring “minimum capital or net worth,” and its regulations require that each plan at all times shall maintain “tangible net equity”⁵³ at least equal to minimum limits set in the law.⁵⁴ PPOs and point-of-service (POS) plans licensed by the DMHC are subject to higher tangible net equity standards due to the increased risk of offering out-of-network services.⁵⁵

If a managed care plan becomes insolvent, the DMHC allocates its enrollees to other managed care carriers serving their service areas. DMHC staff report that this is sometimes difficult to do with larger groups. Health care providers are not protected from the risk of losing payment from an insolvent managed care plan with which they contract.

To ensure the solvency of 109 licensed health care service plans (about 48 of which are full-service plans), the department has 28 positions for financial examiners. The functions of the DMHC financial examiner staff include performing periodic and non-routine financial audits and on-going reviews of financial reports filed by health plans and their affiliates on an annual, quarterly, and (for some plans) monthly basis. The agency can take enforcement actions such as assessing penalties and issuing cease and desist orders (telling a plan to stop enrolling members, for example). If a licensed plan is heading for insolvency, the law allows the department to appoint a monitor or conservator of a plan. Sometimes a troubled plan can be restructured.

In the last five years, about eight managed care plans have been placed in conservatorship; these insolvencies occurred after a period of almost ten years during which plan failures were rare, according to DMHC staff. Three plans are now in conservatorship. In September, regulators took control of Tower Health, following similar actions taken earlier in the year with two other HMOs, Watts Health Plans and Maxicare Health Plans.⁵⁶ Given the recent HMO failures, agency financial staff interviewed said that there is an argument that the capital standards for health service plans are not stringent enough. There is ongoing discussion of recommending somewhat higher capital requirements.⁵⁷

A few years ago, the California Department of Corporations (DMHC’s predecessor) began issuing “limited licenses” to medical groups and other provider organizations that sought to assume the financial risk for providing access to medical services beyond what they were able to provide within their own networks. The department of corporations stopped issuing these limited

licenses after many of the arrangements proved to be financially unstable. Of the dozen limited licenses issued, several are now inactive or are held by firms going through liquidation.⁵⁸

As noted in Chapter 3, most HMOs in California pass insurance risk downward to medical groups, which are not required to be licensed under state law. A representative of the state managed health care industry estimated that over the past five years about 10 percent of the state's medical groups have become insolvent each year. The state senator who sponsored the legislation imposing new financial standards on medical groups reported that more than 100 medical groups have gone bankrupt over the past two years.⁵⁹ Whatever the actual number may be, many factors appear to have contributed to the financial distress of so many medical groups including general cost pressures in the system, mismanagement, and lack of understanding the principle of insurance risk and the need to establish reserves.

The failure of so many unlicensed medical groups has reportedly caused enormous financial losses to their owners and to managed care companies contracting with them and much disruption in the state. When a medical group under contract with a regulated managed care plan goes under, the managed care plan remains responsible for providing health care services promised to enrollees in its contracts.

The consequences of medical group insolvencies for consumers can range from minor inconvenience to major disruption, depending on the patient's health status and the contractual relationships involving physicians, medical groups, and HMOs. For example, if a person's doctor contracts with many independent practice associations (IPAs) and one goes under, the doctor may be able to switch its patients to another IPA under contract with the same insurer, and with little impact on patients' provider and HMO relationships. (Sometimes, HMOs contract separately with individual physicians as well as with IPAs representing the physicians as a backup, in case a medical group becomes insolvent.) More serious problems may arise for patients when a large medical group suddenly closes and they have to shift to new providers or HMOs. Courses of treatment may be delayed or disrupted. Sometimes medical records are hard to locate and transfer. The insolvency of FPA and MedPartners alone reportedly disrupted care systems for more than one million state residents and the recent closure of KPC in Southern California affected about 240,000 enrollees.⁶⁰

Under the new law aimed at improving the financial condition of medical groups, the DMHC still does not license the medical groups and to a large degree must exercise its authority over them indirectly—through the HMOs with which they contract. And a recent setback in court, discussed below, may have seriously hamstrung the department's ability to implement the new law.

Under the statute, the DMHC must develop a process to review and grade risk-bearing medical groups based on four standards, under which the medical groups must:

- maintain positive working capital;
- maintain positive tangible net equity;

- pay claims within mandated time periods; and
- calculate liability in a way that accounts for incurred but not reported claims.

Data collected by the DMHC show that, for the first quarter of 2001, 48 percent of the roughly 250 “risk-bearing organizations” falling under the new standards met all four of them. Twenty percent of the medical groups met three of the standards, 22 percent met two, 10 percent met one, and one percent failed to meet any of the standards.⁶¹

DMHC has issued regulations describing data that medical groups are supposed to submit on a standard electronic form. DMHC staff report that there have been substantial differences in the quality of the information reported, presumably reflecting the financial sophistication of particular medical groups and usually reflecting the size of the organization.

About half of the medical groups sampled in a recent study commissioned by the California HealthCare Foundation failed to meet three of the four new standards as of December 31, 2000.⁶² The study’s authors concluded that the standards are not comprehensive enough to accurately assess the financial health of risk-bearing medical groups. The study suggested that the standards could be improved by adding what it asserts would be a better measure of short-term liquidity — the cash ratio — to the working capital standard while dropping the current tangible net equity standard. The authors noted that a better measure of short-term liquidity is needed because a medical group can be on the verge of bankruptcy while still meeting the current capital standards, much as FPA did four months before it filed for bankruptcy in 1998.

DMHC’s power to collect and disclose data from medical groups and to enforce the new statute has been a source of contention. After being challenged in a lawsuit by the California Medical Association (CMA), the department’s regulations concerning data collection and data confidentiality were ruled to be invalid on February 28, 2002, in a decision of the Sacramento County Superior Court. The court found that, contrary to language in the statute, the new regulations might inappropriately require risk-bearing medical groups to provide information in a way that adversely affected the integrity of their contract negotiations with health care service plans. This ruling is a serious setback to department efforts to implement the new law. According to DMHC staff, without adequate data collection, the department is not in a position to review or grade risk-bearing medical groups. Nor is it in a position to establish a procedure under which to take corrective action with regard to financially deficient medical groups. DMHC staff interviewed as this paper was being edited said the department had not yet decided how to respond to the court ruling. Options included appealing the ruling or going back to the legislature to ask for clearer wording in support of its ability to gather and disclose data.

When interviewed in November 2001, DMHC staff said they wanted to make public as much financial information about the medical groups as possible. In its lawsuit, the CMA sought to prohibit the agency from publicly disclosing the underlying financial data submitted by the medical groups. Before the court ruling, the department had been publishing summary information based on the reported data, reflecting each organization’s compliance. It had been directed to maintain the confidentiality of the underlying financial submissions pending the outcome of the legal challenge. The February 28, 2002, court ruling ordered DMHC to stop collecting data altogether.

The DMHC also has been developing regulations to develop “corrective action plans” for medical groups. These regulations have been placed on hold pending resolution of the data collection issue. Under the new statute, when financial problems are detected, corrective action must be mutually agreed upon by the HMO and the medical group. If these parties cannot come to agreement, the law requires the director of the DMHC to determine what the HMO must do. DMHC staff expressed concern that the law’s corrective action process may place it in a position of arbitrating economic disputes between medical groups and HMOs, thereby potentially changing the nature of the economic transactions. Medical groups are already pressuring the agency to respond to their financial problems by forcing HMOs to raise payment rates. With so many medical groups in financial straits, the agency is concerned that the new law may inadvertently convert it into a rate-setting body.⁶³

CDI’s Approach

Although it oversees health coverage provided to far fewer Californians than its counterpart, many observers note that one of the CDI’s relative strengths is its program to monitor the financial solvency of health insurers. The CDI evaluates and monitors the financial condition of insurance companies to identify problem companies and takes corrective actions to assure policyholders are protected. The agency conducts comprehensive examinations of the state’s domiciled insurers, including health carriers, and exchanges information with regulators in other states. (CDI is a far larger agency than DMHC and regulates a wide variety of insurance products, most of them not involving health coverage.) If a health insurer licensed by the CDI becomes insolvent, the California Life and Health Insurance Guarantee Association, which is funded by assessments on regulated carriers, can help to pay claims.

CDI staff reported that in recent years they have not experienced widespread solvency problems with health insurers under their jurisdiction. Most health insurers licensed by the CDI contract with provider organizations, but they do not transfer insurance risk to them. CDI regulators said that, to a large degree, the organizations under their jurisdiction provide insurance services and not medical services, so there is little or no need to regulate the adequacy of the medical care, as the DMHC does. CDI, however, is authorized, as part of the policy approval process, to seek to ensure that PPO and exclusive-provider network type products offer adequate access to providers.⁶⁴

In 2000 and 2001, the insolvencies that CDI dealt with mostly occurred among workers’ compensation insurers. Generally speaking, health and life insurers under their jurisdiction were financially sound. There was one exception: a self-insured multiple-employer organization (MEWA) whose financial problems are described below. Many commercial insurers that write health policies are diversified and also write life insurance policies and other lines of business.

Insurers under CDI jurisdiction are required to establish reserves to make sure they can cover future losses from insurance policies they write as well as to cover claims liabilities. They are also required to submit regular statements reflecting their financial status and to maintain specified capital and surplus levels. To meet the capital and surplus requirements, insurers licensed by the CDI must maintain the greater of either a risk-based capital standard or a minimum capital and surplus requirement. In most instances, the risk-based capital standard is higher than the minimum capital standard.

In its ongoing surveillance activities, the CDI currently is monitoring some life and health companies presenting financial concerns. For such companies whose core business is health insurance, staff report that the major concerns have to do with profitability and volume of business. For example, some companies that are aggressively writing large amounts of new business are generating higher amounts of incurred underwriting expenses, which could negatively affect their profitability and reduce their capital and surplus. Other firms report adverse claims experience due to drawing sicker-than-average populations.

For carriers that present solvency problems, the CDI can take various actions including asking or ordering an insurer to reduce writing new business, reduce operating costs, seek financial support, or consider the use of reinsurance. As a last resort, CDI will consider taking regulatory control of an insolvent insurer's operations.

When interviewed in November 2001, CDI staff reported that they recently found a self-insured, multiple-employer welfare arrangement (MEWA) covering about 23,000 people in the agricultural industry to be insolvent. The Sunkist Growers and Packers Benefit Plan Trust could not pay providers for services already rendered, and some providers were refusing to provide further services unless it complied with a payment plan they had developed. The providers even had threatened to charge the people covered by the plan directly for services already performed. The CDI reported that it was negotiating with the MEWA's sponsor organization with the goal of getting the sponsor to contribute funds to provide a settlement to the providers. Meanwhile, the CDI also had been negotiating with another MEWA (serving the same industry) that had agreed to absorb the coverage of people previously covered by the insolvent MEWA.

MEWA is an ERISA term referring to arrangements comprising two or more private-sector employee health plans.⁶⁵ MEWAs can take many forms and can be offered by associations, employer coalitions, insurers, or community organizations. While many MEWAs have helped small groups increase their purchasing power and reduce administrative costs, MEWAs tend to be inherently less financially stable than single-employer plans, especially if they are self-insured.⁶⁶ After an outbreak of MEWA insolvencies, Congress amended ERISA in 1983 to allow states to regulate MEWAs. Under these amendments, the full extent of state insurance law can be applied to MEWAs that do not meet ERISA's definition of an employee welfare benefit plan. For fully insured MEWAs that do meet ERISA's definition of employee benefit plan, states may apply insurance laws pertaining to reserve and contribution levels. For self-insured MEWAs, states may apply insurance laws that are not inconsistent with ERISA.

California is among the minority of states with explicit MEWA licensing laws. California's MEWA statute grandfathered in a small number of existing MEWAs but does not allow any new MEWA licenses to be issued. CDI staff report that they prosecute unlicensed MEWAs as unlicensed insurers. The six remaining MEWAs licensed to do business in California covered about 228,000 people as of September 2001. A CDI report issued in December 2001 concluded that many of these MEWAs offer valuable coverage to particular groups of people, such a migrant farm workers, that otherwise might not be able to obtain coverage.⁶⁷ But because of their small size and potential for volatile claims experience, the report recommended that regulatory oversight and standards for MEWAs, such as minimum surplus levels and reserving and reporting requirements, should be strengthened where they are less stringent than for regular insurance companies. The CDI report also said consideration should be given to having MEWAs

participate in some kind of state guarantee association to protect insureds in the event of an insolvency. In contrast to insurers under CDI supervision, MEWAs are not covered by a guarantee association.

California's solvency standards are less stringent for MEWAs than for licensed health insurers. According to CDI staff, the minimum surplus requirement for a MEWA is \$1 million, and there is no minimum capital requirement. For a life and disability insurer, the minimum capital requirement is \$2.5 million and the minimum surplus requirement is \$2.5 million, for a total of \$5 million. In addition, a life and disability insurer is required to comply with risk-based capital requirements (discussed below) while a MEWA is not. Self-insured MEWAs are required to buy stop-loss insurance in California.

Risk-Based Capital Standards

Over the past few years, insurance departments in nearly all states including California have begun using risk-based capital models to determine the financial health of carriers in part to determine when intervention is appropriate and justifiable. As noted above, the CDI now employs risk-based capital standards while the DMHC does not.

Risk-based capital standards provide an elastic means of setting capital standards for insurers to support their overall business operations based on a complex formula that takes into account each company's assets, premium, reserves, and management practices, among other factors. The risk-based capital formula used by the CDI considers various types of risk undertaken by an insurance carrier including underwriting risk, business risk, interest rate risk, and risks associated with various assets and debt that the insurer holds.

Risk-based capital requirements generally replaced traditional, more static minimum capital and surplus standards. In 1995, when risk-based capital standards for health insurers were still being developed, minimum capital and surplus requirements were typically about \$2 million for a multi-line insurer, which were more appropriate for start-up companies than for larger, more established insurers undertaking larger amounts of risk.⁶⁸ At that time, minimum capital and surplus standards for HMOs typically ranged up to about \$1.5 million, depending on the state. Risk-based capital standards include an adjustment to reflect the belief that managed care arrangements decrease the fluctuation in medical costs, and, therefore, the insurance risk borne by the carrier.

Because risk-based capital standards are designed to analyze each insurer's financial profile, they give regulators an added tool with which to take action against troubled carriers before their capital dips below minimum allowable levels. Since regulators often must go to court and have solid evidence to back up remedial actions, failing insurers whose capital exceeds minimum levels can resist early regulatory intervention without such evidence.

Under its risk-based capital system, the CDI gives insurers a rating based on their solvency. As the rating declines, regulators may take actions such as asking the insurer to present a plan for corrective action, issuing a corrective order, or taking control of the carrier. Staff at the CDI said that the risk-based capital standards have been useful on several occasions in initiating early interventions.

A report recently submitted to the DMHC comparing the two state agencies' functions noted that, although it was difficult to compare their approaches toward solvency regulation, the risk-based capital method is more finely tuned than the minimum net equity standard to detecting differences between insurers' financial positions.⁶⁹ The report also noted that some estimates suggest that the risk-based capital standards impose up to two times the capital requirements as the tangible net equity approach. Insurance industry representatives were quoted in another recent report as estimating that reserves required under the risk-based capital approach are 50 percent to 100 percent higher than reserves required of DMHC licensees.⁷⁰

Interplay between Federal and State Law

Generally speaking, consumers in self-insured, private-sector health plans have fewer protections if an organization providing their health care becomes insolvent than those in fully insured plans. ERISA contains no specific financial standards for employee health plans other than imposing a duty on fiduciaries to handle plan assets prudently. California, like all states, regulates the solvency of insurance carriers and managed health care companies competing in the marketplace. Because states cannot regulate employee health plans under ERISA, self-insured plans are subject to neither the consumer protections nor the added regulatory costs posed by state solvency regulation. Under federal law, if financial burdens become too great, ERISA health plan sponsors may terminate health coverage at any time. The voluntary nature of employment-based health coverage—the predominant form of coverage for nonelderly Americans—may leave employees and dependents facing large medical bills or a disruption in care should a plan sponsor terminate or reduce coverage due to financial distress.

California's managed care industry, which provides health care to most covered state residents, is currently undergoing a great deal of financial turmoil brought on in part because much insurance risk was transferred to medical groups that were outside the jurisdiction of state regulators. The failure of many HMOs and many more capitated medical groups has led the state to attempt to increase regulatory control over the medical groups and to consider increasing solvency standards for HMOs. As the state regulators and the managed care industry continue to respond to these issues, the viability of "delegating" insurance risk to unlicensed medical groups is in question.

V. Benefits and Managed Care Standards

In California, fully insured plans are subject to a number of state mandates that prescribe the benefits that insurers and health care service plans must offer, how providers must be paid, and the categories of people who must be covered. In contrast, ERISA imposes very few mandates on self-insured health plans and little is known about the benefits actually covered in them, nationally or in California. This chapter describes benefits requirements and managed care standards under ERISA and California law.

Benefits

Although the federal government is constitutionally authorized to regulate insurers operating across state lines,⁷¹ Congress explicitly delegated authority to regulate insurance to the states in the McCarran-Ferguson Act of 1945. This statute recognizes that insurance regulation traditionally had been the province of state law. Even before ERISA was enacted, many states had mandated coverage of benefits, providers, and categories of people. Benefits mandates require insurers to cover such services as mental health treatment or home health care. Provider mandates include such requirements as covering care provided by chiropractors or nurse anesthetists. Mandatory population coverage includes such groups as newborn and dependent adult children. Courts generally have held that such mandates are saved from ERISA preemption because they regulate the business of insurance.⁷²

Federal Law

ERISA. Until recently, ERISA did not require employer-sponsored health plans to cover any specific services or illnesses. In 1996 Congress added two standards. First, for benefits offered through December 31, 2002, health plans in firms of 50 or more that cover both medical/surgical benefits and mental health benefits must apply no greater aggregate lifetime and annual dollar limits to mental health as to medical/surgical coverage.⁷³ Second, plans covering maternity benefits must cover at least 48 hours of hospital care for a vaginal delivery (96 hours for a caesarean birth) for the mother and newborn.⁷⁴ In 1998 Congress further amended ERISA to require plans that cover mastectomy to offer reconstructive surgery for mastectomy patients.⁷⁵ All three mandates apply directly to private-sector employer health plans and to HMOS and other health insurers offering group coverage. The maternity hospitalization and reconstructive

surgery requirements also apply to policies offered in the individual insurance market. In recent years, the DOL has been both auditing employee plans to monitor compliance with these benefits mandates and providing information to plan administrators and the general public about consumer rights under these laws.⁷⁶

Other federal law. ERISA is not the only federal law affecting private-sector employee health coverage benefits. The federal Civil Rights Law mandates that firms with 15 or more workers treat pregnancy like other conditions and cannot discriminate on the basis of pregnancy, child birth, or related disorders.⁷⁷ This law was recently interpreted to require an employer to cover prescription contraceptives for its female employees.⁷⁸ The Americans with Disabilities Act (ADA) prohibits discrimination against both employees with disabilities and disabled members of the public.⁷⁹ The ADA, however, does permit insurers to underwrite, classify and administer risks consistent with state law and actuarial principles, as long as they are not used as a “subterfuge” to evade the ADA’s objectives.⁸⁰ Employee health plan differences in coverage of benefits, such as mental health care or services for persons with AIDS, have been challenged under the ADA. But courts generally hold that while the ADA prohibits discrimination between people with and without disabilities, it does not prohibit different coverage of services, even if persons with disabilities are more likely to use those services. Consequently, employee health plans do not conflict with the ADA by establishing different benefit limits on mental health or AIDS treatment as long as those services are equally available to people with and without disabilities.⁸¹ The frequency with which employee health plans set financial limits on services for persons with AIDS in California is not known, but a representative of the insurance industry interviewed for this report expressed the belief that it does occur.

California Law

As shown in Table 5, in contrast to the limited number of federal benefit mandates, California law requires insurers and HMOs to cover or pay for a broad list of benefits, persons, and providers. California is among the six states with the highest number of health insurance mandates.⁸² Almost all of these standards apply equally to health insurers and health care service plans, except where the nature of the coverage differs between indemnity insurance and managed health care.

Table 5. California and Federal Benefits Mandates

Mandate	California Requirements		Federal Requirements
	Insurers	Health Care Service Plans	ERISA Plans
<i>Mandated Benefits</i>			
Inpatient and outpatient care, MD care, preventive services, lab and x-ray, emergency services		x	
Breast cancer screening, reconstitution, and prosthesis	x	x	reconstructive surgery
Cancer screening (other “generally medically accepted” screening)	x	x	
Cervical cancer screening	x	x	
Clinical trial participants (routine care)	x	x	
Contraceptives	x	x	
Diabetic supplies and equipment	x	x	
Emergency medical transportation	x	x	
Hospice care	x	x	
Jawbone condition care	x	x	
Laryngectomy prosthesis	x	x	
Mammography	x	x	
Maternity complications	x	x	
Maternity hospital LOS	x	x	x
Mastectomy hospital LOS, no limit	x	x	
Mental illness (diagnosis and treatment of severe)		x	limited mental health parity
Off-label drugs in life-threatening situations or chronic disabling conditions	x	x	
Osteoporosis care	x	x	
Pain management for terminally ill patients		x	
PKU screening and treatment	x	x	
Prenatal testing	x	x	
Prostate cancer screening	x	x	

(table continues)

Table 5. California and Federal Benefits Mandates

Mandate	California Requirements		Federal Requirements
	Insurers	Health Care Service Plans	ERISA Plans
<i>Mandated Benefits (continued)</i>			
Psychiatric disorders care		x	
Reconstructive surgery to improve function or create normal appearance	x	x	
Sterilization	x		
<i>Mandated Offerings</i>			
Acupuncture offering	x	x	
Alcoholism, substance abuse, nicotine use offering	x	x	
Biologically based mental disorders to be treated like other brain disorders offering	x	x	
Blood lead screening offering	x	x	
Diabetic education offering	x	x	
Footwear for disfigured foot offering	x	x	
Home health agency care offering	x	x	
Infertility care (other than in vitro fertilization) offering	x	x	
Orthotic and prosthetic device offering	x	x	
Prenatal genetic testing offering	x	x	
Psychiatric care offering	x		
<i>Covered Persons</i>			
Adopted children	x	x	under medical child support order
Disabled and dependent children	x	x	
Domestic violence (cannot exclude victims)	x	x	
Genetic information (cannot discriminate based on)	x	x	
Newborns	x	x	
Physically handicapped persons offering	x	x	

(table continues)

Table 5. California and Federal Benefits Mandates

Mandate	California Requirements		Federal Requirements
	Insurers	Health Care Service Plans	ERISA Plans
<i>Providers</i>			
Medical transportation providers	x	x	
Nurse midwives and nurse practitioners	x		
Public institutions	x	x	
Telemedicine (cannot refuse to cover services provided via telemedicine)	x	x	
If services within scope of practice, must include categories: MD, DDS, OD, chiropractors, pharmacists, podiatrists, psychologists, LCSW, RN, OT, ST	x	x	

California’s laws on the three subjects regulated by federal law are somewhat broader than the federal statutes. For example, the maternity length-of-stay law allows a discharge before the 48 or 96 hour minimum only if the mother and physician agree and the plan covers a post-delivery visit to assess the mother and child and provide postpartum education. The state’s breast reconstructive surgery standard for health care service plans mandates treatment of the condition itself (while federal law does not require mastectomy coverage). The state’s mental illness treatment mandate for health care service plans requires parity of coverage for lifetime limits, copayments, and deductibles. Because each of these standards is consistent with ERISA’s specific preemption provisions and does not prevent the application of federal law, ERISA does not prohibit the state from imposing these higher state standards on health insurers and health care service plans contracting with ERISA plans.

Preemption of State Benefit Mandates

State health insurance benefit mandates have been upheld as insurance laws, saved from ERISA preemption. They cannot, however, be applied directly to private-sector health plans.⁸³ In its 1985 *Metropolitan Life* decision,⁸⁴ the U.S. Supreme Court held that a state mental health mandate was saved from ERISA preemption because it applied only to insurers and met other criteria for insurance regulation under the McCarran-Ferguson Act.⁸⁵

In enacting the three federal health plan mandates, Congress directly addressed the impacts of the new federal laws on state law, rather than leaving to the courts the decision of whether federal law preempts state insurance laws (applicable to insurers) on the same subjects.

- In the case of post-mastectomy reconstructive surgery, state laws will prevail if they predate the federal law (enacted October 21, 1998) and require at least as much coverage for reconstructive breast surgery as federal law.
- In the case of mental health parity, state laws prevail as long as they do not “prevent the application of” the federal law.”⁸⁶
- In the case of maternal and newborn hospitalization, state laws prevail if they require: (1) at least 48 hours of hospitalization following a vaginal delivery and 96 hours for a caesarean birth, (2) maternity and pediatric care provided under guidelines of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, or (3) that the maternity hospital length of stay is left to the decision of the mother and her attending provider.

Comparison of State and Federal Benefits Mandate Laws

Self-insured plan benefits. Other than the three federal mandates, self-insured ERISA plans are free to design their health benefits coverage as they see fit. There is little information available on the scope of benefits offered by self-insured plans in California or the United States as a whole. Several national studies revealed that benefits and cost sharing features of insured and self-insured health plans were very similar—in some respects insured plans were more generous, while in other areas self-insured plans were more generous. For example, a study by the Rand Corporation⁸⁷ reported that, self-insured plans were as likely as insured fee-for-service (FFS) and PPO plans to cover a list of benefits categories⁸⁸ in 1993–94, while HMOs were much more likely to cover preventive services (adult and well-baby exams and immunizations). And while comparable percentages of employees in fee-for-service and PPO plans and self-insured plans faced annual deductibles, average deductible amounts were somewhat lower for self-insured plan participants. Annual limits on out-of-pocket costs, however, were higher in self-insured plans. Self-insured plans also were more likely than insured plans to impose a ceiling on coverage and more likely to impose a lower maximum ceiling. The likelihood of facing coinsurance and its level were similar across plan types.

More recently, a 2000 survey of employer-sponsored self-insured health coverage revealed that while most covered routine inpatient and outpatient services only 74 percent covered home health care, 72 percent covered routine physician services, 71 percent covered preventive care such as physical exams, immunizations, and 67 percent covered substance abuse services.⁸⁹

What is not clear from this research is whether self-insured plans are more likely than insured plans to limit certain types of services. Before the 1996 federal mental health parity law, the Rand study showed that self-insured plans were more likely to impose tighter caps on mental health coverage.⁹⁰ Several people interviewed for this study reported that self-insured plans do cap the payment for some costly services, but there is no systematic information about self-insured plan benefits in California.

Authority to reduce benefits. Unlike an individual insurance contract, where benefits are guaranteed for the policy term (typically one year), a private-sector employee health plan can be modified at any time as long as the administrator complies with ERISA requirements of (1) a written plan amendment before the change takes effect and (2) notice to plan participants no

longer than 60 days after a material reduction is adopted.⁹¹ Employee health benefits are neither automatically vested,⁹² like pension benefits, nor (except for collectively bargained agreements) enforceable employer-employee contracts. Insurance regulators in other states have reported examples of self-insured firms changing coverage in mid-year to avoid covering costly services.⁹³ Courts have held that ERISA does not prohibit employers from changing health plans mid-year to limit coverage for AIDS treatment.⁹⁴ Nor would the ADA appear to prohibit such plan changes.⁹⁵

Costs and benefits of health coverage mandates. Research on the cost and impacts of state benefits mandates (and managed care standards, such as “any willing provider” laws) is not entirely consistent. A recent review of this literature, however, found that mandates disproportionately affect small employers (that generally are less able to self-insure) and probably discourage some of them from offering insurance because they raise premiums, though there is no consensus on the magnitude of their impact on premiums.⁹⁶ Other recent analysis suggests that employers are not very responsive to price in deciding to offer or drop coverage.⁹⁷ In any event, despite employer and insurance industry assertions, researchers have concluded that mandated benefits are not related to the likelihood that employers will self-insure their health coverage (rather, the likelihood of self-insurance increased with the rate of state insurance premium taxes and state risk pool assessments on indemnity insurers and managed health care plans). Analysts also have found that self-insured plans have been about as likely as insured FFS and PPO plans to include the same general categories of benefits in their coverage that states require, but did not examine the scope of this coverage or whether self-insured plan sponsors would do so in the absence of state laws setting a standard for acceptable coverage. Policymakers must balance competing concerns in considering adopting benefits mandates. Economists point out, for example, that insurance encourages overconsumption of services of marginal benefit to some consumers. On the other hand, requiring all insurers to cover certain benefits assures access to these services and also may serve to prevent the market from otherwise unraveling in response to adverse selection of sick people into insurance plans that offer such benefits.

Managed Health Care Standards

As health coverage has moved toward a more tightly “managed” model, most states have established standards designed to assure consumer access to necessary care. To constrain health care use and expenditures managed care plans use a variety of strategies such as limiting provider networks, requiring authorization before the use of services, channeling care through a primary care provider rather than self-referral to specialists, and creating financial incentives for providers to render care efficiently. While these cost containment and care management strategies can reduce the use of unnecessary and inappropriate care, state regulators have been concerned that, if employed too aggressively, they might deter access to needed care and impair quality. To protect consumers, states have adopted a variety of managed care standards.⁹⁸

- To protect access to providers, many states require managed care plans to:
 - permit enrollees to seek care from specialists such as obstetrician-gynecologists or treatment for chronic conditions without a primary care referral,

- assure that provider networks are adequate to serve enrollee needs and that plans pay for out-of-network care when a needed provider is not in the network, and/or
- pay a provider leaving the network to continue treating an enrollee in the middle of a course of treatment for a prescribed period of time.
- Most states require plans to establish procedures for covering emergency treatment, such as defining an emergency from the viewpoint of a “prudent layperson” or prohibiting prior authorization for emergency coverage.
- Some states have expanded access to pharmaceuticals by requiring coverage of drugs for “off-label” uses (beyond those permitted in the original FDA approval) or a procedure to obtain drugs not on a plan’s formulary.
- A few states require plans to cover the routine costs of enrollees participating in clinical trials.
- Several states require managed care plans to expand access to providers by various approaches, such as:
 - accepting all qualified providers (“any willing provider” [AWP] laws)
 - allowing enrollees to obtain services from all providers, like pharmacies (“freedom of choice” laws)
 - providing procedures whereby providers can apply to participate in networks and obtain a hearing before being terminated from networks.
- Half the states ban certain provider payment financial incentives that might discourage provision of necessary care.
- Almost all states ban provider contract clauses that might interfere with physician-patient communications.

Federal Law

For several years, Congress has been debating national managed care standards. Both houses passed “Patient Protection Acts” in the summer of 2001 but the differences between these bills have not yet been reconciled in a conference committee. Both bills would establish in federal statute many of the managed care standards that currently exist in California law. These standards would be applied to both insured and self-insured ERISA plans. Under both bills, it appears likely that state insurance laws on these subjects providing greater consumer protections would apply to insurers and HMOs provided they did not directly conflict with or prevent the application of federal law.⁹⁹

California Law

As shown in Table 6, California has adopted many managed care standards that the DMHC applies to HMOs and PPOs licensed under the Health and Safety Code. CDI regulates PPOs and EPOs (“exclusive provider organizations,” which are rarely sold in California) offered by

indemnity insurers. But the Insurance Code imposes few managed care standards to protect against network limitations that might reduce access to needed care. For example, insurers must disclose in policy documents the access limitations imposed by EPOs, and CDI can seek to ensure that PPO and exclusive-provider network type products offer adequate access to providers. But to date, CDI has not monitored or regulated the adequacy of provider networks or the access to services provided. The CDI staff justify this policy on the ground that network adequacy is a marketplace issue that could be resolved by the insured through application of "choice;" that is, under traditional insurance models an insured party could and would change his or her provider or insurer if such inadequacies occurred. CDI staff noted, however, that managed care has changed public expectations of what regulatory agencies should be overseeing (particularly since PPO products can be regulated by either agency), so the department is currently analyzing how it might more closely examine managed care practices.

Table 6. California Managed Care Standards

Standard	California Requirements	
	Insurers	Health Care Service Plans
Plan must provide continuity of care and ready referral to needed providers		x
Services must be readily available and accessible		x
Plan must maintain enrollee:provider ratios to reasonably assure that all services will be accessible as appropriate without delay detrimental to enrollee health (guideline = 1 MD:1200 enrollees)		x
Plan must have process to continuously evaluate quality, use, and costs		x
Providers must hold enrollees harmless if plan insolvent		x
Plans must reimburse for emergency services without prior authorization		x
Ob-gyn must be considered a primary care physician	x	x
Plan must permit direct access to ob-gyn for female enrollees	x	x
Cannot use provider financial incentives to reduce or deny medically necessary care		x
"Reasonable person" standard to cover emergency services		x
Notice to enrollee when provider, IPA, or medical group terminated		x

(table continues)

Table 6. California Managed Care Standards

Standard	California Requirements	
	Insurers	Health Care Service Plans
90 days continued care from terminated provider during a course of treatment		x
Standing referral to specialist for persons with chronic illness		x
Process to facilitate continuity of acute services or chronic mental health care for new enrollees receiving it from a nonparticipating provider	x	x

Preemption of State Law

Some state managed care laws have been challenged on ERISA preemption grounds. And although these laws are directed at risk-bearing organizations like health insurers and HMOs, courts have not uniformly held that they are saved as state insurance regulation. For example, courts are split on whether ERISA preempts “any willing provider” laws.¹⁰⁰ The only court yet to consider a state consumer “freedom of choice” law, however, held that ERISA does not preempt a law prohibiting health plans from requiring enrollees to use mail-order pharmacies.¹⁰¹ Some court decisions holding that ERISA preempts AWP laws preceded the Supreme Court’s *UNUM Life Ins.* case, which relaxed the legal test to determine whether a state law regulates insurance. In the wake of the *UNUM* decision, it seems that most state laws establishing managed health care standards—particularly those directly protecting consumers rather than providers—should be defensible against an ERISA preemption challenge.¹⁰²

VI. Information Disclosure to Plan Participants

Providing information about how a health insurance or managed care plan operates is critically important to its effective use. This chapter describes the types of information that ERISA plans, indemnity insurers, and HMOs are required to provide health plan enrollees under state and federal law. Generally speaking, California requires health insurers and health care service plans to provide consumers with more information than ERISA requires of self-insured plans, especially in providing advance warning that coverage may be terminated. In recent years, however, there has been significant expansion of information that ERISA health plans must provide to participants, bringing more parity to the information disclosure requirements under state and federal law.

Federal Law

The ERISA statute requires employee welfare benefit plans to provide to participants a “Summary Plan Description” (SPD) containing several categories of information about the plan.¹⁰³ People enrolled in health plans (especially HMOs or PPOs using utilization review processes) need additional information to facilitate their use of the plan and resolve coverage disputes. Recognizing the importance of fuller health plan disclosure, in November 2000 DOL amended its regulations (effective January 2001) to prescribe the information plans must disclose to participants. (The patient protection bills passed by both houses of Congress in summer 2001 would incorporate many of these disclosure requirements into federal statute.) Federal regulations¹⁰⁴ now require that the SPD contain information on:

- The type of plan (e.g., a group health plan)
- A description of benefits (which can be general if more detailed information is available on request)
- The sponsor’s authority under the plan to eliminate benefits or terminate the plan

- The role of any insurers (name, address, extent to which benefits are guaranteed by an insurance policy, and nature of administrative services—like claims payment—provided by insurer)
- Procedures for processing claims and resolving claims disputes¹⁰⁵
- COBRA rights and obligations of participants
- Statement of ERISA rights (rights to information about the plan and benefits, COBRA coverage, and credit for pre-existing exclusion periods; the fiduciary standard for plan administration; non-discrimination for exercising rights; right to sue to enforce rights and to seek assistance from the DOL; and standards for maternity and newborn hospital care)
- Coverage of hospitalization for newborns and mothers (including provisions of any state law that apply because they are more stringent than ERISA standards)
- Circumstances that could result in participant ineligibility for or reduction of benefits and authority of plan sponsor to terminate or amend benefits or the entire plan (and participants' rights upon termination)
- Additionally, for group health plans:
 - cost sharing provisions
 - annual and/or lifetime caps on benefits coverage
 - the extent to which preventive services are covered¹⁰⁶
 - circumstances under which existing and new drugs are covered
 - circumstances under which medical tests, devices and procedures are covered
 - provisions regarding network providers, composition of network,¹⁰⁷ and circumstances under which out-of-area services are covered
 - conditions or limits on selection of primary or specialty care providers
 - conditions or limits regarding emergency medical care
 - any requirement the plan may impose for pre-authorization or utilization review of benefits.¹⁰⁸

Among the more important disclosure requirements added by the new rules is information on the role of any health insurer in administering an ERISA health plan. People are often confused about whether their plan is insured or self-insured and the implications of this status for their rights to enforce promises made by the sponsoring employer or insurers administering the plan. Whether or not a state-regulated entity is the source of one's health coverage is particularly confusing when an organization holding a state insurance or HMO license administers the plan and processes claims but does not assume insurance risk. The insurer's name on a card or in the

SPD may mislead the participants into thinking they have insurance. The new disclosure requirements should help plan participants understand the insurer's role. People may still not, appreciate, however, the *implications* of being covered by a self-insured plan (subject to only ERISA standards and DOL enforcement) compared to an insured plan (subject to state—as well as federal—law protections, such as solvency and dispute resolution, and state agency enforcement). In issuing the final rules, DOL rejected a suggestion that the SPD explain the consequences of whether an employee health plan is insured or self-insured.

Another important change for health plan participants (enacted in the 1996 HIPAA) shortens the time for the plan to provide plan participants notice of any “material reduction” in covered services. Plans must provide such notice no more than 60 days after the change was adopted.¹⁰⁹ This new notice period is much shorter than the minimum period (210 days after the end of the plan year during which other changes are adopted) that applies to other plan changes. But it still may not be timely for people ignorant of the fact that their coverage is about to change who seek medical care whose costs will no longer be covered by the plan. Courts have enforced ERISA timeframes even when long notice disadvantaged participants.¹¹⁰

California Law

As outlined in Table 7, both California's Insurance Code and Health and Safety Code require health insurers and health care service plans to provide much of the same information regarding health coverage as is required under federal law. For example, state law requires a summary of benefits and description of any restrictions on provider choice. With respect to health care service plans, the law also requires a description of the dispute resolution process, service authorization and denial procedures, use of a drug formulary, and a roster of contracting providers. In addition, both laws require notice of whether a contract requires arbitration to be used to settle disputes between consumers and plans¹¹¹ and the policy on when a second opinion would be covered. Of particular importance to employees whose coverage may be in jeopardy of termination, both state laws require that insurers and health care service plans (1) notify the group policyholder before canceling a policy (the Insurance Code also requires insurers to provide such a notice when changing premiums or benefits) and (2) require in their contracts with group policyholders that the policyholder notify individual enrollees of these changes. Similarly, when a health care service plan terminates a contract with a medical group or IPA, the Health and Safety Code requires it to notify enrollees (including 30 days' advance notice to enrollees in the course of medical treatment or who selected the provider as a primary care provider).

Table 7. California and Federal Health Insurance/Plan Enrollee Information Disclosure Requirements

Information to be disclosed	California requirements		Federal requirements
	Insurers	Health care service plans	ERISA plans
Summary of benefits, exclusions, cost sharing, premiums	x	x	x
Dispute resolution process	(regarding independent medical review only)	x	x
Roster of contracting providers		x	x
Description of restrictions on provider choice	x	x	x
Notice to group policyholder when canceling policy and obligation of licensee to assure that policyholder mails notice to enrollees, including conversion rights	also when changing group premium or coverage	contract with policyholder must require it to mail notice to enrollees, including conversion rights	notice of material reduction in benefits or service within 60 days of adoption
When health plan terminates group or IPA, notice to enrollees (30-day notice before termination to enrollees in the course of treatment or who selected the provider)		x	
Service authorization and denial process	x	x	x
If drug formulary is used	x	x	coverage of current and new drugs
Physician payment methods	x	x	
Policy on when second medical opinion would be covered	x	x	
Role of insurer			x
COBRA rights	x	x	x
Enrollee to be held harmless if plan fails to pay providers		x	

Preemption of State Disclosure Laws

The courts have made clear that California cannot regulate ERISA plans directly. ERISA therefore preempts a state law mandating that private-sector employer plans disclose certain information to health plan enrollees.¹¹² On the other hand, disclosure laws directed at health insurers and health care service plans would seem defensible as state laws regulating insurance. These types of state insurance laws have rarely been challenged under ERISA's preemption clause but should be "saved" because, arguably, they meet at least two of the three criteria courts have established for considering whether a state law regulates insurance.¹¹³

Comparison of State and Federal Law

Largely due to recent federal statutory and regulatory amendments, federal and state law requirements for health plan enrollee information disclosure have become more similar. Federal law now better reflects the importance to employee health plan enrollees of more detailed information about the features of managed care, which have become so prevalent in group health coverage. Nevertheless, in several respects, California law prescribes more information disclosure for health insurance and health care service plan consumers than does federal law for participants in self-insured ERISA plans. For example, both state codes require insurers and health care service plans to require that employer sponsors notify their employees of impending plan termination. The Health and Safety Code requires this responsibility to be part of the group contract. The Health and Safety Code also prescribes a more detailed standard than federal law regarding how health plans must inform enrollees of the process for authorizing, modifying, or denying services. And it requires health plans to notify enrollees when they terminate a provider group or IPA. To the extent that ERISA self-insured health plans contract directly with providers, notice of such a change could be delayed for 60 days after it is adopted.

Furthermore, the courts have interpreted some ERISA notice provisions to be less favorable to consumers than state insurance law. For example, courts routinely interpret ambiguous terms in insurance contracts against the insurer and in favor of the consumer. Federal courts have reached differing conclusions about whether to interpret ambiguous terms of an ERISA plan SPD in favor of the plan or the participant, although an opinion of the Ninth Circuit, governing California federal courts, currently favors consumers.¹¹⁴ Courts also have held that an insurer administering ERISA health plan benefits is not responsible to notify plan participants when their employer has stopped paying premiums, unless the plan explicitly delegates that duty to the insurer.¹¹⁵

Finally, although the CDI cannot require insurers administering self-insured ERISA plans to explain the consequences of self-insurance, the department reported that it intends to provide this explanation in its health insurance brochure, under revision but expected to be published in 2002.

VII. Plan-Enrollee Dispute Resolution

One of the most important ways to protect health care consumers is to assure that people can address disputes with their plan over coverage, payment, and quality of care. Speedy dispute resolution is especially important for enrollees in managed care plans, whose denials of coverage may effectively deny access to care. This chapter describes the procedures by which people enrolled in private-sector employee health plans can appeal plan coverage denials and attempt to resolve other disputes with their health plans and the insurers and HMOs that administer them. It also discusses the legal remedies available to redress injuries resulting from plan officials' decisions and misconduct. The substance and availability of these procedures involve a complex and evolving interplay between ERISA plans and insurers, the courts, and state and federal agencies. ERISA allows some types of state dispute resolution laws directed at insurers and HMOs but limits court-awarded damages for all people covered by private-sector employee plans.

Federal Law

Internal Plan Review

ERISA requires every employee benefit plan, whether insured or self-insured, to provide both: (1) adequate notice in writing to any participant whose claim for benefits has been denied, setting out the reasons for the denial, and (2) an opportunity for a full and fair review of a claim denial by a plan fiduciary.¹¹⁶ Some courts have held that these statutory provisions must be interpreted to require that the plan administrator provide specific reasons for denying the claim, a summary of the evidence on which it relied in making the decision, and an opportunity to rebut the evidence, make written arguments, and be represented by counsel.¹¹⁷

For many years, some courts have expressed concerns that ERISA's claims dispute procedures do not provide adequate consumer protection, especially in light of the prevalence of managed care plans and the economic incentives to ration medical treatment contained in their provider contracts. In November 2000, DOL acknowledged some of these concerns when it issued final regulations outlining the process by which ERISA health plans must process benefits claims. The rules outline procedures for filing benefits claims, notice of benefit decisions, and appeals of adverse decisions. Unlike disputes with indemnity insurers over payment after a service has been

provided, a dispute over coverage under a managed care plan often occurs before the service is provided and may result in denial or delay of the service, to the detriment of the plan enrollee's health. The new DOL rules (which apply to certain non-health coverage employee plans for new claims filed on or after January 1, 2002 and to group health plans on the first day of the first plan year beginning on or after July 1, 2002 but no later than January 1, 2003) prescribe standards for both insured and self-insured health ERISA plans setting forth:

- minimum allowable time frames to determine initial coverage or urgent, non-urgent and pre-and post-care coverage claims,¹¹⁸ resolve appeals of urgent and non-urgent claims,¹¹⁹ decide whether a claim is incomplete,¹²⁰ and extend the decision deadline for non-urgent claims,¹²¹
- information that must be provided to plan participants regarding how to obtain pre-service authorization¹²² and the specific basis of the claim denial,¹²³ and
- procedures for conducting appeals of denied claims, including: reviewer qualifications,¹²⁴ obligation to consider all information submitted by the claimant and review the decision "de novo,"¹²⁵ use of qualified medical professionals for claims involving medical judgment, authority to require up to two levels of review within the plan,¹²⁶ authority to use binding arbitration under limited circumstances,¹²⁷ and prohibition of appeal fees.¹²⁸

These new regulations will expand the leverage consumers (especially those in self-insured plans) may apply to resolve claims disputes in a timely manner. Similar time frames for making health insurance and HMO plan decisions and processing appeals are part of "patient protection" bills passed by both houses of Congress in the summer of 2001.

Judicial Review

Under current law, ERISA permits plan participants whose claims have been denied in the plan's review process¹²⁹ to sue in order to recover benefits due under the plan, to enforce rights under the plan, or to clarify rights to future plan benefits.¹³⁰ Courts may award attorneys' fees and costs to either party.¹³¹ The U.S. Supreme Court has interpreted these statutory provisions to be the exclusive judicial remedy available to plan participants for resolving benefits disputes in insured as well as self-insured ERISA plans. In *Pilot Life Ins. Co. v. Dedeaux*,¹³² the Court held that ERISA preempted traditional state remedies for unfair insurance practices in administering a disability plan. Under the Supreme Court's interpretation of federal law in this landmark decision, ERISA's appeal process entirely preempts state laws that provide remedies for disputes with ERISA plans and does not permit the application of even those state laws that supplement, rather than conflict with, federal law.

Either by statute or under common (court-made) law, most states permit people harmed by insurer claims delay or denial to sue for economic damages (actual costs incurred such as medical expenses or lost wages), non-economic damages (for "pain and suffering"), and punitive damages (to punish a defendant found to have engaged in "outrageous" conduct). In *Pilot Life*, the Supreme Court held that ERISA preempts these remedies because they relate to employee benefit plans by imposing new appeals procedures and are not "saved" because common law remedies are not directed solely at the insurance industry. The Court read ERISA and its legislative history to mean that Congress intended the limited ERISA judicial remedies to be

exclusive. The federal courts subsequently have heard hundreds of ERISA cases involving health plan enrollee coverage disputes and have frequently noted that ERISA’s remedies are inadequate to make an injured health plan enrollee whole. For example, a plan may require an enrollee to obtain approval before it will agree to cover a medical service (for example, to determine whether a service is “medically necessary”). Denied or delayed approval may deny or delay access to a needed service, resulting in injury. ERISA’s limited right to sue to receive promised benefits allows participants to collect payment for a service—available only if the service actually is rendered—or to receive the promised service itself, but does not compensate an injured person for economic and other damages resulting from decisions made by plan officials administering claims.

For example, if a health plan denied or delayed authorization of a medical service and the denial or delay caused the participant’s death, his or her family would have no right to collect any damages for their loss. If the participant’s medical condition merely deteriorated due to the denial or delay of authorization, he or she could obtain payment for the service eventually received but not for lost income due to inability to work or the cost of other medical and custodial care needed to treat the resulting condition.

Many federal court opinions express frustration over ERISA’s damages limits but are bound by the Supreme Court’s *Pilot Life* decision.¹³³ In recent years, however, several federal courts (including a California district court) have begun to craft a distinction between:

- coverage disputes involving an interpretation of what the plan will cover, for which ERISA provides only limited remedies,¹³⁴ and
- disputes challenging the “quality” of care under traditional state medical malpractice theory where health plans can be held responsible for negligence of physicians under their control and other conduct directly affecting providers’ treatment activities.¹³⁵

Although this distinction has helped some people recover damages for health plan misconduct, it is often difficult to draw a line between a dispute over a plan’s involvement in actual medical care delivery and one over coverage. Health plan coverage is often conditioned on a service being “medically necessary,” a determination that implies some level of medical judgment while also requiring an interpretation of the plan’s terms. Some courts appear to favor defining close cases as disputes over medical quality, rather than coverage in order to expand the remedies available to injured plan participants.¹³⁶ But pure coverage disputes remain subject to only ERISA remedies. It is not clear whether the Supreme Court would approve of the distinction between “coverage” and “quality” cases,¹³⁷ and without such guidance, the precise scope of state and federal judicial remedies for many types of enrollee-health plan disputes remains uncertain.

U.S. Department of Labor Enforcement Authority

In its responsibility to administer ERISA, the Pension and Welfare Benefits Administration (PWBA) of the DOL can enforce the statute by bringing actions against both ERISA plan administrators for violating ERISA’s requirements, including breaching their fiduciary duties to plan beneficiaries (e.g., by fraud and mismanagement) and employers for failing to notify beneficiaries about their rights to COBRA continuation benefits as required by federal law. (An employer that creates and funds an ERISA health plan also may act as a plan fiduciary, or the

employer may delegate fiduciary functions such as administering claims to another party.) Generally speaking, the DOL views its ERISA enforcement responsibility primarily to safeguard the collective rights of employee pension and welfare plan participants from misconduct by plan administrators rather than to advocate on behalf of individual plan participants.¹³⁸

The central office in Washington, D.C. establishes policy and coordinates enforcement, outreach, and participant assistance efforts through regional offices, including two in California (located in San Francisco and Los Angeles). The number of DOL staff available to respond to individual health coverage inquiries increased nationally from about a dozen in 1994 to over 100 in 2000. In 2001, the SF office employed nine “benefits advisors” (responsible for Northern California, Alaska, Idaho, Nevada, Oregon, Utah, and Washington) and the LA office employed eight benefits advisors (responsible for Southern California, Arizona, and Hawaii). Callers can reach benefits advisors in their area using a national toll-free phone number.

Benefits advisors can informally intercede with health plan sponsors to attempt to resolve disputes. These contacts may involve more than one phone call during which benefits advisors explain health plan participants’ legal rights, suggest information they should obtain from their employer, and propose next steps to take. Translation services are available for non-English speaking callers. Advisors also may contact employers to explain their legal responsibilities (for example, under COBRA) and urge them to comply. PWBA staff reported that these informal contacts usually resolve the problem. However, PWBA interprets ERISA as not authorizing the agency to bring lawsuits on behalf of individuals in disputes between one participant and a plan, and in recent years, the Department has begun suggesting that participants dissatisfied with the results of their appeal process seek private legal advice.¹³⁹ If an individual’s concern involves a problem that appears to be plan-wide and affects multiple participants, the matter may be referred to DOL enforcement staff for investigation.¹⁴⁰

Relationship between State and Federal Agencies

In recent years staff at the CDI, DMHC, and regional PWBA offices have begun to work together to coordinate referrals of complaints regarding health coverage outside their individual agency jurisdictions. The agencies hold quarterly meetings to share information about each agency’s responsibilities, requirements, and procedures, coordinate cross-referrals, and conduct joint public outreach activities (such as seminars on HIPAA and COBRA compliance). Staff in both state and federal agencies indicated that these meetings have improved the accuracy and efficiency of caller response and the appropriateness of referrals from the other agencies. PWBA staff also report that the evolving working relationships with CDI and DMHC serve as a model for working with similar agencies in other states. As discussed in Chapter 8, PWBA staff have begun to coordinate actively with state dislocated worker offices in order to educate workers facing unemployment about their post-employment health coverage options under COBRA and HIPAA.

California Law

Internal Plan Review Requirements

Typical of state HMO licensure laws, the California Health and Safety Code requires health care service plans to establish an internal grievance system under which enrollees can seek review of denied claims or requests for coverage authorization. The Insurance Code prescribes standards for indemnity insurers using utilization review (UR) criteria, such as medical necessity, to determine requests for benefits. Although this statute does not explicitly require a mechanism for disputes over these insurer decisions, the CDI interprets the Insurance Code's independent review procedures standards to require an internal insurer appeal process for disputes subject to independent review.

Independent Medical Review

Both indemnity insurers and health care service plans must allow enrollees to appeal certain benefits disputes to an organization outside the plan. As in the vast majority of states, in 2000, the California legislature enacted an independent (sometimes called "external") review program that built upon an earlier more limited program for review of disputes over coverage of experimental or investigational therapies. On January 1, 2001, independent medical review (IMR) became available for consumer disputes with health insurers over UR decisions and with health care service plans regarding: (1) experimental and investigational care, (2) services denied, modified or delayed on the ground they are not medically necessary, and (3) payment for out-of-plan emergency or urgent care services. Independent review is available at no cost to enrollees after completing the internal plan appeal process (or 30 days after that process was initiated). The law prescribes time frames (expedited in the urgent cases) for submitting IMR requests and information related to the appeal and resolving the cases.

To gain access to the IMR process, people dissatisfied with the outcome of a health care service plan's internal review may appeal to the DMHC. The Department decides whether the dispute is subject to IMR and, if so, notifies the enrollee. In the case of an urgent appeal, a nurse will review the dispute and attempt to resolve the issue immediately, even the case may have been sent to IMR processing. If the dispute is not subject to IMR, it becomes a standard complaint and the department must decide within 30 days whether the plan correctly denied coverage and, if it did not, may order the plan to provide or pay for the service. As in the IMR referrals, if a standard complaint involves an urgent problem, a nurse will review it and attempt to resolve it quickly. People covered by insurers licensed by the CDI submit their requests for IMR through their insurers or CDI.

The director of DMHC and commissioner of CDI are required to adopt and enforce the IMR organization decision. DMHC has contracted with the Center for Health Dispute Resolution and two other organizations to conduct the independent reviews. Through an interagency agreement, CDI uses these DMHC review organizations. Almost 600 IMR cases have been resolved in 2001, the vast majority involving health care service plans.¹⁴¹

Judicial Remedies

Californians insured as individuals or through state and local government employers face no ERISA barriers to suing their health insurers and managed care plans for injuries due to health

plan coverage delays or denials. For example, people insured through public sector employers, like counties and school districts, have received large awards of economic, non-economic, and punitive damages for injuries caused by health plan coverage denials.¹⁴² The California State Supreme Court recently allowed the widow of a Medicare managed care plan enrollee to sue the plan for delaying approval of care that allegedly led to his death.¹⁴³ But ERISA bars such recovery for people enrolled in private-sector employee health plans. Even though the right to sue insurers and HMOs does not appear to be in doubt, California's legislature, like those in nine other states, enacted a statutory right to sue health care service plans and other managed care entities that became effective in January 2001.¹⁴⁴ The state law allows an enrollee to recover full damages for any substantial harm¹⁴⁵ caused by a plan's failure to use ordinary care in arranging for provision of medically necessary care that results in denial, delay, or modification of a health care service.¹⁴⁶ An enrollee cannot sue under this law before completing the independent review process, unless substantial harm has occurred or will occur before the independent review could be completed.

State Administrative Authority

In contrast to the limited power ERISA grants to the DOL, California law authorizes regulatory agencies to assist people enrolled in health insurance or managed health care products through informal negotiations, enforcement actions against licensees, and review of grievances that are not subject to independent review. DMHC has broader statutory powers than CDI to adjudicate complaints and take enforcement actions on behalf of individual enrollees—CDI refers medical necessity disputes to independent review but does not adjudicate individual claims or resolve factual or legal disputes. An independent Office of Patient Advocate (in the Business, Transportation, and Housing Agency), which coordinates with DMHC, publishes educational materials for HMO consumers and provides information on their rights and responsibilities. Both departments operate toll-free “hot lines” for inquiries and complaints. The DMHC hot line is staffed 24 hours per day, 7 days per week by operators who have access to a medical consultant and nurse evaluators for medical questions. Operators can assist consumers in many languages. The CDI hot line operates 8 a.m. to 6 p.m. Monday through Friday and is staffed with insurance experts. Both agencies require complainants to exhaust their insurer's or health care service plan's internal appeals process and then attempt to resolve the dispute on the telephone or through written correspondence with the insurer or managed care plan. Forms to file written complaints are available on both agencies' Web sites.

In addition to providing personal consumer assistance, both departments monitor complaints to detect patterns of licensing law violations and have taken various types of enforcement actions against licensees in recent years. For example, CDI is currently monitoring several health insurers. In addition to ordering plans to cease and desist from refusing to provide covered services, the DMHC has imposed fines ranging from \$2,500 (for failure to cover an individual service) to \$30,000 (for failure to timely notify enrollees of the termination of their medical group), \$25,000 (for failure to refer an individual to an out-of-plan provider), and \$250,000 (for a pattern of untimely provider payment).¹⁴⁷ A few licensed HMOs have challenged the DMHC's enforcement actions in well-publicized cases.¹⁴⁸ CDI staff reported in interviews that the agency has taken enforcement actions against health insurers but provided no details.

Table 8. California and Federal Grievance Resolution and Remedies Standards

Resolution mechanism	California requirements		Federal requirements
	Insurers	Health care service plans	ERISA plans
<i>Administrative agency process</i>			
Agency head may examine plan regarding solvency, a complaint, or compliance with law	yes	yes	no
Director must examine plans at least every 3 years	no	yes	no
Director must publish statistics on grievances	no	yes	no
Enrollee may complain to department	yes (but no CDI authority to resolve issues of fact or law)	yes (after completing plan's internal process, after 30 days in it, or if health imminently threatened [enrollee may request DMHC review of disputes whether or not subject to external review and Dept. must determine which forum is appropriate])	yes
Toll-free number for complaints	yes	yes	yes
<i>Plan internal appeal process</i>			
	yes (IMR law interpreted by CDI to require internal plan appeal for cases subject to IMR)	yes (must include specific reasons for rejecting claim, licensed provider to review contested claims; expedited review if health imminently threatened, conference with enrollee if plan denies experimental treatment to terminally ill enrollee)	yes (must meet timeframes for review, fees prohibited, prescribed reviewer qualifications, evidence consideration, decision rules)

(table continues)

Table 8. California and Federal Grievance Resolution and Remedies Standards

Resolution mechanism	California requirements		Federal requirements
	Insurers	Health care service plans	ERISA plans
<i>Independent medical review process</i>			
Enrollees may apply to departments for independent medical review of decisions to deny, modify, or delay care: 1. for experimental or investigational therapy for terminally ill patients; 2. for disputes regarding medical necessity (but not those involving what services are covered under the plan) expedited review in cases of imminent and serious threat to enrollee health DMHC uses outside reviewers but adopts the reviewer decision, with which plans must comply	yes (ERISA implications are unclear)	yes (ERISA implications are unclear)	no
<i>Judicial review</i>	Common law allows court suits (but ERISA pre-empts common law remedies and insurance unfair claims statute)	Statutory cause of action for health plan liability (2001) (ERISA implications are unclear)	Damages are limited to cost of benefit in dispute

Complaints and Inquiries Regarding ERISA Health Plans

The DOL maintains national and regional statistics on the numbers of written and telephone inquiries, which include both requests for information and complaints or concerns about ERISA health plans. These inquiries can come from people enrolled in both insured and self-insured plans but they are not categorized by health plan type. In federal fiscal year 2001 (October 1, 2000 through September 30, 2001), the two regional offices serving California and other states noted above received 14,914 inquiries regarding ERISA health plans (data are not available for only California). Similar to the nation as a whole, almost two-thirds (64 percent) of these inquiries involved COBRA issues and another 27 percent involved benefits coverage or payment issues, while the others pertained to subjects including HIPAA, fiduciary issues, reporting and disclosure, and retiree health benefits.¹⁴⁹

The California regulatory agencies provided statistics on consumer complaints regarding licensed insurers and health care service plans. (These statistics do not include general requests for information). Of the 3,738 written health insurance complaints to CDI in calendar year 2000, the largest category involved claims denials (38 percent), followed by claims delays (14 percent), unsatisfactory settlement offers (9 percent), and coverage questions (7 percent). The remaining

complaints involved other problems, such as cancellations, premium refunds, and coordination of benefits. The 2,655 complaints addressed by DMHC in calendar year 2000 involved 3,955 issues, the largest category of which involved denials of care or payment (42 percent), followed by coverage disputes and quality of care (each 17 percent), billing (14 percent), accessibility of providers (7 percent), and provider service attitudes (3 percent). DMHC staff reported that less than one percent of these complaints involved self-insured plans; it referred these callers to DOL.

Another source of complaint data from people enrolled in both insured and self-insured employer health plans is the Health Rights Hotline, which has assisted residents in the 4-county Sacramento area since 1997 who call with questions and complaints about health care and health coverage.¹⁵⁰ For this report, staff of the nonprofit organization operating the Hotline abstracted summaries of contacts from people enrolled in both insured and self-insured private-sector employee (i.e. ERISA) health plans from its July 2000 through June 2001 database.¹⁵¹ Of these 385 contacts, 73 percent were from people enrolled in insured plans and 27 percent from enrollees in self-insured plans.¹⁵² In a few cases, callers raised multiple complaints and/or inquiries, for a total of 206 complaints (submitted by 195 callers) and 199 inquiries (submitted by 196 callers) in insured and self-insured plans.

About half (52 percent) of the 385 Hotline contacts involved requests for information, most inquiring about post-employment coverage options under programs like COBRA and HIPAA. (Many of these callers were already on COBRA coverage and sought information about options following its 18-month time limit.) A small proportion of callers sought information about other coverage options, such as more affordable insurance for dependents or public programs for children or disabled people. A minority of callers requested information on other topics, such as choosing a plan or provider, obtaining medical records, or information on specific medical conditions. As shown in Table 9, a greater proportion of people enrolled in insured plans than self-insured plans sought information on post-employment options.¹⁵³ This difference may be partially explained by the fact that firms offering self-insured plans are more likely to be larger and have human resources departments that can answer these types of questions.

Table 9. Health Rights Hotline Inquiries by Insured and Self-Insured ERISA Plan Enrollees, July 2000 through June 2001

Type of Inquiry	Insured Enrollees	Self-insured Enrollees
Post-employment options	97 (70%)	33 (55%)
Other coverage options	16 (12%)	4 (7%)
How to choose plan or provider	5 (4%)	9 (15%)
Other	20 (14%)	14 (23%)

Table 10 displays Hotline data on complaints submitted by its callers in ERISA plans. The largest category of complaints involves disputes over payment for health care services, followed by problems with denials of coverage or delays in authorizing coverage. The next most frequent category was complaints about poor quality of care, such as dissatisfaction with mental health, hospital, or physician services. Several complaints involved difficulties obtaining access to physician specialists or to providers not part of the managed care plan's network. Some callers complained about delays in obtaining appointments and difficulty contacting or having useful

communications with their providers (including reported discourtesy from providers or their staff). About one-quarter of the complaints were not easily categorized but included such problems as the employer failing to provide notice of COBRA or HIPAA rights, providers leaving the managed health care plan's network, and difficulties with pharmacies and drug coverage. Although the data in Table 10 suggest some differences in the proportion of complaints between enrollees in insured and self-insured ERISA plans, these differences were not statistically significant.¹⁵⁴

Table 10. Health Rights Hotline Complaints by Insured and Self-Insured ERISA Plan Enrollees, July 2000 through June 2001

Complaint type	Insured Enrollees	Self-insured Enrollees
Payment disputes	34 (21%)	11 (24%)
Coverage denial or delay	24 (15%)	5 (11%)
Quality of care problems	21 (13%)	7 (15%)
Access to specialists and non-plan providers	15 (9%)	5 (11%)
Appointment delays	15 (9%)	1 (2%)
Provider communication problems	11 (7%)	4 (9%)
Other	40 (25%)	13 (28%)

While employee health plans and insurers were responsible for some of the problems raised by these Hotline callers (such as payment disputes for services already provided), many complaints involved health care provider conduct. For example, providers are primarily responsible for quality of care, appointment delays, and communications problems. But a medical group also may be responsible for coverage denials and delays if the health plan has delegated to the medical group the duty to authorize coverage. In the case of large HMOs like Kaiser that contract exclusively with large medical groups, the health plan may share responsibility with these providers for such plan and provider functions.

The Hotline data may not be representative of complaints and inquiries from California as a whole (although the four-county area was selected as a telephone hotline demonstration site because its demographic profile and health coverage enrollment are similar to those of the state at large). Other health plan enrollee characteristics (such as employee age and health status and employer size) that might differ between insured and self-insured ERISA plan enrollees could not be controlled for in this analysis.¹⁵⁵ Nevertheless, this database provides a unique opportunity to examine and compare concerns from callers enrolled in both insured and self-insured plans.

ERISA Preemption of State Health Plan Consumer Remedies

To alleviate confusion about the impact of its claims procedures rules on similar state insurance laws, the DOL rules indicate that state laws on the same subjects (for example, time frames for review or reviewer qualifications) would be preempted only if they prevent the application of federal law.¹⁵⁶ Likewise, DOL has taken the position that state independent review programs are

not inconsistent with federal law, even though ERISA contains no provisions for external review of health plan decisions.

With respect to damages remedies, however, the courts have held consistently that ERISA preempts state common law remedies for injuries when health insurers and HMOs deny or delay coverage. ERISA also has been held to preempt state insurance laws that prohibit unfair claims practices, including California's Insurance Code provision, which authorizes not only consumer lawsuits for damages but also state regulator prosecution.¹⁵⁷ What remains unresolved is the applicability to ERISA plans of recent state laws (like California's) providing a statutory right to sue HMOs. A similar law in Texas (the first state to enact a health plan liability law in 1997) survived part of an ERISA preemption challenge, but its relevance to the California law is unclear.

The Fifth Circuit Court of Appeals upheld a lower federal court's decision that ERISA does not preempt portions of the Texas statute that authorizes lawsuits against HMOs for negligent delivery of care by network physicians.¹⁵⁸ At the same time, the Court of Appeals noted, consistent with other courts addressing this issue, that ERISA would preempt state court lawsuits against HMOs for inappropriate coverage or payment decisions.¹⁵⁹ California's health plan liability law (and the accompanying independent review process, which must be exhausted before medical necessity disputes can form the basis of a lawsuit) was drafted differently from that in Texas, but it is not clear how the courts will resolve ERISA challenges to state laws attempting to create a right to sue HMOs for disputes over medical necessity.¹⁶⁰ Furthermore, the courts are divided on ERISA implications for state independent/external review laws. The Fifth Circuit held that ERISA preempted the Texas external review law,¹⁶¹ while the Seventh Circuit held that ERISA did not preempt Illinois's external review program.¹⁶² As this report was being published, the Supreme Court held that ERISA does not preempt the Illinois independent review law, providing precedent to argue that California's law also is safe from preemption.

For several years, Congress has been considering how to expand the legal remedies and appeal mechanisms available to ERISA health plan participants. The patient protection bills passed by both houses (but not yet reconciled in conference committee) would subject all ERISA plans to external review programs and, to different degrees, expand federal court remedies, and authorize some health plan enrollee damages lawsuits to be brought in state court. Because damages remedies remain a major source of contention, it is unclear whether or when the differences between these bills will be reconciled.

Comparison of State and Federal Dispute Resolution Procedures

The recently adopted ERISA health plan claims procedure regulations are more detailed than those applicable to health care service plans under California law. For example, the federal regulations prescribe time frames for completion of various stages of the benefit determination and grievance process, require grievances to be reviewed by people different from those who initially denied the claim without deference to the original decision, and consultation with medical professionals in matters of medical judgment. In further contrast to state law, which permits arbitration of health plan-enrollee disputes, the federal regulations prohibit binding arbitration as part of the required internal plan appeal process unless it complies with the time

frames and other regulatory requirements and permits arbitration decisions to be appealed to court.¹⁶³

ERISA's grievance procedures and consumer remedies are less favorable to consumers than state law in several other respects, however. First, people who obtain health coverage through public-sector employers or the individual insurance market can sue for the full scope of damages available in other personal injury cases, while people covered through private-sector employers may seek only ERISA's limited remedies. Second, consumers may be affected because a court's interpretations of a health insurance or HMO policy may differ depending on the source of the plan. In non-ERISA cases, courts typically interpret ambiguous insurance plan terms in favor of the insured person,¹⁶⁴ whereas the courts are split on whether to interpret ambiguous ERISA plan terms in favor of the plan participant, although the Ninth Circuit decisions favor consumers.¹⁶⁵ Furthermore, in contrast to the practice in insurance benefit lawsuits, courts interpret ERISA to give considerable deference to plan administrators' coverage decisions. In ERISA cases, for example, courts overturn plan administrators' coverage decisions only when they are arbitrary (a high standard for consumers to overcome), rather than when the court might just consider them unreasonable. Courts in ERISA cases also typically do not allow a participant challenging a denied claim to introduce evidence at trial that was not previously presented to the plan administrator.¹⁶⁶ In contrast, in lawsuits involving the individual market or public sector employees, courts generally permit new evidence about the claimant's condition or expert medical opinion to be introduced at trial even if it had not previously been presented to the plan administrator.

Finally, the state agencies have considerably greater legal authority and resources to assist individual consumers in disputes with their health plans. Health insurance and health care service plan enrollees can file complaints with the licensing agencies, both of which employ more people to assist health plan enrollees than DOL. Unlike the DOL, the DMHC is legally responsible to resolve all complaints it receives regarding licensed health care service plans that are not subject to IMR; and consumers can seek independent review of disputes involving medical necessity and experimental treatment with both types of licensees. (Similar to DOL, however, CDI does not have legal authority to adjudicate individual insurance claims.) DOL's national and regional consumer assistance staff is very small in comparison to that of the two state agencies. Furthermore, while in recent years DOL benefits advisors have become more willing to assist individual ERISA plan participants by providing information and informal discussions with employers, the agency does not initiate litigation or other enforcement action on behalf of individuals.

VIII. Health Coverage Continuation, Portability, and Access Rules

This chapter examines California and federal laws designed to help people leaving employment and changing jobs keep their health coverage. It also describes related laws that help people covered by private-sector employee health plans gain access to coverage and that help plan participants, and the plans themselves, gain access to health insurance and managed care products. It concludes with a discussion of how HIPAA presents a new model for the relationship between the federal government and the states in regulating employee health benefits and health insurance and managed care.

Continuation and Conversion Rights

Both the federal government and the state of California have enacted laws designed to help people who are changing jobs or losing employment maintain their health coverage. This complex amalgam of laws, however, leaves many people facing significant barriers in maintaining coverage, particularly if they have serious medical conditions, have low incomes, or simply have no connection to the workforce.

The weakened economy, coupled with the impact of the September 11 bombings and subsequent terrorist-related events, has caused a growing number of workers to lose their jobs and confront the prospect of losing their health coverage. Most of these workers face a double whammy: not only has their income dropped, but they also will face “sticker shock” when trying to buy continuation coverage. Others may find that continuation of their group coverage is not available and their chances of finding affordable coverage in the individual insurance market may be slim to none.

Even in the best of best economies, each year millions of Americans find themselves unemployed for a period of time. For example, the Congressional Budget Office (CBO)¹⁶⁷ recently estimated that about 19 million workers would be unemployed at some time during 1998, a year in which economic conditions were much more favorable than now. More than a third of these, or about 7.5 million workers, would go at least a month without health insurance

during the spell of unemployment. Of those 7.5 million workers, about two-thirds would have been uninsured during the last month they had worked and about one-third would have been insured. CBO estimated that about 11.5 million people would maintain coverage through their entire spell of unemployment.

The Federal COBRA Law

If they cannot retain coverage as a spouse or dependent under a family member's plan, a principal option through which laid-off workers in firms with 20 or more workers can maintain coverage is under a federal law generally referred to as COBRA. Enacted in 1985, the Consolidated Omnibus Budget Reconciliation Act allows many employees and their dependents to continue to be covered, at their own expense, by their employment-based health insurance plan after "qualifying events" such as being laid off.

Under the COBRA law, when an employee of a firm with 20 or more workers is terminated or his or her work hours are reduced, covered employees and qualified beneficiaries must be given the option of electing COBRA coverage lasting up to 18 months. If COBRA-eligible employees or dependents are disabled, COBRA coverage may be extended to 29 months. In cases involving the employee's death, divorce, legal separation, Medicare entitlement, or loss of a child's dependency status, either initially or at any time during the continuation of coverage period, the qualified beneficiary must be allowed to elect COBRA coverage lasting for up to a maximum of 36 months from the first qualifying event.

Former employees who sign up for COBRA coverage typically experience sticker shock because now they must pay the cost of the entire premium. Active employees and dependents usually pay only a portion of their entire health care premium with the employer picking up most of the bill. Under COBRA, however, beneficiaries must pay up to 102 percent of the group premium and they are usually charged the full amount allowed.

Employers and active workers, however, end up bearing part of the cost of COBRA coverage because former workers who enroll in COBRA coverage tend to have higher-than-average levels of health services utilization. Over the years, average claim costs for COBRA enrollees have exceeded costs for active employees by about 50 percent. For example, a survey of 1999 plan year information found that COBRA coverage cost 52 percent more than that for active employees.¹⁶⁸ According to Spencer's research reports, for all but the largest employers, providing COBRA coverage is much like rolling dice because the average cost fluctuates greatly from year to year. The range of claims cost ratios tends to be wide—from less than 50 percent to more than 500 percent with only the largest employers nearing the average. In 1999, average COBRA costs per participant, including claims and administration, were \$6,051. Even though the cost of COBRA may appear steep for laid-off workers, as discussed below, the alternatives in the individual market are usually less attractive.

A recent study found that only 57 percent of non-elderly workers and their adult dependents were potentially eligible for COBRA in 1999 (in part because COBRA's continuation of coverage requirement applies only to employers with at least 20 employees) and only seven percent of unemployed adults had coverage through COBRA.¹⁶⁹ Of those eligible for COBRA coverage, about 19 percent actually elected it in 1999, according to Spencer's research reports.

DOL officials stressed that it is important for individuals losing coverage due to lay-offs or for other reasons to ascertain whether they are eligible for coverage under a spouse's plan before they become locked into COBRA coverage. This is because once someone is covered under COBRA, he or she will not be eligible for a special enrollment period in a spouse's plan, which may cost the person far less than COBRA coverage, until available COBRA coverage is exhausted. Under federal law, employees losing coverage have 30 days to request special enrollment for themselves and family members in another plan for which they are eligible, such as a spouse's plan, regardless of whether this occurs during the plan's regular enrollment period. As with other tight eligibility time periods specified in the checkerboard of complex rules enacted to help people keep their coverage during transitions, the 30-day period in which to request special enrollment in a spouse's plan may not be long enough for people to make informed decisions. The sheer complexity of the various laws and regulations also makes it difficult for people to navigate the system.

Cal-COBRA and Other Options under State Law

Cal-COBRA. Most states, including California, have passed “mini-COBRA” laws that require group health insurance plans to offer continuation coverage similar to COBRA. Under Cal-COBRA, former employees of firms with two through 19 employees can receive such continuation coverage. Eligibility requirements and time limits are similar to those for COBRA.¹⁷⁰ Moving out of a plan's service area, however, terminates Cal-COBRA coverage. In some instances the cost of Cal-COBRA coverage for former employees is capped at 110 percent of the group premium; in other instances the cost of such continuation coverage is capped at 213 percent of the group rate.¹⁷¹ For people aged 60 or older, Cal-COBRA coverage can last up to five years (in effect, until they are eligible for Medicare) if a person has worked for his or her employer for at least five years before applying for continuation coverage (and other eligibility requirements are met). Early retirees and their dependent spouses are among those who benefit from this coverage extension.

HIPAA. In 1996, Congress passed a law called the Health Insurance Portability and Accountability Act (HIPAA), which contains provisions that may help certain former employees keep their coverage once they have exhausted coverage options under COBRA or Cal-COBRA. Under HIPAA, California insurers are required to offer “federally eligible” people the option to buy one of two policies—either their two most popular policies or two representative policies. No pre-existing condition exclusions may be imposed on this coverage. Although California law limits the premiums that can be charged for this type of coverage to certain benchmarks, premiums still may be very expensive.¹⁷² To be “federally eligible” under HIPAA, a person must have had at least 18 months of continuous coverage, most recently in a group health plan, and must have exhausted any available continuation coverage under COBRA or similar state laws as well as other coverage options.¹⁷³ Health insurers serving the individual market also must renew policies, not only for the “federally eligible” people just described, but market-wide.

Conversion policies. In some circumstances when a person's group insurance coverage is terminated,¹⁷⁴ health insurers and managed health care firms are required to offer the option to convert to individual coverage. In California, such a “conversion policy” cannot contain any new pre-existing condition exclusions, but it may require an individual to complete an unfinished pre-existing condition exclusion from his or her former group coverage. The benefits under the conversion policy may be different than those in the former group plan. The rates that insurers

charge for conversion coverage may be much higher than those charged for group coverage. Because conversion coverage is often very limited, the CDI said it always advises callers seeking to continue coverage to first pursue options under COBRA, Cal-COBRA, or HIPAA.

The individual market. As in most other states, Californians seeking to buy individual health insurance policies may face significant price and access problems. California places few limits on what insurers may charge in the individual market.¹⁷⁵ Insurers are not prevented from denying, modifying, or pricing individual coverage based on a person's health or risk status, age, or other factors. California law, however, prohibits health insurers in any market from imposing riders excluding health conditions or treatments. Purchasing individual coverage may be a viable option for some Californians, especially if applicants are young and healthy and have no pre-existing medical conditions. But for those with existing medical conditions, individual coverage simply may be not available, or may be unaffordable, especially for lower-income people.

A recent Georgetown University study demonstrated the kinds of problems consumers can face when attempting to buy health insurance on their own.¹⁷⁶ Designed to test access to coverage in individual health insurance markets, the study constructed seven hypothetical health insurance applicants with a range of health conditions and asked insurers to consider covering them as if they were actual consumers. For each type of consumer, the researchers approached 19 insurers and HMOs in eight markets across the country including one California site (the Fresno area). In the Fresno area, when researchers made seven attempts to buy coverage in the guise of "Frank," a 62-year-old who was overweight, smoked and had high blood pressure, five carriers refused to offer him a policy. Two insurers offered him coverage conditioned on a higher premium than would have been charged to a healthier person. (He was offered policies for \$356 a month and \$877 a month, respectively.) Another hypothetical applicant (named "Greg"), who was described as HIV-positive, was rejected by every insurer in the study, including those in Fresno.

California's high-risk pool. For people rejected for coverage in the individual market, California offers a high-risk pool called the Major Risk Medical Insurance Program (MRMIP). Many of the 17,300 people the pool covers are reportedly grateful for the opportunity to have such coverage. Yet, the high-risk pool's coverage presents several issues. For example, there is a long waiting list; benefits are capped at \$75,000 per calendar year (and \$750,000 lifetime); premiums are relatively costly; and the plans offered may use six-month exclusions for coverage of pre-existing conditions.

Over the past year and a half, the waiting time for MRMIP coverage has grown from about four months to about a year, according to a former member of the board overseeing the risk pool. Because of the long wait, only 25 percent of applicants now take up coverage once reaching the front of the line, according to MRMIP staff. About 5,000 Californians remain on the waiting list.

The Group Market

In many ways, consumers in employment-based health plans enjoy more consumer protections than those buying coverage on their own. As noted earlier in the report, both federal law (HIPAA) and state law require insurers and managed care companies to guarantee issue products to groups with 50 or fewer lives. California also forbids rates for groups of this size to vary by more than 20 percentage points based on a group's health status (not more than 10 percent above

or below the standard rate).¹⁷⁷ In both the group and individual markets, HIPAA requires indemnity insurers and managed health care companies to renew health insurance policies.

Preemption of State Law

The impact of ERISA on state continuation and conversion law is unclear because of conflicts among the few courts that have considered these cases and the lack of Supreme Court guidance on this specific issue. States have enacted laws with varying impacts on the continuation and conversion policies, for example: (1) mandating that firms with under 20 employees allow people leaving employment to remain in the group plan, (2) authorizing conversion to an individual insurance product after group coverage terminates, (3) requiring notice of these rights to departing employees, (4) regulating the content of conversion policies, and (5) providing remedies for breaching conversion contracts.

Since the enactment of COBRA continuation rights for workers in firms of 20 or more employees, ERISA has preempted state regulation of these federally mandated continuation provisions¹⁷⁸ and state damages remedies for insurer or HMO misconduct.¹⁷⁹ Laws such as Cal-COBRA that require smaller firms and their insurers to provide continuation coverage apparently have not been challenged but could face ERISA preemption concerns if they impose responsibilities on employer-sponsored plans rather than just on the insurer.¹⁸⁰

There has been more ERISA litigation regarding state conversion laws than continuation laws, and courts have reached conflicting decisions in these conversion cases. The Ninth Circuit has held that an individual conversion policy is not an ERISA plan so that an insured person can pursue state damages remedies for breach of the insurance contract.¹⁸¹ The Ninth Circuit also has held, however, that ERISA preempts state laws requiring insurers to offer conversion rights.¹⁸² One federal court has held that ERISA does not preempt a state law regulating the content of conversion policies.¹⁸³ Courts are inconsistent in deciding whether ERISA preempts state laws requiring insurers to provide notice of conversion rights.¹⁸⁴

Other HIPAA Access Rules

Besides increasing access to coverage after COBRA rights are exhausted and establishing federal guaranteed issue and renewability standards for insurers and managed care companies, HIPAA contains several other incremental measures primarily designed to help people in employment-based health plans (and the plans themselves) gain access to health insurance. HIPAA sets forth a number of consumer protections applying in parallel fashion to private-sector employee health plans regulated under ERISA as well as to health insurers and HMOs contracting with such plans. Among these rules, which the states may augment in some ways and enforce with regard to licensed insurers and managed care organizations, are the following:¹⁸⁵

- **Nondiscrimination rules:** Individuals may not be excluded from employee health plans or by insurers covering group health plans on the basis of factors related to health status. Similarly, the benefits provided, premiums charged, and employer contributions may not vary within similarly situated groups of employees based on factors related to health status.

- **Limitations on Preexisting Condition Exclusion Periods:** Employee health plans or insurers selling products to them may deny, exclude, or limit an enrollee's benefits arising from a preexisting condition for no more than 12 months following the date of enrollment. A preexisting condition is defined as condition for which medical advice, diagnosis, care, or treatment was received or recommended during the six months preceding the date of enrollment. Pregnancy may not be considered a preexisting condition. States can impose shorter timeframes on licensed insurers and HMOs.¹⁸⁶ For example, California law allows fully insured group health plans only six months to apply preexisting condition exclusions following an individual's effective date of coverage. (For self-insured group health plans, the maximum period to apply such exclusions would be 12 months.)¹⁸⁷
- **Credit for Prior Coverage:** Employee health plans and insurers covering their participants must credit an enrollee's period of prior coverage against its preexisting condition exclusion period. (For example, someone changing jobs who has been covered for nine months may be eligible to have the new employer's 12-month exclusion period for preexisting conditions reduced by nine months.) To be creditable, prior coverage must have been consecutive, with no breaks of more than 63 days. States can increase the 63-day maximum break-in-coverage period applied to insurers. In California, fully insured group health carriers must credit prior coverage if it is not interrupted by a break of more than 180 days, instead of 63 days.¹⁸⁸
- **Certificate of Creditable Coverage:** Employee health plans, insurance issuers, and other entities must provide certificates of creditable coverage to enrollees whose coverage ends. These certificates must document the period the enrollee was covered in order to credit this time against a preexisting condition exclusion period that may be imposed by the next group health plan or issuer.
- **Special Enrollment Periods:** People who do not enroll in a group health plan during their initial enrollment opportunity may be eligible for a later special enrollment period if they originally declined to enroll because they had other coverage, such for example, under COBRA, or lost coverage as a dependent under a spouse's plan. Also, if an enrollee has a new dependent as a result of birth or adoption or through marriage, the enrollee and dependents may become eligible for coverage during a special enrollment period. States can extend these special periods to enroll in licensed insurance products.¹⁸⁹

Efforts to Assist Consumers

Despite the recent economic downturn, regulators operating consumer hotlines in both the DMHC and CDI said that they have not noticed a major increase in consumer inquiries about how to continue their coverage. Staff in the CDI (and regional PWBA offices) said that they receive such calls routinely and sometimes advise consumers about what their best options might be. Although advice varies by individual circumstances, generally speaking, people should look first to spousal coverage, next to COBRA or Cal-COBRA, then to the individual market. If COBRA is not available and they have a preexisting condition, they might consider a seeking a conversion policy or coverage under MRMIP. People with lower incomes might be advised to consider applying for Medi-Cal or the State Children's Health Insurance Program. According to

a written statement prepared for the authors by the CDI, “every option is thoroughly explored by the (hotline) officers with individuals who indicate that they are becoming uninsured.” DMHC staff said they provide consumers with general information about their coverage options, either by phone or in a letter, but typically do not try to evaluate those options.

DOL officials also said that they had not detected an increase in COBRA-related calls during the last quarter of 2001. DOL’s Pension and Welfare Benefits Administration has produced a fact sheet advising people who lose employment of several options for maintaining coverage, including their right to a special enrollment period in a spouse’s plan and their COBRA rights. DOL benefits advisors have been participating in “rapid response” meetings held at job sites where employers are about to lay off workers.¹⁹⁰ At such meetings, they met with more than 40,000 workers across the country in the last quarter of 2001, advising them about how to sign up for unemployment insurance and about employee benefit and pension issues, including options for maintaining health coverage. Several such meetings have been held in the Los Angeles area, which DOL officials said appeared to be one of the hardest hit by layoffs in the country last year.

Comparison of State and Federal Law

California’s mini-COBRA law, which applies to insurers covering employers with two through 19 employees, to a large degree mirrors the requirements of the federal COBRA law applying to firms with 20 or more workers. Should a firm with fewer than 20 employees decide to self-insure its health benefits, neither law would apply. With the passage of HIPAA, the federal government attempted to extend access to coverage to both current employees and those who have lost their jobs. Californians seeking to maintain coverage after employment can explore several other options that include buying an individual policy, exercising conversion rights, applying for coverage under the state’s high-risk pool, or investigating eligibility for programs subsidizing lower-income people. The complex patchwork of federal and state laws that may help people keep access to coverage, however, is difficult to navigate and leaves many people facing significant barriers in maintaining coverage. To complicate matters even more, the impact of ERISA on many state coverage-continuation and conversion laws remains unclear due to conflicts among the few courts that have considered these types of cases. As described below, HIPAA presented a new regulatory model in which the federal government set minimum standards applying to both employee health benefit plans and insurers contracting with them and allowed states to build on these standards and enforce them.

HIPAA as a Regulatory Model

In enacting HIPAA, Congress attempted to apply uniform consumer protections across several types of health plan sponsors, including private-sector employee health plans regulated under ERISA, and between insured and self-insured ERISA plans. Viewed one way, HIPAA was a fairly straightforward expansion of federal standards governing employee health benefit plans. Viewed another, HIPAA represented a compromise in which states lost some jurisdiction to determine the rules for regulating health insurance but benefited from Congress bringing self-insured, private-sector employee health plans—typically outside their regulatory reach—under rules similar to those for state-regulated insured plans (at least in the new substantive areas the law specifies). In order to set federal minimum standards, Congress limited state autonomy over

regulating health insurance; in return, it applied new standards to self-insured group plans governed by ERISA as well as other group health plans.

HIPAA represented a departure in how the federal government and states split responsibility for regulating private-sector employee health benefits and health insurance. This regulatory model is important to note, especially because most of the managed care provisions in the federal patients' rights bills passed in the summer of 2001 by the U.S. House and Senate generally follow its structure. Under HIPAA's approach, the DOL continued to regulate private-sector employee benefit plans but the states were invited to enforce the new federal rules for insurers and managed care companies. The law also specifically allows state legislatures to build on the federal statutory "floor" established by HIPAA for insurers and managed care companies, as long as the state laws are consistent with it.

The DOL, which is responsible for enforcing HIPAA provisions with regard to employee health benefit plans, has been conducting reviews of different types of plans to ascertain compliance with HIPAA and subsequent benefit mandate laws enacted by Congress. According to DOL staff, when they find instances of non-compliance during these reviews, they work with regulated entities to take corrective action. DOL staff also have participated in compliance assistance seminars held at various sites across the country along with state insurance officials and representatives of other federal agencies involved in enforcing HIPAA.

Another important aspect of the HIPAA "model" is that it added yet another regulatory agency to the mix that might serve enrollees of private-sector employment-based health plans – the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. (CMS was known for 35 years as HCFA—the Health Care Financing Administration—until the Bush Administration recently changed its name.) Under HIPAA and subsequent federal benefit mandate laws using its regulatory approach, if states fail to pass legislation conforming to the federal standards (or fail to substantially enforce the standards), then CMS must step in to enforce the federal law.

When HIPAA was enacted, it was generally believed by Congress and the Clinton administration that all the states would quickly opt to enforce the new federal insurance standards and not allow federal officials to enforce regulations in the insurance markets—a traditional state domain. Most federal policymakers were surprised when five states, including California, initially failed to enact legislation allowing state enforcement of all of HIPAA's provisions. After the California legislature initially did not pass legislation conforming to HIPAA's individual market requirements, CMS' San Francisco office assembled an eight-member HIPAA enforcement unit, including an attorney, to enforce the individual market requirement in California and potentially assist with HIPAA-related issues that might arise in other western states.¹⁹¹ California passed conforming legislation in 2000, and state insurance regulators began enforcing HIPAA's individual market rules in 2001. Although CMS' regulatory role continues under HIPAA and related laws, it has diminished significantly, leading the federal agency to centralize responsibility for enforcing insurance standards under these laws in its Kansas City regional office. As more states assumed responsibility for enforcement, CMS dropped the number of full-time equivalent staff dedicated to enforcing HIPAA to 16 in April 2001 from 39 in July 1998.¹⁹² Yet, federal officials are aware that the CMS' role as insurance regulator might expand again with the passage of federal patients' rights legislation.

IX. Conclusion

The purpose of this report has been to map the uneven and often confusing regulatory terrain that faces consumers enrolled in private-sector employee health plans sponsored by employers and by joint labor/management boards operating collectively bargained plans. Health plan consumers face several potential problems. For example, their employee health plan, or the insurer or managed care company contracting with it, may be financially unable to continue their health coverage. Their plan may fail to cover certain treatments or diseases. Consumers may not be provided enough information about the plan to make appropriate choices or use the health care system effectively. A change or loss of employment presents the prospect of losing affordable health coverage or of finding any coverage, especially if a person has a pre-existing medical condition. Should a disagreement arise concerning benefits, payment, or health care quality, processes to resolve these disputes may be tilted against consumers. As employee plans increasingly strive to manage costs, patients have faced barriers to seeing certain providers, longer waiting times for appointments, and limitations on covered services.

A complex array of federal and state laws exists to help people enrolled in private-sector health plans deal with issues such as these. Nevertheless, the assortment of legal protections and corresponding public agencies that enforce them are often confusing to consumers and in many instances do not offer them assistance. As documented in the report, consumer protections available under federal and state law differ not only according to who sponsors the plan (e.g., public-sector vs. private-sector employers vs. individually purchased policies) and whether the plan is insured or self-insured, but also, in California, according to which state agency licenses a particular fully insured product (either the CDI or the DMHC).

In the six years since the authors produced a national study of variations in consumer protections under ERISA and state law,¹⁹³ consumer protection standards have grown both at the national level and in California. But while federal law protections have increased, they are still less rigorous in many respects than corresponding state standards that often are preempted by ERISA. Employers and insurers argue that adding more ERISA health plan standards or state insurance mandates will impose prohibitive costs. As federal standards become more comprehensive, the interplay between federal and state standards resulting from both ERISA's preemption

provisions and the U.S. Constitution's supremacy clause may increase the confusion about which standards apply to which types of health coverage plans.

In several respects, particularly solvency standards, benefits mandates, dispute resolution, and managed care rules, state laws offer greater consumer protections than ERISA (and arguably also impose more regulatory cost). For example, even with differing standards for ensuring health insurer and health care service plan solvency, California's standards and monitoring practices afford considerable protection for enrollees in licensed insurance and managed care products, whereas federal law sets no solvency standards for employee health benefit plans, either fully insured or self-insured. Furthermore, some self-insured employee health plans do not protect themselves with stop-loss coverage. In contrast to employees covered by self-insured plans, people enrolled in insured plans that face bankruptcy may be assisted by California regulators in enrolling in new plans should their insurers or managed care plans become insolvent. How to regulate the solvency of managed care plans is a particularly pertinent issue in California because of the recent bankruptcies of several HMOs and many more independent medical groups that assumed financial risk for providing health care.

In contrast to a few dozen state health insurance mandates, ERISA requires private-sector employee health plans to cover only three specific benefits (regarding newborn hospitalization, post-mastectomy care, and mental health benefits). Because self-insured plans do not have to report the benefits they cover to DOL and states cannot require them to report plan descriptions, little is known nationally or in California about actual benefit design. Some people interviewed for this report, however, indicated that some self-insured health plans cap the amount they will pay for some services, especially for people with costly conditions like AIDS, suggesting that benefits in some self-insured plans may be less comprehensive than those in insured plans.

While recently adopted federal "claims payment" rules offer more appropriate and timely appeals procedures to ERISA health plan enrollees in an era dominated by managed care, California law provides not only an independent review process but also active DMHC involvement in assisting people to resolve other problems with their health plans. Despite increased attention to assisting ERISA plan participants in recent years, DOL staff have neither the resources nor the legal authority to resolve individual enrollee-plan disputes. Furthermore, while California's law authorizing a right to sue health plans may still face some ERISA preemption hurdles (for example, because courts have limited the right to sue ERISA health plans for damages over coverage disputes), the new state law does afford a legal remedy to consumers in employee health plans by providing the right to sue managed health care plans over health care quality.

Like most states, California has enacted a broad array of standards to assure that people enrolled in licensed managed care plans have reasonable access to appropriate and necessary services and providers. While bills passed by both houses of Congress in 2001 would impose most of these standards on all ERISA plans, they do not exist under current federal law. In recent years, self-insured employee plans have been using not only PPO arrangements but also HMO companies to administer their benefits, making managed care standards an important issue for people enrolled in self-insured plans because state managed care standards do not apply to self-insured plans and suggesting the value of more information on how self-insured managed care plans operate in practice.

In a few respects, federal standards offer similar protections to those under state law. For example, HIPAA has standardized pre-existing condition exclusion periods and, to some degree, opportunities to obtain coverage when changing jobs. Yet the options for maintaining coverage when people lose their jobs remain difficult to navigate and often do not provide people access to affordable coverage.

Recent enhancements to federal regulations prescribing information that must be disclosed to health plan enrollees bring these standards closer to those under California law. But health plans under state law are required to provide more expeditious notice that a plan is to be terminated. Furthermore, DOL policy is that while plans must explain the role of insurers (for example, when they do not bear insurance risk), plans do not need to explain the consumer implications of being self-insured, such as the different (and generally weaker) standards for benefits, solvency, and dispute resolution procedures in contrast to state standards for insured products. State agencies could offer this type of consumer education, and CDI indicates its plan to do so in an updated consumer health education brochure.

While California experiences a lower level of self-insurance than the nation as a whole, probably due to the state's strong tradition of using licensed managed care plans, it is possible that the prevalence of self-insurance could increase in the future if more HMOs agree to rent networks and care management services to employee health plans retaining insurance risk. As employers respond to rekindled health care cost inflation and the prospect of increased federal managed care standards and legal liability, the potential of employers switching to "defined-contribution" health benefit design approaches (such as high-deductible plans, which might be insured or self-insured) has many consumer advocates concerned that they will shift costs and financial risk to consumers, especially those with preexisting medical conditions and lower incomes.

In the foreseeable future, the complex checkerboard of federal and state laws governing private-sector employee health plans will probably not become easier to navigate. In the absence of stronger federal standards on issues of plan solvency, benefits, managed care regulation, and damages remedies, variation will continue between federal and state law. State agencies could assist consumers in understanding and using their health coverage more effectively by providing information on the implications of self-insurance and post-employment coverage options and encouraging employers to provide advance notice of major plan changes. Consumers also could benefit from direct assistance in using health coverage plans effectively. The likely continued variation in consumer protection standards also underscores the importance of coordination among federal and state agencies to educate the public, share complaint referrals, and enforce applicable law.

Appendix: List of Interviewees

Individuals interviewed for this report include the following:

California Department of Insurance

Sheldon Summers, Chief, Actuarial Analysis Bureau
Tony Cignarale, Chief, Consumer Services Division
Jose Aguilar, Assistant Chief Counsel, Legal Branch
Robert Conover, Senior Life Actuary
Leone Riffany, Supervising Insurance Compliance Officer
Janelle Roy, Supervising Insurance Compliance Officer
Ann Tang, Senior Insurance Examiner
Cora Okumura, Senior Insurance Examiner
Teddy Robb, Senior Insurance Compliance Officer
Lucy Jabourian, Senior Insurance Compliance Officer
Dairyn Valencia, Associate Governmental Program Analyst
Marsha Seeley, Senior Staff Counsel

California Department of Managed Health Care

Herb Schultz, Deputy Director, External Affairs
Andy Meyers, Deputy Director, Financial Solvency and Standards Board
Mark Wright, Financial Solvency and Standards Board
Penny Fowler, Chief, Division of Complaint Response and Resolution
Joan Cavanaugh, Assistant Deputy Director, Enforcement
Carolyn Gaynor, Division of Complaint Response and Resolution
Suzanne Chammout, Chief, Licensing Branch (Sacramento)

U.S. Department of Labor, Pension and Welfare Benefits Administration

Chris Johnson, Associate Regional Administrator (Los Angeles)
Wendy Morgan Supervisory Benefits Advisor (Los Angeles)
Tina Ly, Supervisory Benefits Advisor (San Francisco)
Karen Handorf, Office of the Solicitor (Washington, D.C.)

Others

Leslie Cummings, Managed Risk Medical Insurance Board (former staff to Assembly Majority Leader)

Emery “Soap” Dowell, former member, Managed Risk Medical Insurance Board and former Senior Vice President of Government Affairs, Blue Cross of California

David Duker, Vice President, Marketing, CaliforniaChoice

Anne Eowan, Vice President, Association of California Life and Health Insurance Companies

Richard Figueroa, Deputy Secretary, Legislative Affairs, Office of the Governor

Richard Froh, Vice President, Kaiser Foundation Health Plan

John Grgurina, Executive Director, California PacAdvantage/Pacific Business Group on Health

Clark Kelso, McGeorge School of Law

Peter V. Lee, President and CEO, Pacific Business Group on Health

Larry Levitt, Vice President, Henry J. Kaiser Family Foundation

Debra Roth, Ruderman and Roth

Shelley Rouillard, Program Director, Health Rights Hotline

Bridget Sheehan-Watanabe, Health Rights Hotline

Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board

Carl Volpe, Vice President, Strategic Health Partnerships, Healthcare Quality Assurance Division, Wellpoint Health Networks

Walter Zelman, President and CEO, California Association of Health Plans

Notes

1. In 2000, about two-thirds of the nonelderly Americans received employment-based coverage, about 14 percent were covered by public programs, less than 7 percent purchased their own health insurance policies, and almost 16 percent had no health insurance. In 2000, about 60 percent of Californians received employment-based coverage, 16.5 percent were covered by public programs, 7.3 percent bought their own policies, and 20 percent were uninsured. (Source: Fronstin, Paul, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey," EBRI Issue Brief no. 240, December 2001, Employee Benefit Research Institute, Washington, DC.) In 2000, 38.4 million Americans including about 6.2 million Californians lacked health insurance, posing a major challenge to many of them in maintaining their health and financial stability. The large number of uninsured also presents major challenges to American health system, which must absorb the cost of uncompensated care, and to policymakers who are faced with the task of considering ways to expand coverage in the face of a weakening economy and tighter public-sector budgets.
2. 29 U.S.C. sections 1001 et seq.
3. Standards for pensions include requirements for holding in trust plan assets used to provide benefits; disclosure of plan information to employees; reporting of plan operations to the federal government; employee plan eligibility and participation; pension vesting; pension funding; plan fiduciary and management standards; and a federal insurance system to fund insolvent pension plans.
4. 29 U.S.C sections 1002 (1), (3).
5. The ERISA statute does not include the term "self-insured;" rather, this term has been coined to connote ERISA plans that bear insurance risk themselves rather than buying commercial products from insurers or HMOs. Self-insured ERISA plans often use licensed insurers to pay claims, create networks, and administer managed care procedures, but these activities do not constitute the business of insurance.

6. Nor are those maintained solely to comply with state workers' compensation, unemployment compensation, or disability insurance laws, 29 U.S.C. section 1003(b).
7. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997). The conflict can result when compliance with both state and federal law is a "physical impossibility," *Florida Avocado Growers v. Paul*, 373 U.S. 132, 142–143 (1962) or when the "scheme of federal regulation is 'so pervasive as to make reasonable the inference that congress left no room for the states to supplement it,'" *Gade v. National Solid Wastes Management Assoc.*, 505 U.S. 88, 98 (1992).
8. ERISA's preemption clause, section 514(a) of the Act, states: Except as provided in subsection (b) [the "savings clause," described below]... the provisions of this [law] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan 29 U.S.C. section 1144(a). "State" includes states and political subdivisions as well as the District of Columbia and the territories and "state law" includes laws, decisions, rules, regulations or other actions having the effect of law, 29 U.S.C. section 1144(c).
9. This was Senator Inouye's characterization (at hearings on Hawaii's bid for an exception) of the Standard Oil District Court's reference to the fact that Congress had not discussed preemption explicitly in legislative history (Fox, Daniel M. and Daniel C. Schaffer. 1989. "Health Policy and ERISA: Interest Groups and Semipreemption." *Journal of Health Politics, Policy and Law* 14(2):239–260 at 248).
10. Fox and Schaffer, "Health Policy and ERISA: Interest Groups and Semipreemption." The preemption language finally enacted was added in the Conference Committee and described briefly in subsequent floor debates. What little legislative history exists to explain it comes from the conference report, which is not detailed (H.R. Rep. No. 93–1280, 93rd Cong., 2d Sess. 383 (1974), U.S.C.C.A.N. 93d Cong. 2d Sess. at 5162.), the post-conference statements on the floor of Congress, and recollections of congressional staff and lobbyists involved in the debate. Recollections of advocates and congressional leaders involved in drafting ERISA suggest, for example, that Congress was aware of contemporary state proposals to tax and regulate private sector employee health plans, such as California's Knox-Keene Act (enacted in 1975) and the Hawaii Prepaid Health Plan Act of 1974 and intended to preempt them.
11. 29 U.S.C. 1185.
12. 29 U.S.C. section 1144(b)(2)(A).
13. *U.S. v. Southeastern Underwriters' Assoc.*, 322 U.S. 533 (1944).
14. 15 U.S.C. section 1101 et seq.
15. 29 U.S.C. section 1144(b)(2)(B). The rationale for this different treatment of self-insured employer plans is that, while these health plans do pool risk, as insurers do, but they are not in the business of insurance, competing with other companies to provide health insurance.

They are instruments through which employers compensate workers in the form of health benefits.

16. Defining self-insurance would seem to be within the Department's authority as part of its requirements that plans disclose their financial arrangements and any insurer functions to plan enrollees (29 C.F.R. sections 2520.102–3(q)). The IRS has defined "fully insured" ERISA plans for purposes of its enforcement of ERISA (through instructions to IRS Form 5500) as an ERISA plan whose benefits are provided exclusively through insurance contracts or policies (issued by state-authorized HMOs and other insurers) and whose premiums are paid directly by the employer or employee organization from general assets (in addition to any premium contributions from employees).
17. One area of confusion is the role of "stop-loss" insurance, discussed in Chapter 4, which some ERISA plans (or their sponsors) purchase to protect the plan from very high cost cases. Some of these ERISA health plans call themselves self-insured. But insurance regulators in many states assert they are using stop-loss insurance as a way to avoid state insurance regulation of plan benefits and taxes.
18. More detailed legal analysis is available in other publications, such as Butler, Patricia A. and Karl Polzer. *1996 Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law* (National Health Policy Forum, George Washington University) and 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.).
19. *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The holding in this case was supported in later cases: *DeBuono v. NYS-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) and *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997). State laws that tax health care providers have been upheld against ERISA challenges based on *Travelers: Boyle v. Anderson*, 68 F.3d 1093 (8th Cir. 1995), cert. denied, 516 U.S. 1173 (1996); *New England Health Care Employees Union v. Mount Sinai Hospital*, 65 F.3d 1024 (2d Cir. 1995); *Connecticut Hosp. Assoc. v. Weltman*, 66 F.3d 413 (2d Cir. 1995). For almost 100 years, the courts have recognized that the U.S. Constitution allows states to regulate to protect the public health, safety and welfare, *Jacobsen v. Massachusetts*, 197 U.S. 11 (1905).
20. See, e.g., *Standard Oil v. Agsalud*, 442 F. Supp. 695 (N.D. Cal. 1977), aff'd, 633 F.2d 760 (9th Cir. 1980), aff'd mem., 454 U.S. 801 (1981); *Alessi v. Raybetos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983); *FMC Corp. v. Holliday Corp.*, 498 U.S. 52 (1990); *Mackey v. Lanier Collection Agency*, 486 U.S. 834 (1988).
21. See, e.g., *Mullenix v. Aetna Life and Casualty Ins. Co.*, 48 F. 3d 1406 (11th Cir. 1990).
22. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) upheld a state law mandating that health insurers include mental health benefits.

23. *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999). A Washington Statute mandating that managed care and other health insurance plans reimburse all the categories of providers that are licensed to render services covered by the plan, *Washington Physicians Service Assoc. v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), cert. denied, 119 S. Ct. 1033 (1999). Federal court decisions are mixed, however, with respect to whether state “any willing provider” laws (requiring managed care plans to include all providers that apply into their networks) are state insurance laws exempt from ERISA. For example, in: *Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), cert. denied, 510 U.S. 1003 (1993) and *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), the laws were held to be insurance laws and not preempted. On the other hand, in *CIGNA Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996) cert. denied, 519 U.S. 964 (1996) and *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) cert. denied, 118 S. Ct. 75 (1997); and *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998), the state laws were held not to be insurance laws and were preempted.
24. Disclosure, reporting requirements, and fiduciary duty standard were enacted as part of the original ERISA language in 1974; child support orders and treating Medicaid as a secondary payer were added in 1983; continuation (COBRA) was enacted in 1985, mental health “parity,” post-delivery hospitalization, reconstructive post-mastectomy surgery and pre-existing exclusion standards were enacted in 1996 (HIPAA).
25. Pension plans must report more financial and transaction information, for example, if they intend to transfer excess pension plan assets to a health plan account, 29 U.S.C. 1021(e).
26. 29 U.S.C. 1023, 1024. Annual reports must be filed within 210 days of the end of the plan’s reporting year on forms provided by DOL (Form 5500). Before 1996 amendments to ERISA, plans also were required to file with DOL copies of their plan descriptions and notice of plan changes (which the law still requires furnished to plan participants).
27. This information is provided on Form 5500 and its accompanying schedules (see 65 Federal Register 5026 et seq., Feb. 2, 2000). Small welfare benefit plans (those under 100 participants) are not required to file the schedules on accountant or actuarial payments and may use a simplified financial reporting schedule.
28. 29 U.S.C. 1104.
29. *Morales v. Health Plus, Inc.*, 954 F. Supp. 464 (D. Puerto Rico 1997).
30. In *Stumpf v. Medical Benefits Administrators*, D. Neb. No. 8:99 CV 185, September 14, 2001, the plan denied the participant’s claim for reimbursement for hospitalization for a pregnancy complication, motivated by the desire to avoid paying a claim that the plan’s stop-loss carrier had indicated it would not cover despite the fact that the claim was covered by the plan’s terms.
31. Some health insurers have been held to breach this duty by failing to disclose information to plan participants, for example, the financial incentives paid to physicians to practice

conservative medical care (*Shea v. Eisensten*, 107 F. 3d 625 (8th Cir. 1997), cert. denied, 66 U.S. 3137 (1997)) or the discounts negotiated with providers that should have reduced patient copayment amounts (*McConocha v. Blue Cross and Blue Shield of Ohio*, 898 F. Supp. 545 (D. Ohio 1995), rehearing denied, 930 F. Supp. 1182). The U.S. Supreme Court held recently, however, that an HMO and its physicians did not act as fiduciaries in making coverage decisions under the plan (*Pegram v. Herdrich*, 120 S. Ct. 2143).

32. The booklet, entitled “Questions and Answers: Recent Changes in Health Care Law” is currently in its 4th edition, is available from the PWBA publications hotline (1-800-998-7542) or on the PWBA Web site, www.dol.gov/dol/pwba.
33. The DOL Web site is located at www.dol.gov/dol/pwba. The Health Benefits Education Campaign brochures are “Life Changes Require Health Choices: Know Your Benefits Options;” “Top 10 Ways to Make Your Health Benefits Work for You;” and “Work Changes Require Health Choices: Protect Your Rights.”
34. *The Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits 2001 Annual Survey*. Henry J. Kaiser Family Foundation, Menlo Park, California, and Health Research and Educational Trust, Chicago, Illinois, 2001, p. 130. California data provided to authors by the Kaiser Family Foundation was taken from the Kaiser/HRET 2001 California Employer Health Benefits Survey. (Note: the national data include state and local government plans, which are not regulated under ERISA, while the California data do not.)
35. See, Butler, Patricia and Karl Polzer, “Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law,” *National Health Policy Forum*, The George Washington University, June 1996, and Polzer, Karl and Patricia Butler, “Employee Health Plan Protections Under ERISA,” *Health Affairs*, September/October 1997.
36. For a summary of the range of new “defined contribution” approaches to providing employee health benefits, see Fronstin, Paul, “Defined Contribution Health Benefits,” *EBRI Issue Brief no. 231*, March 2001, Employee Benefit Research Institute, Washington, DC.
37. “Innovative Pacific Business Group on Health Tries New Alternative to Managed Care,” *Pension and Benefits Reporter*, The Bureau of National Affairs, Washington, DC, vol. 28, no. 46, Nov. 20, 2001, pp. 2882–2883.
38. Rates can vary more widely in the 2–50 life market on the basis of age and geography.
39. Kaiser/HRET 2001 California Employer Health Benefits Survey.
40. The Hotline and its data are described in note 151.

41. White, Ronald D., "More Firms Carrying Health Costs; Benefits: Rising premiums are forcing smaller and smaller employers to dump insurers and assume workers' medical expenses themselves," *Los Angeles Times*, Feb. 19, 2002.
42. A federal Court of Appeal held that Maryland's stop-loss regulation (which held that a stop-loss policy covering costs below \$10,000 was actually health insurance subject to state insurance law, *American Med. Sec. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997), cert. denied, 118 S. Ct. 2340 (1998)). In *Associated Ind. of Missouri v. Missouri Dep't of Ins.* Cole County Circuit Court, CV195-1326CC, Dec. 27, 1995, the court held that the regulation was not authorized by state law and also was preempted by ERISA.
43. Baumgarten, Allan, *California Managed Care Review: 2001*, Allan Baumgarten. Minneapolis, MN. p.
44. California Association of Health Plans. *California Association of Health Plans 2001 Profile and Annual Report*, Sacramento, CA, 2001.
45. *Kaiser Daily Health Policy Report*, Feb. 20, 2002. (<http://www.kaisernetwork.org/dailyreports/healthpolicy>). The results are reported to be based on a survey of 846 California employee benefit managers conducted between May 2001 and August 2001.
46. Baumgarten, Allan, *California Managed Care Review: 2001*, Allan Baumgarten. Minneapolis, MN.
47. Baumgarten, Allan, *California Managed Care Review: 2001*, Allan Baumgarten. Minneapolis, MN. p 14.
48. California Association of Health Plans. *California Association of Health Plans 2001 Profile and Annual Report*. Sacramento, CA, 2001. p. 9.
49. Data from 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey were supplied to authors from a table published by RAND. Readers should be cautioned that, due to small sample sizes, these data are relatively imprecise. Based on the sample size, researchers can be confident that there is a 95% chance that actual number falls somewhere between 41% and 85% with regard to the 63% of self-insured establishments that reported not having purchased stop-loss insurance and that were part of firms with fewer than 500 workers. Similarly, researchers can be confident that there is a 95% chance that the actual number falls somewhere between 23% and 59% with regard to the 41% of self-insured establishments that reported not having bought stop-loss insurance and that were part of firms with 500 or more workers.
50. At the time of ERISA's passage, almost all employee health plans were fully insured and subject to indirect state regulation. In contrast to its treatment of pension plans, ERISA contains no plan solvency standards other than its general standard that requires plan fiduciaries to act prudently and in the sole interests of participants. As they do today, states actively regulated the solvency of health insurers.

51. Kelso, J. Clark, *Regulatory Jurisdiction ver Health Insurance Products: The Department of Managed Health Care and The Department of Insurance* (draft) Sacramento: California Department of Managed Health Care, September 27, 2001.
52. According to DMHC staff, the major types of insurance required include a fidelity bond, malpractice insurance, workers' compensation, property liability coverage, and reinsurance for catastrophic cases.
53. Under sec. 1300.76 of the California Health and Safety Code, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Director. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due; long-term prepayments of deferred charges, and nonreturnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least 110 percent of the amount owing.
54. For full service plans, the minimum required is the greater of 1) \$1 million; or 2) the sum of 2 percent of the first \$150 million of annualized premium revenues plus 1 percent of annualized premium revenues in excess of \$150 million, or 3) specified percentages of annualized health care expenditures.
55. Roth, Debra and Deborah R. Kelch, *Making Sense of Managed Care Regulation in California*. Oakland: California HealthCare Foundation. November 2001.
56. Gellene, Denise, "Third HMO Seized by Regulators," *Los Angeles Times*, September 15, 2001.
57. While DMHC staff said that increasing the TNE standards might be appropriate, at least one interviewed did not think the risk-based capital method used by the CDI would be helpful for managed care plans. He said that the risk-based capital standards seemed more geared toward assessing the value of long-term capital investments, which might be very helpful for many insurance products, but that, with managed care products, tracking "cash" or short-term ability to pay claims was more important.
58. Baugarten, Allan, *California Managed Care Review: 2001*, Allan Baumgarten. Minneapolis, MN.
59. California Senator Jackie Speier, "Chilling Statistics on Patient Impact, and How Policymaking Helps," excerpt from California HealthCare Foundation. *Smart Remarks: Commentary on the Physician Solvency Issue In California*. October 2001.
60. Ibid.

61. From table in “Risk-Bearing Organizations First Quarter of 2001 Reporting Results,” California Department of Managed Health Care Web site, <http://www.dmc.ca.gov/hpp/rbo/reports.asp>, Nov. 29, 2001.
62. CapMetrics, LLC, Paul J. Gertler, and Christopher C. Ohman, *Cash Matters: Results from a Survey of California Physician Groups*, California HealthCare Foundation, October 2001.
63. One regulator commented that while many medical groups currently may think that convincing the DMHC to increase their rates presents a short-term fix for their problems, they “should be careful what they wish for.” (If the department becomes cast in the arbitrator role, another concern may be that some HMOs and medical groups may end up having an incentive to delay coming to agreement. In some cases, delays can worsen a medical group’s financial situation.)
64. To date, the CDI has not monitored or regulated the adequacy of providers or the access to services provided. According to agency staff, these conditions were viewed as marketplace issues that could be resolved by the insured through application of “choice;” that is, under traditional insurance models an insured party could and would change his or her provider or insurer if such inadequacies occurred. (As a consumer advocate reviewing this paper noted, consumers’ ability to exercise such “choice” in today’s marketplace may be substantially more limited. For example, people in employee health plans are usually locked into their plans for a year and can change only during open enrollment periods.) CDI staff noted that with the advent of managed care, the health care delivery system has come under scrutiny and changed “the perspective of what is expected of a regulatory entity in its responsibilities.” CDI is currently reviewing and analyzing how it might respond to managed care practices.
65. ERISA defines a MEWA as an employee welfare benefit plan or other arrangement established to provide benefits to the employees of two or more employers except those established or maintained under a collective bargaining agreement or by a rural electric or telephone cooperative. States can require “fully insured” MEWAs to meet insurance reserve and contribution levels. MEWAs that are not fully insured may be subject to any insurance law that does not conflict with ERISA (*Atlantic Healthcare Benefits Trust v. Googins*, 2 F.3d 1 (2d Cir. 1993), cert. denied, 510 U.S. 1043 (1994); *Fuller v. Norton*, 86 F.3d 1016 (10th Cir. 1996)). MEWAs are distinguished from “multi-employer plans,” such as Taft-Hartley Trusts, through which employers in a single industry jointly create pension and health plans for their collective workforce.
66. For more detail on MEWAs, see: Leibowitz, Arleen, Cheryl Damberg, and Kathleen Eyre, “Study 5: Multiple Employer Arrangements,” in *Health Benefits and the Workforce* (Washington, DC: U.S. Department of Labor, Pension and Welfare Benefits Administration) 75; Polzer, Karl, “Multiple Employer Purchasing Groups (METs, MEWAs, HINs, HPCs): The Challenge of Meshing ERISA Standards with Health Insurance Reform,” *National Health Policy Forum, Issue Brief No. 604*, September 24, 1992, The George Washington University, Washington, DC; and Polzer, Karl, “Preempting State Authority to Regulate Association Plans: Where Might It Take Us,” *National Health*

- Policy Forum, Issue Brief No. 707*, October 15, 1997, The George Washington University, Washington, DC.; U.S. GAO. 1992. *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements*. Washington, D.C.: U.S. Government Printing Office. See also, Tilman, Robert. 1998. *Broken Promises: Fraud by Small Business Health Insurers*. Boston: Northeastern University Press.
67. California Department of Insurance. *Report on Multiple Employer Welfare Arrangements As Required By California Insurance Code Section 742.435*. December 4, 2001.
 68. Klein, Robert and Michael M. Barth, "Solvency Monitoring in the Twenty-First Century," *Journal of Insurance Regulation*, 13, no. 3 (1995).
 69. Kelso, J. Clark, *Regulatory Jurisdiction Over Health Insurance Products: The Department of Managed Health Care and The Department of Insurance*, (draft). Sacramento: California Department of Managed Health Care. September 27, 2001.
 70. Roth, Debra and Deborah R. Kelch. *Making Sense of Managed Care Regulation in California*. Oakland: California HealthCare Foundation. November 2001.
 71. *U.S. v. Southeastern Underwriters' Assoc.*, 322 U.S. 533 (1944).
 72. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the U.S. Supreme Court held that a state law requiring insurers to include mental health benefits did "relate to" ERISA plans because it affected their benefits design. But the Court held the state law was saved as state regulation of the business of insurance because it: was directed at the insurance industry and limited to insurers, regulated the policy terms between insurers and their insureds, and spread risk across policyholders. Under this reasoning, the Ninth Circuit Court of Appeals upheld a Washington State law requiring that HMOs and other health insurers be willing to reimburse a broad variety of licensed health care providers (such as chiropractors or naturopaths) who render covered services (*Washington Physicians Serv. Assoc. v. Gregoire*, 147 F. 3d 1039 (9th Cir. 1998), cert. denied, 525 U.S. 1141 (1999)). One federal district court held, however, that ERISA preempted an Alabama law mandating payment of physicians' assistants because it was not limited to insurers but included "organized delivery systems" and self-funded employer plans (*Hobbs v. Blue Cross and Blue Shield of Alabama*, 100 F. Supp. 2d 1299 (M.D. Ala 2000)).
 73. 29 U.S.C. 1185a. This provision was scheduled to sunset in late 2001 but was extended through 2002 in the DHHS appropriation bill (P.L. no. 107-116). The regulations provide a formula for calculating the mental health limits if different limits apply to different types of medical or surgical benefits. Plans may impose different cost sharing, numbers of days of coverage, and medical necessity standards on mental health benefits compared to medical/surgical benefits. The law does not apply to plans of employers with 50 or fewer employees. The requirement does not apply if it has increased plan costs at least one percent after six months.
 74. 29 U.S.C. 1191. The plan cannot require a showing of "medical necessity" for this hospitalization period nor require prior authorization for it (although plans may require

advance notice of the admission). The mother and her attending physician can decide to leave the hospital sooner, but plans cannot provide incentive payments or rebates to the mother or physician to encourage early discharge nor penalize the physician for providing care required by the law.

75. 29 U.S.C. 1185b.
76. Public information includes brochures available in print and on the PWBA Web site, Web site responses to “frequently asked questions;” and public meetings, such as the “compliance assistance seminar” in Los Angeles in 2001.
77. 42 U.S.C. 2000e(k). *United Teachers v. Board of Education of City of L.A.*, 712 F. 2d 1340 (9th Cir. 1983).
78. *Erickson v. Bartell Drug Co.*, F. Supp. 2d (D. Wa. 6/12/01). The federal district court held that the employer could not refuse to cover benefits uniquely designed for women in its prescription drug plan.
79. 42 U.S.C. 12101 et seq.
80. 42 U.S.C. 12201(c).
81. Courts have drawn this conclusion under ADA provisions involving both employment discrimination (Title I of the ADA) and discrimination in public accommodations (Title III of the ADA): *McNeil v. Time Ins. Co.*, 205 F. 3d 179 (5th Cir. 2000), cert denied, 121 S. Ct. 1189; *Weyer v. 20th Century Fox Film Corp.*, 198 F. 3d 1104 (9th Cir. 2000); *Lewis v. K-Mart Corp.*, 180 F. 3d 1166 (4th Cir. 1999); *Doe v. Mutual of Omaha Ins. Co.*, 179 F. 3d 557 (7th Cir. 1999), cert denied, 120 S. Ct. 845 (2000); *Parker v. Met Life*, 121 F 3d 1–6 (6th Cir. 1997)).
82. Jensen, Gail A. and Michael A. Morrisey. 1999. “Employer-Sponsored Health Insurance and Mandated Benefit Laws.” *Mibank Quarterly* 77 (4):425–459.
83. *Mullenix v. Aetna Life and Casualty Ins Co.*, 912 F. 2d 1406 (11th Cir. 1990).
84. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).
85. See also, *Peterson v. American Life and Health Ins. Co.*, 48 F. 3d 404 (9th Cir. 1995), cert. denied, 516 U.S. 942.
86. 29 U.S.C. 1191a. This general principle of federalism is applied by courts (See, e.g., *UNUM Life Ins. Co. v. Ward*, 119 S. Ct. 1380 (1999)) and explicitly embodied in ERISA for purposes of any of the benefit mandates and portability standards not subject to another explicit preemption provision.
87. Short, Pam F. and Patricia A. Butler, “A Comparison of Self-Insured and Fully Insured Plans in the Employee Benefits Survey (1993–1994),” in *Health Benefits and the*

Workforce, Volume 2, U.S. Dept. of Labor, Pension and Welfare Benefits Administration, 1998. This study did not adjust for employer size; to the extent that small employers are both less likely to self-insure health coverage and more likely to offer less generous benefits, the presence of small employers in the sample may bias the results toward somewhat less generous benefits under insured plans and more generous benefits under self-insured plans. See also, Acs, Greg., Stephen H. Long and M. Susan Marquis. 1996. "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions and Premiums." *Health Affairs* 15(2):266–278.

88. These benefits were: extended (nursing home) care, home health care, hospice care, inpatient and outpatient mental health care, inpatient and outpatient alcohol and drug abuse treatment, hearing care, and birthing centers.
89. Hamer, Richard. *The Self-Insured Employer Market Report*. Minneapolis: Interstudy Publications, October 2000.
90. Short and Butler., *Comparison of Self-Insured and Fully Insured Plans*.
91. See note 109, Chapter 6, for a definition of "material reduction." Notice of other changes can be provided up to 210 days after the end of the plan year during which the change is adopted.
92. *Hughes v. 3M Retiree Medical Plan*, 134 F. Supp. 2d 1062 (D. Minn. 2001). An employer could promise to provide lifetime benefits, for example, to retirees, but to be enforceable, such an intent would need to be explicit and unambiguous in plan documents.
93. Butler, Patricia A. and Karl Polzer. 1996. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: National Health Policy Forum, George Washington University.
94. *McGann v. H & H Music*, 946 F. 2d 401 (5th Cir. 1991), cert. den. 113 S. Ct. 482 (1992), sub nom, *Greenberg v. H & H Music; Owens v. Storehouse, Inc.*, 984 F. 2d 394 (11th Cir. 1993). At least one court has held that an employer cannot exclude coverage for a service while an employee is in the middle of a course of treatment, *Wheeler v. Dynamic Engineering, Inc.* 850 F. Supp. 459 (E.D. Va. 1994). And employers must conform to ERISA requirements in modifying their plans, *Confer v. Custom Engineering Co.*, 952 F. 2d 41 (3d Cir. 1991).
95. See, *Doe v. Mutual of Omaha Ins. Co.*, 179 F. 3d 557 (7th Cir. 1999), cert denied, 120 S. Ct. 845 (2000), holding that the ADA does not prohibit lower insurance caps for services for AIDS-related conditions.
96. Jensen, Gail A. and Michael.A. Morrissey. 1999. "Employer-Sponsored Health Insurance and Mandated Benefits Laws." *Milbank Quarterly* 77(4): 425–459. One study that these authors found persuasive in using marginal costs found that state-mandated benefits increased insurance premiums between 4 and 13 percent. Acs, Greg, C. Winterbottom and Sheila Zedlewski. 1992. "Employers' Payroll and Insurance Costs: Implications for Pay or

Pay Employer Mandates,” in *Health Benefits and the Workforce*. U.S. Department of Labor, Washington, D.C.

97. Marquis, M. Susan and Stephen H. Long. 2001. “To Offer or Not to Offer: The Role of Price in Employers’ Health Insurance Decisions.” *Health Services Research* 36(5):935–958. The authors reported that even premium reductions of 40 percent would increase by only 2.3 percent the number of employers that decided to offer health coverage.
98. Health Policy Tracking Service. 2000. *Major Health Care Policies: 50 State Profiles*. Washington, D.C.: National Conference of State Legislatures.
99. A conference committee can make substantive changes that are not part of either house’s bill, as one did in drafting ERISA’s broad preemption clause in 1974.
100. The Fourth and Sixth Circuit Courts of Appeal have held that ERISA did not preempt state AWP laws that applied only to insurers, *Stuart Circle Hosp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), cert. denied, 510 U.S. 1003 (1993); *Kentucky Ass’n of Health Plans, Inc. v. Nichols*, 227 F. 3d 352 (6th Cir. 2000). A district court in Massachusetts also held that ERISA did not preempt a state AWP law, *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997). But the Fifth and Eighth Circuits have held that ERISA preempts such laws and were not saved as insurance regulation because they did not meet all the McCarran-Ferguson Act criteria, since they: 1) were not limited to insurers because they applied either to HMOs (which some courts have held are not insurers) or to self-insured ERISA plans, 2) their purpose was to benefit providers not health plan enrollees, and 3) they did not spread risk, *CIGNA Healthplan v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996) cert. denied, 519 U.S. 964 (1996); *Texas Pharmacy Assoc. v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) cert. denied, 118 S. Ct. 75 (1997); *Prudential Ins. Co. v. National Park Med. Ctr.*, 154 F.3d 812 (8th Cir. 1998).
101. In *Express Scripts, Inc. v. Wenzel*, 102 F. Supp. 2d 1135 (W.D. Mo. 2000) the court characterized “freedom of choice” laws like provider (and benefit) mandates rather than AWP laws.
102. *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), helps overcome the argument that the practice regulated by a state law must spread risk but it does not address the issue of whether HMOs are insurers. While some courts have held that HMOs are not insurers, the Ninth Circuit, whose decisions are binding in California’s federal district courts, has held that HMOs are insurers for purposes of state regulation and ERISA’s savings clause, the Ninth Circuit Court of Appeals has held that HMOs are insurers in Washington State, *Washington Physicians Service Assoc. v. Gregoire*, 147 F. 3d 1039 (9th Cir. 1998), cert. denied, 525 U.S. 1411 (1999).
103. 29 C.F.R 2520.104b-2.
104. 29 C.F.R. 2520.102–3.

105. While not explicit in the regulation, this should also include voluntary arbitration, which the regulation permits to serve as a level of internal plan appeal.
106. A general statement of these benefits is sufficient as long as detailed information is available from the plan on request and the SPD so indicates.
107. The SPD need not contain the entire network list as long as the list is provided separately and automatically to plan participants.
108. The SPD need not contain the preauthorization and utilization review program details as long as they are provided separately and automatically to plan participants.
109. 29 U.S.C. 1024; 29 C.F.R. 2520–104b-3(d). This rule does not apply to plans that routinely inform participants of plan changes every 90 days. “Material reduction” is defined to mean a change in an average plan participant would consider to be important reduction in covered services, for example, eliminating or reducing benefits, increasing premiums of cost sharing, reducing an HMO’s service area, or new pre-service authorization requirements.
110. For example, a court denied recovery for the cost of medical care obtained after the expiration of COBRA continuation benefits where the participant claimed she would have exercised her right to convert to non-group coverage earlier if she had known the plan were going to terminate the conversion privilege. The plan administrator notified participants six months after the end of the plan fiscal year (which was four months after the change had been adopted), as permitted by pre-1996 law. Despite the fact that the participant was harmed by timing of the notice, the court denied recovery because notice met the statutory requirement, which the court observed was justified on the ground that such limitations on plan liability are what makes employee fringe benefits possible, *Kytle v. Stewart Title Co.*, 788 F. 2d 321 (S. D. Tex. 1992). Courts have held, however, that complete termination of an ERISA plan requires “prompt” notice by the fiduciary sponsor, *Willett v. Blue Cross & Blue Shield of Alabama*, 953 F. 2d 1335 (11th Cir. 1993)
111. This state law and its standards for arbitration clauses was recently upheld by the California Court of Appeals against a challenge that it was preempted by the Federal Arbitration Act., *Smith v. Pacificare Behavioral Health*, 113 Cal. Rptr. 2d 140 (Cal. Ct. App. 2001). The court held that while the state cannot prohibit arbitration of commercial disputes, the McCarran-Ferguson Act allows it to regulate the insurance policy terms disclosing arbitration requirements.
112. *Kodes v. Warren Corp.*, 24 F. Supp. 2d 93 (D. Mass. 1998).
113. See, *Lopez v. Guardian Life Ins. Co.*, 834 F. Supp. 251 (N.D. Ill. 1993), holding that the law was not preempted by there was no financial remedy for the violation. These state laws arguably: are directed at the insurance industry (including risk-bearing health care service plans) and involve the policy relationship between the insurer and insured persons, even though this insurer responsibility does not itself spread risk. In *UNUM Life Ins. v. Ward*, 520 U.S. 358 (1999), the Supreme Court held that because these two criteria were met,

even though the state law in question did not spread risk, the law was saved as insurance regulation.

114. The Ninth Circuit Court of Appeals, covering California, does apply the common law insurance interpretation that ambiguous terms be interpreted against the insurer drafting the policy. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F. 2d 534 (9th Cir. 1990), cert. denied, 498 U.S. 1013 (1990), an approach taken by other courts of appeals, *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991); *Heasley v. Belden and Blake Corp.*, 2 F.3d 1249 (3d Cir. 1993). Other courts of appeals, however, hold that ERISA preempts this state law interpretation of insurance policy drafting, *Finley v. Special Agents Mutual Benefit Assn., Inc.*, 957 F. 2d 617 (8th Cir. 1992); *Brewer v. Lincoln National Life Ins. Co.*, 921 F. 2d 150 (8th Cir. 1990). This conflict among the federal courts can be resolved only by the U.S. Supreme Court.
115. *Kerns v. Benefit Trust Life Ins. Co.*, 992 F.2d 214 (8th Cir. 1993); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992). One federal court of appeals, however, indicated that an insurer might be liable to beneficiaries for failure to notify them of the employer's premium payment default if the insurer knew (based on calls about coverage over months during which premiums were unpaid) that employees were unaware of the policy lapse, *Willett v. Blue Cross and Blue Shield of Alabama*, 953 F. 2d 1335 (11th Cir. 1993). The Willett court also noted that a plan fiduciary (always the employer-sponsor with discretion to administer the plan but the insurer only with respect to functions regarding which it is granted discretion under the plan) would be responsible to notify participants "promptly" of plan termination, and in *Kodes v. Warren Corp.*, 24 F. Supp. 2d 93 (D. Mass. 1998), the district court held that coverage continued until the employer sponsor actually notified participants that it was terminated (for their failure to pay their share of the premium).
116. 29 U.S.C. 1133.
117. *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F. 2d 154 (4th Cir. 1993); *Miller v. United Welfare Fund*, 851 F. Supp. 71 (E.D. N.Y. 1994); *Leonhardt v. Holden Business Forms. Co.*, 828 F. Supp. 657 (D. Minn. 1993); *Guthrie v. Hewlett-Packard Co. Emp. Benefits Org.*, 773 F. Supp. 1414 (D Colo. 1991); *E.D Hayden v. Texas-U.S. Chemical Co.*, 557 F. Supp. 382 (C.D. Tex. 1983).
118. Urgent claims must be determined within 72 hours and non-urgent ones within 15 days if they involve a decision before care is rendered (pre-service determination) or 30 days for a post-service determination, 29 C.F.R. 2560.503-1(f).
119. Appeals ("reviews") of denied claims must be resolved in 72 hours for urgent claims, 30 days for non-urgent pre-service claims, and 60 days for non-urgent post-service claims, *ibid.*
120. A decision on whether an urgent care claim is incomplete must be made within 24 hours of filing the claim; no extension of the decision time frames is permitted, even for incomplete requests. Decision on an incomplete claim for non-urgent care can be extended up to 15 days, *ibid.*

121. A plan can extend the deadline on pre- or post-service non-urgent claims by 15 days if the delay is beyond the plan's control (e.g., incomplete information), which can extend the date for determining the claim, *ibid*.
122. 29 C.F.R.2560.503-1(b)(2).
123. If the plan used a protocol in denying the claim, it must include in the notice of decision either a copy of the protocol or notice of the right to request a copy. The plan also must explain the scientific or clinical judgment it used in deciding that a requested service was not medically necessary or was experimental or investigational if these were the reasons for denying the claim 29 C.F.R. 2560.503-1(g)(v).
124. The reviewer on appeal must not be the person who made the initial decision or his/her subordinate, 29 C.F.R. 2560.503-1(i).
125. "De novo" review means that the reviewer must not give deference to the initial decision and must consider all materials submitted by the claimant even if not considered in the initial decision, *ibid*.
126. Plan participants may be required to pursue two levels of appeal before going to federal court. The regulation permits up to two levels of review within the plan for non-urgent claims but both must be completed within the appeal time frames: 30 days for pre-service and 60 days for post-service reviews, 29 C.F.R. 2560.503-1(c)(2).
127. Plans can require participants to arbitrate claims only if arbitration is one of the permitted two levels of review, arbitration complies with all other applicable regulations (e.g., no fee required, time frames, etc.) and the dissatisfied claimant is not prohibited from going to federal court, 29 C.F.R. 2560.503-1(c)(4).
128. 29 C.F.R. 2560.503-1(h).
129. Courts require that participants first use the plan's internal appeal process, although the statute does not explicitly require this, *Tumulty v. Aetna Life Ins. Co.*, 659 F. Supp. 70 (S.D. Fla. 1987); *U.S. v. International Brotherhood of Teamsters*, 826 F. Supp. 749 (S.D. N.Y. 1993).
130. 29 U.S.C. 1132. ERISA permits these cases to be brought in state and federal court, but a defendant can remove the case to federal court and often does so.
131. 29 U.S.C. 1132(g).
132. 481 U.S. 41 (1987).
133. *Corcoran v. United Health Care*, 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992).

134. Cases holding that ERISA preempts state court damages suits regarding coverage denials and delays include *Przbowski v. U.S. Health Care, Inc.*, 245 F.3d 266 (3d Cir. 2001); *Hull v. Fallon*, 188 F.3d 939 (8th Cir. 1999); *Danca v. Private Healthcare Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999); *Bast v. Prudential Ins. Co.*, 150 F. 3d 1003 (9th Cir. 1998), cert denied, 68 U.S.L.W. 3022 (1999); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir. 1997); cert. denied, 118 S. Ct. 1512 (1998); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996); *Rodriquez v. Pacificare of Texas*, 980 F.2d 1014 (5th Cir. 1995), cert. denied, 508 U.S. 956 (1993); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505 (10th Cir. 1991); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir. 1993), cert. denied, 511 U.S. 1052 (1994); *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th Cir. 1993), cert denied, 510 U.S. 1045 (1994); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); cert. denied, 506 U.S. 1033 (1992); *Garrison v. Northeast Ga. Med. Center, Inc.*, No. Civ. 2:99-CV-8-WCO (N.D. Ga. Apr. 20, 1999); *Brandon v. Aetna Services, Inc.*, 46 F. Supp.2d 110 (D. Conn. 1999); *Thompson v. Gencare Health Systems, Inc.*, 49 F. Supp.2d 1145 (E.D. Mo. 1999); *Andrews-Clarke v. Travelers Ins. Co.*, D. Mass. 984 F. Supp.49 (D. Mass. 1997); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966 (S.D. N.Y. 1994); *Ricci v. Gooberman*, 840 F. Supp. 316 (D. N.J. 1993); *Dearmas Av-Med, Inc.*, 814 F. Supp. 1103 (S.D. Fla. 1993).
135. These cases are based on the tort principle of respondeat superior, that is, the employer is responsible for the negligence of its employees and agents acting within the scope of their employment or agency. A health plan must exercise control over a clinician's practice in order to be held responsible for the clinician's professional errors, *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544 (S.D. Ill. 1994). Because most managed care plans are loose network models, the plan may not exercise enough supervision or control over a physician's practice to be held responsible for medical treatment or diagnosis errors. *Chase v. Independent Practice Assoc., Inc.*, 583 N.E.2d 251 (Mass. App. Ct. 1991). An Illinois court recently held to the contrary, however. *Petrovich v. Share Health Plan of Illinois, Inc.* No. 85726 (Ill. Sept. 30, 1999). This is a factual matter to be determined at trial.
136. In *U.S. Healthcare, Inc. v. Bauman*, 193 F. 3d 151 (3rd Cir. 1999), cert. denied, 120 S. Ct. 2687 (2000), the court of Appeals held a health plan's policy that newborns should be discharged within 24 hours involved a dispute over the plan's medical treatment policy, not plan coverage policy. In *Lazorko v. Pennsylvania Hospital*, 237 F. 3d 243 (3rd Cir. 2000), the Court of Appeals held that a plan's physician financial disincentives that allegedly resulted in a patient's failure to obtain care, leading to suicide, could proceed in state court. In *Dukes v. U.S. Healthcare System of Pa.*, 57 F.3d 350 (3d Cir. 1995), cert. denied, 516 U.S. 1009 (1995), the Court of Appeals held that where a provider failed to provide appropriate tests (not because they were not covered by the plan) the case could proceed in state court. See also, *Giles v. NYLCare Health Plans, Inc.*, 172 F.3d 332 (5th Cir. 1999); *Rice v. Panchal*, 65 F.3d 637 (7th Cir. 1995), *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir. 1995); *Lupo v. Human Affairs Int'l, Inc.*, 28 F.3d 269 (2d Cir. 1994); *Roessert v. Health Net*, 929 F. Supp. 343 (N.D. Cal. 1996).

137. Some analysts believe that the Supreme Court has signaled a willingness to draw the distinction between pure coverage or eligibility decisions and “mixed” decisions involving medical and eligibility considerations. The plaintiff in *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), sued the plan for injuries resulting from a delay in being referred to the plan’s diagnostic facility for an ultrasound test. She asserted the health plan had violated ERISA by breaching its fiduciary duty in its use of financial incentives to limit medical care, for example, discouraging physicians from referring patients to non-network providers. The Supreme Court held that while HMOs contracting with private sector employee health plans may act as ERISA fiduciaries under some circumstances, a health plan’s financial incentives do not automatically create a fiduciary breach. The Court held that managed care plan physicians’ decisions about how to diagnose or treat a patient involves both “treatment” and “eligibility” decisions and that when the eligibility decisions cannot be separated from a physician’s judgment about reasonable medical treatment they are not fiduciary decisions actionable under ERISA. The Court also said that the plaintiff’s ERISA claim was no more than a federal claim for the same conduct that can already be litigated in state court malpractice suits, language cited by some commentators to suggest that the Supreme Court will be favorably disposed to hold that ERISA does not preempt state damages suits alleging injury from both traditional malpractice and even “mixed” treatment and eligibility decisions.
138. In bringing lawsuits against employers or the health plans they sponsor, the DOL sometimes recovers funds on behalf of individuals (for example, if an employer fails to pay premiums to an insurer). But the DOL does not resolve individual disputes or undertake litigation on behalf of an individual plan participant.
139. Polzer, Karl. *HIPAA as a Regulatory Model*; Butler, Patricia A. and Karl Polzer. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: National Health Policy Forum, George Washington University, 1996.
140. An example of an industry-wide health policy problem that the DOL has addressed through litigation is several cases filed against Blue Cross plans (e.g., in Hawaii, Illinois, Massachusetts and Virginia) for failure to pass along the benefit of provider discounts to ERISA plan participants. The Department also files amicus curiae (“friend of the court”) briefs in cases brought by other parties that concern important issues.
141. As of December 31, 2001, DMHC reports a total of 565 completed IMR decisions, 37% of which favored the enrollee and 63% of which favored the plan. As of November 15, 2001, CDI reports a total of 11 completed IMR, 4 of which favored the enrollee, 5 of which favored the plan, and 2 of which were determined not to meet IMR criteria.
142. A jury awarded the plaintiff in *Fox v. HealthNet* (No. 219692 (Cal. Superior Ct, Riverside) \$77 million and the plaintiff in *Goodrich v. Aetna Health Plan of California* (1/20/99, Cal. Superior Ct. San Bernardino) \$120 million.
143. *McCall v. Pacificare of California*, 106 Cal. Rptr. 271 (2001).

144. For a comparison of these laws, see. Butler, Patricia A. *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience*. Menlo Park, CA : Henry J. Kaiser Family Foundation, August 2001.
145. The statute defines “substantial harm” to mean loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, sever and chronic physical pain, or significant financial loss.
146. Cal. Civil Code 3428.
147. DMHC enforcement actions are posted on its Web site (dmhc.ca.gov/library/enforcements/).
148. For example, a California Superior Court ruled that the DMHC cannot fine a plan for refusing to cover a weight-loss drug; a federal court refused to sanction the agency for attempting to regulate Medicare HMOs; and a health care service plan is challenging a \$1.1 million fine regarding hospital care. Fong, Tony. “State HMO Regulator Snagged in Web of Legal Challenges,” *San Diego Union-Tribune*, February 6, 2002.
149. National and regional inquiries are as follows: COBRA: 60% national and 64% regional; benefits coverage and payment: 27% in both jurisdictions; HIPAA: 5% national and 3% regional; fiduciary issues: 5% national and 2% regional; HIPAA: 5% national and 3% regional; reporting and disclosure: 1% national and under 1% regional; retiree health coverage: under 1% in both jurisdictions; miscellaneous: under 1% national and 3% regional. Data provided by PWBA, USDOL, to authors, January 3, 2002.
150. The Hotline serves people residing in El Dorado, Placer, Sacramento, and Yolo Counties and is affiliated with the Center for Health Care Rights and Legal Services of Northern California. It employs seven counselors who (1) answer questions about health care coverage options and how to use health coverage plans and the health care system effectively, (2) assist callers in resolving complaints regarding health care providers and their public and private sector plans (including direct contact with plan representatives), and (3) refer callers to other public and private resources. The Hotline Web site (www.hrh.org) also provides educational materials and model letters to appeal health plan or medical group coverage decisions, obtain medical records, or complain to government agencies. It currently is supported by The California Endowment, The California Wellness Foundation, and the Henry J. Kaiser Family Foundation.
151. This database included detailed case descriptions, from which the authors of this report classified complaints into the categories listed on Tables 9 and 10.
152. Coincidentally, this is the same distribution of people enrolled in insured and self-insured for California as a whole.
153. The differences in these proportions are statistically significant at the 99 percent confidence level ($p < .01$).

154. The p value from the Chi Square test on these data was .74.
155. The Hotline database contains some of this information but it is not available for all cases, which would limit its use for regression or other more sophisticated analysis.
156. 29 C.F.R. 2560–503–1(k). This is the general standard for federal preemption of state law, reiterated by the Supreme Court in the UNUM case.
157. Both state and federal courts held that ERISA preempts California Insurance Code section 790, *Commercial Life Ins. Co. v. Superior Court*, 253 Cal. Rptr. 682 (Cal.1988); *Kanne v. Connecticut General Life Ins. Co.*, 867 F. 2d 489 (9th Cir. 1988), cert. denied, 492 U.S. 906 (1989) because even though the statute regulates insurance, it conflicts with ERISA’s explicit, but more limited, remedies. These courts explicitly acknowledged, but did not address, the issue of whether ERISA preempts state regulators from using the statute to prosecute insurers. This state enforcement authority would seem to have no relationship to ERISA consumer remedies and therefore should not preempt the Insurance Commissioner’s use of this power.
158. *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F. 3d 626 (5th Cir. 2000), affirming 215 F. Supp. 526 (S.D. Tex. 1998).
159. The statute appears to authorize suits for disputes over both coverage and the quality of care delivered by an HMO’s providers, see, Butler, Patricia A. *Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 1997.
160. In an apparent attempt to avoid the ERISA preemption dilemma, the California independent review statute defines disputes involving medical necessity as related to the practice of medicine, rather than coverage decisions, while defining coverage decisions as determinations about what coverage is included or excluded as a covered benefit under the plan. Yet because “medical necessity” is often written into a plan as a prerequisite to coverage, this statutory distinction may be of little help to ERISA plan participants seeking to sue their health plans in state court.
161. In *Corporate Health Ins., Inc. v. Texas Dept. of Ins.* the Court of Appeals held that ERISA preempts the external review law as applied to disputes over medical necessity because even though the law regulates insurance, it “attempts to impose an administrative regime governing coverage determinations” and creates a supplemental remedy that conflicts with ERISA’s limited set of remedies.
162. In *Moran v. State of Illinois*, 230 F. 3d 959 (7th Cir. 2000), the Court of Appeals disagreed with the Fifth Circuit, holding that the external review law not only regulates insurance but also does not conflict with ERISA’s appeals procedures but merely creates “additional safeguards to preserve the integrity of the decision-making process.”
163. Many federal Courts of Appeal have ruled that ERISA permits plans to include binding arbitration clauses in benefit plans as an alternative to litigating in court. Consequently, it is

possible that binding arbitration could still be imposed once the internal plan appeals procedures are completed, which would eliminate the participant's right to go to court under ERISA, but the plan's disclosure of this requirement must be clear. *Chappel v. Laboratory Corporation of America*, 232 F.3d 719 (9th Cir. 2000).

164. *American Bldg. Maintenance Co. v. Indemnity Ins. Co.*, 7 P. 2d 305, 214 Cal. 608 (1932).
165. See cases cited in endnote 114.
166. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Where a plan gives the administrator discretionary authority to determine eligibility (for example, deciding whether a procedure is medically necessary when that is a precondition for coverage under a health plan) courts, including the Ninth Circuit, overturn an administrator's eligibility decision only if it was arbitrary. See, e.g., *Taft v. Equitable Life Assur. Soc.*, 9 F. 3d 1469 (9th Cir. 1993).
167. Baumgardner, James, "Proposals To Subsidize Health Insurance for the Unemployed," Congressional Budget Office, January 1998.
<http://www.cbo.gov/showdoc.cfm?index=317&sequence=0&from=1>.
168. Spencer's research reports on employee benefits, *2000 COBRA Survey: One in Five Elect Coverage, Cost is 152% of Active Employee Cost*, 329.04.-1, Aug. 25, 2000.
169. Zuckerman, Stephen, Jennifer Haley, and Matthew Fragale, *Could Subsidizing COBRA Health Insurance Coverage Help Most Low-income Unemployed?*, Urban Institute, October 17, 2001. The study also noted that smaller firms employ a disproportionate percentage of lower-wage workers. As a result, only 32 percent of low-income workers and their adult dependents (people in families with incomes below 200 percent of the federal poverty level) had the option of COBRA coverage in 1999. Forty-six percent of all unemployed adults without COBRA coverage are uninsured—almost three times the rate of uninsurance for all adults. Thirty-one percent of unemployed adults without COBRA are able to maintain employer-sponsored coverage through a spouse's plan, 14 percent are able to enroll in a Medicaid or state insurance program, and 9 percent obtain other forms of coverage, such as individual policies.
170. Pollitz, Karen, Stephanie Lewis, Robert Imes, and Eliza Bangit, *A Consumer's Guide to Getting and Keeping Health Insurance in California*, Washington, D.C.: Georgetown University Institute for Health Care Research and Policy, June 2001.
171. According to the California Department of Insurance, if the premium charged to the employer is adjusted for the age of the specific employee, the rate for continuation coverage under Cal-COBRA shall not exceed 110 percent of the premium charged by the insurer. If the premium charged is not adjusted for the age of the specific employee, the rate for continuation coverage shall not exceed 213 percent of the applicable group rate.

172. Pollitz, Karen, Stephanie Lewis, Robert Imes, and Eliza Bangit, *A Consumer's Guide to Getting and Keeping Health Insurance in California*, Washington, D.C.; Georgetown University Institute for Health Care Research and Policy, June 2001.
173. To be eligible, the previous coverage also must not have been canceled due to non-payment of premium or fraud.
174. According to CDI staff, termination is broadly interpreted, meaning the employer may have ceased using the insurer or changed insurers, or that the employee has left the employment of the employer offering coverage.
175. Pollitz, Karen, Stephanie Lewis, Robert Imes, and Eliza Bangit, *A Consumer's Guide to Getting and Keeping Health Insurance in California*, Georgetown University Institute for Health Care Research and Policy, June 2001.
176. Pollitz, Karen, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-than-percent Health?* The Henry J. Kaiser Family Foundation, June 2001.
177. Rates can vary more widely in the 2–50 life market on the basis of age and geography.
178. *Qualls v. Blue Cross of California, Inc.*, 22 F. 3d 839 (9th Cir. 1994).
179. *Rubin-Schneiderman v. Merit Behavioral Care Corp.*, S.D. N.Y, No. 00-Civ-8101, April 9, 2001.
180. In *Cellilli v. Cellilli*, 93 F. Supp. 72 (D. Mass. 1996), the federal district court upheld a state insurance law allowing the divorced spouse of an HMO enrollee to continue HMO coverage on the ground that this law is saved from preemption as a law regulating insurance. The law regulated only the HMO and did not impose obligations on the spouse's employer to administer the continuation arrangement.
181. *Waks v. Empire Blue Cross/Blue Shield*, 263 F. 3d 872 (9th Cir. 2001). But see, *Painter v. Golden Rule Ins. Co.*, 121 F. 3d 436 (8th Cir. 1997).
182. *Tingey v. Pixley-Richards West, Inc.*, 953 F. 2d 1124 (9th Cir. 1992).
183. *International Resources v. New York Life Ins.*, 950 F. 2d 294 (6th Cir. 1991) held that the state law is saved from preemption because it regulates insurance.
184. In *Hall v. Pennwalt Group Comp. Medical Expense Benefits Plan*, 74 F. Supp. 507 (E.D. Pa. 1988) a federal district court held that ERISA does not preempt such a state law, whereas in *Howard v. Gleason*, 901 F. 2d 1154 (2d Cir. 1990), a federal court of appeal held that ERISA does preempt such a state law.
185. General Accounting Office, "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators," *GAO/HEHS-98-67*, February 1998.

186. States can: (1) shorten the 6-month “look back” period before the enrollment date to determine what is a preexisting condition; (2) shorten the 12- and 18-month maximum preexisting condition exclusion periods; and (3) expand the prohibition on conditions and people to whom a preexisting condition exclusion period can be applied beyond the exceptions described in federal law (regarding newborns, adopted children and pregnancy).
187. Pollitz, Karen, Stephanie Lewis, Robert Imes, and Eliza Bangit, *A Consumer’s Guide to Getting and Keeping Health Insurance in California*, Washington, D.C.: Georgetown University Institute for Health Care Research and Policy, June 2001.
188. Ibid.
189. States can (1) increase the 30-day period for newborns, adopted children and children placed for adoption to enroll in the plan so that no preexisting condition exclusion period can be applied, (2) require additional special enrollment periods, and (3) reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees).
190. Under federal law, companies with 100 or more employees that intend to lay off or significantly reduce the hours of 50 or more of them must send an early warning notice to the states. States respond to these notices in a variety of ways such as holding worksite meetings to assist dislocated workers.
191. Polzer, Karl, “HIPAA as a Regulatory Model: Early Experiences and Future Prospects,” *National Health Policy Forum, Issue Brief No. 735*, Washington, D.C.: The George Washington University, April 5, 1999.
192. Centers for Medicare and Medicaid Services. Personal communication with Karl Polzer in July 2001.
193. Butler, Patricia and Karl Polzer. *Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law*. Washington, D.C.: George Washington University National Health Policy Forum, June 1996.