ERISA and Variation in California Health Plan Consumer Protections

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Prepared for the California HealthCare Foundation by

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About the Project

This summary report is based on the full report, ***Regulation of ERISA Plans: The Interplay of ERISA and California Law,*** also prepared for the California HealthCare Foundation by Patricia A. Butler and Karl Polzer.

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Introduction

In both California and the United States, health insurance coverage is most commonly obtained through the workplace. In a simpler world, Californians with employment-based coverage could refer to a single set of rules and deal with a single regulatory agency if issues arose with their coverage. And the laws governing their health benefits would be consistent and easy to understand. But the real world is more complex.

The federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from enforcing laws relating to private-sector employee health benefit plans. However, it allows them to regulate indemnity insurers and managed health care companies contracting with ERISA plans. ERISA does not apply to employer health plans offered by state and local governments or churches, which are subject to state regulation; nor does it apply to coverage sold in the individual market.

The interplay of ERISA and state law regulating health insurance means that consumer protections may vary depending upon whether an employer decides to retain the risk of paying medical claims within the employee health benefit plan (i.e., to "self-insure" the employee plan) or to purchase group insurance from a state-licensed insurer or managed care organization. In California, consumer protections for insured employee health plans may also vary depending on benefit design decisions made by plan sponsors. This is because two state agencies split responsibility for regulating health insurance and managed care products.

ERISA health plans are regulated by the U.S. Department of Labor (DOL). Self-insured ERISA health plans are regulated under federal law only, while fully insured health plan contracts are subject to additional state regulation through either the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). Figure 1 summarizes the regulation of private-sector employee health benefit plans through the DOL under ERISA and the regulation of health insurers and managed care companies through CDI and DMHC under state law.

> **Note**
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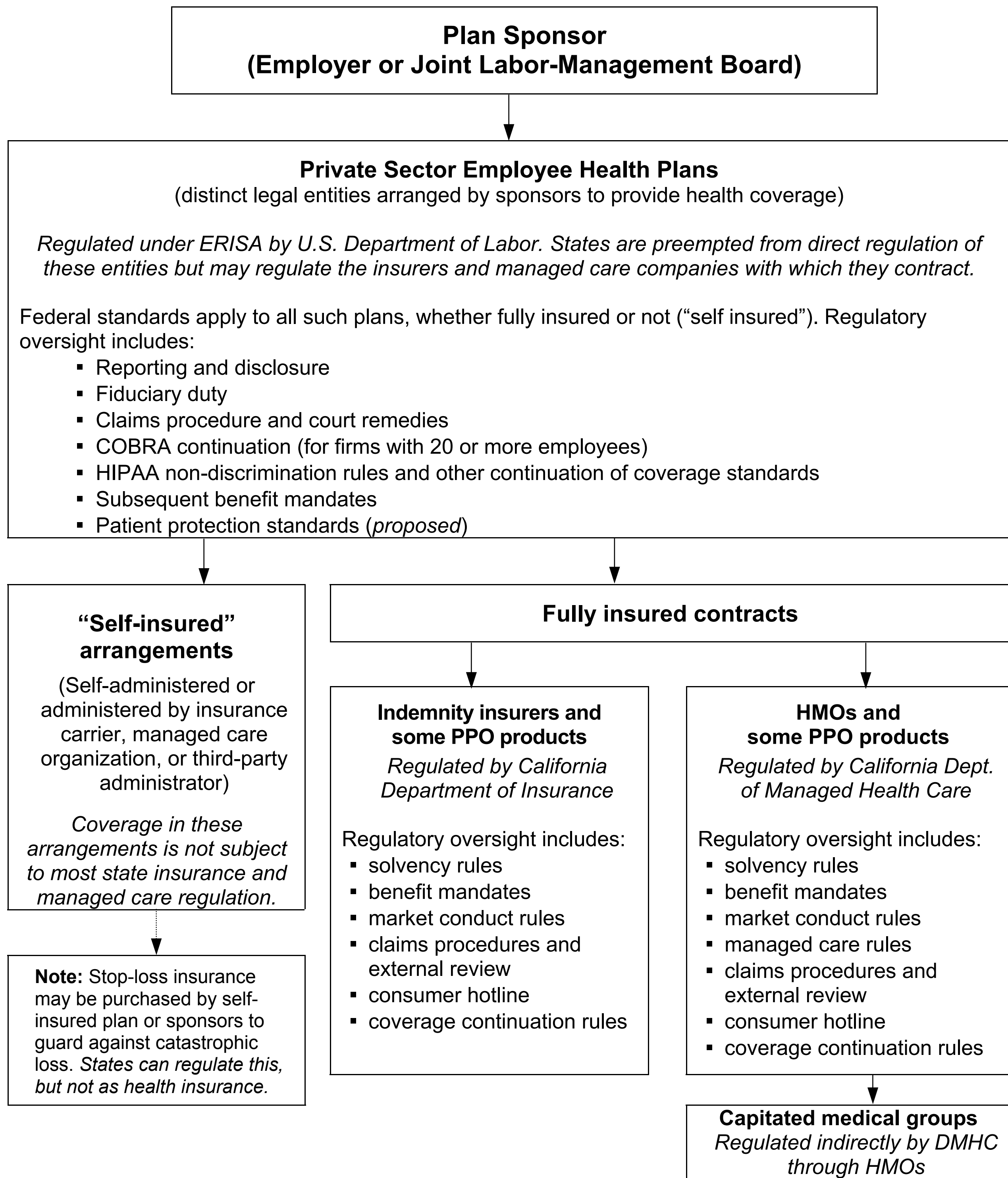
> The term "employee health benefit plan" has a specific meaning under ERISA: these plans are distinct legal entities arranged for by private-sector employers or other sponsors in order to provide health coverage. They are different from the insurance companies or HMOs with which they may contract to provide employee benefits. In this report we refer to such employer-sponsored arrangements as ERISA health plans. Readers should be careful not to confuse this term with the possibly more familiar use of "health plan" to refer to the HMOs or indemnity insurers that compete in the marketplace to provide health care services and insurance.

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



This summary highlights the findings of a more detailed report[1] that documents how ERISA health plan consumer protections vary along a number of dimensions. These dimensions include plan solvency requirements, mandated benefits, standards for managing care, required information, processes for appealing denied claims and remedies for taking plans to court, and options available for maintaining coverage between jobs.

As many people have discovered first-hand as a result of the weakened economy and recent financial turmoil in California's managed health care industry, serious issues may arise for consumers who attempt to use or maintain their health coverage. For example, employers sponsoring plans can go out of businesses, lay off workers, drop their health plans, restrict eligibility, or reduce benefits. Coverage can be lost or compromised through the financial insolvency of health care organizations (e.g., managed health care companies, insurers, and risk-bearing medical provider groups). Claims for needed medical services and insurance payments can be denied. Consumers may not have adequate information to make informed decisions about coverage options or health care use. Necessary treatments and providers may not be available under employee health plan terms or insurance contracts. Under circumstances such as these, consumer protections and regulatory recourse can be critically important. Yet they may vary in ways that are not tied directly to the consumer's experience, but rather to the source and nature of the consumer's coverage.

Sources of Variation

Consumer protections vary for many reasons including (1) the interaction of federal and state laws regulating them; (2) employer and health industry responses to perceived regulatory burdens; and (3) ongoing marketplace efforts to develop benefits that respond to the needs of employees while attempting to contain the rise in costs.

> ERISA, the federal law governing private-sector employee health benefits, preempts states from directly regulating these ERISA health plans, but allows states to regulate insurers contracting with them.

ERISA, the federal law governing private-sector employee health benefits, preempts states from directly regulating these ERISA health plans, but allows states to regulate insurers contracting with them.[2] When ERISA was passed, virtually all employee health coverage was fully insured and subject to state regulation. Because ERISA contained few substantive regulations for health plans and because states heavily regulate health insurers, plan sponsors have had an incentive to deregulate their plans by "self-insuring"—that is, by retaining the risk of fluctuations in medical claims. In the years following ERISA's passage, many large employers, and some smaller ones, have opted to self-insure their health plans in order to reduce regulatory burdens and costs, improve cash flow, and increase their latitude to design benefits.

In 2001, 47 percent of U.S. workers and 27 percent of workers in California were enrolled in self-insured health plans.[3] The lower prevalence of self-insurance in the state reflects a high penetration of HMO products, which historically are less likely to be self-insured than products offered by preferred provider organizations (PPOs) or traditional indemnity insurers. Yet many HMO-based employee health plans are self-insured, and, on a national level, the proportion appears to be growing. Large employers in California, as in the nation, are far more likely to self-

insure their health plans than small employers because of the financial risk that self-insuring poses. In 2001, 36 percent of California workers in firms with 200 or more workers were in self-insured plans compared with 14 percent in firms with fewer than 200 workers.

Neither ERISA nor the U.S. Department of Labor, which administers the law, has clarified exactly what is meant by self-insurance. There are numerous hybrid arrangements that ultimately are classified as insured or self-insured when issues arise. Many employers that self-insure, for example, buy stop-loss insurance that reduces their risk of having to pay for unexpectedly large medical claims. But this stop-loss coverage is not considered health insurance per se. While states may regulate stop-loss carriers (e.g., to ensure their solvency), they generally may not apply health insurance benefit mandates or other health insurance laws to the underlying ERISA health plan through the stop-loss coverage. Though buying stop-loss insurance does reduce the risk of plan insolvency, many state regulators consider the use of large amounts of stop-loss coverage to be a subterfuge to avoid state laws specially geared toward health insurance, such as those imposing benefit mandates, health insurance market reforms, and managed care standards.

Residents of California, as of other states, can contact the DOL if they have an issue with coverage provided by a self-insured ERISA health plan. State regulators have no legal authority to assist them. For most issues, regulation under ERISA alone (for self-insured plans) is considered far less intense and imposes fewer regulatory costs than regulation under both ERISA and state laws governing managed health care companies and insurers (for fully insured plans).

For employees enrolled in fully insured ERISA health plans, consumer protections also vary in California because two state agencies divide the task of regulating managed health care companies and more traditional health insurers. Almost two-thirds of the state's residents, including people in ERISA plans, receive health care from "health care service plans" (mostly HMOs) regulated by the state's Department of Managed Health Care (DMHC), while roughly 1.5 to 2 million are covered by more traditional health insurers licensed by the California Department of Insurance (CDI). State insurance regulators and others interviewed report that the main distinction is that the DMHC regulates managed health care organizations providing both insurance and medical services while the CDI regulates only insurance. But in functional terms, the agencies' jurisdictions overlap. For example, health insurers providing benefits through PPO arrangements that manage care through utilization control mechanisms may be licensed by either agency. The insurance industry generally considers CDI regulation to be much less restrictive. On the other side of the ledger, CDI licensure is more costly and subjects carriers to higher solvency standards.

Another source of variation in consumer protections is court interpretation of how ERISA overrides state law. In many areas of consumer protection, states may regulate insurance carriers contracting with ERISA health plans so long as their laws do not conflict with ERISA's content. This results in differences in consumer protection between insured and self-insured plans. But for some of its provisions, ERISA entirely preempts state insurance laws, regardless of whether they conflict directly with ERISA. For example, courts consistently have ruled that ERISA's relatively limited right to sue for money damages (discussed below) entirely preempts state legal remedies. In contrast, states may apply benefit mandates, information disclosure requirements, and solvency standards indirectly to fully insured ERISA health plans through the insurance carriers and managed health care organizations they license and regulate.

From a national perspective, absolute preemption of state law can be viewed as a source of potential consistency that makes it easier for ERISA health plans to operate. For large employers doing business across state lines, federal preemption of state law has been one of the key values of ERISA.

ERISA's Standards

Most Americans under age 65 receive health coverage through their jobs, offered either unilaterally by employers or as a result of collective bargaining. ERISA governs the coverage of more than 130 million private-sector employees, retirees, and family members. ERISA does not require employers to offer benefits and permits them to terminate employee health coverage at any time.[4]

Passed in the wake of several highly publicized pension plan failures, ERISA imposed a comprehensive regulatory regime for defined benefit retirement plans,[5] but it contained few standards for other types of tax-favored employee benefits, including health plans. ERISA originally required health plans to meet fiduciary, reporting, and disclosure standards, and to establish claims review procedures. It also set out a system for resolving disputes in the courts. Congress has since added several ERISA health plan requirements. These include continuation-of-coverage requirements for firms with 20 or more workers under the Consolidated Omnibus Budget Reconciliation Act (COBRA), enacted in 1985; nondiscrimination and other coverage portability requirements and insurance market reforms under Health Insurance Portability and Accountability Act of 1996 (HIPAA);[6] and three benefit mandates, discussed below. In 1983, Congress also amended ERISA to allow states to regulate clusters of non-union ERISA health plans (called "multiple employer welfare arrangements" or MEWAs) after many—especially those that were self-insured—were unable to pay claims due to financial mismanagement and even fraud. Congress is now debating whether to add several managed health care standards to ERISA as well as whether to increase consumers' ability to sue and recover damages for injuries resulting from decisions by employee health plans and indemnity insurer or managed health care organizations affecting their medical treatments.

ERISA and California Insurance Laws

Over the past five years, health plan consumer protection standards have grown at both the state and federal levels. In most respects, ERISA's health plan standards remain less rigorous than corresponding California laws that apply to health insurers and managed health care organizations. Particularly with regard to solvency standards, benefits mandates, dispute resolution, and managed health care rules, state laws continue to offer greater consumer protections. On the other side of the coin, employers and some insurers often argue that adding more consumer protections to ERISA or reducing its preemption of state law to allow states to regulate self-insured ERISA health plans would increase regulatory costs and inhibit marketplace innovation.[7]

Consumer protections that may be applied to health insurers regulated by the California Department of Insurance, health care service plans regulated by the Department of Managed Health Care, and employee health benefit plans subject to ERISA are summarized in Table 1 and Figure 1 and described in the remainder of this section.

Table 1: Comparison of California and Federal Laws Applicable to Insurers and ERISA Plans

Regulation	Health Insurers	Health Care Service Plans	ERISA Plans
Solvency Standards	Substantial	Substantial	None
Benefit Requirements	Substantial	Substantial	Minimal
Managed Health Care Standards	Limited (access to Ob-gyns; continuity of care for some chronic mental health services	Substantial	None
Information Disclosure	Fairly detailed (including advance notice of plan termination)	Fairly detailed (including advance notice of plan termination)	Fairly detailed (but no advance notice of plan termination)
Claims Appeal Procedures	Internal insurer appeal; IMR; lawsuits over medical care quality	HCSP appeals; IMR; lawsuits over medical care quality	More standards for internal plan appeals but no IMR; limited lawsuit damages
Individual Consumer Assistance by Government Agencies	Refer to IMR, as appropriate	Refer to IMR or resolve dispute	More limited
Continuation of Coverage	Applies to insurance products covering firms, with under 20 workers	Applies to health care service plan products covering firms with under 20 workers	Applies to self-insured and insured plans offered by firms with 20 or more workers

Solvency standards. Even though California's two regulatory agencies have markedly different approaches 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 health care products, whereas ERISA sets no solvency standards for either insured or self-insured ERISA health plans. Furthermore, there is evidence that some self-insured employee health plans, even very small ones, do not protect themselves with stop-loss coverage. In further contrast to employees covered by self-insured plans, people enrolled in insured plans may be assisted by California regulators to enroll in new plans should insolvencies occur. How to regulate the solvency of managed health care plans, both insured and self-insured, 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. These events have led the state to begin regulating risk-bearing medical groups, though regulatory authority is largely applied indirectly through medical groups' contracts with licensed managed health care companies.

Benefit requirements. California is among the six states with the highest number of health insurance mandates, almost all of which apply to insured products sold by both health insurers and health care service plans. In contrast, ERISA requires employee health benefit plans to cover only three specific benefits (it specifies minimum standards for newborn hospitalization stays, post-mastectomy care, and mental health benefits). Because self-insured plans do not have to report benefits to DOL and because states cannot require them to report plan descriptions, little is known nationally or in California about benefits actually offered by self-insured plans. Some people interviewed for our detailed report indicated that some self-insured health plans cap the amount they will pay for some services, especially for people with costly conditions like AIDS.

> In most respects, ERISA's health plan standards remain less rigorous than corresponding California laws that apply to health insurers and managed health care organizations. Particularly with regard to solvency standards, benefits mandates, dispute resolution, and managed health care rules, state laws continue to offer greater consumer protections.

Managed health care standards. Like most states, California has enacted a broad array of standards to assure that people enrolled in managed health care plans licensed by the DMHC 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 managed care standards on all ERISA health plans, such standards do not exist under current federal law. As noted above, more loosely organized managed health care arrangements may seek licensure through either the DMHC or the CDI. In recent years, self-insured employee plans have been using not only PPO arrangements but also HMOs to administer their benefits. This makes managed health care standards an important issue for people enrolled in self-insured plans and suggests the need for more information about access to services and providers among self-insured managed health care plans.

Information disclosure. Recent enhancements to ERISA's regulations prescribing information that must be disclosed to health plan enrollees bring these standards closer to those under California law. But under state law, health insurers and health care service plans are required to provide advance notice that coverage is to be terminated. Under ERISA, plan administrators have up to 60 days to inform participants after making major plan modifications, including plan terminations. (It is likely, of course, that most plans voluntarily give employees advance warning.)

Information about whether a plan is self-insured and the implications of that financing approach could be useful for employees, especially those with a choice among insured and self-insured options. DOL regulations do require that ERISA health plans explain the role of insurers (e.g., when they do not bear insurance risk); but the rules do not require them to explain the implications to consumers of the plan's being self-insured. For example, they need not describe 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, in fact, CDI staff reported that the agency plans to do so in an updated consumer health education brochure to be published in 2002.

Claims appeal procedures, independent review of denied claims, and judicial remedies. The dispute resolution mechanisms available to consumers involve a complex and rapidly evolving interplay between ERISA health plans and insurers, the courts, and state and federal laws and regulatory agencies. ERISA allows some types of state dispute resolution laws directed at indemnity insurers and HMOs, but limits court-awarded damages for all people covered under ERISA health plans, whether self-insured or fully insured.

Some of the recently revised 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 internal appeal process; they require internal appeals to be reviewed by people different from those who initially denied the claim, and without deference to the original decision; and they require that plan administrators consult with medical professionals when reviewing matters of medical judgment.

But in several other respects ERISA's grievance procedures and consumer remedies are less favorable to consumers than state law. First, Californians 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. Under ERISA, participants in both insured and self-insured plans who are denied a benefit may sue to obtain the benefit itself or payment for a covered service that has been provided. But they cannot recover economic or punitive damages for injuries caused by an insurer's or HMO's coverage decisions. California's new law authorizing a right to sue insurers and HMOs may still face some ERISA preemption hurdles (e.g., because courts have limited the right to sue for damages resulting from coverage disputes). But the new state law does afford a legal remedy to consumers in employee health plans by providing the right to sue HMOs (and other insurers providing medical care) over the quality of medical services they provide.

Second, consumers may be affected because the way courts interpret the terms of health coverage plans may differ, depending on whether or not a plan is governed by ERISA. For example, in contrast to the practice in lawsuits involving insurance purchased in the individual market or for public-sector employees, courts interpret ERISA to give considerable deference to plan claims administrators' coverage decisions. In ERISA cases, for example, a court will overturn a plan administrator's coverage decision only when finding it to be "arbitrary and capricious." Furthermore, 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. In lawsuits involving the individual market or public-sector employees, however, courts generally permit new evidence about the claimant's condition or expert medical opinion to be introduced at trial even if it has not been previously presented to the plan administrator.

Third, under California law, if an insurer or HMO denies a claim appeal, consumers who are not in self-insured ERISA plans can seek independent medical review in disputes involving medical necessity and experimental treatment. ERISA has no provision for independent medical review (though patients' rights legislation under consideration in Congress would add such a process). As this report was being published, the U.S. Supreme Court held that ERISA does not preempt an Illinois independent review law, suggesting that California's law also is safe from preemption.

Finally, state agencies' legal authority and staff resources for assisting individual consumers in disputes with indemnity insurers and managed health care companies may be considerably greater than the DOL's authority and resources for assisting consumers who encounter issues with their ERISA health plans. In California, health insurance and health care service plan enrollees can file complaints with the licensing agencies, both of which (like the DOL) have established hotlines to facilitate the filing of complaints. Unlike the DOL, however, the DMHC is legally responsible to resolve all complaints received that are not subject to independent medical review regarding licensed health care service plans. (CDI does not have legal authority to adjudicate individual insurance claims.) DOL's national and regional consumer assistance staff is very small compared to the staff of the two state agencies. Furthermore, while in recent years DOL staff benefits advisors have become more willing to assist individual ERISA plan participants through providing information and informal discussions with employers, the agency does not initiate litigation or other enforcement action on behalf of individuals.[8] DOL may take legal action only if an issue adversely affects plan participants collectively.

Continuation of coverage. A complex patchwork of federal and state laws and programs aims to improve access to health coverage when people face job transitions. But these laws and programs are difficult to navigate and leave many people facing significant barriers to maintaining coverage. Californians seeking to keep coverage after their employment ends can exercise several options, including special enrollment rights to spousal coverage under HIPAA, and the right to continue their employment-based health coverage under COBRA (or a similar state law aimed at insurers covering firms too small to fall under COBRA). Other options may include buying an individual policy, converting group coverage to an individual policy, applying for coverage under the state's high-risk pool, or investigating eligibility for government programs, such as Medi-Cal, that subsidize coverage for lower-income people. But the complexity of the checkerboard of rules can put consumers at a disadvantage. For example, DOL officials have been alerting consumers that becoming locked into COBRA continuation coverage (for which former employees must pay 102 percent of the premium) can result in forfeiture of their right to special enrollment in a spouse's plan (which may cost far less than COBRA). On the other hand, waiting too long to sign up for COBRA coverage might mean forfeiting it as an option. This would thrust an unemployed person into the individual insurance market, where coverage can be very expensive, or even—in the case of a person with a preexisting medical condition—totally unavailable. The 30-day period allowed for employee health plan participants to request special enrollment in a spouse's plan may not be long enough to make informed decisions. The complexity of the various federal and state laws and regulations offering coverage continuation options makes navigating the system very difficult.

The requirements of California's mini-COBRA law, which applies to insurers covering employers with 2 through 19 employees, largely mirror those of the federal COBRA law, which applies to firms with 20 or more workers. Should a firm with fewer than 20 employees decide to self-insure its health benefits, however, neither law would apply. With the passage of HIPAA, the federal government attempted to extend access to coverage both to current employees and to those who have lost their jobs. HIPAA presented a new regulatory model in which the federal government set minimum standards for both employee health benefit plans and insurers contracting with them. HIPAA allowed states to build on and enforce these standards. By setting federal standards across different populations, HIPAA has increased the consistency of some types of standards. However, its enforcement structure may actually have complicated matters.

Under HIPAA and other similarly structured laws, if states fail to enact or substantially enforce a federal standard applying to health insurers, managed health care companies, or state and local government plans, the federal Department of Health and Human Services must step in to do so. They did so in California for several years, until the state enacted legislation in 2000 conforming to HIPAA's individual market reforms. California began implementing this legislation in 2001.

Efforts to Coordinate

In recent years, federal and state regulators have begun to work together to coordinate referrals of complaints about health care coverage that fall outside each individual agency's jurisdiction. In California, staff from agencies including the DOL, the DMHC, and the CDI have been meeting quarterly to share information about each agency's responsibilities, requirements, and procedures; to coordinate cross-referrals; and to plan joint public outreach efforts. Regulators in each agency report that these meetings have helped them coordinate responses to consumer concerns.

What the Future May Hold

For consumers enrolled in ERISA health plans—and for employers, insurers, and medical providers as well—employee health plan and insurance regulation is likely to continue being both uncertain and complex.

In recent years, state policymakers have discussed the idea of merging CDI's regulation of health insurance into the DMHC oversight of managed health care firms. Speculation continues, but many of those interviewed believe that jurisdiction will remain split between the two agencies, at least in the near future.

California's level of self-insurance is lower than the nation's as a whole, probably due to the strong tradition of employers in the state offering licensed managed health care plans. Self-insurance levels might increase if employers begin to experiment with a wider variety of benefit designs. The growth of self-insurance might also be facilitated, as HMOs are increasingly willing to rent networks and care management services to employee health plans that retain insurance risk. Kaiser Permanente, the state's largest HMO, currently offers only fully insured products in California (with the exception of one contract with a large employer). Many of Kaiser's competitors, however, do administer self-insured arrangements.

Many large employers have been concerned about renewed health care inflation, employee complaints about managed health care, and rising regulatory and legal costs. This has led them to consider experimenting with health benefit designs that would shift significantly more financial risk and decision-making to employees. These new product designs are often referred to as "defined contribution" (DC) approaches.[9] Although they are a new and rapidly evolving phenomenon, DC benefit designs bear watching because of employer interest in them. Significant growth in enrollment under DC approaches could raise issues about how these plans fit into the existing regulatory checkerboard.

Another major source of uncertainty is whether Congress will pass patients' rights legislation and what it might contain. Bills passed last year by both the U.S. House of Representatives and

the Senate would establish many federal managed health care standards while explicitly allowing states to enforce these laws with respect to insurers and managed health care companies and to enhance these standards in ways consistent with federal law. As of this writing, congressional and executive branch staff have not resolved their differences over the package of reforms. With regard to possibly expanding the ability of ERISA health plan participants to recover damages for injuries caused by plan officials' medical decisions, it remains unclear whether Congress might limit ERISA's preemption of state law remedies, impose new national federal standards, or develop a hybrid approach. Of course, there is a good chance that Congress and the president will not come to agreement on patients' rights legislation this year. In any event, the courts' interpretation of how ERISA preempts state law will continue to move the boundary lines determining which populations fall under which set of rules.

Because employers voluntarily provide health coverage and employers and insurers often have a choice of regulatory venues, increasing regulatory burdens may have consequences that policymakers do not intend. For example, if federal employee health benefit regulations become more costly or burdensome, some employers might drop their plans. If state regulations become more prescriptive or costly, more private-sector employers might opt to self-insure their health plans. Some health insurers already carefully compare the costs and benefits of licensure with the CDI or DMHC. In part because the current system of regulating employee health benefits and insurance is very complex, regulated entities may have both an incentive and a ready means to circumvent new rules. And when consumers or interest groups complain about what regulated entities are doing to avoid new rules, government officials face pressure to add more regulations—creating pressure for further industry and consumer responses.

In the foreseeable future, it is unlikely that the complex checkerboard of federal and state laws governing ERISA health plans will become easier to navigate. In the absence of stronger federal standards on issues of ERISA health plan solvency, benefits, managed health care regulation, and damages remedies, substantial variation will continue between the consumer protections applied through federal law and state law. State agencies could help consumers understand and use their health coverage by providing information on the implications of self-insurance and on post-employment coverage options. Regulators at both the state and federal levels could encourage employers to provide advance notice of major plan changes. Federal policymakers might consider whether ERISA's current rule allowing employee health plan administrators up to 60 days to inform participants that a plan has been terminated appropriately balances the needs of consumers (for sufficient notice) against the needs of plans (for flexibility). Consumers also could benefit from individual assistance when difficulties arise in using their health coverage plans. Finally, the likelihood of continued variation in health coverage standards underscores the importance of coordination among federal and state agencies to educate the public, share complaint referrals, and enforce applicable law.

Notes

1. Patricia A. Butler and Karl Polzer, *Regulation of ERISA Plans: The Interplay of ERISA and California Law*, Oakland, CA: California HealthCare Foundation, April 2002 (**www.chcf.org**).

2. ERISA covers most private-sector employee health plans but does not include employee coverage offered by churches and public-sector agencies like state and county governments or coverage that people buy individually or receive under publicly funded health insurance programs such as Medicaid.

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

4. There is one exception. In 1983 Congress granted Hawaii an exception to ERISA's preemption provision allowing the state to implement a limited employer coverage mandate.

5. ERISA's comprehensive regulation of defined-benefit pensions is one factor that may have prompted many employers to add or switch to defined-contribution (401[k]-type) pension plans, in which employees carry the risk of making sure enough funds accumulate in their accounts to accommodate their retirement needs.

6. HIPAA applies portability requirements and other consumer protections not only to both insured and self-insured ERISA plans but also across several types of health plan sponsors (including the individual market).

7. Some differences between ERISA and state insurance laws are to be expected because they regulate different types of entities. ERISA is basically a law of fiduciaries and trusts designed to assure that employers meet their promises to provide benefits for defined populations. Under ERISA, employee health plans are formed for the sole purpose of providing promised benefits to plan participants. In contrast, state insurance laws regulate risk-bearing business entities that are competing in the insurance marketplace; insurers have an incentive to expand their market share and may take on too much risk in doing so.

8. DOL staff say that they have neither the resources nor the legal authority to resolve disputes between individual health plan enrollees and plans.

9. For summaries of the range of new "consumer-driven" or "defined contribution" approaches to providing employee health benefits, see Paul Fronstin, "Defined Contribution Health Benefits," EBRI Issue Brief no. 231, March 2001, Washington, D.C.: Employee Benefit Research Institute, and Jon B. Christianson, Stephen T. Parente, and Ruth Taylor. 2002. "Defined-Contribution Health Insurance Products: Development and Prospects," *Health Affairs* 21 (1): 49-64.