09/27/10 - Health Reform and ERISA

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Background

Overview

Enacted in 1974 with the overarching aim of protecting workers' pension plans, the Employee Retirement Income Security Act[1] (ERISA) is also one of the nation's most important health care laws. This is because ERISA governs not only pensions but also "welfare benefit plans" voluntarily offered by employers to their employees and families. Group health plans represent a principal type of "welfare benefit" whose ongoing administration is subject to ERISA.

ERISA reaches all group health plans offered by private employers other than churches,[2] regardless of the size of the employer, as long as the employer is "engaged in commerce."[3] The law also applies to multi-employer groups and unions.[4] Health benefit plans offered by federal, state, or local governmental employers and public unions are exempt from ERISA but would be subject to separate federal and state laws.[5]

ERISA does not require employers to offer group health plans, and if they choose to offer them, ERISA does not require employers to contribute to the cost of coverage. If an employer does contribute, then the employer contribution is excluded as taxable income to the employee, while the contribution is deducted by the employer as a business expense. While ERISA does not mandate health benefits, it does regulate group health plans when they are offered. Thus, because the vast majority of all jobs in the U.S. are found in the private sector, the vast majority of workers and their family members covered under an employer-sponsored group health plan are protected by ERISA.

The Five Key Elements of ERISA

In a health benefits context, ERISA contains five major elements.

- First, ERISA sets federal standards regarding the information that health plans must disclose about benefits, coverage, rights, and responsibilities.[6] The duty of disclosure includes provision to participants and beneficiaries (i.e., workers and their families) of a

"summary plan description" that provides information about the health plan including the name of the insurer that administers the plan as well as benefits offered and appeals rights.[7]
• Second, ERISA establishes certain standards governing group health plan benefits and coverage.

• Perhaps the best known requirement is "continuation" coverage (typically at a much higher premium) in the case of workers and dependents who experience certain "qualifying events" such as death of the covered worker, divorce, loss of employment, and other life events.[8] This right to continuation coverage is often referred to as "COBRA" coverage, after the popular name of the 1985 law that amended ERISA.[9]
• Parity in the case of covered treatments for mental health and addiction disorders (popularly known as mental health parity) offers another example of a coverage requirement applicable to group health plans.[10]
• The Health Insurance Portability and Accountability Act of 1996 (HIPAA) offers yet another example of coverage standards; HIPAA amended ERISA to prohibit discrimination based on health status against group health plan members[11] and established guaranteed issue and renewal rights for group plans that purchase health insurance coverage.[12] HIPAA also created certain coverage "portability" protections for workers and their family members with pre-existing conditions, who otherwise risk the loss of, or delay in, coverage as the result of a job change.[13]

• Third, ERISA establishes a "fiduciary" standard of conduct for ERISA health benefit plan administrators (typically an insurance company or a subsidiary). This standard is designed to ensure that a plan administrator acts in the best interest of participants and beneficiaries and not out of self-interest.[14]
• Fourth, ERISA gives health plan participants and beneficiaries right to appeal a "full and fair review" by the plan administrator of a denial of a claim for benefits.[15]
• Fifth, ERISA gives participants and beneficiaries a right to enforce benefit claims in court,[16] as well as the right to seek judicial relief in the case of conduct that violates the law or the terms of the plan, such as the failure to disclose plan information.[17] Courts reviewing the decisions of plan administrators have traditionally taken a highly deferential approach, although a recent decision by the

United States Supreme Court allows lower courts to take a closer look at administrator decisions and decision-making where there is evidence that the plan administrator may have acted out of a conflict of interest.[18]

ERISA Preemption

Although ERISA establishes important protections for participants and beneficiaries, it also protects group health plans against state laws, in order to achieve a nationwide standard of uniform plan administration. This protection is achieved through a doctrine known as "preemption." Given ERISA's national purpose, the law has been interpreted by the courts to be unusually broad in its scope and sweep, and a long line of decisions by the U.S. Supreme Court has established that ERISA preempts (i.e., overrides) state laws that "relate to" (i.e., refer to plans or demonstrate a connection with) employee benefit plans.[19] While some state laws (such as laws related to the quality of care,[20] laws imposing a sales tax on health care purchasing,[21] or laws that apply to employers directly rather than their benefit plans)[22] are not considered to "relate to" ERISA plans, many state laws that regulate employee health benefits aspects of employment have been preempted over the years.

What makes ERISA preemption so unusual is that under the preemption doctrine, ERISA overrides state laws even when ERISA itself sets no standard on a particular matter. Thus, ERISA does not merely supersede state laws that directly conflict with its provisions but actually displaces certain types of state laws altogether. In this sense, ERISA is considered to "occupy the field" of employee health benefits, thereby preempting state laws even when ERISA itself creates no comparable standard. ERISA's deregulatory impact thus is considerable.

One important exception to ERISA preemption, which has been recognized by the Supreme Court since the mid-1980s, is state laws that regulate insurance.[23] State insurance laws, including laws that regulate health insurance, are saved from preemption when applied to group health plans that buy state-regulated health insurance products (typically small and mid-sized employers). The Supreme Court has articulated a federal standard for determining when a state law is one that regulates insurance: first, the law must be directed at the insurance industry; and second, the law must address issues of financial risk.[24]

While the insurance "saving clause" (as the provision is known) spares state insurance laws from preemption, its effect is felt only on that portion of the ERISA health plan market that involves the purchase of state-regulated insurance products.

Approximately half of all ERISA group health plans in fact are self-insured and buy only reinsurance and plan administration services. As such, these plans are not considered to have purchased state-regulated health insurance products, and therefore they remain shielded from state health insurance law.[25] Paradoxically, many of the same companies that sell state-regulated insurance products also sell the same product as plan administration services to self-insured plans. As a result, it is entirely possible for two spouses working for different employers to have what they think is the same coverage product (e.g., a Blue Cross/Blue Shield PPO plan) when in reality one plan is regulated by state law and the other is exempt.

ERISA preemption does not end at state laws that directly regulate employee health benefit plans. The Supreme Court also has held that ERISA's federal remedy provision, which permits the awarding of benefits that have been wrongly withheld, is exclusive, regardless of whether an ERISA-governed group health plan buys state regulated insurance or is self-insured, and regardless of whether broader state law remedies would be available against the same insurers operating in the non-ERISA group plan market (e.g., state or county employee health benefit plans).[26] As a result, participants and beneficiaries covered by an ERISA plan have the right to sue to recover the value of their benefits but lose whatever rights they might have under state law to recover damages (i.e., money claims for tangible losses and potentially intangible injuries such as pain and suffering). This is true even in the case of plan administrators who are shown to have acted negligently or in bad faith in denying benefits due under the terms of the plan, and even if such denial can be shown to be a proximate cause of the patient's death or injury.

The United States Department of Labor has primary oversight authority over ERISA welfare benefit plans; at the same time, the Labor Department does not have authority over state-regulated health insurers that sell insurance products to ERISA group health plans.[27] In addition, because compliance with ERISA is a condition on an employer's right to deduct the cost of employer-sponsored health plans as a business expense, the Treasury Department also has standard-setting authority. Finally, because ERISA health plans purchase state regulated insurance, the federal ERISA health plan standard-setting process is linked to the federal health insurance oversight process administered by the Department of Health and Human Services. Thus, regulations applicable to ERISA health plans typically are jointly issued by the Departments of Labor, Treasury, and Health and Human Services.[28]

Changes Made by the Health Reform Law
P.L. 111-148

The Patient Protection and Affordable Care Act (PPACA or the Act) changes ERISA

in important ways that increase participant and beneficiary rights, while at the same time leaving its basic requirements and framework untouched:

Offering an ERISA health benefit plan: The Act does not alter ERISA's core provisions related to offering an ERISA health benefit plan; in other words, the Act does not require that employers offer an ERISA health benefit plan. Instead, it establishes alternative pathways to coverage for workers and their families who do not have access to an ERISA health benefit plan. Individuals without workplace coverage will instead obtain "minimum essential coverage" by purchasing a qualified health plan directly or through a state health insurance Exchange. Individuals eligible for Medicaid or CHIP will enroll directly into these programs or be enrolled through an Exchange.

At the same time, however, large employers (50 or more full-time employees) that do not offer a health plan will be required to pay an assessment for each full-time employee;[29] assessments will be subject to certain adjustments and indexed to inflation.[30] Large employers subject to assessments will be required to report certain information to the federal government regarding whether they offer a health benefit plan as well as the elements of such a plan, including waiting periods before coverage begins, total premium costs and the employer's share of the cost, information about covered employees, and other information that may be required.[31] Employers also will be required to notify employees about the information they provide to the government. Employers with 200 fulltime employees or greater that do offer health benefit plans will be required to automatically enroll new full-time employees into their plans and to continue enrolling current employees.[32]

Contributing to the cost of health benefit plans: The Act does not require employers to contribute to the cost of their employee health plans. But large employers that do offer health plans to full-time employees and their dependents will be required to pay an assessment if their employees instead enroll in a qualified health plan through an Exchange and receive premium and cost sharing subsidies.[33] Assessments owed will be indexed to inflation, and employers subject to assessments will be subject to federal reporting requirements.

Information and notice to workers about Exchange coverage and subsidies: Employers that offer a health plan will be required to report on the individuals covered by their plan,[34] which in turn qualifies as the "minimum essential coverage" required of most individuals.[35] At the time of hiring, employers also will be required to provide written notice informing employees about several different matters: the existence of a state Exchange; the services offered through the

Exchange and how to obtain assistance;[36] the premium and cost sharing subsidies available through Exchanges if the employer contributes less than 60% of the cost of employee coverage under the employer plan; and the fact that the employee will lose the employer's contribution in the event that the employee does choose to buy coverage directly through the Exchange and receives premium and cost-sharing subsidies instead, in cases in which the employer does not offer a "free-choice voucher toward Exchange coverage.[37]

Treatment of self-insured plans: The Act makes no changes to employers' option to self-insure their health benefit plans. At the same time, the law establishes new coverage and reporting requirements for self-insured plans, extending to these plans many of the same protections that the law applies to state-regulated health insurance products. This change is expected to reduce the differences in coverage and patient protections that can exist between fully insured and self-insured plans. Provisions applicable to the group health insurance coverage market that are extended to all ERISA plans, whether fully or self-insured, are as follows:

- A bar on lifetime and certain annual limits;[38]
- A prohibition on rescissions;[39]
- Coverage of preventive health services[40] with no cost-sharing;[41]
- Extension of dependent coverage to age 26;[42]
- Uniform explanation of coverage documents and standardized definitions and notification of ERISA plan participants and beneficiaries regarding material modification of plan terms;[43]
- Annual quality of care reporting;[44]
- The right to an independent external appeal in addition to the internal plan appeals previously available to ERISA plan participants and beneficiaries, along with new standards governing internal appeals;[45]
- Patient protections including a choice of primary health care provider, coverage of emergency care when furnished by an out-of-network provider, and direct access to pediatric and obstetrical and gynecological care;[46]
- A prohibition against pre-existing condition exclusions and health status discrimination;[47]
- The use of modified community rating to determine premiums;[48]
- Guaranteed availability of coverage;[49]
- Guaranteed renewability of coverage;[50]
- Prohibiting discrimination against individual participants and beneficiaries based on health status, while permitting certain employee wellness programs that tie premiums to health outcomes;[51]

- A prohibition against coverage waiting periods exceeding 90 days;[52]
- Coverage of individuals participating in approved clinical trials;[53]
- Providing additional information to the Secretary of HHS and state insurance agencies, where applicable, regarding claims payment policies and practices, financial disclosures, data on enrollment and disenrollment, data on claims denials, data on rating practices, information on cost sharing and payments with respect to out-of-network coverage, and information on enrollee and participant rights;[54] and
- Non-discrimination against health care providers licensed under state law.[55]

However, self-insured plans are not subject to two of the insurance reforms that apply to state-regulated insurance products. The first exemption for self-insured plans limits the amount of benefits that can be provided to highly compensated employees. The second exemption in the case of self-insured plans is the requirement related to provision of financial information related to premium increases and limits on medical loss ratios.[56] Furthermore, as noted, the law's essential benefit requirements apply only to individual and small group plans (under 100 employees). This coverage requirement does not apply to self-insured plans or to large group health plans that buy a group health insurance product. Both of these types of plans remain free to engage in benefit design but remain subject to existing ERISA requirements such as mental health parity.[57]

Buying group health insurance coverage: The Act does not affect the ability of employer plans that buy group health insurance coverage to continue doing so. These plans can continue to buy coverage directly from insurers and brokers.[58] Small employers (under 100 full-time employees) also will be permitted to buy coverage through state exchanges (known as SHOP Exchanges in the case of small employers) beginning on January 1, 2014, unless a state elects to limit Exchange participation to smaller employers (50 or fewer full-time employees).[59] States also will have the option, beginning in 2017, to extend Exchange purchasing options to large employers (100 or more employees).[60] Also as noted, the essential benefit requirements do not apply to group products sold to employers with 100 or more full-time employees.[61]

Remedies and ERISA preemption principles: Other than strengthening and expanding the appeals rights available to plan participants and beneficiaries, health reform makes no changes in ERISA enforcement rights. State law damages for

injuries alleged to have been caused by ERISA health plan administrators are still preempted, even if ? as before ? the ERISA health plan buys a state regulated health insurance product. Similarly, ERISA still guarantees a right to sue to recover benefits that are due under the terms of the plan (which may now be broader as a result of the Act) and to sue to halt fiduciary misconduct. Similarly, nothing in the Act changes ERISA's preemptive impact on state insurance laws in the case of self-insured plans. At the same time, the law considerably expands the protections for participants and beneficiaries enrolled in self-insured plans.

Grandfathered plans: ERISA plans qualify for grandfathered status if they satisfy the regulatory guidelines set forth in interim final regulations promulgated by the three agencies on June 17, 2010.[62]

Implementation

Agency

The Department of Labor is the principal enforcement agency and develops ERISA health plan policy jointly with the Departments of Treasury and Health and Human Services.

Key Dates

The law does not provide any specific implementation dates.

Process

In some cases the Act specifies the process to be used (e.g., the Secretary shall conduct a negotiated rulemaking). In other cases, the statute is silent. Because the health reform law will directly affect ERISA plans, the three relevant agencies are expected to rely extensively on a rulemaking process, with informal agency guidance to follow once rules are in place. The reliance on rulemaking is especially important given the magnitude of the interests at stake and Congressional and public expectation of a formal body of interpretive rules that allow notice and comment. Even when rules are issued in interim final form, as many have been, they are subject to the transparency of the rulemaking process and are subject to revision prior to issuance in final form.

Key Issues

The key issues in the case of ERISA tend to focus on the downstream effects of the

Act on employer behavior:

• Will employers continue to offer group health plans? Will the law's changes be viewed as sufficiently significant to lead employers to cease offering ERISA health benefit plans? In fact, with the exception of the right to an external appeal (which many plans already permitted at their discretion), the reform law does not alter the remedies available to plan participants and beneficiaries. Employer plans are no more subject to litigation in the wake of reform than they were prior to passage. While the law adds important new benefit protections such as the extension of dependent coverage, and coverage of preventive benefits without cost-sharing, larger ERISA plans are exempt from the essential benefits requirements and other protections, such as non-discrimination, have been in place since 1996. Employers that do elect to cease offering a health benefit plan will, of course, be subject to an Exchange assessment. The Congressional Budget Office has forecast virtually no significant shift in employer behavior related to the impact of the law on health benefit plans. (Similarly, since establishing its Health Connector, Massachusetts has experienced no change in employee health benefit practices.)
• Will courts continue to recognize ERISA preemption principles? The health reform law is not intended to disturb the preemption provisions of ERISA; at the same time, the law creates new standards for state regulated health insurance products and states will be implementing new purchasing Exchanges that also will alter how health insurance operates. It is possible that health insurers and employers may seek to test the limits of certain new standards or state laws related to Exchanges in the context of ERISA preemption.
• Will small groups use SHOP exchanges, and will health benefit purchasing by small groups in state exchanges be considered the establishment of an ERISA-governed health plan? It is premature to predict the outcome of the development and implementation of Exchanges, but a closely watched matter will be whether small employer groups that do offer health benefit plans will utilize SHOP Exchanges. Furthermore, it is not clear whether small employers that do contribute toward the cost of their employees' coverage through SHOP exchanges will be considered to have established ERISA plans. This question is crucial to the question of whether individuals who enroll in these plans are considered to be governed by ERISA's more limited remedies or to have access to all enforcement remedies

available under state law.

• How will the law's appeals rights change judicial oversight of ERISA benefit cases? The health reform law creates new appeals rights, and implementing regulations appear to emphasize the independence of the external review process when considering an ERISA plan administrator's decision. Subsequent labor Department policy guidance indicates that because the independent review is de novo, the agency anticipates that the deferential review standard will be altered. In cases in which an individual successfully appeals a denial to an independent review authority, the independent reviewer finds in favor of the patient, but the plan administrator does not concur, will courts interpret the new independent review power as reducing the deferential weight that they should give to ERISA plan administrator decisions?

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http://www.dol.gov/dol/topic/health-plans/cobra.htm.

[10] 29 U.S.C. §1185.

[11] 29 U.S.C. §1182.

[12] 29 U.S.C. §1183.

[13] 29 U.S.C. §1181.

[14] Metropolitan Life Insurance Co. v Glenn, 554 U.S. 105 (2008).

[15] 29 U.S.C. §1133.

[16] 29 U.S.C. §1132(a)(1).

[17] 29 U.S.C. §1132(a)(3).

[18] Metropolitan Life Insurance Co. v Glenn, 554 U.S. 105 (2008).

[19] 29 U.S.C. §1144; Shaw v Delta Airlines, 463 U.S. 85 (1983).

[20] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, 514 U.S. 646 (1995).

[21] New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, 514 U.S. 646 (1995).

[22] Golden Gate Restaurant v. City and County of San Francisco, 546 F.3d 639 (9th Cir. 2008).

[23] Kentucky Association of Health Plans v Miller, 538 U.S. 329 (2003).

[24] Id.

[25] Metropolitan Life Insurance Co. v Massachusetts, 471 U.S. 724 (1985).

[26] Pilot Life Insurance Co. v Dedeaux, 481 U.S. 41 (1987); Aetna Health, Inc. v Davila 542 U.S. 200 (2004).

[27] ERISA §502(b)(3); 29 U.S.C. §502(b)(3).

[28] 75 Fed. Reg. 19297-19302 (April 14, 2010); 75 Fed. Reg. 34537-34570 (June 17, 2010); 75 Fed. Reg. 41726-41760 (June 19, 2010); 75 Fed. Reg. 43330-43364

(July 23, 2010); 75 Fed. Reg. 52597-52599 (August 26, 2010).
[29] PPACA §1513 adding §4980H to the Internal Revenue Code.
[30] PPACA §1513.
[31] PPACA §1514.
[32] PPACA §1511.
[33] PPACA §1513.
[34] PPACA §1502 amending Internal Revenue Code to add a new Subpart D.
[35] PPACA §1501, adding Internal Revenue Code §5000a(f).
[36] PPACA §1512 amending the Fair Labor Standards Act of 1938.
[37] PPACA §1512.
[38] PPACA §1001 adding PHSA §2711.
[39] PPACA §1001 adding PHSA §2712.
[40] http://healthreformgps.org/resources/health-insurance-reforms-and-%E2%80%9Cgrandfathered-plans%E2%80%9D/.
[41] PPACA §1001 adding PHSA §2713.
[42] PPACA §1001 adding PHSA §2714.
[43] PPACA §1001 adding PHSA §2715.
[44] PPACA §1001 adding PHSA §2717.
[45] PPACA §1001 adding PHSA §2719.
[46] PPACA §1001 adding PHSA §2719A.
[47] PPACA §1201 adding PHSA §2704 (modified from the previous HIPAA provision).
[48] PPACA §1201 adding PHSA §2701.
[49] PPACA §1201 adding PHSA §2702.
[50] PPACA §1201 adding PHSA §2703.
[51] PPACA §1201 adding PHSA §2705.
[52] PPACA §1201 adding PHSA §2708.
[53] PPACA §1201 adding PHSA §2709.
[54] PHSA §2715A, added by PPACA §1001.
[55] PPACA §1201 adding PHSA §2706.
[56] PPACA §1563(e).
[57] PPACA §1201 adding PHSA §2707.
[58] PPACA §1312.
[59] PPACA §1312(f)(2).
[60] PPACA §1312(f)(2).
[61] PPACA §1202 adding PHSA §2707.
[62] 75 Fed. Reg. 34537-34570 (June 17, 2010). See also http://healthreformgps.org/resources/health-insurance-reforms-and-%E2%80%9Cgrandfathered-plans%E2%80%9D/.

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