Why Is ERISA an Important Issue Today?

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Executive Summary

The issue of the Employee Retirement Income Security Act of 1974 (ERISA) has had significant impacts on health care today. ERISA is noted for preempting states from regulating employer-provided health coverage. Although it was not the law’s original intention, ERISA preemption obstructs people with employer-provided plans to hold their health plans responsible for wrongfully withheld care. Now, patients cannot seek compensatory or punitive damages from their health care providers for wrongful denials or delays in providing health care.

Like any issue, there are stakeholders. The ERISA Industry Committee (ERIC) is an advocate of market-based health care reform and ERISA preemption. The Health Administration Responsibility Project (HARP) on the other hand, feels ERISA severely restricts the rights of patients.

Approximately 123.5 million (84%) Americans are affected by ERISA preemption because they receive health coverage from private employers. The only compensation these millions of people can receive is equitable relief and not monetary damages. This means that patients may sue for benefits, but not for negligence.

The number of people enrolled in self-funded ERISA plans is growing. The total amount in self-funded plans increased by 6 million people from 1989 to 1993. An estimated total of 114 million people were under plans subject to ERISA. This amount increased to 123.5 million people in 1998, showing people subject to ERISA is continually rising.
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PART A: Define the issue

Problem:

Today, patients feel that the Employee Retirement Income Security Act (ERISA) of 1974 severely restricts their rights (10). States cannot require employers to give health care coverage to their employees, but they can require that specific benefits, such as mental health benefits, to be sold. Employers are then given the right to purchase its health care coverage from an insurer, which the state regulates, or from self-funded plans which ERISA preempts (1). Thus, employer provided health plans (known as ERISA plans) are protected from liability for negligent injury to patients (12). Today, millions of people are under self-funded plans (16).

Extent:

Approximately 123.5 million (84%) Americans are affected by ERISA preemption because they receive health coverage from private employers. In Pennsylvania, 6.4 million (89%) workers in employer-based plans are included under ERISA (16). The only compensation these millions of people can receive is equitable relief and not monetary damages (7). This means that patients may sue for benefits, but not for negligence (17).

Public Policy:

Recently a string of cases have been brought to the forefront regarding patients suing their health maintenance organizations (15). A recent ERISA case dealt with a man, Frank Wurzbacher, who was diagnosed with prostate cancer. Because of his condition, it was necessary for him to receive leupron injections each costing $500. Mr. Wurzbacher was told by Prudential that he would only have to pay $180 per injection.
However, he still could not afford this amount and asked his physician for an alternative. He was told that the only alternative was castration. Prudential agreed to pay for the castration and Mr. Wurzbacher had the procedure performed. While at the hospital, Prudential had notified him by mail that a mistake was made and that they would pay the full $500 for each injection. Mr. Wurzbacher sued under state law, but was denied due to ERISA preemption (16).

Another case that has been publicized heavily is Corcoran vs. United Healthcare Inc. In 1992, the U.S. Court of Appeals in the Fifth Circuit ruled that Florence Corcoran was not entitled to compensation from the health provider. Her physician testified that she needed to be hospitalized for her last trimester, but was denied admission, and soon after the fetus died (17).

Yet another key case brought to the public was that of Lori Pegram et. al. vs. Cynthia Herdrich. In 1991, Herdrich’s appendix burst while waiting for eight days for a test at an HMO affiliated hospital. She sued for malpractice and won $35,000 in state court. She then sued the HMO, saying they give incentives to make decisions in the doctor’s interest rather than in the patient’s well being. In June 2000, the Supreme Court dismissed the case saying patients cannot sue HMOs for giving doctors financial incentives to cut medical costs (3).

Congress has been trying to draft a “patients bill of rights,” which would set limits on lawsuits against HMOs in federal courts (3). Currently Congress is struggling to decide if they should do something about ERISA law. If Congress does not decide to change ERISA, the U.S. Supreme Court has hinted it will do something. Currently ERISA allows patients to sue for benefits, but not for negligence (17).
Issue Definition:

The Employee Retirement Income Security Act (ERISA) of 1974 is noted for preempting states from regulating employer-provided health coverage. Although it was not the law’s original intention, ERISA preemption obstructs people with employer-provided plans to hold their health plans responsible for wrongfully withheld care. Now, patients cannot seek compensatory or punitive damages from their health care providers for wrongful denials or delays in providing health care (7).

PART B: Describe issue’s history

Why is ERISA an important issue today?

Emergence:

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to protect employees and their dependents from potential abuses by their pension and health plans (6). The law’s intent was to make employers’ lives simpler by preempting state regulation of benefit plans by covering them with a single federal law (18). However, a small part of the law included the “employee welfare benefit plan.” In 1974, it was not clear to anyone what exactly this was. A possibility was it allowed larger employers to self-insure their employee benefits plans. By the late 1970s, an “employee welfare benefit plan” was given new meaning by Multiple Employer Trusts (METs) (14).

In the late 1970s and early 1980s, the self-funded ERISA plan was born. At this time, the group health insurance market was captured by Multiple Employer Trusts (METs). Third Party Administrators (TPAs) usually administered the self-funded METs. They were large, uninsured, group medical plans that were run just as an insurance
company would be. Small business owners found it hard to afford larger group health insurance companies, so they turned to the self-funded METs. They offered a variety of benefits at prices well below what traditional insurance companies were charging at the time. As a result of their low prices, self-funded METs grew in popularity during this time period.

However, by the early 1980s METs were infamous for their poor underwriting standards. It was at this time that the first ERISA preemption arguments were unveiled by MET attorneys. They argued that ERISA preempted all state insurance laws. The poor underwriting eventually lead to METs going bankrupt and tens of thousands of people with unpaid claims and no health insurance (14). Because of ERISA’s preemption clause, the law turned into a shield of immunity to MCOs due to the evolution of health care from a fee-for-service to a managed care system (6).

The METs left their mark on the health industry and paved the way for the insurance industry. They took Managed Care and ERISA preemption to improbable limits during the 1990s. All major health insurance companies started to notice that ERISA preemption could protect them from state regulations and laws on health insurance. Though Congress never intended it, ERISA impacts almost all employer sponsored insurance plans (14).

**Chronology:**

**1921 and 1926:** Revenue Acts allowed employers to deduct pension contribution from their income. Also allowed pension fund to accumulate tax free (4).

**1942:** Revenue Act gave stricter participation requirements and provided disclosure
requirements (4).

1959: Welfare and Pension Plans Disclosure Act (WPPDA) allowed Depart of Labor to be involved in the regulation of employee benefits plans (4).

1962: The WPPDA is amended. Secretary of Labor is given power over employee benefit plans (4).

1974: Congress enacts the Employee Retirement Income Security Act (ERISA). Health care is currently delivered under a fee-for-service system (6).

Late 1970s: Self-funded Multiple Employee Trusts (METs) start to play a significant role in ERISA development (14).

Early 1980s: METs go bankrupt leaving tens of thousands uninsured and with unpaid claims (14).

1985: The Omnibus Budget Reconciliation Act is added to ERISA providing continuing health coverage to employees if certain events would result in reduction of benefits (4).

1990s: The health insurance industry follows path of METs by using ERISA to protect themselves from state laws and regulations in cases of bad faith lawsuits (14).

1996: The Health Insurance Portability and Accountability Act (HIPAA) is added to ERISA. Helps make health coverage more portable and secure for employees (4).

Trends:

Since ERISA’s inception in 1974, the trend in health care has almost immediately gone from a fee-for-service system to a managed care system. Their responsibilities include patient care through policies, procedures, and cost containment strategies. If a
MCO denies payment for treatment to a patient, access, costs, and quality can be affected (6).

**Access:**

The way Americans obtain health care has dramatically changed since ERISA’s inception in 1974. More than three out of four people are in managed care plans today. From the beginning, managed care was intended to improve access to preventive, primary, and coordinated care (7).

**Costs:**

In the 1980s health care costs equaled 50 percent of many businesses profits threatened the survival of the companies. Today, because of ERISA almost $263 billion a year is spent by businesses to provide millions of workers with affordable health care (2). ERISA has been a key element of containing costs and designing plans fit to employees needs (1).

**Quality:**

ERISA enables businesses to improve the quality of heath care through innovative market-based solutions (2). On the other hand, ERISA allows MCOs not to be accountable for their negligence. This removes the incentive to provide high quality health care. Companies who know that they can be held accountable for their behavior are more like to try to prevent harm to patients (6). States feel ERISA obstructs consumer protections and if they were not preempted they could improve efficiency, equity, and efficacy of health care (1).
PART C: Identify Stakeholders

Introduction:

The issue of the Employee Retirement Income Security Act of 1974 (ERISA) has had significant impacts on health care today. Twenty-six years ago, when ERISA was enacted, the law’s focus was not on group medical and disability insurance. However, a small part of the statute made reference to an “employee benefit plan.” Because of this trivial part of the statute, today, ERISA controls or impacts all employee benefits, including employer-sponsored insurance plans (13).

Stakeholder 1: The ERISA Industry Committee (ERIC)

What is their position on the issue?

The ERISA Industry Committee (ERIC) is an advocate of market-based health care reform and ERISA preemption. ERIC is committed to America’s major employers employee benefits interests. They support any legislation that preserves and strengthens ERISA preemption and lessens government interference with employers’ efforts to provide health care benefits to their employees. ERIC opposes government regulations that limit employer flexibility in creating health plans (5).

What are the stakeholders’ resources?

ERIC consists of seven staff and 127 members that include some of America’s largest employers (8). Annual dues of $15,000 cover full participation in all ERIC programs and services. The dues are the same price regardless of the members’ participation. They mention that their members’ participation is their greatest asset. ERIC provides many resources for benefits professionals concerned with developments
in the courts, the agencies, Congress, and benefits community. ERIC publishes a biweekly newsletter that is sent to ERIC member benefits staff, Washington Representatives, members of Congress and their staffs, and the media, which gives them a reasonable amount of political clout. ERIC Online (www.eric.org) is a private communications network for members of ERIC to use on the Internet. There are regular committee meetings that provide information about legislation, regulatory initiatives, and other policy matters to ERIC’s members. There are opportunities for members to listen to and question lawmakers, policy makers and officials who are active in the benefits area. ERIC works with their members’ Washington Representatives on a monthly basis. They are considered to be an important link in helping with advice and counsel (5).

What actions did the stakeholders play in bringing the issue to government or public?

ERIC is active in lobbying for national employee benefits policy. Members and staff regularly testify on policy and legislative issues before Congress and federal agencies. In federal and state court cases affecting benefits plans of major employers ERIC will file *amicus* briefs. Members also participate in policy discussions around the nation concerning the future of health and other employee benefits policy (5).

What success have they had?

ERIC contends that its testimony, comments, and other material are accurate, thorough, and sought by policy makers and companies. Because ERIC has been an advocate of market-based health care reform and ERISA preemption since 1976, they believe that they have been influential and successful in their efforts (5).
Stakeholder 2: The Health Administration Responsibility Project (HARP)

What is their position on the issue?

The Health Administration Responsibility Project (HARP) feels that the Employee Retirement Income Security Act of 1974 (ERISA), severely restricts the rights of patients. “HARP is a resource for patients, doctors, and attorneys seeking to establish the liability of Managed Health Care Organizations (MCOs) and Nursing Facilities for the consequences of their decisions.” HARP feels that health care organizations are in a rush toward “efficient” medical care, and are losing sight of the “quality” of care (11).

What are the stakeholders’ resources?

There is no information mentioning HARP’s size or budget. Their largest resource seems to be their website, www.harp.org. Through this website consumers are given a variety of resources to use. The website links you to lists that include: costs clinics throughout California; organizations that offer free help to patients; attorneys who have experience in litigation against HMOs; consumer advocates; your legislators; and free drug programs for low income patients (11).

What actions did the stakeholders play in bringing the issue to government or public?

There have been a few cases brought to the courts regarding ERISA by HARP. In June of 2000 a federal appeals court upheld a lower court decision concluding that patients may hold their Health Maintenance Organizations (HMOs) legally responsible for negligent care by a plan physician. However, the court would not allow patients to sue HMOs over decisions to deny care altogether on the basis that the care in question is medically unnecessary or not covered (9). HARP has created a political agenda that they
will try to enact. In order for HARP to establish liability of MCOs some legal obstacles
must be removed by political means. Some of HARP’s ideas include: removing ERISA
preemption of medical claims, removing state regulation, outlawing physician gag
clauses, and removing MCO control of arbitration. HARP has created links to pertinent
sections of Federal and California Codes, relevant cases, and other helpful websites on
theories of liability (11).

What success have they had?

Thus far HARP has only generated suggestions to problems dealing with ERISA
law with no significant signs of successfully administering their ideas (11). Their
political agenda is a well thought group of ideas and if ever implemented HARP will
someday be successful.

PART D: Monitor issue’s development

The number of people enrolled in self-funded ERISA plans is growing. The total
amount in self-funded plans increased by 6 million people from 1989 to 1993. Figure 2
shows the increase of individuals in self-funded ERISA plans from approximately 33% in
1988 to about 46% in 1993 (1). At the same time in 1993 an estimated total of 114
million people were under plans subject to ERISA (1). This amount increased to 123.5
million people in 1998 showing people subject to ERISA is continually rising (7). The
graph below shows this increase.
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