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ResearchReport

ERISA, Self-Insured Benefit Plans, and State Insurance Mandates

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Issue

Describe why self-insured benefit plans are exempt from state-enacted insurance benefit mandates.

Summary

In many cases, a state insurance law does not apply to a self-insured benefit plan (e.g., health care plan) because the federal Employee Retirement Income Security Act (ERISA) pre-empts the state law from applying to these plans.

Although ERISA preemption has been significantly litigated, courts have generally agreed that state-enacted insurance benefit mandates do not apply to self-insured plans. (See OLR Report 2019-R-0183 for a summary of state insurance mandates.)

A self-insured benefit plan is not backed by an insurance policy. Instead, the employer offering the plan funds and administers it (i.e., pays claims covered by the plan from its own money). The employer may outsource or delegate plan administration to a third-party administrator (TPA) (often an insurance company), but the TPA does not provide the employer with any financial backing or assume any financial risk associated with the claims. (In contrast, for a fully insured plan, the insurer assumes the plan's financial risk in return for premium payments.)

ERISA prohibits states from "deeming" self-insured plans to be subject to state insurance requirements. This "deemer" clause says:

> Neither an employee benefit plan…nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer…or to be engaged in the business of insurance…for purposes of any State purporting to regulate insurance companies [or] insurance contracts…(29 U.S.C. § 1144).

As a result, the Connecticut Insurance Department does not have jurisdiction over self-insured plans. Rather, the U.S. Department of Labor (DOL) has jurisdiction over them. See the DOL's website for more information about ERISA.

If a person wants to know if his or her benefit plan is self-insured, the person should contact either the plan administrator identified in the plan materials or his or her human resources contact.

ERISA Law

Background

Congress enacted ERISA in 1974 as a federal regulatory scheme for employee benefit plans, including health care plans. ERISA sets forth requirements for benefit plan participation, funding, and vesting of benefits. It also establishes uniform standards for reporting, disclosure, and fiduciary duties, generally allowing multi-state employers to benefit from a single, consistent regulatory scheme. ERISA does not apply to governmental plans; church plans; plans maintained solely for the purpose of complying with workers' compensation, unemployment compensation, or disability insurance laws; foreign plans; and unfunded excess benefit plans (29 U.S.C. § 1003).

ERISA does not require employers to provide health benefits or to set aside funds to pay expected claims. But if an employer does offer benefits, ERISA establishes the regulatory framework and minimum requirements. For health care plans, ERISA's substantive provisions relate to: (1) administrators' fiduciary standards (to administer the plan in the best interest of beneficiaries) and benefit disclosure requirements for enrollees; (2) reporting requirements; and (3) certain minimum plan design and benefit standards (e.g., continuation of health coverage, group plan guaranteed issue and renewability, nondiscrimination in premiums and eligibility, grievance and appeals procedures, and mental health parity among other benefits).

Preemption

The U.S. Supreme Court has repeatedly found that Congress intended for ERISA to be the dominant regulatory authority over employee benefit plans, generally preempting state laws. ERISA sets out a three-part preemption provision that is generally referred to in terms of its preemption, savings, and deemer clauses. Specifically, ERISA (1) preempts state laws that "relate to" employee benefit plans,

(2) saves from preemption those state laws that regulate the business of insurance, and (3) "deems" employee benefit plans to be neither insurers nor engaged in the business of insurance for purposes of state regulation (ERISA § 514, 29 U.S.C. § 1144).

The Court has also found that Congress intended to preserve the states' regulatory power over the "business of insurance" but not self-insured plans. The Court has held that ERISA does not preempt state laws that have "only a tenuous, remote, or peripheral connection with covered plans, as is the case with many laws of general application" (*District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 n.1 (1992)). However, when the state law in question regards plan administration (e.g., claim processing or eligibility determination), the Court has held that ERISA preempts it, in line with Congress' goals to minimize plan administration burdens and encourage employers to offer employee benefit plans.

For more information on ERISA's preemption provision, see the National Academy for State Health Policy's 2009 ERISA Preemption Primer.

Penalties

Additionally, the U.S. Supreme Court has held that Congress intended for ERISA's civil remedies to be exclusive (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)). Under ERISA, a plaintiff is generally allowed to (1) recover benefits due under a plan's terms (e.g., have a claim denial reversed and coverage provided); (2) enforce rights under a plan; and (3) receive a clarification of rights to future benefits under a plan (ERISA § 502(a), 29 U.S.C. § 1132(a)).

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