

## ***Legislative Malpractice Misdiagnosing Patients' Rights***

**by Greg Scandlen**

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The recent debate in Congress over patients' rights and the regulation of managed care has been predicated largely on a misunderstanding of the Employee Retirement Income Security Act of 1974. The misunderstanding is pervasive, shared by members of Congress and by anti-managed-care activists.

Although it is true that ERISA is an important and vastly complex piece of legislation, it is not true that health maintenance organizations (HMOs) receive special protection from ERISA, or that they are exempt from being held accountable for medical errors because of ERISA.

In fact, HMOs are far less likely than are fee-for-service plans to be self-funded and exempt from state oversight. They are far more likely to be subject to state-mandated benefits, solvency requirements, appeals requirements, and consumer protections than are self-funded "traditional" plans.

And, while all employer-based plans (whether self-funded or fully insured, whether HMO or indemnity) are exempt from state contract and most tort laws, to the extent a plan "practices medicine," it is subject to state-based remedies for malpractice.

ERISA might be ready for a change, or an outright repeal, but the current proposals don't begin to do that. In fact, they extend federal regulation to areas that have always been the responsibility of the states. It would be comforting to know, before it enacts sweeping new legislation, that Congress is acting with full knowledge of the current problems rather than being carried away in a tide of emotionalism. It would also be reassuring to know that the advocates of new legislation had fully considered the implications of a new federal role in overseeing the practice of medicine.

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## **Introduction**

It is hard for physicians to prescribe treatments when they have the wrong diagnosis. And it is hard for Congress to pass a good law when the members misunderstand the problem. The current debate over the “Patients’ Bill of Rights” is an example of a remedy gone wrong. The proponents want to “fix” the Employee Retirement Income Security Act of 1974 to enable patients to sue their health plans when the plans commit medical malpractice. But, because the proposed solution is based on a misdiagnosis, the outcome could worsen the disease.

There may be no more widely misunderstood piece of legislation than ERISA. Even people who are otherwise expert in health policy have trouble understanding the intricacies of this law.

Some of the misunderstandings include the ideas that

- ERISA applies only to self-funded employers;
- HMOs have a special exemption from law suits because of ERISA;
- patients can’t sue their health plans because of ERISA;
- HMOs have increased the amount of self-funding by employers;
- the states are powerless to regulate HMOs;
- all large employers are self-funded;
- self-funding is growing;
- ERISA was intended to apply only to pensions; health care was an after-thought; and
- crafty lawyers created loopholes based on inexact legislative language.

All of those beliefs are mistaken. ERISA certainly has had a major impact on the financing of health care in the United States, and it has been controversial ever since it was enacted. It provides a federal framework for employer benefit plans and eliminates state authority to regulate those plans. Central to the current debate, ERISA elimi-

nates most state-based “causes of action” and replaces them with federal remedies. Whether Congress should have preempted state law in the first place and whether ERISA’s remedies are still adequate 25 years later are both important questions. But much of the current debate is less about ERISA than it is about growing anger that HMOs interfere with the practice of medicine. It is not helpful that so many people misunderstand what ERISA does and does not do—especially when those misunderstandings prompt Congress to write remedial legislation.

## **The Law**

As its name implies, ERISA was enacted primarily to protect retirement income programs (i.e., pensions), but ERISA also covers health care programs (“employee welfare benefit plans”). An employee welfare benefit plans is defined as

any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment.<sup>1</sup>

That definition applies to plans provided by all employers (“any employer engaged in commerce or in any industry or activity affecting commerce”)<sup>2</sup> except governmental plans,<sup>3</sup> church plans,<sup>4</sup> and plans maintained to comply with workers compensation or unemployment compensation laws.<sup>5</sup> In this paper, “employer” plans do not include church and governmental plans.

The purpose of ERISA was to allow employers to provide nationally uniform benefits to all their employees at a time when the states were beginning to enact laws with very different requirements. To provide uniform

benefits, employers wanted nationally consistent standards in such areas as fiduciary responsibilities, employee vesting, disclosure of benefits, appeals procedures, and grievance rights. ERISA was also designed to protect the assets of employee benefit plans from being depleted through litigation. Congress fully intended to prevent state legislatures from taxing those assets or controlling how they would be invested or otherwise administered.<sup>6</sup>

To allow for nationally consistent benefits and regulations, Congress preempted state laws that “relate to” employee benefit plans and substituted federal requirements. The language preempting state law is fairly clear. It says, “[ERISA] shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>7</sup> There have been disputes over the meaning of “relate to,” but the courts have tended to interpret the expression broadly and with due consideration of the intent of Congress.

The preemption was not an accident. The chairmen of the congressional committees with jurisdiction over ERISA made it clear at the time that they intended the preemption to be very broad. Rep. John Dent (D-Pa.), chairman of the Subcommittee on Labor of the House Labor and Education Committee, said on the floor of the House, “I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans.”<sup>8</sup> And Sen. Harrison Williams (D-N.J.), chairman of the Senate Committee on Labor and Public Welfare, said, “This principle (of federal preemption) is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.”<sup>9</sup>

Although Congress intended to give the federal government sole authority to regulate employee benefit plans, it did not intend to regulate the insurance industry. It had passed the McCarran-Ferguson Act in 1946,<sup>10</sup> giving the states sole jurisdiction over the regulation of the insurance industry, and ERISA

was not intended to repeal that law. Congress recognized that the two laws would overlap in some areas, and it tried to clarify the conflicting jurisdictions. ERISA includes three steps to determine which activities are subject to state law and which are preempted by the federal statute:

1. Preemption. Congress preempted any and all state laws that “relate to” employee welfare benefit plans. That is, employer-based plans would not be subject to any state law relating to them.<sup>11</sup>
2. The Savings Clause. To be consistent with McCarran-Ferguson, Congress “saved” (or exempted) from preemption those state laws regulating the business of insurance, even if the insurance company is providing benefits to an employer.<sup>12</sup>
3. Deemer Provision. To make it clear that the savings clause applied only to insurance companies, and not employers, Congress “deemed” that employers who provide benefits to their own employees are not engaged in the business of insurance.<sup>13</sup>

When ERISA was enacted there was very little “managed care.” Health plans’ second-guessing medical decisions was not an issue. The typical dispute was about enforcing the terms of a contract—if a health plan failed to pay for a covered benefit, employees could go to federal court to recover the cost of the denied claim, plus attorney’s fees. With that remedy available, there seemed to be little need for access to the state courts. This particular provision did not become controversial until the growth of managed care and the advent of “medical necessity.” A managed care plan may refuse to pay for a service that it considers not medically necessary. In making that judgment, it is not violating the terms of its contract, but it may very well be guilty of making a mistaken judgment that results in injury to the patient. This is a tort, not a contract, dispute.

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ERISA is complex, and the activities addressed affect vast amounts of money and create conflicts between well-organized parties with vital interests at stake in how the provisions are interpreted. Small wonder, then, that there has been a steady succession of court decisions trying to clarify the meaning of the law.

## The Courts

The Supreme Court has tried to clarify the scope of ERISA with a number of decisions, including those in the landmark cases of *Union Labor Life v. Pireno* (1982),<sup>14</sup> *Shaw v. Delta Airlines* (1983),<sup>15</sup> *Metropolitan v. Massachusetts* (1985),<sup>16</sup> and *Pilot Life v. Dedeaux* (1987).<sup>17</sup> Additional cases are pending or working their way through the court system.

The *Union Labor Life* decision was especially important because it clarified what is “the business of insurance” and therefore “saved” for state regulation. The Court reached back to the McCarran-Ferguson Act of 1946, and said that

three criteria have been used to determine whether a practice falls under the “business of insurance” for purposes of the McCarran-Ferguson Act:

“[F]irst, whether the practice (being addressed by the law) has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.”<sup>18</sup>

Applying those criteria, the Court ruled in *Metropolitan Life* that a state benefit mandate on insurance company contracts (such as those requiring coverage of substance abuse or mental health services) is saved from preemption because it (1) affects

the policyholder’s risk, (2) is integral to the policy relationship, and (3) is limited to insurance companies.

In the *Shaw* decision, the Court ruled that the preemption of state laws that “relate to” an employee benefit plan is very broad and includes any law that “has connection with or reference to such plan.” In *Pilot Life* it ruled that state contract laws are preempted even for fully insured plans, because, although they may affect the policy relationship, they do not affect the transfer of risk and are not limited to insurance entities.

Those rulings are only a few in the long history of case law surrounding ERISA. Virtually every aspect of the statute has been litigated over the 25 years since it was adopted, and as health care financing changes and state and federal law evolves, many more cases will come under judicial review.<sup>19</sup>

The result has been that self-funded employer plans have been given remarkable advantages over the fully insured plans on which small groups usually rely, and all employer plans have even greater advantages over individual insurance. State regulations add significant costs to the provision of health benefits and make coverage less affordable. The compliance costs associated with keeping up with ever-changing state laws and regulations can be a major hurdle for companies in the small group and individual insurance markets—costs that self-funded employers are allowed to escape.

## Private-Sector Effects

The immediate practical effect of ERISA was to exempt employer-sponsored health plans from any and all state regulations—premium taxes, solvency requirements, mandated benefits, appeals and grievance procedures, and assessments for state risk pools and guaranty funds. Insurance companies continued to be subject to those laws, so if an employer purchased coverage from an insurer, the employer was also subject to them indirectly. ERISA provided employers with

a way to avoid complying, however. If the employer “self-funded,”<sup>20</sup> or “self-insured,” benefits, it would not be purchasing coverage from an insurer and would be completely exempt from all those requirements.

This exemption from state law did not attract much attention at the time ERISA was passed because, other than premium taxes and solvency requirements, the states had not yet enacted many of those requirements. In 1974 there were no subsidized high-risk pools for health insurance,<sup>21</sup> only eight states had adopted guaranty funds for life and health insurance,<sup>22</sup> and there was only a handful of mandated benefit laws on the books.<sup>23</sup>

A bigger motivation for employers to self-fund their health benefits in the mid-1970s was to gain control over the investment and income of reserves at a time of extremely high interest rates and inflation. Many employers were skeptical that insurance companies were sharing the benefits of those investments with them. Also, at a time when national health care spending was increasing 13 to 15 percent each year (1974–77),<sup>24</sup> some employers questioned whether health insurance companies were serious about reducing health care inflation. The head of one self-insured manufacturing company told Congress, “When we were insured, the insurer got paid a percentage of the claims paid. They had no interest in holding down costs.”<sup>25</sup>

As the states enacted more insurance laws, including more than 1,000 mandated benefits, risk pools in half the states, guaranty funds in almost all the states, and a host of other regulations, employers became increasingly grateful for the escape hatch ERISA provided. When inflation eased in the 1980s, employers continued to move to self-funding to avoid compliance with all of the other new requirements.

## Current Issues in ERISA

In recent years, consumer advocates have become alarmed that ERISA precludes

employees from using state contract and tort law to redress grievances with their health plans. That concern is especially acute in managed care situations in which the plan may override the recommendations of an attending physician and deny coverage of a procedure for lack of medical necessity. The remedy for a wrongfully denied claim under ERISA is limited to recovery of the cost of the procedure, plus attorney’s fees. Unlike state tort law, there is no provision for punitive or compensatory damages.

In evaluating those issues and concerns, it is important to sort out the facts from the mythology. Many people believe that only self-funded employer plans are exempt from state contract law. Many others believe that HMOs and other managed care entities are more advantaged than are fee-for-service plans. Many people think ERISA prevents health plans from being sued for the wrongful practice of medicine. But, none of those beliefs is true.

- All employer plans are ERISA plans (except those run by churches or units of government).<sup>26</sup> It doesn’t matter what size the employer is. It doesn’t matter if the employer is self-funded, fully insured, or anything in between. They are all exempt from state contract and most tort laws.
- Plans that self-fund are also exempt from state insurance laws (such as premium taxes and mandated benefits), while insured plans are subject to those laws indirectly—but only because the insurance company is subject to them.
- Self-funding is only marginally related to the size of the employer. There remain many very large companies that purchase coverage from insurance companies, and there are firms with as few as 25 employees that self-fund. There is also a host of arrangements in between—partial self-funding, self-funding with stop-loss, and self-funding for indemnity but not for HMO coverage.
- Employers with HMO coverage are far

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**Table 1**  
**Percentage of Employer Plans That Are Self-Funded (500+ employees)**

Year	FFS Plans (%)	PPO Plans (%)	POS Plans (%)	HMO Plans (%)
1995	70	71	47	na
1996	70	72	52	6
1997	72	73	46	10

Source: Joanne Wojcik, "Self-Insurance Sees Gains in Health Plan Financing," *Business Insurance*, February 16, 1998, p. 3 et seq.

Note: na = not applicable.

less likely to be self-funded than are employers with fee-for-service (FFS), preferred provider organizations (PPO), or point-of-service (POS) coverage. Thus, HMOs are far *more* likely to be regulated by the states than are other kinds of plans (Table 1).<sup>27</sup>

- Because an increasing proportion of employer plans use HMOs, the level of self-funding of health benefits has actually decreased in recent years.<sup>28</sup>
- HMOs are no more exempt from state contract law than are fee-for-service plans. They are all exempt when they are part of an employer benefit plan.
- HMOs are generally subject to most of the state regulations that apply to traditional insurers, including mandated benefits, solvency requirements, premium taxes, appeals and grievance procedures, and plain language requirements.
- ERISA does not affect the right of the states to regulate the practice of medicine. The states are free to decide who may and who may not practice medicine and to define what the practice of medicine is and what remedies are available for the malpractice of medicine.

### **Managed Care and Malpractice**

Many of the current complaints about managed care plans, and HMOs especially,

are less about contract violations than they are about quality of care. If an HMO has a contract that states it will pay only for care that it determines is "medically necessary," it has not violated the terms of its contract when it denies coverage for a procedure it believes is unnecessary. However, it may be liable for medical malpractice if a patient is harmed as a result of its decision. If the HMO assumes the responsibility for deciding what is and is not appropriate medical treatment, it should also be held accountable when it makes a wrong decision.

The usual reply from the health plan is that the decision not to pay for treatment is different from the decision not to provide the treatment, and the patient can still receive the care by paying for it directly. That argument is unpersuasive for several reasons: (1) If it is a staff-model HMO in which the physicians are employed by the plan, the physicians are accountable directly to their employer and are unlikely to defy the plan's decision. (2) Even a network HMO, which contracts with a select panel of physicians and hospitals, has far more influence over physician practice than does a traditional fee-for-service indemnity plan. A network physician who defies the plan's policy may soon find himself de-networked. (3) More important, when it comes to major surgical procedures, the decision not to pay is a decision not to treat. It would be unreasonable to expect the patient to pay for such a procedure out of his or her own

funds—after all, the primary purpose of having an insurance plan is to cover rare conditions, treatment of which would otherwise be unaffordable.

Physicians who accept responsibility for treatment decisions are accountable for their errors. Health plans that assume some of the responsibility for treatment decisions should also be held accountable. But making health plans subject to malpractice remedies is not a federal responsibility, nor is it unachievable today. The general ERISA preemption of state tort lawsuits has apparently not preempted malpractice torts. Physicians are subject to malpractice remedies irrespective of whether the patient's bills are paid by an employer, and an HMO that is viewed as practicing medicine should be similarly liable. Georgia, Texas, and California have already enacted legislation clarifying that patients may file malpractice actions against their health plans. Even without additional state action, the courts are holding health plans liable for malpractice. The Illinois Supreme Court recently ruled that the family of a woman who died after being denied a diagnostic test by her health plan could proceed with a malpractice suit against the plan.<sup>29</sup> An Ohio jury awarded \$51.5 million to the estate of a woman who died after her health plan refused to pay for chemotherapy.<sup>30</sup> And the Third Circuit Court of Appeals ruled that a state court action suing an HMO for the death of a two-day-old child who was denied an extended hospital stay could proceed.<sup>31</sup> The court said “[P]atients enjoy the right to be free from medical malpractice regardless of whether . . . care is provided through an ERISA plan.”<sup>32</sup>

Whether ERISA preempts malpractice suits against health plans will ultimately be decided by the Supreme Court, but the weight of the lower court decisions appears to indicate that it does not. If the Supreme Court decides otherwise, it will be interesting to see how the Court distinguishes the liability of doctors from the liability of the health plans that employ them.

## ERISA on the Block

It may very well be time to repeal ERISA. It was enacted 25 years ago at a time of increasing centralization of authority in the federal government, and a time when the states were viewed by Congress as obstructions to progressive government. Today there is much more interest in decentralization and deregulation in all areas of government and industry.

The basic premise of ERISA—that employers should provide nationally uniform benefits—is suspect in any event. National and international employers are capable of recognizing variations in employment markets when it comes to wages and other benefits (subsidized parking, for instance). Complying with local benefit requirements should be no more difficult. Part of the reason the states have enacted so many mandated benefits and other insurance regulations is that large self-funded employers were indifferent to them. Subjecting large employers, along with everybody else, to those laws could force state legislatures to be more careful about enacting new requirements.

But the current debate over patients' rights is not about repealing ERISA. Quite the opposite. Most of the proposals would extend the federal reach. They would replace state oversight of HMOs with a plethora of new federal requirements covering such things as quality control measures, payment for emergency procedures, which specialties may be used as primary care physicians, and appeals and grievance procedures. Even the notion that Congress could instruct the states to apply malpractice remedies to health plans is unprecedented. If Congress can dictate the use of state medical malpractice remedies, can federal oversight of the practice of medicine be far behind?

The fact that ERISA has not kept up with the times and continues to be based on the health care financing conditions that existed 25 years ago should give pause to people who support additional federal regulations today. Once Congress passes a law, it is near-

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ly impossible to change it, but the financing of health care is changing rapidly. HMOs are already revising the way they control costs because of experience and market demands. New federal legislation could freeze into place the kind of health care we have today and inhibit the evolution of newer, more responsive approaches.

## Conclusion

ERISA prevents employees from suing their health plans under state contract law and from collecting punitive damages in federal court. But ERISA does not treat managed care any differently than any other type of health plan. And "fixing ERISA" will affect all health plans, not just HMOs.

Remedies for managed care's interference with the practice of medicine already exist, and they are not likely to be improved by additional federal legislation. Indeed, the groups that have been supporting "anti-managed care" legislation in Congress may want to reconsider whether they really want the regulation of medicine to become a federal responsibility.

Once Congress begins to determine what sort of health plan should be subject to malpractice remedies, can a federal definition of what is an appropriate remedy be far behind? If Congress determines who is and is not "practicing medicine," how long will it be until the federal government starts to issue licenses to engage in that practice?

Federal laws are very hard to change. A law that is enacted today, based on the market conditions that currently exist, could freeze into place the very sort of intrusive health care arrangement that patients' rights advocates complain about. Such a law could keep new, patient-centered health plans from ever being invented. That could be the ironic result of this legislative malpractice.

## Notes

1. 29 U.S.C. § 3(1). The definition goes on to include vacation benefits, day care, scholarships

and training programs, and prepaid legal services.

2. 29 U.S.C. § 4 a(1).

3. 29 U.S.C. § 4 b(1).

4. 29 U.S.C. § 4 b(2).

5. 29 U.S.C. § 4 b(3).

6. Lawrence Atkins and Kristin Bass, "ERISA Preemption: The Key to Market Innovation in Health Care," Corporate Health Care Coalition, 1995.

7. 29 U.S.C. § 514 (a).

8. 120 *Congressional Record*, 29197 (1974), quoted in George Pantos, "Health Benefits Plans and ERISA Preemption," *Health Care Handbook* (Boston: Warren Gorham & Lamont, 1991), p. 27-4.

9. 120 *Congressional Record*, 29933 (1974), quoted in Pantos, p. 27-4.

10. 15 U.S.C. § 1011, et seq.

11. 15 U.S.C. § 514 (a). "[T]he provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

12. "[N]othing in this title shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." 29 U.S.C. § 514(b)(2)(A). Later court decisions would reach back to McCarran-Ferguson to define what is and is not "the business of insurance."

13. "Neither an employee benefit plan . . . nor any trust established under such a plan shall be deemed to be an insurance company . . . or to be engaged in the business of insurance." 29 U.S.C. § 514(b)(2)(B).

14. *Union Labor Life Insurance Company v. Pireno*, 458 U.S. 119, 129 (1982).

15. *Shaw v. Delta Airlines, Inc.*, 103 S. Ct. 2890 (1983).

16. *Metropolitan Life Insurance Company v. Massachusetts*, 105 S. Ct. 2380 (1985).

17. *Pilot Life Insurance Company v. Dedeaux*, 107 S. Ct. 1549 (1987).

18. *Union Labor* at 129. Emphasis in original.

19. One of the more recent and comprehensive



reviews of the legal issues surrounding ERISA is Patricia Butler and Karl Polzer, "Private Sector Health Coverage: Variations in Consumer Protections under ERISA and State Law," National Health Policy Forum of George Washington University, June 1996.

20. Self-funding is the preferred term for self-insurance, since there is no "insurance" involved. Employers pay directly for incurred claims and take the risk of excessive utilization. There are many variations of self-funding. Most employers purchase "reinsurance," or "stop-loss insurance," that caps the employers' liability at some level of exposure. Many other plans are "partially self-funded" and may be subject to some percentage of claims costs up to a certain level.

21. Aaron K. Trippler, *Comprehensive Health Insurance for High Risk Individuals* (Bloomington, Minn.: Communicating for Agriculture, 1991).

22. Guaranty funds pay claims for insolvent carriers. Such funds are funded through an assessment on all carriers doing business in the state. "Guaranty Fund Provisions by State," *1999 Best's Key Rating Guide—Life/Health*, 1999, pp. A3-A4

23. Greg Scandlen, "New Study Shows 992 Mandated Benefits in the States," *Health Benefits Letter*, no. 15 (August 29, 1991).

24. Katherine R. Levitt et al., "National Health Expenditures, 1990," *Health Care Financing Review* (Fall 1991).

25. Richard J. Stefan, Acme Steel Company, Testimony before the Subcommittee on Commerce, Consumer Protection, and Competitiveness of the House Committee on Commerce, 102d Cong., 2d sess., February 5, 1992.

26. Atkins and Bass, p. 48.

27. Joanne Wojcik, "Self-Insurance Sees Gains in Health Plan Financing," *Business Insurance*, February 16, 1998, p. 3.

28. An examination of self-insurance in seven states found that the percentage of firms self-insuring dropped from 19 percent of all firms in 1993 to 13 percent in 1997. The percentage of enrollees in self-insured plans dropped from 40 percent in 1993 to 33 percent in 1997. Susan Marquis and Stephen Long, "Recent Trends in Self-Insured Employer Health Plans," *Health Affairs*, May-June, 1999, pp. 161-66.

29. "Court: HMOs Can Be Sued for Malpractice," Associated Press, October 1, 1999.

30. Ibid.

31. Daniel J. Parks and Matthew Tully, "Liability: Courts in the Lead," *CQ Weekly*, October 9, 1999, pp. 2363-64.

32. E-mail communication with Mark J. McPherson, Esq., Waters, McPherson, McNeill, P.C.

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