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Regulation of Health Benefits Under ERISA: An Outline

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Summary

The Employee Retirement Income Security Act (ERISA) sets certain federal standards for the provision of health benefits under private-sector, employment-based health plans. These standards regulate the nature and content of health plans and include rules on health care continuation coverage, guarantees on the availability and renewability of health care coverage for certain employees and individuals, limitations on exclusions from health care coverage based on preexisting conditions, parity between medical/surgical benefits and mental health benefits, and minimum hospital stay requirements for mothers following the birth of a child. This report discusses certain health benefit requirements under ERISA, as well as proposed legislation in the 110th Congress that would affect the provision of health benefits.

The Employee Retirement Income Security Act of 1974 (ERISA) provides a comprehensive federal scheme for the regulation of private-sector employee benefit plans. While ERISA does not require an employer to offer employee benefits, it does mandate compliance with its provisions if such benefits are offered. Besides the regulation of pension plans, ERISA also regulates welfare benefit plans[1] offered by an employer to provide medical, surgical and other health benefits.[2] ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans).[3]

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[1] ERISA considers a number of non-pension benefit programs offered by an employer to be "employee welfare benefit plans." For example, health plans, life insurance plans, and plans that provide dependent care assistance, educational assistance, or legal assistance can all be deemed welfare benefit plans. See 29 U.S.C. § 1002(1).

[2] These benefits are hereinafter collectively referred to as "health benefits." It is important to note that ERISA governs self-funded plans and insurance plans.

[3] The regulation of employment-based health benefits is affected by the express preemption provision of ERISA. Section 514(a) ERISA preempts state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). However, ERISA sets out certain exceptions to the (continued...)

Health plans, like other welfare benefit plans governed by ERISA, must comply with certain standards, including plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing a denied claim for benefits. However, these health plans must also meet additional requirements under ERISA.[4] This report discusses some of these additional requirements for health plans, as well as various proposed legislation in the 110th Congress that would affect the provision of health benefits.[5]

Current Health Benefit Regulation Under ERISA

As enacted in 1974, ERISA's regulation of health plan coverage and benefits was limited. However, beginning in 1986, Congress added to ERISA a number of requirements on the nature and content of health plans, including rules governing health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, parity between medical/surgical benefits and mental health benefits, and minimum hospital stay requirements for mothers following the birth of a child.[6]

COBRA: Continuing Health Care Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added a new Part 6 to Title I of ERISA, which requires the sponsor of a group health plan to provide an option of temporarily continuing health care coverage for plan participants and beneficiaries under certain circumstances.[7] Under ERISA section 601, a plan maintained by an employer with 20 or more employees must provide "qualified beneficiaries"[8] with the option of continuing coverage under the employer's group health plan in the case of certain "qualified events." A qualifying event is an event that, except for continuation coverage under COBRA, would result in a loss of coverage, such as the death of the covered employee, the termination (other than by reason of the employee's gross

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[3] (...continued)
preemption provision, including an exemption for state laws that regulate insurance. 29 U.S.C. § 1144(b). Thus, health benefits offered through health insurance (i.e., where an employer pays a premium to an insurer to cover the claims of plan participants) may be subject to state regulation. Self-funded (or self-insured) plans, under which an employer provides health benefits directly to plan participants, are not exempt from ERISA's preemption provisions and are, therefore, not subject to state law.

[4] See Title I, Part 6 and Part 7 of ERISA, and discussion *infra.*

[5] Other federal laws regulate the provision of health benefits. These laws include the Internal Revenue Code (26 U.S.C. §§ 1 et. seq.), the Public Health Services Act (42 U.S.C. §§ 201 et. seq.), and Medicare (Social Security Act, Title XVIII, 42 U.S.C. §§ 1395 et. seq.). This report addresses only regulation of health benefits under ERISA.

[6] *See generally* Employee Benefits Law 355 (Steven J. Sacher et al., eds., 2000).

[7] P.L. 99-272, tit. X, 100 Stat. 327 (1985). For additional information on COBRA, see CRS Report RL30626, *Health Insurance Continuation Coverage Under COBRA*, by Heidi G. Yacker.

[8] A "qualified beneficiary" can be an employee (who loses health coverage due to termination of employment or a reduction in hours), as well as a spouse or the dependent child of the employee. 29 U.S.C. § 1167.

misconduct) or reduction of hours of the covered employee's employment, or the covered employee becoming entitled to Medicare benefits.[9]

Under section 602 of ERISA, the employer must typically provide this continuation coverage for 18 months.[10] However, coverage may be longer, depending on the qualifying event.[11] Under ERISA 602(1), the benefits offered under COBRA must be identical to the health benefits offered to "similarly situated non-COBRA beneficiaries," or in other words, beneficiaries who have not experienced a qualifying event. The health plan may charge a premium to COBRA participants, but it cannot exceed 102% of the plan's group rate. After 18 months of required coverage, a plan may charge COBRA certain participants 150% of the plan's group rate.

Additional Coverage and Benefit Requirements

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new Part 7 to Title I of ERISA to provide additional health plan coverage requirements.[12] Other federal legislation amended Part 7 of ERISA to require plans to offer specific health benefits. The requirements of Part 7 generally apply to group health plans, as well as "health insurance issuers"[13] that offer group health insurance coverage.[14]

HIPAA. HIPAA amended ERISA to limit the circumstances under which a health plan may exclude a participant or beneficiary with a preexisting condition from coverage.[15] This exclusion from coverage cannot be for more than 12 months after an employee enrolls in a health plan (or 18 months for late enrollees). HIPAA prohibits pre-existing condition coverage exclusions for any conditions relating to pregnancy. Similarly, newborns and adopted children may not be excluded from plan enrollment if they were covered under "creditable coverage" within 30 days after birth or adoption, and there has not been a gap of more than 64 days in this coverage.[16]

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[9] 29 U.S.C. § 1163.

[10] 29 U.S.C. § 1162(2).

[11] See 29 U.S.C. § 1162(2)(A)(iv). For example, in the case of a death of a covered employee (a qualifying event under section 603(1) of ERISA) coverage can be up to 36 months.

[12] P.L. 104-191, 110 Stat. 1936 (1996). For additional information on HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, and Stephen Redhead.

[13] A health insurance issuer is defined by ERISA as "an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in the State...." 29 U.S.C. § 1191b.

[14] Group health plans and health insurance issuers that provide health coverage will be referred to collectively hereinafter as "health plans."

[15] 29 U.S.C. § 1181(a)(1)-(3).

[16] 29 U.S.C § 1181(d).

HIPAA also created ERISA section 702, which provides that a group health plan or health insurance issuer may not base coverage[17] eligibility rules on certain health-related factors, such as medical history or disability.[18] In addition, a health plan may not require an individual to pay a higher premium or contribution than another "similarly situated" participant, based on these health-related factors.[19] HIPAA also added section 703 of ERISA, which provides that certain health plans covering multiple employers cannot deny an employer (whose employees are covered by the plan) coverage under the plan, except for certain reasons, such as an employer's failure to pay plan contributions.

Mental Health Parity. In 1996, Congress enacted the Mental Health Parity Act (MHPA), which added section 712 of ERISA to create certain requirements for mental health coverage, if this coverage was offered by a health plan.[20] Under the MHPA, health plans are not required to offer mental health benefits. However, plans that choose to provide mental health benefits must not impose lower annual and lifetime dollar limits on these benefits than the limits placed on medical and surgical benefits. The MHPA allows a plan to decide what mental health benefits are to be offered; however, the parity requirements do not apply to substance abuse or chemical dependency treatment.[21]

Certain plans may be exempt from the MHPA. Plans covering employers with 50 or fewer employees are exempt from compliance. In addition, employers that experience an increase in claims costs of at least 1% as a result of MHPA compliance can apply for an exemption. The MHPA is currently authorized through December 31, 2007.

Maternity Length of Stay. In 1996, Congress passed the Newborns' and Mothers' Health Protection Act (NMHPA), which amended ERISA and established minimum hospital stay requirements for mothers following the birth of a child.[22] In general, the NMHPA prohibits a group health plan or health insurance issuer from limiting a hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours, following a normal vaginal delivery,[23] and to less than 96 hours,[24] following a cesarean section.

Reconstructive Surgery Following Mastectomies. The Women's Health and Cancer Rights Act, enacted in 1998, amended ERISA to require group health plans providing mastectomy coverage to cover prosthetic devices and reconstructive surgery

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[17] "Creditable coverage" as defined under ERISA section 701(c)(1) (29 U.S.C. § 1181(c)(1)) includes coverage under a group health plan, health insurance, and various other means of health benefit coverage.

[18] 29 U.S.C. § 1182(a)(1)(A)-(H).

[19] 29 U.S.C. § 1182(b)(1).

[20] P.L. 104-204, tit.VII, 110 Stat. 2874 (1996).

[21] 29 U.S.C. § 1185a(a)(4).

[22] P.L. 104-204, tit. VI, 110 Stat. 2935 (1996).

[23] 29 U.S.C. § 1185(a)(1)(A)(I).

[24] 29 U.S.C. § 1185(a)(1)(A)(ii).

after the surgery.[25] Under section 713 of ERISA, this coverage must be provided in a manner determined in consultation between the attending physician and the patient.[26]

Selected Proposed Legislation in the 110th Congress

Legislation affecting the provision of health benefits under ERISA has been proposed during the 110th Congress. Proposals include the following:

The Genetic Information Nondiscrimination Act of 2007 (GINA). This legislation (S. 358, as reported in the Senate; H.R. 493, as reported in the House) would amend section 702 of ERISA and proscribe plan enrollment restrictions based on information about a request for, or receipt of, genetic services.[27] The bills outlaw charging an individual a larger premium based on the genetic information of an individual or an individual's family member. GINA would also restrict a health plan from requiring an individual or a family member of an individual to undergo a genetic test.

GINA would also amend section 502 of ERISA to create special enforcement provisions. Under the Act, a plan participant or beneficiary may seek injunctive relief for certain genetic discrimination violations prior to the exhaustion of administrative remedies, if it the exhaustion of such remedies would cause "irreparable harm" to the plaintiff. In addition, a court may impose a penalty on a plan administrator who fails to comply with GINA's provisions, and may provide a plaintiff with a retroactive reinstatement of coverage if coverage was denied because of genetic discrimination.[28] The Secretary of Labor would have the ability to impose a penalty on a group health plan for failing to comply with the genetic discrimination provisions.

The Mental Health Parity Act of 2007. The Mental Health Parity Act of 2007 (S. 558, as reported in the Senate) and the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424) contain similar, but not identical, provisions.[29] Neither bill would require a health plan to offer mental health benefits. However, both bills would amend section 712 of ERISA, as well as other federal laws, to require parity between mental health benefits and medical/surgical benefits in terms of (1) "financial requirements" and (2) "treatment limitations" imposed by the health plan. As defined by the bills, "financial requirements"include requirements such as insurance deductibles and co-payments;

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[25] P.L. 105-277, 112 Stat. 2681 (1998).

[26] 29 U.S.C. § 1185b.

[27] For additional information on GINA, see CRS Report RL33903, *Genetic Discrimination: Overview of the Issue and Proposed Legislation*, by Erin D. Williams, Amanda K. Sarata, and C. Stephen Redhead.

[28] It should be noted that H.R. 493, as reported from the Committee on Education and Labor, does not contain the enforcement provisions concerning injunctive relief, penalties imposed on a plan administrator, and the retroactive reinstatement of coverage. See H.R. 493, as reported by the Committee on Education and Labor, 110th Cong. § 101(d) (Mar. 5, 2007).

[29] For additional information on Mental Health Parity legislation, see CRS Report RL33820, *The Mental Health Parity Act: A Legislative History*, by Ramya Sundararaman and C. Stephen Redhead.

"treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or any other limits on the duration or scope of coverage. The bills would define "mental health benefits" to include treatment for substance abuse disorders and would eliminate the existing sunset provision. Health plans may elect to be exempt from the parity requirements if it is actuarially determined that the implementation of the requirements would cause a plan to experience an increase in actual total costs of coverage that exceed 2% of the actual total plan costs during the first plan year, or exceed 1% of the actual total plan costs each subsequent year.

The House and Senate bills differ in a few important ways. H.R. 1424 provides that a health plan must cover certain mental health conditions and substance and addiction disorders, whereas S. 558 allows the health plan to determine what mental health benefits are to be covered. Also, the two bills differ as to the role of state law. S. 558 provides a special preemption rule, stating that the financial requirements and treatment limitations of the bill would supercede state law in this area. H.R. 1424, on the other hand, would allow states to enact more comprehensive mental health parity provisions.[30]

The Routine HIV/AIDS Screening Coverage Act of 2007. This legislation (H.R. 822) would amend ERISA and other federal laws to require a health plan to provide coverage for routine HIV/AIDS screening under terms and conditions that are no less favorable than the terms and conditions applicable to other routine health screenings. The bill contains a number of prohibitions, including the provision of monetary compensation or the denial of coverage solely to avoid the requirements of the section. The bill states that it should not be construed so as to require an individual to undergo HIV/AIDS screening. It also requires a health plan to provide notice to each participant and beneficiary under the plan about the HIV/AIDS screening coverage.

The Breast Cancer Patient Protection Act of 2007. This legislation (H.R. 758, H.R. 119, and S. 459) would amend ERISA and other federal laws to prevent the restriction of benefits for any hospital length of stay to less than 48 hours in connection with a mastectomy or breast-conserving surgery for the treatment of breast cancer. The bills would also prohibit the restriction of benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours. Under the bills, a health plan may not require a health care provider to obtain authorization from a health plan for prescribing any length of stay required under the act. A health plan must provide notice to each participant and beneficiary under the plan regarding the coverage required by this section in accordance with regulations that are to be promulgated by the Secretary of Labor. The bills also state that a health plan must ensure full coverage for secondary consultations by specialists in certain medical fields to confirm or refute an initial diagnosis of cancer.

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[30] See S. 558 (as reported by the Senate), 110th Cong. § 4(a) (2007). *Cf.* H.R. 1424, 110th Cong. § 2(h) (2007).