Order Code RS22643
Updated October 20, 2008

CRS Report for Congress

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, and parity between medical/surgical benefits and mental health benefits. This report discusses certain health benefit requirements under ERISA. It also provides a brief overview of proposed and enacted legislation in the 110th Congress that affects the provision of health benefits, including certain amendments made to ERISA by the newly enacted Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (included within P.L. 110-343) and the Genetic Information Nondiscrimination Act of 2008 (P.L. 110-233).

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. ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans).[2]

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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] 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 preemption provision, including an exemption for state laws that regulate insurance. 29 U.S.C.
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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.[3] This report discusses some of these additional requirements for health plans, as well as selected proposed and enacted legislation in the 110th Congress that affects the provision of health benefits.[4]

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.[5]

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.[6] Under ERISA section 601, a plan maintained by an employer with 20 or more employees must provide "qualified beneficiaries"[7] 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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§ 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.

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

[4] 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.

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

[6] 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.

[7] 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.[8]

Under section 602 of ERISA, the employer must typically provide this continuation coverage for 18 months.[9] However, coverage may be longer, depending on the qualifying event.[10] 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 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.[11] 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 that offer group health insurance coverage.[12]

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.[13] 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.[14]

HIPAA also created ERISA section 702, which provides that a group health plan or health insurance issuer may not base coverage[15] eligibility rules on certain health-related

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[8] 29 U.S.C. § 1163.

[9] 29 U.S.C. § 1162(2).

[10] 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.

[11] 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.

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

[13] 29 U.S.C. § 1181(a)(1)-(3).

[14] 29 U.S.C § 1181(d).

[15] "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

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factors, such as medical history or disability.[16] 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.[17] 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.[18] 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.[19]

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. Recently, Congress enacted legislation which expands the MHPA's requirements.[20] The new requirements apply to group health plans for plan years beginning after October 3, 2009.

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.[21] 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, and to less than 96 hours, 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.[22]

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[15] (...continued)
benefit coverage.

[16] 29 U.S.C. § 1182(a)(1)(A)-(H).

[17] 29 U.S.C. § 1182(b)(1).

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

[19] 29 U.S.C. § 1185a(a)(4).

[20] See section 512 of P.L. 110-343, 122 Stat. 3765 (Oct. 3, 2008), and see *infra* for a discussion of the new requirements.

[21] P.L. 104-204, tit. VI, 110 Stat. 2935 (1996), codified at 29 U.S.C. § 1185.

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

Under section 713 of ERISA, this coverage must be provided in a manner determined in consultation between the attending physician and the patient.[23]

Selected Legislation in the 110th Congress

Legislation affecting the provision of health benefits under ERISA has been proposed and enacted during the 110th Congress. The legislation includes the following:

Enacted Legislation

The Genetic Information Nondiscrimination Act (GINA). H.R. 493, recently enacted as P.L. 110-233, amends section 702 of ERISA and prevents a health plan from adjusting premiums or contribution amounts for a group covered by the plan on the basis of genetic information.[24] "Genetic information," as defined by the bill, includes information about a genetic test of an individual or a family member of an individual, the manifestation of a disease or disorder in the family members of an individual, as well as request for, or receipt of, genetic services.[25] GINA restricts a health plan from requiring or requesting an individual or a family member of an individual to undergo a genetic test. The act includes an exception to this provision, under which a health plan may request a genetic test for research purposes, but only if certain conditions are met. Further, GINA prohibits a plan from requesting, requiring, or purchasing genetic information for underwriting purposes[26] or with respect to an individual prior to the individual's enrollment in the plan.

GINA also amends section 502 of ERISA to authorize the Secretary of Labor to impose a penalty of $100 per day (per participant or beneficiary) against a plan that fails to comply with various requirements of the act. Additional penalty amounts may be imposed if the violation is not corrected before a plan receives notice from the Secretary of the violation. The act also contains certain penalty limitations, and provides that in certain cases, the Secretary may waive part or all of the penalty to the extent that the payment of the penalty would be excessive relative to the violation. The amendments made by GINA apply to health plans for plan years beginning after May 21, 2009.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. This act, included as part of the Emergency Economic

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[23] 29 U.S.C. § 1185b.

[24] 29 U.S.C. § 1182(b). Genetic information under GINA also includes information about a fetus carried by a pregnant woman or an embryo that is legally held by the individual or a family member.

[25] "Genetic services," as defined by the act, includes genetic tests, genetic counseling (including obtaining, interpreting or assessing genetic information), or genetic education.

[26] "Underwriting purposes," as defined by the act, includes a determination of eligibility for benefits or coverage, computation of a premium or contribution under the plan, the application of a pre-existing condition exclusion, and other activities relating to the creation, renewal or replacement of a contract for health benefits.

Stabilization Act of 2008,[27] expands the parity requirements under the current version of the MHPA for mental health and substance use disorder coverage[28] if such coverage is offered by a group health plan. In general, the act amends section 712 of ERISA, as well as other federal laws, to require parity between mental health/substance use disorder benefits and medical/surgical benefits in terms of the predominant (1) financial requirements and (2) treatment limitations imposed by a group health plan. As defined by the act, financial requirements include requirements such as deductibles, co-payments, co-insurance and out-of-pocket expenses; 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 treatment. The parity requirements of the act apply to mental health and substance use disorder benefits as defined by the health plan or applicable state law. Health plans may qualify for an exemption from the parity requirements if it is actuarially determined that the implementation of the act's 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.

Proposed Legislation

The Breast Cancer Patient Protection Act. This legislation (H.R. 758 as passed by the House, H.R. 119, and S. 459) would amend ERISA and other federal laws to require coverage and radiation therapy for breast cancer treatment. The bills would 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, or less than 24 hours in connection with a lymph node dissection, for the treatment of breast cancer.[29] 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. The bills also state that a health plan must ensure coverage for secondary consultations by specialists in certain medical fields to confirm or refute an initial diagnosis of cancer.

Access to Cancer Clinical Trials Act of 2008. S. 2999 would amend ERISA, the Public Health Service Act, and the Internal Revenue Code to provide that if a group health plan provides coverage to a "qualified individual," the plan cannot (1) deny the individual participation in certain clinical trials; (2) deny, limit, or impose additional conditions on coverage of routine patient costs for items or services furnished in connection with trial participation; and (3) may not discriminate against the individual based on trial participation. "Qualified individuals" include individuals diagnosed with cancer and who are eligible to participate in the trial according to the trial protocol. The bill applies to clinical trials (*i.e.*, a research studies or clinical investigations) that relate to the treatment of cancer and that are either funded by certain federal agencies, or are part of a drug trial, under certain circumstances.

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[27] P.L. 110-343, 122 Stat. 3765 (Oct. 3, 2008).

[28] Unlike the original version of the MHPA, the act provides that substance-related disorders are subject to the proposed parity requirements.

[29] The bills that provide these requirements should not be construed as requiring the provision of inpatient coverage if a shorter hospital stay, or outpatient treatment is determined to be medically appropriate.