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 as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA), 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 these health benefit requirements under ERISA.

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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]

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 group health plans, as well as health insurance issuers that provide group health coverage.[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

[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. § 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 Service 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 (1986). For additional information on COBRA, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by (name redacted).

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 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. However, the American Recovery and Reinvestment Act of 2009[11] includes provisions to subsidize health insurance coverage through COBRA. ARRA provides for COBRA premium subsidies of 65% to help the unemployed afford health insurance coverage from their former employer. The subsidy is available for up to nine months to those individuals who meet the income test and who are involuntarily terminated from their employment on or after September 1, 2008, and before January 1, 2010. For more information on the COBRA premium subsidies, see CRS Report R40420, *Health Insurance Premium Assistance for the Unemployed: The American Recovery and Reinvestment Act of 2009*, coordinated by (name redacted).

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 that offer specific health benefits to meet certain standards. The requirements of Part 7 generally apply to group health plans, as well as health insurance issuers that offer group health insurance coverage.[13]

HIPAA

HIPAA was enacted in 1996 in part to "improve the portability and continuity of health insurance coverage in the group and individual markets."[14] One of the ways that HIPAA implements this

[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.

[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. 111-5, 123 Stat 115 (2009).

[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 (name redacted) et al.

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

[14] P.L. 104-191, 110 Stat. 1936 (1996).

goal is by amending ERISA, as well as other federal laws, to limit the circumstances under which a group health plan or insurer providing group health coverage may exclude a participant or beneficiary with a preexisting condition from coverage.[15] A preexisting condition exclusion under a group health plan or group health insurance coverage can be applicable to an individual as a result of information relating to an individual's health status before the effective date of coverage, such as a condition identified as a result of a pre-enrollment questionnaire, a physical examination given to the individual, or review of medical records relating to the pre-enrollment period. Under Section 701 of ERISA, as created by HIPAA, an exclusion period for an individual's preexisting condition may be applied if medical advice, diagnosis, care, or treatment was recommended or received within the six months before the enrollment date in the plan. 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). Further, this 12-month period must be reduced by the number of days that an individual has "creditable coverage," [16] with no significant break in this coverage. A significant break is a 63-day continuous period in which the individual had no creditable coverage after the termination of prior health coverage and before the enrollment date of the new coverage. In other words, if an individual maintains certain creditable coverage, the individual cannot be subject to an exclusion period when moving from one group health plan to another. HIPAA prohibits plans and insurers from imposing preexisting condition exclusions under certain circumstances. For instance, pre-existing condition exclusion may not be imposed for any conditions relating to pregnancy. Similarly, newborns and adopted children cannot be subject to a preexisting condition exclusion if they were covered under "creditable coverage" within 30 days after birth or adoption, and there has not been a gap of more than 63 days in this coverage. [17]

HIPAA also requires health plans to provide a special enrollment opportunity to allow certain individuals to enroll in a health plan without waiting until the plan's next regular enrollment season.[18] For example, special enrollment rights must be extended to a person who becomes a new dependent through marriage, birth, adoption or placement for adoption, or to an employee or dependent who loses other health coverage. Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009[19] amended ERISA to provide that group health plans must permit employees and dependents who are eligible for, but not enrolled in, coverage under the terms of the plan to enroll in two additional circumstances: (1) the employee's or dependent's coverage under Medicaid or SCHIP is terminated as a result of loss of eligibility, or (2) the employee or dependent becomes eligible for a financial assistance under Medicaid or SCHIP, and the employee requests coverage under the plan within 60 days after eligibility is determined. Under these two circumstances, an employee must request coverage within 60 days after termination of Medicaid or SCHIP coverage, or becoming eligible for this coverage.[20]

HIPAA also created ERISA Section 702, which provides that a group health plan or health insurance issuer may not base coverage eligibility rules on certain factors, including health status

[15] 29 U.S.C. § 1181(a)(1)-(3).

[16] "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.

[17] 29 U.S.C § 1181(d).

[18] 29 U.S.C § 1181(f). See also 29 C.F.R. § 2590.701-6.

[19] P.L. 111-3, 123 Stat. 8 (Feb. 4, 2009).

[20] Under other special enrollment circumstances, a plan must allow an employee at least 30 days to request coverage under the plan.

(physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. [21] 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.[22] The Genetic Information Nondiscrimination Act (GINA), passed in the 110th Congress, amended Section 702 of ERISA to prevent certain types of genetic discrimination. Under this section, a health plan may not adjust premiums or contribution amounts for an entire group covered by the plan on the basis of genetic information.[23] "Genetic information," as defined by the act, 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.[24] 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[25] or with respect to an individual prior to the individual's enrollment in the plan. The amendments made by GINA apply to health plans for plan years beginning after May 21, 2009. 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.[26] 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.[27]

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.

[21] 29 U.S.C. § 1182(a)(1)(A)-(H).

[22] 29 U.S.C. § 1182(b)(1).

[23] 29 U.S.C. § 1182(b)(3). 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.

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

[25] "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.

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

[27] 29 U.S.C. § 1185a(a)(4).

Recently, Congress enacted legislation which expands the MHPA's requirements.[28] The new requirements apply to group health plans for plan years beginning after October 3, 2009. These requirements, included as part of the Emergency Economic Stabilization Act of 2008,[29] expand the parity requirements under the current version of the MHPA for mental health and substance use disorder coverage[30] 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.

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.[31] 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, or 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.[32] Under section 713 of ERISA, this coverage must be provided in a manner determined in consultation between the attending physician and the patient.[33]

Michelle's Law

On October 9, 2008, President Bush signed legislation, known as "Michelle's Law,"[34] that extends the ability of dependents to remain on their parents' plan for a limited period of time

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

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

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

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

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

[33] 29 U.S.C. § 1185b.

[34] P.L. 110-381, 122 Stat. 4086 (2008).

during a medical leave from full-time student status. The act requires group health plans and health insurance issuers that provide group health coverage to continue coverage for a child dependent on a medically necessary leave of absence[35] for a period of up to one year after the first day of the leave of absence or the date on which such coverage would otherwise terminate under the terms of the plan, whichever is earlier. A dependent child for purposes of the act is a dependent under the terms of the plan who was both enrolled in the plan on the first day of the medically necessary leave of absence and as a full-time student at a postsecondary education institution until the first day of the medically necessary leave of absence. Michelle's law applies to plan years beginning on or after October 9, 2009 (one year after enactment), and to medically necessary leaves of absence beginning during such plan years.

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[35] A medically necessary leave of absence is defined as a leave of absence (or any other change in enrollment) from a post secondary education institution that (1) begins while the child is suffering from a severe illness or injury, (2) is medically necessary, and (3) causes the child to lose full-time student status under the terms of the plan. The bill would require a certification by the child's attending physician be submitted to the plan or issuer stating that the dependent is suffering from a severe illness or injury and that the leave of absence is medically necessary.