Part Three
Health Benefits

Chapter 20

Health Benefits: Overview

Introduction

Employers offer health benefits in order to provide workers and their families with protection from financial losses that can accompany unexpected serious illness or injury. They also offer the benefits to promote health, to increase worker productivity, and as a form of compensation to recruit and retain qualified workers.

Employment-based health benefit programs have existed in the United States since the late 1800s. In the 1870s, for example, railroad, mining, and other industries began to provide the services of company doctors to workers. In 1910, Montgomery Ward entered into one of the earliest group insurance contracts for its employees.

Prior to World War II, few Americans had health insurance, and most policies covered only hospital room, board, and ancillary services. During World War II, the number of persons with employment-based health insurance coverage started to increase. When the National War Labor Board froze wages as a result of the shortage of workers, employers sought ways to get around the wage controls in order to attract scarce workers, and health insurance was often used in this way. Health insurance was an attractive means to recruit and retain workers during a labor shortage for two reasons: unions supported employment-based health insurance and workers' health benefits were not subject to income tax or Social Security payroll taxes as cash wages were.

Today, as the cost of health care climbs, health insurance remains a valuable employee benefit. Employers view it as an integral component of the overall compensation packages that allow them to attract and retain workers. In addition to health protection for themselves and their family members, many employees view health insurance as a significant source of income protection. Depending on the nature of an illness and the benefits provided, an employee's financial well-being could be jeopardized by unanticipated medical expenses, if he or she lacks health insurance.

Currently, employment-based health insurance is the most common form of health insurance coverage in the United States. In 2006, 105.1 million workers ages 18–64 were covered by employment-based health benefits (Fronstin, 2008). Seventy-six percent of these workers had coverage through

their own employer, while a family member's employer covered the remainder. The employment-based health benefits system also covers 15.1 million nonworking adults, ages 18–64, and 42.3 million children under age 18. In 2008, virtually all employers with 200 or more employees offered health benefits to their workers, while 62 percent of employers with 3–199 employees made the same offering (Claxton et al., 2008).

This chapter first explains the taxation of employment-based health benefits. The chapter continues with sections on employee participation, insurance program administrators, managed care, health providers reimbursement, beneficiary out-of-pocket responsibilities, preexisting condition limitation provisions, health insurance program comparison, other health care plans, the Employee Benefits Security Administration (EBSA),[1] and federal laws.

Taxation of Health Benefits

Under the current tax code, health insurance premiums paid by employers are deductible as a business expense (see Internal Revenue Code (IRC) Sec. 162(a)), and are excluded, without limit, from most workers' taxable income. The exceptions are some cases of highly compensated employees (HCE), when the benefits discriminate in favor of HCEs in non-fully insured plans, and, starting in 2003, in the case of self-employed individuals, partners, and Subchapter S owners who participate in health insurance programs that are not medical savings accounts (see IRC Sec. 162(l)). In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for health care expenses with pretax dollars through the FSA, meaning they are not taxed on the amount of money that is put into the FSA (see IRC Secs. 105(h)(6) and 125(a)), and workers with certain high-deductible health plans are able to make contributions to a health savings account on a tax-preferred basis.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible, though individuals are also allowed to deduct the entire contribution to an HSA even if the amount does not exceed 7.5 percent of AGI. Figure 20.1 contains a summary of the sections in the IRC that affect the provision of employment-based health benefits. The Internal Revenue Service (IRS) Web site (www.irs.gov) provides extensive information on all these matters.

[1] Formerly the Pension and Welfare Benefits Administration.

Figure 20.1

Provisions in the Internal Revenue Code (IRC) Affecting Employment-Based Health Benefits

IRC SECTION	DESCRIPTION
104(a)(3)	Exclusion from gross income of employee for benefits attributable to employee contributions. Available to partners, Subchapter S owners, and self-employed individuals as if they were employees.
105(b)	Exclusion from gross income of employee for benefits attributable to employer contributions (including benefits received from such plans by partners, Subchapter S Owners and self-employed individuals).
105(h)	Any non-fully insured medical reimbursement plan that fails to meet nondiscrimination requirements will result in Highly Compensated Employees (HCEs) being taxed on the "excess reimbursement."
106(a)	Value of employment-based health accident or health plan provided by the employer is excluded from employee's gross income. Not available to partners, Subchapter S Owners and self-employed individuals (see Sec. 162(1) below).
106(b)	Exclusion for contributions to a medical savings account (MSA), but only to the extent allowed under Sec. 220. Also see Sec. 162(1) below(b)(1).
125(a)	Cafeteria plans provide participants with choices between cash (which may include certain taxable benefits) and qualified nontaxable benefits. Participant who chooses nontaxable benefit not taxed on the cash that could have been chosen. If cash is chosen, taxed on cash. HCEs receive this advantage only if the plan does not discriminate in favor of HCEs.
162(1)	Insurance paid for medical care to partners, Subchapter S Owners, and self-employed individuals is deductible from such individuals' gross income (and includable in the income of partners, Subchapter S Owners, and self-employed individuals). For taxable year 2002, 70 percent is deductible; and taxable years 2003 and after 100 percent is deductible from gross income. The remaining premiums that are not deductible, may, with all other IRC Sec. 213(d) allowed medical expenses, be itemized on Form 1040 Schedule A, subject to the 7.5 percent limit and overall limits for itemized deductions allowed under IRC Sec. 68.
213(d)	Determines whether the benefit is a medical benefit that can be excluded from gross income.
220	Tax-favored individual accounts that eligible individuals may establish pursuant to IRC Sec. 220. The Job Creation and Worker Assistance Act of 2002 extends the demonstration period through Dec. 21, 2003. MSAs were originally enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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7702B	Long-term care benefits are defined as accident and health insurance and the amounts received under such long-term care benefits are considered as reimbursement under Sec. 213. Favorable tax treatment is not permitted for long-term insurance under IRC Sec. 125.

The tax preference for health insurance is generally viewed as being regressive. In dollar amounts, the tax exclusion can be viewed as regressive because it benefits higher-income individuals more than lower-income individuals. The regressive tax structure enables workers in higher tax brackets to receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because, although the amount of the benefits is generally the same for all workers with the same employer regardless of income, high-income workers face a higher marginal tax rate.

Figure 20.2 illustrates the value of the health insurance tax exclusion to families with different income levels who work for the same firm. Under the 2003 tax rate structure, the first family in Figure 20.2 faces a 10 percent marginal tax rate. If a $5,000 health plan were excluded from income, the value of the exclusion in terms of taxes not paid that would be attributable to health insurance would be worth $500. For the second family, with $45,000 of taxable income and a 15 percent marginal tax rate, the absolute value of the exclusion is $750, and the absolute value increases to $1,750 for the family with $350,000 of taxable income. The tax exclusion is worth

Figure 20.2

VALUE OF $5,000 EXCLUSION TO SIX FAMILIES OF DIFFERENT TAXABLE INCOME LEVELS, A SIMPLE ILLUSTRATION

	Taxable Family Income	Exclusion as a Percentage of Taxable Income	Marginal Tax Rate	Amount of Exclusion	Exclusion as a Percentage of Taxable Income
Family 1	$ 10,000	50 %	10 %	$ 500	5.0 %
Family 2	45,000	11	15	750	1.7
Family 3	100,000	5	25	1,250	1.3
Family 4	150,000	3	28	1,400	0.9
Family 5	250,000	2	33	1,650	0.7
Family 6	350,000	1	35	1,750	0.5

Source: Employee Benefit Research Institute calculations based on 2007 U.S. tax tables for married persons filing jointly.

nearly twice as much or more to families in the 28 percent tax rate bracket as it is to families in the 15 percent bracket. For families with no taxable income, the value of the exclusion is worth nothing.

However, as a percentage of income, the exclusion may also be viewed as progressive, as the exclusion represents greater savings for lower-income families than for higher-income families (Institute of Medicine, 1993). Again looking at Figure 20.2, for a $5,000 health plan, the value of the exclusion is 5 percent of income for family one, 1.7 percent for family two, 1.3 percent for family three, and less than 1 percent for the other families.

Figure 20.2 shows that while the exclusion is greater in dollar amounts for the families with higher income, as a percentage of income the relative value of the exclusion falls as income rises. When examining the tax exclusion by the percentage of income, it should be noted that it is not progressive at all income levels. Families with no taxable income receive no tax exclusion because they pay no taxes. A refundable tax credit would result in a reduction in taxes for these families.

The analysis above includes only the impact of the federal income tax on employment-based health benefits. Additional savings are realized by employees and employers as a result of not having to pay employment taxes (e.g., Social Security and Medicare taxes). In addition, states with individual tax liability laws may also exclude from state taxable income those amounts received in the form of employment-based health benefits.

Employee Participation

Many employers cover all eligible employees under a single health plan, although different employee groups may have different plans (e.g., union members and nonunion employees may have separate plans). In Feb. 2005, 80.9 percent of wage and salary workers ages 18–64 were offered health insurance by their employer, and 83.5 percent of these workers took the insurance (Fronstin, 2007). Claxton et al. (2006) found that, in 2006, 78 percent of workers (all ages) were offered insurance, and 82 percent of these workers took the insurance. Part-time workers are often not eligible for health benefits.

Most full-time employees are covered at the time they are hired or after they satisfy a waiting or service period. In 2006, the average waiting period for health coverage was 2.2 months (Claxton et al., 2006). Workers in the retail industry were subject to, on average, a 2.7 month average waiting period, while those in state and local governments and health care were subject to, on average, a 1.8 month waiting period. In addition, the waiting period among small firms was longer than in large firms.

In addition to covering employees, many plans cover their dependents. Employers may pay all or part of the cost of the coverage for an employee or for his or her dependents. However, in many plans, the employer contributions for employee coverage may differ from the employer contribution for dependents' coverage. Employee and dependent costs for coverage are generally paid through payroll deduction and may be paid with pre-tax dollars under IRC Sec. 125(a). In 2008, employees paid an average of $60 per month for employee-only coverage (16 percent of the premium), while they paid an average of $280 per month for family coverage (27 percent of the premium) (Claxton et al., 2008).

Type of Health Insurance Administrators

Employment-based health benefits may use any of a variety of administrators: commercial insurance programs, Blue Cross and Blue Shield plans, self-insured plans administered by third-party administrators (TPAs), or multiple employer welfare plan arrangements (MEWAs). Commercial insurance and Blue Cross and Blue Shield plans are primarily regulated by the states where they provide coverage. The federal government regulates self-insured plans exclusively.

Commercial Insurance Plans—Insurance companies are a major source of health insurance. The premium for such insurance protection is calculated to cover the benefits that will be paid, administrative costs, insurance sales commissions, state premium taxes, and surplus (e.g., profit). Generally, for employee groups of 50 or more, the insurer maintains separate claims records for the group and annually adjusts the premium to reflect the group's claims experience; these are called *experience-rated plans*. In contrast, a *community-rated plan* is an insurance plan in which the risk is shared among all members of the community and the premium is based on the health of individuals in the community and claim experience generated by that community or pool. Several states regulate when community rating can be applied. Commercial insurance companies also offer and administer self-funded health plans.

Blue Cross and Blue Shield Plans—Blue Cross and Blue Shield plans were originally started in the 1930s. Blue Cross plans were developed based on the concept of a community-based, voluntary, nonprofit group hospitalization or prepayment plan for hospital services. Based on the same concept, Blue Shield plans cover physician services. Although many plans operate under the Blue Cross and Blue Shield name, each plan is independent, generally operates in a specific geographic area, and offers different benefit structures.

Blue Cross and Blue Shield plans must comply with certain standards established by the Blue Cross Blue Shield Association. In addition, in some states, Blue Cross and Blue Shield plans are required to enroll all applicants regardless of health status. In recent years, several Blue Cross Blue Shield plans have converted to for-profit status and merged into larger plans. These plans are still required to comply with Blue Cross Blue Shield Association standards.

Self-Insured Plans—In a self-insured plan, the employer, or a trust to which the employer contributes, pays employee health care claims directly. Thus, the employer essentially acts as its own insurance company and bears the financial risk of making payments to providers. A limited number of employers self-insure and self-administer their medical plans with TPAs, commercial carriers, or Blue Cross Blue Shield. Other employers self-insure their plans but purchase administrative services contracts to take care of their administrative needs. Additionally, some insurers offer *stop-loss insurance* to employers, which covers catastrophic health expenses above a maximum and, therefore, limits a self-insured plan's liability.

The two main types of stop-loss coverage are individual stop loss (ISL) and aggregate stop loss (ASL). ISL, sometimes called *specific stop loss*, protects the employer against catastrophic claims by single individuals that exceed a dollar limit chosen by the plan sponsor. For example, if a covered participant incurs catastrophic injuries in an accident and has claims exceeding the contract's agreed-upon dollar limit (deductible), the ISL coverage would reimburse the plan for the covered expenses beyond that dollar limit. ASL, or *excess risk insurance*, insures against either non catastrophic or all claims exceeding a total dollar amount for a plan year.

Employers that self-insure do so for a number of reasons. Some employers self-insure in order to retain control of the plan reserves while others self-insure in an attempt to manage health care costs more directly. Some employers prefer to self-insure because these plans are not subject to state mandated benefit laws and insurance premium taxes. In effect, by avoiding state mandated benefits, employers are able to provide a uniform set of benefits to all employees, regardless of where they live. For some employers it makes sense to self-insure because their population of workers is healthier and less costly than the community pool. The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured plans. Finally, some employers self-insure to avoid carrier risk charges and charges for surplus.

Multiple Employer Welfare Arrangements (MEWAs)—A MEWA is an employee welfare benefit plan or any other arrangement that provides any of the benefits of an employee welfare benefit plan to the employees of two or more employers. MEWAs that do not meet certain conditions or are

not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured must meet state insurance laws regulating reserves.

Managed Care

In 2008, 98 percent of Americans with employment-based health benefits were enrolled in some kind of managed care plan (Claxton et al., 2008). Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) represent a great majority of that enrollment, with approximately 80 percent. A managed care system typically provides, arranges for, and finances medical services using provider payment methods that encourage cost containment by contracting with select networks of providers.

Before the spread of managed care in the 1990s, insurance coverage was mostly based on a fee-for-service (FFS) system. Beneficiaries in the plan picked their doctors and hospitals at will. Payment was made by the beneficiary when service was rendered, or the health care provider accepted assignment of the claim from the beneficiary, and afterward claim forms were submitted to the insurance company (or self-insured plan sponsor) for reimbursement. Under managed care, enrollees are often required to follow utilization review and disease management procedures in order to secure coverage for services received.

Reimbursing Health Providers

Health plans calculate payments to providers in different ways: fee-for-service (FFS), discounted fee-for-service, resource-based relative value schedule (RBRVS), per diem, diagnosis-related group (DRG), capitation, or a combination of these. Some health plans are beginning to experiment with pay for performance programs that pay hospitals and physicians additional amounts for meeting specific quality or other targets.

The traditional health care payment system (FFS), which dominated the marketplace from the 1950s through the early 1990s, used a method of reimbursement under which physicians and other providers received a payment, based upon prevailing charges, for services rendered. Most FFS systems today include consideration of usual and customary rate of charges (UCR). UCR means that the provider's usual fee for the service does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. A fee may be considered reasonable when special circumstances require extensive or complex treatment, even though it does not meet the

standard UCR criteria. Today, many health plans arrange prices for services based upon a fee schedule agreed to in advance of services being rendered.

Discounted FFS is a reimbursement methodology in which the provider is paid a fixed percentage discount from full charges. Discounts may be made in a variety of ways such as package pricing, or established prices for specific items or services (i.e., fee schedules) or maximum price limits imposed through determination of reasonableness. Discounted FFS is commonly used by PPOs.

The RBRVS reimbursement methodology ranks physician services according to the resource inputs required to perform these services. The challenge in producing an RBRVS both properly and fairly requires that each of the resource inputs be defined accurately and that its measurement, weighting, and correlation be based on the best available data and a high level of validity. Medicare heavily relies on the RBRVS reimbursement methodology in order to determine payment amount to physicians.

A *per diem* is a set daily payment amount for hospital services, agreed to in advance, by a managed care organization (e.g., HMO or PPO) and the hospital. Per diem payment can be a single amount encompassing all levels of hospital treatment or there can be service-specific per diems (e.g., different amounts for medical/surgical, intensive care, maternity services, etc.).

Another reimbursement system, diagnostic-related groups (DRG), uses diagnosis information to establish hospital payments. Medicare uses the DRG approach, as do some other managed care organizations. This system groups patient needs into about 467 categories, based upon the coding system of the International Classification of Disease.

Capitation reimbursement stipulates a dollar amount established to cover the cost of health care services delivered to a person, usually expressed in units of per member per month (PMPM). The term usually refers to a negotiated per capita rate to be paid periodically—usually monthly—to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services to the covered person under the condition of the provider contract. Capitation is a fixed periodic prospective payment to a provider regardless of the number of services provided to each member. This payment is the same regardless of the amount of services rendered by the provider. Most commonly, capitation reimbursement is limited to HMOs and is confined to primary care services (e.g., it excludes specialty care, hospital care, etc.).

Beneficiary Out-of-Pocket Responsibilities

Virtually all covered services in health care plans are subject to payment limitations and require the employee to share in the costs of coverage. These

cost-sharing features generally include some combination of premiums, deductibles, coinsurance, copayments, and maximum caps on benefits. These plan features are intended to reduce plan costs, encourage employee cost consciousness, and lower administrative expenses.

A *deductible* is a specified amount of initial medical costs that would otherwise be treated as covered expenses under the plan, which each beneficiary must pay before any expenses are reimbursed by the plan. Deductibles typically range from $100 to $500 per person, though they can be higher. In fact, high-deductible health plans associated with a health savings account (HSA) must have minimum annual deductibles of at least $1,100 for self-only coverage and $2,200 for family coverage in calendar year 2008.

Under a plan with a $200 individual deductible, for example, a participant must pay the first $200 in recognized expenses for covered health care services according to the plan provisions. Some plans have different deductibles for different types of health care services. For example, a plan can have one deductible for inpatient care and a different deductible for outpatient pharmaceutical benefits.

The deductible must be satisfied periodically (generally every calendar year) by each participant, sometimes with a maximum of two or three deductibles per family. However, some plans contain a three-month carryover provision. In this case, any portion of the deductible that is satisfied during the last three months of the year can be applied toward the satisfaction of the following year's deductible.

Coinsurance provisions require the plan participant to pay a portion of recognized medical expenses; the plan pays the remaining portion. Commonly, the employee pays 20 percent, with the plan paying the remaining 80 percent of recognized charges. Most major medical plans include both deductibles and coinsurance provisions. Thus, once the plan participant pays the deductible (e.g., the first $200 in medical expenses), the plan pays 80 percent of all other covered charges. Some services may have special coinsurance provisions.

Because 20 percent of a large medical claim may pose a significant financial burden for many individuals and families, most plans limit beneficiaries' out-of-pocket expenditures for covered services. In this case, once a beneficiary has reached the out-of-pocket maximum, covered expenses are reimbursed in full for the remainder of the year. The out-of-pocket limit may be renewed at the start of the calendar year for each individual beneficiary. In 2006, the median employee-only out-of-pocket limit was $1,500 (in-network)/$3,000 (out-of-network) for POS plans and $2,000 (in-network)/$3,000 (out-of-network) for PPOs (Mercer Human Resources Consulting, 2007).

Most medical plans impose a maximum annual or lifetime dollar limit on the amount of health insurance coverage provided. Individual lifetime maximums are usually set at very high levels, such as $1 million or more. Although less common, plans that impose limits may do so on an episodic (or per episode) basis, such as per hospital admission or per disability.

As health benefit costs continue to escalate, employers are increasingly changing the design of cost-sharing features. Employees are often required to contribute toward routine health benefit cost expenses such as premiums and deductibles. However, a growing proportion of employees are protected against catastrophic loss by out-of-pocket limits on the overall amount they must pay toward health care costs.

Pre-existing Conditions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines a pre-existing condition as a health care condition for which care or treatment was recommended or received during the six months prior to coverage under a health plan. Genetic information is not considered a pre-existing condition. Group health plans are allowed to exclude coverage for pre-existing conditions, but they are prohibited from applying pre-existing condition limits for periods longer than 12 months (or 18 months for late enrollees). The pre-existing condition limit cannot be applied in cases involving pregnancy or in cases involving newborns or newly adopted children, who become covered under the plan within 30 days of eligibility. HMOs are allowed to substitute a 60-day affiliation period (90 days for late enrollees) for a pre-existing condition limit.

When excluding a pre-existing condition from coverage, group health plans are required to take into account an individual's prior creditable coverage when determining the length of the limit. A plan must reduce the duration of its pre-existing condition limit by one month for every month of prior creditable coverage, so long as the individual does not have a break in coverage exceeding 63 days. Waiting periods and affiliation periods are not counted as a break in coverage.

Comparing Health Insurance Programs

The term *health insurance* refers to a wide variety of insurance policies. These range from policies that cover the costs of doctors and hospitals to those that meet a specific need, such as paying for dental care. In the past, health insurance po;icies that covered medical bills, surgery, and hospital expenses were typically referred to as comprehensive or major medical policies. Today, when individuals talk about an insurance program, instead

of using the term major medical, they are more likely to refer to FFS (e.g., indemnity), PPO, POS, HMO, or some other type of insurance program. These descriptions more accurately describe for consumers the type of health insurance coverage they have. In evaluating a health program, one should consider services covered; cost (premium, annual deductibles, coinsurance, and copayments); access (ease of obtaining appointments, waiting time in physicians' offices, telephone access to physicians); choice of physicians and hospitals, including referrals to specialists; continuity (do patients see the same physician each time care is sought, what provision is made for changes in the program's coverage of certain specialists); convenience (location of doctors/hospitals and claim filing procedures); coordination (how is care between the primary care physician and specialists coordinated); flexibility (switching physicians, second opinions, denials of care); and quality. The following section discusses differences among health insurance programs in terms of services covered.

Services Covered

Most insurance programs cover medical expenses for hospital and physician fees, surgical expenses, anesthesia, x-rays, laboratory fees, emergency care, and maternity care. Some programs cover physical exams; preventive care (e.g., vaccinations); health screenings (e.g., mammography); chemical dependency treatment; prescription drugs; dental, vision, mental health or other psychiatric care; and home health, nursing home, and hospice care. In addition to reviewing what is covered, one should also consider any financial or other limitations on the coverage offered (e.g., the program may cover physical therapy expenses, but limit coverage to a certain number of visits annually).

Most health insurance programs do not cover treatment that is experimental or investigational. However, virtually every treatment is "experimental" when first introduced. In order to overcome an insurance program administrator's determination that a treatment sought is experimental, the administrator would need to be convinced of at least the following: experts in the field recommend the treatment, the patient will benefit from the treatment, and the treatment is not just for the purpose of furthering scientific research. Some health insurance programs allow access to high-quality clinical trials, while other programs may only pay for the patient care costs associated with participating in clinical trials.

Insurance programs typically cover only medically necessary care. A typical definition of appropriate and medically necessary care is the standard for health care services as determined by physicians and health care providers in accordance with prevailing practices and standards of the

medical profession and community. For example, certain treatments may not be covered as appropriate and medically necessary if the treatment has not been shown to be safe and effective. The utilization review process evaluates requests for medical treatment and determines whether the treatment is medically necessary.

A typical insurance program has many restrictions on coverage. As mentioned above, most policies have a lifetime maximum on what they will pay. Some have a lifetime maximum per illness, per member, and/or per family. Many policies require pre-certification before hospitalization. Pre-certification means that someone must contact the health insurance program administrator and get approval before the plan will agree to pay for services. Health insurance programs can also have limits on hospital room charges, amounts paid specialists, the number of hospital days covered, and other restrictions and limits.

Other Health Care Plans

Medical plans generally exclude services that are not considered medically necessary, including most types of dental, vision, and hearing care. As a result, stand-alone plans providing these benefits are growing in popularity. Because of their highly elective nature, various limits are placed on the benefits provided. For more information, see chapters on dental and vision care benefits.

Employee Benefits Security Administration

The Employee Benefits Security Administration (EBSA), an agency within the Department of Labor (DOL), protects the integrity of pensions, health plans, and other employee benefits for more than 150 million people. The agency mission is to:

- Assist workers in getting the information they need to protect their benefit rights.
- Assist plan officials to understand the requirements of the relevant statutes in order to meet their legal responsibilities.
- Develop policies and laws that encourage the growth of employment-based benefits.
- Deter and correct violations of the relevant statutes.

In order to assist workers in getting information about their employment-based health benefits, the EBSA Web site (www.dol.gov/ebsa/Publications/10working4you.html) provides 10 ways to maximize the value of these health benefits. It recommends that plan participants become

familiar with their benefit options, look for and demand quality medical care, understand how changing jobs or other life events affect health benefits, plan for retirement medical needs, and know how to assert beneficiary rights under the plan.

As part of its mission, on Nov. 21, 2000, DOL published in the *Federal Register* a final regulation that sets new standards for processing benefit claims of participants and beneficiaries who are covered under employee benefit plans governed by ERISA. The claims procedure regulation changed the minimum procedural requirements for the processing of benefit claims for all employee benefit plans covered under ERISA, although the changes were minimal for pension and welfare benefits plans other than those that provide group health and disability benefits. For group health and disability benefit claims, the regulation substantially changed the procedures for benefit determinations. Among other things, it created new procedural standards for initial and appeal-level decisions, new time frames for decision-making, and new disclosure rights for claimants.

In addition, the EBSA is responsible for collecting annual reports (Form 5500) from ERISA-covered health plans. Smaller plans are able to file simplified versions of Form 5500 on a less frequent basis.

Federal Laws

ERISA and Health and Welfare Plans—As discussed in the Introduction section of this book, the Employee Retirement Income Security Act of 1974 (ERISA) is the major federal law governing employee benefits in the United States. ERISA primarily applies to private retirement plans, but almost all employee benefit plans are subject to some provisions of the law. The legislation affects welfare plans, such as health insurance, group life insurance, sick pay, long-term disability income, and retirement plans.

A first important step to understanding ERISA and how it relates to employee health plans is to understand the terms used in ERISA that relate to employee health plans. The term *employee benefit plan* applies to employee pension plans and employee welfare plans. Both terms are given very broad meanings. The term *employee welfare plan* applies to any kind of non pension employee benefit plan, including health plans (both insured and not insured), life insurance, disability plans, etc. Under the terms of ERISA, all employment-based health plans, insured or not insured, are ERISA plans except for health plans maintained by government entities for the employees of federal, state, and local governments and church plans maintained for the employees of churches.

The key provisions of ERISA that relate to employment-based health plans are found in Sec. 514(a) of ERISA, known as the “pre-emption” clause,

which states that, "the provisions of this title and Title 4, shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." The pre-emption by ERISA of state regulations is very broad. Under current law, there is only one way for a state to get around ERISA's pre-emption and that is by an act of Congress with the president's signature. To date, only Hawaii's Prepaid Health Plan has an exemption from ERISA pre-emption. Sec. 514(b), known as the "savings" clause, exempts state regulation of insurance from ERISA pre-emption. Sec. 514(c), known as the "deemer" clause, stipulates that a state cannot deem an employee health plan as insurance to avoid ERISA pre-emption.

The results of these definitions and Sec. 514 are that most private-sector non church employment-based health plans are ERISA plans and therefore exempt from state regulation. However, given that ERISA does not pre-empt state regulation of insurance, states indirectly regulate ERISA health plans that purchase an insurance contract (the state regulates the insurance contract not the employment-based health plan).

An employer can avoid any state regulation of its health plan by self-funding, or self-insuring, the health plan. Under this funding arrangement, the employer assumes the financial risk for the health plan. Under a fully insured arrangement, the employer shifts the financial risk of the health plan to another party, usually an insurance company. The term *self-funding*, although commonly used, can be misleading. The term *self-fund* leads one to believe that the employer sets up a separate fund from which the employer pays health benefit claims. However, most employers that self-fund their health benefit plans pay health benefit claims on a pay-as-you-go basis out of general funds. Also, not all employers that choose to self-fund their health plan are fully self-funded. Some employers find that it is more cost effective to carve out certain segments of their health plan, e.g., mental health benefits or prescription drugs, and purchase an insurance contract to cover the funding of these benefits. By doing this, the carved-out segment of the employer's plan is now indirectly regulated by the state in which the benefit is available.

Another way self-funded plans may be partially insured is through the purchase of stop-loss coverage. To cover against catastrophic losses, some companies that self-fund their health plans purchase stop-loss coverage. There are two types of stop-loss coverage: specific stop-loss coverage, which insures against the risk that any one claim will exceed a certain amount, and aggregate stop-loss, which insures against the entire plan's losses exceeding a certain amount. Most plans purchase both types of stop-loss coverage.

When an employer self-funds its employee health plan, the health plan is exempt from taxes and other assessments that states levy on insurers. Nearly all states assess a premium tax on commercial insurers that operate

in that state. These taxes range from 1 percent to 4 percent of premiums collected. All states operate a guaranty fund that pays outstanding claims when an insurer fails. Depending on their competitiveness and market strategy, many insurers are able to pass this cost on to their customers. These funds get their moneys from assessments on insurers in the state. By self-funding, an employer can avoid these costs.

Self-funded employers are also exempt from state regulations. The most widely known state regulations are the state-mandated benefits. State-mandated benefits are legal requirements that insurers operating in that state must offer specific health services or the services provided by specified providers. The mandates are generally narrowly defined and apply to all commercial insurers, Blue Cross and Blue Shield Plans, and health maintenance organizations (HMOs). As of 2006, there were over 1,800 state-mandated benefits. Research shows that state mandated-benefits increase claims costs, yet their impact on premium costs is unclear.

A further complication of the issue arises when a self-funded health plan contracts with an HMO. State regulation of HMOs varies greatly from state to state. Some states regulate HMOs as they would insurance companies, while other states do not consider HMOs to be insurance. The issue of whether self-funded health plans that contract with HMOs are regulated by the states is still unclear.

Two commonly asked questions regarding self-funded health plans are: how many employers self-fund their health plan and how many individuals are covered by a self-funded health plan? Data on the number of employers that self-fund their health plan are not available. Among the reasons are: current federal reporting requirements focus on pension plans and not health plans; health plans with fewer than 100 participants are generally exempt from reporting; and inconsistencies exist among the data reported for health plans (U.S. General Accounting Office, 1995).

As to the number of individuals covered by a self-funded health plan, the Kaiser Family Foundation/Health Research and Educational Trust survey indicates that in 2008, 55 percent of all workers with health insurance were in a plan that was either fully or partially self-funded. Only 12 percent of workers in firms with 3–199 workers were in full or partially self-funded plans, while 89 percent of workers in firms with 5,000 or more employees were in those plans. Self-funding also varies by plan type. The KFF/HRET survey found that 64 percent of workers in PPOs were in full or partially self-funded arrangements, compared with 29 percent among workers in POSs.

Laws and Jurisdiction

The sections below summarize several major federal laws that affect how workers and their families receive health benefits from employment. These laws are discussed below by federal agency responsibility: Department of Labor (DOL) and the U.S. Equal Employment Opportunity Commission (EEOC). Other federal agencies such as the Internal Revenue Service and the Department of Justice may also share responsibility for these laws.

Department of Labor (DOL)—

- *The Employee Retirement Income Security Act of 1974 (ERISA)*: Offers protections for individuals enrolled in health benefit plans sponsored by private-sector employers, provides rights to information, and outlines a grievance and appeals process for participants to get benefits from their plans.
- *The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*: Contains provisions giving certain former employees, retirees, spouses, and dependent children the right to purchase temporary continuation of group health plan coverage at group rates in specific instances. For more information, see chapter on COBRA.
- *The Family and Medical Leave Act of 1993 (FMLA)*: Administered by the Wage and Hour Division of DOL, this law requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth or adoption of a child or for the serious illness of the employee or a spouse, child, or parent. The employee receives his or her self-only health insurance coverage at the same premium paid by a similarly situated employee on active status. For more information, see chapter on leave benefits.
- *The Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: Includes protections for millions of working Americans and their families who have pre-existing conditions, prohibits discrimination in health care coverage, and guarantees issuance of individual policies for certain eligible individuals.
- *The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)*: Requires that employment-based group health plans cover a minimum hospital length of stay for mothers and newborns of 48 hours for a vaginal birth and 96 hours for a cesarean section. Insured plans are governed by state law and not by NMHPA if the state law fulfills the following criteria:
    - Minimum coverage is a length of inpatient hospital stay of 48 hours for a vaginal birth and 96 hours for a cesarean section.

- Guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association are followed for such purposes.
- The hospital length of stay is allowed to be determined by the attending provider in consultation with the mother.

  Under NMHPA, the length of stay starts either when the child is born or, for births occurring outside of the hospital, when the mother and/or newborn are admitted to the hospital. The attending provider, in consultation with the mother, is allowed to waive the minimum length of stay.

- *Mental Health Parity and Addiction Equity Act of 2008 (MHPA):* Per final legislation in 2008, requires that annual or lifetime dollar limits on mental health benefits be no lower than those dollar limits for medical and surgical benefits offered by a group health plan. For more information, see chapter on mental health benefits.
- *The Women's Health and Cancer Rights Act of 1998 (WHCRA)*: Requires that employment-based group health plans provide coverage for certain breast reconstruction surgery in connection with a mastectomy. Self-insured church plans are exempt from the law.

  If an employment-based health plan provides medical and surgical benefits for mastectomy, it must also cover:
  - Reconstruction of the breast on which mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymph edemas.

  DOL provides guidance in the form of questions and answers on WHCRA at www.dol.gov/ebsa/FAQs/faq_consumer_womenshealth.html

Equal Employment Opportunity Commission (EEOC)—EEOC has developed a *Compliance Manual* section that explains how the employment discrimination laws apply to health insurance benefits. The section covers discrimination in health insurance benefits under the Age Discrimination in Employment Act of 1967 (ADEA), the Americans with Disabilities Act of 1990 (ADA), the Equal Pay Act of 1963 (EPA), and Title VII of the Civil Rights Act of 1964 (Title VII).

Title VII requires employers to provide identical coverage to men and women if they both can contract a condition or benefit from a treatment or

test. Sometimes an employer will use a neutral standard to exclude treatment for a condition that only, or disproportionately, affects members of one sex, race, or other protected group. For example, an employer might refuse to cover certain treatments for prostate cancer as "experimental." In that case, the employer may have to show that its standard was neutrally applied and is based on generally accepted medical criteria.

The Pregnancy Discrimination Act of 1978 (PDA) amends Title VII and requires that women who are affected by pregnancy, childbirth, or related medical conditions be treated the same as any other employee who is similarly able or unable to work. When an employer offers benefits of any sort, it must cover pregnancy and related medical conditions in the same way that it covers other medical conditions. Health insurance for expenses arising from abortion is not required, except where the life of the mother is endangered. Pregnancy-related expenses should be reimbursed to the patient exactly as those incurred for other medical conditions. The amounts payable can be limited only to the same extent as costs for other conditions. No additional, increased, or larger deductible can be imposed. Employers must provide the same level of health benefits for spouses of male employees as they do for spouses of female employees.

Conclusion

For many decades, health insurance plans have played a significant role in employee benefits planning. Modern technology, increased longevity, and a growing emphasis on good physical and mental health make these plans even more important today. The development of managed care plans, and dental, prescription drug, vision, and hearing care plans attests to the dynamic nature of this employee benefit area, as does the development of wellness and employee assistance programs. Future innovative efforts in plan design will be influenced strongly by the continuing need for health care cost management, ever-changing medical technology, and constantly changing government regulations.

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Additional Information

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Society for Human Resource Management
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