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Issue Brief

ERISA at 50: ERISA and Health Benefits

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Key Points

- ERISA sets federal standards for most private employer health benefit plans and preempts self-funded plans from state insurance laws.
- Numerous laws have amended ERISA by placing new requirements on group health plans, expanding federal regulatory oversight, and providing plan enrollees with new rights and benefits.
- ERISA has facilitated health coverage among large multi-state employees.
- Inadvertent downsides of ERISA regulations include inconsistencies in nondiscrimination and wellness program rules, complex asset rules, limited data availability, gaps in regulatory oversight, and negative impacts on fully insured small group plans.

The *Employee Retirement Income Security Act of 1974* (ERISA)[1] is often thought of in connection with employer retirement plans, because the law was primarily instituted to address retirement plan concerns. But importantly, the law also applies to employer health benefit plans, which are a cornerstone of the U.S. health insurance system. In 2022, employer-sponsored group health plans (insured and self-funded) covered nearly 180 million Americans, or 54% of the U.S. population.[2]

To mark the 50th anniversary of its implementation, this issue brief covers the history of ERISA's application to health benefits, subsequent amendments to the law, ERISA's facilitation of coverage under employer-sponsored health plans, and its challenges. ERISA establishes uniform federal standards regarding reporting and disclosure requirements, fiduciary responsibilities, grievance and appeals processes, and plan participation and antidiscrimination rules. In addition, ERISA preempts self-funded employer-sponsored health plans from state insurance laws, thus facilitating health coverage among large multi-state employers. Nevertheless, policymakers and regulators may wish to revise ERISA rules that are complex or inconsistent and address gaps in regulatory oversight.

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Any references to current laws, regulations, or practice guidelines are correct as of the date of publication.

1 *Employee Retirement Income Security Act of 1974* [P.L. 93–406, as amended through P.L. 117–328, enacted December 29, 2022], 29 U.S.C. §1001 *et seq*.

2 U.S. Census Bureau, "Health Insurance Coverage in the United States: 2023," p. 2.

History of ERISA's Application to Health Benefits

Enacted in 1974, ERISA was the culmination of a long series of legislative actions designed to address employer benefit plans' labor and tax aspects. At that time, the employee benefits landscape differed significantly from what it is today. Defined benefit (pension) plans were prevalent, and retirement benefits were a significant issue for employees, employers, policymakers and regulators.[3] Although health benefits were an important part of employee compensation, they were not as significant a benefit as they are today.

In the 1940s, employer-sponsored health insurance grew dramatically in the wake of World War II due to government policies that further bolstered the tie between health insurance and employment.[4] States were the principal regulators of health insurance, and each state regulated health insurance benefits differently, leading to inconsistencies. Health benefits expanded even more in the 1950s as labor unions began to bargain for better benefit options. With the passage of the *Welfare and Pension Plans Disclosure Act* (WPPDA) in 1959,[5] the U.S. Department of Labor (DOL) began overseeing plan filing requirements for employee benefit plans. Then, in 1962, the WPPDA was amended to give the DOL enforcement, interpretative, and investigatory authority to prevent employee benefit plan fund mismanagement and abuse.

ERISA furthered the federal regulation of retirement and health benefit plans by preempting state laws related to the oversight of these plans, instead assigning regulatory responsibility to the DOL, the IRS, and the Pension Benefit Guaranty Corporation (PBGC). However, fully insured employer-sponsored health plans are not preempted

3 The Academy's Retirement Practice Council's issue paper *ERISA: 50 Years of Shaping the Single-Employer Defined Benefit Landscape* and information from related events are available at actuary.org/ERISA-at-50

4 This opportunity arose because to control inflation during the WWII wartime economy, the federal government instituted wage and price controls that limited employers' freedom to raise wages to compete for scarce workers but allowed employers to expand benefits for workers, such as health insurance. In this way, health benefit packages offered one means of securing workers and resulted in a rapid increase in employer-sponsored insurance. Several additional federal rulings followed that increased the attractiveness of the provision of employer-sponsored insurance to workers and their unions. In 1945, the government said that employers could not unilaterally change benefits programs until the expiration of a labor contract, and in 1949, it ruled that benefits should be considered part of the wage package of employees so that unions could negotiate health insurance as part of contract talks. Finally, in 1954, the IRS decided that the contributions that employers made to the purchase of health insurance for their employees were not taxable as income to workers. See "Employer-sponsored health insurance in the United States—origins and implications"; *New England Journal of Medicine*; July 2006.

5 *Welfare and Pension Plans Disclosure Act* [P.L. 85-836, Aug. 28, 1958 (72 Stat.)]

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from *state* laws. And even for self-funded plans, preemption is not absolute, as courts have found that states have the authority to regulate self-funded plans in certain circumstances.[6]

ERISA comprises four titles. Title I contains rules for reporting and disclosure, vesting, participation, funding, fiduciary conduct, and civil enforcement, and is administered by the DOL. Title II amended the Internal Revenue Code to parallel many of the Title I rules and is administered by the IRS. Title III focuses on jurisdictional matters and with coordination of enforcement and regulatory activities by the DOL and the IRS. Title IV covers the insurance of defined benefit plans and is administered by the PBGC.

What Types of Health Plans Are Subject to ERISA?

ERISA defines an "employee welfare benefit plan" as:

> Any plan, fund, or program established or maintained by an employer or an employee organization, or both, for the purposes of providing participants or beneficiaries, through the purchase of insurance or otherwise, with any of the following benefits:
>
> a. Medical, surgical, hospital, sickness, accident, disability, death (life insurance), unemployment (severance), vacation, apprenticeship, training, day care center, scholarship fund, prepaid legal services, or
>
> b. Any benefit described in sect 302(c) of the Labor Management Relations Act of 1947 (the Taft-Hartley Act).[7]
>
> ERISA applies to most welfare benefit plans. However, a few types of plans are excluded, including group health plans that are:
>
> 1. established or maintained by government entities;
> 2. church plans;
> 3. plans maintained solely for compliance with workers' compensation, unemployment, or disability laws; or
> 4. plans maintained outside the U.S. with the primary use for nonresident aliens or unfunded excess benefit plans. Government plans, in particular, may cover a large number of plan participants.

ERISA applies to both fully insured and self-funded health plans, although the preemption of state laws related to employee benefit plans only applies to self-funded health plans.

6 See for example, *Rutledge v. Pharmaceutical Care Management Association* (PCMA), in which the U.S. Supreme Court ruled that an Arkansas statute regulating the reimbursement rates paid to pharmacies by pharmacy benefit managers (PBMs) on behalf of PBMs' self-funded clients is not preempted by ERISA.

7 *Employee Retirement Income Security Act of 1974*; op. cit.

ERISA was enacted to protect the interests of employer-sponsored benefit plan participants and beneficiaries. Under the law, employers and other plan sponsors (e.g., unions) must provide participants with adequate information regarding their plans and disclose certain pieces of information. The law also requires individuals and fiduciaries who manage plans to meet certain standards of conduct. It also includes civil enforcement provisions that ensure plan funds are protected and that participants who qualify receive their benefits. Finally, ERISA contains detailed provisions for reporting plan information to the government.

Legislative Amendments to ERISA

ERISA has been amended legislatively over the years, particularly with respect to health benefits. These amendments have placed new requirements on group health plans, expanded the regulatory oversight federal agencies have over ERISA plans, and provided plan enrollees with new rights and benefits. These laws include (but are not limited to):

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[8] COBRA, which applies to group health plans sponsored by employers with 20 or more employees, gives plan participants (both workers and their dependents) the right to continue their coverage under certain circumstances when it would have otherwise ended. For the worker, this includes a voluntary or involuntary job loss or a reduction in hours worked. For the worker's spouse or dependent child, this also includes divorce, the worker's death, the worker becoming eligible for Medicare, or the dependent child turning 26 years of age. Individuals who elect COBRA coverage pay the entire premium, up to 102% of the cost to the group health plan. Depending on the reason for eligibility, COBRA coverage is limited to 18 or 36 months.

Health Insurance Portability and Accountability Act of 1996 (HIPAA).[9] HIPAA established extensive privacy and security protections for individuals' personal health information. These protections apply generally to ERISA plans, as well as to a wide variety of entities, such as health care providers and health insurance companies. Under HIPAA, individuals have rights to obtain and control others' access to their health information. In addition, HIPAA placed limits on preexisting condition exclusions and provided additional access rights for individuals who lose coverage under a group health plan.

8 *Consolidated Omnibus Budget Reconciliation Act of 1985* [P.L. 99–272, April 7, 1986 (100 Stat. 82)], 42 U.S.C. §300bb–1 *et seq*.
9 *The Health Insurance Portability and Accountability Act of 1996* [P.L. 104-191, Aug. 21, 1996 (110 Stat. 1936)], 29 U.S.C. § 1181.

Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act).[10] The Newborns' Act ensures mothers and newborns receive adequate post-childbirth hospital care. The law's primary provision prevents insurance companies from limiting a mother's post-childbirth hospital stay to less than 48 hours after a vaginal delivery and 96 hours after a cesarean section.

Genetic Information Nondiscrimination Act of 2008 (GINA).[11] GINA prohibits health plans from requiring genetic tests, denying coverage based on a genetic test's results, or charging higher premiums based on a genetic test's results. GINA also limits the incentives that can be offered to wellness plan participants for providing genetic information.

Mental Health Parity Act of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[12] MHPAEA applies to group health plans with more than 50 employees that are subject to ERISA and provide mental health or substance use benefits. The law prohibits those plans from imposing greater burdens on enrollees seeking mental health or substance abuse care compared to the burdens on enrollees seeking medical/surgical care. MHPAEA addresses both "quantitative benefit limits," such as visit limits, deductibles and co-payments, and "non-quantitative" benefit limits, such as referral requirements, pre-authorization requirements, and other managed care review processes.

Patient Protection and Affordable Care Act of 2010 (ACA).[13] While the ACA is best known for its changes to the individual health insurance market, it also placed requirements on group health plans subject to ERISA. These include extending coverage to dependent children to age 26, prohibiting annual and lifetime limits on essential health benefits, prohibiting preexisting conditions limitations, requiring coverage without patient cost sharing for certain preventive services, and employer shared responsibility provisions for employers with 50 or more full-time equivalent workers. In addition, the ACA established modified community rating rules, essential health benefit requirements and limits on enrollee cost sharing that apply to fully insured small group plans.

Consolidated Appropriations Act of 2021 (CAA).[14] The CAA established a number of transparency requirements. These include a prohibition on "gag" clauses in provider contracts, disclosure of compensation paid to brokers and consultants, additional reporting requirements around compliance with MHPAEA, and certain reporting

10 *Newborns' and Mothers' Health Protection Act of 1996* [P.L. 104-204, Sept. 26, 1996 (110 Stat. 2935)], 29 U.S.C. §1185.
11 *Genetic Information Nondiscrimination Act of 2008* [P.L. 110-233, May 21, 2008 (122 Stat. 881)], 42 U.S.C. §2000ff *et seq.*
12 *Mental Health Parity Act of 1996* [P.L. 104–204, Sept. 26, 1996 (110 Stat. 2941)]; *Mental Health Parity and Addiction Equity Act of 2008* [P.L. 110–343, Oct. 3, 2008 (122 Stat. 3881), 29 U.S.C. §1185a; see also "Mental Health Parity"; Regulations and Guidance; CMS.gov.
13 *Patient Protection and Affordable Care Act of 2010* [P.L. 111–148, Mar. 23, 2010 (124 Stat. 119), as amended through P.L.118-42, enacted March 9, 2024], 42 U.S.C. 157.
14 *Consolidated Appropriations Act of 2021* [P.L. 116–260, Dec. 27, 2020 (134 Stat. 1182), as amended through P.L. 118-63, enacted May 16, 2024].

requirements around health care providers and pharmacy benefit managers regarding the cost of health care services and prescription drugs. Within the CAA, the *No Surprises Act* protects patients from balance billing in situations involving unexpected bills, including situations when patients have used emergency care at in-network facilities, obtained non-emergency care from out-of-network providers at in-network facilities, and had to use air ambulance services.

ERISA's Benefits

ERISA facilitates health coverage among large, multi-state employers by establishing federal standards for employer benefit programs and for self-funded plans, preempting a patchwork of inconsistent state laws and regulations.

The law helps employers and other group health plan sponsors provide more uniform benefits to employees located across the country and administer those benefits uniformly. Both plan sponsors and participants benefit from this uniformity, as it simplifies administration and communication of benefits to employees. For larger employers, ERISA also facilitates economies of scale with suppliers and vendors, including third-party administrators, consultants, disease management companies, and pharmacy benefit managers.

ERISA also provides self-funded employers with broad flexibility to tailor benefit offerings to the unique needs of their plan participants, including historically marginalized populations. Preempting state benefit mandates may allow employers to rely on evidence-based care standards in designing benefits.

ERISA's Challenges

ERISA has built significant protections for plan participants, providing employers and other group health plan sponsors with a legal framework to furnish a wide range of benefits. However, its initial emphasis was to address retirement plan concerns rather than to regulate health and welfare benefits. An array of subsequent legislation and regulatory activity has created significant complexity for employer health and welfare plans. This section highlights the various challenges associated with ERISA's regulation of employer health and welfare plans.

Differing nondiscrimination rules. ERISA-related nondiscrimination rules are designed to ensure benefits are similar for all employees and do not favor highly compensated employees and executives. However, the nondiscrimination rules vary among different types of benefits. For example, cafeteria plans must pass availability, utilization, participation and key employee concentration tests. Self-funded plans must satisfy the 70% enrolled or 70% eligible and 80% enrolled test. Each test uses a different definition of highly compensated employee and/or key employee.

Inconsistent rules governing wellness programs. Although the concept of providing for worker welfare existed well before ERISA, wellness programs—which are designed to improve plan participant health and productivity and reduce future health spending—did not become common in the U.S. workplace until after ERISA's enactment. As a result, multiple overlapping statutes to regulate wellness programs were passed over time, including HIPAA, the *Americans with Disabilities Act* (ADA),[15] GINA, and the ACA. The Equal Employment Opportunity Commission (EEOC) has also taken an active role in regulating employer wellness practices. Some of the rules apply only to employees, while others apply to all participants, including employees, spouses, and dependents. Some rules focus on disclosure and reasonable alternative accommodations, while others include bright-line numeric tests, and still others on broad prohibitions with narrow exceptions.

Complex plan asset rules. ERISA's definition of plan assets was formulated to apply to retirement plans, where the need for a legally separate trust for the assets of the plan has been well established. But the concept becomes less clear when this rule is applied in the context of employer health and welfare plans. Often, these plans do not use legally separate trusts. This can cause unnecessary complexity such as in the case of fully insured plans, when it's not clear whether or how to allocate insurance premium refunds between the employer and the employee.

Annual disclosure inconsistency. The DOL's Form 5500[16] and its various schedules provide comprehensive public information regarding a retirement plan's financial position, including cashflow and expense disclosures. For health and welfare plans, insurance commissions must be disclosed on Schedule A within Form 5500, but there is no requirement to disclose other fees paid to service providers.

15 *Americans with Disabilities Act of 1990*, [P.L. 101–336, July 26, 1990; as amended through P.L. 113-287, Enacted December 19, 2014]; 42 U.S.C. §§12101 *et seq*.
16 Form 5500 Series; Employee Benefits Security Administration; U.S. Department of Labor.

Impact of state preemption on the small group market. Although preemption of state laws for self-funded plans facilitates uniform coverage among larger and multi-state employers, it can also serve as an incentive for smaller employers to choose a self-funded plan. Smaller employers are less likely to be able to bear the risk of self-funding and may opt to use level-funded options, incorporating stop-loss coverage. In either scenario, small employers may avoid state insurance requirements and federal prohibitions on underwriting by self-funding health benefit plans. Healthier groups may benefit from lower health benefit costs by shifting from a fully insured plan to a self-funded plan. As a result, small employers with plan participants who have lower expected health costs may be more likely to provide self-funded or level-funded health benefits to take advantage of the lower costs. This shift may worsen the fully insured small group market risk pool, leading to higher small group premiums in that market.

Limits on data availability. Restrictions on data sharing can limit employers' ability to identify their enrollee populations' health care needs and their ability to subsequently design benefits to meet those needs. Data-sharing limitations may also make it difficult for employers to understand whether and how particular coverage or provider payment interventions are affecting health care costs and outcomes. Rules that protect patient privacy are essential; however, ERISA data rules on how data can be shared are ambiguous, potentially hindering the data sharing that can improve health care access and outcomes.[17]

Regulatory gaps. Despite the federal preemption for self-funded plans, states have limited oversight responsibility for the plans, provided the oversight is consistent with Title I of ERISA. Such dual oversight can lead to confusion, running the risk of too little oversight rather than too much. For example, states retain significant regulatory authority over self-funded, multiple employer welfare arrangements (MEWAs). Some states have robust governance, reporting, and solvency requirements for MEWAs, while others do not. A lack of oversight can be linked to multiple MEWA insolvencies over the years. MEWAs are not covered under the states' fully insured carrier requirements and are typically excluded from participating in state guaranty funds; further, ERISA does not contain federal minimum solvency requirements, so MEWAs in states without rigorous oversight run the risk of solvency issues.

17 See "Health Benefit Design Innovations for Advancing Health Equity: Removing the Barriers to Successful Implementation"; American Academy of Actuaries; August 2023.

Conclusion

Over the past 50 years, ERISA has governed employer group health benefit plans, the largest source of health coverage in the United States. The law is designed to protect the interests of plan participants by requiring nationally uniform rules regarding reporting, participation, funding, and fiduciary responsibilities. Subsequent legislative amendments have been enacted to improve coverage portability, patient privacy, and coverage comprehensiveness. By preempting a patchwork of state laws and regulations overseeing self-funded group health plans, ERISA has facilitated health coverage among large multi-state employees.

Moving forward, policymakers and regulators may wish to consider addressing the inadvertent downsides of ERISA regulations. These include inconsistencies in nondiscrimination and wellness program rules, complex asset rules, limited data availability, gaps in regulatory oversight, and negative impacts on fully insured small group plans.

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