

ERISA PLANS

What is it?

ERISA, the federal Employee Retirement and Income Security Act, was enacted in 1974, largely to regulate employee pension funds. Although the law was originally enacted to protect employee pension funds, it also affects employer-sponsored health insurance. ERISA prevents states from directly regulating employee welfare benefits, including employer-sponsored health plans.

Who is it for?

The federal ERISA laws govern employer-sponsored health plans, except those offered by a church or a governmental entity for its employees. Health insurance that is offered by a church or a governmental entity is not governed by ERISA. Neither are publicly-subsidized health insurance plans (such as Medicaid, NC Health Choice, or Medicare), or private health insurance bought in the non-group market.

INTRODUCTION

Congress enacted ERISA to create a uniform federal system of laws to govern employee welfare benefit plans. ERISA restricts the ability of states to enact laws that relate to employee welfare benefits, including employer-sponsored health insurance coverage. Under ERISA, states retain the authority to regulate insurance carriers and health maintenance organizations (HMOs). If an employer purchases a traditional health insurance product or HMO for its employees, then the employees get the benefit of many of the state law protections. However, employers that choose to “self-fund” are not subject to traditional state insurance laws. Under “self-funded” or “self-insured” plans, the employer is actually responsible for paying most of the health bills—not just the insurance premiums. Nationally, about half of insured employees are covered by these self-funded or self-insured plans.

Note: It is often difficult to know whether your employer is operating an ERISA plan or buying a traditional insurance plan or HMO coverage. You may get an insurance card that looks like you are enrolled directly in an HMO or insurance company, even though your employer is still retaining the financial risk for paying for all the health care claims. The easiest way to find out whether you are enrolled in a self-funded ERISA plan or whether you are enrolled directly in the state-regulated HMO or insurance company is to ask your employer.

BENEFITS

Self-insured ERISA plans are not required to provide coverage for *state*-mandated benefits, such as coverage of mammograms or Pap smears. However, there are certain *federally*-mandated benefits that do apply to ERISA self-funded health plans. For example, ERISA plans must cover the following:

- ♦ Breast reconstruction in connection with a mastectomy
- ♦ 48-hour hospital stay following childbirth (or 96 hours in the case of a cesarean section)

At the time of this writing, Congress was considering adding consumer protections and mandated benefits to ERISA plans. For example, Congress was considering an extension of the Mental Health Parity Act (which expired September 30, 2001). Congress was also considering enacting a Patient Protection Act, which would provide additional managed care consumer protections and coverage of clinical trials.

ELIGIBILITY

Employers are not required to offer health insurance coverage to any of their employees. However, an employer offering health insurance coverage may not discriminate against certain employees on the basis of health status or disability. Employers may still exclude employees who do not otherwise qualify for coverage (for example, because they are part-time or temporary employees).

Different federal laws prohibit employers from discriminating against lower wage employees in eligibility or covered services, if the company wants to deduct health contributions from its federal taxes. Note: this non-discrimination provision is complicated, and may require the advice of an attorney or accountant to determine an employer's compliance with the law.

LIMITATIONS AND EXCLUSIONS

Employers may exclude coverage for pre-existing conditions for an insured individual for up to 12 months from the person's initial effective date of coverage. The 12-month pre-existing exclusion period applies if a person seeks coverage when they first qualify (for example, during an open-enrollment period, or when coverage is first offered on the job). Employers can impose an 18-month pre-existing condition exclusion period for late-enrollees.

A "pre-existing condition" is a condition "for which medical advice, diagnosis, care, or treatment [is] recommended or received" in the six months immediately before a person becomes eligible for the employer's health plan. Thus, you could be excluded from coverage for a pre-existing condition for which you received care three months before qualifying for the employer's health plan, but not for the same condition if the last time you received treatment was 12 months earlier.

Generally, once you meet any pre-existing condition waiting period, you cannot be subject to another exclusion. This protection applies if you stay continuously insured—even if you change jobs or your employer offers new insurance coverage. The exception to this rule is if you have a gap in health insurance coverage for more than 63 days. If you have a gap in insurance coverage for more than 63 days, then you can be subject to a new pre-existing condition waiting period.

Late enrollees may be subject to longer pre-existing condition waiting periods. Late enrollees are people who failed to enroll when they were first eligible. If you are a late enrollee, you may be subject to an 18-month pre-existing condition exclusion. Once this waiting period is met, you must be covered just like other insured individuals.

You will not be considered a late enrollee if any of the following conditions are met:

- ◆ You were covered under another health benefit plan with comparable coverage at the time you were eligible to enroll with the employer's plan. In order for this protection to apply, you must state at the time of open enrollment that you are declining coverage because you are covered under another health plan. If you later lose that coverage (through the death of a spouse or divorce, because you lose the other job through which you had coverage, or because the employer that offered the other coverage stopped offering health insurance), you can enroll with the ERISA plan under the terms of the open enrollment period. However, you must request enrollment within 30 days of the time you lose your other coverage.
- ◆ If a court of law has ordered that coverage must be provided for a spouse or minor dependent child and the request for enrollment is made within 30 days of the court order.
- ◆ You have a newborn or adopted child, and the child is covered within 30 days of the child's birth or adoption.

NOTICE AND ENROLLMENT

All employer-sponsored health insurance plans (including both self-funded and traditional insurance or HMO coverage) must furnish participants and beneficiaries with a description of the plan. This written document is called a Summary Plan Description (SPD), and must include rights, benefits, and responsibilities under the plan. For example, the SPD should include information about the following:

- ◆ Cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts
- ◆ Annual or lifetime limits or other limitations in the plan
- ◆ The extent to which preventive services are covered under the plan
- ◆ The extent of drug coverage, if any, under the plan
- ◆ The extent of coverage, if any, for medical tests, devices, and procedures

- ◆ Provider networks, and whether individuals must use providers in the network
- ◆ Coverage for out-of-network services
- ◆ Whether the covered individual must select a primary care provider, and how to access specialists
- ◆ Coverage for emergency medical care
- ◆ The preauthorization or utilization review requirements
- ◆ An individual's appeal rights if coverage or services are denied

Plans must provide covered individuals information about any material changes within 60 days of when the changes are made.

PREMIUMS

There are no limits on the premiums that ERISA plans can impose, or on the amount of cost sharing required of people covered under the plan.

APPEALS

ERISA provides appeal rights for *all* employer-sponsored health plans (including both self-funded and traditional insurance or HMO coverage). Covered employees (or their dependents) can appeal denials of services that are normally covered under the plan. For example, a covered individual can appeal if the employer or health insurer denies coverage for a service because they determine the service is not “medically necessary.” The appeals must be decided within certain specified timeframes. Urgent cases must be decided within 72 hours. However, the health plan has 60 days to decide appeals when the services have already been provided and the only outstanding dispute is whether the services should be covered under the plan. If the covered individual disagrees with the final appeal decision or if the plan fails to make a timely decision, then he or she can file a suit in federal court to obtain coverage.

ADMINISTRATION

ERISA plans are subject to oversight and enforcement by the U.S. Department of Labor.

SOURCES OF LAW

Federal statute(s): 29 U.S.C. § 1001 *et seq.* (Employee Retirement Income Security Act); 26 U.S.C. § 105 (IRS Non-Discrimination Provisions)

Federal regulation(s): 29 C.F.R. §§ 1021-1031; 1101-1114; 1131-1145; 2520.101 *et seq.*; 2560.503-1 (Employee Retirement Income Security Act)

FOR MORE INFORMATION

Pension and Welfare Benefits
Administrative Office of Enforcement
U.S. Department of Labor
Atlanta Regional Office
61 Forsyth Street SW
Suite 7B54
Atlanta, GA 30303
(404) 562-2156