ERISA -- Employer-sponsored Self-funded Health Benefit Plans

What is ERISA?

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law which is primarily concerned with pension plans. However, it also sets minimum standards for many employee benefits, including employer provided health coverage.

ERISA governs approximately 2.5 million health benefit plans sponsored by private employers nationwide. It does not apply to government and church employee plans. Approximately, 134 million Americans are covered by ERISA regulated medical, surgical, hospital and other health care benefits.

What is the difference between a health insurance plan and an employer-funded health benefit plan (ERISA)?

Employee benefit plans can be either fully insured, or self-funded. (Self-funded plans may also be called self-insured or non-insured).

Under a fully-insured employee benefit plan, the employer purchases commercial health coverage from an *insurance company,* and the insurance company assumes the risk for payment of claims. The insurance company is regulated under state law and is subject to rules about mandated benefits, network adequacy, prompt payment of claims, etc. Other employers create "self-funded" health plans for their employees. In these self-funded plans, the employer keeps the risk to pay the bills and usually hires a plan administrator to process the claims. When an employer self-funds the plan, it is generally not subject to state laws and regulations -- so state mandated benefits, state prompt payment rules or standards of network adequacy don't apply. Sometimes insurance companies act as an administrator to process claims for an employer self-funded plan. In these circumstances and wearing the plan administrator "hat", the health plan is not subject to state laws and regulations.

Employer self-funded ERISA plans are not subject to state insurance laws or jurisdiction.

These plans are subject to federal law.

If I am covered under an ERISA plan and my claim is denied, what steps can I take to resolve my claim?

If you are covered under an ERISA plan and your claim for benefits has been denied, take the following steps:

1. Review the summary plan description provided by your employer or plan administrator. The summary plan description gives you a detailed summary of your plan – what benefits is provides, what limits there may be, how the plan works, etc. The summary plan description also must spell out your appeal rights and the process to follow if a claim is denied.
2. Make sure you or your provider has followed the claim submission requirements. The plan must provide a written specific explanation if a claim is denied. The plan must also outline the procedures to appeal the denial, including the required deadlines.
3. Contact your employers' human resources department about the appeal. Make notes and keep copies of all communications concerning your claim, including the date, time, and who you may have spoken with.
4. Follow the requirements for the appeal and provide all required information – your provider or your employer's human resources staff may be able to assist you with this. Generally, you must file the appeal within 60 days, and then it should be decided within another 60 days (or an extension will be requested, but the decision must be made and communicated within 120 days from the filing of the appeal).
5. If the plan does not follow the appeals process, contact the U.S. Department Labor Employee Benefits Security Administration (EBSA).
6. If you cannot get relief in any other manner, you may want to consider hiring a lawyer

Who has regulatory authority for ERISA plans?

Self-funded plans fall under the regulatory authority of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). ERISA protects the benefits of employees and retired employees in private-sector pension and welfare benefit plans. ERISA sets minimum standards these plans must meet, but the Department of Labor's EBSA does not interpret plan documents or determine if individuals are entitled to benefits.
States are not permitted to regulate most self-funded plans under terms of the Employee Retirement Income Security Act (ERISA). These plans are regulated by the U.S. Department of Labor.

In most cases, this means:
- state insurance departments have no authority to investigate complaints that involve self-funded ERISA plans;
- certain other group health plans provided by governments, churches, some school districts and out-of-state employers also are exempt from most Colorado state regulations and laws; and
- state laws requiring specific benefits in health care plans (mandated health benefits) do not apply to valid self-funded ERISA plans. Federally mandated health benefits do apply.

What are required procedures for Employee Welfare Benefit Plans (Self-funded Plans)?

ERISA (Federal Law) requires that self-funded plans set up reasonable procedures for participants. These procedures, which should be outlined in the Summary Plan Description, include:

How to file claims for benefits and a timeline (usually 90 days) for the initial response to claims to be made;

How to submit a denied claim for a full and fair review.

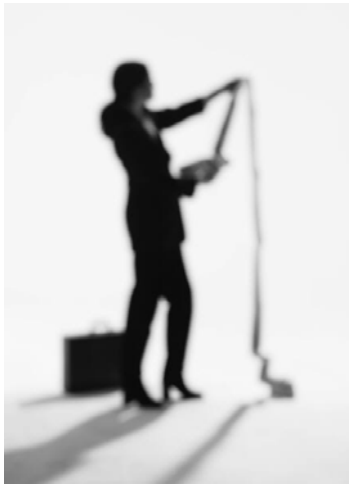
A list of specific additional information which may be required in order to appeal if a denial is made. The participant has at least 60 days in which to appeal the denied claim.

Once the final decision is made, the participant must be told the reason and the plan rules upon which the decision was based. However, ultimate authority rests with the employer, not with the plan administrator.

If a claim for benefits is denied, the participant must be notified in writing (generally within 90 days after the claim is filed) of the reason(s) for the denial and the specific provisions on which the denial is based. The decision, on review, must be furnished to the claimant and include reasons for the decision, and references to benefit plan documents that support a denial.

What is the "summary plan description" and how does it work?

Under ERISA, workers and their families are entitled to receive a summary plan description (SPD). The SPD is the document that gives information about the plan, what benefits are available under the plan, the rights of participant and beneficiaries under the plan, and how the plan works.
Among other information, the SPD of health plans must describe:



- Cost-sharing provisions, including premiums, deductibles, coinsurance and co-payments for which the participant will be responsible
- Annual or lifetime caps or other limits on benefits under the plan
- The extent to which preventive services are covered under the plan
- Whether existing and new drugs are covered under the plan
- Whether coverage is provided for medical tests, devices and procedures
- Provisions on the use of network providers, the composition of provider networks and whether coverage is provided for out-of-network services
- Conditions on primary care providers or specialty care providers
- Conditions or limits applicable to obtaining emergency medical care
- Provisions requiring a pre-authorization or review as a condition to obtaining a benefit or service under the plan.

The Summary Plan Description must explain how benefits are obtained and the process for appealing denied benefits. ERISA requires written disclosure of any material reduction in covered services or benefits to participants and families generally within 60 days of the adoption of the change. Changes that do not result in a reduction in covered services must be disclosed not later than 210 days after the end of the plan year the change was adopted.

ERISA regulation describes the consumer's right to get an answer regarding a health benefit claim. The regulation protects the consumer – providing for a timely response by describing the time frames for a decision, providing for a fair process by describing the standards for a decision, and providing for disclosure by describing the notice that a participant is entitled to receive from the plan.

A participant in an Employer-sponsored Self-funded Health Benefit Plan can dispute a denied claim through the company's written procedures. If not satisfied with the outcome of the claim review, ask the plan administrator for an interpretation of the plan documents and benefits.

If a participant believes ERISA requirements or individual rights were violated under the self-funded plan, the participant may seek professional legal advice for further review.

Do states have the authority to regulate Employer-sponsored Self-funded Health Benefit Plans?

The Colorado Division of Insurance does not have the authority to regulate other private, employer-sponsored plans that are self-funded since they are not insurance. ERISA plans are regulated at the Federal level through the U.S. Department of Labor.

States have the authority to regulate the following types of health insurance:

- individually purchased insurance,
- employer-based plans that are fully insured, and
- Multiple Employee Welfare Arrangement (MEWAs) that are either fully-insured or self-funded.

How many people in Colorado are insured under an employer-sponsored or self-funded health benefit plan (ERISA plan)?

Since it is not a requirement to report whether or not you are insured, it is always an "educated guess" about how many people are insured. The best information available indicates that about 30 percent of all Coloradans have health benefits through an "ERISA" plan, as opposed to insurance through a health insurance company or health maintenance organization. This estimate includes all Coloradans, including those who are not insured.

Of Coloradans who have health benefits through an employer, about half are covered by ERISA plans, and the remainder by traditional health insurance (whether an employer pays part of the premium or whether an individual obtains private insurance.)

Who can provide more information on Employer-Funded Health Benefit Plans?

For more information on ERISA,

call the U.S. Department of Labor at 866-4-USA-DOL.

Details on ERISA plans can be found on the Department of Labor website at:
http://www.dol.gov/dol/topic/health-plans/erisa.htm

Colorado Division of Insurance
1560 Broadway, Suite 850, Denver, CO 80202
(303) 894-7499 - Phone
(303) 894-7455 - Fax
(303) 894-7490 - Consumer Information
(800) 930-3745 – Toll Free (outside Denver)

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