Patient Advocate Foundation
PUBLICATIONS

- *The Managed Care Answer Guide*
  Available in English & Spanish
- *The Patient Pal*
  Available in English & Spanish
- *Your Guide to the Appeal Process*
  Available in English & Spanish
- *First My Illness…Now Job Discrimination: Steps to Resolution*
  Available in English & Spanish
- *Your Guide to the Disability Process*
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- *The National Financial Resource Guide for Patients: A State-By-State Directory*
- *Too Young To Be Ill...*
  A Practical Survival Guide for Caregivers of Children and Young Adults
- *Guide to Health Savings Accounts*
- *Promoting a Healthier African American community*
- *Promoting a Healthier American Indian and Alaska Native Community*
- *"A Greater Understanding" series*
  A series of pamphlets written to provide answers to the most frequently asked questions regarding health care.

If you would like further information about any of these publications, please contact our office or visit our website:

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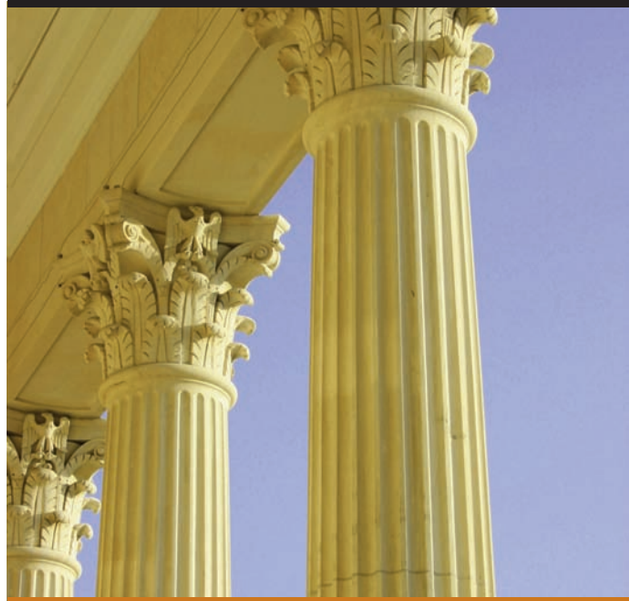
A Greater Understanding

ERISA: What is it & How Does It Effect You



PAF Patient Advocate Foundation
Solving Insurance and Healthcare Access Problems | since 1996

A Greater Understanding

Patient Advocate Foundation
MISSION STATEMENT

Patient Advocate Foundation is a national non-profit organization that serves as an active liaison between the patient and their insurer, employer and/or creditors to resolve insurance, job retention and/or debt crisis matters relative to their diagnosis through case managers, doctors and attorneys. Patient Advocate Foundation seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability.

Editors Note:

This is the seventh in the series "A Greater Understanding" brochures developed by the Patient Advocate Foundation. The information contained herein is in response to frequently asked questions (FAQ's) by patients. This brochure is intended to provide a general yet informative response to these inquires. Any incident, inquiry or issue may vary according to these specific facts and circumstances relating to the individual.

Employee Retirement Income Security Act of 1974 (ERISA)

A federal law established to protect the rights of employees and the security of their retirement funds, medical insurance, vacation benefits, training programs, corporate daycare centers, scholarship funds, and other employee welfare benefit plans. ERISA sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. For the purpose of this brochure, PAF will be focusing on group health and disability plans such as Long Term and Short Term Disability.

In general, ERISA covers any employer with a retirement plan and/or employee benefit plan. Only a few plans are exempt such as group health plans established or maintained by governmental entities (federal, state and local government), church plans, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans. **For more information about ERISA you may visit, www.dol.gov/ebsa**

There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries. One important amendment, the **Consolidated Omnibus Budget Reconciliation Act (COBRA),** provides some workers and their families with the right to continue their health coverage for a limited time after certain events, such as the loss of a job. Another amendment to ERISA is the **Health Insurance Portability and Accountability Act (HIPAA)** which provides important new protections

for working Americans and their families and who have group benefits and who might otherwise be uninsurable. Other important amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

ERISA requires that sponsors of private employee benefit plans provide participants and beneficiaries with adequate information regarding their plans.

In addition under the ERISA law, your employer must provide you with a copy of your summary plan description (SPD) and plan documents within 120 days after the plan became effective. The plan administrator must also distribute SPD's to participants and beneficiaries every five years unless no changes have occurred at which time the administrator may wait 10 years. If a beneficiary requests a copy of the SPD and/or complete plan language it must be supplied within 30 days after receiving the written request. The request must be made to the Plan Administrator with reference to the ERISA law. Failure to comply can result in a penalty of up to $100 per day and is governed by the Department of Labor (DOL).

Under ERISA an employer is required to provide adequate notice to a plan participant whose claim for benefits has been denied.

In the case of group health or disability plans, the notice must contain information about any internal rules, guidelines or protocols that were relied upon when making the decision. The denial letter must outline "the specific reason for such denial, written in a manner calculated to be understood by the plan participant." For example if the decision is based on a plan limitation that excludes treatments that are not medically necessary or are experimental, the notice must explain that scientific or clinical reason for the decision. In addition, the plan participant must be given "a reasonable opportunity…for a full and fair review (ERISA Sec. 1133)."

Under ERISA regulations, a denial of any claim for benefits must be made "within a reasonable period of time." As a general rule, a period over 90 days is deemed unreasonable. If circumstances require a longer processing time, the plan may request an extension up to an additional 90 days after the participant has been given notice. When an urgent case is in need of an expedited decision the plan must make its determination "as soon as possible, taking into account the medial exigencies," but no later than 72 hours after receipt of the claim unless the claim does not provide enough information to make a determination. The Department of Labor emphasizes that no time extensions are allowed in urgent cases. The determination of whether a claim is considered urgent can be made by a person acting on behalf of the plan 'applying the judgment of a prudent layperson possesses an average knowledge of health and medicine." In addition, the plan must notify the patient within 45 days if a benefit claim is incomplete and specify the information required to complete the claim. The participant must be given at least 180 days to complete the claim. It is important that both the plan and the patient follow the deadlines given for appeal. In many cases the plan will no longer view the case if the deadline has passed.

There are three forms of ERISA plans:

- **Fully Funded**
- **Self Funded**
- **Self Funded with Third Party Administrator.** It is imperative to understand the different types of plans as they can offer different appeal options.
- **A Fully Funded or Fully Insured Plan:** Group coverage that an employer purchases, on behalf of their employees, from an insurance company. Products are limited to those offered by the insurance company. Employee contributions, i.e.: premium payments are utilized to cover the cost of the purchased price of the plan. The major benefit of obtaining a fully insured program is that there is no financial risk to the employer. Typically employers with fewer than 50 employees tend to offer a fully funded plan. **Under this plan the beneficiary must follow the appeal rights under it's plan language.**
- **Self-Funded with a Third Party Administrator:** This type of coverage is provided by employers who pay for their own claims but contract with an insurance company to process claims and oversee benefit administration. Employee contributions, i.e.: premium payments are housed in a healthcare fund and used specifically for beneficiary claims. The benefit coverage may either be determined by the employer or chosen from a list of existing products offered by the contracted insurer. Typically a self-funded plan has a stop-loss or reinsurance that will start paying claims after the employer has met what they have established as their cap. For example a large company may choose to elect a self-funded plan and create a $50,000 cap per beneficiary per year. Once this cap is met they have purchased reinsurance to start paying where the employer left off, this should not affect the beneficiary and usually is a smooth transaction. This plan shows to be cost effective for large employers. A positive aspect of this type of plan is if a denial is upheld through the plan administrator you may be able to request a compassionate exception from the employer themselves. Keep in mind if the stop loss has been met this becomes more difficult as the employer no longer controls payment of claims. An important benefit to self-funding is that self-funded plans are regulated by ERISA, which allows the employer to avoid costly individual state-mandated benefits. Also the same plan can be administered at other locations when a multi-state company is involved. **Under this plan the beneficiary must follow the appeal rights under its plan language. However, if the appeals process Third Party Administrator upholds the denial, the beneficiary has the option of appealing to the employer. Should the employer overturn the denial, the employer then becomes responsible for paying the claims regardless of whether or not the stop loss has been met.**
- **Self-Insured:** This type of coverage is provided by employers who both process and pay their own claims. Employee contributions, ie: premium payments are housed in a healthcare fund and used specifically for beneficiary claims. The benefit coverage is determined by the employer. A positive aspect of this type of plan is if a denial is upheld by the plan administrator you may be able to request a compassionate exception from the employer themselves.

ERISA plans are enforced by the Department of Labor's, Employee Benefits Security Administration (EBSA).

You may contact your local office calling 1.866.444-3272 or reviewing http://askebsa.dol.gov/. ERISA plans are immune from state regulation and the State Insurance Commissioner, who can only investigate non-ERISA plans. If your appeal levels have been exhausted you can only contest an ERISA case in Federal Court and an attorney is necessary. Generally consumers have fewer rights under ERISA plans, but some states have been able to modify ERISA loopholes. ERISA plan benefits can be changed at will, and may offer less coverage then traditional plans and may not include state-mandated benefits or be subject to state laws. As medical costs escalate ERISA plans increasingly take back benefits. In addition under ERISA plans don't have to follow standard practices, they may drop benefits without prior notice to the insured. ERISA plans only need to notify the insured within sixty days after the fact. It is important to note that under ERISA, if a consumer is denied treatment he or she may be able to collect punitive damages or compensation only if his or her state has mandated that right under state law. For more information on if your state offers such a law you may visit, http://info.insure.com/health/lawtool.cfm.

It is important to understand the basics of ERISA, however it is a complex law and may require the expertise of an ERISA professional. You may seek the assistance of a professional case manager at the Patient Advocate Foundation, **toll-free at 1-800-532-5274** or via the **internet at help@patientadvocate.org.**

The Patient Advocate Foundation offers direct patient services by professional case managers to assist patients through all of the insurance obstacles that they may face. PAF services and publications are provided at no charge to patients.