

## What Does ERISA Mean to Healthcare Coverage in DC?

ERISA (Employee Retirement Income Security Act of 1974) is the federal law that establishes minimum standards to safeguard consumers who participate in pension and health plans sponsored by private employers. ERISA is amended by additional laws including:

- COBRA (Consolidated Omnibus Reconciliation Act of 1985)
- HIPAA (Health Insurance Portability and Accountability Act of 1996)
- Newborns' Act (Newborns' and Mothers' Health Protection Act of 1996),
- MHPA (Mental Health Parity Act of 1996), and
- WHCRA (Women's Health and Cancer Rights Act of 1998).

ERISA has some basic requirements for plans that protect their insured.

- Plans must disclose important information about the plan such as plan rules and procedures (for enrollment, appeals, etc.), plan finances, and how the plan is managed. Plan administrators must provide plan participants with a summary plan description (SPD) that includes costs to enrollees (e.g., co-payments).
- Plans must establish a grievance and appeals process.
- Plan participants have the right to sue their plan in federal court for certain reasons:
  - Benefits under the plan and
  - Breaches of fiduciary duty.

### How Do I Know if ERISA Applies to a Health Plan?

ERISA applies to employee health benefit plans that are not church plans, union plans, or governmental (federal, state, or local) plans. If one gets insurance directly through the employer, he/she is probably in an employee health benefit plan. (However, if the insured pays the insurance company directly for coverage, even if the employer provides extra money or a voucher to pay for the coverage, it may not be an employee health benefit plan.) If the insurance is obtained indirectly as a dependent through the employer of the spouse or parent, it probably is an employee health benefit plan. However, if one gets insurance directly through an insurance company or through school, he/she probably does not have an employee health benefit plan but an individual policy.



Employee health benefit plans do not include individual insurance for the self-employed or government-sponsored programs (such as Medicaid, Medicare, or SCHIP).

If health insurance is through a federal health plan (i.e., TRICARE or the FEHBP), a union plan, church plan, or a state employee health benefits plan, enrollees have different rights than those of individuals who get their benefits through a private sector employer. For these other plans, the plan itself or a local health insurance assistance program can explain more about the enrollee's rights.

### **Are there any other rights besides ERISA for insureds in the District of Columbia?**

Yes, if the group health plan is “fully insured.” An employee health benefit plan that is covered by ERISA can be either self-insured or fully insured. The difference between a self-insured and fully insured plan is whether or not an insurance company or the employer is responsible for paying claims when they are incurred. If the employer provides the funds to pay for claims, then the coverage is self-insured by the employer. If the insurance company is responsible for paying for claims, then the coverage is fully insured by the insurance company. The easiest way to find out what kind of plan it is is to ask the employer or to call the phone number on the insurance card and ask if the plan is self-insured or fully insured. If the employer offers more than one plan, make sure to specify the plan.

Do not assume that because an insurance company's name is on the insurance card that it is a fully insured plan. The insurance company may be a “third party administrator” or “TPA” for the employer. That means that the employer may have made arrangements with the insurance company to provide administrative duties like determining eligibility for coverage according to the terms of the plan and paying claims. The “summary plan description” or “SPD” booklet (given to all enrollees upon enrollment in the plan) should also indicate if the plan is self-insured or fully insured.

It is common for very large employers to self-insure, while smaller employers almost never self-insure. Self-insured plans are required by law to register with the US Department of Labor so if you are still unsure what kind of plan it is, contact the US Department of Labor at 1-866-444-EBSA (3272), the state insurance department, or a local health assistance program.



**What are the rights under ERISA (and the federal laws that amend it) and DC law?**

ERISA protections apply to all group plans that meet the definition of an employee health benefit plan, but, in DC, as in several states, additional rights apply only to fully insured plans.

	<b>ERISA Self-Insured and Fully Insured Plans</b>	<b>DISTRICT OF COLUMBIA Fully Insured Plans</b>
<b>Appeal Rights</b>	A plan must provide enrollees with an opportunity to appeal any “adverse benefit determination” or denial at least two times. There are 180 days to make an initial appeal, and there is right to an expedited appeal if the claim is urgent. The person reviewing the appeal must be different from the person who made the original decision and must take into consideration all the information, including any additional documentation, provided for the appeal. The enrollee may be represented in the appeal by someone else designate by the enrollee. If he/she does not like the final decision, he/she may sue the plan in federal court.	In the District, after an enrollee exhausts any appeal processes within the plan, he/she can appeal a medical necessity denial by filing a grievance with the Department of Health. If the case qualifies for an external review, the Department will assign the case to an Independent Review Organization. For more information on these rights, contact the Department of Health at 202-442-5979.
<b>Disclosure Requirements</b>	The plan is required to provide enrollees with a summary plan description (SPD) and any updates to the plan. The SPD outlines the plan rules, such as how the plan determines if a service is covered and the responsibilities of plan participants. The patient also has a right to view a record of any decisions made about coverage.	DC law has no additional disclosure requirements.
<b>Mandated Benefits</b>	The Women’s Health and Cancer Rights Act (WHCRA) requires plans that cover mastectomies to also cover reconstructive surgery. Newborns and Women’s Health Act (Newborns’ Act) requires plans to pay for minimum hospital stays after childbirth.	The District’s laws that mandate certain benefits include coverage related to diabetes, breast reconstruction surgery, maternity care, Pap smears, and mammograms. You can contact the Department of Insurance, Securities, and Banking at 202-727-8000 for more information.
<b>Continuation of Coverage</b>	COBRA gives an enrollee the right to continue the group health coverage for 18 to 36 months after the subscriber leaves the job, if the employer has 20 or more employees. The law allows the employer to stop contributing to the cost of coverage and allows the employer to charge the enrollee up to 102% of the cost of the coverage.	The DC Council passed a law after September 11, 2001 that provides for employers with fewer than 20 employees to offer most employees and their dependents who have fully insured health benefits up to three months coverage. If an enrollee is losing coverage and is not eligible for COBRA or this recent law, contact the Department of Insurance at 202-727-8000 to find out if there are any other rights.

