

## ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted by Congress in response to concerns about the reliability and solvency of employee pension and benefit plans. ERISA regulates the administration of these plans, which includes the health plans of millions of Americans. ERISA does not mandate that specific benefits be provided in health plans. State insurance law may regulate or mandate what types of benefits must be included in health plans sold by insurance companies in a particular state. However, employers that provide health insurance to their employees through self funded plans are not covered by these state laws. The rights created by ERISA for plan participants and beneficiaries relate to the manner in which the plans are administered. These include:

- *The right to receive comprehensive information about the plan including:*
- *Procedures for presenting a claim for benefits;*
- *Procedures for seeking a review when the claim is denied;*
- *The right to receive the plan information within 30 days of the request (mailed within 30 days). If the administrator of the plan fails to comply, the participant/beneficiary can initiate a lawsuit. The court can require the administrator to pay up to \$100 a day for failure to provide the information.*
- *The administrator must provide written notice when a claim is denied that articulates the specific reasons for the denial.*

The participant/beneficiary has a right to a "full and fair review" of the denial claim. However, this does not have to be done by a third party and can be done by the administrator. ERISA prohibits any discrimination, suspension, fining or disciplining when an employee exercises these rights.

ERISA provides that certain remedies are available if a participant/beneficiary is denied a benefit under the plan. The law is unsettled at this time regarding whether the remedies created by ERISA apply to ALL employee insurance plans and thus "preempt" state law protections. Some appellate circuits have ruled that ERISA preempts state law remedies and protections for all employee insurance plans – even those that are not self-funded.

This is very problematic for the following reasons:

ERISA allows a participant/beneficiary to bring a lawsuit to recover benefits under the plan, but all that is recoverable is the cost of the benefit (i.e., the cost of durable medical equipment, dialysis, etc.). Lost wages, pain and suffering, punitive damages for failure to provide services that are necessary are not allowed under ERISA.

State law claims for breach of contract and "bad faith" claims by which a person can recover compensatory and punitive damages (described in 1) are a motivation for insurers to provide appropriate services in a timely fashion rather than risk having to pay a hefty damage award. There is a disincentive for consumers to bring a lawsuit where the only remedy is the amount of the benefit and, if successful, attorney fees. The



substantial amount of money required to bring the suit and the risk of losing attorney fees makes it unreasonable for most individuals to do so.

Most states have created systems where individuals with employer insurance (not self-funded) can have their claim denial reviewed by an outside agency or medical reviewer. Health insurers are challenging this review system as being outside the scope of normal insurance regulation and in violation of ERISA. The U.S. Supreme Court will be reviewing a case where the Appellate Court ruled that the state's review law was NOT preempted by ERISA.

Some members of Congress are attempting to "amend" ERISA by passing a "Patient Bill of Rights" to make the rights and remedies of insured individuals uniform. There is continued debate over the circumstances under which a plan participant/beneficiary can sue, the damages that can be recovered in court, the governance of the review process, etc. These are complicated but very important issues for advocates.