

Health Benefits Plan Coverage

The Problem

Employers often don't know their rights or liabilities when it comes to health benefit plan coverage of employees who have ceased working for one reason or another. Leaves of absence, layoffs, and terminations are the usual reasons this issue comes up. Sometimes, employers continue health benefits coverage when they needn't, or when it isn't even an available option. The worse case scenario occurs when an employer continues to pay the premiums for coverage, and, despite this, the health plan's insurance carrier later refuses to pay the employee's claims on the basis that the employee's coverage lapsed under the terms of the plan. In that case the employer may be liable for paying for all the employee's health claims from its own assets. Even if an employer self-funds its health plan, i.e., agrees to pay its employees' health claims out of its own assets unless they exceed a certain cutoff point, this can become a problem. Are there any general guidelines an employer can rely upon in this area?

The Solution

Typically, the definitions for coverage, eligibility and participation in a health benefit plan describe the employees covered by the plan, including the number of hours an employee must work on a regular basis in order to be eligible to participate in the plan and continue to be covered. Ordinarily these definitions are in the employer's insurance contract or the benefit plan booklet given to employees.

When an employee is terminated or the employee ceases to work the number of hours required by an insured plan for continuing coverage, as may be the case when an employee is on a prolonged leave of absence, the employee's coverage generally terminates. Unless an employer has notified its insurance carrier and received its written approval to amend its eligibility rules to cover an otherwise ineligible employee, that person should not be continued under the employer's plan.

Similarly, in a self-funded plan, where the employer generally has stop-loss insurance or reinsurance to reimburse the employer for claims above a certain point, an ineligible employee should not be continued under the employer's plan. The stop-loss carrier can refuse to reimburse the employer for claims over the cutoff, or "attachment" point.

Caveat 1: In addition to insurance contract obligations, employers with 50 or more employees within a 75-mile radius are generally required to continue an eligible employee's health benefit coverage for up to 12 weeks during a authorized Family & Medical Leave Act ("FMLA") leave of absence. State law may provide additional weeks of health benefit coverage.

Caveat 2: Beyond that, an employee has health benefit continuation rights under COBRA, which extends for 18 to 36 months, depending on the triggering event. COBRA applies to all health benefits, including health, dental, vision and prescription drug plans, and health flexible spending accounts.

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