

# Self-administering, Insuring and Funding Benefit Plans

*Bringing benefits in-house has advantages, but it also raises legal obligations and challenges*

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Offering life, health, and disability benefits to employees used to be simple. Employers would receive proposals and select from a number of insurance companies. Except for a few administrative details, the insurance companies would do the rest.

Those days are gone. Now, when employers decide to offer life, health and disability benefits to their employees, they are presented with an array of alternatives, including self-administration, self-funding and self-insurance through captive insurance companies. As a practical matter, it can be difficult to understand these alternatives, compare them, decide among them, and, ultimately, manage the one that is selected. As a legal matter, it is important to appreciate that each alternative carries a different set of legal obligations, exposures and challenges, and is governed by a different combination of private contracts, state and federal laws and state and federal regulations.

This chapter illustrates the various advantages and disadvantages of each of these alternatives, provide information relevant to contract negotiation and evaluation, and provide guidance as to the handling of various types of issues that may arise.

## **Self-administration of Insurance Policies**

The simplest option — and the one that most closely resembles the historical model described above — is for corporations to self-administer traditional insurance policies that they purchase from insurance companies. In this context, self-administration typically involves, among other things:

- providing a minimum level of mandatory life insurance to employees;

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- offering employees the opportunity to purchase supplemental life insurance for themselves, their spouses and their children;
- advising employees of any requirements imposed by the insurance companies, such as providing evidence of insurability under certain circumstances;
- calculating the premiums for the insurance purchased by the employees and deducting them from employees' paychecks;
- forwarding the premiums, and necessary premium-related information, to the insurance companies; and
- maintaining records of the voluntary supplemental insurance that employees have purchased and paid for.

One self-administered hospital system learned the hard way about the challenges of self-administering its life insurance plan. There, a benefits administrator advised an employee that he was entitled to purchase an increase in benefits without any additional documentation, such as providing evidence of insurability. Evidence of insurability was provided a form on which the employee would provide basic health-related information, and which the insurance company would review to decide if the employee was eligible for the requested benefit. The company deducted a premium for the increased benefit from the employee's salary for several months. Then, suddenly, the employee died. When his widow filed a life insurance claim, the life insurer denied coverage for the increased benefit. The reason given was that evidence of insurability had been required for the increase. The coverage was not in place because evidence of insurability had not been obtained.

It turned out that the mistake arose because of an ambiguity in the wording of the evidence of insurability requirement in the summary plan description (SPD). The SPD had been written by the life insurer, so the ambiguity was technically the life insurer's fault. Regardless, it was the employer that put its name on the SPD, provided the SPD to the employee, told the employee the coverage was in place, and deducted premiums for it from the employee's paychecks. Ultimately, the employer itself ended up paying to the widow a sum equal to the denied life insurance benefit.

Every homeowner knows that there's no such thing as just one mouse. The same axiom applies to mistakes in self-administration of insurance plans. Once a mistake has been discovered involving a single employee, a prudent employer should at least consider the possibility that there may be others in the same situation.

With that in mind, the following is a list of some issues that HR personnel should consider when first alerted to a seemingly isolated mistake.

### **Internal Controls**

Is the corporate counsel (in large companies) or legal advisor sufficiently involved in the systems used by HR and benefits personnel to identify and enforce the requirements of a self-administered insurance plan? Especially since the passage of the Sarbanes-Oxley Act of 2002, it has become increasingly risky for an employer to have limited or no oversight in this area. Plan sponsors now face a greater risk of up-front liability. As a first step to having adequate controls, the counsel or advisor should

have a clear understanding of the differing legal obligations and exposures involved in being: (a) self-administered; (b) self-funded; (c) self-insured through a captive insurance company; or whatever combination of these approaches has been selected. Appropriate controls may involve periodic reviews of the various HR forms, revising as necessary to achieve accuracy, consistency, lack of ambiguity and conformity with the underlying plan documents, insurance policies and relevant laws. Other controls may involve periodic reviews of the employee's deductions to verify that the sums being deducted from their paychecks are in accord with the benefits they have selected — and that are in place. Still other controls may involve review of the personnel in the HR department, including hiring practices, training and turnover.

### **Potential Financial Exposure**

Once a benefits issue is recognized for a single employee, all efforts should be made to locate others in the same situation, and to put a dollar value on the benefits at risk. Although tedious, this task must be undertaken promptly, since it will enable corporate counsel to assess the severity of a situation and the resources that should be devoted toward finding a solution. It also will enable public companies, in conjunction with their lawyers and accountants, to assess the need, if any, for disclosures of potential exposure in various filings.

### **Potential Legal Exposure**

Conducting an immediate search for others in the same situation, as described above, has legal benefits in addition to financial ones. For example, if a second issue of the same type is identified, after a company has arguably been placed "on notice" of the problem, the corporation's legal exposure could be different, and possibly higher, than it was the first time. But it would be a good faith defense for a corporation to show that it took steps immediately to identify and avoid continuing problems of that kind and that, although those steps may have failed to address the second issue, they may have succeeded in preventing any further incidents.

### **Labor Relations**

At all levels of a company — from the boardroom to the mailroom — employees can be extremely touchy about errors in their benefits administration. This sensitivity was heightened by the collapse of Enron Corporation and the substantial amount of publicity accorded to Enron employees whose 401(k) funds fell victim to mismanagement. Recognizing this environment, HR personnel are well-advised to move benefits problems to the front burner as soon as they are identified, and to resolve them as quickly and quietly as possible.

### **Legal Complexities**

Problems that arise in connection with benefits can be exceedingly complex as a legal matter. These complexities arise from the juxtaposition of the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Internal Revenue Service provisions, the Sarbanes-Oxley Act, state contract law, state insurance laws and regulations, including mandatory benefits laws, and state unfair trade practices acts, among other things.

To cite one example, if an employee sues his or her employer for the wrongful denial of a health benefit, that suit ordinarily would arise under ERISA, which would preempt both state law and the jurisdiction of state courts (see below). If the same employer sues its stop-loss insurance company for wrongful denial of a claim, that suit ordinarily would arise under state common law for breach of contract, and the state courts would have jurisdiction.

### **Third-party Responsibility**

Due to the nature of self-administered insurance policies, it is relatively easy for employers to conclude — or for insurance companies to convince them — that inconsistencies and possible errors with coverage are solely the result of administrative errors by the HR department rather than recordkeeping errors by the insurer. Often, however, this is not the case. This fact is important because the party responsible for the error typically is the one that is held accountable for paying for it. Employers should not allow themselves to take the fall for errors their insurers make.

It can be very challenging to identify the origin of coverage mistakes, especially when they are made by third parties. HR departments often are understaffed and overworked, and lack the resources and technological capacity of the insurance companies that are deeming them to be accountable. But history has shown that it is very important for employers to invest themselves fully in such efforts. One company, for example, discovered through this process that it had correctly processed millions of dollars of life insurance coverage, but that its insurer had failed to record the coverage correctly at its end. Thus, what initially appeared to be an error by the company turned out to be an error by the insurance company. By working pro-actively together, the corporation and the life insurance company were able to coordinate their records, avoid coverage errors and get the insurance plan back on track.

### **Self-funding of Benefit Plans**

Each year, most large employers — and an increasing number of mid-sized and small employers — choose to self-fund their employee health plans, rather than purchase traditional health insurance. Employers often choose to self-fund based on a general understanding of the cost-saving features of self-funding, such as avoiding premiums, premium taxes and state mandatory benefits laws. All too often, though, they do not fully assess and appreciate the risks that they are assuming and do not understand the small print of the interrelated contracts and policies that are at the heart of most self-funded plans.

As a legal matter, self-funding a health plan is different from purchasing an insurance policy for the benefit of a company's employees. Essentially, under self-funding, the sum that traditionally would be paid by employees as an insurance premium instead is paid to an entity, typically known as "the XYZ Corporation Self-Funded Benefits Plan." The company uses these funds to pay the employees' benefits in a process that is roughly equivalent to, although legally distinct from, an insurance company's payment of insurance claims.

In most cases, the corporation enters into a contractual relationship with an administrator — typically an insurance company — to perform the insurance-specific functions that are required, such as providing self-funded health plans with a network of physicians, laboratories and hospitals, processing claims and determining which ones

should be paid. In addition, the corporation typically purchases a stop-loss insurance policy to cover losses that exceed certain agreed-upon amounts. Both of these contracts are between corporations and entities that either are, or are closely affiliated with, insurance companies. But only the latter type constitutes an insurance policy, with the attendant legal consequences of one.

### **The Advantages of Self-funding**

From a legal perspective, the principal advantage of self-funding is that, for the most part, self-funded plans are not subject to the state laws and regulations that apply to insurance companies. There also are various financial and tax advantages that can flow from self-funding. Instead, most of the activities undertaken by self-funded plans are governed exclusively by ERISA. As a result, most of the activities of self-funded plans fall under the purview of the U.S. Department of Labor (DOL). Except for a few exceptions, self-funded plans can be sued only in federal court, and only to the extent that suits are allowed under ERISA. The legal principle that imposes these two limitations is known as “preemption.”

Since 1974, when ERISA was passed, lawsuits against self-funded plans have been limited in scope due to preemption. For example, participants in self-funded plans have been allowed to sue only for wrongful denials of claims, and for equitable relief. If they win, the most that they can recover is the value of the benefit, interest and the costs of litigation, including attorney’s fees. Notably and controversially, ERISA has precluded the recovery of other damages, such as non-economic consequential damages and punitive damages over and above that amount.

Preemption also means that self-funded plans generally are not subject to regulation by the state insurance departments because they are exempt from state laws that regulate insurance — particularly state mandatory-benefits laws.

State mandatory-benefits laws are laws requiring insurance companies to pay for certain illnesses and conditions, no matter what their insurance policies say. For example, an insurance policy may contain a specific exclusion for infertility coverage. That policy may be sold in a state that mandates coverage for certain infertility treatments, such as in vitro fertilization. The insurance company will have to pay for that treatment despite the presence of its specific exclusion because the mandate trumps the policy language.

To make matters more complicated, each of 50 states and the District of Columbia has a set of mandatory benefits. No two states have exactly the same ones. Some states, like Maryland, California, Florida and Texas, have 40 or more of them. Other states, such as Utah, stick with three or four. Substantively, the mandates vary wildly. Most states mandate coverage for “mainstream” health issues, such as cancer screenings. Other mandates, though, are state-specific. For example, some states mandate coverage for “scalp hair prostheses,” meaning toupees, under certain circumstances. Others mandate coverage for things like infertility treatments, osteoporosis testing, attention deficit disorder treatment and port wine stain elimination.

Particularly for large corporations that provide benefits to employees in many states, mandatory-benefits laws can present daunting problems. Among other things, it may be difficult, under certain circumstances, to assess the scope of the coverage being provided. Such an assessment might require a particular employer, or insurer, to take

into consideration each and every mandate in each and every state that might apply to its employees. The opportunity to avoid these complexities through self-funding, and the corresponding preemption doctrine, is one reason why self-funding is appealing to many companies.

### ***The Disadvantages of Self-funding***

The principal disadvantages of self-funding derive directly from its principal advantage: cost-savings. A self-funded employer saves money by assuming many of the obligations and liabilities that traditionally fell to the insurance company. The price of the cost-savings is that, if there is a wrongful coverage denial, the employer might be held responsible for it.

Certainly, an employer can seek relief from the third party administrator (TPA) it hired to administer the plan, and whose advice it was relying on when it denied the claim. But since TPAs lack a contractual relationship to the plan participant, it is not accountable directly to the claimant. Also, TPAs often contend that they are not responsible for wrongful denials of coverage, relying on obscure and ambiguous contractual provisions. At times, TPAs claim that they only make recommendations to corporations about whether or not claims should be paid, but not the ultimate claim determinations. In short, whenever problems arise in connection with self-funded plans, they have a way of getting blamed on the employer, which is, conveniently, the entity with the least knowledge about the insurance field.

The best way for self-funded employers to protect themselves from the risks inherent in self-funding lies in education and careful planning. Among other things, the decision of whether to self-fund should be made in consultation with legal counsel, not by HR personnel alone. Similarly, once the decision to self-fund has been made, legal counsel should be called upon to review the small print in the summary plan descriptions (SPDs), TPA agreements and stop-loss insurance contracts. Although many corporations do not realize it until they find themselves with serious problems, the presence or absence of just a few words in these contracts can have implications worth millions of dollars.

The following is a summary of some of the contractual issues that companies should think about, either when they first decide to self-fund or when the time comes to renew or replace their existing contracts and policies.

#### ***Does the TPA Contract Minimize the TPA's Obligations?***

More often than not, companies enter into contracts with TPAs to administer their self-funded plans. In most respects, these relationships fall outside of ERISA and are governed by the contract terms, as interpreted under state law. Typically, these contract terms derive from standard forms that are drafted by the TPAs and that ultimately are designed to protect their interests over the interests of their clients. For various legal and factual reasons, contractual terms and provisions that do so may not be enforceable on their face. Nevertheless, corporations should scrutinize these agreements carefully during negotiations and propose changes or amendments that are necessary for their own protection.

The issue of "agency" is a prime example. Typically, TPA agreements attempt to define the nature of the legal relationship between corporations and TPAs. Standard-form

language defining the legal relationship between TPAs and corporations varies greatly from one TPA to another. The following two provisions, which are drawn from actual TPA agreements, illustrate how great the differences can be:

Agency Relationship – [TPA], in performing its obligations under this Contract, is acting only as agent of the Contractholder and the rights and responsibilities of the parties shall be determined in accordance with the law of agency....

\* \* \* \* \*

### RELATIONSHIP OF THE PARTIES

In performing services under this [TPA] agreement, [the TPA] performs all acts as an independent contractor and not as an officer, employee or agent of Employer or Plan Administrator (if other than Employer) or Plan. Nothing in this Agreement shall be construed to mean that Employer retains any control over the manner and means of how [the TPA] performs the services provided for herein.

### 10 Contractual Issues to Consider When Deciding Whether to Self-Fund

- 1) Does the TPA contract describe the TPA's obligations?
- 2) Is the TPA required to make claim determinations?
- 3) Who is responsible for errors in summary plan descriptions?
- 4) What are the TPA's indemnification obligations?
- 5) Does the TPA contract include run-out services?
- 6) Are there gaps in stop-loss insurance coverage?
- 7) Does the stop-loss insurance policy permit "lasering"?
- 8) Has attention been paid to the applicable state laws?
- 9) Does the company's consultant really understand self-funding?
- 10) Is the company paying more than it should?

Also important is the question of the TPA's status as a fiduciary. It always is helpful, although not necessarily decisive, for TPA agreements to identify TPAs as ERISA fiduciaries. Thus, anyone reviewing or negotiating a TPA agreement should pay careful attention to the presence or absence of this particular word.

Under ERISA, a person is a fiduciary "to the extent" he or she: 1) exercises discretion over the management or administration of a plan; or exercises any authority or control over the management or disposition of plan assets; 2) renders investment advice for a fee or other compensation; or 3) has any discretionary authority or responsibility in the administration of a plan.

ERISA's test of fiduciary status requires the application of its definition, despite the actor's official status or title. Thus, courts are increasingly inclined to find that a person is a fiduciary if the person exercises any authority or control over the disposition of plan assets, despite what the contracts say. For example, a claims administrator authorized to write and sign checks from a plan account was held accountable as a fiduciary for erroneously paying \$600,000 in claims to hospitals and others for a child who turned out to be ineligible to participate in the plan (*IT Corp. v. General American Life Ins. Co.*, 107 F.3d 1415, 1421 (9th Cir. 1997)).

*Is the TPA Required to Make Claim Determinations?*

It is common for TPAs to draft plans that attempt to provide – at least on paper – that corporations, rather than TPAs, are responsible for making ultimate decisions about such matters as coverage, just as they may draft plans that affirmatively designate corporations as the plan fiduciaries. Such language can be used by TPAs as swords against the corporations that they are supposed to be protecting. For example, such language has been used by TPAs to argue that only the corporations – and not the TPAs themselves – bear liability for coverage determinations and other matters under ERISA. The threat of sole liability for incorrect decisions can, if used effectively, motivate corporations to do whatever their TPAs say – even if the TPAs are deliberately providing advice that runs contrary to the corporations’ interests and serves undisclosed interests of the TPAs.

Corporations can avoid these problems by affirmatively establishing in their contracts that at least some, if not all, of the liability for incorrect decisions remains with the TPAs. In fact, it makes no sense for corporations to have sole liability because, unless their ordinary business activities outside of their self-funded plans happen to pertain to health insurance, they usually are not capable of protecting themselves against that liability. Take, for example, the decision of whether to approve payment of medical benefits. Most corporations have no ability to make determinations regarding such matters as medical necessity, coverage and plan administration. Similarly, they do not possess the infra-structure that is required to make these decisions well, including computerized databases, actuarial tables, an ability to assess and compare billing codes and practice, and so on. In fact, they do not even have access to medical documentation and information regarding their own employees and plan participants. For reasons of patient confidentiality and in accordance with federal health and employment laws like HIPAA, such data may be exclusively in the possession of their TPAs.

Conversely, it is a recipe for disaster when TPAs have no liability for coverage determinations. This situation creates an unnatural temptation for TPAs to recommend coverage denials, especially if the TPA has a corporate relationship (as is often the case) with the corporation’s stop-loss insurance company. The temptation is particularly strong when the TPAs know that the corporations have no idea whether or not the claims should be paid.

The following examples of standard-form language illustrate that there are many different ways of dividing up liability between corporations and TPAs:

2) ...Claims Administration – [TPA] shall process requests for benefits and pay such benefits using [TPA's] normal claim determination, payment and audit procedures, and applicable cost control standards....

\* \* \* \* \*

... Plan Supervisor shall:

A. Adjudicate (exercising ordinary care and reasonable diligence) group benefit claims in accordance with the terms of the Plan Document ....

The latter contract conspicuously fails to define the term “adjudicate.” It does, however, contain a separate rider entitled “Addendum for Claim Appeal Determination Services” that states:

Where any claim is initially denied in whole or in part [Plan Supervisor shall have the] duty to:

- (i) Provide a notice to the claimant ...;
- (ii) Reference specific provisions on which the denial is based;
- (iii) Describe any additional information or material necessary to perfect the claim...;
- (vii) Provide an explanation of the scientific or clinical judgment on which the denial was based...; [and]
- (viii) The identity of any medical experts consulted in review of and response to an appealed adverse determination ....

By comparison, the first contract is relatively simple. In layman’s terms, it essentially requires the TPA to do the things that TPAs ordinarily do. This language necessarily includes making coverage decisions, which is one of the most important functions of a TPA.

The second contract is a more complicated route to the same outcome. It essentially functions like a “scheduled risk” insurance policy, in that it lists out many of the daily obligations of the TPA. This approach also ends up including coverage determinations, although the use of the undefined term “adjudicate” gives grounds for ambiguity.

### Consequence of TPAs Not Making Coverage Determinations

The following circumstance illustrates some of the problems corporations can face when their TPAs fail to make coverage determinations.

A car dealership with a self-funded plan discovered that one of its mechanics was suffering from cancer. The mechanic’s doctors had prescribed a bone marrow transplant. Instead of granting or denying coverage for the transplant, the TPA contacted the dealership and asked whether or not to pay. The TPA advised that, since an argument could be made that the transplant was experimental and therefore not covered, the TPA had decided that the dealership should make the decision.

The dealership was very unhappy — first, because it paid a substantial fee to its TPA in the expectation that the TPA would make such decisions; and second, because it had no idea how to do so itself. On the one hand, the dealership felt obligated to pay the claim, both to help its employee and to avoid an employee relations problem. On the other hand, the dealership feared that it would be improper to spend plan assets, including the contributions of other employees, on an expensive medical procedure that might not be covered.

The dealership could have avoided this problem by obtaining contractual provisions that clearly required the TPA to make claims determinations.

### Who Is Responsible for Errors in SPDs?

In most cases, SPDs are drafted by TPAs, although they are printed on the employer’s stationery and the employer, not the TPA, distributes them. Companies tend to assume that their SPDs are drafted correctly. These assumptions are perfectly reasonable as

a legal matter, since TPAs are experts in health insurance and should be able to draft clear and accurate SPDs.

Practically speaking, however, there are two problems with such assumptions. The first one is that mistakes happen. The second one is that, when mistakes happen, the liability lies, at least initially, with the company whose name appears on the SPD. In short, the sins of the TPA that drafted the SPD are visited on the employer.

In one recent lawsuit, an employee had completed forms for obtaining supplemental life insurance. The TPA had created the SPD for the plan and the employer had distributed it. On one page, the SPD specified that plan members could increase their benefits without providing evidence of insurability if benefits were increased only one level and at the beginning of the policy year. The employee complied with those requirements when he increased his supplemental coverage from 3 times salary to 4 times salary. The employer approved the increased coverage and charged the employee for it.

The employee subsequently passed away, leaving his wife as the beneficiary. At that time, the employer confirmed that the beneficiary was entitled to 4 times coverage.

To the surprise of both the employer and the employee's widow, however, the insurer disagreed. Citing language elsewhere in the SPD — which conflicted with the provision on which the employer had relied — the insurance company took the position that proof of insurability *was* required for the increase in benefits. The insurance company blamed the employer for the mistake, arguing that the employer relied on the wrong provision in the SPD.

The employee's widow sued the employer — the party whose name appeared on the contradictory SPD and the only party with whom she had contractual ties. The TPA played no part in either the lawsuit or the settlement that ultimately followed.

The employer might have been able to avoid the entire situation had it reviewed the SPD in draft form, and identified and corrected the contradictory language. Every corporation that self-funds would be well-advised to do so. In fact, it may be appropriate for every self-funded employer to have its legal counsel review its SPD to ensure that it is clear and unambiguous and that it accurately sets forth the terms and conditions of the plan.

#### *What are the TPA's Indemnification Obligations?*

The concept of indemnification is inherent in TPA agreements, since companies need to be fully protected from the consequences of acting upon incorrect advice from their TPAs. In fact, the existence of a firmly established right of indemnification can deter TPAs from making careless mistakes, especially with regard to risky coverage denials. Also, given that TPAs and stop-loss insurers sometimes force litigation, indemnity provisions that include legal fees can deter TPAs from taking unreasonable positions — or at least from pursuing those unreasonable positions through the litigation process. Thus, these provisions are valuable tools for employers. They should be included in all TPA agreements.

Many TPA contracts contain indemnity provisions, but they are not all equal. Indemnity provisions, at the very least, should be triggered by negligent conduct on the part of TPAs. Ordinary care, reasonable diligence and negligence are appropriate triggers, in light of the important role played by TPAs and the amount of exposure faced by

corporations who rely on them. The following is an indemnity provision containing such triggers:

**Section 6. General Provisions.**

(B) Performance Standard — [TPA] shall use that degree of ordinary care and reasonable diligence in the exercise of its powers and duties hereunder that an administrator of claims under an insured or uninsured employee benefit plan would use acting in like circumstances. [emphasis added]

(C) [TPA] Indemnity — [TPA] agrees to indemnify the Contractholder and hold the Contractholder harmless against any and all loss, liability, damage, expense, cost or obligation (including reasonable attorneys' fees) with respect to this Contract

(1) resulting from or arising out of the dishonest, fraudulent or criminal acts of [TPA]'s employees, acting alone or in collusion with others, or

(2) for that portion of such loss, liability, damage, expense, cost or obligation that a court determines was the result of or arose out of the acts of [TPA]'s employees in providing services under this Contract not in compliance with (B) above.

In contrast, another form speaks in terms of gross negligence:

Plan Supervisor agrees to indemnify and hold harmless Employer from any claim, liability, cost, loss, expense or damage (including reasonable attorney and accountant fees) which results from Plan Supervisor's gross negligence, willful misconduct or fraud ... [emphasis added]

The practical financial benefits of strong indemnity provisions, however, can be even more important than their deterrent effects. TPAs' mistakes can cause employers to lose substantial amounts of money, such as through handling bills improperly, losing negotiated discounts and negating stop-loss coverage due to payment delays. It may be essential for companies to recoup those losses, possibly in order to avoid the inappropriate expenditure of plan assets. Indemnification provisions often provide the best, if not the only, route for companies to do so.

*Does the TPA Contract Include Run-out Services?*

Every corporation that self-funds should ensure that its TPA agreement includes run-out administrative services. To understand the meaning of run-out administrative services, all that is needed is an understanding of the phrase "incurred but not received." The key point is this: Just because one TPA contract ends at midnight on December 31 and the next one starts at 12:00 a.m. on January 1 does *not* mean that the plan will have seamless TPA services. Instead, there must be an agreement (typically, the existing TPA agreement) for the TPA to process claims that were incurred before the first plan ended but not received until the second plan began. Since health services are being provided continually, there always will be a few claims in this pipeline.

In contracting with TPAs, it is important to understand that claims typically are deemed "incurred" at the time the medical treatment is provided. The standard structure is that claims are then billed to the TPAs, who consider the claims "paid" only when the checks clear the banks. This structure makes it possible for large numbers of claims to be incurred during one contract policy period and paid in another. It also

makes it difficult for companies to assess in advance how many claims will fit into this category.

Employers should read and understand exactly how TPAs will handle claims that are incurred in one contract period, yet billed in another. Employers also must understand what they themselves need to do, if anything, to trigger their TPAs' run-out obligations. For example, if a TPA agreement requires the employer to request run-out services in its termination notice, then the employer should know about this obligation and comply with it.

Run-out provisions can take many different forms. Some TPA contracts contain clearly labeled "Run-Out" subsections. Others, however, do not use the word "run-out," but simply require TPAs to continue to process claims after the policy period ends, provided that the claims were incurred during the policy period. A typical subsection states that the TPA shall, "upon the request of Employer, adjudicate claims incurred but not received by [the TPA] during the term of the Agreement" for three months after termination in return for a specified fee.

No matter what the language is, every self-funded corporation should understand the purpose of run-out claims processing and ensure that its contractual provisions are in line with its needs.

*Separately, Are There Gaps in Stop-loss Insurance Coverage?*

Aside from run-out claims processing, employers should also ensure that they have purchased stop-loss insurance coverage, as needed, for run-out claims. Run-out insurance coverage is completely different from run-out claims processing. The former is purchased from TPAs and is provided for, typically, in TPA agreements. The latter is purchased from stop-loss insurance companies and is provided for, typically, in stop-loss insurance policies. Run-out insurance coverage provides for claims to be covered by insurance if they reach stop-loss limits during the run-out period. Without run-out insurance coverage, corporations face a risk of having claims processing for run-out claims, but no insurance coverage for them.

Stop-loss insurance policies typically provide coverage based on one of the following bases:

<b>Policy Basis</b>	<b>Period When Covered Claims May Be Incurred</b>	<b>Period When Covered Claims May Be Paid</b>
"Paid" or "12/12"	During policy period	During the policy period
"Run-In" or "15/12"	3 months prior to the policy inception date or during the policy period	During the policy period
"Run-Out" or "12/15"	During the policy period	During the policy period or 3 months after the policy terminates

In the first example, a "paid" or "12/12" basis, there would be no run-out coverage for a claim that is incurred during one period and paid during the next period, even if the claim hits and exceeds the agreed-upon stop-loss limit when it is paid. In the second

example, there would be no run-out coverage, but instead there would be “run-in” coverage, meaning coverage for a claim incurred in the final three months of the previous policy period and paid during the current policy period. In the third example, there would be run-out coverage for three months, meaning that claims incurred during the policy period and paid within three months after the policy period would be covered.

The importance of this issue is illustrated by a recent case in which a self-funded employer fell victim to a gap in coverage. The employer’s stop-loss policy provided coverage on a “paid” basis. When the employer decided to switch insurance companies, the original stop-loss insurer would not sell run-out coverage and the new stop-loss insurer declined to offer run-in coverage. The employer ended up with a gap. A six-figure hospital bill immediately fell into that gap, and both the current and previous stop-loss insurance companies denied coverage. This case shows that employers can benefit considerably from the purchase of continuous stop-loss coverage, and thus avoid any gaps.

#### *Does the Stop-loss Insurance Policy Permit ‘Laser’?*

Under federal law, insurance companies generally are not allowed to deny insurance coverage to individuals on grounds that they are sick, and to sell health insurance only to individuals who are healthy. Yet stop-loss insurance companies are able to do so. Stop-loss insurance is sold to sponsors of self-funded plans, not directly to individuals. Stop-loss insurance companies regularly attempt to identify sick individuals and exclude them from coverage at renewal time, up to the amount that they are expected to incur in health costs for the upcoming policy period. The process of carving out sick individuals from a stop-loss insurance plan is called “laser.”

For example, all claims for plan participants might be covered by a stop-loss insurance policy once they exceed \$100,000, except for one participant who has known medical needs and is expected to incur costs of \$250,000. The plan’s stop-loss insurance company may ask the plan, prior to the inception of the contract, to agree to an endorsement establishing a \$250,000 “laser” for this participant, so that his or her claims are not eligible for coverage until they exceed \$250,000. If the employer does not agree, the stop-loss insurance company will increase the insurance premium.

The practice of lasering may defeat the purpose of stop-loss policies for two reasons:

- 1) Large claims are rare. Plans can go for years without reaching their stop-loss limits, even though they pay substantial premiums for stop-loss coverage one year after the next. An insurance company that is covering a plan for only a few years may not be called upon to pay any stop-loss claims at all.
- 2) When large claims do arise, they usually are for serious medical conditions that likely require extended care. Thus, when insurance companies laser participants with serious medical conditions, they are defeating the purpose for which employers purchase stop-loss policies.

Fortunately, this problem can be avoided. During the bidding process for a new policy, employers typically send out requests for proposals (RFPs). These RFPs should specify that the employer will not accept bids that include lasers.

### *Has Attention Been Paid to Applicable State Laws?*

Many employers understand that ERISA exclusively governs their self-funded plans, and that as a result the plans are not subject to state laws that regulate insurers. As discussed above, state laws, along with regulations issued by state insurance departments, are preempted:

Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary ....

... the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in ... this title....

Preemption has considerable value to self-funded employers, particularly because it exempts them from state laws that require traditional “health insurers” to provide coverage for certain illnesses and conditions. These mandates vary widely from one state to another and may prove to be very expensive.

Less widely recognized is that the stop-loss insurance policies that cover self-funded health plans are subject to state insurance laws. As discussed in the section on lasers (see above), employers — not ERISA beneficiaries — are insured by stop-loss policies. Thus, they fall outside of ERISA.

Many states have passed legislation designed to make this fact perfectly clear. For example, in Louisiana:

B. Any insurer authorized to issue property and casualty or health and accident policies of insurance in this state shall report ... any premiums written in this state for stop-loss or excess insurance coverage to the Department of Insurance ...

C. A stop-loss or excess insurance policy form ... shall be submitted to the Department of Insurance for prior approval ...

(La. Rev. Stat. Ann. § 22:675 (2006)). Similarly, Minnesota has enacted statutes that specifically state that all stop-loss policies are regulated by the state Commissioner of Commerce. (Minn. Stat. § 60A.06(5)(a) (2005)).

The legal inconsistency between the regulation of benefit plans versus stop-loss policies can wreak havoc in certain circumstances. For example, some states require stop-loss policies to comply with the state mandatory benefits laws, if coverage attaches below a certain threshold. These states reason that, by providing “first-dollar” or near first-dollar coverage, the stop-loss insurers provide the equivalent of health insurance to the employees, rather than “reinsurance” to the corporations. Minnesota’s statutes provide:

Subd. 3. Health plan policies issued as stop loss coverage. (a) An insurer or health carrier issuing or renewing an insurance policy ... that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan ... shall issue the policy ... as a health plan if [it]...:

1) has a specific attachment point for claims incurred per individual that is lower than \$10,000; or

2) has an aggregate attachment point that is lower than the sum of:

- (i) 140 percent of the first \$50,000 of expected plan claims;
- (ii) 120 percent of the next \$450,000 of expected plan claims; and
- (iii) 110 percent of the remaining expected plan claims.

\* \* \* \* \*

d) A policy ... issued by an insurer or health carrier that provides direct coverage of health care expenses of an individual including a policy or ... administered on a group basis is a health plan regardless of whether the policy ... is denominated as stop loss coverage ....

\* \* \* \* \*

Subd. 4. Compliance. (a) An insurer or health carrier that is required to issue a policy ... as a health plan under this section shall, even if the policy ... is denominated as stop loss coverage, comply with all the laws of this state that apply to the health plan....

(Minn. Stat. § 60A.235 (2005)). Under this statute, stop-loss policies meeting the enumerated requirements may be required to provide coverage according to the relevant “state mandates.” As explained above, this result would deny a major benefit of self-funding. Thus, when corporations purchase stop-loss coverage, they need to make sure that they are not inadvertently losing their ERISA preemption.

The same inconsistency can benefit corporations. For example, Louisiana requires that all applications for stop-loss coverage must provide run-out coverage or else must show that such coverage has been offered and refused. According to the Louisiana insurance commissioner:

This requirement was prompted by policyholder complaints regarding denial of reimbursement for claims incurred during the last few months of a contract period.

(Directive Number 02-171 (which is directed to “Insurers Authorized to Issue Property and Casualty or Health and Accident Policies of Insurance in This State”).

If such an offer is not made, then a 90-day run-out period is written into policies, even when those policies expressly state otherwise (i.e., where the policies state coverage on “paid” bases, without TLOs). (La. Rev. Stat. Ann. § 22:675 (2006)).

Clearly, such statutes can be very useful in negotiating the terms of stop-loss policies that will cover individuals in Louisiana. Companies and their brokers should be aware of any applicable state laws in the states where the policy will be sold or the plan will provide benefits.

***Does the Company’s Insurance Consultant and Agent Really Understand Self-funding?***

Self-funding is a highly specialized area involving interaction among three different types of contracts. Purchasing and negotiating the agreements necessary for self-funded health plans is more complicated than purchasing a traditional health

insurance policy. A fundamental appreciation of federal and state laws, and state insurance regulations, is required as well. Thus, self-funded employers can benefit greatly by working with insurance agents and consultants that are skilled in self-funding.

Similarly, employers should make sure that their consultants provide actual advice, rather than lists of options that they may not fully understand. Some consultants have a practice of merely identifying options without making recommendations as to which option best suits the employer's needs. Many employers, however, lack the information necessary to make an informed choice among these various options. Accordingly, it is important to have a broker that will recommend the best choice.

#### *Is the Company Paying More Than it Should?*

Self-funding has spawned a new industry in recent years. Auditors and other billing experts now provide consulting services to examine whether employers have inadvertently overpaid claims. They advise employers about such matters as whether the TPA has billed the correct amounts and paid claims on a timely basis. Self-funded employers should appreciate that the price of cost expertise is a necessary part of the overall cost of self-funding.

*Mutual Medical Plans, Inc. v. County of Peoria*, 309 F. Supp.2d 1067, 1071-73 (C.D. Ill. 2004), demonstrates, all too clearly, the financial harm that an unsupervised, unscrupulous TPA can inflict upon a self-funded plan. The TPA was paid a "profit bonus" by the stop-loss insurer for avoiding, or at least minimizing, the cost of covered claims. To earn this bonus, the TPA decided to delay bill payments until after the end of a policy period, which meant that the bills paid in the original period did not trigger stop-loss insurance coverage. Doing so deprived the employer of stop-loss coverage for which it paid substantial premiums.

### **Self-insurance Through Captives**

Self-insurance is an increasingly popular method for corporations to reduce the costs of employee benefits. Typically this is done through the formation of a "captive" insurance company. As discussed in more detail below, this approach is not necessarily an option for self-funded benefits plans that wish to enjoy the legal benefits of being self-funded, such as the ERISA exemption. However, self-insurance may offer a unique alternative to the purchase of traditional insurance policies for life insurance, disability insurance and even workers' compensation insurance.

Self-insurance is becoming increasingly popular. For example, in October 2006, *Business Insurance* magazine reported that financial services industry giant Wells Fargo & Co. had just received tentative approval from DOL to reinsure group life and long-term disability policies through its 16-year-old Vermont captive — Superior Guaranty Insurance Co. Just one month previously, DOL gave final approval to a proposal by consumer food products manufacturer H.J. Heinz Co. of Pittsburgh to fund group term life insurance policies through its Vermont captive. Earlier in 2006, the agency gave final approval to the U.S. affiliates of British pharmaceutical manufacturer AstraZeneca P.L.C. to fund benefits through AstraZeneca's Vermont captive, and to AGL Resources Inc., an Atlanta-based natural gas distributor, to use the Hawaii branch of its British Virgin Islands captive to reinsure certain risks.

Self-insurance through a captive insurance company can offer real financial advantages to an employer. For example, it can take a current tax deduction for premiums paid (as “insurance”) prior to the occurrence of an insured risk. However, the corporation must make sure that it meets IRS requirements and the regulatory requirements of the captive’s home jurisdiction. One point to be considered is whether, in a substantive way, the corporation using a captive for employee benefits has, both in fact and in balance-sheet substance, transferred its risks.

Another point to be considered is whether a captive insures only the risks of its parent corporation. That situation could cause problems. Many jurisdictions have set minimum percentages for the amount of insurance that captives must provide to others, outside of the parent corporation. Those requirements must be met for the captive to be valid and in effect.

Self-insuring requires significant initial planning and, legally, can be very complex. Suffice it to say that captive planning has to be very careful to match an employer’s needs and the provisions of tax law surrounding captives generally. The consequence of initial missteps could be a financial and administrative nightmare: the challenge of running a captive without the enjoyment of the tax and other advantages.

Similarly, it is important to appreciate that not all employee benefits can be reinsured through a company’s captive insurance company. In particular, reinsurance, or stop-loss insurance, through a captive would not be appropriate for a company with a self-funded health benefits plan. In order to reap the full legal benefits of self-funding under ERISA, federal law requires that the self-funded benefits plan is distinct from traditional “insurance.” That difference would be lost if the company were to provide 100 percent self-insurance for its self-funded plan. Conversely, to reap the full legal benefits of operating a captive insurance company, the company must ensure that its captive meets certain requirements of a traditional “insurance company.” Thus, there is an inherent conflict between the requirements of a self-funded benefit plan and a captive insurance company.

