

# Current Developments

## August 2003

### Commentary

#### Future of Retiree Medical Benefits

Since the costs are high and getting higher, the future is bleak - particularly for those with only an expectation of benefits. The FAS 106 reserve burden on the employers is *crushing*. The Rx costs, the fastest growing of the medical factors, are a disproportionate percent of the retiree costs. Good news for retirees is not anticipated.

#### Is Colonoscopy Passé?

It will be shortly; to be replaced by a CAT scan.

#### Virtual Medical Visits

The model plan document (micromanaged version) denies medical visits by fax, phone or e-mail, leaving the plan sponsor to cover such items, if it wishes, only by a plan amendment.

#### Rx: Pharmacies v. Supermarkets

In this competition, the supermarkets are winning. The one-stop shopping concept found with the supermarkets is a big attraction to the marketing of Rx. This explains why many of the pharmacies are becoming minisupermarkets.

#### Is State Regulation Losing Its Grip?

Maybe. Since 1871 the only governing body of the insurance industry has been NAIC. Inroads to the NAIC grip are coming because of the plethora of insurer failures in the past few years and the need for a more efficient and competitive insurance market. With the Financial Services Modernization Act of 1999 insurers can go into banking and vice versa, within limits.

#### Health Care Cost Culprits

While Rx, technology, overutilization, etc., have added to the health care bill in a significant way, we should not forget the three *silent thieves* that add some 27% to the health cost bill:

- Mandated benefits
- Fraud
- Litigation.

## **Insight into the Uninsured**

With the high cost of health coverage, low salaried employees will not enroll even if the costs are generously subsidized by the employer. For the employee, the need for livable take-home pay is paramount. Many plans have made accommodation to this problem such as:

- Opt-out allowances
- High-low plans
- Employer direct subsidy of employee-purchased health insurance.

## **Domestic Partners Benefits Gaining Acceptance**

Slowly but steadily, the lobbying by the gay rights advocacy groups is influencing plans to offer such benefits. The employers offering such benefits (numbering in the 4,000-5,000 range) use such benefits to attract employees. The cost increases are said to be minimal.

## **Legion Insurance Co. about to Be History**

A few of Legion's policyholders are hoping to be made whole; the rest will suffer losses. This is the first stop-loss carrier to bring financial harm to self-funders.

## **Rx Pains Stay Front Page News**

Employers would pay a lot for a prescription that would alleviate their Rx pains. What is happening is the growing importance of the *practice of pharmacy*, which is replacing the *practice of medicine*.

## **Consumer Power to the Rescue**

The defined contribution advocates are *betting the farm* that consumer knowledge and empowerment will be cost-effective. We all hope so. Lives of grief and disappointment are what the managed care and cost- containment folks have inherited, it seems.

## **Enron and WorldCom Leaders; More than Jail Time?**

It would appear much of the ill-gotten gains will be used to pay their ERISA-defined fiduciary breaches. The rest, I do believe, will go to their attorneys.

## **HHS and Demand Management**

Tommy Thompson and his HHS are *thumping the drums* for demand management. Long overdue.

## **Mother Met Expands Its Dominance**

It did so recently by buying the group life block of John Hancock. No small purchase. The Met's group life annualized income is now in the \$8.3 billion range.

## **New Insights Into Old Rising Health Care Costs**

Please bear in mind that (a) increasingly, medicine is being practiced in a more costly and high-tech environment; (b) our society is becoming alarmingly litigious; (c) as we get older, we use more expensive Rx, and (d) a Kaiser study showed that of 135 physicians asked to evaluate the same patient who had a urinary tract infection, there were 82 different treatment strategies. Will we live to see that day when we have computer-driven medicine? Sounds *outré*; but maybe not.

## **Health Care Cost Decelerating?**

Yes. The initial 2003-2004 increases predicted to be approximately 20% are coming in at 17-18%. The good news is that the bad news is not as bad as feared.

## **Maine's Universal Health Program**

Massachusetts used it in the 1980s and failed; now it is Maine's turn. But Maine didn't bite on the mandatory coverage as did Massachusetts. Maine's universal health plan is voluntary. A state quasi-public entity will *jawbone* insurers to provide *good* plans to small employers so as to make everyone happy. By trimming the uninsured roles, the present plans and providers will be happy. Lots of happy news to go around. Other than the details and requisite patience to come later, the plan has a chance. Now we will wait for the *good* plans that will please both the small employers and the insurers.

## **New York Raises Its Hospital Bill Surcharge**

New York, as are most states, is badly in need of money. The simple solution to their legislators was to raise the surcharge on hospital bills from 8.18% to 8.85%. New York employers have every reason to be upset:

- The surcharge subsidizes medical education in New York for non-New York students.
- The surcharge is a direct subsidy for their New York competitive employers who refuse to have a health care plan.

# Legal

## Standard of Review

Plan document clearly gave administrator discretion to adjudicate claims. SPD was silent thereon. Even so, the court allowed the arbitrary and discretionary standard because (a) the participant did not rely on the SPD and (b) the plan and SPD were not in conflict. *Davis v. First Union Corp. Long Term Disability Plan*, 213 F.Supp.2d 29 (D.C.Mass. 2002).

## Standard of Review

The court will use more stringent standards of review where the self-funded plan obtained its claim administration and stop-loss from the same insurer. This is the typical ASO arrangement. *Laser v. Provident Life & Accident Ins. Co.*, 211 F.Supp.2d 645 (D.Md. 2002).

## COB

Self-funded plan claimed a secondary position to auto medical; participant had earlier agreed by contract with auto medical insurer that such insurer would be secondary. Self-funder was held the primary. *Community Ins. Co. v. Morgan*, 29 EBC 2104 (6th Cir. 2002).

## Reporting and Disclosure

With a fully insured plan, it is the employer who is the keeper of the documents and not the insurer. *Nichols v. Verizon Communications, Inc.* 29 EBC 1204 (D.C.N.J. 2002); *Coyle v. D.M.R. International, Inc.*, 29 EBC 1945 (S.D.Ohio 2002).

## Employee Benefit Plan

Obtaining a premium discount on a supplementary fully insured benefit that is 100% employee-paid will not make it an ERISA plan. *Revello v. Paul Revere Lift Ins. Co.*, 224 F.Supp.2d. (E.D.Pa. 2002).

## Plan Administrator

With a fully insured plan, the insurer is not the ERISA plan administrator and therefore is not responsible for ERISA filings. *Coffey v. UNUM Life Ins. Co.*, 302 F.3d 576 (6th Cir. 2002); *Coyle v. D.M.R. International, Inc.*, 29 EBC 1945 (S.D.Ohio 2002).

## Employee Benefit Plan

In this matter the court held, following standard industry practices, that a sole proprietor who functions as an employee should be treated as such for ERISA plan purposes. *Voelske v. Mid-South Ins. Co.*, 29 EBC 2216 (N.C.Ct. of App. 2002).

## **Standard of Review**

TPA denied a claim. In the ensuing litigation, it was held the highest abuse of discretion standard should be applied when it was shown that stop-loss was provided by carrier that also owned TPA. *Davidson v. Kemper National Services, Inc.*, 29 EBC 2363 (W.D.Va. 2002).

## **Exhaustion of Administrative Remedies**

Two claims processing errors occurred:

- Participant did not appeal within the 60-day time frame.
- Plan supervisor misclassified the claims.

The court resolved the issue by holding that participant's administrative *glitch* can be excused because it did not have all the facts. *Combe v. La Malelaine, Inc.*, 29 EBC 2325 (E.D.La. 2002).

## **Fiduciary (Physician)**

Insurer's medical advisor was fired for being a *whistleblower* on insurer's practices relative improper denial of long-term disability claims. Physician sued under state's *whistleblower* law. Court turned back the physician's complaint because (a) issue was ERISA plan- related and (b) physician's actions were as fiduciary to the act in question. *McSharry v. UNUMProvident Corp.*, 29 EBC 2305 (E.D.Tenn. 2002).

## **Claim Denial**

Mere denial of a claim by an ERISA plan is no grounds for a breach of fiduciary lawsuit by an aggrieved plan beneficiary. *Post v. Hartford Life and Accident Ins. Co.*, 29 EBC 2931 (E.D.Pa. 2002).

## **Managed Care**

Plan charged participant a \$15 copay on each Rx, even though the HMO was able to buy it (on a wholesale basis) for \$13. The HMO had a *profit-line* on certain Rx. While the participant protested, the court held the practice to be acceptable. Reason: the plan clearly said that such was to be the practice. *Alves v. Harvard Pilgrim Health Care, Inc.*, 29 EBC 2195 (5th Cir. 2002).

## **Hospital Certification of Eligibility**

Hospital gave care by accepting an assignment of participant's health care benefits. Employer was involved in such certification. The difficulty arose when hospital discovered the participant's lifetime maximum had been exhausted. Court ruled that:

- Recovery against the plan as an ERISA matter would fail.
- Recovery against the employer as a non-ERISA state law matter would succeed.

*Transitional Hospitals Corp. of Louisiana, Inc. v. Advantage Health Plan, Inc.* 29 EBC 2558 (E.D.La. 2002).

## **Standard of Review**

Participant attempted, without success, to have a claims denial by a Taft-Hartley plan reversed. Reason was trustees had a financial bias in that they represented, in part, the employees. *Muse v. Central States Health and Welfare Funds*, 29 EBC 2261 (S.D.Ohio 2002).

## **Preemption of Mandated Benefits**

Alabama mandated that a PA should be treated as a *provider*. Court held such mandate was applicable to a fully insured but not to a self-funded plan. *Blue Cross and Blue Shield of Alabama v. Hobbs*, 29 EBC 1345 (M.D.Ala. 2002).

## **Preemption – State Bond Law**

State required general contractors of public works projects to post a surety bond to guarantee performance including self-funded medical benefits. Was this state law preempt? Court said no because it failed to regulate, establish or impose new requirements on existing plan. *Iron Workers District Council v. George Sullit Corp.*, 29 EBC 1131 (W.D.Wash. 2002).

## **Employee Benefit Plan**

The employer's involvement in the plan involved the following:

- Ongoing administration
- Discretion in determining eligibility
- Paying and funding of ongoing benefits
- Employer's clear intention of having the plan ERISA-governed.

Therefore, the court held it to be a welfare plan. *O'Neill v. New York Times Co.*, 29 EBC 2811 (D.Mass. 2003).

## **Welfare Plan**

A freestanding vacation plan is not an ERISA welfare plan; a vacation benefit which is part of an ERISA plan becomes, as a result thereof, an ERISA plan. *Miller v. PPG Industries, Inc.*, 29 EBC 2115 (W.D.Ky. 2002).

## **VEBA Taxes**

VEBA can have unrelated income, which must be taxed. Question before the court was this: Should the tax be at the *trust* or the *corporate* rate? The court ruled it should be at the *trust* rate. *Sherwin-Williams Co., Employee Health Plan Trust v. U.S.*, 29 EBC 2144 (N.D.Ohio 2002).

## **Managed Care**

Plan argued Texas law mandating an independent review of certain denied claims was applicable to fully insured plans and HMOs but not to self-funders. Court in reliance of *Rush Prudential v. Moran* held against the self-funder. *Corporate Health Insurance Inc. v. Texas Department of Insurance*, 314 F.3d 784 (5th Cir. 2002); *Connecticut General Life Insurance Co. v. Maryland Ins. Commissioner*, 810 A.2d 425 (Md.Ct.App. 2002).

## **Managed Care**

Sponsor of a PPO/HMO had retained Firm X to do turnkey administration. When sponsor sued X as a state law breach for X's failure to perform, X claimed ERISA exemption. Sponsor lost because court deemed X to be an ERISA fiduciary. *Vantage Health Plans, Inc. v. ACMG, Inc.*, 830 So.2d 398 (La.Ct.App. 2002).

## **Discrimination – By Sex**

Did plan's denial of a sex-change operation constitute sex discrimination? Court said it did not. *Mario v. P&C Food Markets, Inc.*, 313 F.3d 758 (2d Cir. 2002).

## **Subrogation**

Participant refused to sign the subrogation release and sued when plan refused to pay claims. Plan won on preemption grounds. Participant used his claim for third party recovery as an insurance policy should plan refuse to pay. Such was, in effect, an optional ERISA funding device.

*Kress v. Food Employees Labor Relations Association*, 217 F.Supp. 2d 682 (D.C.Md. 2002).

## **Eligibility for Benefits**

While enrolled for college, but prior to beginning classes, dependent child was hurt and become paraplegic. Claim denial was based on fact that he was *not* a full-time student. Court held for participant. Participant's claim to punitive damages as a state law matter were denied. Under ERISA the only right of participant was to have the claim paid, which it was. *Beach v. Mutual of Omaha Ins. Co.*, 229 F.Supp.2d 1230 (D.C.Kans. 2002).

## **Discrimination – Age**

Participant failed to show that his lay-off was due to age; employer's actions were consistent and not age-biased. The participant lost. *McGrath v. Lockheed Martin Corp.*, 29 EBC 1101 (6th Cir. 2002).

## **Standard of Review**

Plan administrator made grievous procedural errors by *playing games* with TPA and finding every reason to not pay the claim. The claim was “calf reconstruction surgery to improve gait.” Because of this, the court held the review should be *de novo* and not the more lenient arbitrary and capricious. *Shaw v. McFarland Clinic, PC*, 231 F.Supp.2d 924 (D.C.Iowa 2002).

## **Preemption – Managed Care**

HMO denied patient unless he saw a primary network physician, which he refused to do. When his ailment worsened, he sued as a state law malpractice matter. Was this state law preempted? Court said yes. Quality of care was not touched; only the eligibility for care (i.e., quantity of care). *Haynes v. Prudential Health Care*, 313 F.3d 330 (5th Cir. 2002).

## **Potential HMO Class Action Litigation**

The potential litigation dealt with this question. Can an HMO make money for a subscriber's medical encounter? That is, can the HMO *charge* \$1,000 (to the riskpool and to the employer's plan, e.g.) for a medical service that it *buys* from a provider at \$800 and *pocket* the difference? The court held for the HMO; such profiteering was acceptable under HMO laws. *Coughlin v. Health Care Service Corp.*, 29 EBC 1411 (N.D.Ill. 2002).

## **Preemption – Managed Care**

ERISA will apply to the *quality of care* but not to the *quantity of care*. *O'Neill v. Brannigan*, \_F.3d\_ (3d Cir. 2002).

## **Standard of Review**

Plan explicitly said breast reductions were covered only when linked to mastectomy. The claim was for a breast reduction to alleviate the patient's backaches. When the claim was denied for cosmetic reasons, litigation ensued. The court held for the plan. *Thompson v. Blue Cross Blue Shield of Louisiana*, \_F.Supp.2d\_ (E.D.La. 2002).

## **Standard of Review**

The court refused to follow the more lenient abuse of discretion rules and instead invoked the harsher *de novo* standards. Reason was plan was ASO-administered (with stop-loss

provided by the insurer). Court believed the conflict of interest was so serious as to warrant this decision. Insurer also made procedural errors. *Laser v. Provident Life & Accident Ins. Co.*, 211 F.Supp.2d 645(D.Md. 2002).

## **Standard of Review**

FDA had approved the Rx for condition X; physician prescribed Rx for condition Y. As a consequence the plan supervisor denied the claim, which was challenged by patient. Court held by abuse of discretion standards that denial was proper. *Coram Healthcare v. Wal-Mart Stores, Inc.*, \_F.Supp.2d\_ (S.D.N.Y. 2002).

## **Reporting and Disclosure**

Because the participant failed to request plan documents *in writing* the court did not recognize the complaint of the participant. No action was taken against employer. *Masonheimer v. Colonial Penn Group, Inc.*, \_F.Supp.2d\_ (E.D.Pa. 2002).

## **Standard of Review**

It was not clear whether assignment of claims discretionary authority must be *also* set forth in the SPD. In this case, sex reassignment surgery was denied as not medically necessary. *Mario v. P&C Food Markets, Inc.*, 313 F.3d 758 (2d Cir. 2002).

## **Waiving Plan Rights**

Employees agreed to cover *any and all* claims they had against employer as part of a settlement. In a later dispute, employees argued this did not include ERISA claims because such were not specifically cited. Court disagreed and held for the employer. *Chaplin v. NationsCredit Corp.*, 307 F.3d 368 (5th Cir. 2002).

## **Managed Care**

Hospital was distressed to find its \$1,000 bill, discounted by \$150, ended up being a \$1,000 claim to the plan with the \$150 discount being pocketed by the insurer. It sued the insurer for restitution. The court said *no* to the action because the proper defendant should have been the employer (or plan). *Holy Cross Hospital v. Bankers Life and Casualty Co.*, 29 EBC 1355 (N.D.Ill. 2002).

## **Taxes**

Dispute involved employer's deduction from participant's self-funded disability payments for municipal occupational taxes. Court said *no* to the attempt by the participant to make this an ERISA matter and therefore to have a federal court venue. *Miller v. PPG Industries, Inc.*, 29EBC 2115 (W.D.Ky. 2002).

## **MEWA**

MEWA employer sued the agent as a state law matter for misrepresenting the plan's tax benefits. Court held the plan was an ERISA plan in that even if the employer failed to belong to a welfare plan it had, in effect, established its own ERISA-governed plan. This resulted in employer's state law based claims being denied. *Finderme Management Co. v. Barrett*, 809 A.2d 842 (N.J.Super.Ct. 2002).

## **Preemption**

Insurer wanted state's law requiring that PAs be covered; providers preempted for fully insured plans. Court held *against* insurer. *Thompson v. Blue Cross and Blue Shield of Alabama*, 29 EBC 1870 (M.D.Ala. 2002).

## **Stop-Loss**

Stop-loss carrier opined breast cancer surgery was not payable by the plan and would not be covered by the stop-loss. Plan paid and stop-loss carrier denied. In litigation, the court said the stop-loss was liable if the plan said the claim was payable and that ended the matter. The court found no abuse of discretion by the plan. *Computer Aided Design Systems, Inc. v. Safeco Life Ins. Co.*, F.Supp.2d (D.C.Iowa 2002).

## **Risk Management**

### **Drug Formulary**

The state of Connecticut sued Physicians Health Services of Connecticut, believing it violated its state laws in using a drug formulary. The drug formulary worked as follows:

1. For health diagnosis/procedure X, the Rx mandated for treatment was T and there was no copayment. That is, T was a formulary-designated Rx for the subject diagnosis/procedure.
2. If an Rx other than T was used, there would be a copayment payable by the participant.

This agreement of the state was defeated, in part, because the state lacked standing due in part because it was not a direct or indirect plan beneficiary. Also, the state's law upon which the suit was based would be ERISA-preempt. *State of Connecticut v. Physicians Health Services of Connecticut*, \_F.3d\_ (2d Cir. 2002).

### **Juvenile Rx Costs**

Much attention has been devoted to the escalating Rx among seniors. What about the great increase in Rx use by children? For ages 0-19, the Rx trending factor is approaching 30%. Some of the reasons for such a sharp increase include the following:

1. Parents are less accepting of generics for their children than for themselves.

2. Overmedication of antibiotics is commonplace; particularly the pressures are heavy on physicians to treat viral infections with high-powered and expensive antibiotics.
3. Use of such drugs as Ritalin to treat certain neurological problems such as attention deficit hyperactivity disorder is gaining popularity.
4. Childhood asthma is increasing, and the medications used to treat it are increasing in number and cost.
5. The national problem of childhood obesity is creating its own family of illnesses such as gastrointestinal disorders, heart burn and diabetes, all of which are being treated increasingly with expensive Rx. A corollary would be ailments resulting from a sedentary lifestyle.
6. Attitudes of children are becoming far more drug-friendly than has traditionally been the case.

## Clinical Trials as a Covered Plan Expense

There are currently 16 states that mandate clinical trials to be a plan-covered expense at least for fully insured plans:

AZ	GA	MD	NY
CA	IL	NC	RI
CT	LA	NH	VA
DE	ME	NM	VT

It is reported that many employers are softening their traditional approach to such procedures, which has been to deny them on the grounds of experimental or investigational.

Also, an industry practice becoming more accepted is for employers to allow research institutions to approach their employees about being participants in such trials.

It is noted that only the expenses *under trial* are without cost to the plan; other expenses (the cost of hospitalization, e.g.) is a billable provider expense. In many instances, employers may not be aware their participant is in a clinical trial.

Studies have shown that whether a cancer patient is or is not in a clinical trial, the ultimate plan costs are approximately the same.

## Employer Anti-Risk Management Actions

If employers are to *own up* to the top ten bad actions they have followed and that have contributed to our health care mess, here they are:

1. Fostered a mentality of entitlement for their employees.
2. Thrown out fee schedules,
3. Failed to properly explain managed care.
4. Abandoned base + major medical.
5. Passively accepted politician-created plan designs.

6. Embraced large networks and not small, tightly knit networks.
7. Believed a high level of comprehensive benefits could be sustained.
8. Failed to crusade against employers being able to opt out of the system.
9. Were quiet when the *HMO-bashing* was going on.
10. Ignored the quality-of-care factor.

## **Need for a New Benefits Paradigm Largely Being Ignored?**

A recent MetLife survey showed employee retention is a much greater worry to HR practitioners than benefits (and their costs). This means the old paradigm is still very much in place. More the pity because this old paradigm fuels the fire of continually escalating health costs. The new paradigm would have the emphasis on employee compensation, a function of *all* of the following factors:

- Pay
- Welfare plan costs
- Deferred compensation
- Fringe benefits
- Statutory benefits
- Sick pay/disability
- Productivity (if such is measurable).
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That is, escalating health costs translate directly into de-escalating pay (or some other factor) or, if measurable, increased productivity. This paradigm identity crisis translates into the increasing interest in the defined contribution models.

## **Administration**

### **Fraud in Dental Plans**

While fraud is generally recognized to be a serious problem (adding some 10% to health costs), a focus on dental plans is generally not made. Dental fraud is estimated to be 5% of plan dental costs. Dental fraud by providers is comparable with medical fraud:

- Bills for services not provided
- Ordering unneeded tests
- Waiving copayments and deductibles
- Double-billing
- Code-gaming.

Dental fraud is also committed by participants:

- Claims for services not received
- Double-dipping (nondisclosure of other coverage)
- Falsifying documents.

## HIPAA Tips

Filing of HIPAA complaints is to be made to the Office of Civil Rights of the HHS in this format:

- Hard copy, fax or e-mail
- Identify the *entity* and describe the privacy offense
- Filing period ends 180 days from date complainant learned of the violation.

## HIPAA Claim Regulation Litigation

DOL claims regulations, HIPAA-related, presume a DOL-imposed penalty for an infraction of such regulations. The court was asked to decide if there was statutory limit therefore.

**Facts.** The LTD claim took one year to resolve even though the plan required such resolution in 180 days. The usual investigations, documentations, outside opinions, etc., explain the delay. The employer filed suit challenging the denial as well as claiming penalties for tardy claims processing under DOL HIPAA claims regulations.

**Decision.** The court held the plan was remiss in denying the claim for tardy claims payment. There is penalty for delays in disclosing *plan documents*. However, there is no penalty for a delay in disclosing non-plan documents (job description, e.g.). HIPAA regulations permit a participant to bypass a plan's procedures and go directly to court if relevant plan documents are not provided to the participant. Delays in non-plan documents do not give the participant such privilege. *Browning v. A.T. Massey Co. Employees Comprehensive Benefits*, F.Supp.3d. (S.D.W.Va. 2002).

## Claim Fraud – One Scenario

While there are many scenarios, here is one:

<u>Step</u>	<u>Action</u>
1.	Miscreant steals a person's identity (name, address, SSN).
2.	Fictitious claims are made up and sent to insurers, plans, employers, TPAs, etc. All providers are fictitious with PO boxes (mail shops) usually in South Florida.
3.	Claim payments received in fictitious mail boxes by mail shops that forward them to an offshore facility (e.g., Costa Rica, which has lax ID laws).
4.	Money is laundered further by movement to other-country bank accounts.

## Denied v. Pended Claim – New Rules

Because of the time frames set by HIPAA to either pay or deny, TPAs will be sending out denials only when additional information is needed. While seemingly a simple enough change, it will doubtless have an effect on such matters as:

- Proper claim reserves (many potential claims are *in the wings* waiting reopening).
- Ability to *claims game* with stop-loss will be increased or more difficult to detect.

## **COBRA**

### **Notice**

Notice is not required to dependent children but only to the dependent spouse so long as dependent children were residing with one of their parents. *McDermott v. Town of Windham Public Schools*, \_F.Supp.2d\_ (D.Conn. 2002).

### **Non-ERISA COBRA – No preemption**

While ERISA COBRA (nongovernment plans) has preemption, Public Health Service COBRA (government plans) does not have preemption. The West Virginia more liberal state continuation law applied to West Virginia government entities as a result. *Orlofske v. City of Wheeling*, \_S.E.2d\_ (W.Va. Sup. Ct. 2002).

### **Notice**

COBRA notice of the qualifying event (divorce) should go to the dependent spouse directly and *not* to the participant to act as a *delivery boy*. Reasons are twofold:

- Honors sensitive nature of divorce
- Allows plan administrator to establish that notice did, in fact, get properly delivered.

*Phillips v. Saratoga Harness Racing, Inc.*, F.Supp.2d (N.D.N.Y. 2002).

### **Eligibility for COBRA**

Unclear employment agreements as regards health care benefits must be avoided. Otherwise COBRA squabbles will likely ensue. *Barashi v. Silverwear, Inc.*, \_F.Supp.2d\_ (S.D.N.Y. 2002).

### **Claims – Waiting for Election**

Court held it was proper for the employer to put a *hold* on claims pending a COBRA election. *Reutner v. Smith*, \_F.Supp.2d\_ (E.D.La. 2002).

### **Notification of Divorce**

John fraudulently kept his divorce a secret from his employer. His motive was to meet the divorce requirements of providing coverage for his wife by having her fraudulently classed as a dependent spouse and not as a COBRA beneficiary. The financial difference to John was huge. Plan sued John as a state law court matter and won. *Trustees of AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002).

## **Notice**

Plan failed to make the initial notice in a timely manner. The first COBRA notice, upon a qualifying event, was made verbally. Because there was no harm to the COBRA beneficiary and because the law required only notification (written not necessary), the court did not adjudge a COBRA infraction. *Chestnut v. David Montgomery*, 307 F.3d 698 (8th Cir. 2002).

## **Other Coverage**

Having COBRA and severance benefits run simultaneously is not only permissible but may be prudent for the employee. Usual practice of running them consecutively is the less preferred way. *Jenkins v. KLT, Inc.*, 308 F.3d 850 (8th Cir. 2002).

## **COBRA**

Employer relied upon its agent/broker to attend to COBRA details in a correct manner. When agent/broker made a COBRA glitch it was the employer, not the agent/broker who *took the fall*. Employer properly litigated against the agent/broker as an E&O matter however. *Hall v. CWR Construction, Inc.*, \_F.Supp.2d\_ (E.D.Ark. 2002).

## **Plan Administrator**

It is the responsibility of the COBRA participant to show that employer was obligated to provide COBRA and that plan administrator/fiduciary was actually the employer. *Wagner v. Access Cash International*, 212 F.Supp.2d 886 (C.D.Ill. 2002).

## **Notice**

The maximum penalty of \$21,500 was assessed because of the following:

1. Notice was seven months late.
2. Employer somehow expected an unemployed person to pay \$3,300 in COBRA premiums in arrears.

*DiGiovanni v. The Guardian Life Ins. Co.*, \_F.Supp.2d\_ (D.Mass. 2002).

## **Eligibility**

Employer's recordkeeping error kept participant on the plan. As a consequence COBRA benefits had to be offered. Such COBRA benefits could have been avoided had records been maintained correctly. *Swanson v. Greater Metropolitan Hotel Employers–Employee Health and Welfare Fund*, \_F.Supp.2d\_ (D.Minn. 2002).

## **Notification**

It was a COBRA infraction on the part of the employer to expect the employee to give his estranged wife her COBRA notice when employer was aware of such estrangement. *Phillips v. Saratoga Harness Racing, Inc.*, 223 F.Supp.2d 361 (N.D.N.Y. 2002).

## **Federally Mandated Benefits**

### **Medicare Secondary Payer**

In 1997, Congress enacted Pub.L. No. 105-33, which amended Medicare to allow the CMS to bring legal action for the recovery by Medicare of mispayments. The recovery period was three years. The action could be against employers or *others*. In the recovery process, a TPA was the target of recovery in two circumstances:

1. The TPA had the contract for services when the error occurred.
2. The TPA could recover the mispayment from the employer.

Otherwise, the TPA was not liable. The law applied to mispayments after August 1997. Because the law is silent as to mispayments prior thereto, CMS is attempting to proceed against TPAs for such older mispayments. The rules to be followed in the post-1997 recoveries should also apply to the pre-1997 recoveries.

### **Americans with Disabilities Act**

Title IV of ADA forbids discrimination in public accommodations. Does public accommodation include access to insurance? Some have seriously argued that it does, and this issue may have to be tested by a court (maybe in the 9th circuit) sometime soon.

## **Numbers of Interest**

### **What are Employers' Current Benefit Priorities**

- Control health care costs 84%
- Expand Internet usage 39%
- Self-service benefit technology 48%

Source: Deloitte & Touche/ISCEBS, 2000-2002

### **Benefit Objectives**

In monitoring and redesigning their health care plans, employers do have objectives:

• Keep costs low		63%
• Use plans as an HR plus		15%
• Reflect increasing technology	11%	
• Maintain compliance		8%
• Efficient and qualitative administration	<u>3%</u>	
Total	100%	

Source: Deloitte & Touche/ISCEBS Survey, 2000-2002

## Factors Driving Health Care Cost Increases

The reasons for *increases* in health care costs are well-known. Their relative rules in causing the increase is less well-known:

• Technology (medical, Rx, etc.)	21%
• Monetary inflation	18%
• Provider costs	17%
• Mandated benefits (state and federal)	15%
• Utilization (consumer demand)	15%
• Litigation	7%
• Fraud	<u>7%</u>
Total	100%

Source: PricewaterhouseCoopers LLP April 2002

## Retiree Costs

<u>Medicare Card</u>	<u>Monthly Cost Per Individual</u>
No	\$365
Yes	\$195

## Technology as a Trending Factor

Approximately one-third of the 15-17% trending factor in health care costs is due directly to the technology factor. What is sadly true is many providers take advantage of the new technologies to enhance their profits.

## Plan Costs by Degree of Choice

### Monthly Plan Costs - Year 2002

	<u>Individual</u>	<u>Family</u>	<u>Trending Factor</u>
Indemnity	\$240	\$640	17%
PPO	230	600	15%
POS	220	590	12%
HMO	200	545	15%

CD August 2003

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Source: Mercer Human Resources Consulting and Kaiser Foundation

### **Statistics of Interest – Health Promotion**

<u>Program</u>	<u>Popularity Index</u>
Education	70%
Screening	75%
Appraisals	30%
Plan Carrots/Sticks	40%

Source: Health Associates, 2003

### **Menace to Private Health Care System?**

Repeated studies indicate that wastage abuse and splittage add 30% to our health care bill.

### **Medical Inflation – Insured v. Self-Funding**

In 1998, the medical inflation rate for self-funding was about one-half of that for fully insured. At present such rates are comparable.

### **Disability Claims – Psychiatric-Related**

Percentage of disability claims that are of a psychiatric nature:

- Short term 7%
- Long term 11%

### **Reasons for Taking Family Leave**

According to the United States Monthly Labor Review, these are the reasons:

<u>Reason</u>	<u>Percent of Total</u>
Personal health	48%
Maternity/disability	8%
Newborn care	19%
Ill child care	11%
Ill spouse care	6%
Ill parent care	8%
Total	100%

### **Web-Delivered Benefits**

<u>Size of Plan</u>	<u>2001</u>	<u>2002</u>
50 – 999	18%	34%
1,000 – 5,000	39%	50%

Over 5,000                      47%                      66%  
 Source: MetLife Employee Benefits Trends Study 2002

### Popularity of Benefits

<u>Benefit</u>	<u>Percentage of Employees Who Offer or Expect to Offer</u>
Medical	90%
Dental	85%
401(k)	70%
LTD	63%
Vision	60%

Source: MetLife Employee Benefits Trends Study 2002

### Number of Uninsureds

The 41 million people under age 25 reported to be uninsured will likely rise to 46 million in 2005. This would represent some 18% of the population. The survey was government-sponsored.

### Health Care Cost Trending

For larger employers the 2002–2003 trending factor is about 15% (largely managed care). The factor is larger for smaller plans and indemnity plans. Medical is less and Rx is more.  
 Source: TPF&C Survey

### Disposition of Health Care Claims

<u>Provider</u>	<u>Percent</u>
Hospital	32%
Physicians/Clinics	22%
Rx	10%
Nursing Home	6%
Other	23%
Administration	<u>7%</u>
Total	100%

Source: CMS. Study is for both public and private plans.

### Sharing in Employer-Sponsored Health Care

	<u>1980</u>	<u>2001</u>
<u>Annual Cost</u>	\$1,047	\$4,200

Employee	\$188	\$946
Employer	\$859	\$3,254

Employment Policy Foundation, 2003.

## Survey of Case Management Providers

Largest Five in Order of Size  
Measured by Employer Clients

- Managed Care 2000 +
- HHS, Health Options
- Intracorp
- Hines & Associates
- ConCentra Integrated Services

Largest Five in Order of Size  
Measured by Number of Case Managers

- ConCentra Integrated Services
- Intracorp
- GENEX Services, Inc.
- Corvel Corp.
- Medinsights, inc.

Source: *Business Insurance* 2003.

## Survey of Prescription Benefit Managers

Largest Five in Order of Size:  
Measured by staff pharmacists

- Medco Health Solutions, Inc.
- Caremark Rx, Inc.
- Express Scripts, Inc.
- Advance PCS
- Walgreens Health Initiatives

Measured by covered lives

- Advance PCS
- Medco Health Solutions, Inc.
- Express Scripts, Inc.
- Caremark, Rx, Inc.
- Rx America

## Average Employer Cost (Annual)

Health Care Plan – HMO	\$2,260
(Excludes Rx) – PPO	2,623

- POS	3,906
- Indemnity	5,417
Dental	349
Vision	35
Retiree	2,245
Rx	514
STD	333
LTD	114
Plan Administration	397

Source: U.S. Chamber of Commerce, 2001.

## Rx Components

<u>Type of Rx</u>	<u>Minimum</u>	<u>Maximum</u>
Brand	\$0	\$20
Brand Preferred (Formulary)	0	40
Generic	10	50

Source: *Takeda & Lilly Survey Report*, 2001.

## Sources of Health Statistics

The major sources are as follows:

- Center for Studying Health System Changes
- Kaiser Family Foundation/Health Research and Educational Trust
- William H. Mercer, Inc.
- Segal and Co.
- Watson Wyatt/Washington Business Group on Health
- Hewitt & Associates

## Employees Who Plan Not to Retire

A high percentage of employees are presently expecting to work beyond 65. Most do so for financial reasons.

<u>Age</u>	<u>Expecting a Delay in Retirement</u>
Before 54	23%
55 – 65	21
65 +	<u>18</u>
Total	62%

**To order additional copies of *Self-Funding of Health Care Benefits*, visit the International Foundation bookstore at [www.ifebp.org/bookstore/selffundhc.asp](http://www.ifebp.org/bookstore/selffundhc.asp) or call (888)334-3327, option 4.**