

# Current Developments

## June 2003

### Commentary

#### Retiree Medical – Does it have a Future?

Recent surveys indicate the continual termination of retiree coverage and the invocation of restrictions (added participant contributions and benefit cutbacks) should be expected. Overall the future is gloomy for this benefit.

While many present retirees may *not* lose their retiree health benefits, such benefits for future retirees will increasingly be discontinued.

One of the major concerns with retiree medical plans is the very high Rx costs. Being considered for retirees is the defined contribution model. Such model has these advantages:

- For the employers, FAS 106 liabilities are reduced or eliminated.
- Retirees easily grasp the value of the benefits.
- Federal tax disadvantages are avoided.
- Effective coordination with other health plans is more easily accomplished.

As retiree coverage shrinks, seniors will need to cash in their investments to cover their medical costs. Such cashing-in will further depress the already depressed securities market.

#### Health Education

Underlying the defined contribution plan momentum and other more traditional cost containment methods is the presumption that participant involvement will be cost-effective. While doubtless true in many instances, it will likely prove to be an additive, not subtractive, to medical costs. The concept is attractive but it will likely be disappointing cost-wise.

#### Union Resistance to Rate Increases

As health care plans struggle with costs, greater participant sharing (benefit cutbacks and/or contribution increases) are becoming more prevalent. As a direct result of this, growing union opposition (labor demonstrations, e.g.) is being seen.

#### Economic Realities

Consider that employers pay approximately 39% of our base pay for all welfare benefits (11% for health care). We, in turn, pay on average 25% of our pay for

government services as taxes. Eliminating these charges would convert a \$30,000 salary into a \$75,000 salary. This economic reality is one of the driving forces for our manufacturing jobs being sent abroad.

## **Dark Clouds on the Insurance Horizon?**

Maybe. Consider that 30 insurance companies went into receivership in 2001 and 38 in 2002. How many in 2003 is a good question.

The primary reasons are inadequate rates, insufficient reserves, pressure on claims costs (excessive jury awards, e.g.), the hardening reinsurance market (trade tower catastrophe, e.g.) and the depressed economy.

Contributing reasons include poor underwriting, dominance of the *financial mindset* as opposed to the *insurance mindset* and fraud.

One stop-loss carrier (Legion) is now being liquidated with significant losses to many self-funders. Consecro, while not in bankruptcy itself is part of a holding company with companies that are in bankruptcy.

The huge government-owned insurer (PBGC) is presently taking big hits as large companies with unfunded pension plans are seeking Chapter 11 protection. This ploy, in essence, dumps unfunded pension plans on the taxpayers.

As for self-funders that are shopping for stop loss, be careful.

## **News of Note**

### **Ravages of 2002 Health Cost Spike**

The fallout was significant according to a recent Mercer survey:

- Many plans dropped their HMO option, giving the participants fewer choices and causing them to pick up a larger part of the overall cost.
- The overall cost increase for health costs in 2002 was in the 15% range, causing significant inroads in employer earning and participant take-home pay. Expect more of the same in 2003.
- Touted advantages of the PPO option failed to materialize in 2002 in that cost increases for both PPO and non-PPO were about the same.
- The three-tier Rx copay design gained in popularity along with the Rx card.

The three-tier works as follows (as an example):

Brand	\$30 deductible
Formulary	\$20 deductible
Generic	\$10 deductible

### **Captive Insurers**

Archer Daniels Midland can now use its Vermont captive to reinsure its group term life insurance. The old 50% test is now replaced with a facts and circumstances test that looks at these factors:

1. Is the arrangement good for the participants?

2. Is the reinsurer of high quality? Is the insurer of high quality?
  3. Are ERISA-prohibited transactions avoided? This requires the arrangement to use an independent fiduciary.
- Expect more employers to do likewise.

## **Medical Malpractice**

The House-enacted medical malpractice reform bill puts a cap on medical malpractice claims of \$250,000 (noneconomic) and \$250,000 (compensatory). It's up to the Senate to pass or amend.

## **Contraceptive Rx**

Many states have legislated mandates for contraceptive Rx (20 have them and 13 are considering). The movement for all plans (insured and self-funded) to offer such benefits is growing. Also, litigation as a civil rights matter for not offering is a likelihood. Numerous cases have been decided in favor of the female covered person.

## **Privacy of the Social Security Number**

Benefit plans are increasingly attempting to protect the privacy of the participant's Social Security Number. Thieves use stolen SSNs to setup up sham bank accounts and obtain credit cards. Showing SSNs on plan checks, papers, etc., is being eliminated, reduced or protected.

## **Texas Double Scam**

The now-defunct Texas MEWA (American Benefit Plans), referred to as *fraudulent*, used an off-shore stop loss carrier called Britannia International Life & Casualty, Ltd. Britannia is also out of business.

## **The Blues Keeping Rolling Along**

As the big managed care organizations take their hits, the Blues are picking up the casualties. Employers prefer the Blues and their less restrictive PPO model to the tougher HMO model. The Blues currently have nearly 85 million subscribers.

# Legal

## FROM THE BAR

### Standard of Review

Insurance policy said the claims determination would be made *by us* (meaning the insurer). Since the employer, not the insurer, was the plan fiduciary, the plan failed to give adjudication authority to the plan fiduciary. The proper standard of review should be *de nova* and not *arbitrary and capricious*.

*Gallagher v. Reliance Life Insurance Co.*, 305  
F.3d 264 (4th. Cir. 2002).

### Privacy

Privacy laws notwithstanding, the need to protect an ERISA plan from a fiduciary breach will usually be deemed to be paramount over privacy.

*Central States Pension Fund v. Transport Service Co.*, 29 EBC 1314  
(N.D. Ill. 2002);

*Beauchem v. Rockford Products Corp.*, 29 EBC 1468  
(N.D. Ill. 2002);

*PBGC v. Republic Technologies International*, 29 EBC 1117  
(N.D. Ohio 2002).

### Venue

ERISA's language for venue is *where the breach occurred*. This has been interpreted several ways by the court. It could mean:

- Where benefits were denied
- Where payment was due.

Best interpretation is where plan was administered.

*Cole v. Central States Health and Welfare Fund*, 225 F.Supp.2d 96  
(D.C. Mass. 2002)

### Claims Denial

Participant wanted to avoid the ERISA preemption that blocked the invocation of state punitive damages. The plan's denial was believed to be unusually offensive. Even so, the court decided for the plan holding that the egregious nature of the plan's actions was no reason to disallow preemption.

*Beach v. Mutual of Omaha Ins. Co.*, 229 F.Supp.2d 1230  
(D. Kans. 2002)

## **Benefit Interference**

It was an ERISA §510 violation for the company purchaser to cover *actives* but exclude the *inactives* (i.e.; those on disability).

*Lessard v. Applied Risk Management*, 307 F.3d 1020  
(9th Cir. 2002).

## **Standards of Review**

Often the court will apply the *de novo* standard of review where the plan is ASO-administered and the stop-loss is also provided by the insurer. In this instance, the court applied the arbitrary and capricious standard (much less strict on the insurer) because the plan participant did not come to the court with *clean hands*.

*Alford v. DCH Foundation Group Long-Term Disability Plan*, 311 F.3d 955  
(9th Cir. 2002).

## **Claims Denial**

While an ERISA claims denial should set forth the *reasons therefore*, it is not necessary to disclose the *logic behind* such reasons.

*Adkins v. Holland*, 216 F.Supp.2d 576  
(S.D. W.V. 2002)

## **Reporting and Disclosing**

While terminating coverage on former employees is an ERISA violation, it is not a violation of reporting and disclosure, which would attach certain statutory penalties.

*Sampson v. Rubin*, 29 EBC 1293  
(D.C. Mass 2002)

## **Summary Plan Description**

SPD was silent as to the fact that plan administrator delegated discretionary authority to the TPA in the administrative agreement. In a claims dispute, the court held that the proper standard of review should be *de novo* (favoring the plan) as opposed to *arbitrary and capricious* (favoring the participants).

*Mario v. P & C Food Markets, Inc.*, 213 F.3d 758  
(2d Cir. 2002).

## **Benefit Statements**

Where there is sufficient cautionary language, a clerical error will not bind the plan to incorrect benefits.

*Hart v. Equitable Life Assurance Society*, 29 EBC 1831  
(S.D. N.Y. 2002).

## **Reporting and Disclosure**

Employer will not be held liable for failure to disclose a document that it did not have.

*Jones v. Duke Energy Co.*, 29 EBC 1193  
(4th Cir. 2002).

## **Plan Administrator**

A *glitch* in an ERISA plan that is of an administrative nature is not ERISA-preempt; a *glitch* that involves plan benefits, etc., is ERISA-preempt.

*Bui v. American Telephone & Telegraph Co.*, 310 F.3d 1143  
(9th Cir. 2002).

## **MEWA**

Where employers are totally unrelated, plan may be a welfare plan and ERISA-governed. While a welfare plan and ERISA-governed, it may yet be a MEWA with joint state-federal regulations.

*Finderme Management Co. v. Barrett*, 809, A.2d 842  
(N.J. Super. Ct. 2002).

## **Party in Interest**

ERISA plan records were lost in World Trade Center attack. Court did *not* hold insurance company to be a party in interest to the plan and as a consequence responsible therefore.

*American International Life Assurance Co. v. Valezquez*, 29 EBC 1251  
(S.D.N.Y. 2002).

## **Clerical Error – Fiduciary Responsibility**

Administrative firm was sued because of its clerical error of charging a \$4 (rather than an \$8 copay). Because the *gain* from the error went to the Rx manufacturers (and not the Rx administrator), the court held that the administrator was not liable. Also, the role of the administrator was ministerial and purely perfunctory.

*New York State Teamsters Council v. Centrus Pharmacy Solutions*, 29 EBC 1222  
(N.D. N.Y. 2002).

## **Standards of Review**

Plan must say with specificity that the administrator has *discretion* to pay or not pay. Simply saying that claim is payable “when administrator determines that conditions are met” is not enough. In such case, the court held the review should be *de novo*.

*Deal v. Prudential Ins. Co. of America*, 222 F.Supp 2.d 1067  
(N.D. Ill 2002);  
*Ramsdall v. Continental Casualty Co.*, 29 EBC 2024  
(D.C. Kans. 2002).

## **Employee**

Independent contractor never filed a claim prior to sale of company. After it was filed, such person claimed status as a common law employee and sought benefits. Court denied and held for employer.

*Jaeger v. Matrix Essentials, Inc.* 236 F.Supp.2d 815  
(N.D. Ohio 2002).

## **Subrogation**

In seeking a subrogation recovery, the plan argued unsuccessfully that the beneficiary (and her attorney) were ERISA fiduciaries. Reason – it would be contrary to established case law.

*Asbestos Workers Local No. 42 Welfare Fund v. Brewster*, 227 F. Supp. 2d 226  
(D.C. Ill. 2002).

## **Subrogation**

Recent Supreme Court decision *Great West v. Knudson* is thwarting the efforts of the subrogation recovery vendors to recover plan benefits.

*Primax Recoveries, Inc. v. Goss*, 29 EBC 1150  
(S.D. N.Y. 2002).

## **Plan – Establishment**

Employer merely bought and paid for some individual health policies for a selected few of its key officers. In so doing an ERISA plan was created.

*Colarusso v. Transcapital Fiscal Systems, Inc. Top-hat Value Added Plan*,  
227 F.Supp.2d 243  
(D. N.J. 2002).

## **Managed Care**

Matters relative to *quality of care* are ERISA matters and are protected by the ERISA preemption but matters relative *quality of care* are not ERISA matters and are not protected by the ERISA preemption.

*O'Neill v. Brannigan*, 29 EBC 1807  
(3d Cir. 2002)

## **Welfare Plan**

This severance plan, as with most, was held to be an ERISA plan since it was:

- Employer-funded
- Established to provide employee benefits
- Administered with a discernible claims procedure.

*Redstrom v. NOVA Chemicals, Inc.*, 234 F.Supp. 2d 787  
(S.D. Ohio 2002);

*Parshley v. Allied Worldwide*, 29 EBC 1094  
(N.D. Ind. 2002)

## **Reporting and Disclosure**

Insurer acted properly in refusing the beneficiary's request for the UCR data. Reason was that such data has no bearing on the *right* to a benefit but does have a bearing on the *amount* of benefit.

*American Medical Association v. United Healthcare Corp.*, 29 EBC 1488  
(S.D. N.Y. 2002).

## **VEBA – Legal Status of Employer**

Since employer is not a fiduciary, participant or beneficiary, it had no standing to sue. In this instance, employer objected to VEBA administrative errors. Actions against VEBA plan administrator were dismissed because action by participants was for benefits (not fiduciary breach) and administrative remedy rules were not followed.

*Regional Employers' Assurance Leagues VEBA v. Sidney Charles Markets, Inc.*  
29 EBC 2797 (E.D. Pa. 2003).

## **ADA and Claims Denial**

Aggrieved participant sued as an ADA matter because his speech therapy claim was denied. Court held for the plan because a health care plan is not goods offered for public accommodation and is not ADA-controlled.

*Kolling v. Blue Cross & Blue Shield of Michigan*, 29 EBC 2597  
(6th Cir. 2002).

## **Subrogation**

Court applied *Great West v. Knudson* because subrogation action was *legal* and not *equitable* in nature.

*Asbestos Workers Local No. 42 Welfare Fund v. Brewster*, 227 F.Supp.2d 226 (D.C. Del. 2002).

## **Subrogation**

Medical bills were \$100,000; participant settled for \$75,000 of which the attorney kept \$20,000. Plan sought recovery of the \$75,000; participant objected on *made whole* theory. Because of the well-written document and reimbursement agreement, the court held that the plan could recover the full \$75,000 leaving both the attorney and the participant with nothing.

*Palmerton v. Associates' Health and Welfare Plan*, 29 EBC 2913 (Wis. Co. App. 2913).

## **Claims Procedure**

Insurer as ASO administrator approved a claim for Procedure X; beneficiary opted for Procedure Y (less invasive and costly). Insurer denied benefits for Y because of *unproven technology*. When it was shown that insurer has paid for Procedure Y in other similar circumstances, the court held for beneficiary.

*Scaglione v. CIGNA HealthCare of St. Louis, Inc.*, 29 EBC 2823 (E.D. Mo. 2002).

## **Participant to Plan**

Independent contractor has no right to be a participant in an employer's plan because it lacks employee status.

*Mulzet v. R. L. Reppert, Inc.*, 29 EBC 2844 (3d Cir. 2002).

## **Government Plan**

State's continuation of coverage statute, which provides for lifetime continuation for certain government employees, is *not* preempted because the COBRA law is not ERISA but the Public Health Statute.

*State ex rel. Orlofske v. Wheeling*, 29 EBC 1656 (W.Va. Sup. Ct. App. 2002).

# **FROM THE DOL**

## **Service Provider Liability Cap**

The ERISA plan's service provider wished the plan to agree to limit any recovery due to such provider's alleged error to some cap like \$50,000. In DOL Adv. Opn. 2002-BA, it was held that such provision would result in a fiduciary breach by the employer sponsor.

## **MEWA**

A self-funded MEWA, consisting of many small and unrelated employers, survived by having in place 100% reinsurance so that the plan did its own marketing and administration but avoided any risk. The DOL held in Adv. Opn. 2003-3A that the plan was not an employee benefit plan (and consequently not a MEWA) but was subject to regulation by the state.

## **Government Plan**

The Port Authority Police Benevolent Association, Inc (Association) was held in DOL Adv. Opn. 2002-9A to be a government entity for ERISA plan purposes.

## **DOL Final Mental Parity Regulations**

Found in the Federal Register of September 22, 2002 such Regulations extend the law's sunset date to December 31, 2003.

## **Miscellaneous**

- The name Pension and Welfare Benefit Administration was changed to Employee Benefits Security Administration early in 2003.
- The DOL has a new program called H-CAP (HIPAA Compliance Assistance Program) which uses (a) printed items, (b) special web page and (c) regional workshops.

## **Taxes**

### **Self-Employed Deductions**

Special rules apply to these groups:

- Self-employed (independent contractors which show a profit)
- General partner or limited partner who receive guaranteed payments

- Sub-S shareholders with more than 2% ownership.

For such persons, eligible medical expenses, not otherwise reimbursed, are deductible to the extent they do not exceed 70%.

### **Valuable IRS Publication**

- Employer's Tax Guide to Fringe Benefits (2003). Publication 15-B
- Child and Dependent Care Expenses (2002). Publication 503

### **Annual Top Hat Physicals**

The so-called executive physical exams are *not* medical expenses for tax or benefit purposes so long as two rules are followed:

- Family members are not included.
- Where these rules are met, no IRC §105(h) issues will be involved.
- No expenses for treatment are incurred.

Where these rules are met, no IRC § 105(b) issues will be involved.

### **Medical Expenses – Weight Loss Programs**

Diet-related expenses are deductible in only these two instances:

1. Obesity exists without disease and weight loss is medically directed,
2. Hypertension exists without obesity and weight loss is medically directed.

See Revenue Ruling 2002-19.

### **Weight Loss Programs and Health Club Dues**

These are now eligible medical expenses if the program or dues are part of the prescribed treatment for such conditions as obesity or hypertension. However, dues such as for a gym, spa, etc., are not eligible. Special diet foods may be covered but with similar restrictions.

### **Medically-Related Transportation**

The mileage rate of \$0.13 for 2002 becomes \$0.12 for 2003.

### **Premium Option Plan – No Loss of Take Home Pay**

Participant reduces pay by \$100 per month and employer in exchange, pays the participant's group health plan contribution. Employer then makes an \$80 reimbursement payment to participant to equalize take home pay. The \$80 is to reimburse participant for health care premiums. The IRS said *no* to this scheme because the participant never actually paid such premiums which are to be reimbursed. See Revenue Ruling 2002-3.

## **Revised Basis for Earned Income Tax Credit**

A tax break for the low income worker was in the Economic Growth and Tax Relief Reconciliation Act of 2001. That is, an employee's health care plan contribution (defined benefit or defined contribution) is *not* to be counted as income when computing the earned income tax credit. The tax advantage of the credit is that the lower the earned income, the greater will be the tax break.

## **Risk Management**

### **Retiree Medical**

Trend is away from retiree medical benefits. Particularly noteworthy is that many cash-strapped employers must, almost of necessity, drop such benefits.

### **Actuarial Involvement**

The actuarial professional is now focusing on risk management as a deserving topic for their statistical/mathematical skills.

### **Rx Defined Contribution Plan**

Expect this to be a generically-accepted benefit in the near future. The plan works like a consumer-driven health plan. Employers fund a prescription savings account for plan members. When that account is depleted, members are responsible for their own drug costs up to a deductible amount. Drug purchases above the deductible are covered by the plan. Employers can set the exact amounts of the savings account and the deductible level. Unused funds in the saving account roll over to the following year.

To help members make effective drug purchases, the plan will probably feature a comprehensive Web site that informs members about generic alternatives to name-brand drugs.

### **Canadian Rx Purchases**

Even though the practice is illegal, the overt and active encouragement of employers and associations for their plan participants to use Canadian Rx outlets continues.

### **Rx to OTC – How to Handle?**

When a non-sedating antihistamine drug (Claritin) went OTC, what about the other more expensive Rx brands? With a micromanaged plan document, there should be a quick amendment paying for Claritin and lowering the benefit for the comparable Rx brands. With the typical Rx card plan, this can't be done, practically. The Rx companies

have a financial bias against such disincentives. This is one more reason why the Rx card adds to plan costs.

## **Cost Containment**

### **Cost Containment – Ten Key Thoughts**

1. Health care costs are increasing in the 13%-16% range.
2. Managed care has *maxed out* as a *cost container*.
3. Consumerism will be one of the new tools of containment in the near future.
4. Big costs container continues to be higher participant contributions and deductibles and copayments.
5. Role of risk management will increase with demand management being its primary message.
6. High-low plans with the use of the 100% benefit for *steerage* are not proving to be cost containing.
7. *Practice of pharmacy* appears to be as expensive as the *practice of medicine*.

### **New / Popular Cost Containment Programs**

These are currently in vogue:

- Wellness
- Defined contribution
- Multi-tier Rx and carve out
- Demand management.

These are in addition to the ongoing cost shift to plan participants.