

Current Developments

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Legal

COB Eligibility

COBRA beneficiary with his old Employer A went to work with new Employer B. Beneficiary paid his own COBRA premium; Employer B paid his out-of-pocket costs. When beneficiary terminated with Employer B, he was not offered a COBRA notification because Employer B said he was never covered under its plan. Upset that this might have been wrongfully denied continuation, he sued. Court held for Employer B. The outcome would have been different, had the COBRA premiums been paid by Employer B and not by the beneficiary.

Cox v. Transit Group Transportation
___F.Supp.2d___ (S.D. Ohio 2005).

HIPAA Privacy

FBI employee had his diagnosis of depression and compulsive behavior, which were part of his fitness-for-duty reviews, made general knowledge among his fellow employees. This privacy leak was not so much a leak as general knowledge needed for chain-of-command purposes. The FBI agent sued his employer as a HIPAA violation. The court denied his claim citing his complaint to be a private cause of action, which would be disallowed by HIPAA. Open to the FBI agent would be his right to file a privacy complaint with the HHS office for Civil Rights.

Runkle v. Gonzales, ___F.Supp.2d___ (D.D.C. 2005).

COBRA Second Qualifying Event

Former participant and COBRA beneficiary had a dependent son who turned 25, which was a second qualifying event. The insurer was notified in several ways (by both the boy's father and also his mother). The insurer failed to send the boy a COBRA notice; its reason was that it was never notified of the qualifying event. The proper way of handling the event was that the mother (the covered employee) should have formally notified the plan of the boy's change of age. The court did not resolve the matter in summary judgment but left the decision for a jury.

Birkhead v. St. Anne's-Belfield, Inc. ___F.Supp.2d___ (W.D. Va. 2005).

LTD Denial and Standard of Review

For the court to raise the standard of review bar from arbitrary and capricious to *de novo*, the issue of conflicted interest must be existent and recognizable. Also, the claim should, as a general rule, not have been prematurely or improperly denied.

Finley v. Hewlett Packard Employee Benefits Income Plan,
379 F.3d 1168 (10th Cir. 2004).

COBRA Administrator Error

COBRA coverage with a fully insured plan never became effective because the premium never was received by the insurer attributable to a collection/accounting snafu of the (a) Employer and (b) COBRA administration firm. The court held the plan administrator liable and made it pay the claim.

Laden v. Harding Tube Corp., ___F.Supp.2d___ (E.D. Mich. 2005).

Death Benefits-Beneficiary Under Indictment

The court in this dispute reinforces a long-accepted claims rule: if the beneficiary (at least for a death benefit) is under indictment, pay the proceeds under the protection of an interpleader action (i.e., in escrow).

Atwater v. Nortel Networks, Inc., ___F.Supp.2d___ (M.D. M.C. 2005).

HIPAA Privacy

HIPAA regulations of the HHS provides that protected information may be used without the consent of the patient for treatment payment and health care operations. This was challenged in court by a coalition of patient advocacy groups. The argument of the coalition was that the HHS exceeded its authority with its regulations by violating the patient's rights to medical privacy and free speech. The appeals court held that (a) the HHS did not exceed its authority and (b) any infringement on a person's privacy rights did not arise from the regulations but rather on the HIPAA itself.

Citizens for Health v. Leavitt, ___F.3d___ (3d Cir. 2005)

COBRA Notice with Plan Termination

The insurer cancelled the fully insured plan due to nonpayment of premium by the employer on October 1. Participant Ayres was terminated December 1 and sued the owner of the company (Balousek) personally as plan administrator for failure to offer COBRA. The defense of Balousek was that (a) he was not the plan administrator but rather the corporation was and (b) the plan had been terminated prior to the termination of Ayres which made Ayres not eligible for continuation. The court held for Balousek on both points; the reader should note in some similar instances the courts have held that plan termination does not entirely relieve the employer of a COBRA obligation.

Ayres v. Balousek, ___F.Supp.2d___ (E.D. Mich. 2005).

LTD Document Glitch

The employer notified the LTD participants two months prior to a plan benefit change; the notification was a two-page letter. Two years later, the plan participant requested by means of ten separate requests information on plan benefits. Such requests were finally answered 25 days beyond the ERISA 30-day limit. The argument of the employer was that the plan change had been previously provided by the plan participant but obviously lost by such participant. The court awarded such plan participant \$2,500 in penalties.

Otero-Carrasquillo v. Pharmacia, ___F.Supp.2d___ (D.P.R. 2005)

ERISA Statute of Limitations

The participant requested precertification for a medical procedure in accordance with the document of the self-funded health plan. Three years after the final denial of the request for precertification, the participant sued. The employer's position was that the claim was time-based by the ERISA statute of limitation (three years). The court noted that the ERISA statute of limitations of three years does not apply to claims denial and accordingly the court applied the most comparable state law which was ten years. The court therefore held for the participant.

Shaw v. McFarland Clinic, P.C. ___F.3d___ (8th Cir. 2005).

TPA as Fiduciary

Blue Cross in an ASO dispute involving incompetency and breaches said it was not a fiduciary because it was only a perfunctory claims processor. Blue Cross was not the adjudicator of last resort; also, Blue Cross argued that the plan had interceded and demanded that a denied claim be paid. Blue Cross argued that there was rarely enough money in the fund to give Blue Cross free access to payment but rather it had to wait for approval and funding. The court disagreed with all of the arguments of Blue Cross and held it to be a fiduciary with respect to both (a) adjudication and (b) check-writing.

Guardsmark v. Blue Cross & Blue Shield of Tennessee,
___F.Supp.2d___ (W.D. Tenn. 2005).

Relevant Claim Documents

The covered person, with a denied claim, wanted both plan-related and claims-processing type information. Both the TPA and the employer refused to supply such until the covered person filed a lawsuit. The court imposed penalties of \$100 per day on the plan administrator for failure to provide copies of the plan document and SPD, holding that (1) a request may be made by an attorney if there is no reason to question the attorney's authority; (2) a request need not be made directly to the plan administrator if it is forwarded to and received by the plan administrator; and (3) a request need not

specifically ask for documents by name if the plan administrator has knowledge of the surrounding circumstances sufficient to create *clear notice* of the documents sought. The court did not fine the plan administrator for failing to file claims-processing type information, however.

Kollman v. Hewitt Associates, ___F.Supp.2d___ (E.D.Pa. 2005).

Stop-Loss Not a Plan Asset

The employer sued the TPA for failing to timely inform it of some stop-loss insuring. The basis of damages was strictly and narrowly ERISA-related. The TPA pointed out that the ERISA-fiduciary issues were not applicable because the stop-loss was outside the plan. The court agreed with the TPA.

Baker County Medical Services, Inc. v. Fringe Benefits Management Co., ___F.Supp.2d___ (N.D. Fla. 2005).

Severance Plan – ERISA Plan?

The aggrieved former employee sued because his severance benefits were not honored; the suit was in a state court. The court found that this matter was properly for a federal court because the plan was an ERISA plan. The reason for such decision was that the plan had all of the characteristics of an ERISA benefit plan. Even so, the participant failed to qualify for benefits because he did not remain with the employer as the plan required.

Reedstrom v. Nova Chemicals, Inc., ___F.3d___ (6th Cir 2004).

LTD Denial

The master group LTD application clearly indicated that the plan administrator had to have discretionary control for *Firestone v. Bruch* purposes. The insurer prepared the SPD but omitted such language. When a claim contest arose, the plan administrator wished the claim to be reviewed with deference. The court held otherwise (i.e., *de novo*) because the requisite language was missing, for whatever reason. That is, the claim was paid.

Ruttenberg v. United States Life Ins. Co. of New York, 33 EBC 1464 (N.D. Ill. 2004).

TPA Practices Relative to Fraud

Introduction

An opinion expressed by the writer on the topic of fraud and the TPA may be of interest and value to the reader. The key thoughts are offered under these headings:

- Typical TPA Practices
- Duty of TPA to Detect Fraud
- Role of Administration Agreement
- Avoiding Fraud
- TPA as Fiduciary

Typical TPA Practices

The typical TPA practices relative to fraud are as follows:

- a. Congress, through ERISA, sanctified the written plan and the fiduciary obligations to not abuse plan assets; that is, only correct benefits are to be paid. ERISA demands that erroneously paid claims (i.e., abused assets) be restored by either the plan sponsor or the miscreant causing such. ERISA empowers the Department of Labor, as regulatory protector of such assets, to seek such restoration; as it deems appropriate. ERISA makes no distinction whether such abuse was (i) innocent or clerical or (ii) criminal or fraudulent.
- b. The wordings of the primary plan documents reflect the ERISA theme above-cited, but fail to mention fraud as worthy of special distinction. Such primary plan documents are the plan document, certificate booklet and administrative agreement (TPA-Employer). The language of all of these documents predate the time period when fraud was a serious consideration.
- c. Increasingly, as fraud has become a more serious matter (white collar crime and organized crime activities, e.g.), the formal recognition of fraud in plan-related documents is being seen.
 - Stop-loss carriers, as a condition of doing business with a TPA, may ask about the TPA's antifraud practices.
 - Employers, through their consultants or risk managers, may inquire of the TPA in their due diligence questionnaire as to the TPA's antifraud practices.
 - Occasionally, where a TPA-provided performance agreement is given, some condition relative to fraud prevention may be found.
 - TPA's often cite their antifraud practices as a positive service in their sales promotions.

Duty of TPA to Detect Fraud

The subject self-funded health care plan is typically covered by numerous laws/regulations (ERISA, state UR statute, IRC, EEOC, e.g.). They all direct the parties to the plan to do the following:

- Put it in writing.
- Do what you say.
- Say what you do.

Role of Administration Agreement

The standard industry TPA practice with regard to the administration agreement is as follows:

a. For Smaller Plans

- Make the TPA reasonably accountable for errors.
- Require no special incentives/disincentives to gain better than average performances from such TPA.

b. For Larger Plans

- Make the TPA more than reasonably accountable for errors.
- Require special incentives/disincentives to encourage better than average performance. That is, require a contractual performance contract.

Avoiding Fraud

Simple rules to avoid claims fraud are these:

a. Know your provider.

P.O. boxes (or their successors, the mail service firms) must be investigated. Having a tax ID number, as regards fraud, is meaningless. Good providers are usually found in national, state and local medical directories; bad providers are usually found in lists provided by industry, public service or regulatory agencies.

b. Scrutinize computer results.

Blind reliance on the computer in claims, or many other endeavors, will lead to grief.

c. Review with reasonableness in mind.

Suspicious are (i) ill-defined or undiagnosed illnesses and (ii) noninvasive testing. Too many procedures or multiple family members with same treatments must be checked.

d. Screen for bogus patients or treatment.

A simple patient confirmation letter is commonly used and enormously effective.

e. **Emphasize the claims function.**

The claims function is the essence of the TPA's reason for being. Do not treat it as a second-class citizen.

f. **Get employer-consultant feedback**

The TPA may learn a great deal of claim problems from the employers or their consultants.

g. **Analyze claims.**

Periodically review claims grouped by provider, diagnosis, covered person, procedure, etc.

TPA as a Fiduciary

In the early days of ERISA, it was a common recommendation of ERISA attorneys, to put in language such as, "The TPA does not act as a fiduciary..." This is thought by some practitioners to be the best of these three options: (a) disavow being a fiduciary, (b) be silent, or (c) attempt to define when the TPA would not be a fiduciary.

As case law developed, the TPA role as an ERISA fiduciary evolved into a clear definition; regrettably the early language remains *buried* and unchanged in many agreements.

These should be the proper words: the TPA will be an ERISA fiduciary regarding particular acts or function if and only if the TPA has discretionary authority over and/or may exercise discretionary control over such acts or functions; i.e., TPA will be an ERISA fiduciary only if facts and circumstances so indicate, and then limited to specific acts or functions where such discretion may be exercised.

Medical Notes

Oral Bacteria and Overall Health

Periodontal disease is an infectious disease with potentially significant systemic health implications. Gum disease and cardiovascular disease have a strong correlation.

Measures to be considered include the following:

- Increased patient education
- Wellness, screening, prevention programs.

Workplace RNs

These are their tasks:

- Combat workplace accidents and all illnesses.
- Reduce absenteeism.
- Manage cost-containment programs.

Risk Management

Massachusetts Coverage Mandate

Health costs have become the number one concern for small businesses nationwide, according to a study by the Economic Policy Institute. The Institute said that 56.3 percent of small businesses were unable to afford such coverage.

The Massachusetts legislative is proposing making health coverage insurance affordable to all of the state's 500,000 uninsured residents within three years, in part by imposing a payroll tax on businesses that do not presently provide health plans to employees.

Proposed Mandatory 5500 Filing

The DOL currently uses an automated document processing system, known as EFAST, to process Form 5500 filings. EFAST currently accepts (1) government printed *hand print* forms, which must be filed on paper; (2) computer-generated paper forms, which also must be filed on paper; and (3) computer-generated forms that use bar codes to encode data, which may be filed either on paper or electronically. The DOL has now issued a proposed regulation that would mandate electronic filing of the Form 5500 via the Internet. The proposed regulation would apply for plan years beginning on or after January 1, 2007, with the first electronically filed forms due in 2008.

Surveys and Statistics

Health Confidence Survey of 2005

Source of these facts is EBRI. The results:

- 97% of Americans consider the skill, experience and training of their doctors as very important.
- 90% of Americans indicate the provider's communication skills and willingness to listen and explain is very important.
- 89% of Americans think the timeliness of getting care and treatments is very important.
- 85% of Americans think the ease of getting care and treatments is very important.
- 81% of Americans feel the doctor or hospital should have access to their complete medical records.
- 80% of Americans think the personal manner, sensitivity and respect they receive from their health care provider is very important.
- 65% of American feel that increased access to information about the effectiveness of treatment options and the quality of health care providers is very important and 59% feel the knowledge would improve the quality of the health care they receive.
- 63% of Americans tend to view cost as one of the important factors when evaluating health care quality. But cost increases are affecting use: 79% are choosing generic drugs and 71% are taking better care of themselves.

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