

Seven “Deadly Sins” To Avoid When Negotiating Self-Funded Benefits Plans

Every year, an increasing number of corporations decide to self-fund the medical benefits they provide to their employees. They are drawn to readily apparent advantages, such as up-front cost-savings, tax benefits and avoidance of state laws. Due to the specialized nature of this area, however, it can easily happen that neither human resources personnel nor corporate counsel fully understand the small print behind their self-funded benefits



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plans. In particular, they may not appreciate important nuances that can impact the three principal documents of self-funding: third-party administrator (“TPA”) agreements, stop-loss insurance policies and summary plan descriptions (“SPDs”).

Understanding these contracts, and how they interact with insurance regulations, state laws and the Employees’ Retirement Income Security Act of 1974 (“ERISA”) can save corporations in general, and their corporate counsel in particular, significant headaches and expense. Many problems can arise from mistakes related to self-funded

plans, including substantial financial losses, Sarbanes-Oxley exposure, labor relations issues and lawsuits from employees. Some of these problems can be mitigated, or even avoided entirely, by improvements within the plan documentation.

Thus, whether starting up a self-funded plan, or renewing an existing one, corporations should keep the following considerations in mind:

1. Don’t Assume Responsibility for Making Final Determinations.

TPA contracts often attempt to provide that corporations, rather than TPAs, are responsible for the ultimate determinations of medical claims. Such provisions, however, may benefit TPAs more than corporations. It is not essential for corporations to agree to such provisions. Corporations should not do so unless they affirmatively want this responsibility.

In considering this issue, corporations should recognize that they may find it difficult to make final claims determinations. Unless the corporations happen to be in the business of health insurance, they may lack the qualifications and experience necessary to evaluate issues like medical necessity and “usual and customary” rates. They may even be precluded by law from accessing certain necessary information.

TPAs, in contrast, are fully qualified to make final claims determinations and should be held accountable for doing so.

2. Avoid TPA Contracts that Minimize the TPAs’ Fiduciary Duties.

TPA contracts often attempt to minimize the fiduciary obligations of TPAs. Corporations are well served by contract language that has the opposite effect. One example is contract language that affirmatively identifies TPAs as agents, as most states place high legal burdens on agents to act in the interests of their principals. Even without using the word “agent,” there are many other ways in which contracts can impose comparable legal burdens upon TPAs.

Corporations rely heavily upon TPAs for expertise and valuable advice. They should ensure that their contracts require their TPAs to act in the corporations’ best interests, rather than looking out for number one.

3. Avoid TPA Contracts without Indemnification Provisions.

Indemnification provisions are important to TPA agreements because TPAs frequently act on behalf of corporations. Thus, corporations can end up with up-front liability for TPA mistakes. In such situations, indemnification provisions are a way for corporations to make themselves whole. The mere existence of indemnification provisions can have a valuable deterrent effect on TPAs and prevent mistakes from happening.

At the negotiating table, corporations should request indemnification provisions that are triggered by negli-

gent conduct and/or lack of ordinary care and reasonable diligence by TPAs. At the very least, indemnification provisions should be triggered by acts of gross negligence and fraud. No matter the trigger, all TPA contracts should provide for some form of indemnification.

4. Avoid TPA Contracts Without Run-Out Services.

Run-out services are important to TPA contracts because, with medical benefits, there inevitably will be some claims in the pipeline at the end of a contract period. Just because one TPA contract ends on December 31st and the next one starts on January 1st does *not* mean that the plan will have seamless TPA services. Run-out services fill the gap.

Different TPAs have different requirements for obtaining run-out services. Corporations should understand what actions trigger their TPAs' run-out obligations and should take all actions that are required.

5. Avoid Gaps in Stop-Loss Insurance Coverage.

Stop-loss insurance policies are another of the three basic agreements of self-funding. These policies cover medical claims exceeding a particular threshold amount in a given policy period.

In stop-loss policies, coverage typically is based on when claims were incurred and paid. The policy terms can vary widely, with run-in periods at one end of the spectrum and run-out periods at the other.

Stop-loss coverage for run-out claims can be important when corporations decide to change TPAs and stop-loss insurance companies. To smooth future transitions, corporations would be well advised to request that their stop-loss policies set forth, from the outset, the terms and conditions for such coverage at termination.

6. Avoid Agreements To "Laser" Employees From Coverage.

Corporations and traditional health insurers typically are barred from terminating an individual's health coverage on grounds that the individual is ill. Stop-loss policies, however, regularly attempt to exclude individuals on such grounds. This tactic, called "lasering," can leave corporations liable for those individuals' medical benefits, without stop-loss coverage.

The concept of lasering undermines the principle behind stop-loss coverage. If stop-loss insurers laser all likely exposures, then premiums may never lead to actual coverage. For this reason, among others, some states are starting to ban the practice altogether. In addition, corporations can combat the practice by rejecting stop-loss proposals that contain lasers.

7. Avoid Surprises, When It Comes to Applicable State Laws.

Many corporations generally understand that self-funded plans are governed exclusively by ERISA and state laws are preempted. Preemption has considerable value to corporations, particularly because it avoids state-mandated coverage.

Many corporations do not know, however, that stop-loss policies are covered by state insurance laws. Stop-loss coverage constitutes "insurance," which traditionally has been reserved to the states. State regulation of stop-loss insurance policies has positive and negative effects for self-funded corporations. For example, some states deem stop-loss policies to be subject to state mandates in certain circumstances. Other states, however, require stop-loss policy applications to offer run-out coverage and, when it is not offered, provide it statutorily.

Conclusion

While self-funding will never be risk-free, informed corporations have many tools for protecting themselves. A good starting point is to understand the "deadly sins" of contract negotiation and ensure that the final plan documents serve their interests, not just the interests of others.

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