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Self-Administration of Insurance Policies
Are You Qualified to Do It and, If You Err, Who Pays?

By Rhonda D. Orin

Just in case corporate law departments don't have enough to think about, here's one more thought for the new year—do corporations that self-administer their health, life and disability insurance plans do their jobs correctly, and does anyone fully appreciate the exposure if they don't?

These questions are important because self-administration can be like anesthesiology: 99 percent boredom and 1 percent sheer terror. Much of the job involves fairly routine record-keeping, not likely to be of interest to anyone outside of the Human Resources department. But, when something goes awry, the consequences can be great, triggering legal liability, employee relations issues, financial exposure and considerable legal complexities.

One self-administered hospital system learned this lesson the hard way with regard to its life insurance plan. There, a benefits administrator advised an employee that he was entitled to purchase an increase in benefits without providing additional documentation, such as evidence of insurability. 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 was that evidence of insurability had been required after all. 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, known as the 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 who 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. Thus, it was the employer who ended up paying to the widow—out of corporate coffers—a sum equal to the denied life insurance benefit.

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Every homeowner knows that there's no such thing as just one mouse. The same axiom applies to mistakes in self-administration of insurance policies. 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.

The following, accordingly, is a list of some issues that corporate counsel should consider when first alerted to a seemingly isolated mistake down in HR:

Internal Controls

Is the corporate law department sufficiently involved in the systems used by HR and benefits personnel to identify and enforce the requirements

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A Note from the Editor

Liability is a complicated issue for corporations that self-fund their benefit plans and self-administer their insurance policies. The articles in this issue examine who can be held liable for mistakes: insurance companies, third-party administrators or plan sponsors (typically, the corporations themselves). They also address which state and federal laws may apply and which courts may have jurisdiction if lawsuits arise

—Rhonda D. Orin

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of a self-administered insurance policy? Especially since the passage of the Sarbanes-Oxley Act of 2002, 15 U.S.C. §7201, et seq., it has become increasingly risky for a corporation to have skimpy review and oversight in this arena. To have adequate controls, the corporate law department 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 (d) whatever combination of these approaches has been selected by that corporation. 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 and insurance policies. Other controls may involve conducting spot-checks of randomly selected employees, 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 frequency of turnover.

Potential Financial Exposure

Once a mistake is recognized for a single employee, all efforts should be made to locate others in the same situation, and to put a dollar sign on the benefits at risk. Although tedious, this task must be undertaken promptly, as 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 upcoming public 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. Specifically, if a second mistake is made, after a corporation has arguably been placed "on notice" of the problem, the corporation's legal exposure may be higher than it was for the first mistake. But it would be a valid defense for a corporation to show that it took steps immediately to avoid other mistakes and that, although those steps may have failed to prevent the second mistake, they may have succeeded in preventing a third one.

Labor Relations

At all levels of a corporation—from top executives to mailroom personnel—employees can be extremely touchy about the possibility of errors in their benefits. Life, health and disability insurance can have enormous consequences on an individual level. Thus, rumors and unrest, along with a decrease in productivity, can spread quickly at the mere thought of problems. Unfortunately, this sensitivity was heightened by the collapse of Enron Corporation and the substantial amount of publicity accorded to employees who witnessed their 401k funds fall victim to abject corporate mismanagement (Alan Sloan, "Enron Day Provides Little to Celebrate," *Washington Post*, Oct. 15, 2002, at E1.). In recognition of this environment, corporate counsel would be well-advised to move HR 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 ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, et seq.); the Sarbanes-Oxley Act, as mentioned above; HIPAA (Health Insurance Portability and Accountability Act of 1996), Pub. L. No. 104-191, 110 Stat. 1936 (1996); IRS codes and regulations (Internal Revenue Code, 26 U.S.C. §§ 401, et seq.); state insurance laws; and state unfair trade practices acts, among other things. To cite but one example, if an employee sues an 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. 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. Thus, whenever corporate counsel are presented with a potential problem in HR, they should carefully consider which procedural and substantive laws would be applicable to all possible issues.

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Self-administration of insurance plans offers many benefits to corporations, particularly in terms of the bottom line. Corporate counsel should remember, though, that self-administration is not for the faint of heart. When problems arise, as they inevitably will, quick thinking by corporate counsel can prevent this cost-saving measure from turning into a financial sieve.

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Fifth Circuit Holds That Some Claims Against Insurance Companies Fall Under ERISA, While Others Do Not

By Daniel J. Healy

ERISA was enacted for the purpose of, among other things, giving employers certain protections when they sponsor employee benefit plans. A recent decision from the Fifth Circuit, however, highlights how those protections can sometimes be used by insurance companies against employers.

In *Bank of Louisiana v. Aetna U.S. Healthcare, Inc.*, 468 F.3d 237 (5th Cir. 2006), the plaintiff bank had contracted with Aetna both to administer and to provide stop-loss insurance for the bank's employee medical benefits plan. From 1995 to 2000, the plan was self-funded. At the 2001 renewal, the bank converted to a "fully-insured" plan. To protect itself from incurred-but-not-received claims, the bank purchased 90 days of "runoff" stop-loss coverage.

Just prior to renewal, the employee claims on the plan hit the aggregate stop-loss levels, triggering coverage. All of the relevant claims were submitted to Aetna—in its capacity as plan administrator—for payment within the run-off period, but Aetna paid

SPOTLIGHT

Claim Administration Mistake? Take Heart— TPA May Be Deemed a 'Fiduciary' Under ERISA

By Tess Ferrera

If you are a plan sponsor who hires insurance companies or others to administer your health care plan, and you allow them to pay claims out of a plan account, take heart! If the claims administrator makes a mistake, you may have an ERISA remedy for a breach of fiduciary duty. This is true even if your contracts say the administrator is not a plan fiduciary.

Under ERISA, a person is a fiduciary "to the extent" he or she (i) exercises discretion over the management or administration of a plan; *or* exercises any authority or control over the management or disposition of plan assets; (ii) renders investment advise for a fee or other compensation; or (iii) has any discretionary authority or responsibility in the administration of a plan. See 29 U.S.C. 1002(21)(A)(i)-(iii).

ERISA's test of fiduciary status requires the application of its definition, despite the actor's official status or title. Courts, however, 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, even if he or she doesn't exercise discretion.

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).

As a plan sponsor, this means that not every mistake is necessarily your fault. When mistakes happen, as they inevitably will, first look carefully at what caused the mistake and who is accountable for it and then proceed, fully informed, toward a resolution.

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less than half of them during that time. Aetna did not pay those remaining claims until after the run-off period ended. The problem arose when Aetna, switching hats and acting as the stop-loss insurer, then denied coverage for those later-paid claims.

The bank sued Aetna on numerous grounds, including state-law claims for breach of contract, misrepresentation and detrimental reliance. Aetna raised preemption and the district court decided that those state-law claims were completely preempted. The Fifth Circuit reversed in part, based on the determination that the only claims to fall under ERISA were those which required proof of improper plan administration. It held that claims turning on plan administration are preempted because: (1) plan administration is an area of exclusive federal concern, and (2) claims of improper plan administration impact a relationship among traditional ERISA entities.

In finding that the bank's state-law claim for breach of contract was partly preempted, the Fifth Circuit held that the stop-loss policy was not a plan asset because it protected the employer, not the employees. As such, the policy fell outside ERISA and so did causes of action relating to coverage. In contrast, causes of action relating to Aetna's failure to timely process and pay medical claims fell under ERISA because they related to plan administration.

The decision is at odds with some of the central purposes of ERISA—to protect employers and permit them to provide cost-effective benefit plans. Aetna itself has taken the position that contracts for plan administration are outside ERISA and not preempted. For example, a previous issue of this newsletter discussed a case that Aetna brought against an employer alleging state-law breach of contract for the employer's alleged failure to reimburse Aetna for a claim that Aetna had paid. The contrast between these two positions shows that insurance companies try to take advantage of ERISA's complexities—and that employers need to be sure that they are fully informed about these complexities, and protect from such tactics, at all times.

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More than half of the businesses in America now self-fund their employee benefits plans, rather than purchasing traditional insurance policies. This percentage is likely to increase, due to the up-front cost-savings that can be achieved by self-funding and the opportunity for certain legal protections. Yet self-funding is complicated and its advantages are accompanied by a wide variety of disadvantages. This quarterly publication is dedicated to exploring all aspects of self-funding, with a focus on the practical needs of employers.

If you require more information, legal advice or an opinion with respect to a specific situation, please contact our editorial board.

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