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Notice Under Stop-Loss Policies: Don't Take "It's Late" For An Answer!

By John N. Ellison and Jackie Taylor

Many stop-loss or excess-loss policies in the medical benefits area do not include "notice of claim" provisions like companies face in commercial general liability policies. A stop-loss policy typically requires a policyholder to "submit a claim" within a certain amount of time after the end of the period for which the claim is made. The stop-loss insurance company may only require its policyholder to "provide us with whatever information we need for proof of payment or meeting of any deductible." In contrast, a commercial general liability occurrence policy normally requires that it be "notified as soon as practicable of an 'occurrence' or an offense which may result in a claim," and the insurance company specifies what "notice" should include.

What is the Notice-Prejudice Rule?

In a stop-loss policy, the policyholder is submitting a claim for reimbursement of previously paid health care benefits. The policyholder is not providing notice in the same sense and for the same purpose as under a liability insurance policy. However, an insurance company may still argue "late notice" if the company submits claims beyond whatever time period is specified in the policy. In most jurisdictions, late notice does not cut off a claim if the insurance company did not suffer prejudice. An insurance company that seeks to avoid its contractual obligations on the grounds of late notice must demonstrate that it was "actually prejudiced" by the alleged delay in notification. As a result, a policyholder can make a good argument that even a "late" claim should be paid by a stop-loss policy.

"Stop-loss insurance companies will have difficulty winning on a late notice defense because of the nature of the insurance."

Notice Requirements Under Stop-Loss Policies

The notice-prejudice rule applies to stop-loss or excess-loss policies even in states where it does not apply to all types of insurance. In most states, however, the notice-prejudice rule applies to all types of policies. Stop-loss insurance companies will have difficulty winning on a late notice defense because of the nature of the insurance. What constitutes sufficient notice to a stop-loss or excess-loss insurance company will be treated in a more relaxed and lenient fashion than notice is in other circumstances. Since these types of policies are excess coverage or reinsurance, any notice requirement will be typically measured by the test applied to notice obligations to excess insurance companies or reinsurers. Timeliness of a policyholder's notice to an excess insurance company is to be deter-

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A Note from the Editor

This issue addresses topics in self-funding that have received a great deal of attention. The first article deals with the issue of notice under stop-loss policies. Many stop-loss or excess-loss policies in the medical benefits area do not include "notice of claim" provisions that are typical in commercial general liability policies. Thus, employers should be aware that they need not take "it's late" for an answer when they submit claims under these policies.

The second article deals with a recent Seventh Circuit decision that an insurance company providing a policy for a self-funded plan is a fiduciary for purposes of ERISA liability.

Finally, our Spotlight sections asks the question "Is Your Claim's Processor's IT House in Order?"

We hope you enjoy this issue.

—Rhonda D. Orin

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mined by considering whether the policyholder acted reasonably under all the circumstances. Moreover, a stop-loss or excess-loss insurance company will have difficulty proving prejudice because such carriers generally do not handle the policyholder's underlying claims—a third-party administrator or a medical insurance company does. Since the burden of proof is on the insurance company, and prejudice is ordinarily a question of fact, a stop-loss or excess-loss insurance company should generally be unable to defeat a company's ability to be reimbursed for health benefits previously paid.

Specifically, in the context of a stop-loss insurance policy, an insurance company arguing that it was prejudiced must show it lost something that would have changed the handling of the underlying claim. (*Operating Eng'rs Health & Welfare Trust Fund v. Mega Life & Health Ins. Co.*, No. C 02-04072 CRB, 2003 WL 22416395, at *7 (N.D. Cal. Oct. 21, 2003) (quoting *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal. Rptr. 2d 815, 846 (Cal. Ct. App. 1993)). In *Operating Engineers*, the insurance company argued that it was prejudiced in the amount of uncharged premiums because the untimely notification of claims caused it to not raise premiums. The court rejected that argument because Mega Life and Health Insurance Company could have used the information on "summary notification reports" to calculate premiums and because Mega Life's failure to raise premiums is not the type of "actual prejudice" contemplated by the notice-prejudice rule.

That rule "deals with an insurer's inability to settle the claim for less, or reduce or eliminate liability for that underlying claim." (*Id.*) In *Operating Engineers,* Mega Life did not argue that the claims were not covered by the policy or that it suffered from an inability to investigate the claims. Rather, it denied these claims solely because they were submitted after 90 days, and claimed prejudice solely due to its failure to raise premiums at renewal. The court found that the increased premium would apply to a completely different policy, and that Mega Life had not shown prejudice with respect to any of the five claims at issue. The court concluded as a matter of law that "prejudice must be shown with respect to the underlying claim, i.e., that Mega Life would have changed the handling of the underlying five claims had the claim been submitted within 90 days." (*Id.* at *8.)

A policyholder that pays large claims should always try to submit or give notice of those claims to its stop-loss insurance company as soon as possible to ensure reimbursement. If the policyholder is advised that its notice was late, the policyholder should not accept a denial of coverage. With the help of experienced insurance coverage counsel, the policyholder can argue in most jurisdictions that it did not breech any "late notice" requirement, the insurance company in any event did not suffer prejudice, and its claim should be paid.

John N. Ellison is the managing shareholder of the Philadelpia office of Anderson Kill & Olick. Mr. Ellison's practice consists exclusively of advancing policyholders' rights and efforts to maximize their insurance coverage. Mr. Ellison can be reached at jellison@andersonkill.com or (215) 568-4710.

Jackie Taylor is an attorney in the Anderson Kill's Philadelphia office. Ms. Taylor's practice is concentrated in the area of business litigation, with emphasis on insurance coverage. Ms. Taylor also has experience with commercial arbitration matters. Ms. Taylor can be reached at jtaylor@andersonkill.com or (215) 231-3644.

Insurance Company Declared ERISA Fiduciary; Court Cites Company's Actual Coverage Determinations

By Daniel J. Healy

The Seventh Circuit recently held that an insurance company providing a policy for a self-funded plan may be a fiduciary for purposes of ERISA liability, even if not designated as such in the plan. (*Rud v. Liberty Life Assurance Company of Boston, Inc.*, Case No. 04-3655 (7th Cir. Feb. 22, 2006)). The holding is an important victory for self-funding employers, who are often the only designated fiduciaries in their ERISA welfare benefits plans, even though the insurance company makes all coverage decisions.

Rud involved a welfare benefits plan that the

employer, Andersen Windows, Inc. (Andersen), provided for its employees. Andersen insured the disability portion of the plan through the defendant, Liberty Life. Liberty Life had denied permanent disability benefits to the plaintiff, Rud, who then sued for coverage. Interestingly, Rud did not sue his employer (Andersen), only Liberty Life.

ERISA plan participants ordinarily may only sue the plan fiduciary when benefits are denied under an ERISA plan. ERISA provides contractual liability only and limits damages to the value of the benefit denied, plus attorney's fees. Very often, ERISA plans such as Andersen's designate an "administrator" responsible for making coverage determinations and, thus, is a fiduciary. As the court framed the issue: "[t]he plan's administrator was [Andersen], not Liberty Life. But if Liberty Life was not an ERISA fiduciary too, there is no basis for Rud's claim." (*Id*. at 3.)

The court looked beyond the plan language for evidence that Liberty Life was in fact a fiduciary with discretionary authority. Liberty Life's disability policy provided that Liberty Life "shall possess" conclusive and binding authority to construe the terms of the policy and make benefit eligibility determinations. (*Id*. at 3.) Reading the policy and the plan together demonstrated that Andersen and Liberty Life had split the role of fiduciary. Andersen decided who was eligible to participate in the plan and Liberty Life decided who was eligible to receive benefits. (*Id*. at 4.)

Further evidence of Liberty Life's fiduciary status was that when it determined coverage under its policy, it was determining whether benefits would be paid. As the court put it "The policy *is* the plan." (*Id*. at 5) (*emphasis original*). Thus, Liberty Life was a de facto administrator.

The court recognized that its opinion involves a split in authority as to whether two administrators can coexist. In defending its holding, the court stated that the right question to ask in determining fiduciary status is: "whether the particular defendant made a discretionary determination concerning the plaintiff's entitlement to plan benefits." (*Id*. at 5.)

In holding that Liberty Life was a fiduciary, the court denied Rud's claim. He had brought a state law claim against Liberty Life alleging that it was not a fiduciary and had a conflict of interest

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SPOTLIGHT

Is Your Claim Processor's IT House in Order?

By Glenn Perdue, Crowe Chizek and Company

Self-funded companies rely on third-party administrators (TPA's) and insurance companies—through administrative services only (ASO) arrangements—to process their health insurance claims using various computerized systems. Companies should be mindful of the business risks associated with the use of these systems in processing their health insurance claims.

When a claim is presented, one system may check for member eligibility; another may process the claim while considering eligible services; a different system may re-price the claim; and, finally, yet another system may actually process the payment. Furthermore, insurance companies may have separate systems for certain lines of business (e.g., HMO, PPO) or certain types of customers because of acquisitions or other factors.

In addition to problems that arise from attempting to integrate these disparate systems, issues related to data problems, software glitches and human error can cause self-funded entities to overpay claims. IT issues may also cause unnecessary exposure to regulatory, litigation and provider defection risks for the self-funded entity due to the nonpayment, underpayment or slow payment of claims.

A 2002 article titled "Can Aetna Cure Its IT Woes" discussed how Aetna's aging systems allowed claims to be paid multiples times. (David Carr and Edward Cone, "CIO Insight," *Baseline Magazine*. August 9, 2002.) And in a 2005 article titled "Why Software Fails" the author cites a 1996 Oxford Health Plan software implementation as one of the biggest IT failures in history. (Robert N. Charette, *IEEE Spectrum Magazine*. September 2005.) Oxford's October 1997 announcement of losses related to these IT problems triggered a one-day stock price drop of 62 percent and resulted in a shareholder class action lawsuit in which "failure to disclose the total inadequacy of its computer system to verify and process claims

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in making benefit determinations because it had a financial motive to deny benefits.

Conclusion

On a larger scale, *Rud* is an important victory for employers. Despite that insurance companies and TPAs make benefit determinations, they often try to force employers to accept all liability for such determinations. *Rud* makes clear that that practice is not appropriate or supported by the law. The ruling may help employers avoid becoming embroiled in lawsuits with their employees and TPAs.

Daniel J. Healy is an attorney in Anderson Kill & Olick's Washington, D.C. office. Mr. Healy has recovered millions of dollars for self-funded plans from third-party administrators, stop-loss insurers and others, and also have extensive experience in representing policyholders against insurance companies in traditional coverage disputes. Mr. Healy can be reached at (202) 218-0048 or dhealy@andersonkill.com.

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from health care providers or generate bills to its customers" was cited as a primary claim.

Self-funded entities should be aware of potential IT problems that may lead to unnecessary costs and risks when contracting with a TPA or insurance company. Additionally, self-funded entities must be vigilant in monitoring processing activity to insure that claim payments are accurate and risks are acceptable.

Glenn Perdue is an executive in the Forensic Services Group of Crowe Chizek and Company LLC in the Nashville, TN office. Mr. Perdue has extensive experience in business and technology matters as a consultant and expert witness. He can be reached at (615) 360-5609 or gperdue@crowechizek.com

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.

Rhonda D. Orin, Editor	Insurance/ERISA	(202) 218-0049	rorin@andersonkill.com
John N. Ellison	Insurance Recovery	(215) 568-4710	jellison@andersonkill.com
Phillip England	Tax/Captives	(212) 278-1483	pengland@andersonkill.com
Daniel J. Healy	Insurance/ERISA	(202) 218-0048	dhealy@andersonkill.com
Dona S. Kahn	Employment & Labor Law	(212) 278-1812	dkahn@andersonkill.com
Jackie Taylor	Insurance Recovery	(215) 231-3644	jtaylor@andersonkill.com
Sloan J. Zarkin	Employment & Labor Law	(212) 278-1474	szarkin@andersonkill.com

The firm has offices in New York, Chicago, Greenwich, Newark, Philadelphia, and Washington, DC.