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Is Your Self-Funded Health Plan Stable?

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While nothing can be as tranquil as a pristine snowscape, nothing can be quite as frightening as an avalanche. Most avalanches occur in remote areas and often transpire quietly and unnoticed. A new avalanche may be descending on employer sponsored self-insured health benefit plans that could be extremely dangerous. In February of last year, Attorney General Andrew M. Cuomo (New York) announced that he was conducting an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates. At the center of the scheme is Ingenix, Inc., the nation's largest provider of healthcare billing information, which serves as a conduit for rigged data to the largest insurers in the country.

Cuomo also announced that he has issued 16 subpoenas to the nation's largest health insurance companies including Aetna (NYSE: AET), CIGNA (NYSE: CI), and Empire BlueCross BlueShield (NYSE: WLP), and that he intends to file suit against Ingenix, Inc, its parent UnitedHealth Group (NYSE: UNH), and three additional subsidiaries. His six-month investigation found that Ingenix operates a defective and manipulated database that most major health insurance companies use to set reimbursement rates for out-of-network medical expenses. Further, the investigation found that two subsidiaries of United (the "United insurers") dramatically under-reimbursed their members for out-of-network medical expenses by using data provided by Ingenix. The passage of time has seen several of the companies listed above settling with New York with the proviso that they would help fund an updated independent charge database.

Many people reading this article may think what impact does this have on me; it is only happening in New York? The simple answer is other state attorney general's will very likely pick up on this issue and champion it in their states. Another wrinkle would be that this issue could potentially move to a class action status. While fully insured health benefit plans have little to worry about retroactively (prospectively they could anticipate higher future premiums), self-funded plans do since any finding will cause additional payments to be levied directly against the plan sponsor. While most in area claims are covered by a contract that the TPA has with an insurance company, most out of area and or out-of network claims are paid on a reasonable and customary (R&C) basis.

In previous articles that I have written, I have advised employers to audit their self-insured plans to ensure that the plan is being run in compliance with the SPD (Summary Plan Document). Typically these audits uncover savings related to lost Rx rebates, benefit coverage errors or improper payments/discounts made by the third party administrator and uncovering eligibility errors. Typically, these initiatives can uncover up to 10% or higher returns for the employer.

With the Cuomo investigation and anticipated legal actions, further emphasis is added as to the ability a company has to ascertain if there may be exposure to undisclosed financial risks. Every employer with a self-funded plan has a fiduciary duty to assess their programs compliance with the SPD. From a SOX perspective, the employer cannot bury their head in the sand and believe that their TPA (third party administrator) is performing according to their wishes and complying with the myriad of laws and regulations without exerting some oversight, whether direct or through an outside auditing firm. Most TPA agreements insulate the TPA from the liability of improper claims processing. At the end of the day, if the TPA has underpaid claims for the employer, the employer will be held responsible. If claims have been under paid for a number of years, the exposure could be material to your bottom line.

Another interesting wrinkle to watch that has the potential to impact on your medical plans is MetLife Insurance Co. v. Glenn. This case made it to the 6th US. Circuit Court of Appeals which found that there was a basic conflict of interest in the entity paying for and administering benefits under a workers compensation program. A synopsis of the case excerpted from the US Circuit Appeals Court opinion follows:

In the instant case, MetLife is authorized both to decide whether an employee is eligible for benefits and to pay those benefits. This dual function creates an apparent conflict of interest. In discussing the applicable standard of review, the district court identified this conflict of interest as a relevant factor in determining whether an abuse of discretion had taken place. See Glenn v. Metropolitan Life Ins.Co., 2005 WL 1364625 at *4 (S.D. Ohio, June 8, 2005) (citing Firestone Tire & Rubber, 489 U.S.at 115 (“[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a ‘facto[r]’ in determining whether there is an abuse of discretion.”)).

However, the court's analysis of the plan administrator's basis for terminating benefits does not include any discussion of the role that MetLife's conflict of interest may have played in its decision nor appear to give that conflict any weight. It appears to us, as a result, that this factor did not receive appropriate consideration by the district court.

Even when it is reviewed under the highly deferential standard applicable in this case, we conclude that the plan administrator's determination to deny benefits to Glenn cannot be sustained. [The] obligation under ERISA to review the administrative record in order to determine whether the plan administrator acted arbitrarily and capriciously in making ERISA benefits determinations . . . inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. (emphasis added)

Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan [administrator] was able to find a single piece of evidence – no matter how obscure or untrustworthy – to support a denial of a claim for ERISA benefits. McDonald, 347 F.3d at 172.

For the reasons set out above, we conclude that MetLife's decision to deny long-term benefits in this case was not the product of a principled and deliberative reasoning process. MetLife acted under a conflict of interest and also in unacknowledged conflict with the determination of disability by the Social Security Administration. In denying benefits, it offered no explanation for crediting a brief form filled out by the patient's doctor while overlooking his detailed reports. This inappropriately selective consideration of Glenn's medical record was compounded by the fact that occupational skills analyst and the independent medical consultant were apparently not provided full information from the patient's physician on which to base their conclusions. Moreover, there was no adequate basis

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for the plan administrator's decision not to factor in one of the major considerations in Glenn's pathology, that of the role that stress played in aggravating her condition and, in the language of the MetLife policy, in preventing her return to "gainful work or service for which [she is] reasonably qualified taking into consideration [her] training, education, experience, and past earning." Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious.

The Appeals Court reversed the judgment of the district court and remanded the case with directions to reinstate Glenn's long-term disability benefits, retroactive to the date on which they were terminated, and for such other relief as the district court finds appropriate in view of our ruling in this case. On April 23, 2008, the U.S. Supreme Court heard oral arguments in *MetLife Insurance Co. v. Glenn*. Lonie Hassel, a principal of the employee benefits firm, Groom Law Group in Washington, DC, as quoted in the *Washington Business Wire*, believes the ramifications of the case may be more subtle for employee benefits plans than conventional wisdom holds. He also posited that, "a ruling in this case should lead to more uniform decisions on employee benefit claims where facts are similar by establishing the standard of review to be used by courts in reviewing benefit claim decisions made by dual-role administrators. Are there any ramifications for employers should the Supreme Court side with the "inherent conflict of interest" standard used by the 6th U.S. Circuit Court of Appeals? Plan sponsors could choose to change their plan administration process to avoid the consequence of the stricter standard of review that could be required based on an "inherent conflict of interest."

Many companies have also combined their health benefits plans with their workers compensation medical coverage; this could make life even more interesting in light of any decision on emanating from *MetLife Insurance Co. v. Glenn*.

With health care now comprising a major portion of a company's budget, CEOs and CFOs cannot afford to overlook the potential impact on their financial statements. The two major issues we discussed highlight the importance of monitoring compliance and performance of ERISA based benefits. While ERISA plans offer employers many levels of savings and freedom from multiple jurisdictional regulations, it does not relieve them of the responsibility to exercise fiduciary duties. If you have not audited your plan within the last two years, you need to do it as soon as possible. If you have audited your plan recently, did the report evaluate the impact of phantom discounts or R&C? Has it evaluated the fairness of benefit decisions and the veracity of clinical information supporting the underlying decisions to pay or deny a claim? Is there consistency in your benefit decisions across the board (i.e.: highly compensated vs. non-highly compensated employees)? Now look up the slope, is the snow beautiful, or more importantly, is it moving towards you?

About the Author

Lewis D. Bivona, Jr., CPA, AFE (Lew) is the Insurance Practice Leader for WithumSmith+Brown, Certified Public Accountants and Consultants. He has over 32 years of experience in the healthcare and insurance industries. The depth of his experience has been garnered from high-level positions within the public accounting, HMO, consulting and hospital industries as well as a period in HMO regulation. Lew has been the team leader on many financial condition examinations of some of the largest insurance companies in the country. Lew has also lead and participated in the audits of ERISA health benefit plans; he has also been a presenter to numerous employee benefit groups across the region.

He is a member of the American Institute of Certified Public Accountants (AICPA) and the New Jersey Society of Certified Public Accountants (NJSCPA). Lew has authored articles on employee benefits, HMO and insurance company issues, is a frequent presenter at seminars and has been quoted in prominent insurance national magazines. He is a member of the Society of Financial Examiners and is certified as an Accredited Financial Examiner. Lew was also selected to serve as a team member on the Accreditation Review Team of the NAIC in 2009. He also maintains memberships and is engaged in the activities of the Society of Insurance Financial Management and the International Association of Insurance Receivers

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