CHAPTER 18

SAMPLE ERISA PLAN DOCUMENT CHECKLIST

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. The persons responsible for providing that protection are fiduciaries.

The Department of Labor describes the fiduciary duty and potential liability as follows.

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries. These responsibilities include:

- *Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;*
- *Carrying out their duties prudently;*

- *Following the plan documents (unless inconsistent with ERISA);*
- *Holding plan assets (if the plan has any) in trust; and*
- *Paying only reasonable plan expenses.*

Liability

With these fiduciary responsibilities, there is also potential liability. Fiduciaries who do not follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions.

If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the individual decisions of that provider. However, an employer is required to monitor the service provider periodically to assure that it is handling the plan's administration prudently.

The cost of not ensuring that the plan administrator carries out his or her fiduciary duties can be seen in the rising costs and falling benefits of company health plans. It can also be seen in legal actions recently taken against companies and plan administrators who have failed to protect against fraud and other mismanagement of plan funds.[102] Surely lawsuits against companies for failure to provide the best return for employees' contributions to their own health care cannot be far behind. At stake are millions of dollars for a moderate-sized self-insured plan.

To keep from falling short, fiduciaries should address the following areas of ERISA plan contractual terms in negotiations with vendors and/or providers. These are general guidelines to use as a starting point. Please consult your own ERISA attorney for specific advice and a more comprehensive assessment.

Allowable Payment Amounts

- "Usual and customary" or similar language is by far the most common way that health plans cut costs. Definitions of this term vary from very weak to very strong. Ideal language allows the plan administrator to pay the lesser of certain amounts based on costs, Medicare allowable amounts, etc., although any negotiated rate should always be paid to avoid breaching a network or direct contract.
- Although any claim can potentially be negotiated with the right tools, this is much more difficult if the plan document does not have language permitting negotiation and falling back to low "usual and customary rates" in the absence of a negotiation.
- Wrap networks accessed by plans can result in little cost-savings with high fees. For this reason, we recommend an unwrapped service, which helps the plan define a reasonable and fair market, value-based allowable amount for all out-of-network claims—including those that would otherwise be sent to wrap networks—with defensible claims repricing, patient advocacy, and back-end balance-billing support to boot.

Experimental or Investigational

- "Experimental" should explicitly reference criteria such as industry standards, accepted medical practice, service rendered on a research basis, clinical trials, and peer-reviewed literature.
- Noteworthy facets of this language that are sometimes brought into question include off-label drugs and compound drugs. The plan should clearly state how it will treat such claims.

Medical Necessity

- As long as it defines medical necessity based on objective criteria, this language should be acceptable. Ideal criteria include treatment meant to restore health and otherwise appropri-

ate under the circumstances according to the AMA or other sources. It does not include treatment that is maintenance or custodial in nature or disallowed by Medicare.
- Make sure the language does not leave the determination of medical necessity to the full discretion of the treating provider. The plan administrator should always retain this discretion.

Plan Administrator Discretion

- While every plan document necessarily gives the plan administrator discretion to determine payment amounts, watch out for instances where the administrator has too much or not enough discretion. Discretion should be granted to interpret the plan document's provisions and determine issues of fact related to claims for benefits.
- A provision to cover nearly anything the administrator deems appropriate may also cause a stop-loss reimbursement issue.

Fiduciary Duties

- For both self-insuring veterans and those new to the industry, managing the fiduciary duties associated with making claims determinations can be a daunting task.
- Outsourcing fiduciary duties for final-level internal appeals is the most efficient and cost-effective way of handling this responsibility. Leading ERISA firms provide an approach that shifts the fiduciary burden of handling final-level appeals to a neutral third-party.

Coordination of Benefits

- If the plan is always the primary payer, that presents a cost-containment problem. It should pay secondary in all conceivable situations (with the exception of Medicare or when otherwise not permitted) and clearly say so in the plan document.
- Ideal language will describe which plan pays primary/secondary in certain circumstances.

Leaves of Absence

- Many health plans provide coverage for any period of approved leave as determined by the employer. This can translate into individuals being covered based solely on "internal" leave policies of the employer, which are sometimes not even written or are determined on a case-by-case basis by the employer.
- While this is not a problem for the plan document per se, it is a very common problem when it comes to stop-loss reimbursement for claims incurred while an employee is on such an approved leave of absence.

Employee Skin in the Game

- Some employers elect to offer members certain incentives for performing tasks such as choosing certain providers over others, auditing bills for correctness, and purchasing durable medical equipment online at discounted rates rather than from hospitals.
- Typical rewards include offering the member a percentage of savings achieved by the plan or waiving coinsurance and deductibles.

Exclusions

- The plan document should exclude claims that result from "illegal acts." There are different ways to structure this exclusion that can increase or decrease the potential for exposure.
- Another important exclusion is for claims resulting from "hazardous activities," i.e., activities with a greater-than-normal likelihood of injury.

Overpayment Recovery and Third-Party Recovery

- To maximize recoveries, the plan document needs strong language describing both the plan's reimbursement rights and a partnership with a recovery vendor that excels at enforcing the plan's rights.

- Third-party recovery provisions should include:
  - Disclaimer of "made-whole" and "common fund" doctrines
  - Ability to recover from estates, wrongful death proceeds, and the legal guardians of minors
  - Ability to offset any funds recovered by the patient but unpaid to the plan

Compliance and General Drafting

- The terms of the plan document must be compliant with applicable law, including ERISA, HIPAA, COBRA, and many others, in addition to any applicable state law.
- Some in the industry feel that the plan document and summary plan description must be separate documents, but leading ERISA attorneys say that one single document suffices for both.
- The terms of the plan document must be consistent and clear. Without being ambiguous, they should still allow for some interpretation by the plan administrator.

Additional Resources

Please go to healthrosetta.org/health-rosetta for ongoing updates, including lists of high-value, transparent TPA organizations, case studies, best practices, toolkits, and more.