Benefits Hot Potatoes

How to Handle Some Touchy Benefits Issues Without Getting Burned!

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Presented by

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Agenda

- Benefit Plan Service Provider Agreements
- Benefit Issues and Leaves of Absence
- Out-of-Network Provider Disputes
- Leftover Potatoes

We spend .. Wait, WHAT on health care?

SHRM BETTER WORKPLACES BETTER WORLD™

For 2019, Employers Adjust Health Benefits as Costs Near $15,000 per Employee

Plans are steering employees toward expanded telehealth options and high-value centers of excellence

Kiplinger

Cost of Employer Health Coverage to Rise 5% in 2019

It's the sixth year in a row that costs have jumped at least that much.

In 2016, private sector employers paid over $500 billion for health care premiums, and a total of $665 billion in total employee health-related costs (not including workers' comp)

Three Recurring Issues:

Benefit Plan Service Provider Agreements

Benefit Issues and Leaves of Absence

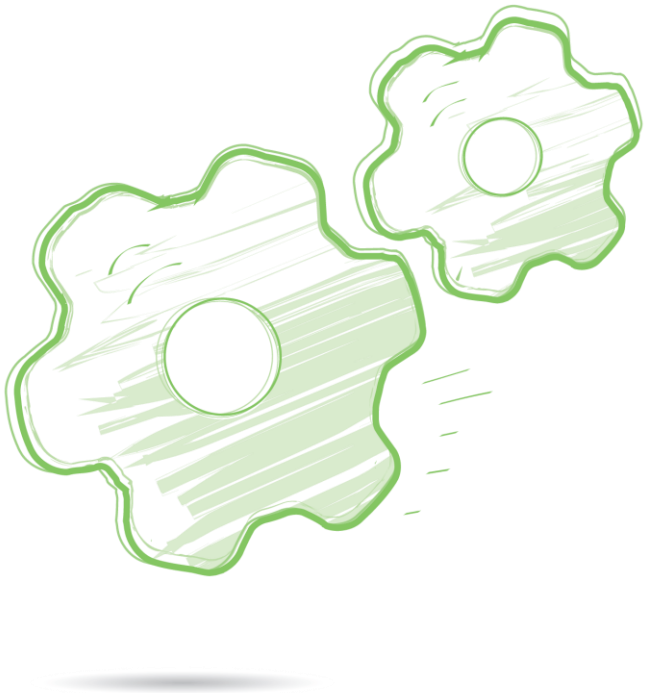
Out-of-Network Provider Disputes

Agreements between your Company (on behalf of the Plan) with…

- Claims administrators
- Insurance brokers
- PBM (pharmacy benefit management) providers
- Wellness program administrators
- 125 cafeteria plan administrators
- COBRA administrators
- HSA administrators
- Any entity that performs plan related services

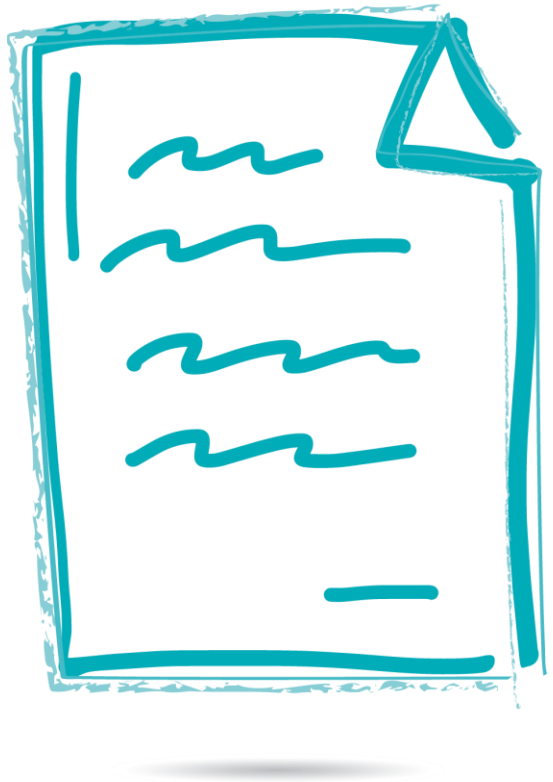
Service Provider Agreements: How do you approach?

- First and foremost: get an EARLY review copy
- Good communication between legal and HR is vital
- Have your own standard provisions
- Use checklist
- Have outside counsel review if needed

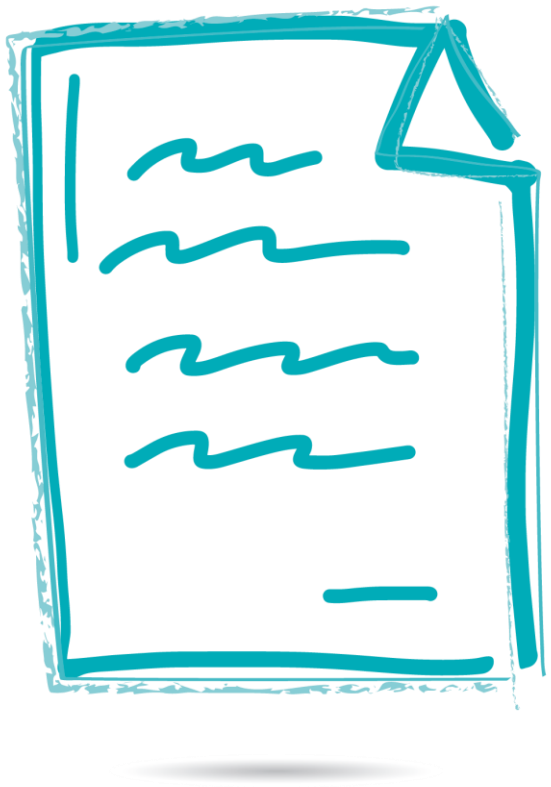


Service Provider Agreement Checklist

- Clear definition of duties and services (what are you paying for/what is excluded)
- Fees
- Fiduciary status, if applicable
- Standard of care (reasonable expert)
- Breach provisions, including damages
- Inappropriate limitations on provider liability
- Indemnification in favor of the Company (NOT 1-sided in favor of SP)
- Term and termination provisions



Service Provider Agreement Checklist



- Insurance requirements, if applicable
- Compliance with all applicable laws and regulations
- Arbitration
- Standard legal provisions
- Business associate addendum
- Privacy provisions beyond PHI
- Unreasonable law and venue

Benefit Plan Service Provider Agreements

Benefit Issues and Leaves of Absence

Out-of-Network Provider Disputes

Scenario

Employee has exhausted FMLA, but is still not healthy enough to return to work. Our employment attorney advises the ADA "interactive process" prevents us from immediately terminating the employee, so we are granting an unpaid "ADA accommodation leave" which may go on for several months.

… CAN WE TERMINATE BENEFITS COVERAGE?

Step One: When in doubt, review the plan document!

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active, Full-time Union Employees of the Employer regularly working a minimum of 30 hours per week.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service; and
6. for an Employee, the date the Employer cancels participation under the Policy.

What difference does it make?

- ERISA fiduciary obligation to follow the plan documents
- Inconsistent approach can tee up discrimination claims
- Possible precedent-setting
- For insured benefits-possible denied claims (and even insurance fraud)…
- …. or cancellation of policy!
- For self-insured plans – possible denied excess coverage under the stop loss policy, claims of fraud or cancellation.
- Last but not least – potential ACA issues.

UHA
HEALTH INSURANCE | Better Health • Better Life

4/4/2019

[redacted]
Attn: HR Comp & Benefits
[redacted]

Re: Agreement for Group Health Plan—Audit of Employee Eligibility for Coverage

Dear [redacted]

Please be informed that UHA Health Insurance is conducting an audit to confirm coverage eligibility of the employees currently receiving health care benefits under your UHA plan as set forth in your Group Health Plan (Section C of Attachment C).

In order to facilitate our audit, please provide the following records regarding UHA-covered employee, [redacted] for the period, November, 2018 through April, 2019:

- Payroll and timekeeping records (including but not limited to all time sheets as completed by the employee or his supervisor)

Yes, health insurers sometimes conduct audits to make sure the employees you say are eligible really are eligible!

Actual audit letter from health plan insurer

What next?

- First and foremost – follow the plan document
- If you don't like what the document says, or if it doesn't say anything at all: Decide what you *want* to do!
  - Continue benefits for duration of all leaves?
  - Cancel benefits after FMLA?
  - Pick a certain period of time on unpaid leave for cancellation?
- Contact all insurers – including stop-loss carriers – to inform them of your decision
- Update all plan documents to reflect your decision (may require amendment to insured documents)

Also: Termination for non-payment during non-FMLA unpaid leave.

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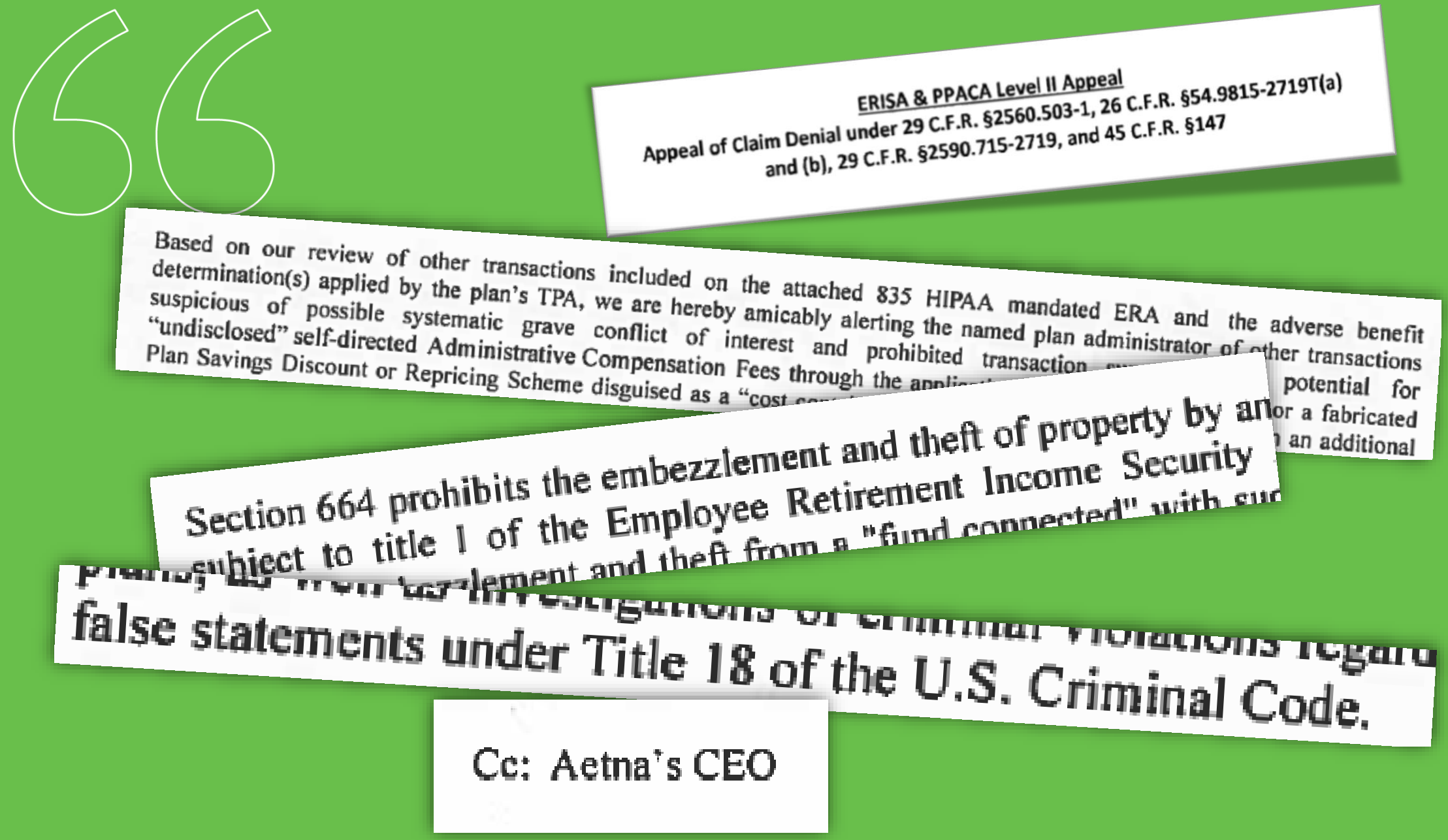
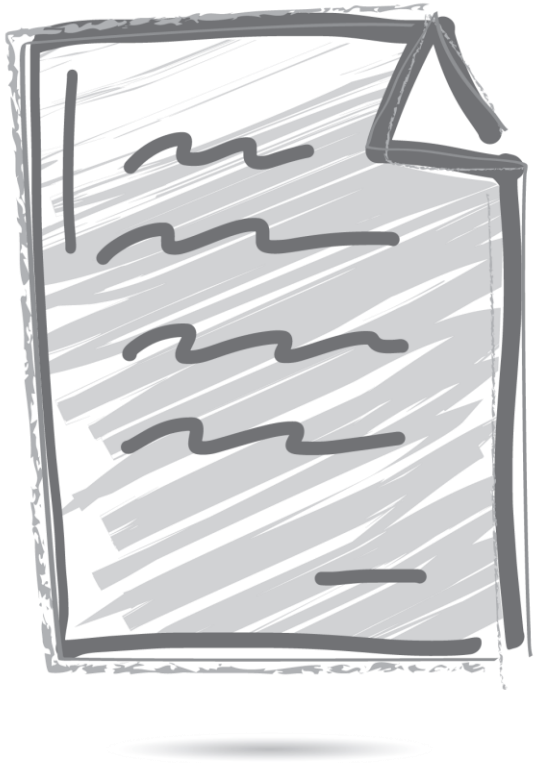

ERISA & PPACA Level II Appeal
Appeal of Claim Denial under 29 C.F.R. §2560.503-1, 26 C.F.R. §54.9815-2719T(a) and (b), 29 C.F.R. §2590.715-2719, and 45 C.F.R. §147
Based on our review of other transactions included on the attached 835 HIPAA mandated ERA and the adverse benefit determination(s) applied by the plan's TPA, we are hereby amicably alerting the named plan administrator of other transactions suspicious of possible systematic grave conflict of interest and prohibited transaction
"undisclosed" self-directed Administrative Compensation Fees through the
Plan Savings Discount or Repricing Scheme disguised as a "cost
potential for
or a fabricated
an additional
Section 664 prohibits the embezzlement and theft of property by an
subject to title I of the Employee Retirement Income Security
false statements under Title 18 of the U.S. Criminal Code.
Cc: Aetna's CEO

What are these letters about?

- They threaten legal action against the covered person for the amount due, and dire predictions of doom for the plan, the employer, the administrators, etc.
- Plans have very specific procedures for paying out-of-network claims
- These letters are attempts by out-of-network provider to recoup the difference between what was billed and what was paid by the plan (a/k/a balance or “surprise” billing”)
- Some letters originate from the providers themselves; others are farmed out to debt collectors



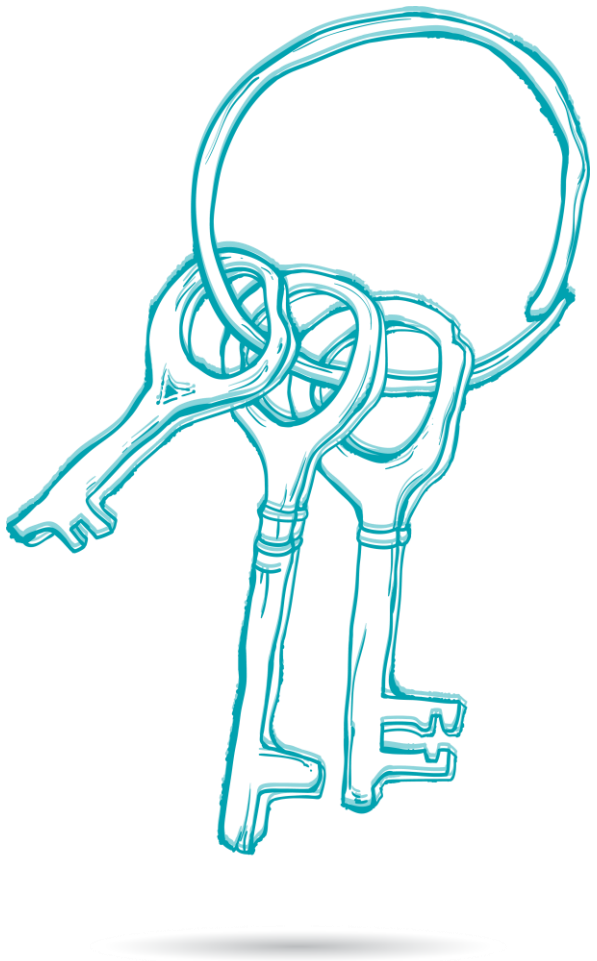
Caution: There is almost always a lengthy, detailed, often overblown, request for documents

- $110/day penalty for failure to provide ERISA required documents within 30 days of request
- Some documents requested are required, some are not
- Others may not be available from the plan sponsor
- Do **not** let the letter sit around in an inbox
- If in doubt – get help from counsel

How do you respond?

- Examine the authorization document carefully and watch your HIPAA obligations!
  - It is a violation of ERISA (or HIPAA, if PHI) to provide documents to a third party unless they have provided valid authorization
- Investigate what caused the reduction – call the claims administrator
- Direct the provider to the appropriate claims process in the SPD or to the claims administrator
- For the document request, identify which documents must be provided
  - Usually only the plan document, SPD, and 5500
  - Provider agreements?
  - What about the claims file?

Bottom Line:



- Never ignore one of these letters, but don’t panic when you receive one
- If benefits are determined by an insurer or outside claims administrator, coordinate with them (insurer should handle any claims issues – that’s what you’re paying them for)
- Review service provider agreements (use the checklist)
- Contact experienced legal counsel for help with any of the above

Leftovers

- Cybersecurity
- Fees
- Employment, Separation and Settlement Agreements
- Section 510
- Remember the fiduciary exception (to attorney-client privilege)

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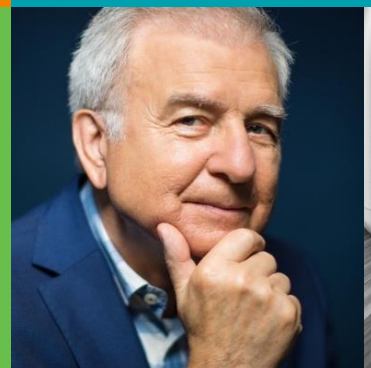
Questions?

This information provided by Littler is not a substitute for experienced legal counsel and does not provide legal advice or attempt to address the numerous factual issues that inevitably arise in any employment-related dispute. Although this information attempts to cover some major recent developments, it is not all-inclusive, and the current status of any decision or principle of law should be verified by counsel.







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