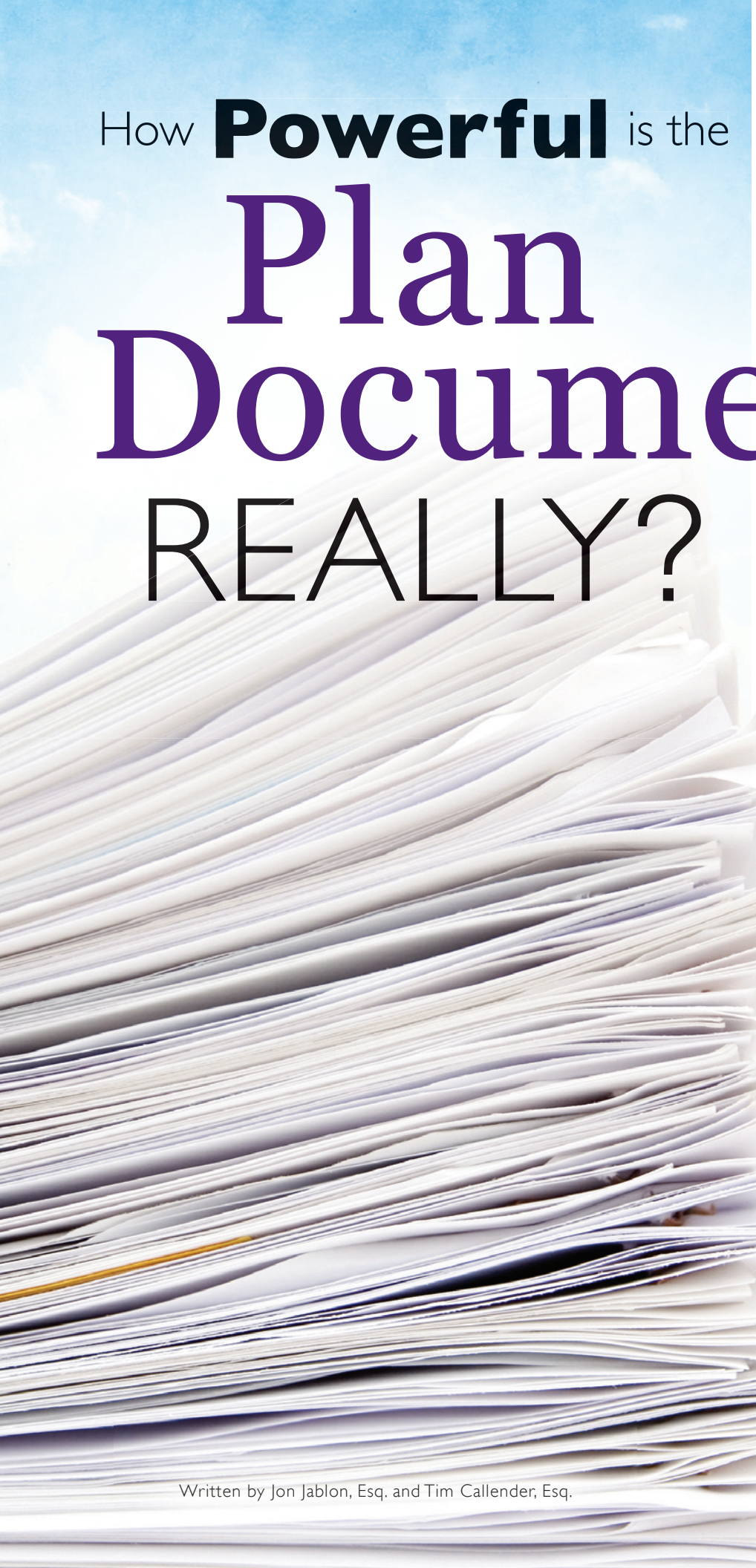
How **Powerful** is the Plan Document, REALLY?



A self-funded plan's governing plan document and the Plan Administrator's discretion used when interpreting that document are jointly considered to be somewhat like decisions issued by the United States Supreme Court – they are "the supreme law of the land." To some extent, that can prove accurate with respect to the plan document; the Employee Retirement Income Security Act of 1974 (ERISA) provides that a plan document's text must be strictly adhered to and fiduciaries of the benefit plan are not permitted to deviate from the document's terms.

A common misconception, however, is that the plan document is the "supreme law of the land" in all of a plan's relations. Many TPAs have seen first-hand that this is not the case and new situations seem to be cropping up all the time, proving this fact time and again. So, what do we do?

Written by Jon Jablon, Esq. and Tim Callender, Esq.

It is paramount that we gain a better understanding of the various scenarios that frequently occur, causing conflict between a plan document and another legal instrument. Through identifying the nuances of these conflicts, we should, hopefully, become better positioned to work preemptively and engage a more thoughtful approach to plan document creation and the interplay between the numerous third-party relationships that are necessary in the self-funded space.

I. Network Contracts

A common dilemma is the treatment of a plan document by a network agreement. Payers often pay in-network claims at Usual and Customary or similar amounts specified within the plan document, rather than as specified within the applicable network agreement. For obvious reasons, this presents a significant problem and a conflict between two legal instruments. When networks and network providers push back against the payer, for failure to adhere to the network contract, payers frequently rely on the incorrect premise that the plan document "overrides" the network contract. This premise is simply inaccurate.

The entities that have entered into the relevant agreements are not the same for each agreement. The plan document is an agreement between the Plan and the Plan participant; benefits can be assigned to a provider, in which case the provider becomes a beneficiary of the Plan and, essentially, a party to the plan document "contract" as well.

The network agreement, however, is almost universally entered into between the network administrator and the Plan Sponsor. To make the network agreement even more complicated, it will typically bind the Plan Sponsor to the terms of a separate contract, which exists between the network administrator and the various providers who make up the network, oftentimes without disclosing the terms of that separate contract, commonly called a "provider agreement." It is easy to see how the alignment of the various parties is often misunderstood and, quite frankly, how it may seem that the various parties have competing obligations.

The Plan Administrator is tasked with administering the plan's language, while the Sponsor is tasked with complying with the agreement it has signed with the network administrator. The network administrator is obligated to protect the interests of the network providers and the financial health of the network, while also honoring the terms of the agreement between the network administrator and the Sponsor.

The practical implications are many: first, since the network agreement is for the Plan's benefit, it is the Plan that is paying contracted claims (in contrast to the plan document's language that may not support payment at a contracted rate) and second, while ERISA governs the Plan's payments (assuming a private, self-funded benefit plan), state law exclusively governs the network agreement. The state law interplay, alone, tends to create some of the most confusing burdens in this contractual comedy, since the usual ERISA remedies and protections that the Plan might enjoy become irrelevant when the legalities of the network agreement are tested in a state court contract action.

In short, the plan document and ERISA preemption, tend to become irrelevant when faced with the complicated scenario discussed above – one where state law contract actions become appropriate remedies due to conflicting terms between a plan document and a network contract.

II. Stop-Loss Policies

Another example of when the plan document is not the "supreme law of the land" has to do with stop-loss policies. While there are some carriers that will explicitly defer to the plan document for exclusions, definitions and the determination of whether a claim is payable, often the stop-loss carrier is forced to interpret the policy in a manner that "overrides" the plan document. This is not to mean that such a denial is manufactured, or disingenuous; instead, it is a function of the self-insured industry, which relies on a multi-party solution for a single case.

More often than not, the various stakeholders may not have had a genuine meeting of the minds when attempting to reconcile the plan document with the stop-loss policy, which may result in gaps – which, in turn, result in stop-loss denials that the Plan believes to be contrary to the terms of its plan document.

Such denials typically come in two forms; one is when the stop-loss policy contains its own exclusions and definitions, which differ from and override those within the Plan's governing plan document. The other form is when the carrier exercises discretion to interpret the terms of the plan document independently from how the Plan Administrator has interpreted that same document during the claims determination process.

While the Plan Administrator is constrained by ERISA or other applicable law and certain legal limits are placed on the Plan Administrator's power to interpret the plan document, stop-loss insurance is an animal unto itself and state insurance law has historically placed no limits on the carrier's discretionary authority when interpreting a plan document for stop-loss reimbursement purposes. This is one paradigm that exists in the

self-funded industry that is changing, though; Connecticut, for instance, has enacted legislation that effectively limits a stop-loss carrier's discretion in terms of plan document interpretation.

At first glance, this appears very favorable to self-funded plans within that state; this change, however, is also expected to have the effects of both increasing the cost of stop-loss premiums as well as blurring the line that separates stop-loss from health insurance – which of course has negative effects on the industry as a whole.

III. Administrative Services Agreements

Another separate legal instrument that tends to consistently "override" the plan document is the administrative services agreement signed between the Plan Sponsor and its third-party claims administrator (TPA). While TPAs and the health plans they serve are couched as allies rather than as adversaries, it sometimes becomes the case that a TPA has allegiances, relationships and strategic partnerships that can end up at odds with the Plan.

In addition, although most ASO carriers require that the health plans they service utilize the ASO carrier's own stock plan document, some ASO carriers allow plans to utilize their own existing plan documents. A plan's ability to keep its own plan document is generally viewed as a good thing – until situations arise where the plan document's language conflicts with the ASO carrier's standard policies.

The best example of the dilemma described above would be the scenario of medical necessity and "experimental and investigational" determinations.

The governing plan document may provide one thing, while the ASO carrier's standard policies provide another. It is reasonable to assume that the plan document would control, but that is often not the case in these types of arrangements. ASO carriers have been known to ignore the terms of the plan document in favor of their own internal guidelines, which is especially prevalent among determinations made with respect to network providers.

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When the same parent company owns both the claims administrator and the network administrator, the claims administrator's loyalty lies not with the Plan but with in-network providers. Situations often arise where an ASO carrier's standard policy is to defer to the treating provider for determinations of medical necessity, even though the plan document might not consider the same claim to be medically necessary. (Common sense dictates that these medical providers are not in the habit of characterizing their hard work as unnecessary.)

The result is often that the Plan is forced by its ASO carrier to pay claims that the plan document may not truly allow – all because of a lack of deference to the plan document. This is a practice that tends to undermine the nature of self-funding.

IV. Conclusion

As we know and as we see time and again, there are many situations where the plan document does not control the outcome of a situation, even when many interested parties believed that the plan document would, in fact, be the controlling authority. There are solutions here, though and there is a "middle ground" to be reached.

Plan Sponsors, oftentimes working through their consultants, should work diligently to have transparent conversations with their vendor-partners, as they put their various self-funded solutions together. Communication is the prime solution here; open and honest communication between all stakeholders and obtaining an expert review of all contracts involved in a given situation can make all the difference down the road.

In addition, the implementation process for a new group, or even the renewal process for a self-funding veteran, should not be taken lightly and should be comprehensive, involving every interested party. Multi-vendor communications and lengthy contractual reviews may be resource-intensive, but the time and effort is well worth it.

In terms of "middle ground," there are many areas where this can be accomplished. For many vendors, this might be to transparently work to identify gaps between contracts and the plan document up front, with the goal of either reconciling those gaps, or simply moving forward, but with "eyes wide open," so to speak.

For the Plan Sponsor, giving up a certain amount of discretion – such as never paying in-network claims at a rate below the contract rate – will be beneficial to the Plan in the long run, by avoiding bad blood and legal conflicts with providers and networks. In addition, the Plan Sponsor might work to make sure the plan document's language matches network contracts, ensuring defensible payments.

In the alternative, perhaps a Plan Sponsor wishes to avoid stringent, network contracts, so it focuses efforts on direct provider contracting, claims negotiation and even reference-based pricing as tools to manage costs, outside of a network setting. A Plan Sponsor might strive to find a stop-loss partner that will afford the plan a greater amount of deference and grant the Plan autonomy without worrying about losing reimbursement. In addition, a Sponsor should work to ally with a claims administrator that has a strong reputation in the industry and is clearly working with the Plan's best interests in mind.

Lastly, an annual audit of all documents related to a self-funded case is a best practice rarely followed. Even if all vendor-partners remain the same, from year to year, a healthy audit and review of all contracts, against the plan document, by a truly objective reviewer, would be an ideal practice. ■

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After being admitted to the bars of New York and Massachusetts, Jon Jablon joined The Phia Group's legal team in 2013. He is well-versed in the ins and outs of ERISA, stop-loss policies, PPO agreements, administrative services agreements and health plans. Jon focuses on providing various consulting services to clients as well as serving as a part of The Phia Group's in-house legal counsel.