Buyer Beware – No Good Deed Goes Unpunished

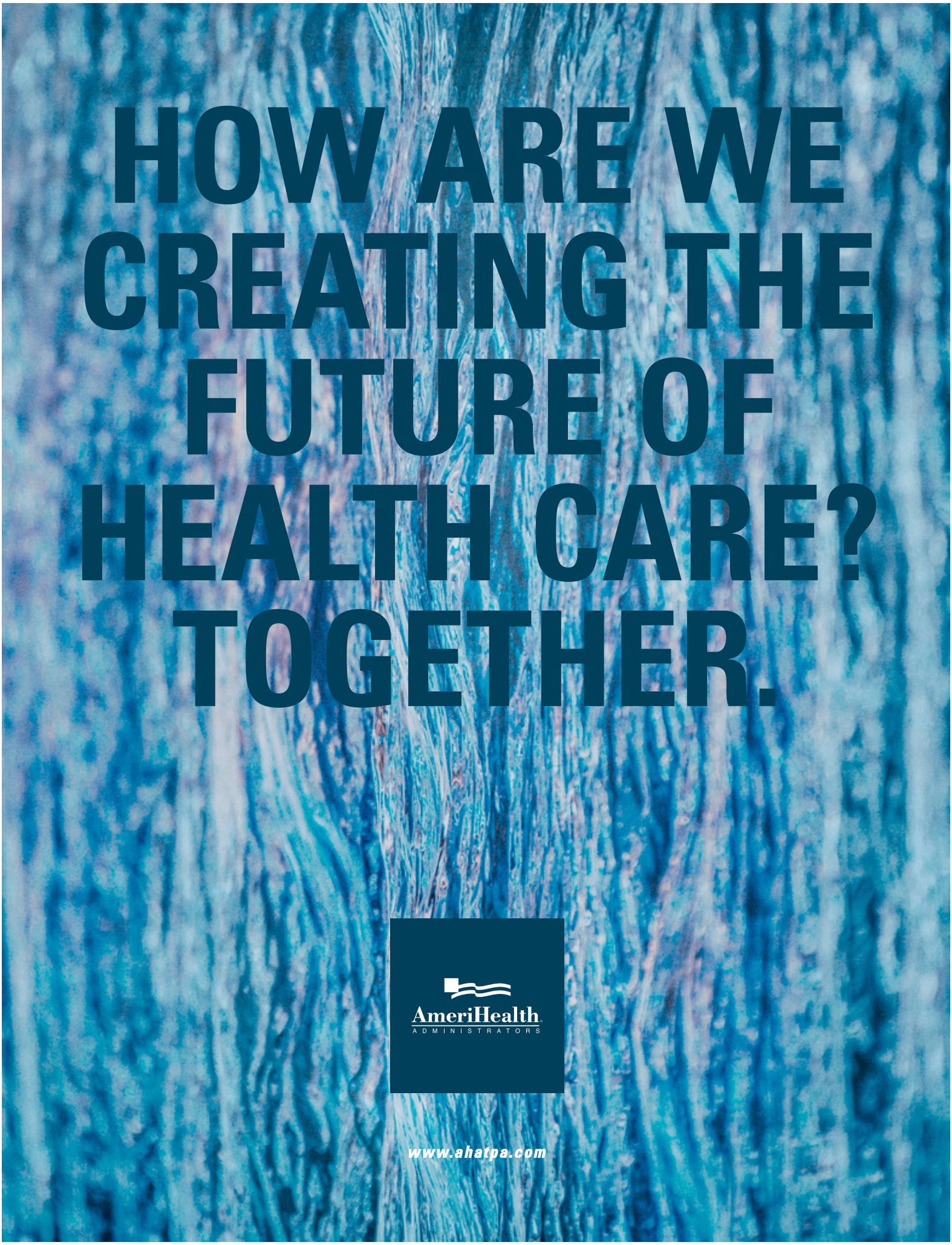
By Ron E. Peck, Esq.

This article represents "commentary" and represents views of the authors. We welcome other opinions on the subject

Employers and their advisors may soon find themselves accused of breaching their fiduciary duty if they continue to allow their benefit plans to pay inflated rates for medical services, without any justification for the excessive prices.

Blindly paying fees that are not revealed until after the service is provided, to practitioners who cannot explain why their rates are many times more than comparable providers of equal or greater skill, is not a prudent use of plan assets and does violate one of the core tenets of the Employee Retirement Income Security Act of 1974 ("ERISA") and fiduciary law.

Employers who choose to provide quality health insurance for their employees are generally performing an act of generosity. Certainly studies show that employers who offer health benefits recruit and retain the best employees, but not all benefit plans are equal - and those employers who choose to offer more than the mandated minimum coverage are indeed combining generosity with good business sense.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As mentioned, however, not all benefit plans are the same. For many, purchasing what we label as "fully funded" or "fully insured" traditional insurance, is enough. For these consumers, risk aversion is king, and they will pay a premium (more likely than not more costly than their employees' health expenditures) to an insurance carrier.

In exchange for that premium, said carrier will take on the risk associated with paying the employees' medical bills. Is there a chance some catastrophic claim, injury, or illness will cause the total medical expense to exceed the collective value of the premium? Sure. Is it likely? No. Insurance carriers are in the business of assessing risk, and calculating premium that will earn profit.

For other employers less concerned with risk, the decision to keep the profit that would otherwise be paid to the carrier, and fund only the actual medical expenses, leads them to engage in the act of self-funding or self-insuring. It is to those employers that I now direct my commentary.

Studies have shown time and again that employers who self-fund their benefit plan are more likely to save money over five years of doing so, when compared to a comparable fully insured policy.

This is due in part to customizing the plan to address only that population's needs, adjusting benefits as the data requires, quickly implementing cost containment programs, shopping around for the best vendors, stop loss, and other elements of the plan, and otherwise ensuring that a customized approach trims the fat and applies each plan dollar where it will do the most good.

So, you ask, if self-funding is such a panacea, why doesn't everyone do it?

The answer is multifaceted. First of all, if you plan to provide benefits to a population with high medical expenses, you may benefit from fully insuring and working with the carrier to spread the risk over their entire risk pool. A self-funded employer takes on the entire plan's expense, with few exceptions.

Next, some employers prefer to pay "more" when that amount is something they can afford, to avoid the risk of paying "MORE" when that amount is something they cannot afford (even if the likelihood of such a massive claim is slim).

Another consideration employers seeking to self-fund must consider (but few sadly do) is the matter of fiduciary authority. Indeed, ERISA dictates, among other things, that an employer who self-funds a benefit plan either acts as or appoints a plan administrator.

That administrator is a fiduciary of the plan and its members, with a very serious legal obligation to perform numerous tasks – all with the plan's best interest in mind. Make one wrong move, and you'll not only have to fix the damage you cause, but potentially be liable for up to treble-damages.

It is true that a self-funded plan administrator can transfer some or all of their fiduciary duties – meaning they share the burden – but most agree that at best the plan administrator is still responsible to monitor that assignee's actions, and at worst, they maintain the burden as well.

As a result, employers who self-fund are not only at risk for the medical bills they will pay on their employees' behalves, but are also at risk of being deemed to have "breached" their fiduciary duty if and when they make a mistake resulting in expenditures not in the best interest of the plan, and take action not in accordance with the terms of the plan document.

This may not sound like a big deal to you. You may be saying, "Ron! I ain't afraid of no breach!" Indeed; it would be great if all we had to do was follow the terms of the plan document like the instructions that come with your kid's new toy. Yet, like those instructions, saying is easier than doing; (where did I put that screw driver)? This is particularly true in today's self-funded industry. Why? Because things are so good! Because today is a great time to be self-funded. What??? At this point you should be thoroughly confused. I did just say that today is the riskiest time to be a plan fiduciary because it is the best time to be a plan fiduciary. Let me explain.

More so now than ever before, innovators are developing new services, products, and methodologies to maximize benefits while minimizing costs. They are taking advantage of the self-funded plan structure, using our ability to customize, and targeting the high cost claims while increasing coverage elsewhere.

Everything is being examined and new approaches are being applied to old issues and new. From medical tourism, to carve outs. From technologically advanced subrogation tactics to reference based pricing network alternatives.

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These are just a few examples of new and amazing ideas helping self-funded plans to evolve. Unfortunately, just like Kevin McCallister (Macaulay Culkin) who, in that 1990 classic film, is left "Home Alone" when the rest of his family rushes out the door to embark on an exciting adventure… so too are plan administrators and their supporting cast rushing into fun and exciting adventures without making sure their plan document is along for the ride.

Too often, these self-funded benefit plans – which are controlled by the terms of their plan document – implement a new, shiny service, product, or process and forget to update their plan document to match.

The plan document is how the plan administrator communicates to the plan members (current and prospective), providers, department of labor, etc., what the plan does and doesn't do – and sets forth the terms by which people decide whether to enroll and contribute their hard earned money in exchange for membership. If the plan in practice doesn't match the plan in writing, that is bad news.

Many self-funded employers believe that by hiring brokers, third party administrators, and advisors, they can somehow protect themselves from this fiduciary threat. Yet, case after case has shown that – even though the broker, TPA, and the rest may ALSO be a fiduciary – the employer / plan administrator is still going to come along for the ride.

The case that has "set me off" and gotten me to head down this mental-path is the case of *Acosta v. Macy's, Inc.,* S.D. Ohio, No. 1:17-cv-00541; (August 29, 2017). In that case, among other things, we see a benefit plan sponsor and their TPA attempting to contain costs by applying a reference based pricing methodology to their claims. This is great, and I applaud their efforts.

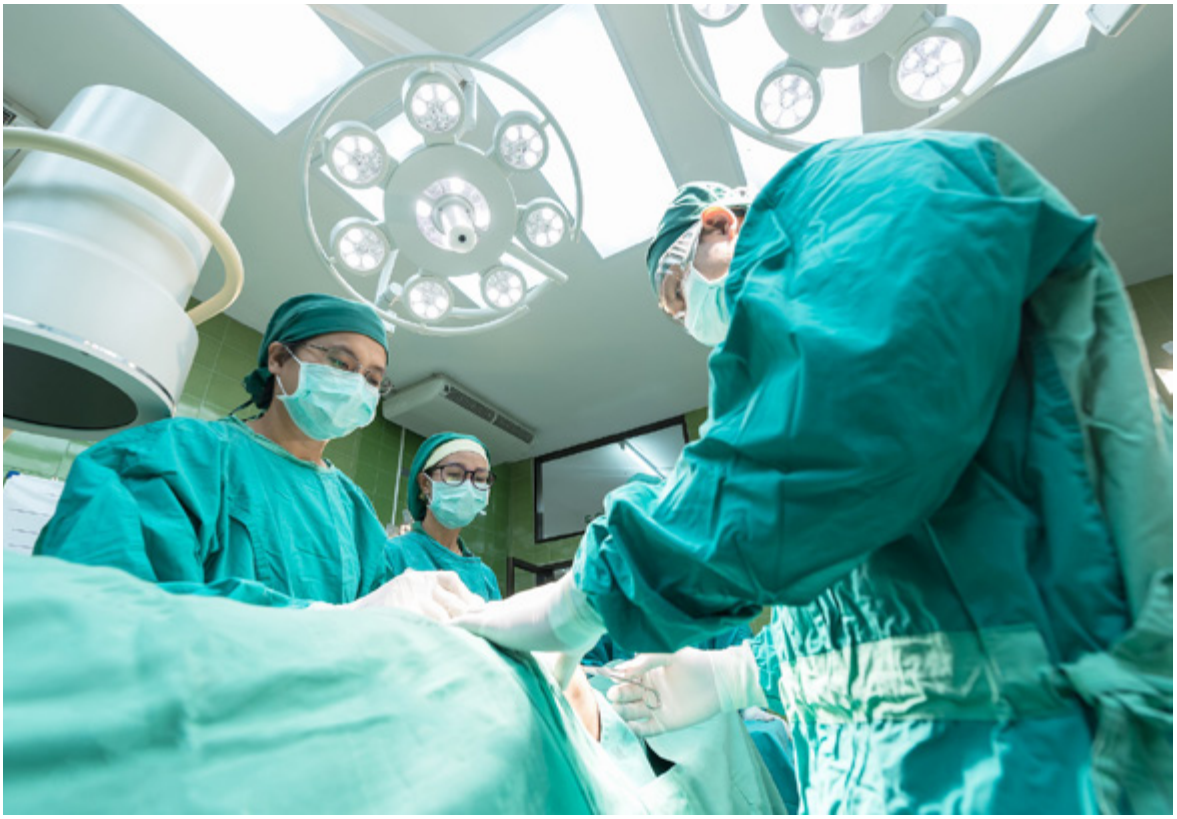
Unfortunately, however, it appears that they may not have adjusted the applicable plan document to adequately reflect this new approach. While I'm sure this employer is thinking, "I thought the TPA does this for me?" Regardless of the truth of the matter, the employer – as a fiduciary – will be dragged into the complaint. This will – at best – harm the relationship between the plan and TPA, but – at worst – it will cause the plan to leave the TPA and possibly self-funding altogether.

This is why I feel that TPAs, and all of us in the business of servicing self-funded employers, need to protect employers even when we're not obligated to do so. I fear, as in this case, that even if a self-funded employer "gets burnt" by something that is in no way, shape, or form our "fault" or "responsibility," it's still a black eye for the industry as a whole.

This takes me, then, to my next concern. For some time now, (since the last major economic downturn), we've been hearing via mass media all about situations where employees are suing employers, and their brokers, over mismanagement of 401(K) and pension plans. Indeed, these advisors are in many instances fiduciaries of these employee investors, and – in most of these cases – the employees are accusing their "fiduciaries" of wasting the plan's (aka their) money on less-than-advisable investments.

Consider, for instance, the case of *Lorenz v. Safeway, Inc*., 241 F. Supp. 3d 1005, 1011 (N.D. Cal. 2017). In this class action suit, the Plaintiff (Dennis M. Lorenz) asserted claims under ERISA against the "Safeway 401(K) Plan's" fiduciaries. Lorenz alleged, amongst other things, that the Defendants breached their fiduciary duty by selecting and investing the plan's assets with funds that charged higher fees than comparable, readily-available funds, and which had no meaningful record of performance so as to indicate that higher performance would offset this difference in fees.

Why does this scare me? I am scared because we could just as easily take this lawsuit (and the many like it) and replace the players with members of our own industry. Health benefit plans routinely spend plan assets to pay medical bills and compensate providers that may be more costly "than comparable, readily-available [providers], and which had no meaningful record of performance so as to indicate that higher performance would offset this difference in fees." Ouch!



"But Ron," you say, "even if we (or the TPA and broker) are fiduciaries of the plan, the decision to contract with over-priced facilities, agree to their fees, and pay these claims, is ultimately a decision made by the plan sponsor (employer) – right? So, while your previous comments about self-funded employers leaving the market when they realize they've been taken for a ride may be true, we are at least safe from liability for fiduciary breach. Right?" Maybe not.

If I am a member of a self-funded health plan, and my administrator is taking my money, and using it to pay for a $3,000 colonoscopy, when a facility down the road would do it for $750… and the more expensive facility has an "as good" or "worse" record when it comes to quality and outcomes… wouldn't I say: "Hey! It looks like that fiduciary isn't prudently managing my assets." I truly believe that, for anyone that is a fiduciary of these plans, the day participants turn on us may not be a matter of "if," but rather, "when."

Consider also the recently filed, *McCorvey v. Nordstrom, Inc.* filed in the California Central District Court on November 6, 2017. In this case, a former participant in the Nordstrom Inc. 401(K) Plan sued plan executives alleging breaches of fiduciary duties in the management of the plan, and is seeking class action status for their claim.

The basis of the claim, similar to the Safeway case discussed above, challenges the reasonableness of fees paid with plan assets, and further, that the plan fiduciaries failed to take advantage of cost-cutting alternatives. The lawsuit literally contends that the defendant failed to adequately and prudently manage the plan, by allowing plan funds to be used in the payment of unreasonable fees and not acting prudently to lower costs.

It doesn't take a rocket scientist to see the parallels between these lawsuits, and out of control spending by health plans. Whether you are someone offering better care for less cost, or someone who can revise the plan's methodologies to maximize benefits while minimizing costs, these trends in fiduciary exposure should galvanize us all to either offer help, or seek it, when it comes to prudent use of plan assets.

Consider *Longo v. Trojan Horse Ltd.,* 208 F. Supp. 3d 700, 712 (E.D.N.C. 2016). In this case, the plaintiff employees of Trojan Horse and Glen Burnie Hauling filed a putative class action against defendant Ascensus Trust. In this case, the Defendant was collecting contributions, submitting them for investment, and keeping a fee for themselves.

There is some dispute regarding what happened to the investments, but ultimately it appears the funds weren't properly invested. The Defendant argued that they did their job, and the issues about which the complaint was filed was outside their immediate control. Yet, the court held that Defendant had a fiduciary duty in regard to the contributions, and that they failed to take affirmative steps to investigate.

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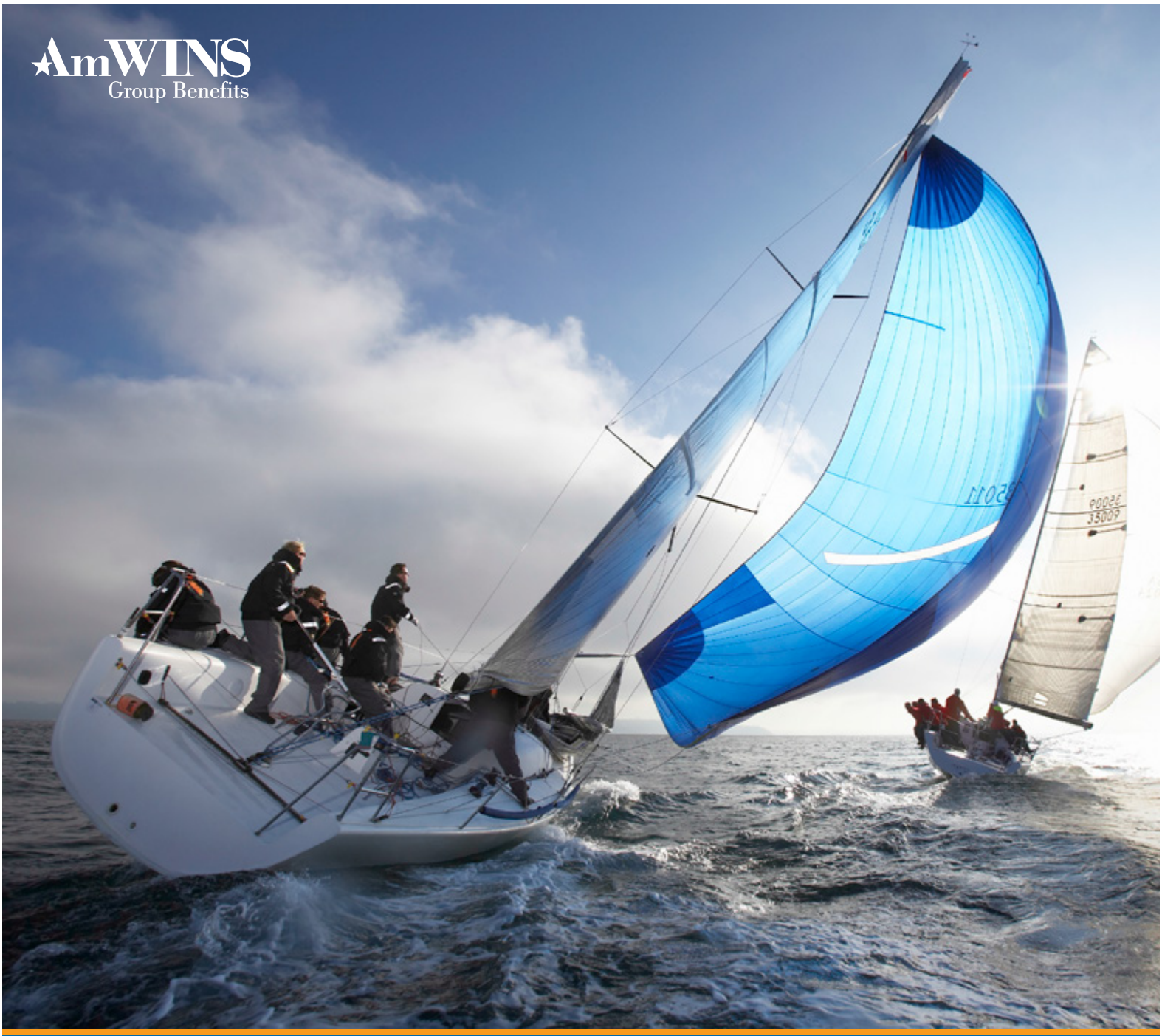

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In other words, pursuant to 29 U.S.C. § 1132(a)(2), fiduciaries are responsible to ensure the plan's welfare is priority number one, even when the actions in question may be taken by another entity or fiduciary. So… following that line of logic… if a TPA, broker, or other advisor is a fiduciary of the plan, and we are aware (or should reasonably be aware) of actions being taken by another fiduciary, that are detrimental to the plan … or options that available to the plan to contain costs, but we knowingly allow another fiduciary to ignore them… we may be on the hook too!

So – in summary – I believe it is proper and necessary for any and all fiduciaries of these self-funded plans to step back, look for wasteful or imprudent behavior – both by the fiduciary itself, and other fiduciaries of the plan – and determine whether there is any action, option, or alternative that would constitute a more prudent use of plan assets.

Likewise, those who seek to help these fiduciaries and the plan reduce their expenditures without harming the plan need to raise their voices and warn their prospective clients of the cost of not working with them. In other words, fiduciaries need to stop clinging to the status quo, and the onus is on all of us to help them do so. ■

Ron Peck, Sr. Vice President and General Counsel, has been a member of The Phia Group's team since 2006. As an attorney with The Phia Group, Ron has been an innovative force in the drafting of improved benefit plan provisions, handled complex subrogation and third party recovery disputes, and spearheaded efforts to combat the steadily increasing costs of healthcare. In addition to his duties as counsel for The Phia Group, Ron leads the company's consulting, marketing, and legal departments.

Ron is also frequently called upon to educate plan administrators and stop-loss carriers regarding changing laws and strategies. Ron's theories regarding benefit plan administration and healthcare have been published in many industry periodicals, and have received much acclaim. Prior to joining The Phia Group, Ron was a member of a major pharmaceutical company's in-house legal team, a general practitioner's law office, and served as a judicial clerk. Ron is also currently of-counsel with The Law Offices of Russo & Minchoff.

Ron obtained his Juris Doctorate from Rutgers University School of Law and earned his Bachelor of Science degree in Policy Analysis and Management from Cornell University. Ron is also a Certified Subrogation Recovery Professional ("CSRP") and a member of the Self Insurance Institute of America ("SIIA") Government Relations Committee.