



Drowning in A Sea of Paper

Written By: Tim Callender, Esq.

The challenges of setting up and administering an employer-sponsored, self-funded health plan are many. One of the largest challenges a self-funded plan sponsor faces is reconciling the vast number of documents that make a self-funded health plan “go.”

When navigated correctly, these challenges yield immense results in terms of rich benefit delivery within a fiscally responsible health plan mechanism. Still, challenges remain and should be discussed openly so that we can continue to grow and strengthen our industry.

The task of reconciling governing documents is challenging for anyone, but it can be an especially daunting job for any plan-sponsor, broker/consultant, or interested party mostly familiar with the fully insured platform. In that relatively simple world, everything “goes” with minimal paperwork – at least in the front of the house – but, this simplicity comes at a significant cost and with a significant lack of control and customization.

Clearly, for most employers that really look into the options, self-funding is the way to go. But, if you want to play in the self-insured world and reap the significant financial benefits of the self-funded model – get ready to read, re-read, audit, reconcile, and review more paperwork than a forensic accountant scouring financial records written in invisible ink.

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In the interest of staging the optics for this brief piece, let me be incredibly clear that I am 10,000% a believer that self-funding is the best model to deliver rich and affordable health benefits, and the success of the self-funded industry is a personal goal and passion of mine. I am a firm believer that all stakeholders in the self-funded space are vital for the success of this model.

The comments made herein are not meant to demonize any one player, nor am I out to state that any particular stakeholder causes more complication than anyone else. Rather, I hope that through an honest, and a little self-critical conversation (laced with humor), we can identify some brutal truths regarding our great industry so that we can continue to work together for the betterment of self-funding, as a whole!

To approach this in an organized fashion, let's make a list of some of the array of paperwork needed for a self-funded health plan to fully function (at least the top documents most commonly involved). From there, we can explore one or two examples that reflect "problem areas," and/or bullet points that we should all think about when reflecting on these documents. Not all problems will be (or should be) explored in this article, but, hopefully, this conversation gets the wheels turning

and points us toward improvements and solutions.

Governing Plan Document / Summary Plan Description – This is the cornerstone of every self-funded health plan. Without a governing plan document, you have.... Well... a nebulous concept of a health plan devoid of any defining rules or benefit structure, with all the details living in someone's head and likely spread across a series of emails and meeting notes! Good luck with a government audit on that one!

Items that could be "problem areas" include:

- Does the plan document contain benefit carve outs that fly in the face of a network contract?
- Is the plan document written before the current plan year is even over?
- Was the plan document compared to the relevant stop-loss policy to look for coverage / reimbursement gaps?

Summary of Benefits and Coverage (SBC) – Thank you Affordable Care Act! As we all know, health insurance is confusing and saturated with paperwork. Well, thankfully the ACA saw fit to "simplify" health coverage by requiring, yes, you guessed it, more paperwork! Better hope your SBC lines up with your SPD or you might be SOL with the DOL while listening to OPP in the LBC.



Items that could be “problem areas” include:

- Do the benefit examples in the SBC actually match up with the intended benefits of the plan document (what if a plan member relies on the SBC for benefits and the plan document has not been fully written/issued yet...?)
- Was the benefit structure of the Plan fully finalized before issuing pre-enrollment SBCs (in other words, how many people have pushed SBCs out, just to “get them done,” while recognizing that the benefit structure of the plan document is likely to change by the time it is finalized?).

PBM Agreement – And then, let’s add drugs. No, I don’t mean “let’s add drugs” in the context of a 1970s Grateful Dead, San Francisco acid test – rather, and as if it’s not confusing enough, let’s take a completely separate entity, bring them to the party to assist with a plan’s Rx benefits, and then, in the frantic insanity that is a 60 hour work week, hope that we all read over the PBM agreement to see if it lines up with the intent of our health plan and that the language in the plan document echoes that same alignment – oh, and maybe stop-loss to?

Items that could be a “problem area” include:

- Is there a clear alignment in the contracting (and the plan document!) regarding which entity might handle / administer claims and appeals for particular Rx benefits? – Has the language in the plan document, as required by the PBM, been reconciled with the Plan’s stop-loss policy, network agreement, and/or SBC?

Network Agreement – Where to start...?

Items that could be “problem areas” include:

- How many parties are expected to be bound by a particular network agreement?
- Are there inconsistencies in how particular benefits should be paid as laid out between the network agreement and a plan’s governing plan document?
- Is the Plan administering a reference-based pricing program, and, if so, have network obligations been taken into account?
- Have all vendor contracts, and their roles, as related to the administration of a plan, been reconciled against the roles and responsibilities of the plan, as laid out in the network contract?
- Are there inconsistent medical management criteria as laid out between the plan document, the network contract, the PBM contract, and other documents?





- Are the benefit payment timelines (and appeal timelines), as between the plan document and the Network Agreement, cogent so as to assure the Plan is not losing a network discount or risking a prompt-payment Network Agreement breach term?

Stop-Loss Policy / Agreement – Too often we see material variances in the wording of definitions and exclusions, as between plan documents and stop-loss policies. To state the obvious, this can create significant coverage gaps, manifesting in reimbursement denials that are not necessarily invalid. Common discrepancies include a disconnect in a “medical necessity” definition or an “experimental and investigational” definition.

Additionally, what about notice provisions? While not directly related to a misalignment between plan document and stop-loss terms, this concept can create havoc when a plan-sponsor does not pay especially close attention to the notice requirements present in a stop-loss contract. More specifically, does the contract require the sponsor to provide notice to the carrier any time the Plan modifies benefits? If so, and if the Plan fails to do so, a significant (and likely valid) coverage gap may exist.

Items that could be “problem areas” include:

- Pretty much everything I’ve written above, plus this one, often forgotten gem: gaps that might exist between a plan document and an employer-sponsor’s employee handbook, related to leave of absence provisions, which may lead to eligibility issues and subsequent reimbursement denials at the stop-loss level.

Administrative Services Agreement (typically with a TPA or a carrier on its ASO platform) – This document can tend to be the “unifier” or the “great divider.” So many solutions and pieces that make up a self-funded plan all fall together in the ASA. This document is key. I’ll say it again, KEY.

Items that could be “problem areas” include:

- Who is the named fiduciary outside of the Plan Sponsor (are there others – are there shared duties – are there fiduciary inconsistencies between the ASA, the plan document and the various vendor contracts involved?)
- Are all vendors mentioned and/or properly referenced within the ASA?
- Does the ASA properly outline a scope of duties and responsibilities in a way that mirrors the intent of the Plan and as reflected in all other governing plan documents?

Employee / Employer Handbooks – This one just splashed onto the scene in a pretty incredible way over the past year or so.

Items that could be “problem areas” include:

- As discussed above, have the handbook, plan document, and stop-loss policy been “bounced together” to assure there are no issues that might result in valid reimbursement denials?
- Leave of absence provisions and plan document eligibility provisions...

Plan Amendments – I had a dream once, about a Plan that had not had its plan document restated in 8 years, and, during that time, the Plan Sponsor had amended the plan 16 times. All amendments existed as separate documents, referencing one another from time to time, and, oftentimes, referencing various vendors that no longer worked for the Plan. Then, the Plan Sponsor came to me and hired me in November to restate the plan for a January 1 kick off. I woke up screaming. That kept me up at night.



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Notifications (of material modification; open enrollment; HIPAA privacy notifications; etc.) – While many of these may not need to line up with a plan’s specific benefit grid, network alignment, or the definition of “maximum allowable,” you can easily see how a bit more paperwork, directly impacting the member’s understanding of a plan, can be cumbersome and can easily cause confusion if not handled carefully, especially when bundled into an envelope (or email) containing a plan document and an SBC!

Miscellaneous Vendor Contracts – Take everything discussed above and add in a few more. Time to turn up the volume!

All the above is enough to strike fear into the heart of the most diligent and thorough paper pushing accountants, advisors, and attorneys. But, it is the price of admission and a piece of our business that we should be aware of and work through carefully. As a best practice, every Plan Sponsor should engage in expert gap reviews of all documents and should do so on a routine basis.

To conclude, and hopefully provide some closure and definition to my thoughts, I will leave you with this: our industry is complicated. There is no denying it. Let’s acknowledge it, be willing to criticize it, and even be willing to poke fun at it.

But, at the end of the day, let’s recognize that our industry – our platform – is the best. So, we owe it to each other, as stakeholders in this space, to work hard to accomplish the goal of aligning the documents that govern the administration of a self-funded health plan.

Should the first and foremost guardian of this alignment be the Plan Sponsor? Absolutely – and with expert guidance! We are all in this together and should strive to achieve harmony in a Plan’s governing documents, wherever possible, together. All boats rise. ■

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