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TAKING AN ACTIVE ROLE IN YOUR EMPLOYEE BENEFIT PLAN CAN SAVE YOU A LOT OF MONEY

By Charles T. Young, Jr.

The continuing rise in the cost of health care is increasing the level of scrutiny and risk associated with an employer's benefit plan. Most employers maintain some sort of responsibility for their employees' health care coverage, but they may engage a third party administrator and/or purchase insurance to cover larger losses. Rising costs have increased the stress on these relationships.

The financial stress has shown itself in a number of different ways. For instance, insurers have a dramatically increased incentive to perform audits or deny reimbursement under "stop loss" coverage. The lack of adequate documentation or records will also tend to cause problems between employers and employees. Moreover, employees who are no longer actively working can get "lost" in the employer's human relations system, which leads to rapidly escalating complications for a business.

In the present environment, many businesses have stop loss insurance that covers catastrophic losses, but the companies themselves are responsible for typical, medical expenses incurred by employees. In this situation, the employer's responsibility to its employees is controlled by an employee benefit "plan." In contrast, the insurer's responsibility to the employer is controlled by an insurance policy. Unfortunately, the language in the plan is not always consistent with the policy issued by the insurer.

Situations arise in which an employer gets trapped between the restrictions in the insurer's policy, the coverage provided by the plan, or a summary plan description ("SPD") provided to employees. For example, many stop loss carriers provide reimbursement only for medical expenses incurred by employees who are actively at work. At the same time, employers may have leave policies or provide benefits to employees suffering family or medical problems. The result can be trouble obtaining reimbursement for the employee's medical expenses.

The motivations and responsibilities of an employer and insurer are not the same. An employer may seek to limit its potential exposure under the Americans with Disabilities Act ("ADA") by providing an employee with reasonable accommodations in the form of supplemental leave time. The stop loss insurer, in contrast, has no such concerns. The employer and insurer must generally afford coverage for 12 weeks under the Family and Medical Leave Act ("FMLA"). Beyond this, an insurer will likely demand that employees be actively at work to receive benefits.

In an effort to reduce costs, an employer may choose to outsource the administration of its employee benefit plan. This third party administrator ("TPA") handles the paperwork associated with the plan, and it may even prepare the SPDs describing the plan to company employees. However, the employer remains responsible for the medical costs incurred by employees, at least up to the stop loss amount. The TPA is administering the process and paying claims with company funds.

As in any other industry, the performance and quality of a TPA varies. Some TPAs are excellent and timely communicate the information an employer needs to intelligently manage its claims. Unfortunately, other TPAs do not communicate well with the business. They do not make wise decisions with respect to paying claims, and they fail to comply with the sometimes burdensome requirements imposed by stop loss carriers providing coverage for catastrophic losses.

With the rising costs of healthcare, a stop loss carrier may increasingly deny claims for reimbursement based on the conduct of an employer's TPA. At the same time, the employer may be increasingly reliant on the TPA because it lacks the personnel and/or commitment to actively monitor the claims made by its employees. Frequently, an employer has little, if any, knowledge of the medical procedures undergone by employees until it is too late.

Inactive employees present a particular problem and risk for businesses. Your HR Department may have little trouble keeping in touch with employees who are at work on a daily basis. The situation can become dramatically different when an employee takes an extended leave of absence for medical or family reasons. During his or her absence, the employee is "out of sight," and frequently "out of mind."

Typically, an employee will transition through active status coverage under the FMLA, and then COBRA continuation coverage (if elected). During this period, the company generally has little contact with the employee. The contact that does occur may consist of form letters generated by the TPA. If no one stays on top of the situation, the gaps in coverage between the plan and policy, or between the SPD and plan, may create real problems for employees seeking coverage for their medical procedures.

While FMLA coverage generally lasts for only 12 weeks, COBRA continuation benefits extend for 18 or even 36 months. The employer often does not understand the former employee's status, and inactive employees can incur very large medical expenses. Proper documentation becomes particularly important. If documentation is inadequate or coordination is lacking, an employer can be stuck paying hundreds of thousands of dollars in medical bills. The employee's leave

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INSURER BAD FAITH TOWARDS COMMERCIAL INSUREDS *By Michael R. Kelley*

As with other policyholders, insurance companies sometimes deny covered claims of commercial insureds without a reasonable basis for doing so. Under the law of Pennsylvania and almost all other states, business and professional insureds have the right to sue to recover the amount covered by the policy, and to seek punitive damages, attorney's fees, and special interest. The latter damages are available under the Bad Faith statute, which has been in place in Pennsylvania since 1990.

But commercial policyholders are often reluctant to pursue "bad faith" damages against an insurer. There are several possible reasons for this reluctance: 1) business persons and professionals are, by nature, reasonable people and assume that insurers always act reasonably – even when they deny a claim; 2) business persons and professionals generally dislike litigation of any kind, let alone litigation that alleges that another business has acted in "bad faith;" and 3) business people and professionals, if they have sustained damages, generally only want to recover the amount they believe they are owed, and not "punitive damages" over and above the policy coverage.

The purpose of the Bad Faith statute is to act as an equalizer between a large insurance company and the usually-much-smaller policyholder. Because of their enormous assets and usually one-sided control of policy language, insurers have a significant edge in leverage in any dispute over policy coverage. Before the passage of the Bad Faith statute, an insurer could simply deny a claim and dare the insured to sue. Even if the insurance company lost, in all but the rarest circumstances, it would have to pay no more than the covered policy amount.

The Bad Faith statute shifts leverage to policyholders because, if the insurer denies a claim in "bad faith," in addition to the covered loss, it can be forced to pay the policyholder's attorney's fees and to pay punitive damages of up to about nine times the amount of the covered loss. Policyholders can even introduce evidence of the insurance company's large assets to support a punitive damage award.

The reported cases are filled with examples of an insurance company acting intentionally or recklessly in denying a commercial claim that was covered. Bad faith was found where an insurer failed to pay a restaurant owner for business income loss for 7 months; failed to resolve a property claim for more than 2 years; refused to pay a commercial fire loss claim for 17 months. A court awarded a mining company $4.5 million in punitive damages where an insurer refused to assist the insured in completing the proof of loss, yet denied the form as incomplete and delayed payment for 4 years. Failure to properly investigate a claim is a frequent reason for a finding of bad faith against an insurance company. A court awarded a bowling alley over $750,000 in damages for a minor roof collapse because the insurer wrongly accused the owner of concealing a prior history of roof problems, failed to follow the law regarding timely payment of claims, and "made numerous exaggerations and misstatements…."

These are just a few examples of insurer bad faith. Many others exist. How can you tell if your insurance company is acting in bad faith in handling your commercial claim? A good rule of thumb is the "jerked around" test. If you feel like you have been jerked around by your insurance company, it's probably time to talk to your lawyer. ■

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time may not have been properly recorded or classified. He or she may never have actually elected COBRA benefits. The employee's injuries may not be covered. Any number of problems can occur.

While a TPA and insurer may handle the bulk of claims administration, an employer can help coordinate their actions and better manage its claims. The motivations of a TPA and insurer are not necessarily the same as those of the employer. The failure to timely communicate information may penalize the employer, and not the TPA. The lack of adequate documentation may result in an employer paying higher claims, and not the insurer. The "lost" employee may create real problems for the employer, and not the TPA or insurer. As such, an employer should seriously consider taking an active role in overseeing its employee benefit plan. ■

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