CHAPTER 26

"ERISA FIDUCIARY RISK IS THE LARGEST UNDISCLOSED RISK I'VE SEEN IN MY CAREER"

Written with Sean Schantzen

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to protect the individuals in these plans. Plan trustees (typically company boards, plan administrators, and others) have fiduciary duties to ERISA plans to ensure these protections are implemented and managed.

Most people know the law in relation to retirement benefits, but it is emerging as an unexpected, yet high-potential, opportunity to drive change in the dysfunctional U.S. health care system. This is because roughly 100 million Americans receive health benefits through self-insured ERISA plans, accounting for more than $1 trillion in annual health care spending (including out-of-pocket spending by plan members). Companies spend roughly double on ERISA health plans what they spend on ERISA retirement plans.

Increased outside scrutiny of how ERISA-regulated health plans spend their dollars is creating immense potential liability for companies, officers, directors, and even health insurers across

the country. We are also starting to see this in benefits departments—one entire benefits department at a large, well-known company was fired (with the exception of one person) when their board became aware of the lack of proper management.

While employer and union health plans are roughly one-half of all health care spending, they likely represent over two-thirds of health care industry profits because they often wildly overpay for health care services.

This is also where a large opportunity to reduce legal risk and increase financial performance exists. Health care is the last major bucket of operating expenses that most companies still aren't actively optimizing and managing like similarly large P&L line items. This makes ERISA plans an attractive target for operational efficiencies.

Doing this is simpler than most think. ERISA requires plan trustees to prudently manage health plan assets. Yet very few health plans have the functional equivalent of an ERISA retirement plan administrator who actively manages and drives effective allocation of plan investments, either internally or externally. This person or team should have the deep actuarial and health care expertise highlighted at the end of Chapter 11, something traditional human resource departments usually lack.

Employers can also do something about the enormous fraud and waste in the system. As we saw in Chapter 8, most employers are doing little or nothing to prevent fraud because they typically aren't aware of its extent or that it's even happening. *The Economist* has reported that fraudulent health care claims alone consume $272 billion of spending each year across both private plans and public programs like Medicare and Medicaid.[176] The Institute of Medicine's study on waste in the U.S. health care system concluded that $750 billion, or 25% of all spending, is waste.[177] It's impossible to imagine any CEO, CFO, or board allowing this in any other area of their company.

Could Emerging Litigation Be Our Savior?

Key events suggest that increased scrutiny of ERISA fiduciary duties is upon us.

First, two Big Four accounting firms have refused in certain circumstances to sign off on audits that don't make allowances for ERISA fiduciary risk. At a meeting Dave attended in the last year, a senior risk management practice leader at one of those firms told a room of health care entrepreneurs and experts that ERISA fiduciary risk was the largest undisclosed risk they'd seen in their career. As more accounting firms follow suit, it could require employers to change how they manage ERISA health plans.

Second, independent board directors have quietly sounded the alarm to auditors of three separate companies (that I'm aware of) about the potential for personal financial liability that director and officer insurance policies may not cover. We expect to see more focus on this issue, given that health care spending is roughly 20 percent of payroll spending for most companies.

Third, regulatory scrutiny is beginning to increase on a number of fronts. Here's just one example. In September 2017, the Department of Labor brought a case against Macy's and two of its third-party administrators alleging violations of ERISA's fiduciary rules, largely relating to payment of out-of-network health care claims.[178] It also included alleged violations of some newer wellness program rules. This is just one example of various types of attention and scrutiny we see emerging.

Fourth, attorneys are actively cultivating cases and litigation strategies in which employers will file suits against their ERISA plan co-trustees or vendors, primarily the plan administrators who actively manage the plan's health dollars. These strategies center on allegations that the co-trustees or vendors breached ERISA fiduciary duties or other related duties by turning a blind eye to fraudulent claims. We expect the number of these cases to significantly increase in the next few years. One firm we're aware of is cultivating dozens.

The implications of this fourth trend could be enormous: If boards and plan trustees know meaningful fraud could exist and don't act to rectify the issues, they could open themselves to liability from shareholders, plan beneficiaries, and others. The magnitude of damages just for fraudulent claims could be similar to those in asbestos and tobacco lawsuits. Conservative fraudulent claims estimates are about five percent and many believe 10-15 percent is more accurate.[179] Employers spend more than $1 trillion per year through ERISA health benefits plans. Extrapolating the five percent estimate over ERISA's six-year lookback period for damages from fiduciary duty breaches, this could create $300 billion in potential damages.

These potentially significant legal risks should prompt employers to more actively manage health spending the same way they manage other large operating expenses. As we've seen, companies already doing this are reducing their health benefits spending by 20 percent or more while providing superior benefits packages.

They use a variety of approaches, but most are relatively straightforward and focus on proven benefits-design solutions that make poor care decisions more costly and better care decisions less costly. Most importantly, they don't focus on shifting costs to employees, but on tackling pricing failure, fraud, overuse, misdiagnosis, and sub-optimal treatment—the sources of most wasted spending. Finally, there are people who can help companies of all sizes implement these solutions and build better-managed plans.

Repeatedly, we've found that the best way to slash costs is to improve health benefits.

ERISA Sample Plan Document Checklist

The Department of Labor describes the fiduciary duty and potential liability as follows:

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries. These responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
- Carrying out their duties prudently;
- Following the plan documents (unless inconsistent with ERISA);
- Holding plan assets (if the plan has any) in trust; and
- Paying only reasonable plan expenses.

Liability

With these fiduciary responsibilities, there is also potential liability. Fiduciaries who do not follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions.

If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the individual decisions of that provider. However, an employer is required to monitor the service provider periodically to assure that it is handling the plan's administration prudently. To keep from falling short, fiduciaries should address the following items of language in negotiations with vendors and/or providers. (These are general guidelines to use as a starting point; please consult your own ERISA attorney for specific advice and a more comprehensive assessment.)

Allowable Payment Amounts

- "Usual and customary" or similar language is by far the most common way that health plans cut costs. Definitions of this term vary from very weak to very strong. Ideal language allows the plan administrator to pay the lesser of certain amounts based on costs, Medicare allowable amounts, etc., although a negotiated rate should always be paid to avoid breaching a network or direct contract.
- Although any claim can potentially be negotiated with the right tools, this is much more difficult if the plan document does not have language permitting negotiation (and falling back to low "usual and customary rates" in the absence of a negotiation).
- Wrap networks accessed by plans can result in little cost-savings with high fees. For this reason, we recommend an unwrapped service, which helps the plan define a reasonable and fair market, value-based allowable amount for all out-of-network claims – including those that would otherwise be sent to wrap networks – with defensible claims repricing, patient advocacy, and back-end balance-billing support to boot.

Experimental or Investigational

- "Experimental" should explicitly reference criteria such as industry-standards, accepted medical practice, service rendered on a research basis, clinical trials, and peer-reviewed literature.
- Noteworthy facets of this language that are sometimes brought into question include off-label drugs and compound drugs. The plan should clearly state how it will treat such claims.

Medical Necessity

As long as it defines medical necessity based on objective criteria, this language should be acceptable. Ideal criteria include treatment meant to restore health and otherwise appropriate under the circumstances according to the AMA or other sources. It does not include treatment that is maintenance or custodial in nature or disallowed by Medicare.

Make sure the language does not leave the determination of medical necessity to the discretion of the treating provider; the plan administrator should always retain this discretion.

Plan Administrator Discretion

- While every plan document necessarily gives the plan administrator discretion to determine payment amounts, watch out for instances where the administrator has too much or not enough discretion. Discretion should be granted to interpret the plan document's provisions and determine issues of fact related to claims for benefits.
- A provision to cover nearly anything the administrator deems appropriate may well cause a stop-loss reimbursement issue.

Fiduciary Duties

- For both self-funding veterans and those new to the industry, managing the fiduciary duties associated with making claims determinations can be a daunting task.
- Outsourcing fiduciary duties for final-level internal appeals is the most efficient and cost-effective way of handling this responsibility. Leading ERISA firms provide an approach that shifts the fiduciary burden of handling final-level appeals onto a neutral third party.

Coordination of Benefits

- If the plan is always the primary payer, that presents a cost-containment problem; It should pay secondary in all conceivable situations (except for Medicare or when otherwise not permitted) and clearly say so in the plan document.
- Ideal language will describe which plan pays primary/secondary in certain circumstances.

Leaves of Absence

- Many health plans provide coverage for any period of approved leave as determined by the employer. This can translate into individuals being covered based solely on "internal" leave policies of the employer, which are sometimes not even written, or determined on a case-by-case basis by the employer.
- While this is not a problem for the plan document per se, it is a very common problem when it comes to stop-loss reimbursement for claims incurred while an employee is on such an approved leave of absence.

Employee Skin in the Game

- Some employers elect to offer members certain incentives for performing tasks such as choosing certain providers over others, auditing bills for correctness, and purchasing durable medical equipment online at discounted rates rather than from hospitals.
- Typical rewards include offering the member a percentage of savings achieved by the plan or waiving coinsurance and deductibles.

Exclusions

- The plan document should exclude claims that result from "illegal acts." There are different ways to structure

this exclusion that can increase or decrease the potential for exposure.

- Another important exclusion is for claims resulting from “hazardous activities,” i.e., activities with a greater-than-normal likelihood of injury.

Overpayment Recovery and Third-Party Recovery

- To maximize recoveries, the plan document needs both strong language describing the plan’s reimbursement rights and a partnership with a recovery vendor that excels at enforcing the plan’s rights.
- Third-party recovery provisions should include:
- Disclaimer of the “made-whole” and “common fund” doctrines.
- Ability to recover from estates, wrongful death proceeds, and the legal guardians of minors.
- Ability to offset any funds recovered by the patient but unpaid to the plan.

Compliance and General Drafting

- The terms of the plan document must be compliant with applicable law, including ERISA, HIPAA, COBRA, and many others, in addition to any applicable state law.

Sean Schantzen was previously a securities attorney involved in representing boards, directors, officers, and companies in securities litigation, corporate transaction, and other matters. He is my co-founder in the Health Rosetta.

Please visit healthrosetta.org/health-rosetta for ongoing updates, including lists of vendors, case studies, best practices, toolkits, and more.