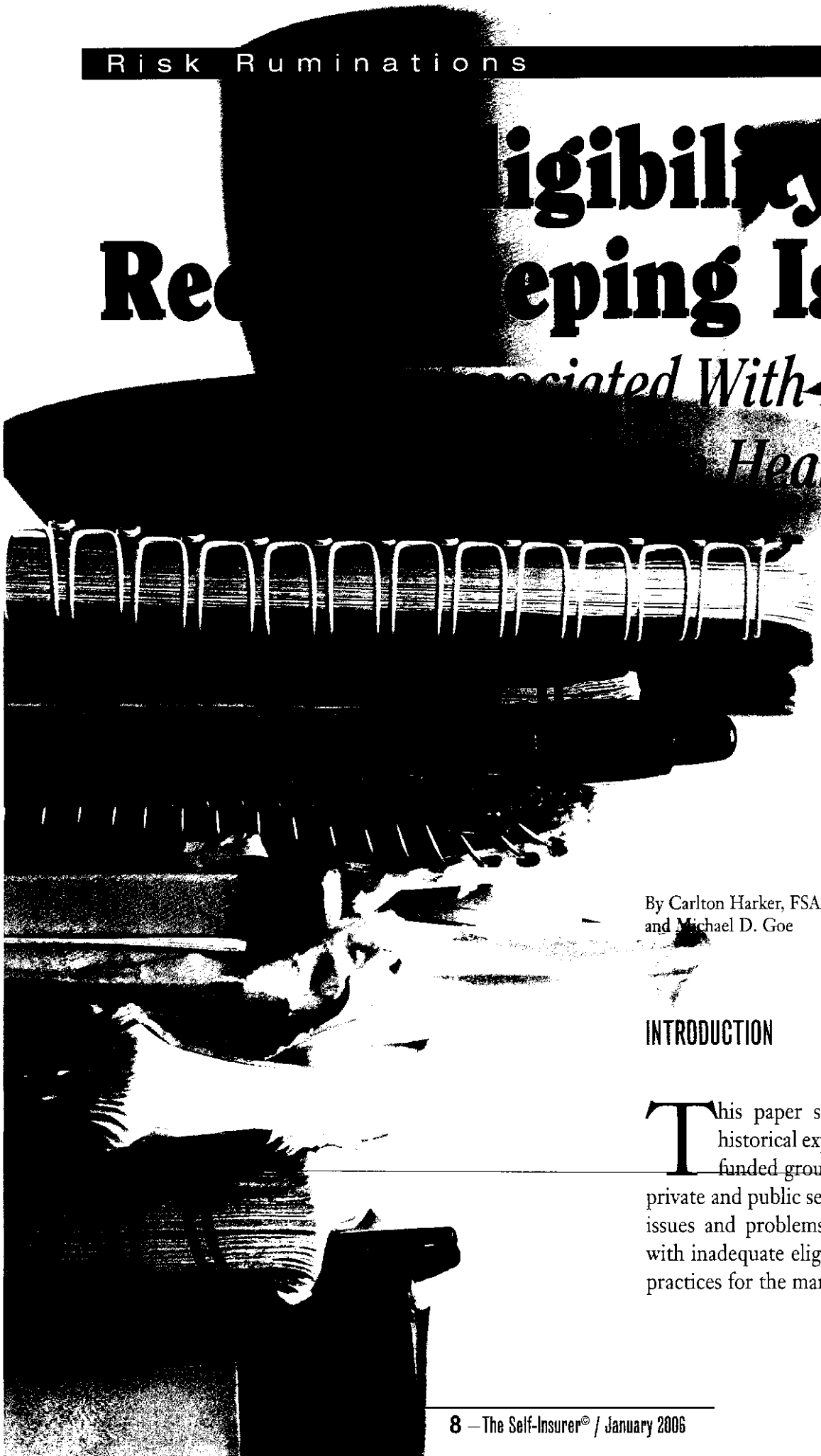
Eligibility and Recordkeeping Issues

Associated With Partially Self-Funded Health Plans



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INTRODUCTION

This paper summarizes some of the historical experiences of partially self-funded group health plan in both the private and public sectors, and some potential issues and problems that may be associated with inadequate eligibility and recordkeeping practices for the management of the plan.

The issues of accountability or responsibility for the accuracy of eligibility information and record keeping were once believed to be transferred from the plan sponsor to the insurer when plans were fully insured. This belief was often carried forward when plans became partially self funded and the plan sponsor contracted for the services of a third party administrator. Time, and challenges to the accuracy of eligibility and recordkeeping information, proved that the perception that a plan sponsor could transfer accountability to a contracted entity was erroneous.

The impact of the Supreme Court decision *Pilot Life v. Dedeaux* made clear that plan sponsors were unable to avoid any responsibility in eligibility and / or record keeping matters by being fully insured. The plan sponsor is responsible for such errors whether made by a hired plan supervisor or by an insurer or third party administrator. The impact of careful attention to eligibility and / or recordkeeping applies equally to the public sector as it does to the private sector. Management's accountability cannot be transferred to another party for such errors reach the private sector plan sponsor through ERISA, and public sector plan sponsors through the Federal Public Health Statute.

From a historical perspective, the impact of record inaccuracy has contributed to disputes. As a percentage of plan disputes, issue involving eligibility / recordkeeping matters increased fro 25 % pre-ERISA, to a current level of approximately 50 %. As legislation has changed over time, at both the state and federal levels, regulations that affect record keeping have increased, and made record keeping more complicated. As matters have become more complex, the need for changes in management procedures and practices has also increased. Unfortunately, plan sponsors have not always responded to meet the need, and as a result may have left themselves open to challenge. Challenge in today's society generally results in litigation- a process which is very time consuming and expensive for the plan sponsor, and often could have been avoided if practices and procedures had been updated to improve accuracy and documentation.

HISTORICAL PERSPECTIVES

With the passage of ERISA, numerous other benefit laws, and court decisions that interpreted the intent of those laws, benefit management and administration became much more complex. Conventional insurers who once dominated the market and who provided all services for the plan sponsor, including eligibility management, became involved in complex relationships with employers / plan sponsors when a plan participant challenged the accuracy of eligibility and recordkeeping information. It soon became apparent in such challenges, that the plan sponsor could not reliably point

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to the third party, and the third party was quick to point out that the employer / plan sponsor was the source for the information. From this scenario it is clear to see what would happen in litigation.

Since the passage of ERISA the landscape for benefit management has changed, and continues to change:

1) ERISA and its benefit mandates codified both ERISA and The Federal Public Health Statute;
2) Continuing legislation, such as COBRA, OBRA, FMLA, Mental Health Parity, USERRA, HIPAA and others have increased the accountability of employers / plan sponsors to have sophisticated eligibility and recordkeeping systems;
3) Cost containment programs have expanded and introduced new concepts and methods to the provision of services and management of benefits;
4) New service arrangements, such as HMO's, PPO's. PHO's have emerged, all of which have been supported by the process of prior authorization or pre- admission certification;
5) New payment methods or risk sharing methods, such as HRA's, HAS's and MSA's have emerged and changed the design of benefits and the sharing of the risk for the cost of those benefits;
6) New focus on emerging trends for alternative or complimentary medicine, carve out programs for certain types of services, wellness programs, demand management programs, and lifestyle issues are shaping the design of benefits.

As economic change continues to occur in the new world market and information age, changes continue to occur in the design of administrative services that support plan management. At one time the concept of "bundled services", through which one service provider arranged and / or did it all, gave plan sponsors the "feeling" that their contracted service provider was accountable for everything. Unfortunately, most of the agreements for these types of arrangements vacated the service provider's responsibility for almost everything.

The paradigm shift to "unbundled services" empowered the employer / plan sponsor to separate each service and arrange contracts for each service. Through this approach the plan sponsor demonstrated its accountability for due diligence and its fiduciary obligation for the management of its plan. By establishing this method, the plan sponsor also clearly demonstrates its accountability for the accuracy of all plan information and data.

THE ROLE OF PLAN SPONSORS

Whether an employer / plan sponsor is in the private sector or the public sector, each has an obligation to demonstrate its fiduciary obligation and stewardship to protect and management the assets for the plan for the exclusive benefit of the beneficiaries.

In the public sector, this role and realization of accountability may represent one of the more significant paradigm shifts over time. Formerly, public sector plans were frequently fully insured and responsibility for plan dated were perceived to have been delegated to the insurer. As challenges occurred and litigation was pursued, it became clear that such delegation could not hold the plan sponsor harmless, and the plan sponsor was in fact accountable for the accuracy and maintenance of all eligibility and recordkeeping.

Whether fully insured or partially self funded, or whether private sector or public sector, who is accountable for the accuracy of eligibility information and plan recordkeeping is very clear- it is the employer / plan sponsor, not a contracted service entity or insurer.

Eligibility information can be made unnecessarily difficult if the plan document is not clear, or is not consistent with employer / plan sponsor policies and practices. Another complicating factor may be requirements under a collective bargaining agreement or "civil / public service" ordinance or rules that apply to covered individuals. It is significantly important that the terms, definitions, and provisions of the benefit plan for eligibility are clearly stated and consistent with all other rules and policies related to employment with the employer, because it is the terms of the plan, not the policies of the employer, that will govern the decisions related to eligibility.

Coverage for retirees by a health plan is more common in the public sector today than in the private sector. A major influence for this shift away from retiree coverage in the private sector was the FASB 106 rule. In the public sector, future issues may be faced when the public entity faces reserve requirements under GASB 43 and GASB 45. Determining and documenting eligibility for individuals who may qualify for continuing benefits, in some form, as retirees will become increasingly important for public sector plans.

LITIGATION

A review of reported pre- ERISA lawsuits involving benefits showed that out of 1,131 cases, 287 (25 %) were related to eligibility / recordkeeping matters and 845 (75%) were related to claim adjudication.

A similar review of post-ERISA but pre-HIPAA lawsuits involving benefits showed that out of 731 cases, 284 (39%) were eligibility / record keeping related while 447 (61%) were claim adjudication related.

It has been projected that post-HIPAA, lawsuits involving eligibility / recordkeeping matters will reach the 50 % mark of all benefit related lawsuits.

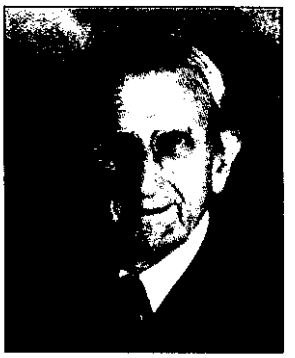
How can employers / plan sponsors reduce the risk of litigation involving eligibility / recordkeeping? Some suggestions include:

1) update internal benefit management procedures and practices and improve the method and quality of documentation;

2) audit enrollment data at least twice per plan year and reconcile enrollment data to payroll information;
3) complete an annual enrollment or open enrollment process each plan year and verify the enrollment information against the current year enrollment information and payroll information;
4) compare the monthly billing statement provided by the insurer to third party administrator against verified enrollment data or payroll information;
5) install a current HRIS system that integrates benefit management with payroll management for data management and information reporting;
6) compare employer / plan sponsor policies and practices to the provisions for eligibility in the plan document and resolve any / all inconsistencies;
7) amend provisions of the plan document as necessary to ensure consistency with employer policies / practices;
8) update and amend plan documents to ensure proper terminology is used in the document, and proper definitions are included.

Provisions of the plan document that should be reviewed and updated as necessary include, but may not be limited to:

1) employee eligibility
2) dependent eligibility
3) employee enrollment
4) dependent enrollment
5) qualified medical support orders
6) acquiring a new dependent, including newborn enrollments
7) late enrollment
8) special enrollment
9) change of life event
10) effective date
11) actively at work
12) continuation of coverage, including FMLA, USERRA, other leaves of absence, COBRA
13) retiree coverage, if applicable
14) termination of coverage
15) annual enrollment or open enrollment
16) HIPAA, including certificates of credible coverage
17) pre-existing conditions
18) workers' compensation v. plan benefits
19) other coverage, including coordination of benefits, maintenance of benefits, subrogation, no-fault coverage, automobile and other coverage, Medicare / Medicaid



Carlton Harker, FSA, MAAA is a well known and respected member of the self-funding community and has been an active participant in the Self-Insurance Institute of America's educational programs for many years. In addition to authoring numerous books on a diversity of subjects related to self-funded health care, Carlton has appeared as a speaker and panel member at various industry educational functions. Harker has appeared as an expert witness in many hearings and trials. Mr. Harker is the Principal of Self-Funding Actuarial Services, 8025 North Point Blvd., Suite 207 W., Winston-Salem, NC 27106. (tel) 336-759-2035, (fax) (336)892-0392, or via e-mail at harker2@earthlink.net He maintains a web site at www.self-fundhealth.com

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