Taking an Active Role in Your Employee Benefit Plan Can Save You a Lot of Money

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The continuing rise in the cost of health care is increasing the level of scrutiny and risk associated with employer health plans. The financial stresses associated with skyrocketing costs have manifested themselves in a number of different ways. For instance, employers with "insured plans" may find that their insurers are now more likely to perform "coverage audits" to ensure that only eligible employees and dependents are participating in the plan.

Common audit issues involve former employees and employees on extended leaves of absence who have been permitted to retain coverage beyond their last day of active employment. Employers are well-advised to consult with their carriers to ensure that there is no disagreement as to whether coverage may be extended in these situations, and for how long.

Another common audit issue involves the eligibility of dependents. Does the carrier's definition of the term "spouse" comport with the definition that the employer uses during open enrollment? Audits also commonly find dependent children who are inadvertently permitted to remain on a plan after surpassing the maximum age limit. Under the Patient Protection and Affordable Care Act ("PPACA"), otherwise known as healthcare reform, most dependents are now entitled to coverage until age 26. This recent statutory expansion of coverage will likely generate a surge in dependent-related coverage audit issues.

Self-insured employers may similarly find that major claims are subject to much greater scrutiny from reinsurers, or stop loss carriers. Common questions raised during claims reviews include: Was the employee properly covered under the plan at the time the claim was incurred? Do all covered spouses and dependents qualify for coverage under the definitions in the plan? Does the employer's Summary Plan Description accurately reflect all conditions or exclusions required? Has the employer or the employer's third party administrator failed to apply a plan exclusion to the claim? Self-insured employers should be mindful of these issues during day-to-day administration of their plans; otherwise, a reinsurer may decline coverage when it is needed most by a plan participant.

Disputes often arise when an employer extends coverage to an employee in an effort to avoid liability under employment laws. For example, employers covered by the Family

and Medical Leave Act ("FMLA") must provide eligible employees with 12 weeks of leave per year (26 weeks in cases involving certain military exigencies). During this leave, benefits must be provided if the employee continues to pay his or her share of the premium. Once FMLA leave is exhausted, an employer may decide to provide additional leave, with benefits, as a reasonable accommodation under the Americans with Disabilities Act ("ADA"). An insurer or stop loss insurer, in contrast, may take the position that coverage should be terminated upon completion of the required FMLA leave and that any additional "supplemental" coverage should be treated as COBRA continuation coverage. This is yet another area where employers should have a clear understanding of their carrier's position.

When an employer outsources its plan administration, another set of issues can arise. Many self-insured employers outsource the administration of their employee benefit plans to third party administrators ("TPA"). A TPA handles the paperwork associated with the plan, and administers the claims process, paying claims with company funds. As in any other industry, the performance and quality of TPAs varies. Some TPAs are excellent, and they timely communicate the information an employer needs to intelligently manage its claims. Unfortunately, some TPAs fail to communicate essential information to their client employers. They may fail to make wise decisions with respect to paying claims, fail to apply benefit exclusions or 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.

Coverage disputes are expensive to defend and can quickly sour a relationship between an employer and employee. Under PPACA, claims appeals processes will be subject to external review and are likely to be more claimant-friendly. Limited proactive involvement by an employer in its benefit plan can go a long way toward preventing these costly and disruptive disputes. Employers are encouraged to conduct self-audits to identify potential issues and resolve them through discussion with their TPAs, insurers and reinsurers on a proactive basis. Plan documents should be reviewed by counsel to ensure clarity and compliance. In the realm of plan administration, the old adage "an ounce of prevention is worth a pound of cure" clearly applies.