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MEDICAL PLAN ADMINISTRATOR SETTLES WITH THE DEPARTMENT OF LABOR

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Employee Benefits

The U.S. Department of Labor (DOL) and a third-party administrator of self-insured group health plans recently agreed to settle a lawsuit in which the DOL alleged that the third party administrator breached its fiduciary duties and committed prohibited transactions in violation of ERISA in connection with certain undisclosed "Network Management Fees" it charged to ERISA-covered plans, its handling of emergency room claims, and its procedure for third party recoveries (i.e., so-called subrogation claims). In addition to the payment of $16,000,000, consisting, in large part, of the return of the undisclosed network management fees to the affected health plans, the third party administrator agreed to improve its claims procedures and communications with health plans. The settlement is memorialized in a consent order. Additional details are in the complaint and consent order.

Caution

The facts set forth in this article are derived from allegations contained in the DOL's complaint and the consent order, and should not be taken as true.

Undisclosed Network Management Fees

According to the complaint, the third party administrator unilaterally imposed a fee – a surcharge – that was added to the charges paid by the health plans to certain medical providers in the administrator's network. While the existence of the fee was disclosed in the administrative services agreement, the services agreement did not disclose the amount of the fee. Furthermore, the administrator's monthly invoices and year-end fee summaries did not identify the fee or disclose the amount of the fees. If true, the administrator's clients had no way of knowing what the medical provider received and what the administrator kept as its so-called network management fee. The complaint alleges that the lack of transparency with respect to the fee enabled the administrator to unilaterally increase the fees without the advance consent of the health plan and prevented the ERISA-covered health benefit plans from filing accurate federal Form 5500 financial reports with the government.

To resolve these allegations, the administrator agreed, among other things, to the following:

- To return at least $14.5 million in network management fees to ERISA health benefit plans, and provide complete and accurate disclosures regarding its fees.
- To offer to all of its health plan clients, the option of a fixed fee arrangement, with no network management fee or other embedded fee.
- For clients who do not choose the fixed fee arrangement, to reprice prospective actual claims over a period not to exceed one year or provide an up-front estimate of the network management fees that a client could expect to incur in a calendar year (or both).
- To provide prospective clients that have not chosen a fixed fee arrangement with access to network provider fee schedules for each CPT code and the administrator's network fee for each CPT procedure.
- To amend its administrative services agreement so that it clearly discloses the existence of the network management fee.
- To not increase any network management fee without giving the health plan at least 90 days advance written notice and the opportunity to terminate the arrangement if it does not agree with the fee hike.
- To disclose totals of network management fees no less frequently than quarterly, and to provide cumulative network management fees on an annual basis for 5500 reporting purposes.
- To provide each health plan a report covering the past three years that separately states for each year the amount of the network management fees.

Emergency Room Claims

In its complaint, the DOL alleged that the administrator's claims processing procedures and disclosures were inadequate. Among other things, the complaint alleges that the administrator's EOB denials did not reference the standard for determining whether an illness or injury qualified for emergency room coverage; did not explain that the claim was denied for lack of sufficient information demonstrating an emergency medical condition; did not reference the specific plan provisions on which the adverse benefit determination was based; and did not describe the Plans' review procedures, applicable time limits, or that the participant or beneficiary has a right to bring a civil action under ERISA. The administrator agreed to take various steps (detailed in the consent order) to remedy these alleged violations.

Third Party Recovery (i.e., Subrogation)

The complaint alleges that the administrator often did not administer the health plan's third party recovery provisions in compliance with the plan document or the DOL's claims procedure regulation. To settle these allegations, the administrator agreed to take a number of detailed and specific steps that are described in detail in the consent order.

What Employers Can Learn From This Settlement

Self-insuring medical benefits is a major undertaking, and involves a significantly greater commitment to the details of plan administration than what is required in connection with the oversight of a plan that is fully insured. Employers that self-insure have a fiduciary duty to supervise their third party administrators to ensure that they are performing their services in compliance with the terms of the plan and ERISA requirements. In this case, the hard work was done by the government. Along with a number of other responsibilities, employers must be sure that they are receiving accurate fee disclosures so that

they can make informed decisions when selecting a service provider and comply fully with important 5500 reporting responsibilities. ERISA regulations contain detailed requirements regarding the manner in which claims are to be administered, including, most importantly, requirements that detail the timing and content of claim denial notices. In this case, the DOL alleged that the EOB forms did not meet ERISA requirements. It is likely that by the standards of this settlement, many EOB forms that communicate denials fail to meet the standards set forth in the consent order. Employers should undertake a review of their health plans claims procedures to ensure compliance with ERISA.