

# Quarterly Review

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## From the Desk of the Editor

As I finalize this quarter's newsletter, we are preparing for the upcoming Employer's Counsel on Flexible Compensation (ECFC) mid-August summer symposium. On the agenda is a discussion of the § 125 final proposed regs (if available) and we expect Treasury and IRS officials to provide a status of their 2006-07 business plan results as they relate to health and welfare plans. Anything newsworthy will be distributed to you immediately.

What do benefits, cost containment and outsourcing have in common? According to some fortune 500 companies, globalization is making it harder to compete with the rising cost of health care and outsourcing is keeping them competitive. So is contingent employment relationships (independent contractors, part-timers), including the ever expanding PEO workforce. This month, several **In the News** articles, and the **Featured** GAO report lay a foundation for looking at health care and pension trends, as well as non-traditional work arrangements. Bob's **From the Hill** discusses the political environment surrounding outsourcing. Matt Coniglio, a new contributor from our subsidiary Vista Management Company (VMC) offers up some simple text to help you communicate with your employees about your defined contribution retirement plans.

Although I appreciate many employers are less than enthused about outsourcing there is a school of thought that it may be an irreversible trend. For an excellent book on point, I strongly recommend The World is Flat by Thomas Friedman. Pulitzer Prize Winner Friedman, foreign affairs columnist for the New York Times, offers an informative read of new technologies and outsourcing and what that means to global economies. No doubt that our children's and grandchildren's careers will be (or are) very different from ours.

*Enjoy, Trish*

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## A Perspective from the Hill

Robert McKnight, Senator

### Outsourcing...Friend or Foe?

As with almost all businesses, our benefits industry struggles with profit margins in 2007. This is nothing new, nor is the attempt to look for new solutions. In the past few years, there has been a great deal of publicity regarding "outsourcing" or contracting with third party contractors, for administrative services. A literal outsourcing cottage industry has been created, especially in countries like India. The angle is that the cost of the outsourcing services is less than in America, and the services are provided by well educated professionals, who speak English. Add the internet to the formula and you have a potential release value for squeezed profit margins in the administration of employee benefits. Perhaps the most common outsourcing service is the creation of call centers overseas for both outbound and inbound calls.

However, as in almost all cases, there are drawbacks to outsourcing, particularly in the public sector. Economists argue on both sides of the issue whether outsourcing is good for America's economy. On one side the argument is that we are shifting employment overseas at the expense of domestic workers, a position strongly supported by American labor unions. On the other side is the argument that outsourcing helps make American businesses profitable, which in

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turn ensures that the businesses have the opportunity to grow and add additional employment in America in the future.

Enter politics, again primarily in the public sector. Most Benefit Administrators (i.e. FBMC) have found public sector competitive bids require disclosure of outsourcing experience or plans in bid responses. In growing frequency, the Requests for Proposal (“RFP”) prohibit outsourcing administrative services. This political issue first surfaced in a significant way in the 2004 presidential election, after incumbent President Bush said that his economists advised him that outsourcing actually created additional employment in America, through expanded international trade.

Obviously, this has created significant potential political fireworks on the Hill—legislation has been filed in both houses to prohibit or restrict outsourcing in federal government competitive bids. Democrats have seized on the issue, and it is so politically explosive, few Republicans have surfaced to oppose the movement, especially as the 2008 election nears. In the meantime, in the private sector, outsourcing continues to expand in size and scope. Investment firms are now rolling up outsourcing companies into their acquisitions to seize on the profit margin advantages.

Although not intended, outsourcing is now being mixed into the mega-explosive political issue of immigration. Fiery rhetoric of taking care of America first is becoming commonplace, and only time will tell if outsourcing remains as a vehicle for improving profit margins in the administration of administrative services, like employee benefits.

## Featured Article

### GAO Report: Analysis of Employer Cost Control Practices

Trish Neely, CFCI

The US Government Accountability Office (GAO) released an excellent report this past April titled **Efforts to Control Employer Costs and the Implications for Workers (GAO-07-355)**. The report was prepared for and at the request of the Chairman of the House of Representatives’ Committee on Education and Labor to evaluate the practices employers are adopting to control the costs of benefits and the resulting impact on

workers, such as those who are sicker, older, or low-wage earners.

The analysis of health benefits used data available on years 2001 through 2006; the analysis of retirement benefits used data available 1999 through 2003. A further analysis of the changes in the composition of employers’ workforces used data available on years 1999 through 2005.

The value of the report for me was the ability to monitor trends across a broad spectrum; the conclusions were not unexpected. GAO consolidated three private-sector surveys of employer-sponsored health benefits and two federal surveys addressing workforce characteristics and benefit costs, and several major 2005 industry surveys of pension plan sponsors in addition to interviews with industry experts, employers, labor unions and advocacy groups.

### A Few Highlights

155 million Americans have employer-sponsored **health** benefits.

From 1991 to 2005 the costs of retirement and health benefits increased 34%; wages increased only 10%.

From 2001 – 2006 premium costs for individual and family coverage rose 60% and 63%, respectively.

Between 2001 and 2005, there were steeper declines in the % of low-wage earners (compared to higher-wage earners) enrolling in employer-sponsored health care.

From 2001 to 2006 the number of **ALL** employers offering health benefits declined from 68 – 61%

- Large employers (≥200) declined from 99 to 98%
- Small employers (<200) declined from 68 – 60%

50% of all private-sector workers participate in an employer-sponsored **retirement** plan.

In 1985 there were 29 million active participants enrolled in defined benefit retirement plans; by 2003 this **decreased** to 21 million.

In 1985 there were 33 million active participants in defined contribution retirement plans; by 2003 this **increased** to 52 million.

Over the past decade, contingent work arrangements have accounted for 30% of the total workforce. This includes temps, independent contractors, part-time laborers.

In 2005 the percent of contingent workers participating in health care benefits was 13% compared to 72% of traditional workers.

In 2005 the percent of contingent workers participating in pension programs was 17% compared to 64% of traditional workers.

The entire 56 page report is available at [www.gao.gov/new.items/d07355.pdf](http://www.gao.gov/new.items/d07355.pdf) along with more detailed information regarding the Kaiser Family Foundation, Hewitt & Associates, and Mercer National surveys.

## In The News

### It's 10PM

#### ***Do you know who's using your identity?***

Gingy Sampson, Benefits Analyst

**Identity theft is serious.** So serious, the *President's Task Force on Identity Theft* was established by Executive Order 13402 on May 10, 2006.

So serious we (FBMC) began this year offering Personal Accident Insurance with *Identity Theft Protection* in our benefits arsenal for clients to add to their benefits packages. In 2005 alone, victims spent almost 300 million hours resolving the problems, compromising employee and business productivity.

As a result many employers are educating their employees with steps to protect themselves against identity theft as well as considering identity theft protection for their employees as a part of their benefits package.

For more information on preventing identity theft, visit the Federal Trade Commissions website at [www.ftc.gov/idtheft](http://www.ftc.gov/idtheft).

### **Dental Plans Now Offer Rollovers**

Robert Dunn, CLU

The latest trend in dental plans lets patients build allowances with regular care. Group dental carriers have begun offering plans that will let patients roll over their unused maximum treatment limits to following years.

The rollover feature typically works by allowing a patient with, for example, a \$1,500 annual maximum benefit, to rollover a portion of that unused balance to the following year, with that portion determined by the insurer. The

rollover feature varies by insurer and the number of years that balances can be rolled over are capped to three or four, or the maximum dollar amount that can be rolled over. Under most of the new plan designs, members must visit the dentist at least once a year to receive the rollover benefit.

The higher maximum limits for members who see their dentist on a regular basis reward those who usually generate small charges by allowing the member to accumulate higher allowances to use toward unexpected dental expenses. Studies have shown that at most only 6% of plan participants ever reach their maximum limit which range up to \$2,000 in most plans for all services except orthodontia.

Insurers claim the new plan designs are meant to encourage participants to visit their dentist regularly for examinations and cleanings to prevent gum disease and tooth decay. The rollover feature also makes the plans more attractive to employers and consumers at a time when they are under pressure from rising medical costs. The rollover feature will also help employers and consumers by encouraging low risk patients not to drop their coverage which, in turn, would leave behind only members in poor dental health, driving up costs for everyone in the plan. Depending on the insurer, the estimated cost of the feature is an additional 0% to 5%.

The new rollover feature only applies to traditional indemnity dental plans. It does not apply to dental managed care or DHMO plans which have no annual maximum benefit.

### **Mini-Med Plans – Update**

Robert Dunn, CLU

In the last issue of QR, we reported on the renewed interest in Mini-med plans as a strategy to address the uninsured epidemic plaguing the country. Typically designed for part-time employees, seasonal employees or those employees who are not yet eligible for their employers' group health plans, Mini-meds become the health plan for some employees. Several clients have questioned if a "mini-med" plan therefore qualifies as a HDHP. The short answer is probably not; however, we do know through our EBIA resource team that the IRS intends to address this in future guidance. *EBIA Consumer Driven Health Care 2<sup>nd</sup> Quarter, 2007.*

An HDHP must meet Code 223(c)(2) minimum annual deductible and maximum out-of-pocket expense limit requirements. Although guidance from the IRS provides that an HDHP can be designed with certain restrictions, the restrictions must be **reasonable**. For them reasonable means that *significant other benefits must be available under the plan.*

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With that in mind, let's look at the restrictions in the two types of plans that classify as mini-med coverage – indemnity and co-pay/coinsurance.

Indemnity plans pay the provider a fixed rate for medical services including doctor visits, hospital stays, prescription drugs, etc. Members are responsible for the difference between the fixed rate and the actual charge. Would these be deemed reasonable?

Co-pay plans pay a percentage of a network discount price or usual customary charges incurred. Members are responsible for any charges in excess of the benefit maximums. Would these be deemed reasonable?

In our opinion, plans that provide only a limited fixed indemnity benefit and that may also cover certain specified diseases and plans with a very low annual out-of-pocket maximum may fail that “reasonable” test to qualify as an HDHP. Interestingly, the IRS has informally suggested that it is **unclear** whether a plan that limits hospitalization benefits to in-patient services and excludes out-patient services would provide significant medical benefits.

More guidance to come . . .

*If you are interested in receiving more information including a comparison of four plans offered by leading underwriters of this type of product, please contact the undersigned at [bdunn@fbmc-benefits.com](mailto:bdunn@fbmc-benefits.com).*

## New Health Info Privacy Web site:

*Stats, Process Flowcharts, Case Studies & More*  
Trish Neely, Privacy Officer

On April 20<sup>th</sup> HHS issued a press release announcing a new and improved Health Information Privacy Web site. The site, <http://www.hhs.gov/ocr/privacy/enforcement> provides information for consumers, health care providers, health plans and others in the health care industry regarding HHS's compliance and enforcement efforts.

Upon visiting the site, I discovered that from 4/14/2003 – 4/30/2007, the agency received approximately **27,000** complaints. To date, 21,000 have been resolved: 6,700 through formal investigation of which 2,200 were determined to have no violation; 4,500 required corrective action; and the remaining 14,300 were resolved without investigation. Approximately 6,000 remain open.

The site also describes HHS activities in enforcing the Privacy Rule. There's a process flowchart and narrative that describes the steps should your plan receive a complaint.

The case studies identify the types of complaints investigated to date – what the plan or the facility did wrong, and the corrective action taken.

*If you are wondering if FBMC has investigated any complaints involving your health plans administered by FBMC, the answer is no news is good news. Our practice is to formally investigate any incident that comes to our attention and submit a written report to you. If you haven't heard from us, we have not researched any privacy or security concerns related to your plan, either self-reported by FBMC staff or brought to our attention through customers.*

## Inflation & Retirement

Matt Coniglio, 401(k) Registered Representative  
Vista Management Company (VMC)

It's general knowledge that inflation results in the gradual rise of prices over time. While we expect (and our employees expect) to pay a little more for some things over the course of a few years, we expect (hope) that our incomes will increase proportionately – or at least an annual cost of living adjustment.

Upon retirement, the stark reality is that an individual's pension (assuming he/she is lucky enough to have one) will most likely NOT keep pace with inflation, giving the retiree less and less purchasing power.

The importance of retirement investment options should be obvious to Boomers (some kept their heads in the sand for too long but that's another article). Where we as employers must focus more energy is on the next generations. Grade school is not too soon. The following information comes from an article I wrote for VMC's Quarterly Newsletter. It's geared toward our 401(k) participants; however, you may find some information that you could use with your defined contribution retirement program. Matt

. . .

Maintaining valuable income to keep up with inflation is precisely what makes a retirement investment option such an attractive solution. Retirement investing will aid you in the long run by providing you with a pool of funds to outperform inflation.

The old adage that people need to save more than 10 percent of their income for savings simply won't suffice anymore. Present experts advise that you should take your salary at or around retirement, multiply it by ten and this is the amount you will need for retirement. But how true is this information? See for yourself in the examples below:

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Mr. Walker is in a fixed retirement scenario and he has \$500,000 at retirement, inflation is at five percent annually for six consecutive years and he is receiving a three percent return on his money. Mr. Walker is also drawing \$30,000 a year for living expenses. Factoring in all of the above, Mr. Walker will only have \$276,801.26 left after six years.

Mrs. Jones has a retirement account worth \$500,000 at retirement as well. She is also subjected to five percent inflation and she draws \$30,000 a year for living expenses. Mrs. Jones will have an average of \$374,079.02 after a six-year period because her retirement account continues to earn an average of seven percent during her six consecutive years of retirement.

See how these figures add up? Mrs. Jones's earnings will make an even larger difference ten years later. In six years, Mr. Walker's balance has been almost cut in half, whereas Mrs. Jones's balance has increased by \$97,277.76. A fixed return sounds nice, but \$97,277.76 is a significant amount of money. If your retirement goals include travel, doting on grandchildren and/or enjoying your golden years thriving instead of just surviving, Mrs. Jones's strategy seems much more appealing.

Always keep in mind that mutual funds in the forms of bonds or stock have the best shot at doing something that fixed retirements accounts can't - keep pace with inflation.

The general rule of retirement investing is to start early. Most people wait to begin contributing to a retirement plan. Remember that it's more affordable to contribute \$100 per month now, than \$5000 later as you try to catch up for the years you missed. Think about the money you could have earned in compounding growth if you started your contributions early.

At a younger age, you should invest more aggressively to grow your balance, allow time to recover from any short-term loss in your retirement investment. In later years, you could scale back to more moderate and conservative investments – switching from aggressive growth to a stable source of funds, such as Fidelity Advisor Freedom Funds. Review your fund performance often, but don't chase returns. Just make sure you're investing in the accounts that will best meet your overall retirement goals. Time and compounding will take care of the rest. Just keep contributing!

Want to have even more at retirement? Instead of shooting for your salary times ten, shoot a little higher at times 12. Stay away from taking loans on your retirement account. While it may be better to pay an interest rate to yourself than to a lender, it's more beneficial for your retirement funds to grow from funds

performance versus loan repayment from your paycheck. Lastly, try to outperform inflation and properly diversify your account. Diversification goes a long way to minimize risk.

The inflation rate can be found at [www.bls.gov](http://www.bls.gov) and should be reviewed annually..

[Reprinted in part from a recent VMC Newsletter Article.]

## Questions from our Clients

Tina Bischoff, CFCI, Compliance Officer

**Q.** Please provide the IRS publication for qualified transportation benefit, regarding tolls which are not eligible items for the QTB plan.

**A.** Tolls can be treated by individual taxpayers as a tax *deductible*, business-related expense on IRS Form 1040. Please see, IRS Pub. 463 at <http://www.irs.gov/pub/irs-pdf/p463.pdf>

But tolls are not contemplated by Internal Revenue Code § 132, which regulates QTB plans rather than an IRS publication. Under Code § 132(f)(1), Employers can establish a QTB plan to reimburse only employees for expenses incurred or paid by them for:

- (i) qualified parking, and/or
- (ii) transit passes, and/or
- (iii) vanpooling (i.e., transportation in a commuter highway vehicle if such transportation is in connection with travel between the employee's residence and place of employment).

"Qualified Parking" Defined. Treas. Reg. § 1.132-9, Q/A-4, defines qualified parking as parking provided to an employee:

- at or near the business premises of the Employer;
- on or near a location from which the employee commutes to work by mass transit, vanpooling, in a commuter highway vehicle, by carpool, or by any other means; and
- for which an Employer pays (directly to a parking lot operator or by reimbursement to the employee), or parking that an employer provides on premises that it owns or leases.

"Transit Pass" Defined. Code § 132(f)(5)(A) and Treas. Reg. § 1.132-9, Q/A-3, provide that a transit pass means any pass, token, fare card, voucher, or similar item (including an item exchangeable for fare media) that entitles a person to transportation (or transportation at a reduced price) on mass transit facilities (whether or not publicly owned) or provided by any person in the

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business of transporting persons for compensation or hire if provided in a highway vehicle with a seating capacity of at least six adults (excluding the driver).

**“Vanpooling” Defined.** Vanpooling means transportation between the employee’s residence and place of employment but only if it is done in a “commuter highway vehicle.” Treas. Reg. § 1.132-9(b), Q&A-21(b) provides that three types of vanpools may qualify as qualified transportation fringe benefits: employer-operated, employee-operated, and private or public transit-operated.

For a copy of Internal Revenue Code § 132, please visit:  
[http://www.taxalmanac.org/index.php/Internal\\_Revenue\\_Code:Sec.\\_132.\\_Certain\\_fringe\\_benefits](http://www.taxalmanac.org/index.php/Internal_Revenue_Code:Sec._132._Certain_fringe_benefits).

**Q.** Last year in answer to a regulatory question involving a husband and wife who both enrolled in our DCAP plan at the \$5,000 maximum, FBMC advised us that exceeding the household max of \$5,000 was not considered a valid CIS event by the IRS because some households may intentionally exceed the max as a way to defer taxes. Instead the couple would report their error on their Form 2441 when they file their federal tax returns. We recently heard through another source that at a meeting officials from the IRS and Treasury indicated that “because the spouses made a mistake of fact about the maximum excludable amount of DCAP benefits, one spouse could ask his or her employer to revoke the election.” How should we proceed going forward?

**A.** For now, we are not changing our regulatory position on this issue. In mid-August, I will be attending ECFC’s 2007 Symposium in Reno. The IRS and Treasury officials whose comments can be relied upon to represent agency policy for café and FSA plans (as well as other tax-favored arrangements) will be there. During an open forum IRS and Treasury officials make themselves briefly available for questions. I will keep you informed if yours is one of the questions they choose to answer.

**Q.** Isn’t it a violation of HIPAA to ask for more than just the Rx number of a prescribed medication, or to ask a participant to identify a medical condition as part of the documentation needed to determine if a claim is eligible for reimbursement?

**A.** When one or more laws overlap such as those regulating health FSA plans and HIPAA privacy standards, we strive to maintain safeguards to assure that our Client-Employers’ programs remain in compliance with **all** plan and regulatory rules.

At the heart of the rules regulating health FSA plans is adequate substantiation. Compliance with this

regulatory requirement protects not only the tax-favored status of the Employer’s health FSA plan but also each participant’s accountability and burden of proof if challenged on IRS audit.

HIPAA demands privacy and security. FBMC enters into a business associate agreement with Employers whereby on their behalf we will administer their health program in accordance with HIPAA and use the same standard of care as if the Employer were administering its own program.

Whether submitting a paper claim or using a debit card, participants may be asked to submit a receipt showing both the Rx number and Rx name, or a statement from the treating health care professional identifying the medical condition giving rise to a recommended treatment or medication. We will ask for additional substantiation if it’s not readily apparent from reviewing the receipt, invoice or other statement submitted that the expense claimed qualifies as medical care for health FSA plan purposes. But, in doing so, only the PHI that is minimally necessary to substantiate a reimbursement request is sought by us.

## GUEST ARTICLES

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### ERISA PLAN MUST CONSIDER MAILBOX RULE IN RESOLVING DISPUTE ABOUT RECEIPT OF REQUIRED PAPERWORK FROM PLAN PARTICIPANT

[Kuchar v. AT&T Pension Ben. Plan-Midwest Program, 2007 U.S. Dist. LEXIS 18141 (N.D. Ill. 2007)]

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This case involved a pension plan participant whose claim for a lump-sum pension payment was denied because, according to the plan, the required election form was received ten days after the deadline. In denying the claim, the plan administrator relied on the date that was stamped

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on the form by plan administrative employees. (The form had been mailed to the plan.) In challenging the denial, the participant made two arguments: (1) that the plan should have treated the date of mailing as the date the form was filed with the plan (the court called this the "received-upon-mailing" rule); and (2) that he had mailed the form sufficiently in advance of the deadline, so that it must have been received by the deadline (the court called this the "presumption-of-receipt" rule). In its claim denial notice, the plan expressly rejected the first argument but did not address the second.

The trial court found that the plan's decision was unreasonable because the plan did not consider all the participant's arguments. Concluding that the administrative record had not been adequately developed, the court sent the case back to the plan administrator for a "new and comprehensive" appeal of the claim, directing the plan to consider new evidence produced by the participant regarding the date the form was mailed and to investigate the plan's own procedures for receiving, date-stamping, sorting, and distributing mail. In particular, the court said that the plan's failure to produce the postmarked envelope containing the election form created an inference that the form had been received on time but had been misplaced, subsequently found, and then stamped with a later date.

EBIA Comment: Disputes about receipt of paperwork arise in many situations, and the reasoning of this decision could apply with equal force to health and welfare plan enrollment forms or forms under a plan's claims procedures, among others. Outside the COBRA context (where the DOL has expressly adopted the "received-upon-mailing" rule for COBRA elections and premium payments), ERISA does not impose particular procedures for determining the timeliness of required paperwork. Nevertheless, it is crucial that plan procedures hold up in court, and, as a result, this court's observations about basic mail-handling procedures and recordkeeping should be required reading for plans and service providers. In particular, serious consideration should be given to amending administrative procedures to require retention of postmarked envelopes whenever time-sensitive forms or other communications are mailed to the plan by participants or beneficiaries. For more information, see EBIA's ERISA

Compliance manual at Section XI.G ("Disputes About Receipt of Paperwork"); EBIA's COBRA Compliance manual at Sections XIX.E.3 ("When Election Form Is Mailed, When Is Election Effective?") and XXII.A.1 ("COBRA Premium Payment Is Made When Sent"); and EBIA's 401(k) Plans manual at Section XXX.C ("Procedures for Processing Claims and Appeals"). See also EBIA's softcover book, Record Retention Requirements for Health and Welfare Plans.

Contributing Editors: EBIA Staff.

## TPA AND EXCESS LOSS INSURER DID NOT EXERCISE DISCRETION AND WERE NOT PLAN FIDUCIARIES

[Sparks v. Duckrey Enterprises, Inc., 2007 U.S. Dist. LEXIS 6540 (E.D. Pa. 2007)] For a copy: <http://www.paed.uscourts.gov/documents/opinions/07d0148p.pdf>

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After a participant's self-insured health plan denied benefits arising from injuries sustained during a home invasion, the participant sued his employer, the plan's TPA, and the plan's excess loss insurer under ERISA for benefits and for breach of fiduciary duty. The TPA and insurer argued that they should not be included in the lawsuit and asked the court for a summary judgment (that is, judgment without a trial).

The court agreed to exclude the TPA and insurer, explaining that to be included in this lawsuit, the TPA and insurer would have to be fiduciaries. The court found, however, that the employer retained all discretion and final authority under the plan. In contrast, the TPA's responsibilities were ministerial--among its duties described in the service contract, the TPA (1) investigated claims and made recommendations to the employer as to outcomes of benefit claims and disputed claims; (2) forwarded payments to providers from an account funded by the employer; (3) provided administrative infrastructure; (4) assisted with determining participant eligibility; (5) provided COBRA notices and HIPAA certificates of creditable coverage; (6) prepared statistical reports and an annual accounting; and (7) reported on matters of general interest. Although

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the TPA also prepared plan and SPD documents, the court ruled that this was insufficient to make the TPA a fiduciary. And the excess loss insurer merely reviewed participant claims after they were paid to ensure that the claims comported with the plan's specifications before reimbursing the plan for the loss. Noting that the "linchpin of fiduciary status is discretion," the court held that neither the TPA nor the insurer possessed the requisite discretion over administration or management of the plan to qualify as a plan fiduciary.

EBIA Comment: TPAs continue to be named as defendants in benefits litigation because of their perceived role in the claims process. As in this case, courts typically find that persons who merely perform administrative services in conformity with plan rules do not possess the requisite discretion to qualify as an ERISA fiduciary. But because a determination of fiduciary status requires a factual analysis of what tasks a TPA actually performs, it is important for employers and TPAs to clearly describe each party's roles and responsibilities and to act in accordance with those stated roles. And keep in mind that although discretion is a key factor, discretionary authority is not necessary when an entity exercises control over plan assets. This court did not address this issue, but several courts have held that TPAs with no discretionary authority were fiduciaries based on their exercise of authority or control over plan funds (for an example, see our article at <http://www.ebia.com/WeeklyArchives/ERISA/CourtCases/18493> (Premium Access subscription required)). For more information, see EBIA's ERISA Compliance manual at Sections XIV.E ("How Employer General Assets Can Become Plan Assets"), XXVIII.B ("Who Is a Fiduciary?"), and XXX.F ("Litigation Involving TPAs"); see also EBIA's 401(k) Plans manual at Section XXIV.B ("ERISA Fiduciary--A Functional Definition").

Contributing Editors: Thanks to attorney Nancy A. Strelau for her contributions to this article, with final editing by EBIA staff. Ms. Strelau is a shareholder of Brownstein Hyatt Farber Schreck, P.C. in Denver, Colorado, and is a contributing author of EBIA's ERISA Compliance manual.

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