
TPA Contracting Principles & Strategies¹

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TPA Contracting Principles & Strategies²

By Cynthia Marcotte Stamer³

This paper focuses of the role written administrative services contracts play in helping employer or union-sponsored health plans , their sponsors or fiduciaries and providers of administrative services (TPAs) to manage their relationships and legal risks by exploring some of the more significant issues and concerns associated with the use of administrative services agreements.⁴ The administrative services might include services relating to the investigation or administration of claims processing generally; coordination of premium and contribution collections and application; the provision or administration or establishment of a provider network (for medical, mental health, dental, transplant, or pharmacy benefits); utilization management services; disease or case management services; claim recovery services; wellness or other screening or education programs; medical bill review, prescription benefit management or other special program features; assistance in plan design; provision of draft plan documents and summary plan description booklets; insurance submission, brokerage or other related services; COBRA or other special eligibility services; regulatory reporting, or the like.

CONTRACT FORMATION BASICS

Under the common law of contracts, the law generally recognizes a TPA and its client as having entered into a contract when the facts and circumstances would cause a reasonable person to conclude that the following conditions are met:

- The TPA has made an offer to provide, or the Client has made an offer to purchase certain administrative services;
- The other party has accepted the offer; and
- Consideration in the form of the payment of money, the commencement of performance or otherwise has commenced.

While most states mandate by insurance code or regulation that businesses providing administrative services as TPAs execute written contracts with their clients, the execution of a formal written is not a prerequisite to the formation of a binding agreement between the parties. Rather, a contract may come into through the execution by the parties of a formal written administrative services agreement, as well as through the entry of an oral agreement between the parties, the oral or written communication by a prospective client of its acceptance of a proposal by the TPA, or various other actions that a trier of fact determines would lead a reasonable person to conclude that the requisites of offer, acceptance, and consideration sufficiently existed to give rise to a contract. For this reason, a TPA contemplating suspending the performance of services to a Client based on the Client's failure to execute a written agreement after the performance of services already has commenced should carefully evaluate likelihood that a jury or judge would conclude that the requisite meeting of the minds between the parties already has occurred which would preclude the TPA from withholding services in response to the Client's refusal to sign the proposed written agreement. If a jury determines that the requisite meeting of the minds and delivery of consideration occurred before a TPA and its client entered into a formal written agreement, the TPA runs the risk that its subsequent presentation of a written agreement by one of the parties will be treated as a proposal to modify the contract created by the original agreement and result in its refusal to render services in accordance with the original understanding as its breach of the original contract.

PURPOSE & BENEFITS OF WRITTEN CONTRACT

Health plan sponsors and fiduciaries and TPAs and other service providers to such plans generally should strive to conduct their business dealings to promote the formation of contracts to provide administrative services only pursuant to precisely crafted written administrative services agreements designed to clearly define the rights and responsibilities of all involved parties, to comply with applicable regulatory requirements, and to incorporate other appropriate risk management provisions relevant to the goals of the

respective party.

An appropriately crafted TPA contract should carefully set forth the rights and obligations of each party, any limitations or conditions applicable to those rights and responsibilities, and any other material terms and conditions of the understanding between the parties. Properly crafted, such written agreements may serve a variety of functions including to:

- Fulfill requirements that the Client document its contractual relationship with the TPA to fulfill applicable regulatory obligations under HIPAA or other laws, the applicable terms and conditions of the governing plan document, applicable stop loss insurance contracts, or otherwise;
- Help the TPA meet state statutory or regulatory obligations to document its contractual relationship with the Client Help minimize legal exposures to government agencies and/or private plaintiffs arising out of the violation of applicable legal standards by documenting party's good intentions and commitments to compliance;
- Memorialize the rights and obligations establishing and governing the legal relationship between the parties for the parties and others with an interest in the relationship;
- Minimize liability producing problems arising out of the administration of the plan and prevent or promote resolution of disputes between the parties by clearly defining the respective responsibilities and rights of each party;
- Provide evidence of the intentions of the parties at the time the contractual relationship was created relating to their intentions regarding the respective responsibilities and rights of the parties;
- Help prevent misunderstandings and missteps that frequently result from misunderstandings created by gaps in services agreements;
- Minimize or allocate fiduciary and other legal exposures and risks by allocating certain allocations of powers, duties, and liabilities, subject to the understanding that ERISA may disregard certain exculpatory allocations where the operation of the plan does not match the written representations; and
- Safeguard certain sensitive information;
- Provide for indemnification, insurance, performance guarantees or other financial assurances and protections in the event of a breach or other liability; and
- Specify rights of termination or other recourse in the event of certain occurrences.

Moreover, the review and negotiation of the contract process itself generally is a critical part of a fiduciary's exercise of its responsibility to carefully select and monitor the service providers acting as fiduciaries or service providers to the plan and to provide for its prudent administration in accordance with ERISA and other law.

Of course, the realization of these and other potential benefits of a written contract depend upon the quality of its terms and the parties' respective willingness and ability to comply with their obligations. A carefully crafted agreement to perform obligations that the TPA is incapable of performing consistent with capabilities and its business model might perceive the written agreement as a liability rather than a benefit. Likewise, a commitment to perform made by a financially insolvent TPA or coupled with liability limitations that insulate the TPA from meaningful accountability could be of limited financial benefit to a disappointed plan sponsor or fiduciary, but still might provide some fiduciary or other liability mitigation. Where both parties legitimately seek to implement and perform in accordance with an appropriately designed arrangement, however, documentation in a carefully crafted agreement generally is in the interest of both parties.

NATURE OF CLIENT & PLAN AFFECTS REGULATORY AND OTHER REQUIREMENTS AFFECTING TPA CONTRACT CONTENT

The nature and identity of the Client and the benefit program sponsored by the Client plays a significant role in determining the design and content of the contract between the TPA and its Client.

- The size of the health plan;
- Whether the health plan and its benefits are provided pursuant to a self-insured arrangement sponsored by the employer, union, or other plan sponsor and funded from the plan sponsors assets, a trust, employee contributions, or some combination thereof, a series of individual insurance contracts, one or more group insurance or health maintenance organization contracts, or some combination thereof;
- The plan design and terms of the underlying arrangement and the conditions imposed attendant to the qualification for that coverage;
- The insurance, reinsurance, and administration arrangements associated with the health plan arrangement;
- Whether and how the health plan regulated under the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and various other Federal laws, state insurance laws, or both;

- The scope of services to be delegated;
- The sophistication of the parties;
- Whether other TPAs also are involved;
- The scope of services to be delegated; and
- A host of other factors.

Failing to recognize and account for these distinctions in the contracting process often leads to unfortunate results.

A health program is likely to be regulated under a plethora of Federal laws and regulations. The Federal legal requirements applicable to a Client's arrangement shape the Client's expectations for the services it seeks to obtain from the TPA. A proper understanding of applicable Federal requirements also plays a critical role in the ability of a TPA to anticipate, plan for, design its contract, and price its services to account for the responsibilities and liability exposures that the party may subject itself to by contracting to provide the requested services. Therefore, each party should obtain a clear understanding of all mandates and other requirements applicable to the Client's program before contracting or proposing to contract for TPA services.

Examples of Federal laws that may impact an ERISA-covered or other health plan sponsored by the Client include ERISA, the Internal Revenue Code (Code), the Americans With Disabilities Act of 1990, the group health plan requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the eligibility and coverage rules applicable to health and other welfare plans under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Family and Medical Leave Act of 1993 (FMLA), the medical coverage continuation requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the secondary payor and other requirements of the Social Security Act (SSA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health plan related provisions of the Small Business Job Protection Act (SBJPA) and the Veterans Administration-Housing and Urban Development Appropriations Bill (VA/HUD Bill) and a host of other Federal laws and regulations. Federal regulatory issues exist even for those arrangements exempt from ERISA coverage, however. For instance, state governmental programs and church sponsored programs that are exempt from ERISA nevertheless may be required to comply with certain mandates imposed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Many TPAs misperceive or fail to adequately appreciate the ERISA implications of dealing with an ERISA-covered arrangement. Except for programs specifically exempted under Section 4 of ERISA, ERISA applies to the design, administration and operation of any such arrangements, regardless of whether the sponsoring employer or union arranges to provide the benefits promised under the program by purchasing a group insurance policy, paying for a series of individual insurance policies, establishing or contributing to a trust to provide the benefits, or providing the benefits from its general assets. The fiduciary responsibility requirements of ERISA have a broad-reaching affect on the Client's program, the liabilities applicable to the Client and the TPA arising out of the administration of the program, the effectiveness of the TPA's efforts to use contractual provisions to minimize liability exposures, the range of state insurance laws and regulations enforceable with respect to the Client's program and its administration, the TPA's ability to subcontract services, and a host of other matters. Many TPAs over-estimate their latitude under ERISA to limit contractually their liability and avoid state regulation, while underestimating their potential exposure to fiduciary and other liability arising out of their involvement in ERISA plan administration and funding arrangements. Some of the more significant aspects of the ERISA-related implications affecting TPA contracts and involvements are discussed in the immediately following paragraphs.

OVERVIEW OF SELECTED ERISA CONCERNS AFFECTING SELF-INSURED PLANS AND THEIR ADMINISTRATORS

Title I of the Employee Retirement Income Security Act of 1974 (ERISA)⁵ defines the persons accountable as fiduciaries and the standards that fiduciaries of ERISA-covered health plans must meet when carrying out their responsibilities with respect to an ERISA-covered health or other welfare plan.⁶ Although Congress enacted these rules more than 25 years ago to determine the fiduciary status and responsibilities for parties involve in the administration of pension as well as health and welfare benefit plans covered by ERISA, the application of these rules in the context of health and welfare plan remains surprising for many health plan sponsors and vendors.

Each party contracting for TPA services with respect to the administration of an ERISA-covered plan needs to clearly understand ERISA's fiduciary responsibility rules and the conditions under which they could be or become a fiduciary for purposes of ERISA.

FIDUCIARY RESPONSIBILITY RULES

➤ Health Plan Fiduciaries Identified

ERISA requires that the written instrument establishing the plan identify one or more individuals as named fiduciaries who jointly or severally have the authority to control and manage the operation of the plan.⁷ The named fiduciary can be either a person named in the plan or a person selected according to a procedure specified in the plan.⁸ While the named fiduciary always stands accountable for fiduciary breaches within the scope of its named fiduciary responsibility, the definition of "fiduciary" for purposes of ERISA is not restricted to person named as fiduciaries in written documents. Rather, the definition of a "fiduciary" for purposes of ERISA encompasses (1) any person or entity that is a named fiduciary in the plan documents, as well as (2) any person or entity that functionally exercises discretion or control over the management of the plan or the management or disposition of assets of the plan, (3) has any discretionary authority or responsibility over the administration of the plan, or (4) is an investment manager.⁹ Because an ERISA fiduciary is defined "not in terms of formal trusteeship, but in functional terms of control and authority,"¹⁰ the linchpin of fiduciary status under ERISA is discretion. The Supreme Court has held that "one is a fiduciary to the extent he exercises any discretionary authority or control."¹¹

For this reason, the courts have ruled that when the plan document or an agreement entered into pursuant to the health plan identifies a party as a named fiduciary or grants to it discretionary authority or responsibility with respect to certain matters relating to the plan or its administration, the person identified as the named fiduciary generally will be considered a fiduciary for purposes of those matters.¹² When an entity or individual is the party named as invested with the power or responsibility to exercise fiduciary power or discretion, the courts generally hold that the named party, often referred to as the "named fiduciary," may be held personally liable irrespective of whether the named fiduciary, in fact, actually made or participated in the improper decision.¹³

While the acceptance of named fiduciary status generally renders the named party a named fiduciary for purposes of ERISA, fiduciary status is not limited only to named fiduciaries. The existing precedent clearly reflects that the disclaimer or absence of a named or other fiduciary status does not foreclose fiduciary status for parties who, in fact, exercise functional discretion and control over health plan administration and investment matters, or have responsibility to do so. Thus, while the mere provision of services (other than investment advisory services) with respect to a health or other welfare benefit plan does not automatically render a service provider a fiduciary to the plan, neither does ERISA allow a service provider to avoid fiduciary status by disclaiming, or refusing to accept, named fiduciary status. Rather, whether a service provider to a health plan will be treated as a fiduciary of the health plan depends upon whether an examination of the particular facts and circumstances surrounding the provision of those services reveals that the service provider exercised discretion or control over the administration of the plan or the investment of its assets, or had any responsibility to do so.

Furthermore, when applying this functional fiduciary analysis, the courts have recognized that certain offices or positions, with respect to an employee benefit plan, by their very nature require persons who hold them to perform one or more of the functions described in Section 3(21)(A) of the Act. For example, a plan administrator or a trustee of a plan must, by the very nature of his position, have "discretionary authority or discretionary responsibility in the administration" of the plan within the meaning of Section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries, regardless of whether the plan documents expressly name- or even disclaim- that individual as a fiduciary.¹⁴ Thus, in *Eversole v. Metropolitan Life Ins. Co., Inc.*,¹⁵ the Court ruled that Metropolitan Life Insurance possessed the requisite 'discretionary authority' in the administration of the plan to qualify as an ERISA fiduciary where Metropolitan had the authority to grant or deny claims.

For offices and positions not inherently invested with fiduciary discretion, fiduciary status is determined by examining the duties, responsibilities, and powers of the individual, and whether the facts and circumstances reflect involvement in or responsibility for the performance of any of the discretionary functions. Pursuant to this analysis, attorneys, accountants, actuaries, consultants or other parties rendering services to an employee benefit plan will be considered plan fiduciaries if the factual situation in a particular case demonstrates that the party either:

- Exercises discretionary authority or discretionary control respecting the management of the plan,
- Exercises authority or control respecting management or disposition of the plan's assets,
- Renders investment advice for a fee, direct or indirect, with respect to the assets of the plan, or has any authority or responsibility to do so, or
- Has any discretionary authority or discretionary responsibility in the administration of the plan.¹⁶

On the other hand, a service provider is not a fiduciary if the analysis reveals that the party performs purely ministerial functions for a health plan within a framework of policies, interpretations, rules, practices and procedures made by other persons because such person does not have discretionary authority or discretionary control.¹⁷

Pursuant to this analysis, where a plan employee or other party appointed to serve as a benefit supervisor has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits, the Department of Labor Regulations indicate that the benefit supervisor would be a fiduciary within the meaning of Section 3(21)(A) of the Act. To become fiduciaries under this functional test, however, the service provider or other unnamed party generally must be shown to actually exercise or bear responsibility to exercise sufficient discretion and control that actually amounts to decision-making power.¹⁸ In contrast, where a plan designates as a "benefit supervisor" a plan employee whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula contained in the written instrument pursuant to which the plan is maintained and the benefit supervisor, after calculating the benefits, would then inform the plan administrator of the results of his calculations, and the plan administrator would authorize the payment of benefits to a particular plan participant, the benefit supervisor does not perform any of the functions described in Section 3(21)(A) of the Act and is not, therefore, a plan fiduciary.¹⁹

Notwithstanding ERISA's functional test of fiduciary status, third party administrators, brokers, and other service providers contracting to provide administrative services for health plans often go to great lengths to incorporate disclaimers of fiduciary status into their contractual agreements with plan sponsors or other plan fiduciaries. It is common, for example, for such parties to draft their agreements to expressly recite that the parties agree that the service provider will not be considered a "fiduciary" or a "named fiduciary," that the services provided by the service provider are "ministerial" in nature, or both. In such cases, the plan documents and service agreements commonly portray the service provider as simply applying mathematical formulas in accordance with the plan in a purely ministerial manner, and the plan sponsor as having the discretionary authority and responsibility for authorizing the payment of benefits. To the extent that the factual realities correspond to this depiction, the service provider generally will not be considered a fiduciary. Consequently, a third-party administrator who merely performs ministerial duties or processes claims is not a fiduciary.²⁰ On the other hand, contractual characterizations of a party's role as "non-fiduciary" or "ministerial" in nature and function will not prevent a finding of fiduciary status if the facts and circumstances reflect that the party in fact exercised discretionary responsibility or power with respect to the plan.²¹

While vendor agreements commonly incorporate written disclaimers of fiduciary status or discretion in their agreement, the agreements themselves often simultaneously provide for the retention or exercise of discretionary power by the service provider or provide that the exercise of such discretion is exercised subject to the supervision of the named fiduciary. ERISA does not require that an entity have total discretionary before it may be considered a fiduciary.²² Considering such situations, the courts frequently are willing to find fiduciary status, noting that ERISA states that a person is a fiduciary if he exercises any discretion, not just complete discretion.²³ The courts also generally recognize that ERISA does not require that an entity have total discretionary powers before it is considered a fiduciary.²⁴ Thus, for instance, in *American Federation of Unions Local 102 Health & Welfare Fund, et al v. Equitable Life Assurance Society of the United States, et al*,²⁵ an insurance agent became a fiduciary, for purposes of ERISA, when he was appointed administrator of the union's health and welfare fund, pursuant to a contract giving him authority to grant or deny claims, to manage and disburse fund assets and to maintain claims files, even though trustees had final authority to grant or deny claims.

In *Brink v. DeLesio*,²⁶ for instance, the court found that the named fiduciaries of the health and welfare fund had delegated responsibility for making important decisions regarding the selection of insurance coverage's and vendors to an insurance broker, who, along with his companies, provided administrative and consulting services to the fund, and that fund trustees relied heavily upon the consultant for other important matters. Based upon its determination that the broker and his agencies in fact possessed effective authority to decide and control these decisions, the court concluded that the broker acted as a fiduciary with respect to the funds, even though he was not a named fiduciary. Accordingly, the court found that the consultant could be held liable along with the named fiduciaries for breaches of fiduciary responsibility committed within the scope of his discretion.

Similarly, in *Reich v. Lancaster*,²⁷ the Fifth Circuit ruled that an insurance agent and his firm that provided insurance advice to a self-funded union-sponsored welfare plan, exercised sufficient discretionary authority and control over the plan to assume fiduciary status, despite disclaimers to the contrary in its service agreement, where the broker and his firm went beyond performing perfunctory services, where agreements between firm and plan called for administrative, actuarial, and consulting services, where the firm was given full authority to investigate, process, and approve claims, where the broker's misrepresentations and other actions denied the

named fiduciaries the power to effectively exercise informed judgment, and the plan was dependent on the agent's special expertise, and uncritically accepted his recommendations.

In *American Fed. of Unions, Loc. 102 v. Equitable Life Assurance Society*,²⁸ the Fifth Circuit found that an insurance agent appointed to serve as a health and welfare fund administrator clearly exercised fiduciary discretion over fund assets where the terms of his contract with the fund empowered him to investigate, process, resolve and pay claims to members, to maintain claims files on fund members, to create a trust account to facilitate disbursements of health benefits, and to maintain a check register accounting for disbursements. In contrast, however, the Court ruled that Equitable's recommendation that the fund trustees consider converting the health plan to a self-insured arrangement did not render it a fiduciary with respect to that conversion decision, as the advice was not given on a regular basis for a fee, and no evidence was presented that indicated that Equitable had control over whether the fund would accept or reject its recommendation to convert the plan to a self-insured arrangement.²⁹ Finally, the Fifth Circuit also refused to impose vicarious liability upon Equitable for the actions of its employee-broker on a variety of grounds, including that the actions taken by the broker were outside the scope of his employment with the Equitable.

Just as service providers risk assuming fiduciary responsibility by exercising discretion over matters for which other parties are the named fiduciaries, parties who have carefully contracted for another party to be the named fiduciary nevertheless can cause themselves to become fiduciaries by undertaking to exercise discretion and control over matters over which they have not retained fiduciary status. In *Genter v ACME Scale & Supply Co.*,³⁰ the Third Circuit ruled that ACME Scale & Supply met the ERISA definition of fiduciary as an employer-administrator of the plan at issue because the employer exercised discretionary authority and control in managing the plan by notifying certain employees when they were eligible for an increase in life insurance coverage not explained in the terms of the plan. The Third Circuit also found that the employer's failure to notify all employees generally was deemed a breach of the fiduciary duty ERISA imposes. Similarly, the Third Circuit ruled in *Smith v. Hartford Ins. Group*,³¹ that a plan sponsor that gave assurances of continued coverage after changing health plans was a fiduciary responsible for its employees' loss in benefits when the new plan failed to cover a disabled employee where after the plan sponsor decided to replace its Blue Cross/Blue Shield policy with a self-funded insurance plan, and because the employees had the option to convert to an individual Blue Cross/Blue Shield policy instead of enrolling in the new plan, and the plan sponsor's personnel director conducted seminars to help employees make their choices.³²

➤ **Fiduciary Duties Generally**

Title I of ERISA "protects employee pensions and other benefits . . . by setting forth certain general fiduciary duties applicable to the management of both pension and nonpension benefits plans."³³ The fundamental purpose of the fiduciary responsibility provisions of ERISA is the "enforcement of strict fiduciary standards of care in the administration of all aspects of employee benefit and the promotion of the best interests of participants and beneficiaries."³⁴ ERISA's legislative history confirms that the Act's fiduciary responsibility provisions were intended by Congress generally to "codif[y] and make[] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the [common] law of trusts"³⁵ subject to those added refinements set forth in ERISA.

Recognizing the language and legislative history of ERISA's fiduciary responsibility rules, the courts have construed Section 404 of ERISA as requiring the Federal courts to develop a "federal common law of rights and obligations under ERISA-regulated plans,"³⁶ which the courts have construed as giving rise to a broad and sweeping obligations to act at all times when carrying out their fiduciary roles and responsibilities prudently in accordance with the standards established under ERISA Section 404.

ERISA Section 404 establishes the core principles from which these duties spring. Under its provisions, a fiduciary must act prudently to administer claims for rights or benefits under the plan:

- Solely in the interest of participants and beneficiaries of the plan;
- For the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan;
- With the care, skill, prudence and diligence that a prudent person acting with like capacity and familiar with such matters would use under the circumstances;
- In accordance with the terms of the written plan documents; and
- In accordance with ERISA, any other applicable Federal law or regulation, and any applicable state law or regulation not preempted by Federal law.³⁷

Additionally, Section 408 of ERISA also generally prohibits plan fiduciaries from engaging the plan in a transaction with certain

parties who are or are related to a fiduciary, a plan service provider, the fiduciaries' employers, officers, directors, and significant shareholders, or certain other individuals.³⁸

➤ **Fiduciary Bond Requirements**

ERISA generally requires that every employee benefit plan fiduciary, as well as every other person who handles funds or other property of a plan (a "plan official"), be bonded if they have some discretionary control over a plan or the assets of a related trust. While some narrow exceptions are available to this bonding requirement, these exceptions are very narrow and apply only if certain narrow criteria are met. Plan sponsors and other plan fiduciaries should take steps to ensure that all of the bonding requirements applicable to their health plans are met at least annually. This process should include adopting a written policy requiring bonding and verifying that appropriate bonds are in place for all internal personnel and outside service providers subject to the bonding requirements. In the case of internal personnel, the adequacy of the bonds should be reviewed annually to ensure that bond amounts are appropriate. Plan sponsors often also will require that third party service providers contract to be bonded in accordance with ERISA, to provide proof of their bonded status or documentation of their exemption, and to provide notice of events that could impact on their bonded status.

➤ **Plan Asset & Trust Requirements**

Safeguarding employee benefit plan assets against improper administration, use, investment, diversion, and application was a significant goal of Congress when it enacted ERISA. To provide protection for these assets, the general fiduciary standards of loyalty and care, borrowed as they are from the common law, as well as the more specific trustee duties itemized in ERISA, generally obligate plan fiduciaries of health and welfare plans, as well as pension plans, to act prudently to collect, preserve and maintain, invest and administer the assets of the plan³⁹ pursuant to a written trust document and administered in accordance with the fiduciary responsibility rules of ERISA. This duty encompasses determining exactly what property forms the subject matter of the trust [and] who are the beneficiaries. The trustee thus is expected to "use reasonable diligence to discover the location of the trust property and to take control of it without unnecessary delay." A fiduciary is similarly expected to investigate the identity of the beneficiary when the documents do not clearly fix such party and to notify the beneficiaries under the plan of the benefits provided to them.⁴⁰ Failure to administer the assets of a health or other employee benefit plan in accordance with these requirements constitutes a fiduciary breach, for which a fiduciary may be held personally liable.⁴¹

Because the expenditure of assets is a fiduciary act, a plan fiduciary must comply with its fiduciary obligations under Sections 404 and 406 of ERISA when making expenditures or investments including those for administrative or other services. In this regard, it is important to keep in mind that the selection of a service provider for an ERISA-covered health plan often involves disposition of plan assets. Consequently, the plan fiduciary should consider quality of service as well as cost of service. The fiduciary should objectively assess the qualifications of the provider, the quality of services offered, and the reasonableness of the fees.⁴² In balancing these factors, the fiduciary need not select the lowest bidder.⁴³ However, the fiduciary must show that, in addition to taking quality of services into account, he has ensured that the fees paid to the provider are reasonable for the services provided to the plan.⁴⁴ A failure to show either factor could create exposure for a breach of fiduciary duty. Furthermore, fiduciaries responsible for the selection and oversight of a service provider should keep in mind their responsibility to monitor the performance of the selected party.

Contributions paid by participants to a health plan, certain employer contributions, as well as recoveries from subrogations or other recoveries, generally are treated a plan assets, which must be administered in accordance with ERISA's fiduciary responsibility, trust, and prohibited transaction rules.⁴⁵ Where such contributions are deducted from the wages of participants, however, special relief from the trust requirements otherwise applicable under ERISA may apply pursuant to special rules promulgated by the Department of Labor.

➤ **Fiduciary's Duty To Communicate**

The United States Supreme Court has ruled that the fiduciary standards and responsibilities imposed under ERISA extend to communications.⁴⁶ The application of the fiduciary standards to communications in recent years has become particularly significant in the area of health and welfare plans. Plans and their sponsors and fiduciaries generally should evaluate the practices that will be accomplished by the delegation of administrative responsibilities to the TPA to ensure that these obligations will be appropriately fulfilled. Care should be exercised to ensure that all required communications are appropriately made, as well as to provide for other communications as may be prudently necessary. In this respect, for instance, care should be exercised that ERISA requirements to accurately and timely disclose the identity of the named fiduciaries, processes for review and appeal, access to documents and items

considered in claims procedures and other requirements are not impeded or forestalled by the contemplated administrative services arrangement.

The fiduciary responsibilities imposed under ERISA have been construed by the courts to impose upon fiduciaries the obligation to inform participants, beneficiaries, and certain other parties of material information where disclosure is prudent. In addition, the plan administrator and other fiduciaries often also are obligated to comply with certain reporting and disclosure requirements imposed by ERISA and its regulations.

Drawing on the Restatement of Trusts and other non-ERISA sources of fiduciary principles, federal courts have recognized that a fiduciary's responsibilities may include a "duty to inform" in many contexts.⁴⁷ The scope of the duty to disclose is governed by ERISA's Section 404(a), and is defined by what a reasonable fiduciary, exercising "care, skill, prudence and diligence," would believe to be in the best interest of the beneficiary to disclose.⁴⁸

As part of this duty of prudence, many courts construe this duty to encompass not only a negative duty not to misinform,⁴⁹ but increasingly also an affirmative duty to inform when the fiduciary knows that silence might be harmful.⁵⁰ Thus, not only are most courts generally willing to hold fiduciaries that make affirmative misrepresentations liable under ERISA on breach of fiduciary duty or equitable estoppel grounds,⁵¹ they also increasingly are willing to find that the duty of prudence of the fiduciary may require the fiduciary undertake to make disclosures or provide information to a participant, beneficiary, or another fiduciary to whom the information may be material when the circumstances prudently require such an undertaking, even in the absence of a specific inquiry or an express misrepresentation.⁵²

Moreover, when weighing the disclosure obligations of a fiduciary, the courts have indicated that the duty of prudence of the fiduciary may obligate the fiduciary to undertake greater efforts to communicate or disclose where the additional protections are prudent, e.g., when a trained fiduciary deals with a lay beneficiary or an unsophisticated fiduciary, or where the fiduciary possesses material information that he knows or suspects that the participant or another fiduciary may not know or appreciate. Thus, the courts have held that a fiduciary has an obligation to make disclosures or provide information in the absence of a specific inquiry from a participant, beneficiary, or even another fiduciary to whom the information may be material.⁵³

The courts also recognized that a fiduciary may have an affirmative duty to provide information to a participant, whether or not the participant has made a specific request for that information. In holding that a third party brokerage firm breached its fiduciary duties to a health fund under ERISA by failing to notify the health fund trustees about questionable integrity of a brokerage employee, who served as the fund's investment advisor, the Court in *Glaziers and Glassworkers Local 252 Annuity Fund v. Newbridge Securities, Inc.*,⁵⁴ found that it is clear that circumstances known to the fiduciary can give rise to an affirmative obligation to disclose material information, even absent a request by the trustees, where disclosure is prudent. Thus, the court ruled that the brokerage firm retained a fiduciary duty to disclose to the health funds material information then in its possession concerning its former employee's conduct when the health funds advised the brokerage firm of its intention to transfer investment management services for the fund from the brokerage to the new firm established by the former employee.

In *Eddy v. Colonial Life Ins. Co.*,⁵⁵ for example, Mr. Eddy, having learned that his group insurance benefits were about to be terminated, contacted the insurer directly, informed them of his situation, and inquired about the possibility of maintaining his coverage. Because of alleged misinformation provided by the insurer, Mr. Eddy did not convert his benefits to an individual policy, and thus lost his health coverage. The Court ruled that once an ERISA beneficiary has requested information from an ERISA fiduciary who is aware of the beneficiary's status and situation, the fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance. Accordingly, the D.C. Circuit held that the fiduciary had a duty to inform him of alternate coverage that was available and appropriate to his circumstance, whether or not he had specifically inquired about it. Accordingly, the Court found that reinstatement to the denied coverage constituted appropriate equitable relief available to Mr. Eddy to remedy Colonial's breach of its fiduciary obligations. Parties to TPA agreements should carefully consider these obligations and exposures when evaluating proposed administrative services arrangements and agreements as well as throughout the course of performance of parties under such agreements.

ERISA & OTHER CLAIMS & APPEALS REQUIREMENTS⁵⁶

➤ Fiduciary Duties In Handling Claims & Appeals

The primary purpose of any TPA agreement presumably is to provide for the appropriate administration of the plan in accordance with

the plan terms and law. Health plans and their fiduciaries clearly enter into the process for this purpose. However, a review of many TPA agreements quickly reveals that the agreement doesn't necessarily meet these expectations in certain respects. These gaps create issues for plan sponsors and fiduciaries, both as to the appropriateness of the contract itself, as well as the appropriateness of the engagement of a service provider under terms of an agreement which reflect that the service provider may not commit to deliver services in a manner suitable for the intended purpose.

Individuals charged with fiduciary responsibility for the administration of claims under a health benefit plan conduct themselves to comply both with the general fiduciary standards of ERISA, as well as the specific claims and appeals procedure requirements established by the Department of Labor.

Pursuant to ERISA § 404, a fiduciary who fails to adhere to ERISA's standards of fiduciary conduct in its administration of claims under a health plan commits a fiduciary breach. Ironically, however, fiduciary breaches arising out of the administration of claims by participants and beneficiaries seldom are expressly plead as breach of fiduciary duties action under Section 409 of ERISA. The courts have ruled that ERISA Section 409 does not authorize recovery to an individual, but only to the plan; rather, an individual seeking to recover for injuries that he has sustained as a result of a breach of fiduciary duty must rely upon the "other appropriate equitable relief" clause of Section 502(a)(3) of ERISA. Accordingly, fiduciary misconduct complaints relating to the administration of the plan most commonly are plead as components of benefit actions brought by participants and beneficiaries, seeking to enforce their entitlement to benefits or other rights under the health plan. Thus, Justice Brennan has written that "[i]t is black-letter trust law that fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits."⁵⁷

While not always conclusive, language in the plan and the TPA agreement can critically impact both determinations of the status of each party as a fiduciary with respect to a particular matter, as well as the degree of deference, if any, afforded to their decisions by reviewing courts. In *Firestone Tire and Rubber Co. v. Bruch*,⁵⁸ the Supreme Court ruled that decisions made by a fiduciary will be reviewed under a *de novo* standard of review unless the benefit plan gives the fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.⁵⁹ The Court further ruled that if a benefit plan gives discretion to an administrator or fiduciary, the courts are to defer to the plan interpretations and claims determinations of the fiduciary unless the fiduciary's decision was arbitrary and capricious, contrary to the plan terms, or contrary to law, operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion. Many courts in recent years have begun to adopt a "sliding scale" analysis for purposes of determining the deference to be afforded to the fiduciary on review.

Where a court determines that a fiduciary is entitled to have his claim reviewed under the arbitrary and capricious, rather than *de novo*, standard of review, the scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of [an ERISA fiduciary]. Nevertheless, the [fiduciary] must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' In reviewing that explanation, the court must 'consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' . . . Normally, [a decision by a fiduciary] would be arbitrary and capricious if the [fiduciary] relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it] or is so implausible that it could not be ascribed to a difference in view or the product of [its] expertise.⁶⁰

The evolving precedent since *Firestone* makes clear that a determination that a fiduciary's decision qualifies for discretionary review can significantly enhance the likelihood that the court will uphold the decision of the fiduciary. *Black & Decker Disability Plan v. Nord*⁶¹ proves this point. *Nord* involved disability benefit plan participant's suit alleging that the plan wrongfully denied his disability benefits claim in violation of ERISA. The employee contended that his asserted disability was supported by the opinions of his treating physicians, and that such opinions were entitled to controlling weight to the same extent as treating physician opinions in social security disability cases. The employee benefit plan argued that it was not required to give the treating physicians' opinions controlling weight, and that the denial of disability benefits was supported by the opinion of the plan's retained physician that the employee could continue to work. Having determined that the fiduciary's decisions qualified for discretionary review, the U.S. Supreme Court held that the ERISA requirement for a full and fair consideration of the employee's claim did not include any requirement that the opinions of the employee's treating physicians be given controlling weight under the treating physician rule applied in social security cases. While the treating physician rule was appropriate for efficient operation of the large social security benefits system, the court deferred to the plan administrators determination that the rule lacked the same efficacy under diverse employee benefit plans. Further, while the employee's treating physicians could be most familiar with his condition, their opinions could also be impaired by insufficient examinations or lack of expertise. Accordingly, the Supreme Court vacated the order in favor of the employee was vacated and the case was remanded for further proceedings.

While the existing precedent makes clear that discretionary grants can be invaluable, the power of this discretionary grant can be undermined if the evidentiary record reflects that the fiduciary acted contrary to law, contrary to the plan terms, in a manner where its judgment was compromised by a conflict of interest, or otherwise arbitrarily or capriciously.

The United States Supreme Court's June 19, 2008 decision in *Metropolitan Life Insurance Co. v. Glenn*⁶² addressed whether and how the existence of a responsibility to pay plan costs or other financial interest in the outcome of a claims decision by the administrator impacts a court's review of the claims decisions made by the administrator. In *Glenn*, the Supreme Court reaffirmed that the inclusion of appropriate language in the plan remains a prerequisite to a court's deferential review of a plan administrator's claims decision, but does not guarantee qualification for deferential review.

According to the *Glenn* opinion, where the plan administrator making the claims decision also funds claims paid under the plan or otherwise has a financial interest in the outcome of the claims decision, the administrator acts under a conflict of interest that under certain circumstances may justify less deferential judicial review of its claims decisions than otherwise would apply in the absence of this conflict of interest. However, the mere existence of this conflict of interest does not automatically disqualify the plan administrator's decision for any deference by a reviewing court. Rather, the existence of this conflict of interest is merely a factor that the reviewing court may consider when deciding whether less deferential review is justified. Whether this conflict of interest justifies a reviewing court's closer scrutiny of the administrator's claims decision depends upon the facts and circumstances.

In its *Glenn* decision, the Supreme Court provided insights about types of evidence that influence the court's decision about whether the conflict of interest merits greater scrutiny of the decision by the court. The Court's decision makes clear that depending on the evidence produced, a court reviewing the plan administrator's decision appropriately can decide the conflict of interest warrants no special scrutiny or significantly greater scrutiny of the plan administration decision. However, the Court expressly declined to establish any specific formula to govern how courts make this decision. As a consequence, plan fiduciaries should anticipate that the *Glenn* decision would result in their being required to present evidence to the court to rebut claims of bias made by claimants alleging conflict of interest compromised the plan administrator's decision.

Whether or not a court concludes discretionary review applies, the existing precedent establishes the value to plans and their fiduciaries of administering claims through a prudent, well documented process that enables the plan and its fiduciaries to produce the evidence needed to support their determinations. The *Glenn* decision and other precedent makes clear that documentation and procedures established in connection with the contracting process can critically affect the outcome of these determinations.

➤ **ERISA Claims & Appeals Regulations**

Pursuant to regulation, all ERISA plans must provide reasonable claims procedures.⁶³ All claims and appeals of claim denials under health plans must be administered in accordance with reasonable claims and appeals procedures mandated by Department of Labor regulations.⁶⁴ To ensure that participants and beneficiaries are properly advised about the claims procedures, Department of Labor regulations require that the summary plan description for a health or other benefit plan must include a description of the claims and appeals procedures for filing and appealing claims. Those procedures must not unduly hamper or inhibit the processing of claims. The procedures must comply with Federal requirements for the processing of claims, including notifying participants of claim denials and administering appeals of claims denials.

The regulations also establish time limits for completing claims procedures and regulate the contents of the written notices. If the plan administrator denies a claim or an appeal of a claim, its written notice of the denial decision must:

- Specifically identify the reasons for the denial of the claim in plain language understandable to the claimant;
- Refer to the plan provisions on which the denial rests;
- Include a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why this material is necessary; and
- Provide appropriate information on the steps a claimant must take to appeal the denial of a claim.

Noncompliance with ERISA's claims and appeals procedures can be a costly mistake. In one lawsuit, for example, the Fourth Circuit ruled that a self-insured medical plan could not refuse to pay for medical expenses incurred for inpatient alcohol and drug treatment beyond those authorized under the medical plan's precertification procedures because the administrator failed to comply with the procedural requirements relating to the denial of claims established under the Regulations.⁶⁵ On the other hand, where the fiduciary substantially complies with the claims and appeals procedures of ERISA and the participant does not, the participant's failure to follow

the administrative procedures of the plan generally will bar the participant from subsequently appealing the fiduciary's decision to deny his claim to the courts.⁶⁶

➤ **HIPAA Electronic Data Transaction Standards Requirements**

Since October, 2003, ERISA covered health plans also generally also have been required to be able to transmit and receive health plan related data electronically in accordance with new electronic data interchange standards implemented as part of HIPAA. Pursuant to these EDI rules, uniform identifiers are assigned to individuals, providers, employers, and health plans. A standard set of codes must be used to encode data elements. HIPAA's transaction regulations establish standard transaction formats for specific types of common transactions. Electronic data interchange (EDI) occurs in over 400 different formats, and the lack of standardization makes software development difficult and increases costs for providers and payers. HIPAA proposes to use uniform data elements for eight transactions and refines existing standards. The transaction regulations use *de facto* industry standard code sets already in place by most health plans, clearinghouses, and providers. HHS officials have indicated that for purposes of enforcing the rule, they consider not only whether health plans and other covered entities properly using the mandated code sets and electronic procedures, but also whether the claims are being timely and appropriately processed in accordance with the applicable plan terms and other regulations.

**FUNDING ARRANGEMENTS OF ERISA-COVERED HEALTH PLAN AFFECTS
STATE & FEDERAL REGULATORY REQUIREMENTS APPLICABLE TO PROGRAM, ITS SPONSOR AND TPA**

For arrangements regulated by ERISA, TPA historically have (or perceived themselves as having) enjoyed more flexibility in designing its contract with its Client if the Client's program qualifies as "self-insured" versus "insured" for purposes of ERISA.

➤ **Funding Affects Applicability of State Law**

With regard to state insurance regulations, ERISA § 514 may in fact provide some enhanced flexibility. However, the emerging precedent increasingly suggests that many TPAs and other service providers to self-insured ERISA-covered plans may over-estimate the scope of this flexibility.

State insurance laws and regulations generally impose a number of licensing, contracting, and other mandates on health insurance and the insurers, brokers, administrative services providers and others involved in their sale and administration. These mandates generally vary from state to state, as well as based on the nature of the coverage, the number of persons covered by the contract, and various other factors. A TPA needs to understand the applicable requirements of state law, if any that apply to it and its Client's arrangement and make appropriate provision to address these concerns within its contract with the Client. Development of this understanding depends initially upon an appropriate determination by the TPA of the extent to which ERISA § 514 excuses its Client's and its plan and/or the TPA from the necessity of complying with an applicable state insurance regulation.

ERISA § 514 generally bars states from enforcing state insurance, banking, and securities regulations or other laws that relate to an employee benefit plan against an ERISA-covered plan or its sponsor. However, ERISA § 514(b) generally preserves the enforceability of state insurance, banking, and securities regulations against entities considered to be engaged in the business of insurance, banking and securities while prohibiting the state from considering an ERISA-covered plan from being engaged in these businesses for purposes of those state regulations. The courts generally have interpreted these provisions to provide that state insurance regulations and mandates cannot be enforced against an ERISA-covered plan or its sponsor. If an ERISA-covered health plan is considered insured for purposes of ERISA, however, the Courts have ruled that ERISA permits the enforcement of state insurance laws not directly in conflict with ERISA's general administrative scheme insurance contracts and insurers and other vendors engaged in the business of insurance dealing with ERISA-covered plans, even though ERISA bars the state and its courts from enforcing those state regulations directly against the plan itself or its sponsor. Under these provisions, an insurer as well as TPA contracting to assist the insurer in the administration of an insurance product used in conjunction with an insured ERISA-covered plan generally remains subject to regulation under state insurance law. The existing is less settled whether and when a TPA remains subject to state licensing and other insurance regulations as an entity engaged in the business of insurance with respect to its provision of administrative services to a self-insured ERISA-covered plan. While many TPAs dealing with ERISA plans commonly assume that ERISA § 514 fully insulates the TPA from the obligation to comply with these mandates in its dealings with self-insured ERISA-covered plans, the existing precedent remains somewhat unsettled in this regard and many state regulators and private plaintiff's dispute this interpretation. TPAs generally should monitor the precedent arising out of efforts by state regulators and private plaintiffs to enforce state insurance regulations against TPAs providing services to self-insured ERISA-covered plans until existing precedent becomes more resolved in this respect.

Of course, the ability to qualify for this broader preemptive protection under ERISA § 514 necessitates that the Client's arrangement actually qualify as self-insured for purposes of ERISA. The United States Supreme Court generally has ruled that a health plan is considered "self-insured" for this purpose only to the extent that the plan sponsor or plan has not shifted the risk of providing the coverage or benefits provided under the ERISA-covered plan to a third party. Risk shifting generally occurs when an insurer or other third party undertakes to assume from the plan sponsor or the plan the risk of providing the coverage and benefits promised under the arrangement in return for the payment of a premium by the plan or plan sponsor.

The purest models reflect the distinction between an insured versus self-insured arrangement with relative clarity. An arrangement providing health benefits consisting of one or more individual or group insurance or health maintenance organization contracts, pursuant to which the issuer, in return for the payment of a premium, contracts to provide directly to the covered persons all of the promised coverages and benefits is the archetype of an insured arrangement. In contrast, the model of a self-insured health plan in its purest form exists when an employer or union commits to pay for, or provide for the reimbursement of, specified expenses or charges for health care treatment, equipment or supplies to a group of employees or their dependents from its general assets under an arrangement self-administered by the plan sponsor, a fiduciary appointed from its internal staff, or a third party administrator engaged to administer the plan.

Unfortunately, the typical configuration of health benefit arrangements today rarely clearly fit squarely into either of these models. The distinction between insured versus self-insured arrangements becomes increasingly more difficult to predict as arrangements intended to be self-insured incorporate risk shifting elements. The increasingly common practice of attempting to combine in a single health plan design, both fully insured and self-insured features and programs have on more than one occasion resulted in regulators characterizing an arrangement assumed by its designers to be self-insured to be characterized as insured. Thus, regulators in California, Oklahoma and various other states were permitted to enforce state HMO benefit mandates to against health plan vendors where the contractual commitments made in connection with their administrative services agreement was accompanied by a commitment that the specified fee would include certain annual examinations and wellness benefits.

Utilization of certain reinsurance, cost guarantees, advance funding, pooling, and other common cash flow features in conjunction with an arrangement intended to be self-insured also may disqualifies all or a portion of the plan for treatment as self-insured. For instance, health plans or their sponsors frequently seek protection against extraordinary claims such as stop loss, maximum liability guarantees, or other commitments. For instance, the sponsor or fiduciary of a self-insured health plan may elect to purchase stop-loss or other reinsurance to limit its exposure to extraordinary claims. If properly implemented, the courts have recognized that the purchase of reinsurance to protect the plan or its sponsor against expenses that it might incur to fund extraordinary claims arising under the plan need not disqualify the plan for treatment as self-insured where the reinsurance arrangement reimburse the self-insured health plan or its sponsor for certain qualifying extraordinary claims, rather than to pay benefits directly to the covered person under the health plan. This is true even though the plan sponsor of the self-insured arrangement views the health plan to be "partially self-insured."

On the other hand, arrangements presumed by the TPA, reinsurer and/or plan sponsor as self-insured may in fact be considered fully-insured for purposes of determining the applicability of state law regulations by virtue of the use of cost caps or other pricing and expense guarantees.

An otherwise applicable state law exemption also may be lost if the health plan design allows employees of employers sharing less than 80 percent common ownership to participate in an otherwise self-insured health plan. Such arrangements may be multiple employer welfare arrangements subject to state insurance regulations pursuant to ERISA § 514(b)(6).

Accordingly, proper classification of any employer or union-sponsored health these standards generally requires a careful evaluation of the particulars of the arrangements in questions, including the underlying insurance agreements and commitments.

➤ **Funding & Administration Differences Affects ERISA Fiduciary Responsibility**

As reflected in the ERISA principles discussed earlier in this article, funding arrangements relating to an ERISA-covered plan also affects the fiduciary liability concerns that may affect a TPA and its Client in various ways. Some selected examples of material differences that many TPAs commonly fail to appreciate include the following:

One of the most significant distinctions between an insured versus self-insured arrangement typically is the determination of the

identity of parties considered to be fiduciaries. A party generally is subject to liability as a fiduciary under ERISA if it either is a named fiduciary under the governing plan documents or it in fact exercises discretion over plan assets or in connection with the administration of the plan.

In an insured arrangement, the insurer's assumption of responsibility to pay claims and determine benefits generally focuses fiduciary liability for these decisions on the insurer. However, a TPA or its client may be subject to fiduciary liability to the extent that it is responsible for the collection and application of employee contributions or other plan assets, it makes discretionary determinations about eligibility or other determinations relating to the administration of the plan or bears responsibility to do so, it selects or exercises discretion or control over the selection of plan fiduciaries or vendors, or engages or is responsible for other fiduciary activities.

When involved in the administration of a self-insured plan, the TPA and its Client by virtue of the very self-insured nature of the program are likely to be found to have undertaken a much greater range of fiduciary liability. In practice, many TPAs make all or most determinations arising out of the administration of benefits (and sometimes even eligibility) with little consultation or involvement by the plan sponsor or other company-related party technically named as the fiduciary. Even where TPAs have structured their relationship with the named fiduciary to be advisory or consultative in nature so that a procedure for involving the named fiduciary in claims decisions or appeals, courts often nevertheless find that the TPA's role as the technical expert or other factors constitute sufficient discretion to qualify the TPA as a fiduciary. Accordingly, TPAs frequently are found to have exercised sufficient discretion or control over the administration of claims or other aspects of the plan to be considered fiduciaries. Where a TPA is considered to have in fact functioned in a fiduciary capacity, the courts generally have ruled contractual provisions purporting to disclaim fiduciary status by the TPA or limit its liability for fiduciary breaches unenforceable exculpatory provisions under ERISA. If found to be a fiduciary, the TPA may be exposed to liability for its own fiduciary breaches, as well as co-fiduciary liability for breaches of fiduciary duty by other fiduciaries in which it participated, that were facilitated by its own fiduciary breach, or of which the TPA fiduciary knew or should have known but failed to take action to correct.

TPAs collecting or accessing participant and employer contributions, subrogation recoveries, or other funds and assets should carefully evaluate the likelihood that their activities might be considered involvement in the investment of plan assets or the exercise of discretion or control over those assets. ERISA typically requires that participant contributions and other plan assets be held in trust and used and administered for the exclusive benefit of participants and beneficiaries. These fiduciary responsibility rules, as well as certain state insurance regulations commonly included under applicable TPA insurance regulations, may necessitate that the TPA observe certain limitations and safeguards when dealing with these contributions and other assets.

ERISA's prohibited transaction rules typically present a greater barrier to the ability of a TPA or other vendor to a self-insured ERISA-covered health plan to sell services from other commonly controlled entities that are separately incorporated, the brokerage operation of a principal or employee of the TPA, or the like. Prohibited transaction exceptions that might apply to similar dealings of insurance companies providing insurance with respect to the arrangement often do not apply to similar practices by an administrative services provider to a self-insured arrangement.

HIPAA BUSINESS ASSOCIATE & OTHER PRIVACY & SECURITY STANDARDS

Virtually all group health plans⁶⁷ are required to comply with the Standards for the Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the Standards for the Security Of Electronic Protected Health Information (the "Security Rule") and the Standards for Electronic Transactions (the "EDI Rule") of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA provides substantial penalties as a result of the wrongful disclosure of "individually identifiable health information." HIPAA defines "individually identifiable health information," in part, as "any information, including demographic information collected from an individual," that is created or received by a health care provider, health plan, or employer; relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, and identifies the individual; or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. With respect to the wrongful disclosure of an individual's health information, HIPAA provides that a person who knowingly and in violation of HIPAA either: (1) uses or causes to be used a unique health identifier; (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person, faces significant criminal sanctions. Such a person may be fined not more than \$50,000, imprisoned not more than 1 year, or both; or, if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; or if the offense is committed with intent

to sell, transfer, or use individually identifiable health information for commercial advantage, person gain, or malicious harm, fined not more than \$250,000, imprisoned not more than 10 years, or both.⁶⁸ Organizations also face similar vicarious liability under the Federal Sentencing Guidelines unless they maintain and properly administer an appropriate compliance program.

Before allowing any vendor to create, use, access or disclose protected health information or electronic protected health information on behalf of the health plan, the Privacy and Security Rules each require that health plans obtain specific written agreements with plan-related vendors and service providers to comply with the requirements of the Rules. Because allowing vendors to use any PHI or ePHI in the absence of these assurances generally violates the Privacy and Security Rules, these requirements must be appropriately addressed as part of the contracting process. Therefore, to the extent that the health plan uses an administrator, accountants, lawyer, accountant, auditor or other service providers to help the health plan and its fiduciaries operate the program, the written agreement with the vendor or a separate supplemental agreement must incorporate the required assurances. The Privacy Standards specify what these agreements must contain to obligate the service provider to adhere to the Privacy Standards. Many health plan sponsors assume that their health plan vendors or other service providers automatically supply all of the services, procedures, and documentation needed for their health plan and the sponsor to comply with HIPAA. Unfortunately, this rarely is the case. Agreements should expressly incorporate all of the required provisions. In addition, the agreements should be carefully crafted to delineate the specific scope of each party's responsibilities. While many health plan vendor agreements originally sought to short cut compliance with the Privacy and Security Rules by incorporating only the core provisions specified by the regulators, this approach typically doesn't adequately address the responsibilities and concerns of the respective parties and creates undesirable ambiguities. For instance, provisions concerning termination, record retention, and audit required by HIPAA rarely mesh smoothly with standard termination provisions. Special crafting of audit, notice, indemnification, confidentiality and other provisions often also is desirable.

FEDERAL COORDINATION OF BENEFIT & HEALTH CARE FRAUD RULES

When selecting vendors to assist in or administer health plans, health plans, their sponsors and fiduciaries also should consider potential exposure under Federal rules regulating the coordination of benefits with other federal health plans and other federal health care fraud regulations.

➤ Coordination of Benefits

Most health benefit arrangements covered by ERISA incorporate complicated coordination of benefit provisions, pursuant to which the benefits otherwise payable under the health plan may be reduced by benefits paid, or deemed by the claims fiduciary to be payable, under another plan. Such coordination of benefit rules are designed to regulate the offset and interaction between coverages of two separate plans by preventing the payment of benefits on a combined basis from exceeding 100 percent of covered charges and defining rules for determining which plan is entitled to take into account, and reduce the benefits otherwise payable under that plan due to the availability of benefits under another program or plan.

As discussed in greater detail in the paragraphs that follow, when designing or administering the coordination of benefits procedures of a health plan, it is critical to ensure that the coordination of benefits with Medicare, Medicaid, and certain other government health programs do not violate Federal law. In addition, if the health program is insured, state insurance law generally will require that the insurer design and administer the coordination of benefit provisions and practices of the plan to comply with restrictions and mandates imposed against group insurance policies under state insurance laws. Where the health plan is self-insured, however, state law restrictions upon a plan's coordination of benefit practices generally are preempted⁶⁹ As a result, the plan sponsor of a self-insured plan generally may design the coordination of benefit procedures of the health plan as it sees fit, as long as these procedures comply with applicable federal mandates.⁷⁰

The Social Security Act requires that most health plans comply with special rules regarding the coordination of Medicare benefits with benefits received under an employer-sponsored plan. OBRA '93 amended these rules in several respects and also extended similar coordination of benefit rules to Medicaid. With respect to Medicaid, federal law generally mandates that ERISA health plans determine benefits and coverage without regard to Medicaid eligibility or enrollment.

Since October 2, 1995, the Department of Health & Human Services regulations have construed these secondary payer rules, taking into account the OBRA '93 and other statutory changes. Accordingly, the regulations address a wide range of issues, including the actions that constitute a prohibited taking into account of Medicare eligibility. In this regard, the Regulations identify prohibited actions as including: (1) failure to pay primary benefits; (2) offering coverage that is secondary to Medicare to individuals entitled to Medicare; (3) terminating coverage because an individual has become entitled to Medicare, except as permitted under the COBRA continuation rules; (4) in the case of a large group health plan, denying or terminating coverage because an individual is entitled to Medicare coverage due to a disability, without denying or terminating coverage for other similarly situated individuals who are not

eligible for Medicare on the basis of a disability; (5) imposing limitations on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan, such as providing less coverage, imposing additional exclusions, reducing benefits, imposing higher deductibles or coinsurance, providing lower annual or lifetime benefit limits, or applying more restrictive limitations for preexisting conditions; (6) charging a Medicare-entitled individual higher premiums; (7) requiring a Medicare-entitled individual to wait longer for coverage to begin; (8) limiting payments to providers and suppliers to no more than Medicare would have paid while paying higher amounts for the same services and supplies for plan beneficiaries who are not entitled to Medicare; (9) providing misleading or incomplete information that would induce a Medicare-entitled individual to reject an employer plan, such as by informing the individual of the right to accept or reject the employer plan but failing to disclose that if the plan is rejected, the plan cannot provide or pay for secondary benefits; (10) including a notice in a plan's brochures, claim forms, or other materials distributed to beneficiaries, providers, and suppliers that Medicare is to be billed first for services furnished without also stipulating that this directive applies only when Medicare is the primary payer; and (11) refusing to enroll an individual for whom Medicare would be a secondary payer when enrollment is available for similarly situated individuals who are not entitled to Medicare.

➤ **Health Care Fraud Rules**

HIPAA amended the fraud and abuse requirements of the Social Security Act to apply to all federal, state and private health care plans. HIPAA Section 262 amends the definition of "health care plan" for purposes of the fraud and abuse rules to include: (1) a group health plan which has 50 or more participants; or is administered by an entity other than the employer who established and maintains the plan; (2) an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers; (3) a health insurance issuer; (4) a health maintenance organization; (5) Part A or Part B of the Medicare program; (6) a Medicare supplemental policy; and (7) a long-term care policy.

HIPAA also makes it a felony for any person acting in a matter involving a health care benefit program in connection with delivery or payment of health care benefit items or services to knowingly or willfully: (1) falsify, conceal or cover up any tricks, scheme or device or a material fact; (2) make any material false, fictitious or fraudulent statements or representations; or (3) use any materially false writing or document knowing that it contains a materially false, fictitious or fraudulent statement or entry. Persons convicted of these activities face up to five years of imprisonment, fines, or both. HIPAA defines "health care fraud" as an act committed by any person who knowingly and willfully executes or attempts to execute a scheme or artifice to defraud any public or private health benefit program, or to obtain by any false or fraudulent pretenses, representations, or promises any of the money or property owned by or under the custody or control of a health care benefit program in connection with the delivery or payment of health care benefits, items or services. Therefore, individuals convicted of engaging in health care fraud face serious criminal sanctions. For instance, if the violation results in serious injury, the person shall be fined under HIPAA, imprisoned for up to 20 years, or both. If the violation results in death, the guilty party may be imprisoned for life, fined, or both. Otherwise, violators may be imprisoned for up to 10 years, fined, or both. HIPAA also provides that any person who knowingly and willfully embezzles, steals, or otherwise without authority converts to his own use or the use of any other person who is not the rightful owner, or intentionally misapplies any monies, funds, securities, premiums, credits, properties, or other assets of a health care benefit program is subject to imprisonment for up to 10 years, fines, or both.

In recent years, health care providers and others increasingly are facing prosecution for defrauding health plans under these and other laws. *U.S. v. Baldwin*,⁷¹ for example, apparently marks the first federal decision upholding the application of these expanded provisions as applied to claims made against a private sector health plan. As in other cases, however, the Baldwin court refused to recognize the health plan as holding a private cause of action under HIPAA's fraud provisions to recover fraudulently obtained funds.

VENDOR SELECTION AND CONTRACTING POINTERS FOR PLAN SPONSORS & FIDUCIARIES SEEKING TO MANAGE FIDUCIARY RISK

Despite differences in the concerns that motivate a plan sponsor's plan design decisions and the relative weight that different plan sponsors assign to these concerns, the operating principles of most plan sponsors are remarkably similar in a number of respects. This is because the broader operating principles that guide the plan design decisions of most plan sponsors are remarkably similar. These common operating principles serve as the 'golden rules' that reflect the common plan design ideals shared by most plan sponsors. Although often expressed by different plan sponsors differently, these basic operational rules usually include the following:

- The vendor contract must deliver services in a manner that delivers the desired health benefits in a manner consistent with the purposes that justify the plan sponsor's continued provision of the health benefits.

- The vendor contract must incorporate the required provisions necessary to fulfill the business associate agreement rules of the HIPAA Privacy Rule.
- The vendor contract must provide services in a manner consistent with the plan sponsor's overall plan design and related business practices.
- The vendor contract must deliver services in a manner consistent with the federal and state regulatory obligations applicable to the plan sponsor.
- The vendor contract must adequately minimize the exposure of the plan sponsor to legal liabilities arising from its participation in the vendor contract, including fiduciary liability, vicarious liability, corporate negligence, and contractual liability.
- The vendor contract must establish and document the framework for an effective working relationship.
- The vendor contract must establish and document clear performance obligations applicable to the parties; the manner in which compliance will be measured; and the consequences of any breach of those obligations.
- The vendor contract must provide access to necessary information.
- The vendor contract must define the dispute resolution procedures, if any, that apply to disputes between the parties in a manner that does not unduly prejudice the plan sponsor's ability to administer the plan; fulfill its legal obligations to covered persons and relevant regulators, or conduct other business activities.
- The vendor contract must clearly document the scope of services that the service provider will provide under the agreement, the services that the service provider will not provide, and the services that the service provider only will provide at an additional charge.
- The managed care agreement must clearly document the relationship between the standard plan provisions and the managed care procedures. This should include a discussion regarding the extent to which the plan's standard utilization, precertification, and medical necessity review procedures, coverage limitations and exclusions, proof of loss, and other provisions are waived or replaced for care obtained under the managed care plan.
- The managed care agreement should require the service provider to ensure that its provider contracts do not contain terms or provisions (other than as intended by the plan sponsor) that would undermine the enforceability of the plan sponsor's benefit design.
- The managed care agreement should require the service provider to ensure that contracting providers understand that their entitlement to payment or benefits depends upon satisfaction of all applicable terms and conditions of the plan and incorporate procedures to ensure the enforceability of these commitments.
- The vendor contract should obligate the service provider to modify its procedures in response to changes in the law or regulations that may be adopted from time to time.
- The vendor contract should include terms that preserve the subrogation rights of the Plan.
- The vendor contract should require the service provider to warrant its authority to bind contracting providers and other parties whose cooperation and performance is required under the contract as part of the package of services to be delivered under the service provider's proposal.
- The vendor contract should require the service provider to warrant that its agreement with other contracting providers does not conflict with the terms of the vendor contract and ensures that these related providers are bound to perform in the manner contemplated by the vendor contract.

DRAFTING, REVIEWING & NEGOTIATING SPECIFIC CONTRACTUAL PROVISIONS: DETAILS MATTER

Having surveyed certain core legal considerations impacting on the design of a TPA's contract to provide administrative services with respect to an ERISA-covered plan, the remainder of this publication seeks to help parties to such contracts and their advisors develop a richer practical appreciation of the use of various contract terms and negotiation strategies on the TPAs operations and liabilities through an examination of selected contractual provisions.

➤ **Outline Of Common Contract Provisions**

Health plan TPA contracts typically should address a wide range of issues. A party leaves itself unnecessarily at risk whenever it enters into a contract that omits, or inadequately documents, the material expectations of the party about the services provided, the limits on those services, the requirements applicable to the parties, or a legally mandated contractual term. Both parties should exercise caution to inform themselves about the legal requirements applicable to the program to be administered, the Client and the TPA that may affect the parties' responsibilities and expectations and review all documents associated with such arrangements to avoid being surprised by unanticipated allocations of responsibilities or liabilities under the contract. Some of the core provisions which a TPA contract generally should address might include the following:

Parties To Contract

Recitals To Contract

Obligations And Representations Of TPA

- Duties Of TPA.
- Exclusions and Limitations on Responsibilities and Scope of Services
- Conditions Precedent
- Insuring Provisions, If Applicable
- Allocation Of Fiduciary Status.
- Withholding And Reporting.
- Licensing.
- Bonding to comply with state law and ERISA unless exemption verified.
- Record Maintenance And Ownership.
- Claim Processing Accuracy.
- Administration Forms.
- Performance Guarantees.
- Professional Liability Insurance.
- Notice Of Capacity.
- Funding, Premiums And Contributions.
- Adjudication Of Claims.
- Proprietary Rights.
- Underwriting.
- Compliance With The Plan And Law.

Plan Sponsor/Health Plan Obligations

- General Duties and Responsibilities of Plan Sponsor/Health Plan.
- Exclusions and Limitations on Responsibilities.
- Eligibility Data.
- Fiduciary and Plan Administrator Status
- Exclusions and Limitations on Responsibilities
- Transmission Of Claim Forms And Notification Regarding Claims Inquiries.
- Compliance With The Plan And Law.
- Compensation Of TPA.
- Funding Of Premiums/Benefit Payments.

***Business Associate Agreements and Other Medical and Plan Records Issues
Indemnification, Etc.***

- Indemnifications Of The TPA by The Plan Sponsor/Plan.
- Indemnification Of Company By The TPA.
- Presumptions With Regard To Claims.

Term And Termination Of Agreement- General.

- General.
- Termination By Plan Sponsor/Health Plan.
- Termination By TPA.
- Obligations On Termination.

Miscellaneous.

Defense of Claims.
Time Of Essence.
Notice And Taxpayer Identification Numbers.
Successors And Assigns.
Merger Clause.
Governing Law.
Captions.
Gender And Numbers.
Severability.
Enforcement.
Waiver Of Breach.

Execution.

SELECTED CONTRACT PROVISIONS

The remainder of this publication explores selected issues and contract provisions that might commonly arise in connection with the review and negotiation of a TPA agreement.

Parties To Contract.

Example Provisions.

EXAMPLE A

This Agreement is entered into by and between [_____] (hereinafter referred to as "Plan Sponsor") and the TPA Company (hereinafter referred to as "TPA"), a managed care service company organized pursuant to the laws of the State of _____.

EXAMPLE B

This Agreement is entered into by and between the [_____] Plan, (hereinafter referred to as the "Plan") acting through its Administration Committee, and the TPA Company (hereinafter referred to as "TPA"), a managed care service company organized pursuant to the laws of the State of _____.

Commentary.

The question often arises as to who is the proper party to a contract on the part of the ERISA plan. In some cases the Plan Sponsor may want the Plan itself to be a party to the agreement, however, most TPAs will want a clearly and adequately capitalized legal entity, typically the employer sponsoring the Plan, as a party to the contract. Plan Sponsors or fiduciaries often unintentionally broaden the scope of fiduciary or contractual liability by failing to consider this issue.

Recitals To Contract.

Commentary.

The recitals set forth or document the purposes of the contract in straightforward terms. In many form contracts, the recitals merely introduce the parties and recite their desire to enter into the agreement. In other cases, more detailed recitals are used. In some cases, there are no recitals.

Typically considered the "preamble" to the actual terms of the agreement, the recitals provide a convenient place to define common terms such as the "Plan." It is also a convenient place to describe the TPA and the Plan

Sponsor and what their purpose is for entering into the agreement. In negotiating the recitals, each party may set the tone for the expectations in the body of the agreement, however, it is always recommended that the recitals be reviewed after the body of the agreement has been negotiated to confirm that the recital "fit" with the agreement as finally negotiated. Recitals also can provide valuable fiduciary records by documenting fiduciary due diligence.

It should be assumed, however, that recital terms are not part of the agreement unless restated or incorporated by reference into the body of the agreement. For this reason, if any recital term is material, it should be incorporated as a representation or warranty of the party, either by restatement or by incorporation by reference to the recital.

Ministerial Versus Discretionary Capacity Issues.

Example Provisions.

EXAMPLE A - TPA PROVISION

The TPA shall perform all acts and duties assumed hereunder in a ministerial capacity as an agent of the Plan Sponsor. The TPA shall have no responsibility for the design or implementation of the Plan, such responsibility being solely the Plan Sponsor's. The TPA shall have no power to interpret ambiguities or conflicts that may exist in any provision of the Plan, but shall abide by the decisions of the Plan Sponsor on all questions of substance and procedure respecting the Plan. The TPA does not insure nor underwrite the liability of the Plan Sponsor under the Plan and serves only as the agent of the Plan Sponsor in connection with administration of the Plan. Nothing in this agreement shall be construed as establishing the relationship of Plan Sponsor-employee between the parties hereto, and no employee of either party shall be deemed to be an employee of the other. The TPA shall be deemed the "TPA" of the Plan as that term is defined in the Employee Retirement Income Security Act of 1974 (P.L. 93-406) and in any and all regulations promulgated by the Secretary of the Treasury and the Secretary of Labor pursuant thereto.

EXAMPLE B - PLAN SPONSOR PROVISION

The TPA hereby agrees that it shall perform all duties assigned it under the Plan or the Agreement in accordance with the terms of the Plan as originally stated or as subsequently amended, the provisions of this Agreement, the provisions of ERISA, and any other applicable provision of federal or, to the extent not preempted by ERISA, state law. For purposes of ERISA, the Plan Sponsor or such other individual, entity or committee appointed by the Plan Sponsor shall oversee the administration of the Plan and shall be responsible for complying with all reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA other than those assigned to the TPA under the Plan or this Agreement. The TPA further agrees that it shall be the named fiduciary for purposes of Section 402(a)(1) of ERISA with respect to all duties and powers assigned to TPA under this Agreement or the Plan. The named fiduciary with respect to all other duties shall be the Plan Sponsor or such other person designated in writing by the Plan Sponsor pursuant to the Plan. The parties agree that a named fiduciary shall have the exclusive right to interpret the terms of the Plan and to determine eligibility for coverage and benefits with respect to all duties assigned to it under this Agreement or the Plan, and its good faith interpretation shall be binding and conclusive upon all persons.

Commentary.

Fiduciary allocations can be critical both to defining authority to make decisions and liability under ERISA as a named fiduciary for decisions made. The general approach of many TPAs will be to disclaim or limit its fiduciary status and the scope of its duties under ERISA and the agreement. The Plan sponsor's approach will be to expand the scope broadly. Thus, the TPA will seek to be defined as only a nondiscretionary or "ministerial" service provider for purposes of ERISA. The Plan sponsor may seek to designate the TPA as a named fiduciary with respect to all responsibilities under the Agreement and the Plan. The TPA, however, probably will be reluctant to take on all duties and responsibilities under the Plan unless specifically identified. It should be noted that ministerial representations will not prevent the attachment of fiduciary liability to the extent that the TPA is found in fact to exercise discretion. In such event, exculpatory provisions

also generally would become unenforceable. As a practical matter, the parties will need to closely analyze what duties are actually intended for the TPA under the agreement and the Plan and determine whether the scope of those duties more appropriately fits the definition of "TPA" or fiduciary under ERISA. To a large extent, the scope of fiduciary status will depend upon who makes benefit decisions under the Plan.

Complaint Resolution

EXAMPLE:

Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach hereof shall be resolved by arbitration in _____ before the American Arbitration Association in accordance with the rules then pertaining. Judgment upon the award rendered may be enforced in any court having jurisdiction thereof. The parties shall each pay their own share of the fees and attorneys' fees, if any.

Commentary.

During the term of the contract the parties probably will have many disagreements. Many agreements may be resolved by negotiation. Occasionally, however, more serious agreements may arise that require outside assistance for their resolution. The contract may provide for the resolution of complaints and conflicts. Because the independent contractor relationship is complex, different provisions to resolve financial, administrative, and professional problems may be needed. A provision for compulsory arbitration of financial and administrative impasses by a stated person or persons (or procedures to select an arbitration panel) may be desirable. Some TPAs or Clients, however may avoid agreeing to arbitration or other binding dispute resolution procedures for a variety of reasons. Some may view arbitrators as tending to split the difference between the parties regardless of who is "right" and who is "wrong." Some believe that the threat of termination of the contract or litigation in the event of a dispute serves as a greater deterrent than an arbitration clause to any temptation to violate the terms of the contract. Clients also may be reluctant to arbitrate claims relating to disputes arising out of pending fiduciary or claims litigation where the arbitration would result the dispute between the TPA and the Client before the litigation or potential litigation exposure is resolved.

Indemnification Provisions.

Example Provisions.

EXAMPLE A - TPA PROPOSED PROVISION

The Plan Sponsor agrees upon demand to indemnify the TPA for all premium taxes, or any other taxes imposed in lieu of premium taxes, including interest and penalties assessed against such taxes, charged by any state government in connection with the administration of the Plan. The Plan Sponsor also agrees on demand to protect, indemnify and hold the TPA harmless from and against any and all claims, demands and causes of action of every kind and character, including, but not limited to amounts of judgments, penalties, interest, court costs and attorneys' fees and costs in defense of same, that may arise in favor of third parties on account of, in connection with, or arising out of the TPA's performance of this Agreement.

The TPA shall indemnify and hold the Plan Sponsor harmless from all cause of action resulting solely from the TPA's negligence in the performance of this Agreement.

The Plan Sponsor agrees, upon demand, to indemnify the TPA for all premium taxes, or any other taxes imposed in lieu of premium taxes, including interest and penalties assessed against such taxes, charged by any state government in connection with the administration of the Plan.

In the event that a state or other jurisdiction, in accordance with existing or future law, determines that TPA is liable for payment of any tax, benefit payment, surcharge or assessment with respect to any aspect of the Plan, or this Agreement, the Plan Sponsor agrees to reimburse TPA for the amount of any such tax, payment, surcharge or assessments, in the interest expense assessed against or incurred by TPA before or after payment of such amounts. In the event that a state or other jurisdiction, in accordance with existing or future law, imposes upon TPA the duty to act as agent for collection of any tax, benefit payment, surcharge or assessment imposed upon the Plan or the Plan Sponsor or with respect to any aspect of the Plan, or this Agreement, the Plan Sponsor will pay over any such amount to TPA when requested to do so by TPA.

EXAMPLE B - PLAN SPONSOR PROVISION

The TPA agrees to save, hold harmless and indemnify the Company, the Client, the Plan, and their related corporations, its officers, directors, employees, representatives, assigns, agents, and successors, from and against any and all liability, claims, damages, suits, losses, costs, including attorneys' fees, and expenses relating to, directly or indirectly, or arising from or growing out of the breach of or failure by the TPA or any of its contracting providers, agents, employees, officers, directors, or assigns to perform or fulfill any representations, warranties, covenants, guarantees, agreements or duties of the TPA under this Agreement or any agreement attached hereto or incorporated by reference into this Agreement in accordance with the terms of this Agreement or any Exhibit or Schedule attached hereto, the Plan, or any applicable provision of federal or state law; from the negligence, willful misconduct, strict liability, common law fault, or statutory fault of the TPA or its contracting providers, agents, employees, successors, or assignees in its performance of services under this Agreement or the Plan; or any other any duty assumed hereunder. The TPA further agrees that it and its contracting providers shall indemnify and hold harmless the Plan, the Company and their agents, officers, directors, or assigns for any and all losses, costs, fees, expenses, and liabilities incurred as a result of their receipt or payment of any overpayment under the Plan and to reimburse the Plan for all benefit payments paid in excess of the benefit amount authorized under the terms of the Plan, and any attorney's fees, penalties, interest, costs or other expenses incurred by the Plan or the Company of which the Plan, the Plan Sponsor or their duly authorized representative notifies the TPA of such overpayment on or before the date which is four years after the later of the date that the TPA or provider received such overpayment or the date that this Agreement terminates.

The Plan Sponsor agrees to indemnify and hold harmless the TPA against all damages, claims and liabilities, including without limitation all costs, fees and expenses sustained or incurred by the TPA in the performance of its duties or actually and reasonably incurred by the TPA in connection with the defense of any legal action brought by any party, other than the Plan Sponsor, arising out of the negligence, gross negligence, willful misconduct, strict liability, common law fault, or statutory faults of the Plan Sponsor of its duties under this Agreement, other than those incurred by the TPA as a result of its failure to perform its duties in accordance with the terms of the Plan, this Agreement, or other applicable provision of federal or state law, or arising out of the imprudence, gross negligence, negligence, willful misconduct, strict liability, common law fault, or statutory fault of the TPA or its agents or employees. In the event that legal action is brought against the TPA in connection with its performance of its duties under this Agreement or any other action with respect to the Plan, the TPA hereby agrees not to settle any such action without the written consent of the Plan Sponsor and the Plan. Should the parties become involved in any legal action, each party is responsible for its own defense subject to the aforementioned indemnity agreement.

Commentary.

An indemnification provision seeks to protect the indemnified party against damage or expense by obligating another party to pay the amount of such damage or expense. These provisions are often strongly negotiated and the breadth of the indemnification can be influenced both by custom in the relevant market and the bargaining power of the parties. Of course, their value is only as good as the indemnitor's ability to pay and the scope of the indemnity.

In this context, negotiations will often dwell on the following issues:

- . Who is being indemnified? Does the indemnification expand the class indemnities beyond the parties to the contract, such as directors, officers, and affiliates?
- . Whose acts (or omissions) are being indemnified? Does it include contractors and subcontractors (or providers) of the TPA? The level of control of the TPA or level of integration of providers with the TPA may determine the willingness of the TPA to indemnify for the acts of its providers, (i.e. if it cannot control or influence the professional behavior of the providers, the TPA may be unwilling to indemnify for their malpractice). Indemnification could also be important to a Plan Sponsor if a court holds there is a duty (e.g. COBRA notification) which is not delegable to another. With indemnification, the Plan Sponsor still has legal recourse for failure of TPA to fulfill contracted duty which court finds nondelegable.
- . The standard of conduct required for indemnification? Does the indemnification cover negligent acts, criminal conduct, fraud?
- . Who provides attorneys? Who pays attorneys fees? In many cases defense costs may be indemnified, but each party is responsible for providing their own defense. In some cases where there is no conflict of interest, the indemnification may provide for one party providing defense for both parties.
- . Taxes and assessments. As various state and local governments have sought more creative ways to tax directly and indirectly activities related or services provided in relation to ERISA plans, the TPAs have sought, through indemnification or otherwise, to pass these costs on to the Plan Sponsor.

Often Plan Sponsors will seek to control any litigation over such fees, however, TPAs will typically seek control over litigation to preserve consistent treatment between Plans.

Network Establishment And Administration.

Example Provisions.

EXAMPLE A- TPA PROVISION

TPA will assist the Plan Sponsor to make arrangements for the Plan Sponsor to contract with one or more Managed Care Networks for Covered Persons to have a right to access the Managed Care Network. "Managed Care Network means the network, as it is constituted from time to time, of selected health care providers who have entered into agreements with TPA to make themselves available to provide medical care, dental care, prescription drugs, or mental health and chemical dependency care to Covered Persons. "Network Providers" means a health care provider who has entered into an agreement with TPA to participate in the Managed Care Network. ...

The Plan Sponsor understands and agrees that Managed Care Network and its Network Providers and not the TPA is responsible for the delivery of such services and the operation of the Managed Care Network. The Plan Sponsor further understands and agrees that TPA is not responsible for any care rendered or not rendered or health care item or service provided or not provided to Covered Persons by Network Providers or Non-Network Providers in that TPA will not be providing any health care pursuant to this Agreement.

TPA shall make reasonable efforts to calculate benefits covered by the Plan for services provided by Network Providers shall be determined based upon the rates for fees for services set forth in the agreements governing participation of Network Providers in the Managed Care Network then available to the TPA in accordance with its usual practices. As such agreements provide for payment of Network Providers for health care services rendered to Covered Persons on the basis of the number of Covered Persons assigned to the Network Provider (known as capitation fees) or on some basis other than or in addition to, on a fee for service basis, then benefits covered by the Plan shall include such payments. The Plan and the Plan Sponsor shall be liable to Network Providers for such payments and checks issued and credits of funds made by TPA to make such payments shall be funded by the Plan Sponsor in accordance with the provisions of this Agreement. TPA shall have no liability therefore and shall be indemnified and held harmless by the Plan and Plan Sponsor for all liabilities, payments assessed, costs and expenses including attorneys' fees, costs, and other assessments and penalties, that TPA shall directly or indirectly incur as a result of its performance of such duties and responsibilities.

EXAMPLE B- PLAN SPONSOR PROVISION

Installation and Administration Guarantee - The TPA hereby represents and warrants that it shall provide all services under this Agreement to the satisfaction of the Plan Sponsor, in the exclusive discretion of the Plan Sponsor. The TPA hereby agrees that if the Plan Sponsor is not completely satisfied with the installation of this Agreement in any respect, the TPA shall pay the Plan Sponsor \$_____ within ____ days of the Effective Date of this Agreement. For purposes of this Agreement, "installation" shall mean (i) the establishment of the Plan service points and PPOs in each location in a form satisfactory to the Plan Sponsor, (ii) the provision of directories and updated directories in a manner that the Plan Sponsor determines to be timely, (iii) the provision of assistance satisfactory to the Plan Sponsor for employee meetings in all locations, (iv) the establishment of mutually agreed upon claims targets in a manner that the Plan Sponsor determines to be timely, and (v) the performance of such other services or actions as shall be necessary or prudent to ensure that the Plan is implemented and administered in accordance with its terms and any provision of federal or state law applicable to the Plan or the Plan Sponsor to the satisfaction of the Plan Sponsor.

The TPA agrees to prudently design, establish, maintain, and administer a preferred provider network ("PPO"), through which care, treatment, services, and supplies shall be provided in accordance with the terms of the Plan, ERISA, and any other provision of federal or state law applicable to the Plan. The TPA agrees that it shall design, establish, maintain, and administer such PPO in accordance with any applicable federal law and, to the extent not preempted by ERISA, any applicable state law. The TPA agrees to design, establish, maintain and administer such PPO to ensure that at least XXX percent of all Covered Persons are satisfied with the services, care, treatment and supplies provided by or within the PPO. The TPA further agrees that it shall pay \$100,000.00 to the Plan Sponsor if a customer service survey conducted by an independent third party mutually agreeable to the parties at such time as designated by the Plan Sponsor fails to demonstrate that at least XXX percent of all Covered Persons are satisfied with the services, care, treatment and supplies provided by or within the PPO.

Records Access And Audit Rights.

Example Provisions.

EXAMPLE A- TPA PROVISION

Subject to the provisions of this Section, the Plan Sponsor may audit TPAs compliance with its obligations under this Agreement and TPA shall supply the Plan Sponsor with access to information acquired or maintained by TPA in performing services under this Agreement. TPA shall be required to supply only such information which is in its possession and which is reasonably necessary for the Plan Sponsor to administer the Plan, provided that such disclosure is not prohibited by any third-party contracts to which TPA is a signatory or any requirements of law. The Plan Sponsor hereby represents that, to the extent any disclosed information contains personally identifiable or health information about a Member, the Member has authorized disclosure to the Plan Sponsor or the Plan Sponsor otherwise has the legal authority to have access to such information.

The Plan Sponsor shall give TPA prior written notice of its intent to perform such an audit and its need for such information and shall represent to TPA that the information which will be disclosed therein is reasonably necessary for the administration of the Plan. All audits and information disclosure shall occur at a reasonable time and place and at the Plan Sponsors expense.

The Plan Sponsor may designate a representative acceptable to TPA to conduct or participate in the audit, or to receive access to such information provided that the Plan Sponsor and the representative enter into a written agreement with TPA under which the representative agrees to use any disclosed information solely for purposes of administering the Plan, to keep such information confidential and not to disclose the information to any other entity or person.

Any reports, information or documentation provided, made available, or learned by either of the parties to this Agreement which contain personally identifiable or health information about any Member or health care provider or which contain information about either party's business or operations which is not available to the public, or which contain information which has been designated as proprietary or confidential by either party shall be held in the strictest confidence, used solely to perform obligations under this Agreement or to administer the Plan, not be disclosed to any other entity or person, and maintained in accordance with the requirements of all applicable laws.

EXAMPLE B- PLAN SPONSOR PROVISION

The TPA agrees that the Plan Sponsor shall have a right to and the TPA agrees to permit duly authorized representatives of the Plan Sponsor or the Plan to inspect, review, and audit all records and information at such times as requested by the Plan Sponsor or the Plan. TPA hereby agrees that it shall provide the Plan Sponsor, at such reasonable times as the Plan Sponsor shall request, any documents, records, or information regarding utilization of the network necessary to monitor the network's performance and meet its other cost containment and wellness program objectives.

Within 120 days following the close of a Contract period, the TPA will prepare and submit to the Plan Sponsor a financial accounting for the Agreement period which details all administration charges, benefit payments, and other charges and expenses assessed or assessable with respect to the Plan, all payments made by the Plan, and all other relevant information regarding such amounts.

Commentary.

Given the expanding willingness of courts and the Labor Department to hold plan sponsors and fiduciaries accountable for the prudent selection and oversight of service providers, Plans, their sponsors and fiduciaries increasingly are, and should be, seeking to expand broader oversight and audit rights. TPAs generally will seek to restrict or regulate the exercise of these rights. The TPA will want clearly defined terms as to when the Plan Sponsor can audit and how the expenses of an audit are to be allocated. TPAs also frequently will seek to insulate certain information from audit as confidential trade secrets. Plan fiduciaries should be leery of such provisions to the extent that such practices or data will be used in the administration of the plan as Labor Regulations generally would require disclosure of that information in explanations of benefits provided as part of claims and appeals administration. Audit provisions also can play a critical role in determining the substance and value of performance guarantees. The Plan Sponsor will often focus on the audit provision as a means of establishing projected versus actual achievement of performance goals by the TPA.

Selection, Credentialing And Deselection Of Providers.

Sample Provisions.

EXAMPLE A- PLAN SPONSOR PROVISION

The TPA hereby agrees, represents and warrants that the TPA will exercise any and all procedures, care, and other precautions as shall be necessary or advisable to ensure that such Participating Providers are selected and

monitored in a manner consistent with the requirements of ERISA and all other applicable legal requirements and standards under federal or state law.

All Network Providers will be credentialed and recertified in accordance with standards prudently established by the TPAs. TPA shall provide all notifications to the Health Care Data Bank or otherwise of any deselected providers.

Commentary.

The service contract may address how physicians and other providers will be credentialed, selected and deselected by the TPA. In many cases, larger TPAs will cross-reference to internally developed policies and procedures which, as a practical matter, are revised frequently. The Plan Sponsor may wish to negotiate some minimum level standard for credentialing in order to insulate itself from any exposure for "negligent credentialing." The problem from the TPA's standpoint is defining this standard. Obligations to provide required notifications and due process procedures also should be clearly defined.

Compliance With Federal And State Laws.

Example Provisions.

EXAMPLE A- PLAN SPONSOR PROVISION

The TPA hereby agrees that it shall perform all duties assigned it under the Plan or the Contract in accordance with the terms of the Plan as originally stated or as subsequently amended, the provisions of this Contract, the provisions of ERISA, and any other applicable provision of federal or, to the extent not preempted by ERISA, state law. For purposes of ERISA, the Plan Sponsor or such other individual, entity or committee appointed by the Plan Sponsor shall oversee the administration of the Plan and shall be responsible for complying with all reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA other than those assigned to the TPA under the Plan or this Contract.

Commentary.

This provision divides responsibility under ERISA and sets forth the obligations of the parties to comply with applicable federal, if not preempted, state law. The provision above also includes the requirement for the TPA to perform all duties assigned it under the Plan as originally stated or as subsequently amended; a term which may be opposed by the TPA if the Plan Sponsor can amend the Plan without notice or right to terminate. The TPA may also oppose responsibility for reporting and disclosure requirements unless specifically identified.

Administrative Services Provisions.

Example Provisions.

EXAMPLE A- TPA PROVISION

The TPA will provide the Plan Sponsor with services for the administration and operation of the Plan. The cost of services below is included in the Administration Charges outlined in Section XXX. The cost of services in (B) below is not included in the Administration Charges outlined in Section XXX. The Plan Sponsor shall have all liability for funding of benefits under the Plan and the TPA assumes no such liability hereunder.

(A) Standard Services

- (1) Claims Administration - The TPA shall process requests for benefits and pay such benefits using the TPA's normal claim determination, payment and audit procedures, and applicable cost control standards, in accordance with the terms of the Plan and this Contract. Also included are installation and administration of the following services: [LIST]

(3) Administration - The TPA shall develop and install all agreed upon administrative and recordkeeping systems, including the production of employee identification cards.

(4) Description of Plan - The TPA shall prepare or shall review the description of the Plan which is attached hereto as Appendix I and any amendments thereto.^{72/}

(5) Benefit/Account Structure - The TPA shall design and install a benefit-account structure separately by class of Covered Persons, division, subsidiary, associated company, or other classification desired by the Plan Sponsor.

(6) Monthly/Quarterly/Annual Accounting Reports - The TPA shall prepare accounting reports in accordance with the benefit-account structure for use by the Plan Sponsor in the financial management and administrative control of the Plan, including: [LIST]

(7) Plan Design - The TPA shall provide the following services in connection with the Plan Sponsor's design and development of Plan benefits, both initially and in connection with revisions to the Plan: [LIST]

(8) Claim Settlement/Cost Containment - The TPA shall make available claim settlement services which include but are not limited to:

- (a) provision of standard claim forms and envelopes;
- (b) surgical and medical reasonable and customary profiles;
- (c) coordination of benefits;
- (d) chiropractic guidelines;
- (e) podiatry guidelines; and
- (f) medical necessity determination.

(9) Subject to the Plan Sponsor's review and concurrence, TPA shall provide the following services in connection with the Plan Sponsor's development of a "Summary Plan Description" for the Plan:

- (i) prepare draft language, and
- (ii) prepare printer's proof. The Plan Sponsor and TPA will include in the booklets, the Summary Plan Description information as may be required under ERISA and other applicable laws, provided that the Plan Sponsor will be responsible for the legal sufficiency of the booklets.

(B) Special Services - The TPA shall provide such other services as mutually agreed upon for an additional direct charge. Such services may include but are not limited to:[LIST]

EXAMPLE B- PLAN SPONSOR PROVISION

The TPA shall do the following in accordance with the terms of the Plan as originally stated or as subsequently amended, the provisions of ERISA, and any other applicable provision of federal or state law:

- (1) Investigate and process claims for benefits and appeals of denials of claims for benefits with respect to Covered Persons and calculate the amounts due and payable in accordance with the Plan;
- (2) Pay claims from funds provided by the Plan, the Plan Sponsor, or the Trust in accordance with the terms of the Plan and ERISA;
- (3) Provide written notice to a Covered Person of any denial of a claim and of the procedures through which such Covered Person may appeal such denial in accordance with the Plan and ERISA;
- (4) Administer appeals of denials of claims in accordance with the terms of the Plan and ERISA and provide written notice regarding its determination regarding the appeal in accordance with the terms of the Plan and ERISA;⁷³
- (5) Maintain current and complete records and files of claims payments for each Covered Person in accordance with the TPA then current practices and such other specifications as the Plan Sponsor shall establish from time to time;
- (6) Administer and enforce any and all rights to subrogation or assignment provided under the Plan and the Trust in accordance with the terms of the Plan and the Trust to the extent permitted by federal law⁷⁴;
- (7) Communicate prudently with Covered Persons, their beneficiaries, providers and other parties in connection with its administration of the Plan in accordance with such procedures as shall be prudent under ERISA or any other applicable federal or state law;
- (8) Design, print, inventory and supply all forms and materials necessary and required to install and administer the services specified in this Contract. Such forms and materials shall be designed in a format acceptable to the Plan Sponsor, shall comply with all requirements applicable to the Plan, the Plan Sponsor and their agents under ERISA, the Code, and any other provision of federal or state law, and shall incorporate such other language or information as shall be prudent or advisable to ensure its ability to administer and enforce the terms of the Plan;
- (9) Administer appeals of denials of claims in accordance with the terms of the Plan and ERISA and provide written notice regarding its determination regarding the review in accordance with the terms of the Plan and ERISA;
- (10) Comply with the Business Associate Agreement provisions of this Agreement; and
- (11) Comply with the otherwise applicable provisions of this Agreement in all actions taken with respect to the Plan and its administration.

Selected Termination Of Contract Provisions.

Example Provisions.

EXAMPLE A- TPA PROVISION

This Agreement shall be effective of as of January 1, ____ for an initial Agreement Period of twelve (12) months and shall continue automatically for successive Agreement Periods of twelve (12) months unless it is terminated earlier in accordance with this Section.

This Agreement shall terminate at the earliest time specified below:

As of the date of termination of the Plan, as specified to TPA by the Plan Sponsor,

As of any date agreed to by the TPA and Plan Sponsor,

As of the due date of any charges or fees provided in this Agreement if the Plan Sponsor fails to pay the fee or charge when payable as described in Section XX of this Agreement,

As of the date the Plan Sponsor fails to provide funds for the bank account as required in Section YY of this Agreement,

With respect to a breach other than that described in paragraphs (iii) or (iv) of this subsection, as of the fifth (5th) day following the date notice is given to the Plan Sponsor by TPA that the Plan Sponsor has breached this Agreement if the Plan Sponsor has not cured the breach by that fifth (5th) day,

As of the last day of an Agreement Period by either party giving thirty (30) days prior written notice to that effect to the party, or

As of the effective date of a revision in the service charges if the Plan Sponsor gives TPA written notice within thirty (30) days of receiving notice from Plan Sponsor of the change in the service charges.

In the event that either party reasonably believes that any state or other jurisdiction will penalize it for proceeding with its performance under the Agreement, the party may immediately terminate the Agreement's application in such state or jurisdiction by providing notice to that effect to the other party. In that event, the Agreement will continue to apply in all other states or jurisdictions.

Termination of this Agreement will not terminate the rights or liabilities of either party arising prior to termination.

EXAMPLE B- PLAN SPONSOR PROVISION

In General. This Agreement shall take effect as of the Effective Date and shall continue for a term of one year unless terminated prior thereto in accordance with this Article. This Agreement shall automatically be renewed for additional one year terms unless and until either party hereto shall notify the other party in writing, not less than 30 days prior to the expiration of any annual term, that said party elects for this Agreement to terminate at the end of the then annual term.

Termination by Plan Sponsor. Notwithstanding any other provision of this Agreement to the contrary, the TPA agrees that the Plan Sponsor shall have the right to terminate this Agreement at any time by providing written notice to the TPA as provided in the business associate provisions of Section __ of this Agreement or at any other time that the Plan Sponsor determines that termination of this Agreement is prudent or otherwise required or advisable to fulfill its duties and obligations of the Plan or the Plan Sponsor under ERISA or any other provision of federal or state law.

Termination by the TPA. The TPA may terminate this Agreement by providing written notice of its intention to terminate the Agreement to the Plan Sponsor and the Plan, to be effective as of a certain date set forth in the written notice, which shall not be less than 30 days from the date of the receipt by the Plan Sponsor and the Plan of such notice, if any and all amounts due hereunder are not paid to the TPA by or on behalf of the Plan Sponsor or the Trusts within 60 days following the date the TPA notifies the Plan Sponsor, the trustees or the Trusts, or their designates that such amounts are due and payable or if the Plan Sponsor fails to contribute funds for the payment of benefits as required by the Plan within 60 business days after the TPA shall have made a proper written request for such funds.

Obligations on Termination. Upon termination of this Agreement, except as otherwise directed by the Plan Sponsor, the TPA shall process and administer all requests for claim payments under the Plan incurred prior to the termination of this Agreement unless the Plan Sponsor has failed to provide funds for the payment of

benefits due within 60 days after the TPA shall have made a written request for such funds or to process requests for claims incurred by a Covered Person after the termination of this Agreement. After the termination of this Agreement, the Plan Sponsor shall continue to be responsible for contributing such contributions as shall be required under the terms of the Plan to provide for the payment of all benefits payable under the terms of the Plan which are outstanding upon the termination of this Agreement.

Commentary.

Termination provisions clearly set forth when the parties may "get out" of the contract. From the TPA perspective, the TPA wants to terminate the contract if it is not being paid its fees or charges or if the Plan Sponsor fails to fund its obligations under the Plan or the Agreement. As to other breaches, the parties may desire to provide a notice and failure to cure provision as a condition precedent to termination rights. A standard provision would be a right to termination with notice prior to any renewal. The Plan Sponsor may desire to negotiate a termination provision if the TPA has the right to change service charges unilaterally. Both parties will probably desire a right to terminate if required to comply with law and the Plan Sponsor may seek a right to terminate under a prudent man standard. The TPA will seek to incorporate termination penalties to preclude termination in the event a "better deal" is offered the Plan Sponsor.

Banking Provisions.

Example Provisions.

EXAMPLE A- PLAN SPONSOR PROVISION

Upon termination of this Agreement, or if later, at the end of a period during which TPA has agreed to continue processing claims pursuant to this Agreement, the funding arrangement described in this section in place prior to the termination of the Agreement shall remain in effect for a reasonable period of time as determined by TPA. At the end of this period, the Plan Sponsor shall deposit in the bank account funds equal to the amount necessary to fund checks which were issued pursuant to this Agreement but which have not been cashed. Such deposits shall remain in the bank account for a reasonable period as determined by TPA in order to fund such checks as they are cashed. At the end of this period, if there have been no checks presented to the bank for payment for a 3-month consecutive period, stop payment transactions shall be placed on all checks which are not cashed, the bank account may be closed, and any funds remaining in the bank account shall be returned to the Plan Sponsor.

After a reasonable period of time, as determined by TPA, TPA shall place stop payment transactions on checks issued pursuant to this Agreement which are not cashed. The Plan Sponsor shall be responsible for compliance with applicable abandoned property ("escheat") laws, if any, with respect to any checks which are not cashed.

Commentary.

The banking provisions in a TPA contract will set forth the details of how a bank account is to be set up, how the bank account will be funded, and the amounts to be maintained in the bank account in order for the TPA to make claim payments. It should also set up provisions as to how claims after termination will be processed and the responsibility for fees associated with the bank account. The TPA will typically require some type of authorization to access the bank account. During recent years, Plan Sponsors increasingly are requiring that TPAs agree to hold monies in trust. This change is largely attributable to the promulgation by the Department of Labor of additional guidance about ERISA's plan asset and trust requirements.

Risk Sharing Provisions.

Commentary.

Plan Sponsors and TPAs may consider using risk sharing provisions to hold the TPA accountable for cost projections and efficiency. Drafted various ways these provisions seek to place the TPA at risk for failure to

manage costs within certain parameters or reward the TPA for exceeding certain targets when managing costs. Often, the risk sharing arrangements are structured as part of so-called "self-insured HMO arrangements." Problems also can occur when the plan sponsor contracts to obtain designated managed health care services from a health maintenance organization (HMO) and the plan sponsor specifically wishes to limit the designated services in a manner that exclude certain services that are mandated benefits under the HMO laws and regulations applicable to the HMO. Under such circumstances, the applicable state or federal statutes may preclude the HMO from contracting to limit services in the manner contemplated by the plan sponsor. On the other hand, the plan sponsor may not technically have any obligation to comply with these mandates. For instance, ERISA generally pre-empts the enforcement of state HMO or insurance statutory mandates to provide benefits to employees and their dependents against employer sponsored health benefit arrangements. In recent years, many HMOs have attempted to use "self-insured" HMO arrangements to circumvent their applicable statutory mandates. While wide variation exists between the structure and details of these self-insured HMO arrangements, they generally involve the replacement of capitated premium arrangements with scheduled fee arrangements. Although little judicial precedent exists regarding the effectiveness of this approach, HMO regulators in various states view these arrangements as highly suspect. In a number of states, regulators have notified HMOs participating in these arrangements that the applicable licensing statutes prohibit an HMO from selling services on a selective basis even if the contract is not a capitated arrangement.

The incentive to maximize savings under risk sharing arrangements may result in inappropriate management of care or claims processing. These concerns may encourage the TPA or its providers to violate ERISA claims administration standards or treatment standards. Also, the potential for benefit or loss in the claims administration process may result in less judicial deference to administrative decisions made by the TPA.

Responsibility of TPA for Plan Funds.

Commentary.

Traditionally, TPAs refused to accept funds in a fiduciary capacity. Increasingly, they are under pressure to hold some or all of such monies in trust. This pressure comes from various sources. These include licensing laws (which may or may not be preempted by ERISA when applied to ERISA covered plans), ERISA trust and plan assets rules, financial insolvencies or conversions of plan assets for use by TPAs, and other factors.

Provisions For Overpayment Of Plan Benefits.

Commentary.

Underpayments and overpayments of Plan benefits are inevitable. The Plan Sponsor will want to allocate the risk of overpayments to the TPA. Alternatively, the TPA will want to control the pursuit of overpayments without taking on the risk. These provisions often can be negotiated based on the parties' understanding of what underpayments or overpayments are preventable by the TPA. For example, the responsibility for informing the TPA of an employee's ineligibility due to termination would be the employer's responsibility. Another method of approaching the overpayment/underpayment issue is through performance guarantees based on claim processing accuracy and audit provisions.

Records Ownership And Access.

Commentary.

Records access and ownership provisions bring together the competing interests of the Plan Sponsor to have broad access to the records of the TPA in administering the Plan against the interest of the TPA which seeks to preserve physician-patient confidential information, proprietary systems information, and other confidential information such as peer review records. In many cases the TPA will also seek a representation from the Plan Sponsor that any patient specific information obtained by the Plan Sponsor is authorized by the patient or by other law. (See Confidentiality of Information and Records, Section 19 below for sample provision.)

TPA Recordkeeping Requirements.

Commentary.

To provide for the defensibility of claims and appeals activities, TPAs generally should be expected to create and maintain appropriate records of their investigatory and determinative processes and related activities. Obviously, TPAs will want to minimize these obligations while Plan Sponsors and fiduciaries will seek more expansive commitments.

Typically the TPA will want to maintain records for only as long as the agreement remains in force or such shorter period allowed by law. These practices often need to be reviewed in light of HIPAA.

The Plan Sponsor will desire expansive recordkeeping requirements and will want to set standards such as prudent insurance recordkeeping standards for the recordkeeping. This provision will often be negotiable based on the ability of the TPA to maintain the records as requested and the actual needs of the Plan Sponsor as long as the HIPAA requirements are met and suitable documents are retained to provide for the defense of actions taken in the event of an audit or litigation.

Ownership of these records also should be addressed. Typically, plan sponsors and fiduciaries will want the agreement to provide that the Plan owns these records as a plan asset. TPAs typically will seek compensation for copying or otherwise transferring these records on termination.

Cooperation In Defense Of Claims.

Commentary.

Reciprocal provisions requiring cooperation in defense of claims where the TPA, the Plan or Plan Sponsor are sued or brought into administrative proceeding should be outlined. In some instances, the TPA retains control over the litigation when it is a named party. In some cases, the TPA may desire to place the responsibility and cost of defense of such an action on the Plan Sponsor. In other cases, the parties may want to agree on a joint defense and the conditions under which that joint defense will be provided. In yet other cases, the approach is to set forth who controls the defense of each party in a proceeding in which it is named and to refer to indemnification provisions as to how the cost of defense is to be distributed.

Plan Sponsors often want the right to control the cost of litigation, particularly where they are required to indemnify the TPA for these expenses. Similarly, unless the TPA agrees to indemnify the Plan Sponsor for liabilities arising from its activities, the Plan Sponsor generally will want the ability to ensure lawsuits under funded to minimize the Plan Sponsor's liability risks.

Plan Sponsors Duty To Provide Data.

Commentary.

In most instances, the TPA will have to rely on information provided by the Plan Sponsor as to the names and eligibility of employees under the Plan. Without enrollment information which is periodically updated, the TPA cannot appropriately process claims or determine eligibility for benefits. As more benefit determinations are made on the basis of enrollee choices (such as a choice of the Primary Care Physician), the importance to this information being passed to the TPA is heightened. On the other hand, the Plan Sponsor typically expects the TPA to have a system that minimizes the Plan Sponsor's enrollment responsibilities. Plan Sponsors also usually must rely on the TPA for insurability and other provider-related eligibility requirements. Thus, the Plan Sponsor usually will not accept responsibility for these issues. Ultimately, the parties should seek to negotiate the contract to allocated liability and responsibility to the entity that will actually perform that function.

Confidentiality Of Information And Records.⁷⁵

Federal law requires that health plans secure the commitments regarding the confidentiality of PHI and ePHI required by the Privacy and Security Rules. Certain aspects of these rules may require tailoring or other special procedures to appropriately administer. For instance, disclosures to the plan sponsor for administrative purposes require certain certifications. The agreement should specify the procedures for meeting these conditions.

Because of other privacy and identity theft considerations, it also generally may be desirable to one or both parties to secure other commitments regarding the privacy and security of other sensitive individual or business information. Beyond these provisions, parties generally also will negotiate provisions relating to trade secrets and other confidential information and processes. Plan sponsors and fiduciaries often will require that exceptions to these limitations be provided when required to meet regulatory obligations or defend actions by the TPA.

Performance Guarantees.

EXAMPLE – PLAN SPONSOR

Performance Guarantees. The TPA agrees to administer its duties under this Agreement at all times with the degree of skill, prudence and diligence required under Section 404 of ERISA, in accordance with the terms of this Agreement, and in a manner that comports with all requirements applicable to the performance of such duties under ERISA and any other applicable federal or state law or regulation that applies to the claims, transactions or duties which are the subject of the Plan or this Agreement. The TPA shall perform all duties and responsibilities assigned to it under this Agreement or under the Plan (a) solely in the interest of Covered Persons, (b) for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries under the Plan and defraying reasonable expenses of administering the Plan, (c) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims, and (d) in accordance with the provisions of ERISA, with the requirements of this Agreement, the terms of the Plan, and any applicable federal or state law or regulation. TPA further specifically agrees as follows: [LIST].

Commentary.

Performance guarantee provisions can take many different forms. In some contract provisions, as above, the performance guarantee is stated in the form of a penalty. In other contracts, the performance guarantee may be a penalty if certain standards are not met and in the form of a bonus or additional payment to the TPA if certain standards are exceeded. Typical measures of performance can include processing time for claims, dollar accuracy for claims, check accuracy, claim coding accuracy and medical coding accuracy. Typical negotiations will focus on what is the yardstick for measuring the standards and who will do the measuring.

Liability Insurance.

Example Provisions.

Professional Liability Insurance. The TPA hereby represents and warrants that it has and shall maintain in effect a professional liability insurance policy providing a minimum amount of coverage per occurrence of at least \$X,XXX,XXX.XX with a domestic insurance carrier satisfactory to the Plan Sponsor for liabilities and suits relating to acts and omissions committed by the TPA or its agents relating to this Agreement or the Plan. The TPA agrees to provide proof of such coverage to the Plan on the Effective Date and at such times thereafter as shall be requested by the Plan, the Plan Sponsor, or their designates. The TPA agrees that the Plan Sponsor shall have the right to terminate this Agreement at any time if the TPA fails to maintain such coverage in effect. The TPA agrees to notify the Plan Sponsor immediately of any change or termination of the coverage required under this Section.

Commentary.

Liability insurance requirements should be of concern to the Plan Sponsor if there are questions as to the ability of the TPA to pay any judgment for professional liability which could arise. In most instances these professional liability policies do not cover the malpractice liability of the TPA's health care providers. Plan sponsors and fiduciaries also should seriously consider obtaining fiduciary liability insurance both to protect against their own acts and omissions, and to provide coverage against liabilities and costs of defense arising from actions by the TPA or otherwise.

ERISA Fiduciary Provisions For Administrative And Managed Care Services.

Example Provisions.

EXAMPLE A - PLAN SPONSOR PROVISION

The Plan Sponsor hereby grants and delegates discretionary authority to the TPA to supervise, administer and generally manage the Plan, in accordance with terms of the Plan as originally stated or subsequently amended by the Plan Sponsor the provisions of the TPA's Agreement as originally stated or subsequently amended; and any other applicable provision of federal or, to the extent not preempted by ERISA, state law. The TPA is a party-in-interest within the meaning of ERISA.

EXAMPLE B - PLAN SPONSOR PROVISION

Allocation of Fiduciary Status. For purposes of ERISA, the Plan Sponsor or such other individual, entity or committee appointed by the Plan Sponsor shall oversee the administration of the Plan and shall be responsible for complying with all reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA other than those assigned to the TPA under the Plan or this Agreement. Pursuant to this Agreement, the Plan Sponsor has selected the TPA to act as the Claims TPA of the Plan. As the Claims Administrator, the TPA shall administer and issue payment on claims submitted under the Plan, process enrollment applications and premium payments for persons entitled to coverage under the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and perform such other duties as set forth in the Plan and this Agreement. The TPA shall be the named fiduciary for purposes of Section 402(a)(1) of ERISA with respect to all duties and powers assigned to the TPA under this Agreement or the Plan. The named fiduciary with respect to all other duties shall be the Plan Sponsor or such other person designated in writing by the Plan Sponsor pursuant to the Plan. A named fiduciary shall have the exclusive right to interpret the terms of the Plan and to determine eligibility for coverage and benefits with respect to all duties assigned to it under this Agreement or the Plan, and its good faith interpretation shall be binding and conclusive upon all persons.

Commentary.

These provisions typically will be requested by the Plan Sponsor in response to its legal obligations under ERISA and other federal laws. TPAs often prefer not to acknowledge fiduciary status in writing. Some TPAs also resist agreeing to perform to the procedure and other standards applicable to the Plan under ERISA and other federal laws.

Fee Arrangements.

Commentary.

The agreement should clearly define all compensation terms with auditable precision. Incentives may also be used by the TPA to encourage a Plan Sponsor to design its plan to encourage utilization of network providers. The TPA will desire this from the network development perspective, since if the plan design steers patients to Network Providers, the TPA will be able to negotiate better rates with the Network Providers overall. Likewise, Plans, or their sponsors and fiduciaries may seek to induce better performance by incorporating rewards or penalties for the TPA. Plan fiduciaries generally should investigate and document the reasonability of fees.

Network Participation Agreements Non-Solicitation Provisions.

Example Provisions.

EXAMPLE A - TPA PROVISION

This Participation Agreement shall be in full force and effective for a period of one year commencing on the effective date. In the event of termination for any reason, Plan Sponsor agrees that Plan Sponsor will not directly contract with the TPA facilities for a period of one year following the date of the termination.

Commentary.

As employers and Plan Sponsors become increasingly sophisticated in managed care and the administration of their Plans, there has been a trend to direct contract with providers. Non-solicitation provisions protect the TPA from the Plan Sponsor that wants to circumvent the TPA and directly contract with the provider network developed by the TPA.

Utilization Review Provision.

Example Provisions.

EXAMPLE A - TPA PROVISION

The TPA shall make recommendations and advise to Covered Persons regarding the medical necessity and/or appropriateness of hospital services and health care to be provided only as those services and care relate to the qualification of such care and services for benefit eligibility under the Plan. The TPA shall notify the Covered Person (or the person responsible for payment) the Covered Person's physician or other health care provider responsible for treatment of its precertification, utilization, and medical necessity determinations.

EXAMPLE C - TPA PROVISION

Utilization Review. The TPA shall use its ordinary business practices to evaluate the medical necessity and appropriateness of charges and treatments provided with respect to a Covered Claim in accordance with the Act and to make a recommendation to the Plan Sponsor regarding the compensation under the Act to be paid by the Plan Sponsor with respect to such Covered Claims, using the TPA's materials and such other supplemental materials as the TPA shall deem appropriate or helpful. The Plan Sponsor hereby represents, warrants and agrees that it shall at all times maintain and provide compensation with respect to all Covered Claims in accordance with the Act and all other applicable requirements of law.

Commentary.

Utilization review has become a commonly accepted process in managed care and other health plan arrangement, particularly in relation to hospital confinements, mental or nervous disorders, chemical dependency, surgeries and maternity care. In many cases, the provisions will outline what types of reviews (e.g., preadmission, prospective, concurrent or retrospective) are to be performed for a specific health care service. ERISA's claims and appeals procedures require that special procedures be used when making and communicating these determinations. Many TPA practices and procedures do not conform to these requirements.

Scope Of Services.

Example Provisions.

EXAMPLE A - TPA PROVISION

Plan Sponsor agrees that it will provide to the Plan Sponsor the managed care services with respect to medical care proposed to be provided to Covered Persons of the Plan Sponsor. Managed care services means any or all of the product components listed in Exhibit A. If the Policy has multiple claim suffixes, the particular product components for each suffix are identified in Exhibit A. Exhibit A: Managed care includes the following components: (1) utilization review and (2) case management.

Commentary.

As the scope of managed care services provided to ERISA plans expands beyond utilization review to areas such as case management and mental health management, it is increasingly important for the TPA to define the scope of services and what will be provided under these services.

Medicare Related Restrictions On Scope Of Services.

Federal law prohibits employer-sponsored group health plans from discriminating against certain Medicare eligible persons and requires that those plans adhere to certain rules when coordinating plan benefits with Medicare and Medicaid. HMO and certain other managed care contracts often include provisions that exclude or discriminate against Medicare and Medicaid-eligible persons in a manner that would cause the plan sponsor to violate these rules. Since the penalties for violation of these requirements are severe, the plan sponsor usually must insist upon alteration of these contract terms.

Assignment.

Example Provisions.

EXAMPLE A - TPA PROVISION

Nothing in this Agreement shall be construed to prevent the TPA, at any time and in its sole discretion, from contracting or otherwise delegating the duties and obligations of the TPA hereunder to any other qualified person or entity. If the fees to be charged by such other person or entity exceed the TPA's fees, the TPA will request that the Plan Sponsor pay the excess. If the Plan Sponsor does not agree to pay the excess, the TPA shall have no further obligation to provide services to the Plan Sponsor under this Agreement.

EXAMPLE B - PLAN SPONSOR PROVISION

This Agreement shall bind and inure to the benefit of the successors of the Plan Sponsor and the Plan, but except as provided in this Article XXX shall not otherwise be assignable by the TPA. To the extent authorized by ERISA, the TPA may assign or subcontract any or all rights or obligations under this Agreement to a subsidiary or affiliate of the TPA subject to the following terms and conditions:

- . The TPA hereby agrees that it shall prudently select and monitor any such subsidiary or affiliate;
- . The TPA shall require any such subsidiary or affiliate to perform all duties and responsibilities assigned or subcontracted to such subsidiary or affiliate in accordance with this Agreement; and
- . The TPA shall bear full responsibility and liability to the Plan, the Plan Sponsor, the participants, and their duly authorized representatives for any acts or omissions committed by such subsidiary or affiliate.

Commentary.

In a marketplace where mergers, consolidations and divisions of corporate entities is commonplace, assignment provisions need to be scrutinized more. The desire to have liberal assignment provisions must be tempered against the risk that the obligations of the contract will be assigned to a party unable to fulfill the obligations of the agreements.

Assignment provisions also raise fiduciary responsibility and prohibited transaction concerns under ERISA. When duties are delegated to another party, ERISA generally requires that the entity receiving the delegation be prudently selected and monitored. Additionally, ERISA's prohibited transaction rules can impose significant liabilities on both the Plan Sponsor and the TPA if the TPA delegates its duties to an entity that is a party-in-interest under ERISA. Other qualification and bonding requirements also may apply. A Plan Sponsor usually will seek either to prohibit assignments or to require that the TPA agree to accept fiduciary responsibility for its delegations and assignments and responsibility to compliance with these legal responsibilities, as well as ensuring that the entity to whom services are delegated performs in accordance with the parties' contract and the Plan Sponsor's plan.

Sample HIPAA Privacy Standards Business Associate Contract Provisions⁷⁶

The CMS Office of Civil Rights ("OCR") published selected sample business associate contract provisions in the preamble to its preamble to the Privacy Rules.

EXAMPLE PROVISIONS⁷⁷

Definitions (alternative approaches)

Option A: Catch-all definition:

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

Option B: Examples of specific definitions:

- a. Business Associate. "Business Associate" shall mean [Insert Name of Business Associate].
- b. Covered Entity. "Covered Entity" shall mean [Insert Name of Covered Entity].
- c. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
- d. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- e. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- f. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501.
- g. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

Obligations and Activities of Business Associate:

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

- b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. [This provision may be included if it is appropriate for the Covered Entity to pass on its duty to mitigate damages to a Business Associate.]
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- f. Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner [Insert negotiated terms], to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524. [Not necessary if business associate does not have protected health information in a designated record set.]
- g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner [Insert negotiated terms]. [Not necessary if business associate does not have protected health information in a designated record set.]
- h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available [to the Covered Entity, or] to the Secretary, in a time and manner [Insert negotiated terms] or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
- j. Business Associate agrees to provide to Covered Entity or an Individual, in time and manner [Insert negotiated terms], information collected in accordance with Section [Insert Section Number in Contract Where Provision (i) Appears] of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.

Permitted Uses and Disclosures by Business Associate:

General Use and Disclosure Provisions [(a) and (b) are alternative approaches]

Option A: Specify purposes:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of Protected Health Information would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity: [List Purposes].

Option B: Refer to underlying services agreement:

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in [Insert Name of Services Agreement], provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

Specific Use and Disclosure Provisions [only necessary if parties wish to allow Business Associate to engage in such activities]

- a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
- d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

Obligations of Covered Entity

Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions [provisions dependent on business arrangement]

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.
- c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. [Include an exception if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate].

Term and Termination

- a. Term. The Term of this Agreement shall be effective as of [Insert Effective Date], and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section. [Term may differ.]
- b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement [and the _____ Agreement/ sections ____ of the _____ Agreement] if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement [and the _____ Agreement/ sections ____ of the _____ Agreement] if Business Associate has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

[Bracketed language in this provision may be necessary if there is an underlying services agreement. Also, opportunity to cure is permitted, but not required by the Privacy Rule.]

c. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon [Insert negotiated terms] that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous.

- a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
- c. Survival. The respective rights and obligations of Business Associate under Section [Insert Section Number Related to "Effect of Termination"] of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Commentary.

Many parties have incorporated these provisions as an addendum to their TPA and other agreements as a quick and dirty means of meeting the Privacy Rule business associate agreement requirements. Typically, this does not work very well, a reality anticipated by OCR when it shared the sample provisions. Indeed, it noted when it shared these sample provisions:

“These provisions only address concepts and requirements set forth in the Privacy Rule and alone are not sufficient to result in a binding contract under State law. They do not include many formalities and substantive provisions that are required or typically included in a valid contract. Reliance on this sample is not sufficient for compliance with State law and does not replace consultation with a lawyer or negotiations between the parties to the contract.

Furthermore, a covered entity may want to include other provisions that are related to the Privacy Rule but that are not required by the Privacy Rule. For example, a covered entity may want to add provisions in a business associate contract in order for the covered entity to be able to rely on the business associate to help the covered entity meet its obligations under the Privacy Rule. In addition, there may be permissible uses or disclosures by a

business associate that are not specifically addressed in these sample provisions, for example having a business associate create a limited data set. These and other types of issues will need to be worked out between the parties.

In open disregard of this cautionary note, vendors and plans generally have largely relied upon the sample language as sufficient to meet the HIPAA privacy and data security rules. This practice gives rise to numerous concerns, including:

- The provisions are not adequately tailored to avoid internal conflicts and ambiguities within the Agreement;
- The provisions require supplementation to meet the goals intended by the regulations;
- With respect to ePHI, the provisions fail to address the required safeguards needed to meet the requirements of the Security Rule;
- The omission to include certain provisions makes the compliance obligations of the business associate unnecessarily burdensome or otherwise complicates the administration of the Privacy and Security Rule responsibilities; and
- The failure to make appropriate provision for coordination with other plan service providers creates unnecessarily burdensome obligations and other challenges.

Miscellaneous Provisions.

Commentary.

Most agreements also contain various miscellaneous provisions. Frequently, these provisions parallel provisions incorporated as a matter of course into most services or insurance contracts. The parties should review these provisions carefully to ensure the inclusion of and actual terms of these provisions are consistent with the purposes of the agreement and the parties needs and expectations.

Regarding the licensing provision, for instance, a TPA may resist agreement to maintain licensing. Some dispute exists among the jurisdictions regarding the extent to which ERISA allows TPA's providing services to ERISA plans not to comply with licensing laws. In other instances where the Plan Sponsor's employees reside in a number of states, the TPA may question whether the residency of the covered person provides that state sufficient jurisdiction to enforce its laws against the TPA. On the other hand, many Plan Sponsor's view the licensure as a credential that helps to establish the prudence of the selection of the TPA. Additionally, the Plan Sponsor often may be concerned that efforts by a State regulator to enforce the licensing requirement could result in disruption to the Plan.

Regarding the bonding provision, ERISA imposes certain bonding requirements on fiduciaries. State licensing laws also may impose bonding requirements that may or may not be pre-empted by ERISA. A Plan Sponsor typically will insist on bonding at least to the extent required by ERISA.

Concerning the TPA's role in the design and development of the Plan and the right to amend the Plan, the perspective of the parties may vary from contract to contract. If the TPA takes risk or has system limitations that could restrict its ability to administer certain plan designs, it generally will seek to preserve stricter control over the plan design and changes to it. In such cases, the TPA may insist on the ability to make plan design changes, the right to approve changes in the Plan in advance, or the ability to modify rates or to terminate the agreement in response to plan design changes. In contrast, the Plan Sponsor usually will want input and guidance from the TPA about the appropriateness of the plan design and recommended design changes but will want the right to decide the actual terms of the Plan.

TPAs usually agree to provide booklets describing the benefit provisions relating to their contract but may resist committing to draft those booklets to comply with the summary plan description rules of ERISA. On the other hand, Plan Sponsors usually expect that the TPA will design these booklets to satisfy the summary plan description and other legal requirements relative to the communication of the Plan. Additionally, both parties usually want the right to have input and control regarding the content of communication documents. The parties should draft the contract to ensure that it reflects the parties' agreement regarding these responsibilities.

The parties usually agree that notice should be provided to Covered Persons about the capacity in which the TPA provides services, but the parties may disagree regarding who should be responsible for providing this notification. Although these provisions usually are formulated in response to State insurance laws that purport to place this responsibility on the Plan Sponsor, these statutes usually are pre-empted by ERISA when applied to the Plan Sponsor. Additionally, many Plan Sponsors expect the TPA to assume responsibility for communications regarding the Plan. Therefore, the Plan Sponsor usually will view this as the responsibility of the TPA. In contrast, the TPA often views this as the responsibility of the Plan Sponsor. The parties should negotiate these provisions to clearly reflect their agreement regarding this matter.

The parties also should focus more carefully on provisions regarding the amendment of the Plan and agreements. Some recent court decisions raise concerns that inadequate specificity in the crafting of provisions regarding modification or amendment of plan documents, TPA agreements, insurance agreements, and other contracts may undermine the ability of the parties to enforce changes in plan design and coverages against covered persons.

The TPA usually requires some discretion to interpret and administer the Plan to carry out its duties. To qualify for greater deference to its decisions under ERISA, the parties generally will want to include in the Plan and their contract a grant of exclusive discretion to the TPA to make these interpretations and decisions. The inclusion of that grant of discretion, however, may undermine the ability of a TPA to minimize its fiduciary status for purposes of ERISA.

Where the parties are not incorporated in the same State, Choice of Law provisions often taken on special importance. Typically, each party will want the contract construed in accordance with the laws of the State in which their corporate offices are located. In some cases, however, more favorable laws may be available in other jurisdictions. The Plan Sponsor also usually will want the agreement to designate the same jurisdiction as the Plan Sponsor has designated to govern the interpretation of its plan document. As a result, some parties may prefer to designate other jurisdictions.

¹ This paper is a condensed version of a more detailed paper discussing TPA contracting principles & strategies previously published and presented by Ms. Stamer.

² This paper is a condensed version of a more detailed paper discussing TPA contracting principles & strategies previously published and presented by Ms. Stamer.

³ Chair of the American Bar Association Health Law Section Managed Care & Insurance Interest Group and the Vice Chair of ABA Real Property, Probate & Trust Section and Past Chair of its Welfare Plan Committee, Cynthia Marcotte Stamer is nationally recognized for her cutting edge work helping employers, insurers, governments, and others manage health benefits, disability, and related human resources costs and liabilities. "Cindy" has more than 20 years experience helping clients design, administer and defend effective, legally compliant consumer driven and other tools and strategies for managing benefit costs, employment liabilities and workplace disruptions from illnesses and disabilities affecting employees and their families. Board certified in labor and employment law by the Texas Board of Legal Specialization, Cindy combines her in-depth knowledge of employment, employee benefit, health care, and insurance laws and realities to cut through the consumer-driven health care hype to develop practical solutions tailored to the client's employee benefit and human resources goals. Her experience includes extensive experience advising public and private employee benefit plans, their sponsors, fiduciaries, administrators, insurers, and others about design, tax qualification, implementation, administration, termination and defense of self-insured and insured employee health and other welfare benefit, pension, profit sharing, deferred compensation and workers' compensation programs for public and private employers to meet their budgetary goals, business objectives, and applicable IRC and other federal and state legal requirements. She also has extensive experience advising ERISA, Medicare & Medicaid Advantage, and other health and other employee benefit plan sponsors, fiduciaries and administrators about investment and vendor selection, monitoring, vendor and provider contracting, performance, and other fiduciary and operational concerns for domestic and ex-pat health plans, wellness programs, on-site health facilities PBM arrangements and other health and disease management efforts and programs; the defense of employers, plan fiduciaries, insurers, service providers and others against employee benefit, insurance, employment and other lawsuits and enforcement actions by private plaintiffs and Federal and state governmental agencies; the establishment, administration and defense of claims investigation and processing, privacy and data security, broker and other service provider selection and compliance, and other internal controls and risk management procedures. She also has worked extensively with businesses and governments domestically and abroad on the design and evaluation of legislative and regulatory reforms affecting health care, employee benefit, social security, migration, education, taxation, and other workforce matters. In addition to her leadership involvements in the ABA and other professional and civil organizations, Ms. Stamer also is a widely published author and highly sought-after speaker on health care, employee benefit, tax, employment, insurance and privacy and data security matters. The author of hundreds of articles, training programs, and workshops, she regularly is retained to conduct training for professional organizations, boards and other leadership teams, and others. For a sampling of her publications, programs and papers and other details about Ms. Stamer, see www.cynthiastamer.com.

⁴ ERISA plans are plans covered by the Employee Retirement Security Act of 1974, as amended ("ERISA"). Plans generally are covered by ERISA if an employer or union maintain it to provide benefits to employees or union members, regardless of whether the plan is self-insured, fully insured, or a HMO contract arrangement.

⁵ 29 U.S.C. Section 1001 et. seq.

⁶ See, e.g., *Varity Corp. v. Howe*, 516 US 489 (1996) (citing *Mass. Mutual Life. Ins. Co. v. Russell*, 473 US 134, 153 (1985)) (holding that ERISA empowers a participant or beneficiary under a welfare benefit plan to recover appropriate equitable relief for any act or practice that violates ERISA, including a breach of the statutorily created fiduciary duties of the administrator); *Bixler v. Central Penn. Teamsters Health & Welfare Benefit Fund*, 12 F.3d 1292 (3rd Cir. 1993) (holding that beneficiary of a health plan could sue health plan trustees and administrators for breach of fiduciary duties based on alleged misrepresentations about availability of continuation coverage).

⁷ ERISA Section 402(a)(1).

⁸ ERISA Section 402(a)(2). Unlike pension plans, health and other welfare benefit plans commonly are drafted with little thought about the designation of fiduciaries. Frequently, the documents identify "the Company" or the "Employer" as the plan administrator and named fiduciary. While this probably suffices for purposes of satisfying ERISA's technical requirement that at least one named fiduciary be identified, see Dept. of Labor Reg. Section 2509.75-5, the better practice would be to identify the individual or committee of individuals within the company who in fact will carry out those responsibilities, either by designating a committee or a particular individual, either by name, or through specified procedures for ascertaining their identity. Clearer identification of the individuals serving in this function can help to insulate others not intended from serving in this capacity from being accused of serving in fiduciary roles.

⁹ ERISA Section 3(21).

¹⁰ *Mertens v. Hewitt Assoc.*, 508 U.S. 248.

¹¹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989).

¹² See *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 133 (3rd Cir. 1993) (finding an employer to be a fiduciary solely on the basis of its role as plan administrator under ERISA); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1158 (3rd Cir. 1990) (holding that when employers serve as plan administrators, they assume the role of fiduciary under ERISA); *Reilly v. BCBS United of Wis.*, 846 F.2d 416 (7th Cir. 1988) (holding that as the administrator of a self-insured health plan, Blue Cross was a fiduciary).

¹³ See, e.g., *Curcio v. John Hancock Mutual Life Ins.Co.*, 33 F.3d 226 (3rd Cir. 1994) (holding that employer was an ERISA fiduciary where employer announced new life insurance plan to employees through literature and meetings, and printed and distributed its own booklet certificates describing plan and each plan amendment, and where booklet stated that plan would be administered through employer's employee relations department and employer could modify or amend plan at any time at its sole discretion, since employer maintained sufficient discretionary authority and responsibility in plan's administration to satisfy statutory definition of fiduciary and therefore is liable for making affirmative misrepresentations under ERISA under either breach of fiduciary duty.); *Kyle Railways Inc. v. Pacific Administration Services Inc.*, 990 F.2d 513 (9th Cir. 1993).

¹⁴ See Dept. of Labor Reg. 2509.75-5 (D-3).

15 500 F.Supp. 1162 (1980).
16 See Dept. of Labor Reg. 2509.75-5 (D-3).
17 See Dept. of Labor Reg. 2509.75-5 (D-2).
18 See *Reich v. Lancaster*, 55 F.3d 1034 (5th Cir. 1995) (finding that insurance agent in fact exercised decision-making power over policy product selection and commission arrangements).
19 See Dept. of Labor Reg. 2509.75-5 (D-3). See also *Painters Dist. 21 Welfare Fund v. PriceWaterhouse*, 879 F.2d 1146 (3rd Cir. 1989); *Confer v. Custom Engineering Co.*, 952 F.2d 34 (3rd Cir. 1991) (holding that employee who, while acting as the plan supervisor, denied claims in accordance with the plan terms was not liable as a fiduciary and was not a fiduciary liable for plan sponsors improper denial of benefits by backdating a plan amendment, as he had no discretion to grant or deny claims, but was obligated to follow the plan document).
20 See *Id.*; *Kyle Rys. v. Pacific Admin. Serv. Inc.*, 990 F.2d 513, 516 (9th Cir. 1993).
21 See *Reich v. Lancaster*, 55 F.3d 1034 (5th Cir. 1995); *Kyle Rys. v. Pacific Admin. Serv. Inc.*, 990 F.2d 513, 517-518 (9th Cir. 1993); *Pacificare*, 34 F.3d 834, 837-38 (1994) (9th Cir. 1994) (finding that ERISA plan health insurer who had discretionary authority to approve or deny claims could bring action pursuant to ERISA); *Tregoning v. American Community Mut. Ins. Co.*, 12 F.3d 79, 83 (6th Cir. 1993) (indicating that an employer's sole authority under plan documents to grant or deny claims was crucial factor in determining that employer was a fiduciary within 1002(21)(A)(iii)).
22 See, *The Sixty-Five Security Plan v. Blue Cross of New York*, 583 F.Supp. 380 (S.D.N.Y. 1984).
23 *Id.*
24 *Id.*
25 841 F.2d 658 (5th Cir. 1988).
26 496 F. Supp. 1350 (D.Md. 1980).
27 55 F.3d 1034 (5th Cir. 1995) (enjoining a broker and his insurance agency and ordering them to pay restitution based upon a finding that the agent and the insurance agency he controlled breached their fiduciary duties to a self-funded, union welfare plan by inducing the plan to purchase whole life, rather than term insurance policies, and to pay the broker and the agency excessive commissions where the evidence showed that the agent structured his advice to maximize commissions, rather than on the best interests of the plan and its beneficiaries).
28 841 F.2d 658 (1988) (holding that insurance agent was a fiduciary with respect to commissions and administrative expenses paid to him under compensation agreement, although terms of compensation were negotiated with fund at arm's length before he became fiduciary, since he exercised discretion over which claims would be paid, and thus is liable to fund for portion of commissions and expenses based on payment of claims to ineligible persons.)
29 *Id.*
30 776 F.2d 1180 (3rd Cir. 1985).
31 6 F.3d 131 (3rd Cir. 1993).
32 See *id.* at n. 13.
33 *Varity Corp. v. Howe*, 516 U.S. 489 (1996).
34 *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 158 (1985) (Brennan, J., concurring).
35 H.R.Rep. No. 93-533, p. 11 (1973).
36 See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56. See also *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, n. 26 (1983) ("a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans") (quoting 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)).
37 See ERISA Section 404. See also *Reilly v. BCBS United of Wisconsin*, 846 F.2d 416 (1988).
38 See ERISA Sections 404, 406.
39 See *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985).
40 See *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 570 (1985).
41 See, e.g., *UMWA 1950 Benefit Plan v. Bituminous Coal Operators' Ass'n.*, 898 F.2d 177, n. 6 (D.C.Cir. 1990) holding that contributing employer to multi-employer health and welfare fund trustees could establish fiduciary breaches by union fund trustees if it proved its allegations that (1) the Trust has improperly used contributions collected under the 1988 Agreement to pay for health care provider bills incurred under the 1984 Agreement; (2) the Trust refused to reallocate proceeds of settlements received by the 1950 Pension Trust and miscalculated its reallocation needs from the 1950 Pension Trust; and (3) the Trust has failed to obtain full and prompt reimbursements from Medicare); *OCAW Local Union 4-447 v. Chevron Chemical Co.*, 17 Employee Benefit Cas. (BNA) 2212 (E.D.La. 1994)(holding fiduciary that wrongfully applied health plan contribution to health plan sponsored by employer, rather than union plan, breached its fiduciary responsibilities and must make restitution to the plan for the diverted contributions). See also, *Central States, Southeast & Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559 (1985)(holding that the grant of audit authority under the plan document was consistent with the duty to collect and administer health and welfare plan fund, but stopping short of ruling that an audit was required to fulfill these responsibilities under ERISA).
42 See DOL Opinion Letter (Feb. 19, 1998), 1998 ERISA Lexis 6.
43 See *id.*
44 See *id.*
45 See Dept. of Labor Reg. Section 2510.3-102.
46 *Varity Corp. v. Howe*, 516 U.S. 489.
47 See *Smith v. The Hartford Ins. Group*, 6 F.3d 131, n. 13 (3rd Cir. 1995) (holding that employer, who misrepresented to a participant and his spouse that their nursing home benefits would be unaffected if they switched their enrollment from an existing insured health plan to a self-

insured plan, was liable as a fiduciary to make up the difference in coverage from its assets); *Bixler v. Teamsters of Central Pennsylvania Health and Welfare Fund*, 12 F.3d 1292 (3rd Cir. 1993) (recognizing the duty to disclose as "a constant thread in the relationship between beneficiary and trustee"). See also, e.g. *Varity Corp. v. Howe*, 516 U.S. 489 (1996); 919 F.2d 747 (D.C. Cir. 1990); *New York State HMO Conference v. Curiale*, 64 F.3d 794 (2nd Cir. 1995).

⁴⁸ *Glaziers and Glassworkers Local 252 Annuity Fund v. Newbridge Securities, Inc.*, 93 F.3d 1171 (3rd Cir. 1996) (holding brokerage firm, who discharged an employee who had primary responsibility for the investment of the health fund's monies, had a fiduciary duty to alert the health fund trustees of concerns about the trustworthiness of the former employee when notified of the fund's intention to allow the former employee to continue to provide investment advice following his termination by the brokerage).

⁴⁹ See *Varity Corp. v. Howe*, 516 U.S. 489 (1996). See also, *Maez v. Mountain States Tel. & Tel., Inc.*, 54 F.3d 1488 (10th Cir. 1995); *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130 (3rd Cir. 1993) (Fischer I); *Berlin v. Michigan Bell Tel. Co.*, 858 F.2d 1154 (6th Cir. 1988); *Bixler*, 12 F.3d 1292; *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747 (recognizing duty to exercise prudence to avoid making affirmative representations) Also see, *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, - F.Supp.-, 19 Employee Benefit Cas. (BNA) 1556 (3rd Cir. 1995) (holding retirees may maintain a claim that former employer breached its ERISA fiduciary duties by allegedly misinforming employees that once they retired their medical benefits would continue for the rest of their lives, where plan had subjected their right to continued eligibility to employer's reservation of rights to terminate the plan).

⁵⁰ See *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747 (D.C. Cir. 1990) (holding an ERISA fiduciary who is aware of the beneficiary's status and situation has an obligation to convey complete and accurate information materials to the beneficiary's circumstance even if that information comprises elements about which the beneficiary has not specifically inquired. Therefore, ERISA fiduciary had a duty to inform plan beneficiary of available continuation options under plan once plan terminated). See also, *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, - F.Supp.-, 25 Employee Benefit Cas. (BNA) 2105 (3rd Cir. 2001) (Unisys II) (holding Unisys had an ongoing duty to inform participants of the true state of affairs such that as long as Unisys had reason to believe that the retirees remained unaware of the material fact that the company retained a right to cut off their "lifetime" medical benefits, it was a violation of trust every day for it not to inform them.); *Bixler*, 12 F.3d 1292 (holding that plan beneficiary may sue plan trustees and plan administrator for breach of fiduciary duties for failing to provide all information likely to be relevant after receiving a request for information with knowledge of the beneficiary's circumstances).

⁵¹ See, e.g., *Curcio v. John Hancock Mutual Life Ins. Co.*, 18 ENC 1822 (3rd Cir 1994); *Fischer v. Philadelphia Elec. Co.*, 994 F.2d 130, 133-135 (3rd Cir. 1993); *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3rd Cir. 1993) (holding that plan beneficiary may sue plan trustees and plan administrator for breach of fiduciary duties for providing her with misinformation about continuation of medical coverage.).

⁵² See, e.g., *Glaziers and Glassworkers Local 252 Annuity Fund v. Newbridge Securities, Inc.*, 93 F.3d 1171 (holding that if a brokerage firm was a fiduciary, the health funds' failure to request information concerning the departure from employment with the brokerage of the individual who served as its investment manager had no bearing on whether the brokerage firm breached the duties it owed the Funds by not volunteering the information.); *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292 (3rd Cir. 1993); *Eddy*, 919 F.2d 747 (holding that given the fiduciary's knowledge about the material circumstances of a health plan participant, the failure of the participant's spouse to comprehend or ask about a technical aspect of the plan did not absolve the health plan administrator from providing information about conversion and coverage continuation rights available under the plan, about which not specific inquiry had been made).

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ 919 F.2d 747 (D.C. Cir. 1990).

⁵⁶ Note: For a more comprehensive discussion of the particulars of these requirements, see Stamer, "ERISA Claims & Appeals Boot Camp" (Solutions Law Press, 2008) available online at www.cynthiastamer.com.

⁵⁷ *Massachusetts Mutual Life Ins. Co.*, 473 U.S. at 152-53 (Brennan, J., concurring) (footnote omitted).

⁵⁸ 489 U.S. 101 (1989).

⁵⁹ 489 U.S. 101 (1989) (citing the Restatement (Second) of Trusts 187, Comment d (1959)).

⁶⁰ *Reilly v. BCBS United of Wisconsin*, 846 F.2d 416 (7th Cir. 1988). See also *Dennard v. Richards Group Inc.*, 681 F.2d 306, 314 (5th Cir. 1982) (indicating the arbitrary and capricious standard for an administrator of a pension plan under ERISA may require an analysis of the following three factors: "(1) uniformity of construction; (2) 'fair reading' and reasonableness of that reading; and (3) unanticipated costs.")

⁶¹ 538 U.S. 822 (U.S. 2003).

⁶² *Metro. Life Ins. Co. v. Glenn*, 128 S. Ct. 2343 (U.S. 2008).

⁶³ See Labor Reg. 2560.503-1.

⁶⁴ See Labor Reg. 2560.503-1.

⁶⁵ See *Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154 (4th Cir. 1993).

⁶⁶ See *Baxter v. C.A. Muer Corp.*, 941 F.2d 451 (6th Cir. 1991); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 986 (6th Cir. 1991); *Makar v. Health Care Corp. of Mid-Atlantic*, 872 F.2d 80 (4th Cir. 1989) (holding participant's action seeking benefits under a group health plan is barred where participant failed to exhaust the plan's administrative procedures.)

⁶⁷ The Privacy and Security Rules apply to virtually all employer and union-sponsored health plans including fully insured health programs. However, a group health plan may be exempt if it has less than 50 participants, is self-administered, and is funded exclusively from the sponsoring employer's general assets. In addition, certain otherwise applicable requirements do not apply to certain small, fully-insured plans.

⁶⁸ Codified at 42 U.S.C. Section 1177.

⁶⁹ See *FMC Corp. v. Halliday*, 498 U.S. 52 (1990).

⁷⁰ See *id.*

⁷¹ 2003 WL 21982822 (D.D.C. August 14, 2003).

⁷² "The TPA may desire to modify this if its involvement in preparation or amendment of the Plan is minimal."

⁷³ Plan sponsors typically should not reserve the right to make a final determination on benefit denials. The TPA may want more specific provisions as to the appeals process if the Plan Sponsor reserves the right to make final determinations on benefits denials under the Plan.

⁷⁴ Many service contracts separate out claim recovery services such as pursuit of overpayments due to provider billing errors, retroactive social security awards, workers compensation awards, coordination of benefits disputes or fraud and abuse as a separate service provided by the Service Provider under the Agreement. In these cases it is important to set forth who has authority to compromise or settle claims for recovery and the TPA will typically seek the cooperation of the Plan Sponsor in the prosecution of any legal proceedings.

⁷⁵ Note: These provisions do not substitute for the provisions necessary to comply with HIPAA's business associate agreement requirements. The contract should also specifically incorporate these requirements.

⁷⁶ Sample provisions taken from sample language for business associate agreements published by the Office of Civil Rights of the Centers for Medicare & Medicaid Services at 67 Fed. Reg. 53182, 53264 (August 14, 2002).

⁷⁷ *Id.* CMS notice reflects its intention that words or phrases contained in brackets in its supplied model language are intended as either optional language or as instructions to the users of these sample provisions and are not intended to be included in the contractual provisions.