

The Benefit

August 2008



2008 BOARD OF DIRECTORS

- Jo Lester, President**
Group Resources, Inc. 2100 Ross, #900
Dallas, TX 75201
214/922-8880; 214/922-9802 fax
jlester@groupresources.com
- Gary Chapman, Immed Past President**
HealthFirst TPA, Inc. 3333 Lee Parkway, #600
Dallas, TX 75219
214/665-9575; 214/665-9590 fax
gdchapman@hftpa.com
- Robyn Jacobson, Vice President**
Entrust, Inc. PO Box 441588
Houston, TX 77244-1588
281/368-7878; 281/368-7828 fax
rjacobson@entrustinc.com
- Joanie Verinder, Secretary/Treasurer**
Group & Pension Administrators
Park Central 8, 12770 Merit Dr., 2nd Floor
Dallas, TX 75251 972/744-2528;
972/238-8924 fax joaniev@gpatpa.com
- Sheryl Bonner, Director**
Boon-Chapman PO Box 9201
Austin, TX 78766
512/233-7182; 512/459-1552 fax
sbonner@boonchapman.com
- Sam Francis, Director**
Jl Specialty Services, Inc. 10535 Boyer Blvd.,
#100 Austin, TX 78758
512/427-2302; 512/427-2304 fax
sam.francis@jicompanies.com
- Jay McIlraith, Director**
IMS PO Box 15688
Amarillo, TX 79105
806/373-5944; 806/373-3121 fax
jaym@ims.net
- David Smith, Director**
Smith Administrators 3800 Sandshell Dr., #260
Fort Worth, TX 76137
817/867-2582; 817/335-9734 fax
dsmith@smithadmin.com
- Clint Wilson, Director**
Mutual Assurance Administrators Inc.
4004 Belt Line Rd., #160
Addison, TX 75001 972/774-1100 x223
972/774-1218 fax clintwilson@maa-tpa.com
- Fred Newman, Vendor Advisor**
Interface EAP 10370 Richmond Ave., #1100
Houston, TX 77042
713/781-3364; 713/784-0425 fax
fnewman@ieap.com
- John Farnsley, Vendor Advisor**
HealthSmart Preferred Care
2002 W Loop 289, #103 Lubbock, TX 79453
806/473-2542; 806/473-2525 fax
jfarnsley@healthsmart.net
- Burnie Burner, Legal Counsel**
Long, Burner, Parks & DeLargy
106 E. Sixth Street, #300 Austin, TX 78701
512/474-1587; 512/322-0301 fax
bburner@longburner.com
- Bob Kamm, Lobbyist**
The Law Offices of Robert Kamm
1304 Guadalupe Austin, TX 78701
512/477-2008; 512/477-2029 fax
bob@robertkamm.com

Laura Firestone CPA, Exec Director
PO Box 380236 Duncanville, TX 75138-
0236 972/572-1551; 972/709-0611 fax
admin@tpbaa.com www.tpbaa.com

A Message From The President

August all ready! As the beginning of a new school year approaches, TABA is preparing for a new year also – the next legislative session. There are several bills on the horizon that could impact our ability to do business in the state of Texas. We need every TABA member to be involved and to help us educate our legislators about who we are and what we do. If you have not visited with your state Senator or House Representative, you need to do so. Getting your clients involved is also a great tool. Politicians like to hear from their constituents on issues that impact them directly.

Speaking of being involved, I hope to see each of you at the TABA Fall Conference, September 8-9. There will be legislative updates as well as informative break-out sessions. TABA has been recognized on a national level for our ability to stay informed and get things done. The bill that we developed and passed last legislative session has become the model for legislation in many other states. Everyone needs to get involved!

If you haven't registered, do it today! I look forward to seeing you in Westlake in September.

Jo Lester
TABA 2008 President

TABA 2008 Calendar of Events

TABA	SIIA	SPBA
<ul style="list-style-type: none"> 2008 Fall Conference September 8-9, 2008 Board of Directors Mtg September 10, 2008 Marriott Solana Hotel Westlake, TX 	<ul style="list-style-type: none"> 28th Annual National Educational Conference & Expo October 5-8, 2008 JW Marriott Desert Ridge Phoenix, AZ 	<ul style="list-style-type: none"> 2008 Fall Conference October 27-29, 2008 Hyatt Regency Hotel Minneapolis, MN

The Future of HRA and HSA OR, Is The Sky Really Falling?

Contributed by Mike Whitney, Flexible Benefit Group, Inc.

As TPAs, our stock in trade is to provide knowledgeable benefit plan services to employers and plan participants. Almost every year something will happen that causes many to run in circles like Chicken Little, crying that the sky is falling and our industry is going the way of the dodo bird. Then we wake up, examine the situation and find ways to increase our business using whatever was going to kill us.

Today there are several reasons for concern. One area of concern is the election and programs to nationalize healthcare under a single payer system and/or efforts to replace group insurance with individual insurance. Of course while we may be concerned about those issues there is not much we can do about them in our day to day lives. We can get involved in supporting whomever espouses a view that fits ours but we can not directly incorporate that into our current business.

However, there is another concern of more immediate impact which can be and should be part of our current business plan. Premium inflation and its impact on the renewal rate of existing group insurance plans is something we face every day. It is something that we have to address if we hope to keep and grow our block of business. And, it is something that we have effective tools that do allow us to meet the client's needs.

For example, consider these three cases:

Case #1, self funded employer with 150+ employees. They had a triple choice plan (\$500 deduct with Dr. and RX co-pays, \$1,000 deduct with larger co-pays, \$1,500 deduct with no co-pays) but were not realizing the appropriate savings because the employees were stuck in the low deduct plan. The employer added an HSA and adjusted the employee premiums to motivate movement from the low deduct to the high. Over the past 4 years more than 80% of the employees moved and the employer was able to hold their budget FLAT.

Case #2, self funded with 500+ employees. They also had a similar multiple choice plan and also had been unable to motivate employees to move to the higher deductible plans. This employer added an HRA with a threshold deductible and full carry over of unused value to either pay deductible eligible charges over the threshold or to fund a post retirement medical spending account for any section 213 (d) eligible medical, dental or vision expense. By shifting the focus to post retirement value the employer was able to motivate employees to move to higher deductibles resulting in a medical inflation rate of less than 5% per year.

Case #3, fully insured with 100 + employees. They had a \$1,000 deductible 80/20 of \$5,000 with a \$30 Dr. and \$15/\$25/\$50 RX co-payments. They were facing a 15% rate increase. They bought a \$5,000 deductible 100% co-insurance fully insured with no co-payments. They added an HRA (with no carryover [MERP]) that paid 80% of deductible eligible claims in excess of \$500 for one plan (Plan A) or 100% of deductible eligible claims in excess of \$1,500 single or \$3,000 family for a second plan (Plan B). Plan B participants are then eligible for an HSA. The combined cost of the \$5,000 deductible plan and the HRA/MERP was 10% LESS than the current plan. The employer used a portion of the savings to make matching contributions to the HSA (inside the 125 plan) to motivate employees to accept Plan B. The plan allowed the employer to hold their budget flat for the first two years.

Or consider this case. Imagine you are an employer with 23 employees, 11 with dependents. You provide a \$500 deduct, 80/20 of \$10,000 for a \$2,500 Out Of Pocket (in network) with a \$25 Dr. and \$15/\$30/\$50 RX co-pay plan. Annually you collect \$36,432 from your employees and pay \$175,210 yourself for a total annual premium of \$211,642. You are facing a 15% rate increase.

We offer you a \$2,500 deductible 80/20 of \$12,500 plan with Blue Cross with a total annual premium of \$145,828. If you and your employees pay the same ratio you save \$54,485 and your employees save \$11,329. Of course, they will hate you for forcing the high deductible so we also offer you an HRA/MERP that will reimburse 80% of deductible eligible charges from \$500 to \$2,500 then 20% of co-insurance eligible charges from \$10,500 to \$15,000 resulting in the participant having an OOP risk of \$2,500.

The maximum operating cost of the HRA/MERP (including administration and assuming everybody has claims in excess of \$15,000) is \$235,968. The annualized cost of the current plan at the 15% renewal is \$243,398. The expected cost of the HRA/MERP is \$170,352. Funding to the expected costs at the same employer/employee ratio as the current results in savings for the employer of \$34,182 and for the employees of \$7,107 over the current plan.

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The Future of HRA and HSA OR, Is The Sky Really Falling?

Contributed by Mike Whitney, Flexible Benefit Group, Inc.

Continued from page 2

You, as the employer could use half of that savings (\$17,000) to fund an FSA of \$500 for each single employee and \$1,000 for each employee with dependents. This would be as an offset for the loss of the co-pays and would effectively pay the deductible. Or you could simply provide your employees with that amount as a benefit bonus and allow them to do as they wish.

What would you do? Would you accept your rate increase, passing a pro-rata share along to your employees and swallowing an addition of \$26,281 of cost? Or would you move to the HRA/MERP and have a probable savings of \$34,182? Or would you move to the HRA/MERP and provide some of that savings for your employees as shown above?

Are you prepared to design and operate these plans? Do you think your clients might want to see these options? Do you want more information on how these plans work? We will be spending 2 hours of CE eligible time discussing the details at the TABA Fall Conference on September 8. We hope to see you there!

Flexible Benefit Group, Inc. (FBG), a Dallas, Texas based TPA, specializes in designing and providing administrative services to employers who sponsor cafeteria plans for their employees. The services provided include assisting the employer in selecting permitted benefits for the plan, assuring proper preparation and set up of the plan documents, tracking plan operations to ensure compliance with cafeteria plan rules in ongoing operations, reviewing claims (for flexible spending accounts), tracking account values for all benefits, preparing the required discrimination reporting, providing regular reports of plan status to both employer and employees, and providing the information for the form 5500 at year end, if required. FBG also provides full 105, HRA and HSA services.



Interface EAP

An Update on Mental Health Parity

Contributed by Fred Newman, Interface EAP

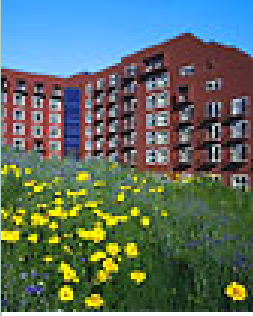
Mental Health Parity continues to move forward at the federal level. As expected, father and son from the Kennedy clan are playing a key role in negotiating a compromise with the subcommittee authorized to reconcile the differences between the Senate and House versions.

Ted Kennedy recently stated his goal of bringing a compromised bill out of Congress and to the President by the end of July. Apparently that did not happen, but we have been told by Patrick Kennedy's office that parity is a priority for this session of Congress. Patrick Kennedy's office further advised us that the major hurdle right now is how to pay for the parity bill if it becomes law. The House version contains provisions in this area that are not acceptable to the Senate side.

The only compromise that has been reported to date deals with mandating all diagnosis in the DSM-IV be covered under parity (the House version). It has been stated that the subcommittee has agreed to remove that provision and move towards the Senate version, which would allow employers to determine which diagnosis they cover. I am not sure how the other critical item between the two bills will be settled – which has to do with mandating non-network mental health coverage if non-network medical coverage is provided. The House bill mandates it while the Senate version does not. As I stated in my article published by TABA last year on parity, the other differences between the two bills are not significant in my mind. The only other major unknown is what the effective date would be for parity if it does pass in this session. My guess given we are into August, and it would be September before a final bill could come out of Congress with their summer break underway, most likely the effective date would be for plans renewing on or after January 1, 2010, but obviously that is an unknown at this time.

The one question that I have not heard anyone ask is “what impact will parity have on stop-loss?” I expect stop-loss rates to be affected by parity, as there will be real exposure for large claims under many ERISA plans for the first time. This is one key area that TPAs need to be looking at addressing. I am sure your clients will be asking for answers to minimize this impact.

Join me at the TABA 2008 Fall Conference at the Dallas Marriott Solana on Tuesday, September 9, 2008 from 3:30pm to 4:30pm where I will provide “A Proactive Solution” to various mental health issues.



TEXAS ASSOCIATION OF BENEFIT ADMINISTRATORS

2008 Fall Conference/Exhibition

Marriott Dallas Solana Hotel

Westlake, Texas

September 8-9, 2008



There's Still Time To Register For This Year's Conference!

You are invited to join the Texas Association of Benefit Administrators (TABA) at the 2008 Fall Conference & Exhibition, September 8-9, 2008. Attending the Fall Conference and Exhibition offers you an opportunity to meet with your peers and talk one-on-one with companies that offer the products and services you need to build an effective health benefit plan. This year's conference will feature keynote speaker and renowned author, Chip Bell, founder of the Chip Bell Group, sponsored by CVS/Caremark. Other topics of interest will include information on HSAs and HRAs, risk management and self funding, legislative issues affecting TPAs, a TPA panel discussion on marketing and sales tips and mental health parity.

Meeting Registration

Registration fee includes all food and beverage functions, admission to the exhibit hall and all education sessions. Please note that registration fees are slightly higher after August 25, 2008. Dress code for the conference is business casual.

Refund and Cancellation Policy

Conference registration cancellations received in writing prior to August 25, 2008 will receive a refund less a \$25 administrative processing fee. All refunds will be processed after the conference. No refunds will be issued at the conference.

Hotel Information/Location

Please make your reservations directly with the Marriott at 800-228-9290 or 817-430-5000. The hotel is located at 5 Village Circle, Westlake, TX 76262, phone 817-430-5000. Indicate that you will be attending the TABA Conference, September 8-9, 2008. The TABA room rate is \$134 for a single/double/triple. Reservations must be made on or before **August 17, 2008**, to receive the guaranteed room rate and subject to availability within our room block..

TABA Fall 2008 Conference & Exhibition Schedule

Monday, September 8, 2008

- 8:00a – 4:00p Exhibit Hall Set-Up
- 8:00a Golf Tournament, Sky Creek Ranch Golf Club
- 1:00p – 5:00p Registration Desk Open
- 3:00p – 5:00p **Session I – “The Future of HSAs and HRAs” (Course #51617CG020; 2 hr CE; Prov #3913)**
Speaker: Mike Whitney, CEO, Flexible Benefit Group, Inc.
- 5:00p – 6:00p **Session II—”Risk Management & Benefits of Self Funding vs the BUCAs” (1 hr CE pending approval)** Speaker: Barbra Rabinowitz, Berry, Odom & Rabinowitz, LLP and Adam Russo, The Phia Group
- 6:00p—7:30p Early Bird Reception with Exhibitors/Sponsors; Exhibitor Door Prizes/Golf Tournament Winners

Tuesday, September 9, 2008

- 7:30a—5:00p Registration Desk Open
- 7:30a—8:30a Breakfast with Exhibitors/Sponsors
- 8:30a—9:00a Annual Membership Meeting: Reports from the President, Secretary/Treasurer, Membership Chair and 2008 Nominating Committee Report & Elections; 2009 Legislative Agenda
- 9:00a—10:00a **Session III—”Legislative Issues Affecting TPAs”** Speaker: Bob Kamm, TABA Lobbyist and Burnie Burner, TABA Legal Counsel (1 hr CE pending approval)
- 10:00a—10:15a Morning Break
- 10:15a—12:00p **CVS Caremark Keynote Speaker: Chip R. Bell, The Chip Bell Group** “Customer Loyalty Guaranteed: Growing Business by Creating, Leading and Sustaining Remarkable Service”

12:00p—1:30p Lunch with Exhibitors/Sponsors; **Session IV—”The Problem With Potentially Punitive PPO Payment Provisions”** Speaker: Andy Willoughby, Group Resources

1:30p – 3:00p **Session V — “TPA Panel Discussion: Industry Issues Facing TPAs Today” (1.5 hrs CE pending approval)**
 Speakers: Steve Rasnick, Self Insured Plans LLC; Dan Riston, Managed Care of America; Ron Zoeller, Aze-ros Healthcare LLC

3:00p – 3:30p Refreshment Break with Exhibitors/Sponsors

3:30p - 4:30p **Session VI – “A Proactive Solution” (1 hr CE with Provider #2690)**
 Speaker: Fred Newman, Interface EAP

4:30p – Exhibitor Booth Breakdown

NOTE: You must attend at least 90% of each CE session in order to receive CE credit.

Wednesday, September 10, 2008

8:00a – 12:00p TABA 2008 4th Quarter Board of Directors Meeting

Conference Attendee Registration Fees:

	Members		Non-Members	
	Thru 8/25	After 8/25	Thru 8/25	After 8/25
TPA				
Initial Registration	\$265	\$295	\$395	\$425
Additional Registration	\$225	\$255	\$355	\$385
Third Registration	\$110	\$140		
Non-TPA (i.e. Vendor)				
Initial Registration	\$285	\$315	\$630	\$660
Additional Registration	\$245	\$275	\$420	\$450
Special One Day Registration (Monday ONLY)				
Monday, September 8	\$ 55	\$ 80	\$110	\$160

TABA Golf Tournament • Price per Player: \$70

Exhibitor Fees (incl 1 registration): Member Company \$800 Non-Member Company \$1300
Additional Exhibitor Personnel: \$190 per person

Name _____

Company _____

Additional Registrant Names and Email Address For Each:

Address _____ Ste. # _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

Golfers: Handicap _____ Pair Me With _____

Member Registration \$ _____

Non-Member Registration \$ _____

Additional Registrants from Same Company (#____). \$ _____

Golf (**\$70 per player**) \$ _____

Exhibitor Fee (attach signed contract). \$ _____

Additional Exhibitor Personnel \$ _____

Fall 2008 Conference Exhibitor/Sponsor Information and Contract

Instructions: Complete all information blanks. Sign, date, and mail this Agreement with check made payable to: TABA. Texas Association of Benefit Administrators, referred to as "TABA" and the undersigned firm, referred to hereinafter as "Exhibitor," and the Renaissance Hotel, referred to hereinafter as "Hotel" agrees as follows:

1. Exhibit Fees are \$800 for a member company and \$1300 for a nonmember company; this includes one complimentary registration to the Conference. Exhibit Fee is payable upon return of signed contract. Signed contract and payment must be received by August 25, 2008, to guarantee exhibit space for the 2008 Fall Exhibition.
2. TABA will provide exhibit space and facilities as described in accordance with items two through nine below.
3. Due to extremely limited space only Tabletop Exhibits will be allowed.

Does your booth exceed 6' and is less than 10'? yes no

If you choose to bring exhibit that exceeds 10' wide, you will be charged for two booths. _____ (*please initial*)

Do you need Internet access? yes no Do you need electricity? yes no If yes to either, please contact the hotel directly. You will be responsible for paying any charges to the hotel.

Explain any special needs for display:

Description of Exhibitor Company's Services/Products and Display Items:

4. Exhibitors are limited to products and services used by and useful to Professional Benefit Administrators. The Exhibits Manager will make the final determination as to whether this criteria is met.
5. Exhibitor may cancel this agreement in writing prior to August 25, 2008 and receive a refund less a \$25 administrative processing fee. No refunds will be made for cancellations after this date.
6. The Hotel or TABA shall not be liable to the Exhibitor for any damage to, destruction or loss of an exhibit or property of the Exhibitor by fire or other casualty, whether caused by the negligence of the Hotel, TABA, their officers, agents, staff, employees or otherwise. The Exhibitor waives all claims for such losses, and Exhibitor shall indemnify and hold the Hotel and the TABA harmless from such claims.
7. Exhibitors or their agents shall not injure or deface the walls or carpets or the equipment or the booths provided. Exhibitors are forbidden to drive tacks, nails or screws into the walls or woodwork in the exhibit area. Should such damage occur, the Exhibitor is liable to the owner of the property so damaged.
8. TABA reserves the right to refuse any exhibit or Exhibitor and further reserves the right to close down any exhibit or Exhibitor for breach of this agreement, or for cause. In the event that an exhibit is closed down, TABA's liability is limited to the refund of contracted and paid space.
9. Exhibitor declares the value of this exhibit at: \$ _____. Exhibitor declares the weight of this exhibit at: _____ #. And stays within the 10' width guidelines _____ (*initial*).
10. Exhibitor materials may be shipped directly to the hotel within 3-5 days prior to the event start date. Shipments received earlier may be refused and returned to sender. There will not be any charge for storage up to 15 boxes and will be a \$5.00 storage fee for each additional box. All materials should be clearly marked with the Group Name, Meeting Date, Group Contact Person and Hotel Sales Manager Name, Frehiwot Tesfa.

Please type or print:

I, the undersigned, have read all of the above and will abide by the same:

Representative Name _____

Signature of Representative _____

Signature of TABA Representative _____

Return forms with payment to: TABA, P.O. Box 380236, Duncanville, TX 75138-0236 or fax credit card payments to 972/709-0611. For Conference Inquiries call: 972/572-1551 or email: admin@tpbaa.com.

Fall 2008 Sponsor Packages and Events

Choose One Event from Your Category

PLATINUM \$4000

- One 6' exhibit table and choice of location
- 2 complimentary registrations
- Your company brochure inserted in the conference registration packet
- Company logo and description on TABA website
- Recognition from the podium at sponsored event and other gatherings
- Recognition by appropriate signage at sponsored event and at booth
- Recognition on conference program
- Recognition by distinctive badge ribbons
- List of all conference attendees

GOLD \$2250

- One 6' exhibit table and choice of location
- 1 complimentary member registration
- Company logo and description on TABA website
- Recognition from the podium and by signage at sponsored event
- Recognition by distinctive badge ribbons
- Recognition in conference program
- List of all conference attendees

SILVER \$1750

- 1 complimentary member registration and golf player fee
- Recognition from the podium and by signage at sponsored event
- Recognition by distinctive badge ribbons
- Recognition in conference program
- List of all conference attendees

BRONZE \$1200

- Recognition from the podium and by signage at sponsored event
- Recognition by Distinctive badge ribbons
- Recognition in conference program
- List of all conference attendees

EVENT OPTIONS

- Breakfast w/Exhibitors Tuesday
- Lunch w/Exhibitors Tuesday (*Swiss Re*)
- Golf Tournament Title (incl 2 players)
- Keynote Speaker (*CVS Caremark*)

EVENT OPTIONS

- Early Bird Reception Monday
- Martini Bar—Reception Monday (*Phia Group*)
- Afternoon Break Tuesday (*Hines & Assoc*)

EVENT OPTIONS

- Golf Tournament Beverage Cart
- Golf Tournament Lunch
- Golf Trophies

EVENT OPTIONS

- CE Sessions (4 available)
- Registration Bags (*WellDyneRx*)
- Name Badge Lanyards (*WellDyneRx*)
- Golf Tournament Hole (*WellDyneRx*)

Method of Payment

I have enclosed a check for \$ _____ OR Charge \$ _____ to VISA MasterCard AMEX
Card Number _____ Exp. Date _____
VAL Code (*last 3 digit number found on reverse side of card*) _____
Name of Cardholder (please print) _____
Billing Address _____ Phone _____
Signature _____

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The Importance of the Supreme Court's Decision in *MetLife vs. Glenn*

Contributed by Adam V. Russo, Esq., The Phia Group LLC

The issue of discretionary authority when administering an ERISA plan and the deference federal courts must show to such discretion, has been the new hot topic in ERISA law. The Supreme Court first stated in *Firestone Tire and Rubber Co. v. Bruch* that health plan administrators are due deference when asserting discretionary authority administering a plan. Federal courts could only overturn administrator benefit determinations if they find that the administrator has abused its discretion, which is an arbitrary and capricious standard of review.

While many have tried to chip away at the deference shown to administrators over the past twenty years, few have succeeded in overcoming the ultra-deferential standard of review. As a result, plan administrators have rarely had their decisions overturned, so long as those decisions have some evidence to substantiate them, and are thus not arbitrary or capricious. One basis for questioning administrative decisions that has been raised repeatedly over the past two decades relates to administrators with conflicts of interest - a personal stake in how the claims are processed.

In *MetLife Insurance Co. v. Glenn*, 2008 U.S. LEXIS 5030 (U.S. June 19, 2008) the questions that flow from the conflict of interest issue were addressed by the Supreme Court. The Court began by asking what constitutes a conflict and is such a conflict created when the same company both administers and funds a benefit plan, and when such a conflict does exist how is it to be factored into a court's review of an administrator's denial of benefits?

The story began when Glenn brought an ERISA claim against MetLife in 2002, alleging that the company had wrongfully denied her benefits. MetLife both processed the claims they receive and pay the claims with their own funds.

MetLife had denied Glenn's claims based upon an analysis of records by their own expert and select documents produced by Glenn's own doctor; referring to a report in which Glenn's doctor had deemed Glenn physically capable of performing sedentary work. The district court ruled against Glenn, finding that MetLife had thus not abused its discretion. Glenn appealed.

The court of appeals overturned MetLife's decision. Before considering what MetLife based its decision upon, compared to other evidence available to the administrator, the court expressed concerns that MetLife - both as plan sponsor and administrator - was operating under a conflict of interest that would have to be "weighed" when considering the administrator's procedures.

The court discovered that MetLife had never addressed numerous letters from Glenn's doctor stating explicitly that Glenn could not withstand the emotional stress of even sedentary work. Likewise, MetLife did not address a ruling by the Social Security Administration that Glenn was completely disabled. The court reasoned that while MetLife's decision was based upon some evidence, when weighed against the evidence contrary to their decision and in light of the conflict of interest, their decision could not stand.

MetLife appealed the decision to the Supreme Court. There, MetLife argued that MetLife's administration of claims is unlikely to be affected by the company's concurrent obligation to pay benefits because of "the realities of the insurance business." Furthermore, MetLife claimed to have strong business incentives to serve as a fair administrator and that the financial incentive for MetLife to deny claims to avoid having to pay benefits is less than it seems. Indeed, MetLife argued that like all insurance carriers, the company structured its business in anticipation of having to pay benefits.

According to Glenn, MetLife acted under "an obvious conflict of interest." Every claim that MetLife denied represented payments that MetLife would not have to make. Furthermore, there are documented cases of other insurers adopting a practice of denying payable claims for the purpose of enhancing profits.

The Supreme Court ruled on June 19, 2008 in favor of Glenn, affirming the Court of Appeals' decision. This ruling makes it clear that a company which both administers and funds a benefit plan operates under a conflict of interest that must be considered as a factor in a court's review of claim denials. The question now, of course, is how much weight will such a conflict have? Would a conflict of interest change the standard of review or be a tie breaker when evidence could equally support or counter the administrator's decision.

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The Importance of the Supreme Court's Decision in *MetLife vs. Glenn*

Contributed by Adam V. Russo, Esq., The Phia Group LLC

Continued from page 8

According to the Supreme Court's majority opinion, the Court of Appeals properly weighed the conflict of interest "as a factor determining whether there was an abuse of discretion." The Court stated that there should still be a "deferential standard of review"; that the presence of a conflict of interest does not automatically authorize a court to apply heightened scrutiny to a claim denial normally analyzed only for an abuse of discretion. Instead, the conflict simply ranks as "but one factor among many that a reviewing judge must take into account."

Once the court decides the relative importance of the conflict of interest, it must examine the evidence substantiating the administrative decision. If these factors, viewed deferentially, still result in a "close balance" for and against the decision, or fail to adequately support the decision even when looked at deferentially and leaving the court uncertain as to whether the claim denial was reasonable, the conflict of interest may serve as a tiebreaker.

As if this new test wasn't vague enough, conflicts of interest are assigned "weights." The weight is the relative importance of the conflict of interest in the particular case. If the conflict seems more important or seems to have a direct impact on the decision, the court needs to search more when considering evidence contrary to the administrator's decision. If the conflict seems to have little impact on the decision, the court will apply what almost seems like a classic deferential review.

Unlike the majority, that assigns a weight to all conflicts, Chief Justice Roberts wrote that he would only give a conflict of interest weight if circumstances demonstrated that the conflict had actually influenced the claim denial in question. In dissent, Justice Scalia and Justice Thomas criticized the holding as creating a vague test with no applicability. An administrator's conflict of interest, they wrote, should not be weighed at all unless the administrator could first be shown to have had an improper motive during the process.

The bottom line is that the decision does not change the standard of review since the decision does not itself imply a rule that would entail large scale de novo review. The decision does not create or encourage special procedural or evidentiary rules. Nor does the decision purport to provide a detailed set of instructions.

So how does this decision impact administrators' claim processing? Plan administrators should act preemptively to "lessen the weight" of any potential conflicts. You should take steps now to reduce bias, remove the potential for self-serving when denying claims, separate the source of funding from the claims administrator, and enforce the Plan in strict accordance with the terms of the Plan Document.

Adam V. Russo, Esq. is co-founder of the The Phia Group LLC., a claims recovery subrogation company, based in Braintree, MA and is partner at the Law Offices of Russo & Minchoff, based in Boston, MA. Mr. Russo can be contacted at arusso@phiagroup.com or 781-535-5678. The contents of this document are not deemed to be legal advice. Specific facts and circumstances should be reviewed and analyzed by your in-house legal counsel, as well as any individual self-funded welfare benefit plan and its legal counsel, in light of specific facts, circumstances, SPDs, subrogation, reimbursement and/or set-off provisions and specific state and federal laws and regulations.



*Enjoy A Phia—Tini
Join Us At The TABA Fall Conference
September 8-9, 2008
Dallas Marriott Solana Hotel, Westlake, Texas
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Monday Evening Reception*

The Ingenix Saga Continues....

Contributed by *Barbra Rabinowitz, Berry, Odom & Rabinowitz, LLP*

A Court Approved \$255 Million Settlement Places The Use Of The Ingenix Database In The Spotlight Again

In the April 2008 issue of *The Benefit*, I discussed the New York Attorney General's recent challenges to Ingenix, Inc.'s database used for out-of-network provider reimbursements. Specifically, the New York Attorney General's investigation found that Ingenix Inc. operates a defective and manipulative database to set reimbursement rates for out-of-network medical expenses, and that the "reasonable and customary" rates produced by Ingenix (and relied upon by insurers and some third-party administrators) were remarkably lower than the actual cost of typical medical expenses. While, to my knowledge, the New York Attorney General has yet to file suit against Ingenix or its parent (UnitedHealth Group), at least one insurer, Health Net, Inc. has been the subject of three class action lawsuits arising out of its use and reliance on Ingenix's database in reimbursing out-of-network providers.

The three class action lawsuits (*Wachtel v. HealthNet*, *McCoy v. HealthNet*, and *Scharfman v. HealthNet*) alleged that Health Net used a flawed database produced by Ingenix to reimburse out-of-network providers. The plaintiffs were beneficiaries of employee benefit plans that purchased point of service insurance policies from Health Net (New Jersey).² In determining what percentage of an out-of-network charge Health Net paid for a particular service, Health Net (like most insurers and third-party administrators) looked to the usual, customary and reasonable (UCR) charge, which it defined based on its reliance on data contained in national databases provided by Ingenix. The plaintiffs alleged that, in so doing, Health Net (New Jersey) relied on "antiquated data and improper methods to define UCR charges, thereby violating both New Jersey law and the Health Net companies' duties as statutory fiduciaries under ERISA. The plaintiffs filed suit under § 502 of ERISA to recover benefits and to redress the alleged violations of fiduciary duties and failure to supply information to beneficiaries.³

Apparently Health Net was also charged with violations of the U.S. Racketeer Influenced and Corrupt Organizations Act (RICO) by systematically underpaying its plan members.⁴

On July 24, 2008, it was announced that the U.S. District Court Judge approved a \$255 million settlement in the three class action lawsuits against Health Net and several of its subsidiaries involving more than two million people in several states.⁵ Pursuant to the settlement, Health Net agreed to pay \$215 Million to the members of the certified class and agreed to change its business practices which is valued at \$40 million.⁶ Health Net denies any wrongdoing.⁷

Consumers appear to be jumping on this bandwagon, as evidenced by a lawsuit recently filed in Connecticut against Ingenix itself (as well as several insurers), alleging that Ingenix and the insurers conspired to calculate lower rates using flawed Ingenix data.⁸

As I have previously noted, this issue has an enormous impact on self-insured plans as many third-party administrators use the Ingenix data. While those affected in the industry are eagerly awaiting the outcome of the investigation by the New York Attorney General, it appears that more and more consumers may want to capitalize on any adverse determinations and outcomes at the courthouses around the country arising out of the use of the Ingenix data. However, again, to the extent the goal of regulators and/or the effect of the class action suits is to increase payments to out-of-network providers, it may be likely that there may be a similar increase in the consumers cost of coverage. In any event, third party administrators may want to re-evaluate their use of the Ingenix database when defining UCR.

Adam Russo and I will be presenting a presentation on "Risk Management & Benefits of Self Funding vs. the BUCAs" at the TABA Fall Conference, on Monday, September 8, 2008. Come join us!

¹ See Wilentz, Goldman & Spitzer, P.A., Release, 7/24/08, www.wilentz.com.

² See *Wachtel v. HealthNet, Inc., et al.*, 482 F.3d 225, 227 (3rd Cir. 2007).

³ *Id.*

⁴ See Wilentz, Goldman & Spitzer, P.A., Release, 7/24/08, www.wilentz.com.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*



Using Retail-Hosted Clinics To Help Lower Health Care Costs

Unique health care delivery solution provides cost-savings and convenience to your clients and plan participants alike. Contributed by Eric McKinnon, R.Ph., CVS Caremark

Like many plan sponsors, your clients seek ways to lower their overall health care costs and improve the health of their plan participants. Retail-hosted health clinics are a new health care solution that emerged earlier this decade. They provide plan sponsors and plan participants with access to an efficient and cost-effective health care delivery that complements traditional health care services.

Retail-hosted clinics typically:

- Treat common family ailments, such as ear infections and strep throat; some offer vaccinations and health screenings
- Reduce costs when compared to the emergency room or urgent care center for similar treatment
- Offer consumer-friendly hours, are open seven days a week, including evenings and weekends, with no appointment necessary
- Fit consumers' lifestyles with locations near home and work, in pharmacies, grocery stores and other retail settings
- Are staffed by board-certified practitioners, who can prescribe medications (when clinically appropriate) for treatment of acute symptoms and counsel patients
- Are supervised by local board-certified, practicing physicians
- Provide referral listings to primary care physicians for patients who lack "medical homes"
- Offer in-network status with major health insurers

Retail-hosted clinics are not designed to be a replacement for primary care. Rather, they provide adjunct services when consumers cannot see their regular providers. These clinics do not treat complex situations or chronic illnesses, such as wound care, trauma or acute asthma. Many clinics will refer patients to a primary care provider for ongoing management and treatment of a chronic condition — and triage patients to an emergency room if the situation warrants.

Anticipated benefits of retail-hosted health clinics include:

- **For third-party administrators:** Enhance offerings by providing an innovative, cost-effective option to clients who want to help minimize health care costs
- **For plan sponsors:** Help lower health care costs, and help increase productivity by reducing health-related absenteeism
- **For plan participants:** Obtain affordable, quality care when it is needed

Innovative, Affordable Health Care Delivery from MinuteClinic®

MinuteClinic provides high-quality care for common family ailments, as well as preventive services including vaccinations and screenings. A subsidiary of CVS Caremark Corporation, MinuteClinic is the pioneer and largest provider of retail-hosted health care in the United States. It is the only retail-hosted clinic to earn accreditation from The Joint Commission. MinuteClinic can help make health care more convenient and affordable for consumers, provide cost savings for your clients, while also offering implementation and reporting support to make it easy to sell this solution to your clients.

Innovative solutions that can help your clients lower their overall health care costs include:

- **Copay reduction programs**—Reduced copays* are one of the biggest incentives to drive MinuteClinic usage; MinuteClinic is in network with most major insurers
- **A flu vaccination program**—Flu shots significantly decrease upper respiratory illnesses and reduce absenteeism; MinuteClinic offers flu shots at all locations, with no appointment necessary, throughout the entire flu season (October-March)
- **Health screenings for cholesterol, diabetes, hypertension and obesity****— Screenings help identify health problems before they become major medical issues

Typical Charge for a Sore Throat Visit ¹		
MinuteClinic® Cost	Urgent Care Cost	ER Cost
\$69*	\$130	\$328
Savings	\$61	\$259

* \$59 for visit, \$10 for strep confirmation test

MinuteClinic provides plan participants with significant savings when compared to similar treatment provided at an urgent care center or emergency room.

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Using Retail-Hosted Clinics To Help Lower Health Care Costs

Unique health care delivery solution provides cost-savings and convenience to your clients and plan participants alike. Contributed by Eric McKinnon, R.Ph., CVS Caremark
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Focus on Consumer Trust

The board-certified practitioners at MinuteClinic follow evidence-based guidelines established by the American Academy of Family Physicians (AAFP), American Academy of Pediatricians (AAP) and Institute of Clinical Systems Improvement (ISCI). The following MinuteClinic practices also foster consumer trust:

- Use of an electronic medical record system that helps assure privacy
- Visit summaries sent to primary care physician, with the patient's permission
- Referral listings to local primary care physicians who are accepting new patients
- Triage to a primary care physician or an emergency room if patient presents with symptoms outside the scope of treatment; MinuteClinic does not charge patients who present with symptoms that cannot be treated by the practitioner

Satisfaction surveys validate the MinuteClinic model. MinuteClinic delivers high patient satisfaction with a 97 percent patient satisfaction rate. Ninety-seven percent of MinuteClinic users are likely to recommend MinuteClinic².

Include MinuteClinic in Your Offerings

MinuteClinic has more than 500 locations in 25 states and is located inside select CVS/pharmacy stores. Visit www.minuteclinic.com for more information, including locations, services and treatment costs. Contact your CVS Caremark account representative for more information about MinuteClinic and how it can benefit your clients.

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for an office visit in accordance with a Plan, which may be a deductible, a percentage of the office visit price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

**Available in all states except: Maryland, Nevada, New York and Pennsylvania.

¹ 2005 HealthPartners Study

² MinuteClinic Patient Satisfaction Data, September 2007 to April 2008.

Market Strategies, "Retail Clinics: National Study of User and Non-User Attitudes, Preferences and Behaviors," April 2007.



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Helping TABA’s Legislative Efforts—Your Association has discussed a \$21,650 political action committee goal for this calendar year. The money, if available, would be contributed to Legislators to help them with campaign costs, as well as costs of being in office that the State does not cover. Legislators are paid \$7200 per year (\$600 per month). Many spend their own money to cover costs that don’t get reimbursed by the State. You and your employers can participate in the legislative process by helping legislators with these costs.

Here is a plan to meet that goal: We are asking each member TPA to commit to contributions in an amount equal to their membership fee. This amount will come from personal contributions from TPA owners and key employees. Corporate contributions are prohibited by Texas law. Many of our member TPAs already contribute in this manner but many do not. We need the support of all members! Also, we would ask that any TPAs not contributing to the level of their membership fee, to solicit an increase in contributions or broaden the base of contributors in their office. A number of the TPAs whose contribution level already exceeds their membership fee have found that its success lies in its ability to attract contributions from a number of their key employees. This has been brought about by a payroll deduction plan that makes contributing much easier. They have found that it is much easier to make a contribution of \$5 a week than to make a one time donation of \$250. The president of each TPA member company convenes a meeting of key employees. In the meeting, the president explains TABA’s legislative goals and why those issues are important to the company and to the industry. Each company establishes an annual company goal based on the number of key employees. If, for example, there are six key employees, the annual goal could be \$1000 with five employees paying in \$100 and the president \$500. Along with the annual goal, a payroll deduction is instituted for this expense. Each key employee will contribute \$8.33 per month; the president, \$41.66 per month. Once in place, the goal is met every year. No golf tournaments, no fancy galas, no auctions – and none of the time and planning those events require. Not very flashy, but it would be dependable, predictable, simple, and hugely successful.

TABA Political Action Committee “TABAPAC” Contribution Form

GOLD \$150 (\$12.50/mo.) **PLATINUM** \$300(\$25/mo.) **RUBY** \$600 (\$50/mo.)
DIAMOND \$1,200 (\$100/mo.) **OTHER** \$ _____

Note: Corporate contributions to TABAPAC are prohibited. Individual contributions only!

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Check the appropriate box(s) that apply:

() I have enclosed a **check** payable to TABAPAC for the selected level.
 () Please **charge** my contribution **Monthly/Quarterly/Annually** in the amount of \$ _____ to my credit card:
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*This authorization is to remain in force until TABA has received written notification from me of its termination. I authorize TABA to charge my credit card as shown above. I understand that the statement will read “Texas Professional Benefit Administrators Association.” I understand that contributions to TABAPAC are NOT tax deductible. **Mail checks to: TABA, P. O. Box 380236, Duncanville, Texas 75138-0236 OR fax credit card authorizations to 972-709-0611.***