



# THE BETTERLEY Report

## Managed Care Liability for Employers 2000: Benefits Plan Purchaser Coverage Attracts Significant Interest

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*Editor's Note: In this issue of The Betterley Report, we evaluate the insurance products designed to cover an emerging liability for employers: suits that allege injury caused by the managed care components of employee benefit plans. A product pioneered by Lexington, it is now offered by three additional insurance companies, including Chubb Executive Risk, TIG and Legion. We first covered this liability in 1996 with additional analysis in 1999. Both issues focused on the emerging liability, offering additional information on insurance coverage. Only Lexington wrote a meaningful amount of premiums.*

*With four carriers now in the market, we are focusing our analysis on the insurance product itself. Also included is Alden Bianchi's update of the liability for employers and the need for coverage. Alden wrote the liability analysis included in our two previous issues as well.*

*Since this area is evolving rapidly, please see our website (betterley.com) for updates.*

### Introduction

Historically, employers have been protected against liability claims by their employees that allege failures in medical care. Liability arising out of medical malpractice events did not extend to the employer, even if the employer's benefit plan was paying for the care, specified the provider and included managed care strategies to control cost.

Even if the employer was very active in designing the benefit plan and its usage and cost features, it could be sure that it was immune from successful suit.

As Alden Bianchi's accompanying article indicates, the protection for employers is eroding, creating opportunities for unhappy employees and their families to bring suit against the employer.

Typical corporate insurance policies are unlikely to cover lawsuits by an employee benefit plan beneficiary alleging they were harmed by the benefit plan. As analyzed in our February 1999 issue, there is no good source of coverage for such claims in traditional corporate insurance plans. But, because the liability was so remote, risk managers did not see this gap in coverage as meaningful. There just wasn't much exposure.

Now, things are changing.

With increasing public antipathy toward managed care, politicians' awareness of the unrest this antipathy creates and the view of some members of the plaintiff's bar of the litigation opportunity it offers, we expect the interest in coverage will accelerate.

Special coverage has been available from Lexington (Sherwood Insurance Services) since 1994, under the name Healthcare Purchaser Liability insurance. TIG has offered a similar coverage since 1995 and Professional Indemnity Agency (PIA) since 1996 (defense only). A new market entrant, Chubb Executive Risk, released its new product in November of 1999, dubbed Plan Purchaser Protection.

There is no consistently recognized name for this product; we think the term "Managed Care Liability for Employers" (MCLE) best describes it, and will use it here.

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Market Trends

MCLE has been a very slow-moving product, due to the lack of perceived need. Few brokers or risk managers are aware of the coverage's existence, and based on the low risk of a claim, have had little reason to. The main market has been employers that are heavily involved in the actual delivery of healthcare services and/or claims administration. This is in contrast to employers that primarily negotiate, purchase and oversee benefit plans.

For example, as one product manager told us, employers that are midsized, self-insured, and design their own plans, have been the market for MCLE. That left out most employers.

Now that the health insurance costs are resuming their rapid increase, and liability protections for employers are eroding, we find more interest in the coverage. Admittedly, few brokers seem to be aware of the coverage or its need, but that will change rapidly.

Types of Products

There are two types of MCLE coverage: The first, and more prominent, is the stand-alone, monoline policy; the second is a Fiduciary liability endorsement.

Stand-alone coverage is available from Lexington, TIG and now Chubb. These policies include indemnification and defense coverage. Fiduciary policy endorsements are available from Chubb and PIA.

Generally, stand-alone policies are better suited for employers that are more active in the administration of their benefits plans, contract directly with healthcare providers or offer direct medical care.

Fiduciary endorsements typically are more limited in coverage and are better suited to the more passive employee benefit plan sponsor.

Since Chubb offers both, a comparison is instructive.

Its Fiduciary endorsement offers enhanced bodily injury coverage, and protection against claims alleging denial or delay in benefits, negligent managed care selection and the plaintiff's legal expenses (which can be significant).

Chubb's stand-alone policy builds on the Fiduciary version to include vicarious medical malpractice liability, breach of confidentiality, negligent claims handling, case management as well as adding human resources personnel as insureds.

Note that PIA's policy, written on Legion paper, provides defense cost coverage only. For an insured interested in their Fiduciary liability product, this is an inexpensive way to add some useful additional coverage. We expect to see more Fiduciary carriers taking a similar approach to coverage, adding defense costs, or even a sublimit, for MCLE claims to the core policy.

State of the Market - Volume and Claims

At this time, little business is being written. One carrier admits to only writing a handful of policies, primarily for Fortune 500 companies.

However, we are seeing early signs of growth in the market. Another carrier reports growth in the 11%-25% range for premiums written, which is certainly respectable. And there is increased interest on the part of brokers. If the expanding exposure continues, and there is more awareness of the risk, we think this product is likely to be in great demand. When, not if, is probably the question.

Claims are still infrequent, according to underwriters' reports.

Market Information

As mentioned, there are 2 MCLE markets: a stand-alone market, represented by Chubb Executive Risk's monoline policy, Lexington, and TIG, and the Fiduciary endorsement market, represented again by Chubb, and also by PIA. Both have their attractions.

The stand-alone policies are oriented toward the more active benefit plan sponsors, and have broader coverage. It is likely that they also have higher premiums. For employers

that participate in the actual provision of services, beyond the typical design, selection, and oversight, the endorsed product may be sufficient.

Stand-alone product carriers are unwilling to commit themselves to target market information we request. The response is “we would like to consider applications from any source.” However, it seems that the mid-sized employer is likely to be a good source of applications.

Endorsement products are slightly more limiting. Chubb (Fiduciary endorsement product only) discourages applications from labor management trust accounts and public entities; PIA is not interested in union or multi-employer plans.

With the exception of Lexington (Delaware), all carriers will entertain business from all states (there are no prohibited states for underwriting reasons).

#### Types of Insureds and Applicants

Lexington has found that manufacturing companies, particularly those that are unionized, are frequent applicants. Chubb is too new to this market to offer useful information; neither PIA nor TIG provided information.

Clearly, there is a dichotomy between markets in terms of employer size. Lexington sees primarily larger employers with little activity in the under 1,000-employee range. PIA, on the other hand, has almost one third of its book (by insured count) in the under 1,000 range.

Chubb (too new) and TIG did not report, but we understand that TIG has seen mostly Fortune 500 accounts so far.

#### Distribution System Experiences

Since this product is still in its infancy, we are interested in its distribution successes. Lexington reports that brokers that pay close attention to their clients’ needs are a good source of business (no surprise there).

PIA commented that their product is typically of interest to the broker that focuses on its insureds’ Fiduciary Liability coverage. This of course makes sense, since PIA only offers coverage as part of a Fiduciary placement.

TIG reports that its business comes from managed care brokers, those that focus their business not on the employer, but the managed care providers (such as HMOs). Thus, the type of exposure that a managed care industry broker would be familiar with—managed care liability—is being extended into the employer-side of the industry. It makes sense that the

knowledge of the liability arising out of managed care activity is being applied to other markets, in this case, employers.

Perhaps insurance brokers and carriers will need to promote their MCLE products to their employer customers, before the managed care brokers do it for them.

#### Limits, Deductibles, Co-insurance and Commissions

There is substantial capacity available to insureds. Chubb’s Fiduciary endorsement, Lexington and TIG each offer up to \$50 million limits. Chubb’s monoline limit is \$35 million, while PIA offers up to \$10 million.

Minimal deductibles are available; PIA and TIG can offer first dollar coverage; Chubb starts at \$2,500 and Lexington at \$5,000.

Co-insurance is not a factor in this line of business.

#### Types of Benefit Plans Covered

Carriers tend to cover all health-related benefit plans (health, disability, vision care and Workers Compensation). Chubb’s endorsement product is limited to health and vision care, while both disability and WC can be added to its stand-alone product.

#### Claims Reporting, ERP, Selection of Counsel and Consent to Settle

Each of these coverages is a claims-made form; Extended Reporting Periods vary from 1 year at 25% of expiring annual premium to unlimited at 150% for TIG. Chubb offers a variety of choices, and Lexington’s standard offer is 3 years at 150%.

Carriers generally control the choice of counsel, but are very attentive to the insured’s preference. Chubb contractually allows the insured to select counsel (stand-alone only; carrier selects for the Fiduciary endorsement product).

Panel counsel requirements are not imposed by any carrier unlike, for example, Employment Practices Liability products.

Carriers can generally settle without the consent of the insured, which we think is potentially damaging to the employer. Chubb will not settle without consent; although it applies a so-called “hammer clause” (carrier is not liable for costs above the settlement opportunity), it will share such excess costs 50%/50%. We think this is a big advantage, one that all insureds can benefit from.

Both Lexington and TIG can settle without the consent of the insured, but are emphatic that they are sensitive to wishes of the insured.

### Prior Acts Coverage

Prior Acts is an important coverage issue. All carriers except Chubb include Prior Acts in their standard form; Chubb offers it as an option. Of course, all carriers excluded known claims.

Neither Chubb nor PIA requires previous coverage for Prior Acts to be included.

### Definition of Coverage

Critical differences in coverage between the five products are found in the Definition of Coverage. This policy section lists the employer activities and exposures that the policy covers. Insureds should make sure that the definition includes all of their plan purchaser activities.

Please see the attached table “Managed Care Definition” for details of each carrier’s coverage.

### Coverage Territory

Although most managed care activity is in the US, there can be exposures elsewhere. Chubb provides true worldwide coverage (suit brought anywhere), Lexington and TIG limited worldwide (suit brought in US/Canada/territories), while PIA covers occurrences in US/Canada only.

### Exclusions

Exclusions vary between products. For example, only TIG includes personal injury exclusions. However, TIG gives back coverage for injury arising out of breach of confidentiality of medical records.

A discrimination exclusion in the Lexington policy applies, except to utilization review and credentialing.

All carriers exclude punitive damages, unfortunately. TIG is willing to negotiate it, which we expect other carriers may be willing to consider as well. Will we see a Bermuda wraparound product for punitive damages and/or intentional acts? Not yet, but if this product grows, perhaps we will.

Intentional acts are generally excluded, except by PIA. However, both Chubb and Lexington include a non-imputation clause (so that the intentional act of one insured does not preclude coverage for other insureds). And, Chubb will provide a defense as well.

Unauthorized access to claims systems is only excluded by TIG.

### Summary

As is evident by Alden Bianchi’s accompanying article on the changing managed care liability exposure for employers, there is an increasing need for insureds to carefully evaluate their risks, fine-tune their risk management techniques, and consider insurance protection. It is unlikely that hiding behind the wall of ERISA will be sufficient in the future.

### Why Chubb Executive Risk Decided To Offer Plan Purchaser Protection Products

We asked Carrie Brodzinski, who is Underwriting Manager Not-for-Profit and Fiduciary Liability at Chubb Executive Risk, the reasoning behind their decision to offer this product. She offered these comments:

“Employers are facing increasing exposure in the managed care area as a result of the public outcry for managed care reform. The protections afforded to employers by ERISA have been significantly eroded for employers who self-administer their health care benefits, and that erosion is likely to continue as a result of court decisions and legislative action. Our goal with Plan Purchaser Protection is to provide employers with meaningful coverage tailored to meet their managed care exposures.”

## Claims Against Employers for Negligent Benefit Plan Administration: Preparing for the Next Wave

Alden J. Bianchi, Esq.

A great deal of attention has been lavished recently on the extent to which employers and employee benefit plans are protected from a broad range of claims by certain provisions of the Employee Retirement Income Security Act of 1974 (or “ERISA”). Indeed, the largest single stumbling block over Congress’s attempt to reform health care has to do with proposals which expand the range of remedies available to plan participants. Those arguing in favor of expansion claim that ERISA’s purpose, which is to protect participants in employee benefit plans, has been thwarted by the manner in which ERISA has been interpreted by the courts. In particular, they claim that lawmakers never intended to limit participant claims to claims for benefits and perhaps attorney’s fees. Those arguing in favor of the status quo point out that one of the principal purposes of ERISA was to expand coverage by holding down costs.

While it is true that the legislative history of ERISA can be read to favor those hoping to expand remedies, it is very difficult to square the actual text of the statute as adopted with that result. On the other hand, there is very little support in the legislative history for cost containment or the expansion of coverage under employee benefit plans. Whatever the original intent, it is doubtful that anyone standing in the White House Rose Garden at 11:00 a.m. on Labor Day, 1974 could have predicted the manner in which the ERISA regulatory standards have evolved.

The protections afforded health plans under ERISA have sheltered not only health plans from liability but employers as well—so much so that employers have perhaps been lulled into a false sense of security. There are at least three reasons why this may be about to change:

(1) *Health Care Reform*. Health care reform is on the horizon. On July 15, 1999, the Senate passed the Patients’ Bill of Rights Plus Act (s. 1344). That bill does not include any tort reform measures. On October 7, 1999, the House of Representatives passed the Bipartisan Consensus Managed Care Improvement Act of 1999 which does contain tort reform measures. The battle over tort reform is now joined. The two bills will now go to conference committee, and it is difficult to underestimate the stakes. The principal focus is now on the “tort reform” provisions of the Bipartisan Consensus Managed Care Improvement Act of 1999 which allows patients to sue for unlimited damages.

The House bill would amend ERISA to allow participants or beneficiaries to bring an action in state court, and under state law, against a health plan or HMO to recover damages including punitive damages resulting from injury or death to a covered individual in connection with the provision of insurance, administrative services, or medical services to or for a group health plan. This rule would apply with equal force to employers who sponsor self-funded medical plans.

To this general rule is an important exception under which a plan or a health insurance issuer would not be liable for any punitive damages for any cause of action that arises out of an externally appealable decision if the recommendations of an external review procedure are followed. The bill also contains an expansion of the particular remedial provisions of section 502 of ERISA by adding a new section 502(n) allowing suits to be brought against a group health plan or issuer for failing to follow proper utilization review procedures, failing to furnish access to emergency, specialty or obstetrical/gynecological care, failure to observe certain continuity of care requirements, prescription drug utilization review procedures and clinical trial coverage. Suits under these provisions however may not be brought as a class action, and they are limited to obtaining benefits allegedly due together with attorney’s fees and the costs of litigation.

There is another significant difference between the two bills that will further complicate the task of the conference committee. The way that the Supreme Court has interpreted the ERISA “savings clause,” plans which furnish benefits through insurance are subject to state insurance law benefit mandates and other state insurance regulation. As noted above, “self-insured” plans, i.e., plans that do not shift risk to commercial insurance companies, are not subject to state regulation of any kind. (Self-insured plans are sometimes erroneously referred to as “ERISA” plans. ERISA regulates insured and self-insured plans alike, but insured plans are also subject to state mandates.) Post-ERISA man takes it as an article of faith that benefit mandates may be imposed on insured plans. However, there is ample evidence in the legislative record that this result was *not* intended by Congress. A proposed 1979 law submitted by Senators Williams and Javits, two of ERISA’s principal sponsors, contained provisions which were intended to preclude mandated benefits on a state-by-state basis. The sponsors made clear their view that this bill was simply clarifying what they thought to be existing law. Their views notwithstanding, history has recorded a different result.

The Senate bill is restricted to self-insured plans that are not subject to state regulation. These plans cover about 48 million out of the estimated 161 million Americans covered by employer sponsored medical plans. The Senate has left it to the states to further regulate insured arrangements as they see fit. Critics charge that this approach is flawed since that it is not always easy to distinguish between insured and self-insured plans. While the locus of the risk should determine the character of the plan, there are a number of hybrid arrangements (e.g., minimum premium arrangements and stop-loss/reinsurance features, among others) that defy easy classification. Moreover, why should the protections afforded these individuals depend on the plan sponsor's choice of financing mechanisms? The House bill regulates all ERISA-covered plans whether or not insured. As a consequence, even if the conferees can reach agreement on tort reform, they will also need to agree as well on the scope of the reform.

(2) *The Supreme Court.* While the health insurance lobby has been successful so far at keeping reform efforts aimed at containing the expansion of tort remedies at bay, it is possible it may win the battle and lose the war. Simply derailing Congressional health care reform will not end the matter. The Supreme Court decisions that have established our present understanding of ERISA preemption are written on paper, not carved in stone. In a footnote in a recent case involving disability benefits, the Supreme Court indicated its willingness to reconsider its earlier rulings. The case was *UNUM v. Ward*, and the Court was responding to an argument advanced by the Solicitor General (at the urging of the Department of Labor) in an amicus brief. Although the amicus brief urged reconsideration of the scope and application of the insurance savings clause, it's no secret the Department of Labor disagrees vehemently with the manner in which courts have interpreted the ERISA preemption doctrine. The Department can be expected to press the Court at every opportunity to substantially limit or overrule *Pilot Life*. If that happens, then any legislative victory will be hollow.

The health care lobby might be better off dropping its opposition to tort reform and press instead for limitations on the right to sue such as punitive damage caps and venue restrictions, among others. If the health care industry fails to take the longer view, it could well win the battle and lose the war. The Supreme Court reads the newspapers, after all, and they are not immune to public sentiment. There is simply too much pressure for reform for something not to give.

(3) *The Class Action Plaintiffs' Lawyers Have Discovered ERISA.* This is perhaps the most chilling of the prospects for "reform." For most of ERISA's 25-year history, the development of the law has been driven by guidance from and the litigation policy of the IRS and the Department of Labor and by lawsuits brought by plan participants. Arguments about the contours of the ERISA's preemption have been largely settled by this limited group of players.

Class action plaintiffs' lawyers are the new players in the ERISA game. They have advanced some novel and in many instances aggressive readings of ERISA and the cases that have defined ERISA to date. It is simply not possible to underestimate the stakes. If ERISA's preemption provisions can be undermined, and the plaintiffs' bar can develop sufficiently novel and effective theories of liability, then the potential for recovery is enormous.

At present, it is too early to predict the future of this development. If cases are routinely denied class action status; if defendants are resistant to settlement; and if verdicts don't go their way, the class action lawyers will abandon ERISA in a heartbeat for more lucrative opportunities. Otherwise, they can be counted on to play a significant part in the development of ERISA going forward.

From the employer's perspective, this is a potentially costly development. The plaintiff's class action bar is interested in one thing and one thing only: large dollar settlements against plaintiffs with deep pockets. They couldn't care less if the "deep pockets" are attached to an HMO, an insurance company, or a self-funded plan sponsor.

There are currently three principle area of exposure that would be most impacted by any significant shift in the protections now afforded plan sponsors under ERISA's preemption doctrine. They are:

(1) *Suits for Negligent Selection of Providers or Insurers.* Although rare, there have been a few cases in which a plaintiff complains that its employer has negligently selected a commercial benefits provider thereby resulting in some compensable harm. In a 1992 case, *Greany v. Western Farm Bureau Life Insurance Co.*, the plaintiff claimed that the employer was negligent in failing to provide adequate health insurance coverage. The trial court agreed with the plaintiff but the Ninth Circuit reversed holding that the negligence claims were preempted. A similar result occurred in a 1999 district court case, *Georgas v. Kreindler & Kreindler et al.*

While these results are heartening to employers and their providers, they may not be sustainable in the long run even in the absence of tort reform. The Department of Labor has long since recognized that a plan sponsor can act in a number of different capacities vis-à-vis a plan. It can be the plan sponsor, or "settlor," and it can also stand in a fiduciary relationship to plan participants and beneficiaries. In a 401(k) plan with self-directed accounts, for example, plan participants may have responsibility for the investment of assets in their accounts from among a number of investment options, but the plan sponsor has a fiduciary duty to prudently select the universe of investment options. If it does so negligently, it may be liable to participants for any resulting losses.

A currently pending, and highly visible, case involving employees of First Union Corporation illustrates the problem in the 401(k) setting. The employees claim that First Union's practice of limiting the plan's investment options to its own mutual funds resulted in lower returns for plan participants while producing higher fees and more marketing opportunities for First Union. Should the court ultimately rule in the employees' favor, then it will only be a matter of time before claimants will seek to extend that holding to the selection of welfare benefit plan providers.

(2) *Vicarious Liability or Negligence in the Administration of Benefits*. Here, the essential feature of the claim is that because of an employers' negligence, a participant or beneficiary has suffered personal injury or death. Typical of these cases is a 1993 case, *Spain v. Aetna Life Insurance Company* involving a self-insured plan administered by Aetna Life Insurance Company. The decedent, Steven Spain, was diagnosed as having testicular cancer for which an autologous bone marrow transplant (ABMT) was recommended. Aetna initially authorized then withdrew its authorization for the procedure, and Spain brought suit to compel authorization of treatment. Following the patient's death, his wife and daughter sued claiming negligence on the part of both the employer and Aetna. The court refused to grant the relief requested.

Such claims have generally been decided in the employer's favor to date, but that may change for at least two reasons. First, the contours of ERISA's preemption doctrine are narrowing since the Supreme Court decided the *Travelers* case in 1992, and second, the courts have been recently and consistently finding that medical malpractice claims are not barred by ERISA's preemption doctrine. In the case of a self-insured plan, it's a short leap to conclude that the employer is vicariously liable for medical-necessity decisions made by utilization review committees or medical consultants.

(3) *Cases Where a Participant or Beneficiary Claims to Have Been Injured*, whether financially or physically, as a result of an employer's actions. In contrast to the proceeding two categories of claims where the case law is relatively limited, the case law involving claims of negligent plan administration number in the hundreds and perhaps thousands. Some of the more prominent claims include the following:

- Misrepresentation about the terms of the plan. Often these claims are dismissed because they are preempted by ERISA. Some claims for estoppel are not preempted by ERISA, and because those cases involve determinations of fact, they usually survive a motion to dismiss.

- Denying or terminating benefits. Plan Administrators prevail when they can show that they exercised no control or discretion in the decision to deny or terminate benefits. They are also more likely to prevail if the arbitrary and capricious standard of review is applied.
- Negligence, emotional distress or breach of contract. These claims are preempted by ERISA. The only time these claims might survive is when a benefit offered by an employer, like an early retirement package, is determined not to be an ERISA plan.
- Failing to respond to a request for plan documents. This is a tremendous area of potential liability. While in many of the earlier cases, courts chose not to impose a penalty, employers should not count on that being the case today. Under ERISA courts can impose a penalty of up to \$100 per day. This can easily amount to a penalty in excess of \$25,000. Sometimes the penalty can exceed the amount of the benefit in dispute.
- Inappropriate amendments to plan documents. Often the decision will rest on whether the plan gives the Plan Administrator the right to amend the plan.
- Negligent denial of medical care under a health plan. This is a big issue today. More courts are allowing claimants to sue Plan Administrators for medical malpractice when they make decisions about medical necessity under a Plan. *Moscovitch v. Danbury Hospital*, 25 F. Supp. 2d 74 (D. Conn. 1998) is an excellent example.
- Conflicting plan documents, especially where a Summary Plan Description conflicts with other plan documents. While there are exceptions, most courts will apply the terms of the SPD if they conflict with other plan documents. ERISA requires Plan Administrators to provide the SPD.
- Failure to abide by ERISA's reporting and disclosure requirements. These claims range from failure to provide notice of a pension plan amendment to failure to abide by ERISA's notice requirement when denying a claim.
- Violation of the Americans with Disabilities Act where a plan has limited benefits for mental health or specific illnesses.
- Failure to provide notice of conversion rights. Most cases hold that if the SPD sets forth conversion rights, that is sufficient notice under ERISA.

The bottom line is that change is in the wind, and it may not be good news for employers. ERISA's preemption doctrine as it has been interpreted to date has been a boon to employers, but its unlikely that things will remain this way for long. The public dissatisfaction with HMOs and insurance companies will spill over to the employers in their role as plan sponsor. This is true whether the plan sponsor has the clinical risk (i.e., self-insured plans where the claims will be directly for damages) or where the plan sponsor lays off the clinical risk on a third party (i.e., insured arrangements where the claims will be for negligent selection).

An employer's best defense is to (i) exercise care in the selection of all manner of service providers and vendors; (ii) take care to effectively communicate the material terms of the plan and claims procedures to plan participants; and (iii) adopt administrative practices and procedures designed to ensure compliance with ERISA and other applicable laws. With increasing emphasis on the quality of medical care, employers should be able to ensure the prudent selection of its service providers and vendors. Communication of plan term is an area in which the employer has substantial if not

total control but where noncompliance is rampant. There is simply no excuse for an employer not to have proper plan documents, summary plan descriptions, and related materials. Critical in this regard is for employers to reserve to themselves a favorable standard of review. With that simple precaution, an employer can find itself at a disadvantage in the case of a disputed claim.

Simply put—employers are not defenseless even if ERISA based remedies are expanded legislatively or through the courts. What will be required is compliance (with ERISA and other laws) attention (to practice and procedures), and diligence (in staying ahead of developments). This is an instance where an ounce of prevention will be worth several pounds of cure.

Note: Alden Bianchi is a partner with the law firm of Mirick, O'Connell, DeMallie & Lougee, LLP 100 Front Street Worcester, MA 01608-1477. He has been writing and speaking on the liability of Managed Care Organizations and employer plan sponsors since 1996, and has written our two previous articles on the subject. He can be reached at P: 508/799-2541 Email: [ajbianchi@modl.com](mailto:ajbianchi@modl.com)

### Who's Buying Insurance For The MCLE Exposure?

Insurance broker Dick Clarke, of Palmer & Cay, Inc. in Atlanta (P:404\504-8165), has been actively selling Managed Care Liability for Employers coverage. His thoughts on why some employers buy it, while others do not:

The primary reason for an employer's use of "managed care" (meaning, in a simple sense, an HMO, PPO, or similar arrangement), is to reduce employee health insurance costs. What is being slowly realized is that with the cost reduction comes a corresponding liability exposure. Four states have now passed statutory legislation allowing some form of employee suit against medical care providers, and federal legislation containing this provision is currently being considered by a House/Senate joint committee. So, the liability exposure looms larger with the passage of time.

Employers with large employee counts are most likely to consider "employers managed care liability insurance", once limitations in current insurance coverages are realized. Self-insured major medical, and the use of HMOs, PPO's, and similar arrangements cause the employer to consider appropriate insurance coverage, which is only recently beginning to emerge. The more

managed care arrangements are in place, and the more complex those arrangements, the more likely the employer is to become concerned with the exposure. Now that purchase of the insurance has been made easier through recent announcements of availability for a reasonable additional premium charge, the more likely this coverage is to be considered by employers, especially larger employers.

Smaller employers, and those with simpler group health insurance arrangements, are less likely to consider the coverage, as they are more difficult to convince of the exposure. Further, it is somehow more difficult for smaller employers to become convinced that an employee would actually bring litigation, as this trend of the 1990s becomes ever more realistic. Once federal legislation is passed, however, allegations will become easier to make, as will litigation designed to show negligence on the part of the employer in obtaining, and maintaining, group health insurance coverage in both a cost efficient, as well as broad coverage, basis.



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