

## HHS and DOL's Unexpectedly Supportive Analysis of Self-funding

The health reform law mandated two reports on self-funded employer-sponsored health plans to answer such loaded questions as whether self-funding entails unreasonable denials and conflicts of interest. Because the approach seemed biased, the self-funding community was bracing itself for the worst. The reports, however, found that economically healthier companies self-fund, their benefit packages were no leaner than that of insured plans, their claims denial rates were no higher than that of insured plans' and employee contributions in self-funded plans were growing more slowly than they were in fully insured plans. On the other hand, they showed that the authors have an incomplete understanding of stop-loss and a continuing suspicion of stop-loss policies with low attachment points. **Page 2**

## Inpatient Treatment for Anorexia Covered as Physical, Not Mental, Ailment

The insurer/administrator of an ERISA health plan abused its discretion when it invoked mental health limits to deny benefits for a hospital stay whose goal it was to nurse a dangerously underweight girl back to health. Based on the fact that the insurer's policy gave it the authority to determine benefits, the district court ruled in the insurer/administrator's favor. The appeals court on expanded *de novo* review, found that behavioral matters were not the reason for the admission. The patient's condition, physician's intent and discharge criteria based on physical, not mental, improvement. The appeals court said healing the patient's physical ailments was what the hospital stay revolved around. It reversed the lower court's decision. **Page 6**

## Privacy Lawsuit Against Plan Vendor Not 'Completely' Preempted by ERISA

ERISA did not preempt an employee's lawsuit against his group health plan's subrogation vendor for alleged improper disclosures of his medical records, a federal district court recently ruled. The patient sued, alleging state privacy law violations because his billing and medical records were not needed for a subrogation notification to be made. The vendor argued that the lawsuit was preempted as a claim for benefits under an ERISA plan. The court disagreed, saying the problem was less a claim for benefits than a commonplace run-of-the-mill state-law claim. The lesson: If a plan thinks medical or billing records are essential to protect its subrogation or reimbursement rights, then it will need to reserve its right to see such records in its summary plan description's subrogation section. If it will rely on a third party as a subrogation agent, it needs an updated HIPAA- and HITECH Act-compliant business associates agreement in place. **Page 10**

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