

Reform Affordability Penalties Triggered By Self-only Cost

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TPA That Controlled Claims Process Is Liable for Improper Claim Denial

Despite contractual language stating that its duties were only ministerial, a third-party administrator was found jointly liable under ERISA for improperly denying more than \$500,000 in medical claims because in reality it exercised actual control over the claims process, a federal appeals court held. The TPA had authority to: (1) unilaterally deny claims it considered routine; and (2) decide which claims were routine. It didn't consult the employer even when claims were very large, and the plan gave the TPA authority to deny ALL claims, no matter how major. The court decided this combination of facts overrode the contract language saying the TPA performed only ministerial duties. The appeals court ruling made the TPA liable for \$512,000 in rehabilitative hospital claims, and \$453,000 in attorney's fees. *Page 5*

U.S. Must Revise False Claim Allegations of MSP Fraud

In a case brought under the federal False Claims Act, the government alleged that an employer fraudulently billed it more than \$300,000 after it fabricated a COBRA election to avoid paying primary on a plan member's health bills. After trying and failing to get workers' compensation to cover the loss, the employer enrolled the beneficiary in COBRA in order to make Medicare primary, the government alleged. Two of five of the government's fraud charges survived the plan's motion to dismiss. On the other hand, the employer plan managed to dismiss an FCA fraud-conspiracy charge for lack of evidence, and two state-law charges on procedural grounds. United's actions appeared to be an effort to shift the primary liability to Medicare. *Page 7*

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Why Self-funded Plans Can Thrive In a Post-reform World

By Adam Russo, Esq.



Adam V. Russo, Esq. is the co-founder and CEO of The Phia Group LLC, a cost containment adviser and health plan consulting firm. In addition, Russo is the founder and managing partner of The Law Offices of Russo & Minchoff, a full-service law firm with offices in Boston and Braintree, Mass.

He is an advisor to the board of directors at the Texas Association of Benefit Administrators and was named to the National Association of Subrogation Professionals Legislative Task Force. Russo is the contributing editor to Thompson Information Service's Employer's Guide to Self-Insuring Health Benefits.

As 2014 approaches, many employers will see an opportunity to drop health coverage, pay a relatively small penalty and exile employees to health insurance exchanges. But there are many reasons to keep health benefits in-house and many more reasons why self-funding health coverage remains the best option for all sizes of employers.

The Problem for Employers

The combination of the individual mandate and new requirements on insurance policies (guaranteed issue, medical-loss ratios, essential benefits, preventive care mandates, dependent coverage expansion and annual and lifetime limits) has made insured group policies more expensive. Many in the industry believe that fully funded insurers raised premiums aggressively before the reform law's adoption, expecting that in the future they would be limited in their ability to do so. (The law requires review of premium rate increases for non-group, small-group and fully insured large-group plans.)

Modified Community Rating

Beginning in 2014, the health reform law requires modified community rating in the individual and small-group health insurance markets that will allow insurers to vary rates only based on age, geographic location, family size and smoking status. These rating rules will apply to products offered in the state insurance exchanges and to fully insured products purchased outside of the exchanges by employers with up to 100 employees. The maximum ratio of rates for older people compared to those for younger people will be 3-1, in contrast to a 5-1 or 6-1 ratio that makes up typical pricing today.

Significant Problem With Exchanges

Timothy Jost reports in his "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues" that the most significant problem that pre-reform exchanges have grappled with has been adverse selection. Adverse selection occurs when those that are financially responsible for providing benefits to a sicker population see an opportunity to shift that burden onto someone else.

The fact remains, however, that adverse selection has occurred for generations as employers with low-risk populations self-fund rather than add their healthy lives to large insurers' risk pools. Insurers cover unhealthy lives that employers that do not want to be financially responsible for (beyond payment of a premium). Therefore, those that support reform-created exchanges feel that adverse selection is very likely.

In addition, the supporters are concerned that a greater concentration of older and less healthy workers presently covered by their employers' fully insured plans will likely

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CONTRIBUTING EDITOR: **ADAM RUSSO, ESQ.**
THE PHIA GROUP LLC
BRAINTREE, MASS.

DIRECTOR OF PUBLISHING: **LUIS HERNANDEZ**

ASSOCIATE PUBLISHER: **GWEN COFIELD**

EDITOR: **TODD LEEUWENBURGH**

DESKTOP PUBLISHING SPECIALIST: **SHAWNE HICKS**

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See *CE Column*, p. 18

Reform Affordability Penalties Triggered By Self-only Cost; Family Cost Not Considered

The IRS has provided clarity to employers on the extent to which family coverage costs could trigger penalties under health reform's premium tax credit rules. Employers may charge what they want for family coverage without the threat of having to pay fines, provided that self-only coverage remains below 9.5 percent of the employee's wages. That's because self-only coverage is the only measure that can trigger health reform's unaffordability test, under proposed rules issued by the IRS on Jan. 31.

Earlier proposed rules were unclear on whether payments would be triggered if family coverage was 9.5 percent or more of household income.

The shared responsibility payments will be triggered if self-only coverage is 9.5 percent or more of an individual's salary.

Example: Clara is married to John and the Widget Corp.'s plan requires her to contribute \$5,300 (11.3 percent of Clara's household income) to cover herself and John. But because Clara's required contribution for self-only coverage (\$3,450) does not exceed 9.5 percent of household income, the Widget Corp.'s plan is affordable, and Clara will be considered as getting minimum essential coverage from her employer throughout the year.

In comments on the earlier proposed rules (issued in the Aug. 17, 2011 *Federal Register*), some commenters requested that the affordability of coverage should be based on the portion of the annual premium the employee must pay for family coverage. The IRS declined to do this, saying it was constrained by language in the Internal Revenue Code and in the health reform law, which say self-only costs are the key measure.

Except for the family coverage clarification, generally the final rules adopted the proposed rule language without change.

The shared-responsibility rules take effect Jan. 1, 2014.

Other Coverage Can Be Minimum Essential

A separate proposed rule creates a process for designating other health coverage as minimum essential, and of verifying that individuals have coverage

that falls into these excepted categories. In addition to exceptions for religious objections, Indian Tribe membership and incarceration, it also identifies five kinds of health coverage that trigger an exception.

The 94-page long proposal, issued Jan. 31 by the U.S. Department of Health and Human Services, said many people have sources of health insurance that would not be classified as minimum essential coverage because they are neither group health insurance coverage nor individual health insurance.

The five kinds of health coverage that would satisfy the individual mandate and be exempted from the minimum essential requirement are:

- 1) **Self-funded student health insurance plans.** Some institutions of higher education offer student health coverage to students with their own funds, assuming the risk for payment of claims.
- 2) **Foreign health coverage.** Many foreign nationals reside in this country and many of these individuals are covered by health coverage from their country of citizenship.
- 3) **Refugee medical assistance.** Foreign refugees can get eight months of federally funded health coverage under U.S. law.
- 4) **Medicare Advantage plans.** Coverage options that include Medicare Part A and B benefits offered by private companies should be considered minimum essential, HHS proposes. The statute

See *Shared Responsibility*, p. 4

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HHS Requests Feedback From Small Business on SHOP Registration

Small business gets the chance to weigh in again on the enrollment form they will use to apply to the health insurance exchanges tailored specifically to small business under health reform.

Small businesses with fewer than 100 employees will be able to purchase coverage through the Small Business Health Option Program beginning in 2014. HHS estimates about 200,000 employers will apply to a SHOP in 2014; 133,333 will apply in 2015 and 200,000 will apply in 2016.

Small businesses will register with exchanges to prove their employees are eligible, and they will administer enrollment of employees into SHOP coverage, using the uniform forms under development, which will be used to make eligibility determinations for SHOP.

The U.S. Department of Health and Human Services developed a model online application and website to help employers make eligibility determinations. Applications will vary from state to state, but all must be approved by HHS. The exchanges will start collecting information from small employers in October 2013.

In the call for comments, the agency asked for ideas on data to collect to support eligibility determinations and enrollment, such as using automated collection techniques or other forms of information technology to reduce the burden.

In response to the first round of public comments, the government added a privacy statement, information on

See *SHOP Enrollment*, p. 11

Shared Responsibility (continued from p. 3)

designated only Medicare coverage under Part A as minimum essential coverage.

- 5) **AmeriCorps coverage.** Coverage offered to AmeriCorps volunteers, which is the domestic counterpart to the Peace Corps.

HHS says coverage under these plans is often comparable to coverage designated as minimum essential coverage under the statute.

Before these types of coverage will be recognized as satisfactory, they must be certified to be substantially compliant with the health reform law's insurance mandates, the proposal stated.

Comments on this proposal are due in mid-March, 45 days from the publication date in the *Federal Register*.

Individual Mandate Triggered if Employer Coverage Available

In a third rule designed to provide guidance on the liability of individuals for not maintaining minimum essential coverage, the IRS specifies that individuals will not get a coverage exemption if they could get coverage through an eligible employer-sponsored plan, whether as an employee or as an individual related to an employee. It also clarifies what is eligible employer sponsored coverage for this purpose.


The 74-page rule is designed to help individuals decide whether they can get coverage on state-run health insurance exchanges with a premium tax credit or whether they lose that eligibility because they could get

coverage through their (or their spouse, parent or guardian's) employer. Comments must be received May 3 in time to be included in a May 29 public hearing.

The proposed regulations clarify that:

- 1) An employee or related individual is treated as eligible for coverage under an eligible employer-sponsored plan for the entire plan year if he or she could have enrolled during that plan's one-month special enrollment period.
- 2) If an employee or related individual is eligible to enroll in an eligible employer-sponsored plan, any eligibility for other coverage is disregarded for purposes of the exemption for lack of affordable coverage.

The proposal further clarifies that the required contribution for a related individual's coverage is determined by reference to the premium for the lowest-cost coverage under the eligible employer-sponsored plan in which the family member would be eligible to enroll. Thus, the required contribution for a spouse and claimed dependents (who are not otherwise exempt) is the premium that the employee would pay for the lowest cost coverage covering the employee, the spouse and the claimed dependents, the proposal states.

If the related individual is not eligible for coverage under any employer-sponsored plan, then his or her required contribution would be determined under the rules applicable to individuals eligible only to purchase coverage in the individual market. 

TPA Controlled Claims Process, Court Says; Becomes Liable for Improper Claim Denial

Despite contractual language stating that its duties were only ministerial, a third-party administrator was found jointly liable under ERISA for improperly denying more than \$500,000 in medical claims because in reality it exercised actual control over the claims process, a federal appeal court held. The TPA had authority to unilaterally: (1) deny claims it considered routine; and (2) decide which claims were routine and which were not.

In affirming a lower court decision, the 5th U.S. Circuit Court of Appeals said the specific claims denials were plainly at odds with plan requirements. The TPA ignored and/or misapplied a seven-part test for determining when a facility was a skilled nurse facility and applied payment exclusions for SNFs anyway, the appeals court found in *LifeCare Management Services v. Insurance Management Administration Corp.*, 2013 WL 57035 (5th Cir., Jan. 4, 2013).

The Facts

Two patients were enrolled in separate ERISA plans sponsored by their employers (Bill & Ralph's Inc. and Carter Chambers L.L.C.), but those plans were administered by the same TPA, Insurance Management Administrators. They stayed in LifeCare facilities after suffering major injuries:

- A spinal fracture that rendered the patient a quadriplegic created a \$170,000 bill.
- An acute stroke that resulted in death after a two-month stay created a \$340,000 bill.

The plan denied each, saying they were not covered under plan exclusions for SNFs.

Note: The definition of SNFs was identical in both plans, namely that they had to “fully meet” seven requirements, including strict performance and staffing guidelines. One of the plans offered up to 120 days of coverage for stays at a SNF, while the other barred payment to SNFs altogether.

On the other hand, both plans covered hospital stays, defining a hospital as JCAHO-accredited, fully staffed and having surgical, diagnostic and therapeutic facilities, among other things.

The Denials

The TPA refused to pay the first patient's claims, saying LifeCare did not meet the definition of a hospital,

and because it was “a rehab facility as defined in the plan,” and the plan did not cover rehab. The plan justified the second denial, saying the facility satisfied two of the plan's seven-part SNF test, namely it: (1) helped patients convalesce; and (2) was licensed as a specialty hospital. Further, the IMA claim manager denied the claim because LifeCare was a long-term acute care facility.

Later in deposition, the claim manager at IMA admitted a facility had to meet *all* seven factors to meet the SNF exclusion, even if the facility referred to itself as an LTAC facility, the ruling stated.

After the denials, LifeCare filed lawsuits under ERISA and related state-laws against the TPA, the employers and both employer plans. The district court consolidated the cases.

The district court found under ERISA, that IMA abused its discretion when categorizing the LifeCare facility as an SNF. The district court also found that the TPA could be held liable for the wrongful denial of benefits. It awarded LifeCare more than \$512,000 in benefit payments and more than \$453,000 for attorney's fees. It dismissed the state-law claims.

The plaintiffs appealed the district court's rulings on the abuse of discretion finding; the finding that the TPA could be held liable; and the attorney's fees award.

Appeals Court: Claims Were Improperly Denied

The appeals court agreed with the district court that IMA's interpretation of the plans was incorrect — IMA's finding that LifeCare was an SNF was inconsistent with a fair reading of the plans.

The plans stated that a facility must meet all seven parts of the plan test in order to be considered to be a SNF. But IMA denied one claim based on satisfying only two of the seven factors; it denied the second claim without any mention of the seven-factor test.

IMA contended that an “alternative” and “independent” second definition of an SNF allowed the plans to classify a provider as an SNF even when the seven other criteria were not met. Whenever a facility called itself a “long-term care facility” or a rehab facility, the claim could be denied on that basis alone, and LifeCare had called itself both, triggering the exclusion, IMA argued.

See *TPA Controlled Process*, p. 6

TPA Controlled Process (continued from p. 5)

This reading was unacceptable, the court stated, for two reasons: first, the terms “LTAC” and “rehab facility” were mentioned in the context of a statement by the plan saying that an SNF will be classified as such even if it calls itself LTAC instead of an SNF.

By its plain language and logically, [the sentence] clarifies that an SNF by any other name is still an SNF. ... [B]y its explicit language, [it] clarifies that the “term” SNF encompasses facilities that use nomenclature other than SNF.

Further, deposition testimony from IMA’s claims manager indicated that she based her decision on the seven-factor test (albeit incorrectly because it was based on just two factors being satisfied), and not on the terms “LTAC” or “rehab facility.”

Therefore, the clearly stated plan requirement that all seven conditions be met was not changed.

The Contracts

The contracts IMA signed with the employers allowed IMA to:

- 1) process health care claims;
- 2) audit processed claims to determine accuracy;
- 3) distribute checks in payment of claims to employees or service providers; and
- 4) provide an explanation of claim settlements “to the Plan Participant and Plan Administrator.”

There was also language designed to shield IMA from liability that stemmed from controversial claim denials: The contracts also specified that IMA’s duties were “ministerial in nature” and to be “performed within [the employer’s] policies, interpretations, rules, practices and procedures.” Further, there was a statement that the TPA had no control of the disposition of plan assets.

Ruling on TPA Liability

The appeals court said the ERISA statute put no limitation on the kind of entity that could be sued to recover benefits under ERISA. In analyzing case law, it then said that examining the TPA’s actual role in the claim denial was the essential element in determining liability. If a TPA has “actual control” over the claims process (and could misread the plan and effectuate an improper denial) then it is possible to hold it liable, the three-judge panel stated. IMA did exactly that in the current case, the court concluded.

IMA had broad autonomy to process routine claims, and it had the ability to decide which claims were routine and which were not. It was held liable because:

- it didn’t consult the employer even when claims were very large;
- it unilaterally decided these were routine claims;
- the plan gave it authority to process ALL claims;
- the plan gave it authority to decide which claims were routine and not; and
- the plan gave it authority to interpret plan terms when denying claims.

The court decided this combination of facts overrode the contract language saying IMA performed only ministerial duties. But it also said the case would have turned out differently had the contracts not given IMA the power to deny claims it considered routine. It further stated:

Had IMA referred all disputed claims to BRI and Carter for resolution it would not now be liable for having exercised discretionary authority in denying Evans’ and Wall’s benefits claims.

The court then affirmed the lower court’s decision, including attorney’s fee award.

Implications

This ruling is another illustration that an entity’s status as a plan fiduciary is determined not by the terms of the agreement between the plan and its TPA (in this case, an administrative services agreement), but rather by the level of discretion exercised. This fiduciary status can create substantial problems for the plan and any administrator that attains fiduciary status, as it can subject those parties to liability. For example, status as a plan fiduciary can subject an administrator to lawsuits from patients, providers and PPOs.

Lessons Learned

Clear responsibilities set out in an ASA, while important, are not alone sufficient. Plans and their administrators must make sure that plan terms are clear and that the administrator can point to those terms when interpreting the plan to make claims decisions. Any discretion exercised due to an ambiguity or uncertainty in how plan terms should be applied brings the ministerial nature of the duty into question, thereby subjecting that party to a fiduciary standard and liability. 🏠

U.S. Must Revise False Claims Act Allegations Of MSP Fraud Against Employer

The federal government takes a dim view of any person or entity that unlawfully tries to shift financial liability to federal programs such as Medicare. When it believes that such a thing has happened, it will fight back with a lawsuit.

The problem for employers (and all federal fraud enforcement targets) is that the government has strong enforcement tools that private insurers do not have. These include double and triple damages under the False Claims Act, a Civil War-era statute that rose from dormancy and for the last two decades has been the government's leading weapon against Medicare fraud and abuse.

Most employer sponsors expect enforcement only from ERISA or state health benefit regulations, but as this case shows, vigilant plan management is needed to avoid allegations from an unexpected quarter: the federal FCA.

Targets Fear FCA Triple Damages

In the face of litigation against the government with its bottomless pockets and the prospect of multiple damages under the FCA, many targeted entities (providers and more recently drug companies, but also health plans) look for a way to settle quickly after being accused, so as to avoid litigation's cost, uncertainty and disruption.

The good news is employers are usually not in the government's FCA sights. But employers can become exposed to the FCA hammer if the government alleges them of abusing Medicare's Secondary Payer rules.

In *U.S. ex rel. St. Joseph's Hospital, Inc., et al. v. United Distributors Employee Health Benefit Plan et al.*, 2013 WL 142700 (S.D. Ga., Jan. 11, 2013), the government alleged that it was fraudulently billed more than \$300,000 because an employer allegedly fabricated a COBRA election to avoid paying primary on a plan member's very expensive health bills. After trying and failing to get workers' compensation to cover the loss, the employer fraudulently enrolled the beneficiary in COBRA in order to make Medicare primary, the government alleged.

In this case, the government made two of five fraud charges stick — they survived the plan's motion to dismiss. On the other hand, the employer plan managed to dismiss an FCA fraud-conspiracy charge for lack of evidence, and two state-law charges on procedural grounds.

The Facts

An individual identified in the court's opinion only as W.A. was a truck driver for United Distributors who was covered by its self-funded ERISA health plan. In March

2008, while he was at work, he lost consciousness, fell and hit his head. He was taken to a hospital for emergency care and was transferred to another hospital where he underwent surgery to remove a subdural hematoma. Following the surgery, he complained of stomach pain due to a colon rupture that was unrelated to his head injuries. He underwent another surgery, but unfortunately he developed a widespread infection, and his condition deteriorated rapidly. He fell into a coma, and about two months later, he died. As a result, he incurred about \$1.4 million in hospital and medical expenses.

At first, United sought to determine if the cost of his health care would be covered by its workers' compensation program, but it turned out that it was not. Then there was a discussion between the TPA and the plan about W.A.'s coverage. After that, the plan told W.A.'s wife that he was on COBRA continuation coverage. (Note: The effect of selecting COBRA was to move primary liability from the United plan to Medicare.)

Since he was over age 65, he would be entitled to Medicare, which would be primary to his COBRA coverage. As a result, she was advised that, "all claims will go first to Medicare and then to the [United plan]." The employer assured her that, "the important point is that you will not pay anything for any medical services."

An internal United email issued at about the same time explained the disposition of the matter, which was apparently issued at about the same time, saying, "this worked out quite well, as [W.A.] is over 65 and [the United plan] will only have to pay the balance of what Medicare does not cover."

Government Allegations

According to the government, the COBRA election was fraudulent. United did not notify anyone of Mrs. A's COBRA election nor did it notify United's COBRA administrator that a qualifying event had occurred. COBRA forms were not filled out or executed, the government said. Only on May 25, the day W.A. died, did the plan inform the hospital that it would not be primary and that the plan had filled-out COBRA enrollment forms endorsed by W.A. or his wife.

The government filed suit, alleging three counts of abuse under the FCA, one count of unjust enrichment and one charge of payment by mistake of fact.

Medicare paid \$341,800 to the hospitals and physicians that were involved W.A.'s care. It is not clear from

See MSP Fraud, p. 8

the court's opinion why Medicare paid that amount when the full cost of W.A.'s health care was almost \$1 million more than that. Perhaps Medicare discovered the facts stated above and stopped payment and brought its lawsuit, alleging that its payments were based on false claims presented to Medicare.

The defendants (United, the United plan, and United employees involved in the matter) moved to dismiss the complaint, arguing that the government's complaint failed to identify the specific acts that caused the submission of false claims or a conspiracy to defraud Medicare and that the claims submitted to Medicare were not false as a matter of law. The government argued that its pleadings were sufficient and included the necessary elements and supported an FCA verdict.

Charges Alleging Potential Fraud Survive

The court analyzed each of the government counts to see whether it included the required "who, what, where, when, and how" of improper practices and fraudulent submission.

The government's first FCA charge survived the plan's motion to dismiss because the government showed a connection between plan's alleged actions and the government's loss. The United defendants had attempted to dismiss this count because the complaint had "not shown how the alleged conduct caused or influenced Medicare's payment as primary issuer." But the court concluded that the alleged fabrication of a COBRA election clearly enabled the United plan to deny coverage and instead submit claims to Medicare, the court said.

Further, the employer, the plan and the plan's accused officer acted in a way that was either "deliberately ignorant of the truth or falsity of the information or had actual knowledge of its falsity," the court held.

In its second count, the government alleged that the United defendants "knowingly [made, used, or caused] to be made or used, a false record or statement material to a false or fraudulent claim." The United defendants moved to dismiss this count "because any false statements they made were not material to establish liability." Again, after summarizing the parties' arguments, the court ruled that the allegations were sufficient to state a claim for relief under the FCA that each of the defendants acted with necessary knowledge to make, use, or cause to be made or used a false record material to a false or fraudulent claim.

Charges Alleging Conspiracy Dismissed

In its third count, the government alleged that the defendants violated the FCA by entering into a conspiracy

to defraud the United States by getting false claims paid. This time the court found that dismissal was warranted because nothing in the complaint specifically alleged a conversation involving conspiracy to change W.A.'s primary coverage to COBRA. In addition, the government did not provide factual allegations concerning statements or specific conduct that indicated the existence of a conspiracy. However, the government asked for leave to amend its complaint, and the court granted it 14 days to do so.

In the fourth and fifth counts the government alleged that the defendants were unjustly enriched by their actions with respect to W.A.'s sham COBRA election and that the government made payments by mistake of fact. The court said that it was unclear whether the government's claims of unjust enrichment and payment by mistake were pled under federal common law or Georgia state law, so dismissal of these counts was warranted. However, the government had requested leave to amend its complaint, and the court granted it 14 days to do so.

Whistleblower Motives

The case had a whistleblower: the hospitals that treated the patient. It's quite possible they did so because Medicare payment rates are significantly lower than private payer rates (and presumably, the employer's plan paid at private payer rates). Therefore it's possible that the employer's decision to make Medicare primary may have hit the hospital in the pocketbook, prompting it to report to the government.

There was another motive: Under the FCA, the whistleblower takes home up to 15 percent of the final settlement or judgment, making it even easier to see the provider's motivation to blow the whistle.

Implications

It appears from the facts alleged in the opinion, the action taken by the United employees was at best a questionable, and at worst fraudulent, effort to shift the primary liability to Medicare.

Clearly, if W.A. had retired rather than gone to work on the day he collapsed, he would have been eligible for Medicare. If United did not provide retiree health coverage, he would have been eligible for COBRA coverage, and could have elected it when he retired. Then, had he collapsed on his way home, this lawsuit never would have occurred.

There is little doubt that the government would have difficulty in amending its complaint to correct the three counts that the court ruled were improperly pled. However, the government still has a chance to prove that United's actions were fraudulent, and United is still burdened with proving that its actions were not. 🏠

HRAs With Individual Policies Will Violate Reform Ban on Limits, Feds State

Health reimbursement arrangements that are not integrated with group health coverage will violate health reform's prohibition on annual benefit limits, the federal governments recently clarified. HRAs that are integrated with individual policies will be seen as "nonintegrated," thereby violating the ban on annual limits, the agencies implementing health reform stated. And if employees don't sign up for primary coverage, even integrated HRAs be treated as nonintegrated and violate reform's bar on limits.

HRAs can escape the prohibition if they are available only to employees who are covered by employer-provided group health coverage that has no annual limits on dollars spent on health services.

The Jan. 24 guidance issued by the U.S. departments of Health and Human Services, Treasury and Labor resolves key questions on how HRAs interact with health reform's prohibition on annual and lifetime limits, which takes full effect in January 2014.

No Individual Coverage

The government intends to make it clear that HRAs cannot be integrated with individual market coverage whether or not the employer plan arranges employee enrollment. Such HRAs will not be considered integrated.

Must Be Enrolled in the Group

Likewise, if an employer offers compliant primary coverage and an HRA, but the enrollee skips the primary coverage and gets just the HRA, the HRA will be considered standalone, and in violation of the bar on limits, the guidance stated.

Background

In June 26, 2002, the IRS authorized HRAs. They are most often used with high-deductible plans, primarily to cover expenses incurred before the deductible is satisfied and coverage starts. See ¶291 of Thompson's *Guide on Flex Plans* and ¶381 of its *Guide to Complying with IRS Employee Benefits Rules* for more information on HRAs.

HRAs are paid for solely by the employer and not provided via salary reduction election or otherwise under Section 125 cafeteria plans. They reimburse health care expenses incurred by employees and their dependents and spouses up to a maximum dollar amount for a coverage period, and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward the next plan year.

If HRA reimbursements are used either for medical expenses or insurance premiums, the amounts are not considered taxable income to employees.

Reform's Ban of Limits

Under Section 1001 of the reform law, all individual and group health plans must eliminate maximum annual limits on the dollar value of "essential health benefits" for any participant or beneficiary. Go to Sections 310 and 320 of Thompson's *The New Health Reform Law, What Employers Need to Know*, for more information on the prohibition on annual and lifetime limits.


Questions arose because at first it appeared that the rules mandating elimination of annual dollar limits would apply to HRAs, which by their nature are dollar limited. But in June 2010 rules implementing the ban of limits (75 Fed. Reg. 37188), the agencies implementing health reform created a broad exception, recognizing that most HRAs are a supplemental vehicle to pay cost sharing amounts not covered by an actual health plan. It explained that:

[w]hen HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with [ban on annual limits] the fact that benefits under the HRA by itself are limited does not violate PHS Act Section 2711 because the combined benefit satisfies the requirements.

But of course that other health coverage must comply with the annual limit restrictions. If that other coverage does so, and is integrated with an HRA, the waiver applies to the combined coverage and the HRA is not implicated. The Jan. 25 guidance makes it clear that HRAs cannot integrate with individual policies, and HRAs are never integrated if a plan participant is not enrolled in the primary plan.

The question remains if HRA accounts might be used to help employees buy coverage on health insurance marketplaces (previously known as exchanges). The government does not completely resolve that question in its guidance.

If insurance bought on the marketplace is considered to be group coverage provided through the employer, then the HRA would be integrated and shielded; but if marketplace coverage is considered as individual coverage, then employer HRAs would be nonintegrated and HRAs will violate the ban on annual limits. There is no mention of the status of marketplace coverage in the Jan. 25 guidance.

The guidance does permit amounts accumulated in a stand-alone HRA before Jan. 1, 2014, to be drawn on after that point if certain conditions are met. 

Medicare Payment Does Not Trump Plan Exclusion, So Specialty Rx Denial Stands

A federal district court blocked an effort to force an ERISA health plan to pay secondary for an expensive specialty drug that was excluded from coverage because it wasn't filled at an in-network provider as required by plan terms. The U.S. District Court for Northern Illinois rejected the plaintiff's argument that whenever Medicare covered a claim that the plan excluded, plan exclusions were wiped out and the plan had to pay secondary.

The case is *American Service and Product v. Aetna Health*, 2013 WL 182812 (N.D. Ill., Jan. 17, 2013).

Also, plan language giving the plan sponsor final say over claims administrator decisions weakened the plaintiff's argument that the claims administrator could be sued under ERISA and forced to pay benefits.

The Facts of the Case

Warren Ingram was a plan participant under his employer (Air Tran)'s self-funded employee health plan, and American Service and Product, Inc. is a supplier of specialty drugs. Aetna Health administered claims for Air Tran.

Ingram was a hemophiliac being treated with a self-injectable specialty drug called Kogenate.

Note: Kogenate treats a rare form of hemophilia affecting just 15,000 American males. The average wholesale price of Kogenate FS ranges from \$1,400 to \$1,700 for a 1000IU vial. Since the drug is given daily and indefinitely, its cost can mount to more than \$150,000 a year.

Starting Jan. 1, 2005, the plan was amended to require that refills of Kogenate and certain other self-injectable drugs be obtained only from Aetna-owned pharmacies. Self-injectable drugs that were not obtained from Aetna's specialty pharmacy network would not be payable.

Ingram received a letter about the policy change before it took effect, but nevertheless called Aetna requesting out-of-network coverage of Kogenate. On March 21, an Aetna representative allegedly told Ingram that the plan would cover Kogenate on an out-of-network basis from the pharmacy of his choice.

On three occasions in April 2005, Ingram obtained Kogenate from ASAP, which was out of Aetna's network. Aetna denied the claims, saying ASAP was out of network.

Four years later, ASAP revisited the issue. Medicare had paid primary for the three claims in the meantime, but ASAP claimed Aetna Health owed it the unpaid 20 percent. On May 20, 2009, Aetna rejected ASAP's claim for the remaining 20 percent. ASAP and Ingram sued the plan.

The Charges

ASAP and Ingram initially asserted claims for: (1) estoppel based upon Ingram's communications with the plan representative; (2) failure to produce plan documents as required under ERISA; and (3) wrongful denial of benefits.

The court rejected the plaintiffs' argument for estoppel, because:

- 1) their allegations about the substance of the conversation were unclear; and
- 2) they didn't allege the representative made his statements in writing, a necessary element of an ERISA estoppel claim.

It dismissed the second claim for lack of evidence of a written request for plan documents. That left only the wrongful denial of benefits charge.

Wrongful Denial Charge Falls

Aetna said Ingram and ASAP's wrongful denial charge had no support because Aetna was the wrong party to sue.

Ingram and ASAP said Aetna was a proper party because it made the decision to deny benefits.

The decision to compel a party to pay benefits due under an ERISA plan is enforceable only on the plan, unless separate ERISA provisions establish liability on another party, ERISA provides.

But courts do recognize an exception to this limitation when "the lines between the plan, the plan administrator and the plan sponsor are indistinct or contested," the judge stated.

On the other hand, the court cited a series of cases in which a third-party administrator's discretion to make claims payment decisions did not absolve plaintiffs from having to sue the plan.

Therefore, the court took on the question of whether the distinction between the plan and Aetna was clear.

The following plan language clearly established the distinction between the plan and its claims administrator, the court found:

These benefits are not insured with [Aetna] but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer.

See *Specialty Rx Denial*, p. 11

Specialty Rx Denial (continued from p. 10)

Therefore, Aetna was an improper party to the lawsuit.

But the court decided not to grant judgment on that basis alone, because courts may be evolving away from the requirement that parties have the right to sue their plan only, led importantly by *Schultz v. Aviall, Inc. Long Term Disability Plan*, 670 F.3d 834 (7th Cir., 2012).

The court checked into allegations of ambiguity in the plan, but it found that the limitation on Kogenate was clearly stated in writing and not ambiguous.

Secondary Payer Status Doesn't Change Denial

A second area of ambiguity in the plan might have been the “Effect of Medicare” section of the plan document, the plaintiffs alleged.

ASAP and Ingram argued when Medicare became primary payer, that the Air Tran plan’s secondary payer provisions bound the plan to covering secondary expenses on any claim Medicare approved and paid.

In other words, plan exclusions (including the requirement that the list of specialty drugs be obtained at an Aetna pharmacy) would be overridden if Medicare approved a claim and paid primary.

But the court rejected this as well, stating that the definitions of “Plan Expenses” and “Expenses covered under the Plan,” excluded Kogenate if it were purchased at an out-of-network pharmacy.

An expense had to be covered in the first place in order for it to be paid secondarily, even after Medicare (or another payer) covered it. The plan’s own coverage exclusions were not overridden by Medicare’s (or any other payer’s) more liberal payment policy, the court concluded.


Accordingly, the court upheld the plan’s benefit denial.

Implications

This case reaffirms the notion that courts will defer to clear and unambiguous health plan terms. The actions of outside entities, such as Medicare, cannot circumvent such terms to force payments that are not allowed under the plan.

Lessons Learned

Use of multiple sections of the plan, such as “exclusions” and “covered expenses” can be invaluable to limit a health plan’s exposure. By ensuring plan terms explicitly exclude some type of claim, or an amount greater than certain limits, a plan not only can avoid exposure to claims it does not intend to cover, but also can avoid liability by ensuring deference from the court.

Plans and service providers must be aware that a party’s role as a fiduciary is determined not solely by plan terms, but also by whether the party’s action is one typically reserved for a fiduciary. While service providers can typically perform ministerial duties, actions using discretion of plan terms can often attach fiduciary responsibility onto the actor. 

SHOP Enrollment (continued from p. 4)

the availability of other coverage, pre-population of certain applicant information and whether the employee is waiving SHOP coverage.

Responsibilities

Qualified small employers have several responsibilities related to SHOP registration. They will have to: (1) tell employees that they have an offer of coverage through the SHOP exchange; (2) give them instructions on how to enroll in the SHOP exchange and get coverage there; (3) describe the formats employees can use to submit an application, including online, paper and phone; and (4) tell those who are hired whether they are qualified for a special enrollment period.

Qualified small employers are also required to notify the SHOP exchange about an employee’s change in eligibility for coverage in the SHOP exchange, including when a dependent or employee becomes eligible, or stops being eligible.


The government expects employers will use electronic or paper distribution, but doesn’t expect employers to mail such notices to employees.

HHS said it expects some 1 million employees will apply for SHOP coverage in 2014; 666,666 employees in 2015 and approximately 1 million in 2016.

Every qualified employee of an employer participating in the SHOP will need to file an application in order to get coverage through the SHOP.

Under current proposals, employees can submit an application for the SHOP online, using a paper application, over the phone through a call center operated by an exchange, or in person through an agent or broker.

HHS says employees will spend approximately 15 to 30 minutes to apply for SHOP coverage electronically and about 20 to 45 minutes if they apply on paper.

HHS is seeking information collection request comments on this process. It is also seeking comments on a single form that would make eligibility determinations for health insurance exchanges (where individuals would go to get coverage), Medicaid and Children’s Health Insurance Programs. 

Departments Create Enforcement Safe Harbor For Employer Supplemental Rx Coverage

Employers that sponsor retiree drug benefits have new incentives under health reform to join Medicare Part D while including supplemental or wraparound benefits that help them mirror pre-existing retiree plans.

New government donut-hole coverage and the phased-out tax exemption on retiree-plan subsidies are leading employers toward Employer Group Waiver Plans. Employers that adopt EGWPs must administer the “standard” Part D benefit according to federal health coverage requirements (such as ERISA, HIPAA and the new health reform law). Meanwhile, supplemental, non-Medicare drug benefits constitute an excepted benefit and are not subject to the federal health coverage requirements.

Employers can identify exempted supplemental coverage using the guidelines in a Jan. 25 Part D Bulletin from the Centers for Medicare and Medicaid Services.

Background

Part D benefits can be provided through prescription drug-only plans and Medicare Advantage prescription drug plans (for workers and retirees not covered by employer drug plans); but employees or retirees who are Medicare beneficiaries can also get drug coverage through employer or union group health plans.

When Part D emerged in 2007, there was fear that employers would phase out retiree drug coverage and send their covered retiree lives to the Part D program. To incentivize companies not to do this, Medicare set up a retiree drug subsidy that refunded 28 percent of retiree drug plan costs to employer health plans. But recently the health reform law has made Part D coverage richer and reduced the value of the RDS, making company-sponsored drug coverage more expensive. Here’s how:

- The tax free status of RDS refunds expired on Jan. 1, 2013.
- The feds increased direct premium subsidies, and began progressively filling the donut hole for Part D coverage.

To help employers continue sponsoring drug coverage, the government opened a new option — EGWPs — with which employer sponsors of retiree plans would administer “standard” Part D benefits along with supplemental benefits. EGWPs are for employers that:

- 1) want or need to retain group plan sponsorship for their Medicare retirees; and

- 2) must closely replicate or maintain current benefit design for retirees.

EGWPs are often operated by a Part D pharmacy benefit manager. They are available to employer groups only. Employers are moving from RDS to an EGWP because they will benefit from higher federal Part D subsidies and replace the newly taxable RDS benefit.

But employers need to separate out non-Medicare supplemental benefits being given to active employees covered by Part D.

Like MA-PD plans, EGWPs are a mix of the core government-funded drug benefit and supplemental coverage. With MA-PD plans, the government has no problem identifying the portion it pays distinct from supplemental coverage, because MA-PD plans are subject to an approval process during which the government separates “standard” from “supplemental” Part D benefits. But the government does not subject EGWPs to a public bidding process, because that would have a chilling effect on the companies sponsoring their own Medicare PDPs, the feds state.

Rules for Fully Insured Plans

Fully insured EGWPs can distinguish their supplemental coverage from the “standard” Part D benefit they administer and gain an exemption from federal coverage rules for the supplemental portion, if:

- 1) plan enrollment is limited to people eligible under the employer’s group health plan;
- 2) the supplemental coverage is provided through a separate policy, certificate or contract of insurance;
- 3) the supplemental coverage is independent of the primary coverage; that is, it was issued by an entity other than the entity providing the primary coverage;
- 4) the coverage must be specifically designed to fill “gaps” in the primary coverage, such as co-insurance or deductibles, but may not become secondary or supplemental only under a coordination-of-benefits provision;
- 5) the supplemental coverage must not cost more than 15 percent of the primary coverage; and
- 6) the supplemental coverage must not differentiate among individuals in eligibility, benefits, or

See Enforcement Safe Harbor, p. 13

Employers Get Reprieve From Health Reform's Exchange-notice Requirement

Employers do not have to start distributing notices to all employees on the existence of health insurance exchanges on March 1 as required by the health reform law.

This requirement is now deemed impracticable because many state exchanges have not been set up, and will not become operational until Jan. 1, 2014. Also, the requirement does not take effect until the U.S. Department of Labor issues a rule describing how to comply. That rule has yet to be issued.

Therefore, DOL issued a memo on Jan. 24 stating that until such regulations are issued and become applicable, employers are not required to comply with that provision.

DOL said it expects it will move the date up to late summer or fall of 2013 before requiring employers to distribute the notices, which will be in time for the exchanges' first open enrollment period.

Other Reasons for Delay


The requirement is being stayed for other reasons, DOL stated in a series of frequently asked questions at <http://www.dol.gov/ebsa/faqs/faq-aca11.html>:

- Educational efforts from the U.S. Department of Health and Human Services and IRS guidance on minimum value need to come out first.
- Employers need adequate time to both comply and let employees receive the information.

Enforcement Safe Harbor (cont. from p. 12)

premiums based on any individual's health factor. Sponsors may not discriminate based on health status since there is no medical underwriting used in connection with any Part D plan.

Self-funded Supplemental Drug Plans Go Scot-Free

CMS and the U.S. Departments of Labor and Treasury said they will not take any enforcement action against a self-funded EGWPs because their non-Medicare supplemental drug benefits do not comply with the health coverage requirements released an FAQ that provides an enforcement safe harbor for such plans. See ACA Implementation FAQs Part XI, Jan. 24, 2013. 

Notices Available Through Exchanges

DOL is considering providing model, generic language that could be used to satisfy the notice requirement.


It said compliance could be satisfied if employers give employees information using the employer coverage template as discussed in the preamble to the Proposed Rule on Medicaid, Children's Health Insurance Programs, and Exchanges (the Jan. 22 *Federal Register*, see page 4641 — <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>). That form will be available at exchange websites.

Future guidance on complying with the notice requirement is expected to provide flexibility and adequate time to comply.

Background

The reform law required that employers provide each employee a written notice about the existence of health insurance exchanges to buy health coverage that are within price and value norms set by states, for use by employees in the event the employer offers either no coverage, unaffordable or inadequate coverage.

The now-postponed notice is supposed to include:

- a description of the services provided by the exchanges, and how the employee may contact exchanges to request assistance;
- an explanation that if the employer's share for plan payments is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit, if he or she purchases a qualified health plan through an exchange; and
- a statement saying if the employee buys a qualified health plan through an exchange, he or she may lose the employer contribution (if any) to any health plan offered by the employer and be excludable from income for federal income tax purposes. 

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Clear Disclaimers on Vendor Non-agency Save Plan From Paying \$1.7M Bill

Disclaimers that preauthorization is not a guarantee of payment, and clear language in contracts with a third-party administrator, utilization review vendor and dispute resolution vendor saying they were not acting as plan agents chased away a hospital's attempt to extract more than \$1 million from a union health plan.

In *Tenet 1500 San Pablo v. Hotel and Restaurant Employees Int'l Union Welfare Fund*, 2013 WL 75056 (Cal. App., Jan. 8, 2013), the San Pablo hospital sued the hotel and restaurant employees' health plan for payment for life-saving services provided to a patient.

The plan escaped unwanted payment to the hospital because preauthorization and medical necessity determinations were made by vendors who clearly told the hospital that their statements were not binding on the plan.

The Facts

A patient needing life-saving treatment was transported from a hospital in Nevada to the San Pablo hospital by air ambulance on June 16, 2008, and he remained there for three months.

For the first two months, the hospital believed the patient was covered only by another policy (issued by TriWest Healthcare Alliance). But on Aug. 27, the patient's wife informed the hospital that the patient was covered by the hotel and restaurant employees' multi-employer health plan.

On the same day, the hospital called the plan's third-party administrator (American Benefit Plan Administrators) to confirm that he had coverage. ABPA verified he was eligible, but also issued automated and live disclaimers that eligibility was not a guarantee of payment.

It then called the plan's utilization review vendor, Encompass, for a medical necessity determination. Encompass authorized treatment, but also provided disclaimers that this was not a guarantee of payment.

The hospital billed the plan more than \$1.7 million to pay for the patient's services. It called in Jack London, a consultant, to negotiate a discount. The contract between the plan and London indicated that he could not sign contracts on behalf of the fund:

The parties are not, and shall not be construed to be, in a relationship of employer and employee, principal and agent, partnership, or joint venture.

London negotiated and signed a letter of agreement with the hospital reducing the amount to \$1 million.

However, the plan did not see the letter until it was already signed, and disavowed any obligation to it. The plan told the hospital that London had no authority to bind it. It denied payment. The hospital submitted a formal appeal, and after review the plan paid \$15,000, its maximum payment to a noncontracting provider.

In May 2010, the hospital sued, and a federal court remanded the case.

In state court, the hospital asserted five "pre-discharge claims," for which the hospital demanded the entire \$1.7 million, in spite of the fact that the other insurer had already paid some \$460,000. Those claims included breach of contract, misrepresentation and paying amounts due (*quantum meruit*). It asserted violation of the plan's authorization of coverage and medical necessity determination.

The hospital also advanced three "post-discharge claims," alleging violation of the LOA signed with London, for which it demanded the \$1 million in the LOA.

The lower court ruled in the plan's favor, finding ERISA preemption and a lack of evidence supporting its charges. The hospital appealed.

Preemption

Even though the federal court remanded the case, finding there was no complete preemption, the lower state court said the five "pre-discharge" claims were preempted because they "related to" an ERISA health plan. The plan argued that the remaining three "post-discharge" claims were preempted, but the court said it didn't need to decide on those, because even if all eight were not preempted, the hospital failed to create a triable issue for any of the charges.

No Issues of Material Fact

The hospital failed to demonstrate error in the lower court rulings on *quantum meruit*, two charges of breach of good faith and fair dealing and breach of accounts stated, so the appeals court threw out those four charges.

No Implied Contract

The hospital alleged that the plan entered into an implied contract to pay the hospital's billed amount because it got verification of coverage and a medical necessity determination from plan agents.

See *Clear Disclaimers*, p. 15

Clear Disclaimers (continued from p. 14)

Implied contract requires parties capable of contracting, their consent, and an agreement in which both parties want and expect the same thing, the court said.

But the plan's director, and executives from the TPA and utilization vendor said the two vendors never had the power to enter into contracts or make binding decisions on the plan's behalf.

The hospital received disclaimers from ABPA and Encompass stating that their verifications and authorizations were not guarantees of payment and in deposition, a key hospital employee admitted that such disclaimers are customary in the health business.

The hospital employee also admitted in deposition that he knew that verification of coverage and authorization of services was not a guarantee of payment of claims, that plans deny payment after giving authorization and that the plan never told the hospital that it would pay for the patient's treatment. The hospital did not produce evidence to counter this admission. Therefore, the court found the hospital failed to support its argument that there was an implied contract to pay.

No Misrepresentation

The hospital said the two vendors and the negotiator made promises to pay, that the promises were false when made, and that the hospital relied on the promise to its detriment.

Unfortunately for the hospital, the evidence showed that the plan and the vendors were always clear: the fund was not bound to pay. In emails, London asked the plan: "Let me know how you will respond to [the hospital]," making it clear the plan held ultimate decision on payment. Elsewhere, the fund told the hospital that London did not have the authority to commit plan funds. Also, the key hospital employee in deposition admitted that he knew that London had authority to negotiate, but not to bind the plan.

All sides also understood that London's role was to negotiate a deal with the hospital and bring it back for review by the plan, after which another round of negotiation would ensue, until the deal was eventually hammered into shape. That was far different from the plan being bound by the first deal the negotiator proposed with the hospital, the court said.

In deposition, London testified that he never had the status as agent on behalf of the plan, and could not pay claims with plan money. Further, the contracting agreement between London and the plan expressly stated that the two were not in a relationship of principal and agent.


For its part, the hospital failed to supply evidence that London had "ostensible" authority. Ostensible authority hinges on the acts and declarations of the principal, in this case the plan, and not on the acts and declarations of the ostensible agent, in this case London.

But the hospital admitted that the plan never told it that London was authorized to enter into the LOA on behalf of the plan. Therefore, the hospital's "ostensible agency" arguments failed.

Finally, the hospital's "ratification" arguments failed. Ratification requires the principal's unequivocal assent to the unauthorized act. That failed because the plan clearly disavowed the LOA after learning of its existence.

Implications

This case is important due to the prevalence of service providers that enable employers to self-fund their employee health benefits. It illustrates that administrators and other service providers can act on the plan's behalf without conferring with it at every juncture. Such a decision allows service providers to be certain that with careful protections through disclaimers, they can act in certain capacities without binding the plan.

Further, the plan can void certain acts performed by the administrators. This also allows service providers to provide themselves with additional protections from crossing into the role of plan fiduciary, which places them in line for liability. 

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Contraception Under Reform: Religious Employer Exemption to Include More Employers

To further accommodate religious organizations outraged over a health care reform requirement mandating the coverage of contraceptive care, three federal agencies — Treasury, Labor and Health and Human Services — jointly issued a proposed rule Feb. 1 that would exempt more group health plans and policies established or maintained by certain religious organizations from the requirement, and expand the type of eligible organizations that can be provided with accommodations under the law.

Background

Generally, the Patient Protection and Affordable Care Act (Pub. L. 111-148) requires that non-grandfathered group health plans and policies provide certain preventive health services without cost sharing, to include contraceptive coverage. Many religious entities objected strenuously to this requirement, and several lawsuits challenging its enforcement are pending. A series of rules were promulgated, a temporary safe harbor for certain non-profit organizations issued in February 2012 (77 Fed. Reg. 8725). The safe harbor is in effect until the first plan year that begins on or after Aug. 1, 2013.

Subsequently, the agencies issued proposed rules in March 2012 (77 Fed. Reg. 16501) on potential approaches that religious organizations can use to comply. As evidence of the level of controversy, the agencies received approximately 200,000 comments.

One key concern was on the scope of the definition of religious employer. Currently, under the 2012 final rules, a religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization.

Some argued the definition was too narrow. For example, group health plans of some religious employers

do not qualify for the exemption because the employer provides benevolent services (such as a soup kitchen) to individuals irrespective of religious faith. Others argued that the definition was appropriate and broadening it would hamper women's access to important preventive health care services.

Another concern was the adequacy of the accommodations made for religious organizations. For example, some commenters felt that for insured group health plans, plan sponsors would end up funding the coverage in the form of higher premiums or fees. Other commenters said secular organizations with religious objections also should be accommodated. Some third-party administrators were concerned that if they took on the administration of contraceptive coverage (instead of the plan sponsor), they would become surrogate insurers subject to state insurance laws.

Proposed Changes

The proposed rules would make two principal changes to take into account religious objections of eligible organizations:

- Amend the criteria for the religious employer exemption to ensure that an otherwise exempt employer plan is not disqualified because its purposes extend beyond the inculcation of religious values or it serves or hires people of different religious faiths.
- Establish accommodations for health coverage established or maintained by eligible organizations, or arranged by eligible organizations that are religious institutions of higher education, with religious objections to contraceptive coverage.

Religious Employer Exemption Amended

The proposed rules would amend the definition of religious employer by eliminating the first three prongs of the definition and clarifying the application of the fourth. Generally under this proposal, an employer that is organized and operates as a nonprofit entity would be considered a religious employer for exemption purposes.

“By eliminating the first three prongs of the current definition, there no longer would be any question as to whether group health plans of houses of worship that provide educational, charitable, or social services to their

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See *Contraceptive Rule*, p. 17

Contraceptive Rule (continued from p. 16)

communities qualify for the exemption,” according to the agencies. It also would “avoid any inquiry into an employer’s purposes, as well as any inquiry into the religious beliefs of its employees and the religious beliefs of those it serves.”

Eligible Organization

These proposed rules would clarify that for accommodation purposes, an eligible organization includes nonprofit religious institutional health care providers, educational institutions and charities with religious objections to contraceptive coverage. However, the agencies are not including for-profit secular employers in this definition, noting they have religious accommodations in related areas of federal law, such as Title VII of the Civil Rights Act of 1964.

Each organization seeking accommodation would be required to self-certify that it meets the definition of eligible organization, following a process similar to that under the temporary enforcement safe harbor. While the self-certification form would not have to be submitted to the government, it would have to be made available for examination upon request to verify the organization’s status. Future guidance will provide more specifics on the form.

Separate Contraceptive Coverage For Plan Participants and Beneficiaries

In order to provide women with contraceptive coverage without cost sharing and protect eligible organizations that object on religious grounds, the agencies are proposing different rules for insured and self-insured plans.

Insured Plans

The insurer for insured group health plans of eligible organizations would have “sole” responsibility to provide the coverage. The eligible organization would give the insurer a copy of its self-certification. The insurer would set up individual policies (which would become a new category of excepted benefits) for plan participants and beneficiaries. The insurer would not be held liable if an organization’s representation about its eligibility status was incorrect. Conversely, the organization would not be held liable if the insurer failed to comply with the law.

Self-insured Plans

The agencies are considering alternative approaches:

- A TPA receiving the copy of the self-certification would have an economic incentive to voluntarily arrange for separate individual policies — it

would be automatically compensated for arranging for coverage through an insurer. Here, the TPA would be acting as an agent of the plan — not a TPA.

- The TPA would automatically arrange for an insurer to assume sole responsibility for providing the separate individual policies. The insurer would pay any of the TPA’s reasonable administrative costs.
- The TPA receiving the copy of the self-certification would be directly responsible for automatically arranging for coverage. It would become the plan administrator “solely for the purpose of fulfilling the requirement that the plan provide contraceptive coverage without cost sharing.” As such, this raises legal implications under ERISA’s reporting, disclosure, claims processing and fiduciary provisions for both the TPA and the eligible organization, the agencies noted.


Under all approaches, the insurer providing the individual policies would be able to offset its costs by claiming an adjustment in federally facilitated exchange user fees.

Other Provisions

The rules also propose that:

- Insurers providing contraceptive coverage would be responsible for providing an annual notice of availability to participants and beneficiaries in both insured and self-insured plans of eligible organizations.
- Each employer in a multiple employer group health plan would have to independently meet the definition of eligible organization or religious employer in order to take advantage of the accommodation or the exemption.
- Nonprofit religious institutions of higher education with religious objections to contraceptive coverage would have accommodations comparable to nonprofit organizations regarding student health insurance coverage.

Comment Period

The agencies are seeking comments on the proposed rules. The deadline will be in early April (60 days after the rules are published in the Feb. 6, 2013, *Federal Register*). Comments can be submitted several ways, including electronically at <http://www.regulations.gov>, or by mail to Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9968-P, P.O. Box 8013, Baltimore, MD 21244-1850. Refer to file code CMS-9968-P. 

be dumped by their employers into the exchanges. All this makes enrollment in the exchanges more expensive.

But employers with large risk pools, or low-risk populations, do not want to give away those lives, and their employees' money, to exchanges or insurers so that other, unaffiliated, high-risk lives can be affordably insured. It is their fiduciary responsibility to ensure that their employees receive the most bang for their buck as employers have seen their plan costs increase dramatically and need relief.

Higher Premiums for Fully Insured Plans

The bottom line is that fully insured premiums are expected to increase at a much faster pace than self-funded plan costs. Insurers will need to increase their group health premiums due to health reform, which creates a number of new direct and indirect expenses, expanded coverage risks and additional claims expenses. Insurers for fully funded plans can only spend a certain amount of premium dollars for administrative expenses; the rest must be spent on claims payment and health improvement type efforts. Some have shifted internal expense allocations but have not reduced costs.

Pay or Play: Why Not Pay the Penalty?

Some employers assert that the rising cost of providing benefits is too much to bear, and is forcing them to make workforce cutbacks. As a result, they are considering eliminating their health coverage and instead paying the penalty on their full-time employees; the "pay" option in reform's "pay or play" scenario is cheaper than maintaining benefits. So much for incentivizing employers to maintain their benefit programs.

Under health reform, the decision the employer is going to make does not relate to the "method" of providing benefits (self-funding vs. fully funded insurance), but rather, whether to stop providing benefits altogether. In my opinion, most employers believe that their first responsibility is to their staff. Employers have offered health plans for decades because health benefits are a valuable form of compensation used to both attract talented people and give a return on investment to the employer in the form of healthy employees.

While the pay option might be worth considering, there are strong reasons why employers should look carefully at all of their options and do their best to calculate the actual outcomes of each.

Tax Breaks

Employers that eliminate health coverage or opt not to offer it to full-time employees will be missing out on tax

breaks as will their employees. Employer contributions for health coverage are not considered taxable income to the employee and are deductible by the employer. Employee premiums that are paid through a Section 125 plan reduce the employee's taxable income, which reduces both the employer's and the employee's FICA tax.

Federal Reporting Remains

Employers that don't offer health coverage will still face federal reporting requirements so the penalty amount can be determined. Employees who are not offered coverage are likely to go to the exchanges for coverage. These exchanges will require a variety of employee data from employers, particularly for employees who may be eligible for the premium tax credit, which means employers may have to deal with a significant number of inquiries from exchanges, leading to increases in staff time dealing with these issues and ultimately higher costs.

Reputational Harm

Employers that opt not to offer health coverage could be doing long-term damage to their employment brands, making it difficult to attract top talent in the future. Even worse, they could lose current employees to organizations that do provide coverage. And the damage to the brand could be even greater for employers that once offered coverage but elect to eliminate it in favor of paying penalties. Employees who are forced to use exchanges may feel undervalued or abandoned by their employers.

Lastly, employees may demand additional compensation from employers that elect to drop coverage to cover the cost of health care they must now purchase with their own, after-tax dollars.

Reform Made Self-funding More Attractive

The reform-specific restriction of modified community rating mentioned above increases burdens on insured plans, but not on self-insured plans. Therefore, experts predict firms with younger workforces will be drawn toward self-insuring.

In fact, many employers that can no longer afford insurance, but don't want to relinquish control over their employees' benefits entirely, have started looking at self-funding as a viable option. Employers find that the fully insured environment is constraining. They don't have the ability to manage health costs, and they're held hostage to premium increases that come with full insurance. Employers want more control over their own destiny. This, in turn, has resulted in an increasingly competitive market for third-party administrator services and stop-loss insurance.

See **CE Column**, p. 19

Self-insurance offers a number of advantages for employers including:

- lower premiums in return for taking on the risk of covering workers' medical costs;
- greater flexibility in the health benefits they provide;
- the ability to tailor plan design to the specific needs of the employee population;
- better reporting and access to claims data, which is especially important to large employers seeking to understand health spending trends; and
- better management of manage cash flow, since funds are not drawn until claims are processed.

Even before health reform, self-funding was favored because generally self-funded ERISA plans are not subject to state premium taxes and state-mandated benefits.

Health reform gives self-funded plans additional advantages over fully insured plans as they are not subject to reform's essential benefit, risk adjustment or risk pooling requirements, and are not required to pay the annual fee that insurers must pay on fully insured products.

There is no question that you can design a self-funded product with ultimate costs that are less than the fully insured premiums, because stop-loss insurers can base reinsurance rates on factors not allowed under reform, such as gender, age or medical status. Best of all, if a self-funded group's risk worsens, it could move immediately back into either the insurance market or the exchange. By the way, this is exactly what the exchange proponents fear. The framers of health reform and the big insurance companies have said self-insurance will siphon off healthy lives needed in their exchange and big-insurance pools.

As always, self-funded employers can readily adapt targeted cost containment with proven employer return on investment, such as effective wellness programs.

A self-funded plan sponsor occupies a better vantage point to capitalize on health reform gaps. Rather than simply focusing on what the law says must be done, a self-funded plan sponsor can look for plan design opportunities the law does not preclude. A self-funded plan should be better able to react to specific claims expenses and to better adjust plan rules to contain costs. Employers considering investments in wellness are focusing more on self-funding so they, not the insurer, directly capture the ROI.

Reform Fuels Interest in Self-funding

Reform's enactment, along with the prospect of increasing insurance premiums in a difficult economy, appears to have intensified employers' interest in self-insurance.

In 2011, about 60 percent of U.S. workers covered by employer-sponsored health insurance were in firms that self-fund, up from 41 percent in 1998 according to the Kaiser Family Foundation. The number in firms with 200 to 999 workers in self-funded plans remained steady at about 50 percent, but a 2011 Booz & Co. study found significant interest among mid-sized companies in moving to self-fund products, largely to avoid the costs associated with premium taxes imposed by reform.

The percentage of workers in self-funded plans in firms with fewer than 50 employees has been close to 12 percent in most years examined but as of 2011, the Kaiser study found no evidence of an increase in smaller firms self-insuring their health plans.

However, health reform provides incentives for small employers to consider self-insurance and for insurers and TPAs to offer small-employer products supporting self-insurance. A number of policy analyses (Linehan 2010; Jost and Hall 2012) have observed that, in combination, guaranteed issue, elimination of waiting periods for coverage and community rating for small groups could cause large numbers of small employers to self-fund, adversely selecting the new Small Employer Health Options Programs exchanges, as well as the small group insurance market more generally.

As readers of my articles know, Massachusetts is the only state to have enacted health reform similar to PPACA. What you may not know is that my home state has seen an increase in the percentage of workers in self-funded plans among all firm sizes, except among workers in firms with fewer than 50 employees. Since 2006, when the Massachusetts health reform law was enacted, the percentage of workers in firms with 50 or more employees in self-funded plans increased from 54.4 percent in 2006 to 67.2 percent in 2011. In addition, Massachusetts currently is third in the country based on the largest amount of self-insurance in firms with fewer than 50 employees, at 18.8 percent.

Conclusion

I expect the small-employer self-funded numbers to go up significantly for the reasons stated in this column, but only time will tell. Barring a move by the federal government to limit stop-loss, the reform law will cause more employers to self-fund. Only the same reformers can stop its growth at some point down the road through more regulation. 📌

Subject Index, Vol. 20

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