

Health Reform Ruling Should Focus Employers on Compliance

The U.S. Supreme Court's landmark ruling on June 28 to uphold nearly all provisions of President Obama's health-reform law removes any excuse for employers to drag their feet implementing reform-driven changes to their health plans, says Attorney Ron Peck with the Phia Group. Now those plans have much less time to plan, Peck continued. Peck likens the employer attitude on compliance before the ruling to a student with a test in the morning. Instead of studying for the exam, the student relies on weather reports that school will be cancelled the next day due to snow. He wakes up only to find out weatherman was wrong; he will have to take a test in a few hours. And this could be the situation in many ways. *Page 3*

Litigation May Await If Plan Sponsors Try to Skirt Health Reform Duties

Significant legal risks come with health reform, because it creates tax, plan design and employee rights obligations. Participants will sue plans, plans will sue vendors and new fiduciaries will be created and scrutinized. Efforts by small or mid-sized employers to rejigger workforces or move employees into a new plan, in an attempt to skirt reform obligations could trigger lawsuits. Disputes could arise over mandated benefits, including pre-existing conditions, annual and lifetime limits and coverage of dependents. New challenges may arise over failure to implement, or communicate the availability of, coverage mandates. Independent review organizations will have binding authority over fiduciary decisions. Therefore plans may sue IROs for breach of fiduciary duty, and plans may be sued for not implementing the IRO's final determinations. These are but a few examples. *Page 5*

Shoddy Denial Processing Negates TPA's Exhaustion Defense

A third-party administrator's disregard of a self-funded ERISA plan's claim procedures allowed a plaintiff's case to survive — even though the plaintiffs did not exhaust the plan's administrative remedies. The plan failed to meet required timeframes for notification of the initial claim determination, and it never described the reasons it underpaid the physician's bill, a federal district court ruled in *Haag v. MVP Health Care*. The court discarded the TPA's arguments that it was not a proper defendant because it was not named as a "plan administrator" in the summary plan description. The court did so because the record showed that the TPA acted on its own when deciding the amount paid and handling the claim once it became disputed. There was no evidence of involvement by the employer and named plan administrator. *Page 9*

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No Plan Left Behind! The Battle for Self-Funding's Survival

By Adam V. Russo, Esq.



There is a war raging against the self-funded industry. Let me repeat this for those of you who are laughing at my first sentence. There is a war raging against the self-funded industry. While it has taken me a long time to acknowledge that this fight is bigger than a school yard brawl, I finally have to face the realization that there are major forces attempting to drive self-funding to extinction. If we don't act as a unified industry soon, there may be a time in the near future in which we have no industry.

I'm an optimist at heart and I always look for positives in any situation, or at least attempt to. But the reality is that our industry may evaporate not because of anything bad it did, but for the exact opposite reason — because we are really great at what we do. The best example of this is what's happening in California today, and make no mistake: it will spread to other states in rather short order. But there is a way for us to stop this from happening; that is, countering the insurance commissioners and state lawmakers who are opposing us.

While legislation (S.B. 1431) restricting smaller employers' ability to obtain stop-loss insurance continues to advance in California, the federal government is taking a closer look at how the availability of stop-loss insurance facilitates the growth of the self-insurance marketplace and what that means for health reform. This is all a little bit frightening, as the U.S. Health and Human Services, Labor and Treasury Departments recently issued a formal request for information about stop-loss insurance. What this means is that they are noticing our industry. But that attention is by no means a good thing.

I urge all of you to respond to the RFI based on your work with self-funded plans, but communicate with industry experts (the Self-Insurance Institute of America, the Society of Professional Benefits Administrators and the Health Care Administrators Association, for example) to ensure your answers are correct and consistent. The more educated the regulators are about our processes, successes and expertise, the less reason they will have to eliminate us.

All We Are Saying Is Give Self-funding a Chance

The RFI, particularly in its preamble, indicates that the agencies are spurred by concerns that employers may dodge health reform requirements by self-funding and obtaining stop-loss insurance with low attachment points. They also cite "adverse selection," yet to be proven by the agencies' own studies.

I've been in the self-funding industry for a long time and have yet to come across these low attachment point options except on a few occasions. The marketplace just doesn't exist for these products and most that do show up from time to time because of an influx of brokers in our industry looking to sell insurance under the self-funded title. Should a few misguided apples ruin the whole bushel?

It's not yet clear if the agencies' objectives are to satisfy the critics, or if they really feel that the self-funding industry must be more closely investigated. Is there a predetermined outcome in this process, or are they acting in good faith? The last two government reports have proven they can objectively report on our success, but I remain concerned there is a predetermined outcome.

The main possibility is that the agencies have specific regulations in mind and that they are using the RFI process

See *CE Column*, p. 16

Employer's Guide to Self-Insuring Health Benefits

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Health Reform Ruling Means Employers Must Now Set Sights on Compliance

The U.S. Supreme Court's landmark June 28 ruling upholding nearly all provisions of President Obama's health reform law removes any excuse for employers to drag their feet implementing reform-driven changes to their health plans.

For example, plans and third-party administrators may have held off producing summaries of benefits and coverage, Attorney Ron Peck with the Phia Group in Braintree, Mass., told the *Guide*. They were holding off deciding whether they will outsource SBC drafting, what they would include in the SBC and whether they should call on government agencies for help. Now those plans have much less time to decide, Peck continued.

Peck likens the employer attitude on compliance before the ruling to a student with a test in the morning. Instead of studying for the exam, the student relies on weather reports that school will be cancelled the next day due to snow. He wakes up only to find out the weatherman was wrong; he will have to take a test in a few hours. This could be the situation in very many ways.

Play-or-pay Questions Will Be Asked

Employers with 50 or more employees that were not previously insuring health for workers are being required to buy benefits (maybe for the first time) or pay a penalty. They might have not ever sponsored a plan, and are now faced analyzing whether to field a plan or pay a penalty.

Employer penalties for not providing coverage may turn out to be less costly than actually providing coverage (particularly if health costs continue to rise as they have in the last 15 years). If that is the case, employers may choose to pay the penalties rather than provide insurance to workers for the first time.

Employers with existing plans will be assessing the value of their plans in relation to IRS guidelines, how they size up next to their state's "essential benefits package," and whether health plans are a recruitment advantage. Then they will look at costs to decide whether to drop plans (or options) or keep them as they are.

The individual mandate that every person be covered will drive employees who previously opted out of coverage to now join employer plans. Employers must foot no less

than 60 percent of the total premium cost for each new employee.

Summary of Benefits and Coverage

Employers that sponsor health plans must issue a new uniform four-page SBC (both sides of the page may be used). They must be provided to participants and beneficiaries who enroll or re-enroll, starting on open enrollment periods that start on or after Sept. 23, 2012.

Basis: 77 Fed. Reg. 8668 (Feb. 14, 2012).

SBCs are to be distributed by insurers to health plan sponsors and by health plan sponsors to participants and beneficiaries. Only in the case of individual policies are they required to be distributed to dependents.

Reporting Health Coverage on Forms W-2

Employers must begin reporting the value of health coverage as an information item (but not a taxable income item) on employees' W-2 forms at the end of the year. The W-2 reporting requirement was originally scheduled to become effective for the 2011 tax year, but IRS delayed the mandatory compliance date to the 2012 tax year.

All employers that provide "applicable employer-sponsored coverage" during a calendar year are subject to the requirement. This includes federal, state and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements.

On April 26, 2012, IRS issued Notices 2012-32 and 2012-33, which invited comments to help inform the development of guidance on annual information reporting

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related to health insurance coverage. More IRS information about W-2 reporting can be found at <http://www.irs.gov/newsroom/article/0,,id=257101,00.html>.

Determining Whether Coverage Is Minimum-Value

Notice 2012-31, which IRS issued on April 26, 2012, calls for comment from the public in determining what kind of strategy it will recognize when plans present evidence that their coverage meets or exceeds coverage norms the government sets. IRS says it prefers to choose from among these three:

- 1) an actuarial value calculator (AV calculator) to be provided by the agencies;
- 2) design-based questionnaires and checklists that would certify that a plan passes muster without actuarial calculations; or
- 3) certification from an actuary when a plan's features escape measurement by either of the first two methods.

On Feb. 24, 2012, HHS issued an actuarial value bulletin (<http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>) describing the assumptions and methodology that HHS anticipates will govern the calculation of actuarial value.

To comply with the law's tax reporting requirements, employers will either have to have systems in place that track certain insurance-related payments or have a contractor do the reporting for them.

In addition, beginning Jan. 1, 2013, employers will be required to increase Medicare withholding. Under the new rules, employers will be responsible for withholding 0.9 percent on an individual's wages and compensation paid in excess of \$200,000 in a calendar year.

Employers also will be required to cap contributions on health flexible spending accounts at \$2,500, effective Jan. 1, 2013. IRS Notice 2012-40 provides information on the effective date of the \$2,500 limit and on the deadline for amending plans to comply with that limit.

Communicating and Reporting

Employers must address many administrative requirements, including new mandates for how employers communicate benefits to employees and how those benefits are reported to the federal government, says attorney Penny Wofford with Ogletree, Deakins, Nash, Smoak & Stewart in Greenville, S.C.

Employers whose benefit plans follow the calendar year need to begin preparing their materials immediately, Wofford said. Although companies may provide the

information electronically, it's a good idea for employers to plan on mailing printed copies to each enrollee's home. That will improve the odds that every household legally entitled to receive the information gets it, she said.

Written Notice of an Exchange

All employers covered by the health reform law have to give employees written notice of a health insurance exchange, for all new hires starting March 1, 2013, and for all existing employees on or by that date. Exchange notices must provide written information:

- that an exchange exists, including a description of the services provided by the exchange and contact information to request assistance;
- that if the employer plan's share of the total allowed costs of plan benefits is less than 60 percent of the costs, then the employee may be eligible for a premium tax credit and a cost-sharing reduction if the employee gets coverage through the exchange; and that
- if the employee purchases coverage through the exchange, he or she may lose the employer contribution to employer-sponsored coverage and that there might be tax implications for the employee in that case.

Plans may have the will to implement health reform, but cannot do so because the government hasn't yet explained important reform requirements. Attorney Jim Napoli with Proskauer Rose LLP identifies at least four instances:

- **What is an "essential health benefit"?** This is important, because failure to offer such a package of benefits can subject employers to fines. **Note:** On July 20, the government issued a final rule on identifying benchmark plans that will serve as essential-health-benefit templates in their states (see http://www.ofr.gov/OFRUpload/OFRData/2012-17831_PI.pdf). Future rules will be needed to set up systems for health plan accreditation.
- **How is a full-time employee defined** and how do you count your employee base for purposes of determining "shared responsibility" payments?
- **How will automatic enrollment work?** Not many health plans auto enroll their workforce, and questions remain about harmonizing enrollment periods, notice requirements and opt-out provisions, Napoli says.
- **How will they notify employees about insurance exchanges** and the differences between employer coverage and exchange coverage? Contact and comparison information might not exist because exchanges themselves might not exist when his provision becomes effective in March 2013. 🏠

Health Reform Will Spawn More Audits, Lawsuits and Liability, Expert Predicts

Audits from government agencies, more participant lawsuits and the dreaded play-or-pay rule could heap liability and risk on employer plans, all as a result of the health reform law that was just affirmed by a majority of the U.S. Supreme Court.

Employers must take these new liabilities into account when they move workers to part-time status or divert retirees into retiree-only plans, attorney Stacey Barrow of Proskauer Rose LLP's Boston office said at a July 9 webinar for Thompson Interactive.

Audits Expected to Increase

Enforcement of reform rules will trigger new reform compliance audits by the U.S. Departments of Labor, Health and Human Services and the IRS, Barrow said.

DOL, for one, added a section to its audit list to verify grandfather status. These audits are required under the law, and they started before the health reform ruling, Barrow explained. For the first few years, DOL's goals are about increasing awareness rather than exacting penalties. If employers demonstrate they are applying a good faith interpretation of the rules, they should not see harsh penalties, he said.

Litigation May Await Employers

Significant legal risks come with health reform, because it creates tax, plan design and employee rights obligations, Barrow says. Participants will sue plans, plans will sue vendors and new fiduciaries will be created and scrutinized, all as a result of alleged failures to meet the health reform law's requirements.

Importantly, efforts by small- or mid-sized employers to rejigger workforces or move employees into a new plan, as a means of skirting substantial reform obligations could trigger lawsuits. Here are new liabilities he identifies.

- **An increase in participant lawsuits is possible if employers seek to avoid play-or-pay penalties.** Workforce realignment may trigger litigation. The employer mandate requires employers to provide health insurance to all full-time employees (defined as those working 30 or more hours a week). Employers may try to increase the number of part-time workers (defined as those working fewer than 30 hours), so they can avoid providing coverage and still not pay a penalty. Any such realignment inherently carries with it a risk under ERISA of interfering with someone's rights. Workforce

realignment could result in running afoul of other federal anti-discrimination statutes, including the Americans With Disabilities Act, Age Discrimination Employment Act and Title VII of the Civil Rights Act.

- **New litigation risks also relate to retiree plans and exit strategies from retiree coverage.** Reform mandates generally don't apply to (so-called retiree-only) plans with fewer than two active employees. Some employers have spun off retiree plans from plans that used to cover both active employees and retirees, so they don't have to provide enhanced benefits to retirees. An extensive body of retiree-rights litigation under ERISA and the Labor Management Relations Act holds that retirees cannot be deprived of vested benefits. So restructuring existing plans to create retiree-only plans will probably fall into the traditional ERISA and LMRA battlegrounds, Barrow said.
- **Disputes could arise over mandated benefits.** Participants may bring lawsuits to enforce insurance mandates, including those regarding pre-existing conditions, annual and lifetime limits, coverage of dependents to age 26, etc. Participants may challenge the way the plan implemented a given coverage mandate; or they may challenge the manner the coverage was communicated.
- **Independent review organizations may become plans' enemies.** The reform law requires that non-grandfathered plans must use IROs to make final decisions, and those decisions are binding. Therefore, IROs can exercise discretionary authority after the plan, and could be subject to suit for breach of fiduciary duty. Plans may be sued over implementation of the IRO's final determinations, and plans may dispute the IRO's final decisions.
- **Interaction of employer plans with state-insurance exchanges.** Employers may face litigation if they use insurance exchanges as part of their overall benefit strategies. For example, if an employer terminates its retiree health plan and uses the exchanges a soft-landing for affected retirees. "We can see litigation about details timing and implementation of these strategies," he said.
- **Play-or-pay problems in states that won't expand Medicaid.** Unlike the employer and

See *Reform Audits*, p. 6

individual mandates, the Supreme Court did strike down the law's approach to Medicaid expansion in the states, but the stricken requirement that states expand Medicaid coverage could expose employers and plan sponsors to problems.

In states that opt out and don't expand Medicaid, individuals who would have been eligible for Medicaid may now obtain coverage through a public exchange and get a federal subsidy to do so. And that could expose employers to additional costs and increased exposure under the play-or-pay mandates, something Barrow called an unforeseen consequence.

Here are the most immediate compliance duties caused by reform, according to Barrow.

- **Form W-2 reporting requirements** for the 2012 tax year take effect for forms due to be reported in January 2013. Employers will first have to know amounts spent on health insurance by each employee, and by the employer for each employee. To figure out how to capture this data and report it, consult with your payroll company, benefits consultant, and maybe with an attorney or accountant. Small employers that issued fewer than 250 W-2s are exempt from the requirement next year. This requirement does not operate on a tax control-group basis, so if your organization is under a separate EIN with fewer than 250 workers, the subdivision is allowed to count the smaller number even if it is part of a larger entity. Employers definitely will want to explain to employees that they're not going to be taxed on this benefit, Barrow advised.
- **\$2,500 limit on health FSA.** This cuts last year's limit in half. One shred of relief is the lower limit can be implemented for plan years that start in any month in 2013. The other shred of relief is plan documents don't have to reflect the change until plan years starting 2014, but the actual limits must be implemented as required in 2013. Barrow, however, recommended that employers amend their plans soon to communicate accurately and clearly to participants.
- **SBC requirement.** Starting with open enrollments on or after Sept. 23, 2012, insurers must prepare and draft SBCs for insured plans. Self-funded plans should work with their ERISA counsel and third-party administrator to prepare the document.
- **Notifying employees of availability of the exchanges.** Originally slated for March 2013, this will not take effect until after October 2013.

Here is a list of 2014 mandates for which guidance has not been issued yet.

- **Pay-or-play mandate.** Employers with 50 or more will have to cover employees or face a penalty. Barrow says guidance is needed.
- **Employer certification to HHS** whether plan provides minimum essential coverage. Agencies have not issued rules, but Barrow expects guidance late in 2013.
- **Increase in permitted wellness incentives** from 20 percent to 30 percent. There's a chance that regulators may increase incentives to 50 percent, he said.

In 2014, employers will face completion of insurance mandates started in 2010. These include:


- complete prohibition on annual dollar limits;
- guaranteed availability and renewability of insured group health plans; and
- prohibition on pre-existing condition exclusions.

Future Regulations Needed

Not surprisingly, the regulated community gets frustrated as the government gives it duties and threatens penalties for noncompliance, but has left unexplained vital details about how to comply. The health reform law is no exception, and Barrow identified areas where plans need clarification as soon as possible.

Nondiscrimination. One rule that's been indefinitely delayed (to the delight of employers, Barrow said) is the application of nondiscrimination rules, which typically apply to self-insured plans, to non-grandfathered insured plans. Self-insured plans will tell you, these rules can be tricky. Congress managed to indefinitely delay these rules pending studies, Barrow said. Insured plans have these protections based on the insurer's underwriting guidelines in the laws. It is possible this rule may be issued in 2014, but that is uncertain.

Preventive care. The law requires plans to provide preventive services without cost sharing. There will be limited exceptions for self-funded employers and for religious employers relating to coverage of contraceptives for women. Barrow said rules are expected.

Essential health benefits. In a recent bulletin, HHS said essential health benefits will be defined on a state-by-state basis, not that it will not be a national standard. The agencies may develop a national definition for self-funded plans, but those plans will have the option of aligning their benefits to the state essential health benefit standard. 

U.S. Supreme Court to Resolve New Limits On ‘Equitable’ Health Plan Recoveries

The U.S. Supreme Court agreed on June 25 to decide whether an employee health plan is subject to equitable limits when it demands reimbursement of benefits paid for the care of a covered employee who also recovers money from third parties.

A 2011 ruling on this issue by the 3rd U.S. Circuit Court of Appeals troubled plan administrators because it allowed plaintiffs to argue that the term “appropriate” in “appropriate equitable relief” authorized courts to override clear plan terms for reimbursement of *all* costs a plan paid from third-party awards. It seemed to expand the variety of lien reduction arguments available to participants holding on to settlement awards, regardless of ERISA-plan subrogation language.

In *US Airways v. McCutchen*, 2011 WL 5557411 (3rd Cir., Nov. 16, 2011), the circuit ruled the outcome would not be “appropriate” because the participant would have had to go into his personal funds to completely reimburse the plan, as the ERISA document required.

The Supreme Court will be considering this question:

Whether the 3rd Circuit correctly held — in conflict with the 5th, 7th, 8th, 11th, and D.C. Circuits — that [ERISA’s enforcement provisions] authorize courts to use equitable principles to rewrite contractual language and refuse to order participants to reimburse their plan for benefits paid, even where the plan’s terms give it an absolute right to full reimbursement.

The Facts

James McCutchen survived a catastrophic auto accident involving two cars and a truck, killing two drivers and rendering him functionally disabled. He underwent emergency surgery, spent several months in physical therapy, underwent a series of back surgeries, and had a complete hip replacement.

He was covered by US Airway’s self-funded ERISA health plan, which paid \$66,866 after the accident.

He retained an attorney who agreed to represent him for a contingent fee of 40 percent of any recovery.

But because the driver at fault had minimal liability insurance, and one of the other people responsible for the accident died, he settled the case for only \$10,000. He and his wife received another \$100,000 in underinsured motorist coverage for a total third-party recovery of \$110,000.

Circuit: Make-whole Trumps Plan Language

After paying a 40-percent contingency attorney’s fee and expenses, McCutchen’s net recovery was less than \$66,000. It was then that U.S. Airways sought reimbursement for the entire \$66,866. McCutchen’s attorneys responded by placing \$41,500 in trust. The airline, as administrator of the ERISA benefits plan, sued when McCutchen did not pay.

A district court ruled that McCutchen had to pay the plan the full \$66,866 based on a clear plan provision calling for complete reimbursement of plan benefits. That would have included the \$41,500 from the trust account plus \$25,366 from his personal assets.

McCutchen contended the outcome would be unfair and inequitable, and the plan would be unjustly enriched if it was allowed to collect from him without any allowance for those costs, because US Airways made no contribution to his attorney’s fees and expenses.

On appeal, the 3rd Circuit concluded that US Airways’ claim for reimbursement is subject to equitable limitations, and vacated the district court’s judgment, remanding the case for further proceedings.

It harkened to the Supreme Court’s statement in the *Great-West Life v. Knudson*, 534 U.S. 204 (Jan. 8, 2002) that courts should limit equitable relief to what is “appropriate” under traditional equitable principles. In this case, the principle of unjust enrichment should limit US Airways’ claim, it said.

The 3rd Circuit also hung its hat on the Supreme Court decision in *Cigna Corp. v. Amara*, 131 S. Ct. 1866 (May 16, 2011), which ordered a plan to rewrite a plan provision that had been misrepresented to the detriment of plan participants. Even though there was no misrepresentation by US Airways in *McCutcheon*, a court is authorized to refashion a plan provision to achieve an equitable result even in the absence of misrepresentation.

Plans Object

Plan attorneys objected to the use of the word “appropriate” as used by the *McCutchen* panel. The expanded “appropriate equitable relief” definition could require self-funded plans to share the plan participant’s legal fees and expenses in achieving a tort settlement or judgment, which is something many plans often do voluntarily, they say. This outcome, on the other hand, erodes the

See *Equitable Limits*, p. 8

Experts Describe Major Changes Needed To Bring Health Costs Under Control

Health costs have been growing much faster than the rate of inflation, and most observers agree that while health reform addresses the issue of access to insurance, it inadequately addresses the underlying problem: the cost of care itself.

Unanswered questions surround reversing the unsustainable cost of health services. For example, would replacing the fee-for-service system with one that rewards care coordination and quality outcomes curb cost growth? Is health reform the spur needed to prompt plans and providers into together adopting value-based strategies? What will be needed to persuade consumers to consume health services more economically?

Experts from the insurance and employer-plans communities shared their ideas about reducing amounts spent on care by rewarding quality and paying for excellent care coordination, at a July 17 summit sponsored by *Health Affairs*.

Cut Costs, Don't Just Shift Them

If the country is unable to get to the root of the problem, cost-shifting will remain the name of the game. Patients have not been looking for ways to streamline care or lower billed amounts; instead they try to shift increased costs to insurers and employers, said Mark Smith, president and CEO of the California HealthCare Foundation. Providers charge private payers much more than public payers because they contend they are short-changed by Medicare and Medicaid.

There's no way to reduce cost if the nation does not consume fewer health services, said Helen Darling, president and CEO of the National Business Group on Health.

The insurance reforms passed in 2010 and just upheld by the U.S. Supreme Court will be inadequate, she said, because insurance reform without payment system and care delivery reform will not reduce health costs. The nation cannot have one without the others.

The key, Darling said, is to tying the way care is paid for to the way care is delivered. "We have to tie evidence to coverage and coverage to evidence." Bonuses should go to physicians for quality performance and outcomes, and for taking patients who are newly insured under reform, she suggested.

For example, under reform, states define unbridled benefits for obesity as part of the essential benefit, which would require all plans to cover that level of benefit in that state. Given the present epidemic in obesity, this

could be a cost disaster for plans, even though the service has unproven effects.

Cost control would be greatly advanced by transparency in the form of full disclosure of hospital and physician rates, and cost transparency on all supplies drugs and DME, she said.

Money's Running Out

When it becomes clear time is running out, people work harder. Likewise when it becomes clear money's running out, health care might get the incentive it needs to figure out how to better manage care, phase out unnecessary services and target high-cost conditions efficiently.

That is why effectiveness pilots, such as those sponsored by Medicare, need to be applied more broadly, Darling said.

Managed Care-only Strategy Failed

A managed care-only strategy — reducing coverage, tightening enrollment and cutting reimbursement — has not yielded sufficient results, said Bill Kramer, executive director for health policy at the Pacific Business Group on Health. Nor is it really clear that high-deductible health plans persuaded consumers to manage their health costs better, he said.


However, insurers, employers and plans can promote these tools to inform and create incentives to seek out less costly, more effective care:

- **Price comparison data**, for example, of replacement joints, or colonoscopy services, are available in some areas. But price transparency must be ramped up in scale or it will have little effect, he said.
- **Better management of chronic conditions**, identifying the proper quality improvement measures, and

See *Systemic Change*, p. 9

Equitable Limits (continued from p. 7)

ability of clear plan language to uphold a plan decision not to do that, they say.

Furthermore, the panel failed to fully explore the circuit's order that the plan "reform" targeted plan terms from *CIGNA v. Amara*, because key facts that supported the achievement of "equity" in *CIGNA* were not present in *McCutchen*, they contend. 

Shoddy Denial Processing Negates TPA Defense That Plaintiff Skipped Plan Appeals

A third-party administrator's disregard of a self-funded ERISA plan's claim procedures allowed a plaintiff's case to survive — even though the plaintiffs did not exhaust the plan's administrative remedies.

The plan failed to meet required timeframes for notification of the initial claim determination, and it never described the reasons it underpaid the physician's bill, a federal district court ruled in *Haag v. MVP Health Care*, No. 12-CV-536 (N.D. N.Y., June 6, 2012).

The court discarded the TPA's arguments that it was not a proper defendant because it was not named as a "plan administrator" in the summary plan description. The court did so because the record showed that MVP acted on its own when deciding the amount paid and handling the claim once it became disputed. There was no evidence of involvement by the employer and named plan administrator.

The Facts

Karen Haag was covered by the self-funded health plan sponsored by her employer, The College of Saint Rose. The employer wore three hats: plan administrator, plan sponsor and named fiduciary. It contracted with MVP to perform claims and appeals administration.

Haag underwent a double mastectomy with breast reconstruction as part of her breast cancer treatment. The surgery was performed by Dr. Dimitri Koumanis, an out-of-network provider.

Koumanis ordered a revision of the reconstruction as a follow-up to the first procedure. MVP verified that the procedure was covered on June 2, 2011. Then, on June 16, Koumanis performed a successful revision on Haag.

See *Shoddy Denial*, p. 10

Systemic Change (continued from p. 8)

tracking clinical outcomes — not just processes — will help control costs as well, Kramer predicted.

- **Value-based design** can give consumers an economic incentive to do the right things whether they are healthy or have a chronic condition. Making right decision will be rewarded, said Mike Cropp, CEO of Independent Health in Buffalo, N.Y.
- **Networks of high-performing providers** and incentives for patients to go to them. Under such a regime, plan members who use providers from the high-performing network will get lower out of pocket costs.
- **Patient centered dashboards**, where patients and health providers can view a patient's x-rays, lab work, and medical notes electronically, in the event they see a new provider or have an emergency. The regional system of health records would be a community owned asset, Cropp said.

Insurance Reforms

Karen Ignani, president of America's Health Insurance Plans, a group representing large insurers, said cost drivers in health reform include an essential benefits "buy-up" and a new health insurance premium tax. Part of the problem is the sudden nature of the changes, which include:

- **Sales tax on health insurance**, imposed by the reform law on insured plans and individual policies. They are passed on to individuals, small businesses, privately administered Medicaid plans and Medicare Advantage plans (thereby plans cancelling out added value and driving people away from those plans), she said.
- **Rating bands** — the ratio expressing the premium variation between the youngest members and the oldest members — will change under reform from 5-1 to 3-1 overnight, Ignani said. The abrupt way this will be done will force insurers to increase premiums, she said, although it will be a welcome development for elderly individuals.
- **Essential health benefits**: Consumers who have been making do with limited coverage and catastrophic only coverage will abruptly have to buy much more comprehensive coverage with a far less affordable premium, she said.

She went on to say: (1) more system conformity would contribute to cost control; (2) public and private measures to reform health delivery need to be coordinated; (3) transparency must support consumer driven health efforts and value based benefits; and (4) health care no longer can be considered an economic growth industry. 🏠

Koumanis billed the plan \$38,500 on June 28; a sub-contractor to MVP contacted the physician and offered to pay \$32,000 as full and final resolution of the bill in exchange for an expedited payment. Though Koumanis accepted that offer, he never received payment. Four months later, in response to follow up inquiries, MVP advised Koumanis that the the payment was still under consideration.

On Nov. 6, MVP remitted payment to Dr. Koumanis in the amount of only \$2,633 with an explanation code on the check stub indicating: “XNG Multiplan — No Negotiations Obtained.” Koumanis appealed for an upward adjustment, but on Dec. 23 received notice of MVP’s refusal to increase the payment; little further explanation was offered. As a result, Haag and Koumanis sued to recover the unpaid amount (\$35,866), as well as attorney’s fees and costs.

The Plaintiffs’ Claim

In seven state-law claims filed in the Supreme Court of Saratoga County, they alleged that MVP failed to comply with ERISA claim procedures and improperly failed to pay the full cost of Haag’s breast revision. MVP removed the case to federal court on the grounds of ERISA preemption.

Haag and Koumanis’ issued a proposed amended complaint that alleged the plan administrator failed to:

- 1) provide proper notification of an adverse benefit determination in violation of ERISA;
- 2) provide full benefits due under the plan, triggering ERISA’s enforcement provisions; and
- 3) comply with the notice requirements of The Women’s Health and Cancer Rights Act.

MVP tried to quash the plaintiffs’ motion to amend, arguing that the case was futile because:

- 1) MVP was not a proper defendant;
- 2) Haag failed to exhaust the plan’s administrative remedies; and
- 3) Haag failed to state a claim upon which relief could be granted.

The Decision

The court said it would consider the proposed amended complaint because the plaintiffs did not add new defendants and because MVP had adequate time to respond. It remarked that in order for a motion to dismiss to succeed, the plaintiff must have little or no support

for their charges. Then it went on to consider MVP’s arguments.

Plan Member Lacked Standing

In an interesting move, the court dismissed all charges brought by the plan participant, concluding that only the surgeon — by virtue of being assigned benefits by the plan member — had legal standing to recover the cost of the surgery. (The court ruled this way even though neither side argued the point of whether Haag lacked standing under ERISA.) Therefore, the court decided that all claims by Haag would be dismissed.

Claims Administrator Was Proper Party

The court addressed the questions of standing. MVP argued that it was not named in the SPD as a plan administrator. Haag and Koumanis argued that in spite of that, MVP controlled the benefits claim process and was a proper defendant.

Normally, the plan administrator and trustees are proper parties in ERISA disputes. The court said that even though the named plan administrator here was the College of Saint Rose EPO Group Health Plan, even if a plan identifies the employer as the sole plan administrator, courts may still decide the employer is not liable if it took no action in the benefits dispute.

The evidence showed that MVP alone decided to pay Koumanis just \$2,633, and it alone rejected Koumanis’ attempt to get more money. There was no evidence that anyone other than MVP participated in those decisions. Further, the SPD identified MVP as being in charge of determinations of medical necessity, prior authorizations and claims appeals.

Thus, plaintiffs sufficiently allege that even though the plan is self-insured, MVP controls all aspects of the claims procedure, decides whether to grant benefits, controls the distribution of funds and reviews all levels of appeals. There are no allegations that The College of Saint Rose took any action whatsoever about the denial of full benefits at issue.

Since the College of Saint Rose did not help decide the disputed claim, and plan administrators can avoid being sued in disputes over claims they did not work on, there could be no defendant if not MVP. The court accordingly let MVP remain as a defendant at this stage of the proceedings.

Plaintiff Need Not Exhaust Plan Remedies

The court rejected the plan’s argument that Haag and Koumanis failed to exhaust their administrative remedies,

See *Shoddy Denial*, p. 11

saying that defense was obviated because MVP failed to comply with procedural requirements.

If a plan has reasonable claims appeal procedures, plan participants must exhaust those procedures before taking complaints to court, case precedent states. Here, it was undisputed that the plan had reasonable procedures and the plaintiffs did not exhaust them.

However, MVP did not follow the plan's notification procedures.

- The plan required MVP to notify a plan participant in writing of an adverse benefit determination within 30 days of the day it received the claim. Instead, it waited four months before announcing its decision.
- Notices of adverse benefit determination must include: the specific reason for the denial, which specific plan provisions supported the denial and additional information needed to process the claim. But the only explanation for the payment denial was a few words on the check stub ("XNG Multiplan — No Negotiations Obtained"). MVP failed to provide the specific reason for the adverse benefit determination, and the other requirements. Its notification fell far short of satisfying the plan's provisions, the court said.

The court rejected MVP's argument that there was no adverse benefit determination, noting that on a claim for \$38,500, MVP paid only \$2,633, after the claim had been pre-approved and after MVP's vendor negotiated with the provider to settle the claim for \$32,000. That constituted an adverse benefit determination.

Thus, Haag and Koumanis were deemed to have exhausted the plan's administrative remedies and became eligible to pursue ERISA enforcement in court.

Claim Adequately Stated

Finally the court assessed whether Haag and Koumanis stated a valid claim. MVP said that there was no denial because it had approved and paid the claim at plan rates. The court disagreed because, as detailed above, the determination was three months late, the payment was just 7 percent of the claim, insufficient justification was provided for the withholding of the additional 93 percent, there was no reference to specific plan provisions supporting the denial and MVP omitted any description of information needed to perfect the claim.

Those were sufficient allegations to survive a motion to dismiss. The court decided against remanding the case

back to the administrator because discovery might reveal that a plan appeal would be futile.

Haag's claim for ERISA plan benefits also survived the motion to dismiss. The plan contended it approved the claim and paid the plan's approved amount, even though it was 7 percent of what the surgeon billed.

But the plaintiffs said MVP's underpayment coupled with processing delays and the inadequate notification combined to frustrate their effort to get required plan benefits. The court agreed that these were sufficient allegations at this stage.

The court dismissed Haag's allegation that MVP violated notice requirements of The Women's Health and Cancer Rights Act. It reasoned that because the SPD had adequate details on what was covered, Haag was made aware of coverage limits and requirements and used that information to get her surgical procedure done.

The court ordered Koumanis to submit an amended complaint that removed Haag as a litigant and removed claims under the WHCRA, which would be allowed to proceed.

Implications

As illustrated by this case, notice of adverse benefit determinations discussions have become increasingly relevant.

Content Requirements

What is required as it relates to notice of an adverse benefit determination?

An adverse benefit determination includes notice of the reasons for a claim determination and a reference to the relevant plan provisions, a description of information needed to perfect the claim, and a description of the procedure for appealing the denial. In addition to these requirements, PPACA requires non-grandfathered plans to implement supplemental appeals processes.

Right to Payment vs. Rate of Payment

This is particularly true in relation to payment of benefits issues. It is important to first distinguish between the "right to payment" and the "rate of payment." A right to payment issue arises when a plan fails to issue payment on a participant's claim, and require an adverse benefit determination. A right to payment issue is regulated by ERISA. However, a rate of payment issue is independent of ERISA and creates a contractual duty with the provider.

As providers are not beneficiaries of an ERISA plan, they should not have any rights under the plan.

See *Shoddy Denial*, p. 12

Provider Lawsuit Stays in U.S. Court Because Denials Reflected ERISA Terms

An out-of-network provider failed in its effort to return his lawsuit against a group health insurer to state court, because the payment dispute was an effort to enforce the plan and the provider had no independent contract other than the ERISA plan, a federal district court in Texas decided.

The reasons for denials on explanation-of-benefit forms pointed back to ERISA plan provisions, and they usually had to do with the *right* to payment, rather than the *rate* of payment, which are key factors in deciding that ERISA should preempt.

Paragon Office Services was out of network with Aetna and had no express contract relationship with Aetna for its services. Its business was providing anesthesia services incident to outpatient surgeries performed by obstetricians and gynecologists.

The provider nevertheless sought remand to state court arguing that the problem did not hinge on an interpretation of plan terms, but on a duty that was independent of the plan and ERISA. The case is *Paragon Office Services v. Aetna Inc.*, 2012 WL 2423103 (N.D. Tex., June 27, 2012).

The court relied on a similar opinion in *Paragon Office Services, LLC v. UnitedHealthGroup, Inc.*,

2012 WL 1019953 (N.D. Tex., March 27, 2012), with nearly identical facts. (For more details and background, see the May 2012 *Newsletter*.)

The Facts

Paragon billed Aetna for professional and equipment components. Aetna began taking inconsistent positions on the equipment component, Paragon alleged, sometimes paying and sometimes denying it. Thereby it underpaid the provider, Paragon said.

The practice knew it had no written contract setting out terms and rates of payment, but it contended that Aetna had:

implied contracts with [Paragon] to pay for equipment ... as part of the professional services rendered by the anesthesiologist.

It also alleged that Aetna stole services by: “intentionally or knowingly secur[ing] the performance of Paragon’s services by agreeing to pay for them, confirming its intent to pay by its words and conduct.”

The ruling centered on whether these state-law actions were preempted by ERISA.

See Complete Preemption, p. 13

Shoddy Denial (continued from p. 11)

However, participants (who do have rights under the plan) may assign their rights to the providers under their plan. With this assignment of benefits, the provider is entitled up to the amount of benefits that the participant had. Providers may try to use this argument to suggest that the ERISA protections would apply in a “rate of payment” conflict.

In light of this growing issue, plans should be cognizant of providers attempting to apply ERISA’s protections — particularly when an assignment of benefits has been conferred.

Liability of Claims Administrator

This case further illustrates that a claims administrator can be sued, and held liable for its actions on behalf of the plan if it exercises adequate control over plan assets or the decision making process regardless of any labels it may, or may not, be given in the SPD. An employer may still be shielded from liability where it

takes no action in a benefits dispute, even if it is named as the sole plan administrator.

Lessons Learned

Plans should follow their policies and procedures in order to ensure the full protection of ERISA. Failure to follow procedures and requirements as listed by the plan may result in the ability of the plan participant or beneficiary to fail to exhaust all the administrative plan remedies before filing in court.

Although rate-of-payment conflicts are typically independent of ERISA and are instead governed by contract principles between the plan and the provider, a provider may enjoy ERISA protections as a result of an assignment of benefits.

Claims administrators that seek to avoid liability as a plan administrator should take care to follow plan terms closely and seek plan discretionary determinations on questions of interpretation. 🏠

Provider Had Standing

The court concluded that Paragon had standing to claim ERISA rights by virtue of assignments of benefits. Aetna produced print records from its electronic database system showing two instances of Paragon's services being billed under AOBs to ERISA plans. Aetna also provided an:

accompanying affidavit of an Aetna Manager stat[ing] that the letter "A" in the Assignment field of these records indicates that the medical claim was submitted under an assignment to Plaintiff of the member's rights under the health plan.

That was enough to confer standing even if Paragon were not currently seeking money on those specific patient accounts, the court said.

Already, Aetna in *Spring E.R., LLC v. Aetna Life Ins. Co.*, 2010 WL 598748 (S.D. Tex., Feb.17, 2010) successfully used a similar defense saying: Evidence that an assignment was executed — even without the billing — is sufficient to confer standing in an ERISA suit.

Preemption Test

Aetna demonstrated that for most of the hospital claims (where standing was achieved through AOBs), standing was derived from the beneficiary's ERISA plan rights.

Under *Aetna Health v. Davila*, 542 U.S. 210 (2004), a case falls under ERISA's enforcement provision (and is therefore preempted) if:

- 1) it could have been brought under ERISA § 502(a)(1)(B), and
- 2) no other independent legal duty is implicated by a defendant's actions.

As happened in *Paragon I*, the court held that because at least one claim met this test for complete preemption, the entire complaint could be heard in federal court. Aetna's data printouts showing that Paragon had been assigned ERISA rights, plus Paragon's own acknowledgment that some of the plans at issue were ERISA plans, proved at least one claim met that test's first prong.

No Independent Duty

The court then rejected Paragon's argument under *Davila*'s second prong that its claims relied on a legal duty that was independent of ERISA.

Aetna (like United before it) showed explanations of benefits that cited ERISA plan terms; for example, those payments would be duplicative or unbundled under the plan. The court also looked at several EOBs saying Paragon was not on the ERISA plan's list of recognized facilities and surgery centers.

Looking at that evidence, the court concluded that the dispute centered around the *right* to payment (normally the purview of ERISA plans) and not the *rate* of pay (normally more indicative of independent contracts). Therefore it was an ERISA plan determination, and *not* covered under an implied independent contract. Quoting from *Paragon I*, the court said:

Courts have held that when the question is the right to payment, as opposed to the rate of payment, ERISA complete preemption is triggered and plaintiffs' motion for remand must fail.

Paragon was out of network, it lacked a provider agreement with Aetna, and it was seeking plan benefits through assignment. Accordingly the court ruled Paragon's case was preempted and it would stay in federal court.

Implications

This case should be an indication that providers and plans are starting to pay attention to the news. As plans are repeatedly seeing, situations wherein providers (particularly out-of-network providers) do not receive payment for services rendered as billed are making headlines.

Since this is becoming newsworthy, more and more plans (and insurers) are reviewing and scrutinizing bills as they arrive from providers. Upon review of the claims, the plans and insurers are exposing unauthorized or ineligible claims.

Unlike for in-network providers, plans have the ability to audit claims from out-of-network providers for mistakes and errors. The ability to perform these claim audits has the potential to save the plans money — and should be taken advantage of. 📌

Lessons Learned from *Paragon Office Services v. Aetna Inc.*

- 1) *Creating precedent.* As more out-of-network providers bring suits, more precedent is being established. These cases illustrate when cases of this kind will stay in federal court.
- 2) *Trend in the news.* The topic of auditing and/or reviewing claims is becoming increasingly popular. Plans should recognize their ability to review out-of-network claims to ensure accurate payment to providers. They should decide which duties tie back to the ERISA plans and which duties tie back to an ASA. EOBs should be reviewed to ensure they are clear and complete. 📌

Plan Effort to Recover for Bad Network Changeover Survives TPAs' ERISA Preemption Challenge

ERISA did not preempt a plan sponsor's lawsuit against a third-party administrator that allegedly phased out a "wrap network" without informing the plan, a federal district court ruled. Finding that the lawsuit neither "related to" an ERISA plan nor was an effort to enforce ERISA plan terms, the court therefore denied the administrator's motion to dismiss the lawsuit, which sought millions in damages based on myriad state-law claims.

The administrative services contract renewal that Scripps Health signed with its TPA seemed to give it access to Aetna's PPO discounts (Aetna was in the midst of acquiring the TPA). But after a few months, Aetna removed the wrap network without informing the plan, resulting in the loss of discounts on hundreds of paid claims, the lawsuit stated.

Scripps Health leveled state misrepresentation, breach of contract, negligence and other claims against the TPA and Aetna in *Scripps Health v. Schaller Anderson*, 2012 WL 2390760 (S.D. Calif., June 22, 2012), alleging that it lost \$4.4 million.

After hearing both sides' arguments, the court favored the plan: Its state-law charges were *not* preempted by ERISA. Further, its quest for punitive damages could advance as well.

The Facts

Scripps is an integrated health delivery network whose self-funded group health plan was administered first by Schaller Anderson, then by Aetna.

Scripps contracted with Schaller Anderson to perform claims administration services in 2002. In 2007, Aetna acquired Schaller Anderson. In April 2008, Scripps chose an Aetna PPO as its provider network, giving it access to discounted rates when billed by Aetna-contracted providers.

Scripps contended that Schaller Anderson and Aetna never told it that the PPO was in fact a "wrap network" that Aetna could eliminate when it wanted.

Note: Wrap networks pay claims from non-participating providers during transition periods and often expand discounted provider access beyond the primary network.

When it renewed in January 2009, Scripps thought the terms it chose in 2008 would continue. The 2009 renewal did say that Schaller Anderson was transitioning services to its new owner Aetna. And from Jan. 31 through Sept. 15, 2009, the plan was administered as

before, without any documents or policies reflecting the new administrative regime.

On Sept. 15, 2009, Scripps signed an administrative services agreement with Aetna. The ASA said no discounts would go to out-of-network providers, but implied that in-network providers would still get them. The ASA expired on Dec. 31, 2009.

Vanishing Wrap Network Costs Plan \$4.4 Million

During an audit of the Aetna's claims administration 2009 work for Scripps Health, an auditing firm discovered that Aetna never applied in-network discounts for claims submitted to providers in the wrap network at any time during 2009. The audit showed the plan overpaid \$4.4 million in non-discounted charges in one 12-month period.

Scripps sued under ERISA and 10 state laws, namely: (1) common law breach of fiduciary duty; (2) breach of written contract (against Schaller Anderson); (3) breach of written contract (against Aetna); (4) breach of implied contract; (5) intentional misrepresentation; (6) negligent misrepresentation; (7) unfair business practices; (8) negligence; (9) estoppel; and (10) declaratory relief. Scripps also fielded a claim for punitive damages. Aetna moved to dismiss the 10 state-law actions.

To survive such a motion, the court said, Scripps' complaint didn't need detailed facts; only enough facts to state a claim that is plausible on its face.

Preemption Arguments Fail

Aetna argued that the 10 state-law allegations were preempted by ERISA. The court rejected this after analyzing the case under both "conflict preemption" and "complete preemption" theories.

Conflict preemption

According to ERISA's conflict preemption provisions at Section 514(a), a legal claim can be preempted if it "relates to," meaning it has a "connection with or a reference to," an ERISA plan. Ninth Circuit precedent holds that conflict preemption usually requires a dispute to be over a denied benefit claim and/or failure to pay properly as per plan provisions, the court said.

Scripps' claims, while superficially involving its own ERISA plan, were "traditional state claims ... only tangentially related" to an ERISA plan, the court said. Its claims were not about violating plan terms and denying benefits due under the plan. Instead, Scripps was accusing

See *Wrap Network*, p. 15

Aetna of breaching the ASA contracts and failing to pay claims properly. Therefore its state-law allegations could not be preempted.

The state-law complaints also fell outside of ERISA's central missions, which include employee benefit structure, claims processing standards and a uniform administrative regime, the court held. In contrast, Scripps' state-law complaints alleged misconduct in areas traditionally regulated by states.

Scripps' state-law claims therefore were not "conflict preempted" by ERISA Section 514(a), the court ruled.

Complete preemption

Under ERISA's complete preemption doctrine, a claim is preempted if it at one time could have been brought under ERISA Section 502(a)(1) enforcement provisions. In other words, the case must be to defend or enforce rights derived from the ERISA plan.

Under *Aetna Health v. Davila*, 542 U.S. 210 (2004), a case falls under ERISA's enforcement provision (and is therefore preempted) if: (1) it could have been brought under ERISA Section 502(a)(1)(B); and (2) no independent legal duty is implicated by a defendant's actions.

The first prong of the *Davila* test was not satisfied, the court said, because Scripps' state-law claims could not have been brought under ERISA Section 502(a)(1). Unlike a beneficiary seeking benefits due under the plan, Scripps was seeking damages for acts (violating an ASA and negligently paying non-discounted charges) that did not fall into ERISA Section 502(a)(1)'s purview, the court ruled.

If a litigant bases its charges on an agreement other than an employee health plan, its claims are normally not preempted, the court said. Here, Scripps' case was based on obligations created by the ASA, not the ERISA plan. The fact that the mis-administration happened over an ERISA plan did not negate the fact that proper administration in this case was an independent legal duty, so the TPA failed in its attempt to invoke the second prong of the *Davila* test.

Because Aetna failed both prongs of the *Davila* test, complete preemption was not possible. Accordingly, the court refused to preempt the 10 state-law causes of action.

Punitive Damages

The defendants also filed to strike the punitive damages claim. Their argument that punitive damages were not recoverable in this case also failed.

First, the cases Aetna used to support its position that damages are not an available remedy in ERISA cases

involved only beneficiary claims against plans for unpaid health claims.

Scripps successfully argued that those cases said nothing about the question of plans seeking punitive damages from a fiduciary.

But more importantly, Aetna's argument against punitive damages was premised on a finding that all state claims were preempted by ERISA, the court said. But Aetna had just failed to get those claims preempted. On the contrary, the state-law allegations all remained standing, and Aetna advanced no arguments that punitive damages were barred for any of those causes of action.

Accordingly the motion to strike punitive damages from the complaint failed, as had the motion to dismiss the 10 state-law claims against Schaller Anderson and Aetna.

Implications

This case illuminates the need to review the health plan as a whole package. In an effort to prudently manage plan assets, plan administrators may hire outside contractors to perform certain ministerial tasks. Although a task may be delegated, the plan administrator is still responsible for ensuring prudent asset management.

Just as health plans must be aware of their own plan terms, they must be cognizant of the terms of any outside agreements they may have. These supplemental agreements could impact the application of their plan provisions in the claims administration process. Neglecting to review accompanying agreements — the administrative services agreement, provider network agreement, or stop loss policy — is a big mistake.

Performing a broader all-encompassing review can bring to light any potential gaps in coverage or provisions, which may inadvertently cost the plan and create a question regarding how plan assets are being managed. 🏠

Lessons Learned from *Scripps Health v. Schaller Anderson*

- 1) *Prudently manage plan assets.* Many cases arise when a plan is charged with mismanaging plan assets. It is crucial that the plan is prudently administered, potentially evoking the need for the assistance of an outside entity.
- 2) *Various agreements.* Since a plan may engage another entity to perform certain services, the plan must review the accompanying agreement for terms or provisions which may conflict or create coverage issues for the plan. This case is a perfect example of an administrative services agreement which did not capture the true desires of plan, and resulted in the loss of significant discounts. 🏠

to identify excuses to put those new rules in place, which will satisfy the critics and keep the mobs at ease.

The conventional understanding of separation of powers dictates that should the regulators conclude that the self-funding marketplace needs to be regulated differently than what the health reform law provides, they should make such a recommendation to Congress so it can address it through legislation. Instead, from what I'm hearing, it sounds more like the ERISA agencies are preparing to use rule-making to restrict the availability of stop-loss insurance and make other changes that would harm the stop-loss insurance marketplace.

Presents Under the Tree for Insurers

In fact, the U.S. Department of Treasury breached its statutory authority when the IRS proposed a rule that would let people get subsidies to buy health insurance through a federal exchange although the legislative language specified that that the subsidies could only be used for state exchanges.

In other words, rather than admit they are trying to contain and control self-funding and deal with ERISA, they are trying to sneak regulation in through the back door through state law and stop-loss regulation.

Sticks and Coal for Self-funding

Despite strong opposition by SIIA and other groups, the California State Senate Health Committee has passed S.B. 1431, which would prohibit stop-loss insurance with specific attachment points lower than \$95,000 for companies with 50 or fewer employees. (**Note:** In mark-ups at the state Assembly on June 27, the limit was lowered to \$60,000.)

SIIA contends that S.B. 1431 is likely to be preempted by federal law and will therefore expose the state to litigation. SIIA's comments were supplemented by the California Chamber of Commerce and the California Health Underwriters, which also provided testimony at the hearing. The HCAA and the National Federation of Independent Business joined SIIA in formal opposition to the legislation.

Testifying in support of the S.B. 1431 was the California Department of Insurance, Blue Cross Blue Shield of California and Service Employees International Union, all contending that the legislation is needed to prevent stop-loss insurers from cherry-picking healthy groups and therefore creating adverse selection market conditions that could compromise the viability of that state's reform-mandated insurance exchange.

The bill could effectively take away the ability of smaller employers in that state to operate self-funded group health plans by restricting access to stop-loss insurance. We as an industry must continue to express strong opposition to this legislation.

The cost of health insurance premiums has spiked for all California employers; this is especially challenging for smaller employers that wish to provide quality health benefits for their workers. S.B. 1431 would make this problem worse by eliminating the self-funding option for many companies within the state that otherwise must choose between absorbing increased costs every year or to drop health coverage altogether.

S.B. 1431 would make stop-loss insurance no longer available with policy terms appropriate for smaller employers; it therefore would subject them to unacceptable financial risk. Quite simply, if employers cannot retain stop-loss insurance with terms consistent with their financial risk transfer needs, they are not able to self-fund.

Small and Healthy Beats Big and Sick

For many employers, self-insured plans provide cost containment advantages and are often customized to meet the specific needs of the plan participants.

With so many important health inflation and health delivery issues facing our nation, I cannot understand the reasons behind California's move.

I truly believe that the size of the plan is not the only factor to consider when deciding whether to offer a self-funded plan, regardless of stop-loss coverage. For example, if I run cash heavy IT companies with 30 young active employees, why wouldn't I be self-funded? It sounds less risky than if I were running a 500-person factory where 80 percent smoke and 60 percent are overweight. I'd take my chances that the smaller employer has less risk.

ERISA Might Preempt State Stop-loss Law

It is my position that ERISA preempts S.B. 1431, since it prohibits states from imposing regulations that affect the administration of self-funded group health plans. Since the bill would restrict employer risk transfer arrangements, this directly affects plans administration and therefore would invite an ERISA preemption challenge.

The problem has been the confusion among policymakers about how self-funded group health plans actually operate and the role of stop-loss insurance, which has led to erroneous conclusions about

See *CE Column*, p. 17

regulatory deficiencies and adverse selection. A better understanding of actual marketplace practices can easily address these issues.

Self-funding Is an Important Safety Valve

The fact remains that through self-funding, companies pay for only the health care their employees use, rather than fixed premiums that potentially are more expensive and are certain to rise each year. Self-funding also gives companies some insight and control over their health costs, as they see all claims activity and can to steer certain employees toward wellness programs. Some companies, such as those with a fair amount of cash on hand, consider this a cost effective alternative to fully funded insurance plans.

It seems that self-funding works “too well.” Normally, the government encourages innovation so as to increase growth and encourage job creation. But when it comes to self-funding, the government instead seems to want to punish employers that self-fund.

It looks this way to me: You have a successful self-funded plan, your employees are happy, your costs are down, and you have a great wellness program contributing to workforce efficiency. Well guess what? The government doesn’t see any of that and instead is fixing to punish you and force you also to pay premiums for some lazy guy who won’t get off his couch.

A critical component of self-funding employee benefits is the purchase of stop-loss insurance. This coverage protects employers against catastrophic claims, such as chronic illness or a car accident. Stop-loss acts as a shield to a company’s self-funded plan, as it kicks in once an employee or the company itself incurs medical bills beyond a certain threshold, reimbursing the company for claims that might otherwise devastate its bottom line.

Keep in mind that self-funded plans pay medical bills. Let me repeat that – the plan pays the doctors. Stop-loss doesn’t pay medical bills. They don’t pay doctors or hospitals. They pay the plan after the plan produces evidence that it paid claims. Stop-loss, on its own, then determines if the claim is covered for reimbursement.

The Plan Is on the Hook for Benefits

A self-funded benefit plan’s stop-loss claims may be denied for any number of reasons. This happens often, and when it does, the self-funded plan still has to pay the medical bills. With health insurance, if the insurer

denies, the provider is the one that suffers, and the employer is out of the equation. How anyone can confuse these two distinct scenarios — defined by the employer bearing the risk versus shifting it to an insurer — is beyond me.

However, some states, including New Jersey, have received complaints that: (1) small employers that “self-fund” but have stop-loss are actually fully insured, and are using the self-funding label to avoid state regulation; and (2) some insurers selling stop-loss policies to small employers have been selectively marketing and underwriting coverage to groups with healthier workforces, which by definition are less likely to incur claims against the stop-loss plan.

This, the state argues, is not only “sham” self-funding, but is also a direct threat to the exchanges — due to the distribution of healthy lives to self-funding and sick lives to the exchange. The stop-loss insurers, the state argues, used medical questionnaires to find out the health status of individual employees at a prospective small company client and set rates based on these factors.

According to the regulators, the concerns about such practices are two-fold: state law bars traditional health insurers from setting premiums of small companies using anything other than geography and the age and gender of employees. So it would be unfair for a stop-loss policy, which is not regulated as health insurance, to do differently. But the problem is that stop-loss coverage is not health insurance.

Life insurers and auto insurers can set higher rates for individuals they consider more likely to cost them more in claims, but health insurance does not follow this approach.

Why is this the case? Why is it fine for auto insurers to discriminate against drivers who had 15 accidents and not charge them the same as the person who never had an accident in 50 years?

This may be due to the fact that the government’s stance on self-funded health insurance is different than its stance on life and auto insurance.

They Want to Tax Us

So, why are states like California doing this? Let’s consider California and the state of its economy. The Golden State is dead set on creating the exchanges and reaping the benefits of premium taxation (something self-funded plans don’t pay). California can better ensure that the exchanges are full of healthy lives by restricting the ability to self-fund.

See *CE Column*, p. 18

Employee Numbers Not Sole Determinant

Consider a self-funded employer in Los Angeles with 45 employees in the high tech industry. It has a wellness program that encourages employees to work out, run during lunch and eat healthy foods.

This employer offers preventive care at no cost to the employees to ensure early diagnosis of high cost chronic disease. It purchases stop-loss coverage at a \$50,000 specific deductible just in case there is a very large medical bill out there.

Here is the best part of the entire self-funded plan: The employer can design the plan any way it wants. If it wants to cover acupuncture it can. If it wants to cover chiropractic care at 100 percent for active employees who tend to rock climb on the weekends, it can. The plan can have its data audited daily to identify problem areas for its employee's health, use analytics to stop fraudulent claims and have an aggressive cost containment policy.

Everyone seems happy as the premiums have not gone up in two years, yet benefits have increased and the overall workplace is more productive due to the healthier employees not taking sick days.

These are the employees that the state wants in the exchanges. Since states cannot regulate self-funded plans, there is only one way to get the states' hands on these employers: Regulate the ability to purchase stop-loss. If S.B. 1431 passes, the above referenced plan would not be able to self-fund. Just like my company, The Phia Group, would not be able to self-fund. Therefore, the only option for this employer would be to join the California exchange and no longer have the ability to design their employees' health plan to meet the unique needs of their staff.

As mentioned, the big worry is that by enticing healthier labor pools to self-fund, the fully insured market would become increasingly concentrated with sicker companies, thus pressuring costs of premiums to rise even higher. State insurance commissions are aggressively barring stop-loss insurers from cherry picking healthier groups through selective marketing and medical underwriting, even though they allow the same thing for automobile and life insurers.

Next Steps

So what can we do about all of this? It has been argued that a state's ability to regulate stop-loss could be preempted by federal law (ERISA). This is because

stop-loss policies are a component of self-funded plans, which typically fall under the purview of the U.S. Department of Labor. In other words, regulation of stop-loss impacts the administration of self-funded plans.

Others questioned the department's legal basis for regulating stop-loss policies on the same grounds as a health plan, foreshadowing the battle to come when a formal regulatory proposal is introduced. The fact remains that, as previously mentioned, stop-loss is not a health insurance product, it's a reinsurance product. It has only one purpose, to reimburse catastrophic losses to self-funded plans when those losses — not medical services — are covered by the policy.

A number of steps can be taken: support industry associations with money, time and knowledge; donate time to assist industry groups; draft memos; educate the public; and encourage them to reach out to their representatives in Congress.

I recently went to a human resources conference to see if anyone mentioned self-funding during their speeches. So I sat and listened and waited. I heard speakers discuss their innovative processes in their health plans; how they scrub their claims data for efficiencies, how they have innovative plan design, and so on.

They kept talking for hours until I finally raised my hand and asked if their plan is self-funded, and of course the response was yes. That "small" fact was not mentioned until I brought it up.

Then people in the audience started commenting about how they don't have the ability to do any of the innovative, plan customization tactics mentioned by the speakers because they are fully insured!

What can we do to defend ourselves? First we need to get every TPA to send the same template letters to all of their employers explaining the issues and asking for testimonials about how self-funding has allowed them to offer more benefits more efficiently.

We also need to have a letter employers can distribute advising employees to reach out to their state and federal representatives.

People in self-funded plans across the country don't appreciate that they are self-funded, or the flexibility it affords them, and people in fully insured plans don't realize what they are missing. We need to act in a fashion never seen before in the self-funded community: with defiance, bravery and aggression toward those who seek to drive this industry to extinction. We need to spread the message. 🏠

Subject Index, Vol. 19

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 19, Nos. 1-11. Entries are listed alphabetically by subject and the name of the court case. The numbers following

each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "19:11/2" indicates Vol. 19, No. 11, page 2.

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