Employer's Guide to
Self-Insuring Health Benefits

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Keys to Successful Cost-plus Provider Reimbursement

Self-insured health plans are wondering what they can do to ensure that they are billed rationally for hospital and other health-provider services. The answer, says Contributing Editor Adam Russo Esq., lies in cost-plus and Medicare-plus payments. Under a cost-plus program, the plan or administrator first reviews what the services cost the hospital. Under Medicare-plus reimbursement, they refer to what Medicare normally pays the facility. These methods could result in balance billing of patients if they are not properly rolled out, and hospitals and providers are not known to take pay cuts lying down. One key is to pay more than Medicare on specific services, visits or specialties, as a bargaining chip with the facility. Russo describes the pitfalls and the many cautionary steps plans must take to make this process work for a self-funded plan. ***Pages 2, 3***

Self-funded Plans Prepare to Pay Transitional Reinsurance Tax

The transitional reinsurance tax will be imposed on health plans to help stabilize premiums for individual market coverage from 2014 through 2016 under health reform. Self-insured plans are subject to the $63 per year per member charge, even though they will receive nothing back because they are not insurers. The rule taxes plan sponsors and insurers based on the number of lives covered in major medical plans, according to a new health reform rule. The rule excludes certain types of coverage from reinsurance contributions. Third-party administrators may pay the fees on behalf of self-insured plans, although the plans themselves are ultimately responsible for the payments. ***Page 5***

Free-Access Rules Will Raise Premiums, Insurers Contend

Starting in January 2014, most insurers offering coverage must accept any individual or employer that applies, subject only to limits on network or financial capacity, under the rules. That means no pre-existing condition exclusions and much less underwriting of health insurance. Self-insured plans have the same no-exclusion rules. Also, insurers are strictly limited in premium variations for age and tobacco use, but no longer gender, occupation, past insurance claims or health status. A major association of health insurers said the provisions will increase insurance rates and may lead some insurers to limit their product offerings. The group also said new age rating bands could increase premiums for younger individuals who live in states that currently have higher age bands but would have to drop them. ***Page 7***

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An Employer's Perspective: Defining The Dilemma of High Hospital Costs

By Adam V. Russo, Esq.

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The high cost of health care is making national news these days and as a result, the national media is finally asking a question that the self-insured community has been asking for years: Why aren't medical facilities paid based on the cost of care given?

In his March 2013 *Time Magazine* cover article, "Bitter Pill: Why Medical Bills are Killing Us," Steven Brill shares the story of Sean Recchi, who was diagnosed with non-Hodgkin's lymphoma at age 42. The total cost for Sean's treatment plan and initial doses of chemotherapy was $83,900. Had Medicare been paying, the hospital would have received far, far less in payment. Why? Because Medicare pay is based on a hospital's cost of providing a service, including overhead, equipment and salaries. That is the key to Medicare's approach to payment. It uses the rational approach of reviewing the cost of care *before* issuing payment.

Unfortunately, this is not how the private health insurance marketplace behaves. Generally, the cost is set with little or no effort to justify it.

If private insurance and self-funded employers would adopt cost-based or Medicare-based reimbursement, many cost-control problems would cease. By focusing on costs, we can finally reduce the ridiculous level of health care spending in this country — and make access to health insurance more affordable for all. However, this can only be done through an overhaul of hospital charges and the current payment process.

Exorbitant Health Spending

When Brill asked the hospital to comment on Recchi's bill, it released a written statement that said in part, "MD Anderson's clinical billing and collection practices are similar to those of other major hospitals and academic medical centers." It never backed up its charges; it just said they are a common practice. This is part of the problem — just because everyone does it, doesn't make it right.

Based on Brill's article, our country is likely to spend $2.8 trillion in 2013 on health care. The federal government will pay roughly $800 billion through Medicare and Medicaid. This figure is what's driving the federal deficit. The other $2 trillion will be paid mostly by private health insurance companies, self-funded plans and individuals who have no insurance or who will pay some portion of the bills covered by their insurance. This is what's increasingly burdening businesses that pay for their employees' health insurance and forcing individuals to pay so much in out-of-pocket expenses.

States Gradually Adopt Needed Price Controls

When you look at the hospital bills that all insurers and self-funded employers pay each day you realize there is no rationale behind any of the charges. The self-funded

See *CE Column Hospital*, p. 10

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Keys to Successful Cost-plus Provider Reimbursement

By Adam V. Russo, Esq.

As health care costs continue to skyrocket across the country, more and more self-funded plans are looking for alternative ways to reduce the cost of health insurance for their members. One of the emerging ways is to implement cost-plus, or Medicare-plus, reimbursement.

To give a clearer understanding of what this means, let's take a typical hospital bill. Under a self-funded PPO program, the plan agrees to pay the bill with a pre-negotiated discount of 20 percent within 30 days of receiving the bill. End of story. So a $100,000 bill is paid at $80,000 with few or no questions asked by the third-party administrator or the plan.

Under a cost-plus program, the TPA would first review what the services cost the hospital or what Medicare would have paid the facility. This information is available publicly or through specified firms with access to this information. Then, the plan would apply an agreed-to multiple to see what the payment should be. So to make this simple, let's say that Medicare would have paid $30,000 and the plan allows Medicare plus 40 percent as its payment, then the plan would pay $42,000 to the facility. So we are looking at a $38,000 difference between what the plan would traditionally pay and the new amount.

The key to the program is having the right specialists and attorneys handling the process. It may be necessary to have someone represent patient interests separately from the plan and TPA. It is vital that you attempt to negotiate with key providers ahead of time. This relies heavily on how many similar providers are located in the region. There are plenty of incentives and arguments that can be used by plans, such as assignment of benefits, steerage, prompt payment, electronic payment, and plan payment of copays and deductibles, for the capped payment from the plan to be viewed as payment in full.

In order for these types of plans to have any chance of success, administrators must educate employers and employees on the entire process. If the provider is not satisfied by the assignment of benefits and the guaranteed plan funds it brings with it, it should return the assignment to the patient so that the plan can pay the maximum allowable under plan terms and deal directly with the patient for payment. Hospitals do not want to deal with patients paying claims if they can obtain funding directly from the plan. Under health reform and IRS rules, the hospital will be limited in its billing processes as well as the amount they can actually pursue. Therefore, the days of threats and overcharging these individuals may soon be coming to an end!

Getting Agreement from Providers

One of the key ingredients to a successful cost-plus program is for the plan to promote utilization review by steering patients toward preferred providers with whom the plan has pre-negotiated better discounts or have agreed to be reimbursed based upon a cost-plus methodology. There is no way to prevent balance billing from occurring unless you have a contract between the parties agreeing to accept a certain amount as payment in full.

Based on my experience, plans use PPOs to ensure that the patients will not be balance billed and all participants are aware of the providers and hospitals that are in the network. So while there is no way to prevent balance billing entirely, plenty of strategies can limit and combat it.

Many plan administrators fear setting a precedent by agreeing to a higher payment than originally offered under a cost-plus plan. However, in certain circumstances paying more is justified in order to settle balance

See *CE Column Cost Plus*, p. 4

CE Column Cost Plus (continued from p. 3)

billing issues and reduce noise. Paying a higher amount is not looked upon as setting precedent in these cases since they are all so unique. The blow can be softened by pointing to unique facts applicable to the particular instance, as well as listing multiple parameters the plan can use in deciding what the payable amount is. The fact remains that no two claims are alike.

Retain Plan Autonomy to Pay Differently From Medicare

The plan design is the key to a successfully run program. It is important that there is no actual black and white definition of what your payable amount is. Instead, Medicare should be one of many factors the fiduciary considers in calculating the reasonable amount to be paid. Many items must be included in the language. There are specific items that you need to include and certain references you must avoid, such as mentioning a network for facility or hospital claims.

Many of these cost-plus plans do not use this methodology for all of their claims. For instance, office visits and physician claims may be paid using a physician network, while hospital claims may be paid based on the cost-plus process. The best types of plans will do it all. They will have carve-outs for certain specialties, there will be a limited network for hospital claims, direct facility and provider contracts, a physician-only network for typical office visits, cost-plus options for large out-of-network bills, and great cost containment options in the mix. Sadly, not enough of these plans currently exist, but that's slowly changing.

Huge Pitfalls of Weak Preparation

I see plenty of situations where the plan document clearly defined what the maximum payable amount or ceiling for payment on a particular claim would be. The parameters used by the auditor or repricer must be supported by the language and terms in the plan document.

> **Example:** The TPA or plan hires an audit firm to review a $200,000 hospital bill. The audit firm is paid based on a percentage of savings from the total billed charges. The audit firm advised the plan that the Medicare payment on the claim would have been $40,000 and thus that is what the plan should pay. It then receives a check from the plan on the $160,000 it "saved" the plan for a total of $40,000 based on its 25-percent fee. Thus, the plan actually ends up paying $80,000 on the claim. Well, a year later the hospital sues the plan and the patient for the $160,000 it didn't pay, as well as for interest and legal fees associated with the claim itself. The audit firm never received sign off from the hospital that it actually accepted the payment as payment in full. However, the auditor was paid in full and now it is nowhere to be found. The plan document states that the plan must pay the claim based on the usual and customary charges in the area of the hospital.

Well folks, I can tell you that Medicare was not the U&C rate charged by hospitals in this area. That number was roughly $180,000. So the lesson here is to ensure the audit firm you work with follows the plan document terms. If they do not ask you for a copy of the plan document, then you know to stay away from that company.

The best plans use a variety of pay methods: Physicians may be paid through a network while hospitals may be paid cost-plus for the most part but with carve-outs for certain hospital services.

Prepare Air-tight Process That Fends Off Challenges

If you want a plan with no noise from hospital administrators and one in which the patient never has to worry about receiving letters from hospitals or creditors asking for additional payment, then cost-plus or Medicare-plus type plans are not for you or your employees. These plans require toughness and patience but also offer tremendous savings.

To stop attempts at cost-plus reimbursement from turning into a painful charade, we recommend that the following steps be taken (the following are imperative to success):

1) There must be a well-established patient advocacy and balance-billing process that starts in-house and uses an experienced attorney when necessary.
2) Get help preparing cautionary language and layout on ID cards, EOBs, correspondence to members, and to providers.
3) State exactly how much will be paid for a specific service — no more and no less.
4) Have available credible information on the hospital costs and profits as well. Prove they are making more than they would under Medicare, so it will be hard for hospitals to argue they deserve to be paid more than what your plan offers.
5) Be prepared to go to court, and be ready to prove the hospital does not deserve to be paid more.

See *CE Column Cost Plus,* p. 5

HHS Finalizes Transitional Reinsurance And Other Market Reform Rules

The federal government has been busy recently when it comes to finalizing various health reform rules. In the March 11 *Federal Register*, the U.S. Department of Health and Human Services issued two final regulations: one on the transitional reinsurance program, and another on benefit and payment parameters relating to various health insurance market reforms.

Under the health reform law, beginning in 2014 individuals and small businesses will be able to purchase health insurance through affordable insurance exchanges or "marketplaces." Individuals who enroll in qualified health plans through such exchanges can receive premium tax credits. The reform law also instituted premium stabilization programs to help protect against adverse selection: (1) a risk adjustment program to stabilize premiums in the individual and small group markets as, and after, market reforms are implemented; (2) a temporary reinsurance program established in each state to help stabilize premiums for individual market coverage from 2014 through 2016; and (3) a temporary risk corridors program that will permit the federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 through 2016.

In December 2012, proposed rules laid out the framework for these programs, and the final rules, which were published in the March 11, 2013 *Federal Register*, describe program standards in more detail and include payment parameters. The rules also establish standards for: (1) the administration of premium tax credits for low- and moderate-income enrollees in a QHP through an exchange; (2) cost-sharing reductions on essential health benefits for certain QHP enrollees; and (3) a medical loss ratio program that requires an issuer to rebate a portion of premiums if its MLR ratio falls short of the applicable standard for the reporting year. Separately, HHS published a related interim final rule that would make an adjustment to risk corridors calculations and set standards for issuers of QHPs to use alternate methods to calculate the value of certain cost-sharing reductions.

Below are more details on the temporary reinsurance program.

Transitional Reinsurance Program

This program will be established in each state to help stabilize premiums for individual market coverage from 2014 through 2016. Several standards and parameters were finalized with a few technical clarifications, including: (1) provisions excluding certain types of health coverage and plans from reinsurance contributions; and (2) the national per capita contribution rate and the methodology for calculating the contributions to be paid by health insurance issuers and self-insured group health plans. In addressing public comments, HHS made several observations, including:

1) **State authority over self-insured plans.** Several commenters opposed the collection of additional funds by states from self-insured plans, and urged HHS to specify in regulatory text that states cannot collect from ERISA self-insured plans. The agency reiterated that nothing in the statute or rule gives a state that authority.

2) **Third-party administrators.** HHS clarified that a "contributing entity" for purposes of reinsurance contributions is a health insurer or self-insured group health plan. This is to make clear that a self-insured plan is ultimately responsible for reinsurance contributions, even though it may elect to use a TPA or contractor to transfer the reinsurance contributions.

3) **Medicare coordination.** The rules finalize provisions that state a contributing entity must make reinsurance contributions for its health coverage except to the extent that such coverage is not

See *Temporary Reinsurance*, p. 6

CE Column Cost Plus (continued from p. 4)

6) Be prepared for legal challenges asserting that you breached a PPO contract. Amend PPO contracts in advance.

7) Amend plan language. You will need someone to provide reliable data analysis and accurate claims pricing that matches your new plan language.

8) Expend necessary resources on educating members, employers and providers before services are obtained and billed to the plan under the new arrangement.

I have found that success in these programs lies in preparation, not reaction. If you negotiate with providers before they treat patients, add language to plan documents and ID cards before claims are incurred, and educate clients and their employees, your results will be much better than if this is sprung on everyone. The growth of these plans is immense but the key to the success will be how well they are serviced.

Temporary Reinsurance (continued from p. 5)

"major medical coverage." In doing so, the rules codify proposed language on Medicare coordination to indicate that when an individual has both Medicare coverage and employer-provided group health coverage, the Medicare Secondary Payer rules would apply. Therefore, the group health coverage will be considered major medical coverage only if the group health coverage is the primary payer of medical expenses (and Medicare is the individual's secondary payer) under the MSP rules.

4) **Prescription drugs.** HHS clarified that a self-insured group health plan or health insurance coverage that is limited to prescription drug benefits is excluded from reinsurance contributions. Since they only provide coverage for prescription drug benefits, these plans are not major medical coverage.

5) **Health saving accounts and health flexible spending arrangements, and employee assistance plans, disease management programs and wellness programs that typically provide ancillary benefits**. HHS finalized proposed language indicated that such programs are not major medical coverage and thus are exempt from reinsurance contributions.

6) **Stop-loss and indemnity reinsurance policies.** HHS finalized proposed language that these policies are not major medical coverage subject to the reinsurance program. "No inference is intended as to whether stop-loss or reinsurance policies constitute health insurance policies for purposes other than reinsurance contributions," HHS added.

7) **COBRA.** HHS noted that COBRA or other continuation coverage is a form of employment-based group health coverage paid for by the former employee. Therefore, to the extent the COBRA coverage provides major medical coverage, is it subject to reinsurance contributions.

8) **Aggregation of self-insured group health plans and health plans.** HHS also finalized the various methods that a health insurance issuer and self-insured plans may use to determine the average number of covered lives for purposes of the reinsurance contribution. In doing so, it finalized language that if a plan sponsor maintains two or more group health plans or health plans that collectively provide major medical coverage for the same covered lives, those multiple plans must be treated as a single self-insured group health plan for purposes of calculating any reinsurance contribution amount. However, the final rules also provide plan sponsors with the option: (a) to count any coverage options within a single group health plan separately if the coverage options are treated as offering major medical coverage; and (b) not to aggregate group health plans for purposes of counting covered lives if each group health plan is treated as offering major medical coverage.

Small Business Health Options Program

Final HHS rules on Notice of Benefit and Payment Parameters (78 Fed. Reg. 15410) also clarify and expand on standards for the Small Business Health Options Program, which states can set up to offer qualified health plans to small businesses. The rules establish a number of standards and processes for implementing SHOP (and federally facilitated SHOP) exchanges, including:

- standards on the definitions and counting methods used to determine whether an employer is a small or large employer and whether an employee is a full-time employee (the agency clarifies that the definitions will apply to plan years beginning on or after Jan. 1, 2014, and in connection with open enrollment activities beginning Oct. 1, 2013);
- a method for employers to make a QHP available to employees in the federally facilitated SHOP;
- the default minimum participation rate in the FF-SHOP;
- QHP standards linking FFE and FF-SHOP participation and ensuring broker commissions in FF-SHOP that are the same as those in the outside market; and
- allowing exchanges and SHOPs to selectively list only brokers registered with the exchange or SHOP (and adopting that policy for FFEs and FF-SHOPs).

HHS also noted that because of operational challenges, effective implementation of employee choice in the FF-SHOP will not be possible in 2014. Therefore, a separate SHOP proposed rule published March 11 (78 Fed. Reg 15553) establishes that: (1) the effective date of employee choice and premium aggregation requirements will be Jan. 1, 2015; (2) SHOP exchanges may offer employee choice and perform premium aggregation for plan years beginning on or after Jan. 1, 2014; and (3) an FF-SHOP will not offer employee choice and premium aggregation until plan years beginning on or after Jan. 1, 2015.

New Reform Rules Guaranteeing Better Access May Result in Higher Costs, Says AHIP

Final health insurance market reform rules issued Feb. 22 could result in higher health premiums, a major association of health insurers predicted, even though the policy goal is make health insurance more dependable and valuable for consumers.

The final rules issued by the U.S. Department of Health and Human Services are designed to ensure that consumers will not be denied, or prevented from renewing, health coverage because they have a pre-existing health condition. Workers at fully insured firms will be the primary beneficiaries of these protections, says a fact sheet on the rules. (See http://cciio.cms.gov/resources/factsheets/marketreforms-2-22-2013.html.)

Guaranteed Issue and Renewability

Insurers offering nongrandfathered coverage must accept any individual or employer that applies, subject only to limits on network or financial capacity, starting January 2014 under the rule. In other words, individuals and plan participants may not be denied health coverage due to pre-existing conditions. The guaranteed issue and renewability provisions still have exceptions for fraud, nonpayment of premiums, failure to meet contribution or participation rules and plan termination. The guaranteed renewability rules existed in the group market but are being extended to the individual market under the rule.

America's Health Insurance Plans had said in a March 2012 study of eight states with guaranteed issue and renewability that such provisions increased insurance rates and led some insurers to quit offering individual coverage.

Premium Rating Bands

Health reform limited the variation in premiums attributable to health status and other characteristics, and eliminated several rating criteria that have been used in the past.

Starting January 2014, insurers can vary premiums based on age, but the law limits the age rating band to 3:1. In a Feb. 22 statement, AHIP predicted the new age rating bands could increase premiums for younger individuals who live in states that currently have higher age bands.

Insurers can vary premiums based on tobacco use within a 1.5-to-1 ratio, the rule states.

Insurers may increase premiums based on family size and geography, but nothing else. Eliminated are increases due to health status, past insurance claims, gender, occupation, how long an individual has held a policy and size of a small employer.

Catastrophic Plans

The final rules also include provisions for enrollment in catastrophic plans, where younger people with lower expected costs can get coverage with cheaper premiums. Catastrophic plans generally will have lower premiums, protect against high out-of-pocket costs and cover recommended preventive services without cost sharing — providing affordable individual coverage options for young adults and people for whom coverage would otherwise be unaffordable, HHS said in a press release.

Single Risk Pools

Health insurance companies will be required to maintain a single state-wide risk pool for the individual market and single state-wide risk pool for the small group market. They will no longer be able to move customers into separate risk pools and charge them higher premiums.

Enrollment Rules

Employer groups of any size must be afforded a year-round open enrollment period. Individuals' open enrollment periods must correspond to those established by the state health insurance exchanges being developed the reform law.

Insurers may no longer condition small groups' enrollment on meeting contribution and participation requirements. The version of the rules originally proposed Nov. 26, 2012 (77 Fed. Reg. 70584) would have allowed this, but "upon further consideration" HHS decided this would go against the plain language of Public Health Service Act Section 2702, as amended by the reform law. However, insurers may limit the enrollment period for small groups that fail to meet these requirements.

In both the group and individual markets, insurers also must grant a special enrollment period for events that would trigger COBRA eligibility.

The final rules also add marketing restrictions to prohibit practices or benefit designs that discourage "the enrollment of individuals with significant health needs," or discriminate in other impermissible ways. Insurers must continue to comply with state laws on insurance marketing.

The rules were published in the Feb. 27 *Federal Register*.

Reform's Essential Health Benefit Rule Clarifies Employer Plan Obligations

Health reform's final essential health benefits rule makes it clear that self-insured and large group health plans do not need to comply with limits on growth in employee cost-sharing, offer all 10 categories of essential health benefits, or meet actuarial minimums like small-group and individual policies do.

However, the regime explained in the rule is still important for self-insured and large group plans because they are still subject to many of its requirements; they may want to voluntarily apply elements to their own plans even though they're not required to do so; and some EHB rules may bear on other reform mandates.

The final health reform rule, published Feb. 25, further defines the core package of benefits that health plans must offer while also: (1) setting maximum out-of-pocket expenses for covered lives; (2) limiting the growth of those expenses; and (3) ensuring that consumers get a minimum value for the premiums they pay.

After receiving thousands of public comments, the U.S. Department of Health and Human Services issued a rule that largely conformed to the proposed rules (77 Fed. Reg. 70644) issued in November 2012.

EHBs are a core set of benefits that includes the following general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse
- Prescription drugs
- Rehabilitative and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

Non-grandfathered insured small groups, individual policies and all coverage sold on the exchanges must:

- offer the 10 EHB categories of benefits;
- adhere to the cost-sharing limits ($2,000 self-only and $4,000 self-plus); and
- meet the AV levels required by the law.

Note: The actuarial level of coverage must be 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan and 90 percent for a platinum plan.

Actuarial value is defined as the percentage paid by a health plan of the total allowed costs of benefits. "Total allowed benefit costs" is defined as the anticipated covered medical spending for EHB coverage paid by a health plan for a standard population, computed based on the health plan's cost-sharing rules.

In its preamble, the final rules addressed a variety of comments on the type of plans affected by the EHB provisions, and specifics on the scope of benefits to be covered in an EHB package. Following is an overview of some key issues discussed. HHS, along with the U.S. departments of Labor and Treasury, also issued some FAQs related to the new rules.

Large and Self-funded Plans Must Limit Growth of Out-of-pocket Expenses

The rule implements provisions that regulate the rate of growth in cost sharing for all plans to the premium adjustment percentage — this applies to both large and self-insured group health plans. Self-insured plans had argued they should get an exception because when they carve out coverage (for example for drug benefits), controlling out-of-pocket growth becomes difficult. HHS, DOL and Treasury issued "sub-regulatory guidance" identifying enforcement safe harbor to address those operational concerns; however, the rule will remain essentially intact.

Self-funded Plans Escape Prescriptive Deductible Limits

Under health reform, limits for deductibles for exchange, small-group and individual coverage are $2,000 for self-only coverage; and $4,000 for self-plus coverage. The growth rate can be no more than premium adjustment percentages. Self-funded and large group plans will not be subject to these exact amounts, HHS clarified in the final rules. However, further rulemaking is expected to further flesh out the agency's reasoning.

Compliance with Federal Mental Health Parity Rules

The agency confirmed that individual and the small group insurers must ensure that EHBs comply with federal mental health and substance use disorder parity

See *Essential Benefits,* p. 9

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requirements. HHS added that states would not have to defray the cost of plans coming into compliance.

Drug Coverage Questioned

Commenters challenged the proposal that a certain number of drugs in a class be covered without regard to the specific drug brands. Some didn't like U.S. Pharmacopeia being the sole source of coverage class determinations; and others questioned whether new drugs would be efficaciously added to plan formularies. In the final rules, HHS noted that states and exchanges would monitor drug coverage, and no alternative to USP had been suggested.

Expect More Rules on Habilitative, Pediatric Dental and Vision Services

Commenters recommended using Medicaid plans as benchmarks to define habilitative, pediatric dental and vision benefits on a state-by-state basis. The government did not commit to the idea; instead it said it will write rules to provide for state flexibility in determining how to define habilitation services and to include coverage for pediatric dental and vision services.

On the other hand, the agency declined entreaties to extend the definition of "pediatric" beyond age 19. It also declined to define "habilitative" services, leaving that to the private plans, while promising to study the issue over time.

Actuarial Value

The rule includes an AV calculator for health plans. The proposed tool allows users to measure the actuarial value of health plans and compliance with actuarial value standards required by health reform.

AVs will help consumers compare and select health plans by allowing them to compare the relative payment generosity of available plans, HHS stated.

AV Will Include HSAs and HRAs

The proposed rules had established a standard under which for the treatment of small-group market high-deductible health plans offered with a health savings account or health reimbursement arrangement, so that HDHP and HSAs or HRAs are integrated. Calculating the AV based on the insurance plan alone would have understated the value of coverage if the value of the HSAs or HRAs were not included, HHS said. This provision was finalized; however, HHS clarified that in order to count toward the AV calculation, employer contributions to HSAs and amounts made newly available under integrated HRAs that may only be used for cost sharing must be known to the issuer when the plan is purchased. So, for example:

> [A] $1,000 HSA employer contribution is treated in the AV Calculator as if a plan with $1,000 deductible is reduced to $0. The $1,000 HSA contribution does not get counted as $1,000 in the numerator of the AV Calculator because the equation is based on total population expected spending by the total population, rather than by particular individuals. Instead the $1,000 contribution is counted as the average dollar value it would cost to reduce a $1,000 deductible to $0.

The agency noted that whether other types of integrated HRAs might count toward AV is being given further consideration, so more federal guidance on this issue will be issued.

After receiving thousands of public comments, HHS issued a rule that largely conformed to the proposed rules issued in November 2012 on actuarial values, deductible limits and growth in OOP costs.

In-network Services Only Will Be Counted

HHS finalized proposed language noting that when considering actuarial value, in-network services only will be considered, because out-of network utilization is considered to be a minor portion of total health plan spending. Similarly, the annual limitation on cost sharing would be applicable to in-network services only. Although some commenters had questioned the exclusion of out-of-network services for this purpose, "[W]e have decided to apply cost-sharing limits to in-network visits only to promote health plan affordability," HHS stated.

FSA Contributions Not Considered in Deductible Limits

The health reform law permits, but does not require, contributions to flexible spending accounts to be taken into account when determining the deductible maximum for small group plans. HHS finalized its proposal not to increase the deductible levels by the amount available under an FSA. Some commenters had sought such increases; however, the agency prohibited them, calling them operationally infeasible. HHS did add that "we will revisit this policy in later years."

Clarifying Calculator Differences

The health reform law requires a determination on whether an employer-sponsored group health plan (not

See *Essential Benefits*, p. 10

CE Column Hospital (continued from p. 2)

industry, in my humble opinion, was the first sector of the health insurance marketplace to ask why the bills are so high. Everyone else, including most politicians, has been asking who should be paying the bills.

One problem is that other than Medicare, only one state sets rates. That state — Maryland — is the only to have succeeded in controlling costs for about four decades now. It is the only state that sets rates for hospitals, with the state government deciding what every Maryland hospital can charge for a given procedure. The system started in 1976, when Maryland had hospital costs 26 percent higher than the rest of the country. In 2008, the average cost for a hospital admission in Maryland was down to national levels.

From 1997 through 2008, Maryland hospitals experienced the lowest growth in cost per admission of any state in the nation, the state concluded in a 2010 report. So why don't other states follow Maryland's lead? One word answers that question: Politics. Rate setting is not popular in this country due to the heavy lobbying efforts of the hospital industry. I think it's rather interesting that one of the most respected hospitals in the country, Johns Hopkins, happens to reside in a rate-setting state and can still somehow operate profitably in an amazing fashion. If Johns Hopkins can do it, why not other hospitals?

We are seeing a shift in states like Massachusetts, which finally passed a provider price control bill after enduring six years of a health insurance exchange under which hospital bills were growing out of control, but more needs to be done.

> The crisis has no reasonable end in sight, which is why self-funded employers are looking into alternative ways to offer health coverage, including cost-plus and Medicare-plus reimbursement.

Self-funded Plans Must Fend for Themselves

This crisis, which has no reasonable end in sight, is why so many self-funded employers have decided to take the rising costs of care into their own hands. They are doing this by looking at alternative ways to offer health coverage to their employees that still aligns with their fiduciary responsibility to spend their claim dollars carefully. What has resulted is an increased interest in cost-plus type plans. Trust me, the hospitals, PPOs and large insurers are beginning to take notice.

It is worth time to see how these plans work. In this issue we will give a detailed look at cost-plus reimbursement and Medicare-plus reimbursement and other promising but daunting ways of reining in hospitals that have used unbridled billing for far too long. (See article, page 3.)

Essential Benefits (continued from p. 9)

in the individual or small group insurance markets) provides minimum value in order to assess an employee's eligibility for a premium tax credit. As part of this process, HHS had proposed an "MV Calculator" and some commenters questioned why it had to be distinct from the AV Calculator. In the final rules HHS explained that different calculators are needed to reflect the different types of affected plans. Most key, it noted that the MV Calculator is now available at http://cciio.cms.gov/resources/regulations/index.html#pm.

The final rules also: (1) reflect proposed preamble language that employer contributions to an HSA and amounts newly made available under integrated HRAs will be taken into account in determining MV (as with AV, more guidance will be issued); and (2) clarify that an employer-sponsored plan provides MV if the percentage of the total allowed costs of plan benefits is no less than 60 percent; the rules provide methodologies plans can use in this determination.

Nondiscrimination

HHS finalized proposed language stating that an issuer does not provide EHB if its benefit design, or its implementation, discriminates based on factors to include an individual's age, race, gender disability or other health conditions. However, the final rules clarify that an issuer will not be prevented from using reasonable medical management techniques (for example, requiring preauthorization for coverage of the zoster (shingles) vaccine in persons under age 60).

Still Important for Self-funded, Large Plans

In spite of the fact that the law does not require large or self-funded plans either to cover all 10 EHBs or adhere to all the cost-sharing limits, EHBs are important for large, self-funded employers because they bear on other reform mandates, such as lifetime limits. For example, if a self-funded plan does cover any EHBs, it may not impose limits on them.

Small Employers May See Fewer Choices On SHOP Exchanges in 2014, HHS Says

A reform requirement that all insurers must offer four levels of health coverage to small businesses would be delayed until 2015 under proposed rules published March 11 in the *Federal Register*. Under the U.S. Department of Health and Human Services proposal, small employers may get just one choice of health coverage in 2014.

Starting in 2014, small businesses with up to 100 employees will have access to state-based health insurance exchanges under the Small Business Health Options Program. The levels of coverage are connected to actuarial value: bronze (60 percent), silver (70 percent), gold (80 percent) and platinum (90 percent). Facilitating employee choice at a single level of coverage selected by the employer — bronze, silver, gold or platinum — is a required SHOP function.

Employers can choose the level of coverage they want for their employees but SHOP plans would get a grace period for the year ending Jan. 1, 2015, during which they could offer just one coverage option.

HHS said that delaying the requirement until 2015 would give the insurance market time to adjust, foster competition among SHOP plans and allow small businesses to take part in insuring their workers (with some using federal insurance subsidies).

Gold, silver and bronze and platinum plans must be offered on the regular, non-SHOP exchanges beginning in 2014.

Special Enrollment

The new SHOP proposal also provides the following rules on special enrollment periods.

Special enrollment periods in the SHOP are within 30 days of the triggering event. These special events are: (1) loss of eligibility for other private insuance coverage; or (2) a person becoming a dependent through marriage, birth or adoption. It does so to align SHOP rules with the length of special enrollment periods in group markets with existing HIPAA rules.

If an employee or dependent becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program or loses eligibility for Medicaid or CHIP, this would be a triggering event, and the employee or dependent would have a 60-day special enrollment period to select a qualified health plan.

Background

HHS said in the proposed rule that because of poor economies of scale, small businesses pay higher premiums and administrative costs per covered life than large businesses. Also, they are at a disadvantage in negotiating with insurance companies because they lack bargaining power. The SHOP exchanges are designed to remedy these disadvantages, according to HHS. The agency said premiums for SHOP coverage will be 4 percent cheaper for small businesses.

SHOP exchanges will include web portals to help small businesses shop for coverage.

More businesses will be eligible for SHOP starting in 2017 — then, businesses with more than 100 employees can buy SHOP coverage.

SHOP Coverage Can Result in Tax Credits

The reform law exempts the 5.8 million U.S. firms with fewer than 50 employees from reform's employer responsibility requirements, which include affordability and coverage mandates, according to the White House.

To encourage such firms to insure their workers (some for the first time), the reform law authorized tax credits for small employers with fewer than 25 full-time equivalent employees and average annual wages of less than $50,000 if they buy health insurance for employees.

To be eligible for a tax credit, the employer must contribute at least 50 percent of total premium cost. For-profit small employers can get a tax credit to 50 percent of the amount they spent providing workers SHOP. Tax-exempt small businesses can get tax credits of up to 35 percent of their contribution, the White House stated.

For more information on the small business subsidies and the SHOP see Section 810 of *The Health Reform Law: What Employers Need to Know,* from Thompson Information Services.

Contraceptive Mandate Challenge Was 'Unripe;' Too Early for Employer To Be Harmed, Court Says

A religious employer with objections to health reform's contraceptive mandate had no case because the government had issued a safe harbor excluding it from enforcement, and had pledged not to pursue it in the months after the employer filed its compliant.

While the government's promise of non-enforcement and the promulgation of an enforcement safe harbor were not sufficient to quash the employer's standing to challenge the coverage requirement, they were sufficient to persuade the court that the employer was not harmed by the requirement, a federal court in Texas decided.

The matter was not ripe for the court because the diocese had not suffered hardship, and its ability to plan ahead to determine the required scope of its self-insured health plan did not suffer.

The court ruled that the religious employer's challenge was not ripe for review in *Roman Catholic Diocese of Dallas v. Sebelius,* 2013 WL 687080 (N.D. Texas, Feb. 26, 2013).

Feds Broaden Safe Harbor For Religious Objectors

Like several other religiously conscious employers, the diocese sued to stop health reform's requirement that health plans cover contraceptives, sterilization procedures and family planning counseling without cost sharing.

The diocese was covered by a new enforcement safe harbor that includes religious employers that serve and employ a wide variety of people.

Federal rules requiring coverage of contraceptives, sterilization and family planning counseling remain in effect although the government has promised not to enforce them. Here's a brief history of the evolution of the religious employer safe harbor on contraceptive coverage.

- **The government issued its rules** on preventive care coverage in July 2010, where it handed authority over to the Institute of Medicine to specify which services would be covered without cost-sharing. About a year later, the IOM said contraceptive, sterilization and family planning should be covered as preventive services under reform.
- **In August 2011,** the federal Health Resources and Services Administration set up an exemption for religious employers that required fulfillment of four prongs: (1) having inculcation of religious beliefs as its purpose; (2) employing predominantly religious workers; (3) serving predominantly religious people; and (4) being a non-profit.

  (**Note:** Lawsuits challenging the contraceptive mandate continued from employers that did not meet all of these prongs.)
- **Most recently, in February 2013,** the agencies implementing health reform issued a proposed rule reducing the number of prongs that had to be satisfied the enforcement safe harbor. One goal of this was to make sure that religious employers did not lose their eligibility for an exemption just because inculcation of religion is not their sole purpose or because they serve people of other religious faiths. The only remaining condition now (apart from objecting to the mandate) is that the organization must be a non-profit.

The Diocese Objects

The diocese is a non-profit Catholic employer whose religious principles do not support the use of contraception, sterilization, morning-after pills or family planning. It operates 74 parishes and quasi-parishes, 38 K-12 schools, and other charitable enterprises in the Dallas area, meaning it employs and serves non-Catholics.

The diocese admitted that it qualified for the February 2013 temporary enforcement safe harbor, but said it feared that the government might lift the safe harbor, potentially forcing it to provide the objected coverage in the future, which it contended was an actionable harm.

The diocese sued, alleging government entanglement in church governance and interference in the free exercise of religion and other First Amendment violations. It sought a declaration that the mandate violated the Religious Freedom Restoration Act and U.S. Constitution; an injunction prohibiting the government from enforcing the contraceptive mandate; an order vacating those health reform rules; and expert and attorney's fees. It argued that the health reform law and its implementing regulations, once enforced, would require it to provide its employees with health insurance coverage for services and medications that defy its religious tenets.

See *Catholic Diocese*, p. 13

Catholic Diocese (cont. from p. 12)

The government filed a motion to dismiss, asserting that the diocese lacked standing and that the issues in the complaint were not yet ripe.

The employer said the February 2013 proposed rule establishing a safe harbor (into which it fell) did not change the fact that the coverage requirements remained in effect. The government could reverse its enforcement stance, or vacate the safe harbor, leaving the employer exposed to enforcement, it contended.

Promise of Non-enforcement Not Ironclad

The government contended it was in the midst of amending the regulations with the express intent of accommodating employers like the diocese, and that the employer would never have to comply with the mandate or suffer imminent injuries, and as a result, it had no standing to bring the lawsuit.

But the court held that the temporary safe harbor was not enough to dispel the threat of real injuries occurring from the underlying requirements still in effect.

The court also refused to accept that the government's promise of non-enforcement would be sufficient to provide that the diocese had no standing to challenge the law.

Therefore, the plaintiffs had standing because the underlying requirement was final, and the diocese might face enforcement in spite of the safe harbor and government promises.

Claims Not Yet Ripe

However, the court still held that it was too early for the diocese to file its case. In the case law reviewed by the court, complaints are not ripe for review when:

1) the plan the hardship is theoretical and not real;

2) the case requires substantial factual development;

3) the case depends on future events that may not occur; and

4) adequate harm has occurred.

In this case, the court said the issues were too "up in the air" to be resolved. A finding that a case is ripe for review requires: imminent injury; concrete injury; the bulk of the questions being settled about whether or not sufficient injury occurred; and most of the alleged injury having already happened.

But here, in the time since the diocese filed its complaint in August 2012, the government actually issued its non-enforcement safe harbor, and the court said that in fact did reduce the chance of imminent injury.

The court also rejected the employer's argument that the birth control rules had imposed real and actual harm in the form of extra work to decide on the scope of its self-funded plan, and to plan for potential future enforcement actions.

> Plaintiff's argument "would effectively create a rule where any future event, however remote or speculative, could constitute a burden when a plaintiff claims that it must prepare now for this future contingency."

The court dismissed the complaint in its entirety.

Implications

This case is an illustration of the concept of "ripeness," which provides that a state or federal court cannot intervene in an issue until it is ready to be resolved. In order to be ripe, it must be shown that all other avenues for determining the case have been exhausted, there is a real controversy and the law needs to be settled on one or more issues raised by the case. In the context of this case, the court said it would not intervene until the diocese actually suffers or would imminently suffer an injury.

Plans should be careful to ensure they have suffered sufficient injuries before bringing claims to avoid the substantial expenses of trial.

Oral Contract Between Plan and Provider to Pay Based on UCR Rates Is a State, Not ERISA, Issue

ERISA did not preempt state-law claims against a health plan brought by a physician practice alleging consistent underpayment, after an ERISA health plan promised (but failed) to pay claims at "usual, customary and reasonable" rates, the U.S. District Court of the Central District of California decided.

The physicians' complaint could not have been brought under ERISA, and that it implicated independent obligations for payment that were not based on an ERISA plan, District Judge Christina Snyder said in *Orthopedic Specialists of Southern California v. ILWU-PMA Welfare Plan,* CV 12-7512-CAS (C.D. Calif., Feb. 28, 2013). She remanded the case (originally filed in July 2012 and moved by the plan to federal court in August 2012) back to state court.

The Facts

The physicians were out-of-network, and were not under a contract with the plan. However, the provider argued that the plan's statements to pay based on UCR rates created an oral contract. In so doing, these payments pursuant to an independent oral agreement with out-of-network providers were regulated by California law.

The court then looked to California managed-care rules, which provide that payments to non-contracted providers must accord with "fees usually charged by the provider" and prevailing provider rates in the region where services are rendered.

The physicians argued that contrary to state law, and despite assurances that the plan would pay based on UCR; the plan consistently underpaid for services rendered to plan participants. It did so using "illegal and flawed" databases to calculate payment to out-of-network providers.

The physicians further argued that they would not have accepted payment unless they expected the plan to apply the appropriate UCR rates and would have withheld treatment from the patients if the plan had represented how little it would really pay. They said they were forced to waste time and energy pursuing the claims, and their relationship with their patients had been harmed in the process.

As a result, the providers sued for recovery of payment, breach of contract, estoppel, quantum meruit, negligence, and for California Health & Safety Code violations.

The plan contended that the physicians' case was completely preempted by ERISA because they were trying to recover ERISA benefits that had been assigned to them.

The Decision

Under *Aetna Health v. Davila,* 542 U.S. 200 (2004), the U.S. Supreme Court established that any state-law case that "duplicates, supplements, or supplants the ERISA civil enforcement remedy" is preempted. To determine preemption, the facts must pass a two-prong test:

1) Whether the plaintiff could have, at some point in time, brought [the] claim under ERISA's enforcement provision at Section 502(a)(1).

2) Whether "no other independent legal duty is implicated by a defendant's actions."

Snyder said the facts supporting non-preemption in this instance were in line with 9th Circuit precedent. Whereas UCR was greater than the amount paid under the ERISA plan, and the doctors were seeking that differential, the dispute was over the separate, oral agreement in which the plan agreed to pay UCR, and not over the ERISA plan, Snyder wrote. Therefore, the court held that the complaint could not have been brought under Section 502(a)(1). Since the first prong of preemption was not met, the court did not need to analyze the final prong, but it said the oral agreement constituted independent duty.

Implications

Any agreement, promise or assertion made by a plan representative to providers or enrollees about coverage specifics without support from plan terms can jeopardize the ability to preempt state law and withstand challenges. Accordingly, agreements, promises and assertions must conform strictly to plan terms.

Further, solely citing plan terms may be insufficient where the plan has unique definitions of commonly used terms, like UCR. Any terms that can be ambiguous or that have a standard, widely used definition must be defined and appropriate qualifiers communicated.

If Only the Plan Had Communicated

If the plan in this case had only communicated to the providers that it would pay claims based on plan terms or made clear that it used a different standard in determining UCR rates from what the physicians were used to, it likely would have been able to have the case heard in federal court. As we have seen numerous times, the federal court likely would have deferred to the plan and used an arbitrary and capricious standard of review, and more likely upheld the plan's right to apply its own definition of UCR and pay in accord with those terms.

IRS Proposal Gives Health Plans A Weapon in Limiting Balance Billing

There is now a key weapon at an employer's or employee's disposal as it relates to the balance billing of a patient and what a provider can and cannot do in its pursuit of payment. If the hospital is a tax-exempt organization under Code Section 501(c)(3), it cannot engage in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.

This Affordable Care Act provision added Section 501(r) to the tax code and the provision was developed in proposed rules last year. It can be a big element in your efforts to control hospital charges.

No More Gross Charges

To maintain Section 501(c)(3) tax-exempt status, hospital organizations must limit the amounts charged for emergency or non-emergency medical care to patients eligible for financial assistance to not more than the amount generally billed. These hospitals also need to implement a financial assistance program for people in need. They cannot engage in extraordinary collection actions before making reasonable efforts to determine whether the individual is eligible for financial assistance.

The Affordable Care Act provisions, enacted March 23, 2010, also prohibits the use of gross charges. Hospitals may only bill patients at their best or lowest negotiated commercial rate, an average of the three lowest negotiated commercial rates, or the applicable Medicare rate. This is a huge game changer from the current way self-pay patients are being billed, and it may tip the scales in the favor of self-funded employers.

Proposed Payment Methodologies

In June 2012, the IRS issued proposed rules (77 Fed. Reg. 38148) that would require that a hospital use one of two calculation methods to determine the amounts generally billed for particular care. The simpler method allows the hospital to calculate charges based on Medicare Part A or B billing amounts, as well as the amount that would be paid by the beneficiary out of pocket.

An alternate method would allow the hospital to take into account the amounts normally billed to patients who are insured by both Medicare and private insurers. This method would require the hospital to multiply the gross charges for its services by an amounts generally billed percentage, which the hospital must update at least annually.

A Change for the Better

The bottom line is that this regulation only applies to individuals eligible for financial assistance. While hospitals are generally free to determine what form of financial assistance to provide those who are eligible under the hospital's financial assistance policy, Section 501(r) prohibits hospitals from charging more to eligible individuals than the amounts generally billed to insured patients for emergency or medically necessary care, and requires that charges for any other care be less than the full, undiscounted charge for services for that care.

Self-insured plans can take comfort in the realization that the rules do not allow nonprofit hospitals to balance bill patients the full billed charges. There are now limits, which is good news for self-insured plans.

Hospitals must forestall extraordinary collection actions until they execute regulatory steps to confirm the patient isn't eligible for financial aid.

Extraordinary collection actions include selling debt to a third party, garnishing wages, foreclosing on property, seizing accounts, filing a civil suit for collection of the debt, or making an adverse report to credit reporting agencies.

This represents a change for the better because many hospitals take these actions soon after a bill is regarded as overdue. These practices are what mainly dissuade employers from holding firm on their payment policies.

In spite of the fact that the regulations are not final and still contingent on a lot of factors, self-insured plans can take comfort in the realization that the rules do not allow nonprofit hospitals to balance bill patients the full billed charges.

There are now limits, which is good news for the entire self-insured industry.

Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-7. 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 "20:7/2" indicates Vol. 20, No. 7, page 2.

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