Employer's Guide to

Self-Insuring Health Benefits

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Delay in Employer Mandate Could Cost Employer-sponsored Plans

Last month, the Obama administration postponed until 2015 the reporting rules and penalty provisions connected with health care reform's play-or-pay requirement. Getting another year to consider options, prepare funds, and study the intricacies of health reform is good news for many employers. Savings will result from not paying penalties, not counting employees using new rules and not dealing with other new administrative burdens. On the other hand, many of the other mandates remain in place, such as the individual mandate, the health insurance exchanges and other employer coverage and reporting rules. As a result, employers may lose sight of the need to maintain robust health plans and then end up losing employee lives to the exchanges through 2014, and beyond, Contributing Editor Adam Russo writes. ***Page 2***

For-profits Are Ineligible for Opt-out From Reform's Contraceptive Mandate

Brushing aside requests from the business community, the federal government refused to make a religious exemption available to for-profit employers in new health reform rules. In a major impact for the self-funding industry, third-party administrators must become plan administrators for ERISA purposes when providing contraceptive coverage for an objecting self-funded plan sponsor. For insured plans, the insurer will have to directly pay employees' claims for contraceptives without cost-sharing. Ironically, the rule came out just a few days after a federal appeals court ruled in favor of a self-funded for-profit employer objecting to providing certain mandated birth control products. ***Pages 7 and 15***

Plan's Clear Disclaimers Void Participant's Equitable Defenses

Applying the overriding principle from the U.S. Supreme Court ruling in *US Airways v. McCutchen* on ERISA remedies, a federal district court in Connecticut held that a participant's arguments did not override clear plan provisions rejecting the make-whole doctrine. Further, the court found that the plan document's claim on 100 percent of amounts it paid trumped remedies (such as windfall or unjust enrichment) that were not explicitly refuted in the plan document. That is because ERISA's principal function is to protect contractually defined benefits, the court said. The health plan sought recovery after it paid $21,306 to cover the participant's medical bills incurred in an accident and he secured a $250,000 settlement from the tortfeasor. It remains to be seen whether other jurisdictions will require more specificity to protect plan rights or whether general disclaimers will be sufficient. ***Page 10***

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The Real Deal Behind the Employer Mandate Delay

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Employers got a break when the Treasury Department announced July 2 that it is delaying health care reform's shared responsibility (play-or-pay) penalties and related employer and insurer reporting obligations until 2015.

It *seems* like good news, providing an additional year to consider benefit design options, prepare funds and study the intricacies of health reform. But there's a dark side: While employer penalties are stayed, many of the other mandates remain in place, such as the individual mandate, the health insurance exchanges and other employer coverage and reporting rules.

As a result, employers may lose sight of the need to maintain robust health plans and then end up losing employee lives to the exchanges through 2014, and beyond.

Why the Delay is No Surprise

Based on what we have seen in response time and difficulties the government has had resolving health care reform issues, the delay should come as a shock to no one. (See page 3 for a detailed story on the delayed employer mandate.) The news comes on the heels of several indications that something under the reform law was about to change.

For example, the IRS already had granted many employers with non-calendar year health plans a reprieve from the play-or-pay mandate until the first day of the 2014-2015 plan year. Also, implementation of the public health insurance exchanges was well behind schedule, with a senior Democrat acknowledging their operation was doubtful by the statutory deadline.

In March, the administration said small businesses wouldn't be able to give their workers a choice of health plans in exchanges set up just for them (see http://smarthr.blogs.thompson.com/2013/03/11/small-employers-may-see-fewer-choices-on-shop-in-2014-hhs-says). In January, a plan to create new nonprofit insurers in states was curtailed after Congress capped funding for the companies.

The only surprise from my standpoint was that there was not a matching postponement for the public health insurance exchanges or the individual mandate (that all Americans secure minimum health coverage or pay a penalty).

However, the exchanges are still supposed to be operational on Oct. 1, 2013, and the individual mandate is still going to take effect on Jan. 1, 2014. Employees will be able (and sometimes expected) to get subsidized coverage through exchanges, even though employers will be not required to offer affordable coverage until 2015.

On the heels of the new policy on the employer mandate, the IRS issued separate rules that enable exchanges to use a lower verification standard when individuals

See *CE Column*, p. 18

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Employer Mandate Delayed: Obama Gives In To Employer Concerns Over Reform

In a startling move, the Obama administration delayed the employer mandate (for companies with 50 or more workers) to offer health insurance to workers or pay a penalty, until January 2015 (a one-year delay) while it reassesses employer reporting burdens and gives employers more time to arrange compliance with the health care reform statute and rules.

Mark Mazur, Assistant Treasury Secretary for tax policy, who posted the news as a blog entry on the evening of July 2, gave two reasons for delay:

> First, it will allow us to consider ways to simplify the new reporting requirements consistent with the law. Second, it will provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees.

Unworkable for Business

Business was accusing the administration of imposing unreasonable paperwork, recordkeeping and reporting demands on companies. Mazur alluded to this, saying:

> Just like the Administration's effort to turn the initial 21-page application for health insurance into a three-page application, we are working hard to adapt and to be flexible about reporting requirements as we implement the law.

A similar example that rankled businesses was the summary of benefits and coverage, which initially required a substantial amount of detailed information to be fit on a too-small amount of space. The government took months to correct that problem there as well.

Many observers saw that the administration had taken on more than it could handle. Reform implementation was held up because of legal challenges, unforeseen complications, details that needed to be ironed out and opposition from various kinds of employers.

IRS Formalizes One-year Delay

An official announcement on transition relief for employers from information reporting requirements under health care reform, as well as on the delay of key provisions of the employer play-or-pay mandate, was issued July 9 in Notice 2013-45 from the U.S. Department of the Treasury and IRS.

The notice stated that sometime this summer, proposed rules to flesh out the reporting program will be issued by IRS. Afterward, the government will collect attestations of coverage from employers on a voluntary basis through the remainder of 2014. Such voluntary reporting will not trigger no-coverage or inadequate-coverage penalties, IRS noted.

The Information Reporting

Section 6055 of the health care reform law requires annual information reporting by health insurers, self-insuring employers, government agencies and other providers of health coverage. Section 6056 requires annual information reporting by applicable large employers about the health coverage that they offer (or do not offer) to their full-time employees. This reporting will help determine whether an employer (that employs 50 or more workers) is liable for penalties under reform's shared responsibility penalty provisions in Section 4980H of the law.

Section 6056 information reporting is important for the play-or-pay mandate because without it, an employer typically will not know whether a full-time employee received a premium tax credit.

Notice 2013-45 added additional details.

- The delay will allow the government to spend time for dialogue with employers and other stakeholders in order to simplify the reporting requirements.
- No penalties will be applied for failing to report the information in 2014.

See *Employer Mandate*, p. 4

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Employer Mandate (continued from p. 3)

- Employers will not be required to calculate a penalty, because they presumably will not have filed the information reports.
- Proposed rules on the information reporting provisions are expected to be published this summer.
- Once the information reporting rules have been issued, employer plans and insurers will be encouraged to voluntarily comply with the information reporting provisions for 2014.
- The mandate that individuals be insured remains in effect; state-based health insurance exchanges will operate starting Oct. 1 this year; they will still issue health policies to individuals; and tax credits (subsidies) will be issued to those who demonstrate need.
- Individuals will continue to be eligible for the premium tax credits and coverage through exchanges. They can get tax credits to buy such coverage if they show that their household income is within 100 percent and 400 percent of the federal poverty limit, and that they are not eligible for minimum essential coverage through their employer or another source.

In 2015 after the play-or-pay aspects of the employer mandate resume, IRS will analyze Section 6056 reporting and tax returns it receives from individuals claiming a tax credit to assess shared-responsibility penalties. It then will contact employers and give them a chance to respond to the possibility that they owe penalties.

In Over Their Heads

"I was not surprised at all by the news. I have been saying for quite some time that there was no way this could be implemented on time. … I suppose the next issue is whether it will be delayed further. As things progress, you never know where a delay will lead," says employee benefits lawyer Paul Hamburger, with Proskauer Rose in Washington, D.C.

"It seems pretty clear that they were over their heads in believing that all of this could have been implemented so fast," attorney Adam Russo, president of the Phia Group in Braintree, Mass., tells the *Guide*.

Details and Open Questions

The delay raises questions about how the individual mandate will work without the employer mandate undergirding it. The individual mandate is still in effect. Some of those workers will be able to get insurance on exchanges, which are still slated to be up and running Oct. 1, selling coverage that takes effect Jan. 1, 2014.

State-based health insurance exchanges where individuals can buy government-approved health coverage are still required to be up and running, but their operations could be hindered if they are unable to determine whether employers offer minimum essential coverage or not.

The delay puts another mid-term election in between now and employer implementation, which could turn into a potentially destabilizing referendum on health reform.

Reasons for the Delay

According to Hamburger, the government was trying to build — in an impossibly short time frame — a gigantic data collection and organization infrastructure for insurers and employers to report information about the affordability and value of coverage to covered individuals and the government.

"This information and the infrastructure needed to collect and coordinate are not easy to explain and build," Hamburger tells the *Guide*.

Also impossible to build in the limited time frame was the structure for data interchange between employers (and insurers), state exchanges, government agencies (including the IRS) and individuals needed to properly enforce penalties, he says.

Legal challenges to the health care reform law (culminating but by no means ending with the June 2012 U.S. Supreme Court decision upholding the constitutionality of the statute) put its implementation in a holding pattern. "As long as there was a chance the Supreme Court would strike down the law, there was a delay in building the regulatory and infrastructure base," he says.

In fact, true implementation didn't even resume in earnest until President Obama was reelected in November 2012.

The Law Threatened to Backfire

Business reaction to the new mandate included proposals to move to part-time workforces, which would not only put those workers out of the reach of needing health insurance, it would harm them by lowering their earning power. Eliminating workers' full-time status affected wages and benefits, not just health coverage.

Hamburger says: "There were many stories circulating about employers contemplating 'workforce realignment' or workforce restructuring. That meant that employers were thinking about firing people to stay

See *Employer Mandate*, p. 14

Feds Soften Eligibility Verification Checks For Premium Tax Credits

Through 2014, state-run health insurance exchanges need not perform complete eligibility verifications on all individuals applying for federal premium tax credits, under final rules published on July 15 from the U.S. Department of Health and Human Services.

For the first year of operations, those state-run exchanges (in 16 states and the District of Columbia) will be allowed to accept an applicant's attestation of projected annual household income without further verification, according to the rules.

HHS is finalizing a process that was originally proposed in January 2013 (78 Fed. Reg. 4594). The proposed rule envisaged comprehensive verification of applicants' income, and for HHS to have control over what methods would be used to verify it. The agency asked for public comments on what would be feasible if that were not possible.

The possibility of less than total verification was discussed in the proposed rules. While exchanges will become operational on Oct. 1, 2013, the final rules acknowledge that some states' verification systems would not be ready by that date, a key admission that the process was not feasible as originally planned. In response to the proposed rules, one state commented that data was not available to perform verifications in all situations; another state said a reprieve would give HHS time to specify more steps needed and refine its process; and yet another said it would welcome the reduction of cost and burdens associated with the federally imposed system.

Background

In order to qualify for premium tax credits under the exchange program, employees have to lack adequate insurance from their companies, and they must have salaries between 100 percent and 400 percent of the federal poverty limit.

The health care reform law requires that exchange applicants, not employers, provide information on employer coverage for qualification purposes. Under the final rules, an applicant for premium tax credits will be required to attest whether he or she has employer coverage, and if so its cost and scope.

Beyond the verification system language, most of the final rules focus on miscellaneous exchange operations, new Medicaid and Children's Health Insurance Program eligibility rules, including eligibility notices and delegation of appeals.

Variance From Proposed Rule

Under the earlier proposed rules, the exchanges would verify every applicant's income and insurance status to determine eligibility for health insurance subsidies, which come in the form of premium tax credits. Exchanges would verify income levels reported by applicants against a federal database that contains data on the applicant's federal income tax returns, as well as information on his or her Social Security benefits.

> HHS is finalizing a process that it first proposed in January 2013. It envisaged verification of applicants' income using IRS and Social Security data, and for HHS to have control over verification methods.

But if the income level reported by the applicant is 10 or more percent less than what comes back from those reports, exchanges would have to check: (1) current and accurate electronic data approved by HHS; (2) HHS' own data on eligible employer plans; (3) data from a Small Business Health Options Program in the same state where the exchanges is; or (4) any other data on an applicant's or family member's employment and insurance status.

The new rules finalize this language, but vary from the proposed rules when this data is unavailable. In that case, the final rules permit states to take the applicant's word for it. However, the applicant is also entered into a larger pool of applicants to be audited to ensure the accuracy of their reported income.

The reason given for the change was that the exchanges are taking more time than originally scheduled to get their verification systems in place.

> After reviewing and considering the appropriate public comments and completing a technical analysis, we have concluded that the service described in the proposed rule is not feasible for implementation for the first year of operations. This service would involve a large amount of

See *Eligibility Verifications*, p. 6

Eligibility Verifications (continued from p. 5)

> systems development on both the state and federal side, which cannot occur in time for October 1, 2013.
>
> While we believe it is important for Exchanges to implement the [verification] procedure to support program integrity and minimize financial risks on behalf of the tax filer at reconciliation, we acknowledge that some Exchanges may not have the resources and operational capability to conduct the sampling process in the first year.

Random coverage checks rather than the fuller requirement could create an increase of subsidies paid out by the government, says attorney Paul Hamburger, with Proskauer Rose in Washington, D.C. This may raise questions on how increased subsidies will be paid for. Hamburger notes that health care reform financing generally may be impacted now that employers will not have to pay shared responsibility payments until 2014 at the earliest. So in order to deal with issues such as general financing shortfalls and a potential increase in subsidies provided, he says the government may decide to increase the transitional reinsurance fees (which currently costs employers $63 per covered life).

Employers Impacts Lessened in 2014 Due to Separate Policy Change

Generally under the reform law, to establish eligibility for tax credits, individuals must establish that their income is between 100 percent and 400 percent of FPL, as noted above. They also have to report that they are not getting minimum essential coverage (as defined in federal rules) from an employer. The accuracy of such employee reports could have an impact on whether an employer pays play-or-pay penalties under reform.

On July 2, the government delayed the mandate for employers to report on the status of health insurance they offer to employers because it said it needed more time to build a system to collect information from employers on whether they have adequate coverage. The lack of data on employer coverage in turn would make it impossible to determine which employers owe play-or-pay penalties. Therefore, the government also decided it would delay the penalty portion of the employer mandate as well.

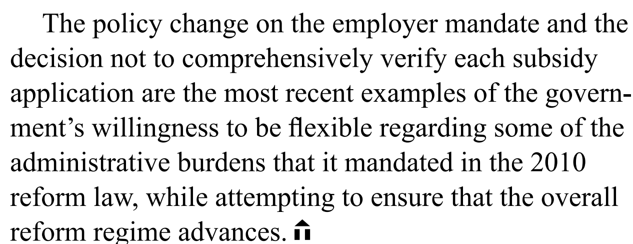
Therefore, those penalties will not be levied in calendar year 2014. As a result, unsubstantiated attestations of low income, or that employer health coverage doesn't exist or is below minimum value, will not result in direct penalties at this time. However, they may have other negative implications, such as forcing the employer to dispel such reports.

Other Provisions in the Rule

The final rules also provide that the exchanges and the IRS separately still must notify employers every time one of their employees receives premium tax credits. Specifically, exchanges will send a notice to employers telling them that an employee has sought a tax credit and exchange coverage, and that the employer has a right to appeal this determination. The notice also will tell the employer that, based on this finding, it may be liable for play-or-pay penalties, even though that will not be the case in 2014; it presumably will be the case in 2015.

Also as part of this process, tax credit applicants are required to substantiate whether they have received an offer of coverage from their employer. The final rules provide a voluntary pre-enrollment template to help applicants report on the status of their employers' coverage. The employer is not required to help with this substantiation process, but HHS said it hoped employers will help their employees fill out substantiation forms by making pre-populated forms available to employees. Employers can plug information into the template to substantiate employees' coverage and tax credit claims, the rules state. Third-party administrators also are encouraged to help with the process, although they are not required to.

The proposed rule originally expected exchanges to send eligibility determinations to applicants in writing, and under the final rule they are still required to do so unless they get an affirmative request to send them electronically. Likewise, small business purchasing group insurance on the SHOPs will be allowed to elect electronic transmission of communications. State exchanges will not be required to have the capability of making electronic transmissions until January 2015.



The policy change on the employer mandate and the decision not to comprehensively verify each subsidy application are the most recent examples of the government's willingness to be flexible regarding some of the administrative burdens that it mandated in the 2010 reform law, while attempting to ensure that the overall reform regime advances. ⌂

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For-profits Remain Subject to Contraceptive Mandate; Rule Turns Some TPAs into ERISA Fiduciaries

Brushing aside requests from the business community, the federal government refused to make a religious exemption available to for-profit employers in July 2 health reform rules (78 Fed. Reg. 39870) that finalize policies on providing contraceptive coverage to health plan enrollees. Instead, non-profit organizations that object on religious or moral grounds from having to "contract, arrange, pay or refer for" such coverage can gain the exemption. The rule's exclusion of for-profit employers with religious objections is out of step with an important appeals court ruling in favor of for-profit crafts store Hobby Lobby on June 27 (*see story page 15*).

In a major impact for the self-funding industry, third-party administrators must become plan administrators for ERISA purposes when providing contraceptive coverage for an objecting self-funded plan sponsor.

For insured plans, the insurer will have to directly pay employees' claims for contraceptives without cost-sharing.

The final rules, which were jointly issued by the federal Labor, Health and Human Services and Treasury departments, reflect public feedback received in response to Feb. 6, 2013 proposed rules (78 Fed. Reg. 8456). In the proposed rules, the government exempted more group health plans and policies established or maintained by religious organizations from health reform's requirement that plans and polices cover contraceptives without cost-sharing, and expanded the type of eligible organizations that can be exempted from the requirement.

Who Will Be Eligible

The proposed rules specified that group health plans of a religious employer could get an exemption from the contraceptive mandate if the employer: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its its religious tenets; and (3) primarily serves persons who share its religious tenets.

The final rules simplify this definition of a "religious employer" by eliminating those requirements. The simplified definition is based solely on Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code, which primarily concerns churches and other houses of worship.

In providing an exemption to non-profit religious organizations that object to contraceptive coverage on religious grounds, the final rules define an eligible organization as one that:

- on account of religious objections, opposes providing coverage for some or all of any contraceptive services otherwise required to be covered;
- is organized and operates as a nonprofit entity;
- holds itself out as a religious organization; and
- self-certifies that it meets these criteria in accordance with the provisions of the final regulations.

This change is intended to clarify that a house of worship is not excluded from the exemption because it provides charitable social services to, or employs, persons of different religious faiths.

For-profit Companies Are Not Exempt

Some commenters asked the feds to change the definition of eligible organization to include nonprofit secular employers and for-profit employers with religious objections to contraceptive coverage. The feds denied both requests, saying they will limit the exception to organizations that have to be both to nonprofit and religious. So although the religious employer exemption was loosened, it wasn't loosened as much as some employers had hoped.

Rule Clashes With Hobby Lobby Opinion

The final rules are out of step with a recent 10th U.S. Circuit Court of Appeals ruling in favor of Hobby Lobby, a for-profit concern with religious objections. The 10th Circuit said that the employer's argument that the Religious Freedom Restoration Act should protect it from having to comply with the mandate should be allowed to advance (*see page 15*). The court sent the case down to the district court to get an injunction from fines under the reform rules because the employer's case was likely to succeed on the merits.

Note: Rulings like the 10th Circuit's could set up a face-off between the health reform law and the RFRA, resulting in the invalidation of parts of the health reform law, experts say.

Feds Provide Form to Attest Objections

Separately, the federal agencies issued a form for employer plans to self-certify (http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf) that they qualify for an exemption under the final regulations.

See *Contraceptive Mandate,* p. 8

Contraceptive Mandate (continued from p. 7)

The certification form does not have to be filed with the government, but it will have to be filed with insurers and TPAs. The rules state that an insurer or TPA may not require more documentation to substantiate the employer's self-certification.

Separate Payment System

The government tried to both shield objecting employers from paying for contraceptives and ensure women at those companies still pay no cost-sharing. In doing so, it shifts the costs of drugs and devices themselves, and their administration, to TPAs and insurers. The government announced that separate payments for contraceptive services will be available for women in the health plan, at no cost to the women or to the organization, but questions remain about the cost impacts on insurers and TPAs.

Insured Plans

Objecting employers with insured plans will provide a copy of its self-certification to its health insurer. These insurers then must provide separate payments for contraceptive services for the women in the health plan of the organization, at no cost to the women or to the organization.

Group policies will be amended on the one hand to announce that the plan sponsor does not cover some or all contraceptives, and on the other hand, that payments for government mandated contraceptives are available with no cost-sharing from the insurer through direct payment.

The government dropped an provision in the proposed rules that would have forced insurers to tailor a separate coverage exemption to each requesting plan sponsor, in the event, for example, that a sponsor objected to only some of the mandated coverage. The final rules instead allow insurers to use a standard exclusion from a group health insurance policy that encompasses all recommended contraceptive services. However, individuals can arrange with the insurer for a direct payment of services excluded from the plan.

Insurers are not required to write a separate policy of insurance for women wanting free contraceptives at objecting companies. They will make direct payments for those drugs, without collecting premiums from those individuals.

Also, payments for contraceptives must be segregated from the employer, and they must be accounted for under prevailing accounting standards.

Self-funded Plans: TPAs Become Plan Administrators

Employers with self-insured health plans will provide a copy of their self-certification to their TPA. The self-certification must: (1) state that the eligible organization will not act as the plan administrator or claims administrator regarding contraceptive services or contribute to their funding; and (2) cite the regulatory language explaining the TPA's obligations.

Upon receipt of self-certification, the TPA may decide not to enter into, or continue, an administrative services contract for the plan. However, if it does maintain the contractual relationship, the TPA then must provide or arrange separate payments for contraceptive services for the women in the health plan of the organization, at no cost to the women or to the organization. In doing so, the federal agencies will require TPAs to become plan administrators for those services only. This means that the TPAs will take on ERISA obligations the often seek to avoid. The rules state:

> Third-party administrators must also take on the statutory responsibilities of a plan administrator under ERISA, including setting up and operating a claims procedure under ERISA section 503, providing plan participants and beneficiaries with disclosures required under ERISA Section 104, and complying with the requirements of Part 7 of ERISA.

The rule makers mention the fact that TPAs consider the new duties to be an unprecedented burden. In comments to the regulators, TPAs said forcing them to serve as fiduciaries would increase their exposure to legal liability and also create conflicts with plan sponsors given that many TPA agreements expressly prohibit TPAs from acting as fiduciaries. Self-funded plan sponsors said TPAs would merely pass the cost of coverage on to sponsors in the form of higher administrative charges. In spite of these reservations, the government decided that TPAs contracting with an objecting organization become plan administrators of contraceptives only, and if they don't want that, basically they can withdraw from the contract.

Self-insured Plans Without TPAs

If a self-funded plan doesn't use a TPA (a rare occurrence), the final rules offer a special accommodation: a safe harbor from enforcement of the contraceptive coverage requirement. Generally, the plan must: (1) send HHS an attestation that it does not use a TPA; and (2) inform participants and beneficiaries at enrollment that it does not provide benefits for contraceptives. Specifically, the plan's attestation, which must be sent via email to marketreform@cms.hhs.gov, must:

See *Contraceptive Mandate,* p. 9

Contraceptive Mandate (continued from p. 8)

- identify plan information, the eligible organization that acts as the plan sponsor, and an authorized representative, along with that representative's telephone number and mail address;
- list the five most highly compensated non-clinical plan service providers including contact information, a concise description of services provided, and the annual amount of compensation paid to each provider; and
- attest that the plan is established or maintained by an eligible organization, and is operated in compliance with all applicable requirements of part A of title XXVII of the Public Health Service Act, as incorporated into ERISA and the tax code.

HHS reserves the right to reject a self-funded plan's attestation, and one way it might do so is to direct the plan to hire a TPA to administer the contraceptive coverage.

Notice Required

Insurers and TPAs must send out separate notices about the separate contraceptive coverage. Generally, the notices must be provided contemporaneously with (to the extent possible), but separate from, any enrollment application materials distributed in connection with that is effective beginning on the first day of each plan year to which the exemption applies. The notices must indicate that the eligible organization does not fund or administer contraceptive benefits, but that the issuer or third party administrator (contact information is required) will provide separate payments for contraceptive services at no cost. The rules provide model language that can be used or adopted for this purpose.

Other Reform Criteria Must Be Met

Separate payments for contraceptives need to meet other reform criteria; for example, nondiscrimination and no annual or lifetime limits. This applies to both insured and self-funded plans.

FFE and Other Adjustments

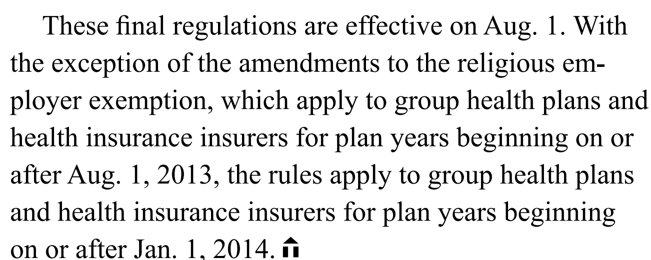
To help fund the payment of contraceptive services provided to self-funded plan participants and beneficiaries, the rules make adjustments to the Federally Facilitated Exchange user fees paid by participating insurers. Generally, a participating insurer may qualify for an FFE user fee adjustment to the extent that it either: (1) made payments for contraceptive services on behalf of a TPA; or (2) seeks an adjustment to the user fee for a TPA that, following receipt of a copy of the self-certification, made or arranged for payments for contraceptive services. TPAs will have to submit to HHS a notification that they intend for a participating insurer to seek an adjustment. This notification must be provided by the later of Jan. 1, 2014, or 60 days following the date on which the TPA receives a copy of a self-certification.

The rules go on to describe the adjustment process and how the insurer will pay the TPA the portion of the adjustment attributable to contraceptive services payments.

Separately, HHS intends to clarify in guidance that an issuer of group health insurance coverage that makes payments for contraceptive services under these final regulations may treat those payments as an adjustment to claims costs for purposes of medical loss ratio and risk corridor program calculations.

Effective Date

These final regulations are effective on Aug. 1. With the exception of the amendments to the religious employer exemption, which apply to group health plans and health insurance insurers for plan years beginning on or after Aug. 1, 2013, the rules apply to group health plans and health insurance insurers for plan years beginning on or after Jan. 1, 2014.



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Bolstered by *McCutchen*, Plan Invokes Clear Disclaimers to Void Equitable Defenses

Applying the overriding principle from the latest U.S. Supreme Court ruling on ERISA remedies, a federal district court in Connecticut held that a plan participant's made-whole defense does not override clear plan provisions explicitly rejecting that defense and reserving access to settlement funds.

The court in *Quest Diagnostics v. Bomani*, 2013 WL 3148651 (D. Conn., June 19, 2013) remarked that the facts were similar to *US Airways v. McCutchen*, 133 S. Ct. 1537, April 16, 2013), the latest U.S. Supreme Court opinion shaping the concept of equitable relief available to ERISA plans. That ruling affirmed the primacy of the written ERISA plan document (which binds two parties like a contract) over the equitable defenses posited by participants seeking to shield their settlement proceeds from plan recovery.

Ironically, the *McCutchen* court reduced the plan's recovery because it lacked language preventing the diversion of plan recovery monies to participant attorneys under the common-fund doctrine.

The difference in the *Bomani* case is the plan had explicit language disavowing the make-whole doctrine, which was precisely the equitable defense that the participant attempted to plead. That, and the other the equitable defense raised, was no match for the plan language. Also, attempts to allege discrepancy between summary plan description and plan document, and invoke a state anti-subrogation statute, both failed.

The Facts

Talib Bomani worked for Quest Diagnostics and participated in the company's self-funded health plan, where he was enrolled in an HMO option administered by Aetna.

Bomani was injured in a bicycle accident, and his health plan paid $21,306 to cover his medical bills. Later he sued the person who hit him. After Bomani secured a $250,000 settlement from the tortfeasor, Aetna initiated a recovery with the aid of the Rawlings Co., a subcontractor specializing in plan recoveries. On Quest's behalf, they demanded what the plan spent on Bomani's care.

The health plan claimed that its recovery provision entitled it to the full $21,306. Bomani's law firm (Ganim, Ganim & Ganim) was holding that amount. The plan went after both Bomani and the law firm.

Bomani's Equitable Defenses

Bomani argued that Quest's claim violated the make-whole doctrine and was not "appropriate" equitable relief under ERISA's enforcement provisions because his harm from the accident exceeded his recovery. He marshaled four other arguments, the first two of which were equitable defenses. He said:

- Quest's requested relief would not be "appropriate" because it would receive a windfall recovery;
- Quest might have had inequitable motives or acted in bad faith pursuing the award, thereby violating the "unclean hands" doctrine;
- the reimbursement clause came from the summary plan description rather than the actual plan document; and
- the plan's pursuit of payment violated the Connecticut anti-subrogation statute.

Cross motions for summary judgment were filed. In the meantime, the High Court issued the *McCutchen* ruling. In its decision, the federal district court rejected Bomani's arguments.

Made-whole Doctrine Expressly Refuted by Plan

The Quest plan expressly blocked the core of Bomani's argument, the make-whole doctrine: "The medical plan has the first right to reimbursement and a priority over the funds you recover from the third party, ... *regardless of whether you or your dependent have been made whole*." Quest's plan language left no room for that equitable defense to operate. The recovery provision also said:

> If you or your dependent recover funds from a third party as a result of a judgment, settlement or otherwise, you are responsible for reimbursing the medical plan for 100% of the amounts paid by the medical plan on your or your dependent's behalf.

Windfall Argument Can't Overcome Plan's Provisions

The idea that a plan's recovery constituted a "windfall" became far less valid after the Supreme Court's *McCutchen* decision, the court noted. Plan terms take precedence, and principles of unjust enrichment, windfall, double-recovery and common-fund are no longer allowed to trump clear plan language to the contrary, the court held.

See *Equitable Defenses*, p. 11

Equitable Defenses (continued from p. 10)

Furthermore, equitable relief allowed in the plan document trumps remedies that are conjured up by one party (such as windfall or unjust enrichment) and not in the plan document. That is because ERISA's principal function is to protect contractually defined benefits, the court said.

Unsubstantiated 'Unclean Hands' Allegation

The court said Bomani simply did not produce sufficient competent evidence to build an unclean hands allegation. Bomani was mainly complaining about the Aetna and Rawlings' conduct during discovery (not easily imputed to the plan) and no evidence was produced that showed the conduct supported such an allegation. And again, the ruling in *McCutchen* underscored that if plan language is clear and being followed, other equitable defenses (not just those related to unjust enrichment) fall by the wayside.

SPD Didn't Diverge from Plan Document

As to the SPD argument, the plan presented the recovery policy as written in the SPD, and the court accepted it as representative of what was in the larger document. Importantly, Bomani failed to show a discrepancy between the SPD and the official plan document. The SPD was sufficient for Quest's purpose of demonstrating it was plan policy, the court said.

Connecticut's Anti-Subrogation Statute Preempted

The state anti-subrogation statute invoked by Bomani (Conn. Gen. Stat. §52–225c) might have been effective had the Quest health plan been insured. Then ERISA's savings clause would apply, because the insurance company working for Quest would be subject to state rules and ERISA would not preempt. But Quest's plan was self-funded, not insured. There was no insurer under state law, and ERISA's "deemer clause" prevents states from appraising self-funded ERISA plans as being insurers subject to their insurance laws. Therefore, the anti-subrogation statute could not operate.

Therefore, the court backed Quest, and said it was entitled to a refund of the $21,306 it had paid.

Implications

The court in this case affirmed the ideas stated by the U.S. Supreme Court that equitable limitations will not be applied when a health plan explicitly disclaims them.

Although the plan explicitly disclaimed the made-whole rule, the court seemed to accept the plan's general references to 100-percent recovery as sufficient to disclaim application of some other equitable defenses such as the "clean hands doctrine" and doctrines against windfalls and unjust enrichment.

At least in this case, the court did not require the plan to specifically reference every possible equitable remedy that typically might be available to a plan participant in order to avoid its application.

The case shows how jurisdictions may rule when plans prohibit equitable defenses blocking their recovery rights. It remains to be seen whether other jurisdictions will require more specificity to protect plan rights or whether general disclaimers will be sufficient.

Bomani Resembles *McCutchen* … Except in One Important Respect

The facts of *Quest Diagnostics v. Bomani* were similar to those of *US Airways v. McCutchen*.

In *McCutchen*, the U.S. Supreme Court affirmed that equitable theories, such as make-whole, common-fund, unjust enrichment and double-recovery, should not override clear plan language reserving a plan's right to full reimbursement for benefits it paid when all other contractual conditions are met.

But the Supreme Court also ruled in *McCutchen* that the employer's plan document lacked language disavowing the common-fund doctrine, under which plan recoveries can be reduced by the percentage retained by the plan participant's attorney in securing the settlement. That omission left the court open to allowing payment of the attorney and a reduction in the plan's recovery.

In contrast, the Bomani plan had explicit language disavowing the make-whole doctrine, which was precisely the equitable defense that the participant attempted to plead. That equitable defense and others were no match for Quest's plan language in the wake of the *McCutchen* ruling's strong affirmation of plan document primacy.

4th Circuit Upholds Employer Mandate; Brushes Aside Religious School's Constitutional Objections

In the first major ruling on a constitutional challenge to the health care reform law since the U.S. Supreme Court upheld it last summer, a federal appeals court ruled that Congress had clear authority to require larger employers to provide health insurance for their workers or pay a financial penalty to the government. The 4th U.S. Circuit Court of Appeals decided that the employer mandate is a valid use of Congress' constitutional power to regulate interstate commerce, in *Liberty Univ. v. Lew*, 2013 WL 3470532 (4th Cir., July 11, 2013).

It reiterated the High Court's conclusions about the individual mandate, that while it may be more objectionable (than the employer mandate) under the Commerce Clause, it was authorized as a form of taxation, regardless of what it was called in the statute.

Background

In 2010 (days after initial passage of the health reform statutes), Liberty University in Lynchburg, Va., challenged both the "individual mandate" (that individuals must get minimum essential health coverage or pay a penalty, starting Jan. 1, 2014) and the "employer mandate" (which requires larger employers to offer health coverage to their employees or pay a penalty).

In November of that year, however, the district court dismissed both claims on the merits in *Liberty University v. Geithner*, 2010 WL 4860299 (W.D. Va., Nov. 30, 2010). Then, in *Liberty University v. Geithner*, 671 F.3d 391 (4th Cir., Sept. 8, 2011), the 4th Circuit shot down the school's appeal to that outcome based on the Anti-Injunction Act, holding that Liberty's action could not proceed until the penalties started being assessed.

In *NFIB v. Sebelius* (132 S. Ct. 2566 (2012), the U.S. Supreme Court upheld the individual mandate, and Liberty's arguments against the individual mandate were vacated as a result. In NFIB, the High Court upheld the individual mandate as a lawful exercise of Congress' taxing power.

The Supreme Court agreed to hear the *Liberty* case, and in November 2012 vacated and remanded it to the 4th Circuit for further consideration in light of the *NFIB* outcome. The month before, Liberty filed an amended motion for rehearing contending that its freedom-of-religion questions were not resolved in the June 2012 Supreme Court decision. Liberty contended that its religious objections to the law were not vacated in the Supreme Court's opinion upholding the individual and employer mandates.

Taxation Function Does Not Bar Pre-enforcement Challenge

The government attempted to invoke the Anti-Injunction Act ("no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court") to prevent the challenge to the employer mandate. The 4th Circuit says that in fact, the law does not consistently refer to the employer-mandate penalty as a tax, and as such, Congress probably did not intend the penalty to be protected from challenge like a *bona fide* tax. Therefore the AIA did not bar the suit.

Plaintiffs Have Standing

The government argued the plaintiffs did not have standing to sue because they had not suffered an actual or imminent injury, adding that nothing guaranteed that Liberty will have to pay a penalty under the employer mandate. Liberty countered that it could be subject to a penalty but also it alleged that the employer mandate will increase the cost of care, and of providing health insurance. The court sided with Liberty on this, holding that the institution had made plausible arguments that the mandate will increase its cost.

It also agreed that in spite of the delay in the employer mandate until 2014, it still will have financial burdens to ensure compliance.

Similarly, the court decided that the individuals who alleged harm from the reform law also had standing, after concluding that their current lack of insurance plus the fact that they have to purchase coverage, was sufficient evidence of reform's alleged harm.

Did Congress Have Authority?

Liberty argued that Congress did not have the authority to order employers to provide insurance, and that such a mandate "goes far beyond" wage and hour rules normally enforced by Congress and the administration.

The government countered that health insurance is a longstanding benefit that is part of employee compensation packages, and that Congress has the power to regulate such ordinary elements of employment.

The government argued that Congress had authority to mandate insurance purchases under the U.S. Constitution's Commerce Clause because the lack of insurance leads individuals to forgo routine care and end up in emergency rooms, generating much higher bills that society has to pay for either directly or through higher

See *Liberty University*, p. 13

Liberty University (continued from p. 12)

overall costs, after providers shift the losses to other payers through higher charges.

Note: In the June 2012 U.S. Supreme Court decision upholding the health care reform law, five of nine Justices found that the individual mandate exceeded Congress' Commerce Clause authority. (The law was upheld, however, as an exercise of Congress' taxing authority.) Those five justices described a situation in which the government will become emboldened to command citizens to buy items: Today it could be insurance; tomorrow, virtually anything.

The 4th Circuit dismissed such concerns, however, stating that the employer mandate is different from the individual mandate and is authorized under the Commerce Clause.

> [The employer mandate] is … simply another example of Congress's longstanding authority to regulate employee compensation offered and paid for by employers in interstate commerce. To begin, we note that unlike the individual mandate (as construed by five justices in *NFIB*), the employer mandate does not seek to create commerce in order to regulate it. … All employers are engaged in economic activity. All employers are in the market for labor.
>
> Further, contrary to Liberty's assertion, the employer mandate does not require employers to "purchase an unwanted product." Although some employers may have to increase employee compensation (by offering new or modified health insurance coverage), employers are free to self-insure, and many do.

Also supporting the idea that it is fair game under the Commerce Clause is the fact that employer-sponsored insurance is a preponderant source of coverage in the United States, and health insurance is a major sector of the U.S. economy.

> Requiring employers to offer their employees a certain level of compensation through health insurance coverage is akin to requiring employers to pay their workers a minimum wage.

The court went on to note that employer-based health insurance affects workers' interstate mobility; for example, by making some of them reticent about changing jobs if their insurance coverage would be jeopardized as a result.

Religion-based Arguments

Liberty University objected to the health reform mandates saying they would force them to violate their religious belief by making them fund abortions. It alleged that the mandates violated the Free Exercise Clause of the First Amendment and the Religious Freedom Restoration Act.

The court backed the government position here as well, concluding that the Free Exercise Clause does not compel Congress to exempt religious practices from neutral laws of general applicability, and the reform law is just such a law.

In contrast, the RFRA can counter a law of general applicability, but only on the condition that the law substantially burdens religious practice. If so, the government must show that: (1) imposition of the law is for the furtherance of a compelling public interest; and (2) the government's approach is the least restrictive means of furthering that interest.

The 4th Circuit found in favor of the government on this point as well:

> Plaintiffs present no plausible claim that the Act substantially burdens their free exercise of religion, by forcing them to facilitate or support abortion or otherwise. The Act specifically provides individuals the option to purchase a plan that covers no abortion services except those for cases of rape or incest, or where the life of the mother would be endangered.
>
> … [T]he Act "contains strict safeguards at multiple levels to prevent federal funds from being used to pay for [non-excepted] abortion services."

The Law's Exceptions

The law allows two exceptions to the individual mandate: one for *religious conscience objectors* and another for *health care sharing ministry members*.

Liberty University objected to these, saying the safe harbors are excessively narrow. For example, the safe harbor for conscience works only for sects that conscientiously oppose all insurance benefits, provide for their own members, and were established before Dec. 31, 1950. Liberty didn't like the HCSM exception because it used an arbitrary formation date of Dec. 31, 1999 as the eligibility cutoff date.

But none of these objections triggered common law precedent showing the tipping point on when it's appropriate to hinder enforcement of laws of general applicability because they interfere with religion. Laws that: (1) have a secular legislative purpose; (2) neither advance nor inhibit religion; and (3) do not excessively entangle the government in religion, should not be subject to forced non-enforcement. The 4th Circuit decided that the reform law's exceptions passed those tests.

See *Liberty University*, p. 14

Employer Mandate (continued from p. 4)

under the 50 full-time employee threshold or reducing employee hours to below 30 hours a week to avoid penalties. This was a significant area of concern to regulators and policymakers."

Note: The U.S. House of Representatives is presently considering legislative proposals to change the definition of full-time employee (from 30 under reform) to 40 or more hours a week, to mitigate employer desires to modify work schedules. This would further destabilize health care reform, as it would change the calculation method for penalties and lives that must be covered by employers.

"Legislative action might lead to significant changes as Congress has a chance to look closely at the impending health care reform implementation in 2015. Now that employers have had a taste of what will come when the play-or-pay mandate is fully implemented, they might put more pressure on Congress and the administration to modify the rules significantly," Hamburger says.

The federal rules could hardly interface well with the huge variety of companies in the U.S. economy, he adds. "Employment patterns vary among industries and geographic locales," he notes. "Also, employment practices have developed over decades in this country without such a regulatory scheme and it is not easy to turn those practices over based on incomplete proposed regulations that do not come close to answering so many key questions."

Implications for Employers

Employers will enjoy reduced pressure to develop systems to track full-time employees based on complex rules. That will save a lot of aggravation and money, Russo says.

Most large employers (with 50 or more workers) already provide to full-time employees the kind of coverage that would comply with the employer mandate, he adds.

James A. Klein, president of the American Benefits Council, said in a statement that the delay "provides vital breathing room to implement the law in a more thoughtful and administrable way. … Major employers have led the way in providing coverage to their workers and are expending great resources to ensure compliance with the new law." He said ABC would continue to work with the Obama administration to mitigate burdens and costs of health reform implementation.

Reform Has Still Left Its Mark

Employers are still required to comply with reform's insurance mandates, including: (1) coverage for dependent children up to age 26; (2) no exclusions for pre-existing conditions; (3) no annual or lifetime limits on payments; and (4) coverage with no cost-sharing for preventive services.

The requirements to prepare and distribute summaries of benefits and coverage, and notices of the availability of exchanges remain, as do penalties failing to comply with them.

The bottom line is that the delay is welcome relief to employers struggling to get a handle on the new rules and how they will impact their businesses. At the same time, it builds some uncertainty on its long-term impact on health care reform implementation.

Liberty University (continued from p. 13)

> They … rationally related to the Government's legitimate interest in accommodating religious practice while limiting interference in the Act's overriding purposes.

After refusing to consider Liberty's last-minute arguments against new rules implementing health reform's contraceptive mandate, it dismissed Liberty's entire case for failing to state a claim on which relief could be granted.

Implications

The 4th Circuit created a roadmap for other jurisdictions looking to support the health care reform law in its current version. It did so by using the same argument brought forth by the government with the individual mandate. As it related to the individual mandate, the government argued that all people are or will be engaged in the health care market, and therefore, the Commerce Clause allowed the government to require individuals to purchase health insurance. The Supreme Court disagreed with that assessment, but now the circuit has adopted the same argument that failed for individuals, and said it fits employers better.

The government's argument that all employers are engaged in economic activity and are in the market for labor, seems an extension of the argument made for the individual mandate with a key addition, that the government can regulate ordinary elements of employment such as compensation and benefits.

The circuit's seeming divergence from the argument made by the Supreme Court and the government's position that the First Amendment and RFRA do not preclude the government from requiring the provision of coverage seems to set the stage for further clarification by the Supreme Court as to what constitutional protections may prevent the government from requiring the provision of certain health benefits under health care reform.

Hobby Lobby Won't Have to Pay Millions in Fines While It Challenges Contraceptive Mandate

A self-funded employer's legal challenge to the new federal contraceptive coverage requirement received a resounding endorsement from the 10th U.S. Circuit Court of Appeals, opening the possibility that more employers would be able to carve out specific contraceptives and other services they object to from health reform's prescriptive coverage mandates, even if those companies are for profit.

Hobby Lobby and sister company Mardel, which the owners run according to Christian principles, objected to having to cover payments for Plan B morning-after drugs and birth control devices such as intra-uterine devices, saying that they induce abortions. (**Note:** The government denies that the disputed birth-control methods are abortifacients.)

Hobby Lobby is a for-profit $3 billion arts-and-crafts store chain with 514 stores in 41 states and 13,240 full-time employees, and Mardel sells Christian books and supplies.

In *Hobby Lobby v. Sebelius et al.*, No. 12-6294 (10th Cir., June 27, 2013), the appeals court unanimously ruled that owners David and Barbara Green: (1) were likely to win a case under the Religious Freedom Restoration Act, which provides that "Government shall not substantially burden a *person's* exercise of religion" (emphasis added); (2) were substantially burdened by the contraceptive-coverage requirement; and (3) had persuasively argued they would suffer an irreparable harm if the government enforced the rule. The court sent the case back to the federal district court in Oklahoma, which granted the company a preliminary injunction until Oct. 1.

District Court Ruling Reversed

The ruling overturns a lower court ruling that went against Hobby Lobby.

On Nov. 19, 2012, the U.S. District Court for Western Oklahoma rejected Hobby Lobby's legal attempt to prevent the government from enforcing its contraceptive mandate. The government gives exceptions to religious organizations (certain for-profit organizations with religious objections are currently under a safe harbor), but Hobby Lobby is not such an organization, the government argued in *Hobby Lobby v. Sebelius*, 2012 WL 5844972 (W.D. Okla., Nov. 19, 2012). The government contended that non-profit status is an objective criterion for determining whether an entity is a religious organization for purposes of civil rights statutes and labor laws. As such, the RFRA does not extend to for-profit corporations like Hobby Lobby.

Hobby Lobby and Mardel got expedited federal review because the stores would have faced fines for not covering the required forms of contraception. The court noted that the employer objected to just four out of the 20 forms of contraception that the government requires employers to cover. The mandate to cover preventive services kicked in on July 1.

RFRA Protects Hobby Lobby

First, the court analyzed the RFRA and case law to find that the RFRA's definition of "persons" covered by the act includes corporations like Hobby Lobby. "We hold as a matter of statutory interpretation that Congress did not exclude for-profit corporations from RFRA's protections," the court held.

Substantial Burden to Sincere Beliefs

Next, the court said the penalties for not covering the contraceptives are so substantial that it was justified to issue an injunction. Hobby Lobby faced a "Hobson's Choice": (1) violate its sincere religious beliefs; (2) pay an astronomical fine for violating the preventive care mandate; or (3) phase out its health plan entirely and pay a $26 million-a-year no-coverage penalty under health reform.

If the employer insisted on providing a health plan that does not meet the contraceptive-coverage, it would be fined $100 per employee per day. With more than 13,000 employees, that would come close to $475 million per year.

Hobby Lobby's other option would be to drop health coverage, and that would entail a $2,000 per-employee fine, requiring the company to pay about $26 million per year, and putting the employer at a competitive disadvantage in recruitment and retention.

Court Allows Employer to Draw the Line

The government had argued that the contraceptive benefit is no different from a cash benefit, like a wage, and had no moral component. The employer of course objected, drawing a line to exclude contraceptives it said induced abortions.

The court said it would not draw that line, but instead said it would respect the line drawn by the employer at this stage.

See *Hobby Lobby*, p. 16

Feds Push to Publicize Exchanges In Wake of Unpreparedness Charges

More than a month after Max Baucus, D-Mont., an early proponent of health reform, said the implementation of state-based health insurance marketplaces was going so poorly that a "train wreck" would ensue, the Obama administration is now launching a public relations effort aimed at teaching consumers how to buy marketplace coverage.

Marketplaces are supposed to be up and running by Oct. 1, capable of selling full health insurance coverage to individuals and small businesses. Since millions of people will be applying for coverage on those marketplaces (with coverage taking effect Jan. 1, 2014), the government increased its public outreach efforts in the last 100 days before this keystone feature of reform takes effect.

The new outreach materials are geared to helping with enrollment and describing the consumer-protection aspects of health reform (such as guaranteed issue, no rescission and an end to underwriting for factors other than smoking, geography and age).

The crown jewel of this is the newly revamped healthcare.gov website, unveiled June 24. On the updated site, consumers also will get answers to frequently asked questions, search engine features and a customer service number that will be running 24 hours a day, seven days a week, the White House and the U.S. Department of Health and Human Services announced. (The Spanish version of the site, CuidadoDeSalud.gov is being updated as well.)

At this Internet location, the Centers for Medicare and Medicaid Services placed a trove of documents to help states, small businesses and consumers tell the public about the new exchanges. These include the employer application form (http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/shop-employer-application-5-31-2013.pdf) to the Small Business Health Options Program. There are also *fact sheets*; for example, "Things to Think about When Choosing a Plan" and "Helping Consumers Apply &

See *Reform Outreach*, p. 17

Hobby Lobby (continued from p. 15)

Compelling Public Interest Not Seen

The government also tried unsuccessfully to demonstrate that forcing compliance with its contraceptive mandate is "the least restrictive means of advancing a compelling interest," the court concluded. But the government failed because it argued only broadly about the interest of enforcing government mandates in general, the court said.

The court did not refute government arguments that the mandate would advance the interests of public health and gender equality. But it noted that health reform allows plenty of other employers to escape the requirement. Health reform does not require the mandate for tens of millions of Americans in plans with fewer than 50 employees, grandfathered plans and colleges and universities with a religious purpose, all of which are exempt.

The court also refuted the government's argument that Hobby Lobby are imposing their religious views on their employees or burdening their employees' religious beliefs. The court noted that Hobby Lobby is not preventing employees from using their own money to purchase the four contraceptives at issue.

Overly Restrictive

Hobby Lobby objected to covering only four forms of contraceptives it considered to be abortifacients. The government requires coverage of 20, and Hobby Lobby would cover 16 of those. The government never explained why accommodating such a limited request frustrates its goals, the court said.

Government arguments that Hobby Lobby is imposing its religious beliefs on its employees. The court said that was not true, because the employers never would prevent employees from using their own money to purchase the four contraceptives at issue here.

Of course Hobby Lobby employees would lack a benefit with the result that they would pay more if they chose to use Plan B or other objectionable contraceptive. But the government failed to prove that *that* much smaller injustice created a compelling government interest.

New Rules on Contraceptive Coverage

On June 28, the government issued final rules on preventive services that finalize a proposed simpler definition of "religious employer" for purposes of the exemption from the contraceptive coverage requirement in response to concerns raised by some religious organizations. The final rules also explain the accommodation for other non-profit religious organizations that object to contraceptive coverage.

Reform Outreach (continued from p. 16)

Enroll through the Marketplace;" *drop-in articles*, including "Are You Ready? The Health Insurance Marketplace is Coming;" *short messages* on open enrollment and other key dates; *public service announcements* for radio broadcast; as well as *flyers*, *posters* and other media.

Exchange Notices

Employers with more than one worker and doing more than $500,000 of business per year must inform their workers of the existence of exchanges — including coverage options — by Oct. 1, 2013. Last month, the U.S. Department of Labor/EBSA issued separate model notices in English for: (1) employers that offer a health plan (http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf); and (2) employers that do not offer a health plan (http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf). EBSA has now posted comparable notices in Spanish.

Will This Game of Catch-up Work?

This comes on the heels of a Congressional report showing that state-run and federally facilitated exchanges will not be ready for action on Oct. 1 because so many interim deadlines were not being met. In particular, some 44 percent of the key activities CMS initially targeted for completion by March 31, 2013, were behind schedule, a June 2013 Government Accountability Office report stated.

GAO reported that many key activities are incomplete and some are behind schedule. Core functional areas where progress was incomplete included:

- **eligibility and enrollment** (that is, development and testing of IT systems to determine eligibility and to enroll consumers);
- **plan management** (primarily review and certification of qualified health plans that will be sold on exchanges); and
- **consumer assistance**, such as funding and development of the navigator program in state exchanges with federal involvement, to give small employers enrollment assistance and outreach.

In the report, 18 states reported lagging behind in a significant number of projects that need to be completed, preferably by Oct. 1. These included signing data agreements, training call center personnel, publishing eligibility applications, launching branding and marketing campaigns, posting plan options online and designing complaint-tracking systems.

Another indication of lagging preparedness is the recent final rule allowing insurers to put only one variety of coverage up for sale on the SHOPs. The requirement to offer four levels of coverage (bronze, silver, gold and platinum) will take effect in 2015; not 2014 as originally planned. Likewise, employers will not need to offer multiple levels of coverage to employees until 2015.

CMS replied that missed interim deadlines still did not reflect often significant progress states and feds had been making on these exchange setup activities, and it expressed confidence that exchanges will be open and functioning in every state by Oct. 1. Go to http://www.gao.gov/products/GAO-13-614 to see the GAO report.

State Breakdown

HHS/CMS has approved 18 states' SHOPs and it has issued 17 approvals to states to run health insurance exchanges for individuals.

In 15 states, HHS/CMS will institute and operate SHOPs and exchange markets with the help of states.

The federal agencies will operate SHOPs by themselves in 18 states as well as exchanges selling individual policies in 19 states, with no help from those state governments.

Stop-loss Insurers Maneuvered Out of Navigator Role in Final Reform Rules

Stop-loss insurers for self-funded health plans are among the entities excluded from assisting consumers and small businesses in researching health insurance exchange options under health care reform. Those insurers, as well as individuals and other entities with too close a financial relationship to such insurers, cannot be "Navigators," according to final rules issued July 17 by the U.S. Department of Health and Human Services (78 Fed. Reg. 42824). The rules become effective on Aug. 12, 2013.

HHS said in order to provide information to consumers, Navigators must be "fair and impartial." However, in the agency's view, stop-loss insurers cannot meet this standard because they have a financial incentive both to encourage small employers to self-fund, and to not explain coverage options that may include insured products. Under the reform law and its exchange regulations, exchanges are to give grants to Navigators.

Navigators are not to not make eligibility determinations and will not select QHPs for consumers or enroll applicants into QHPs. They will, however, help consumers through the eligibility and enrollment process, by: (1) giving them "fair and impartial" information on insurance choices; and (2) referring them to consumer assistance programs and health insurance ombudsmen.

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apply for subsidies on an exchange through calendar year 2014. That's more proof that the government took on more than it can handle. Not an encouraging trend, even though it lessens burdens on employers.

Delayed Employer Mandate: Impacts

Many businesses were behind in reform preparations and time was running short. Many employers, particularly those in the retail, restaurant, hospitality, agriculture and entertainment industries, had been scrambling to implement new health plan features and protocols to track employee hours, and were making related payroll adjustments in order to comply with the mandate.

Some employers had even begun reducing employee hours in order to render them part-time employees and thus ineligible for employer-sponsored health coverage. The fact is: For many employers in industries with full-time but low-wage employees, the choice to play or pay has been a difficult one, as many cannot afford the expense under either scenario.

As described in last month's article, many of those employers were looking at the possibility of developing skinny plans, which would limit cost exposure through plan designs that provide very modest benefits.

The one-year reprieve gives employers more time to decide upon benefit designs and implement systems, and gives the exchanges more time to develop products to meet employers' needs. Employers won't have to pay penalties for "no coverage" or "inadequate coverage," or spend money and time calculating full-time employees under reform's cumbersome definitions. And maybe lawmakers will make the law less painful. Clearly, these are positive for employers in the short term.

The delay doesn't help some employers however; namely, large companies with more than 50 employees that already offer health benefits to full-time employees and wouldn't have faced penalties anyway.

Even so, the employer mandate would have required even those employers to expand coverage to employees working between 30 to 40 hours a week, due to reform's redefinition of "full-time employee." Now that redefinition will not be in effect until 2015 and those employers won't have to perform the painful exercise of expanding coverage to non-full time workers who nevertheless averaged more than 30 hours a week.

So the delay will provide employers some breathing room to update their health coverage and could potentially add some flexibility to the rules moving forward.

What's Next?

I think delays to implementation of the public health insurance exchanges and the individual mandates are quite likely. Employer mandate penalties are supposed to supply at least some of the cash for subsidies in the exchanges, but there won't be any such penalties in 2014. Now there's even less cash available to support exchanges that are already behind schedule, over budget and underfunded!

To show just how much money we are talking about, the Congressional Budget Office in May 2013 estimated that penalties from employers would add up to approximately $10 billion in 2014 (see http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf).

That money's not forthcoming, so how will the subsidies for individuals be funded through 2014? Will the government increase the transitional reinsurance fee on employers (which is already $63 per covered life per year)?

Self-reporting?

The government delayed the mandate for employers because it couldn't collect the information from them on whether they have adequate coverage. The question became how will individuals prove that they're eligible for subsidies on the exchange if there's no data from employers on adequate coverage?

Individuals are not supposed to be eligible for subsidies to buy insurance in the exchanges if they are offered reasonably robust and affordable coverage from an employer. Now, the authorities will not know what type of coverage employers are offering in 2014.

To me, this shows a potential for fraud and abuse. An individual's attestation that his or her employer is not adequately covering them is enough to cover the first prong of a two-prong test. But what type of proof will be required to prove an individual's attestation that the employer's coverage is really inadequate? Word will be sent to employers that an attestation has been made against them, and they will have a chance to dispel that allegation. Since there will be no employer penalties in 2014, no harm no foul. Or is that the case? The system puts the onus on employers to dispel false reports. If they don't, those false reports will stick.

To get a subsidy, individuals also need to prove that their income is between 100 percent and 400 percent of the federal poverty limits. Most income verifications will come through tax returns and Social Security reports. However, some exchanges may accept a statement of projected annual household income without further

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verification, the government decided. This self-attestation policy appears to leave the door open to more fraud as well.

Now, some people will apply and they may state that they fall within the eligible income levels, when in fact they do not. The result: Plenty of people who are not qualified for subsidies will get them anyway.

Burdens Remain

Until we hear differently, employers still must now supply their employees with notices about the public health insurance exchanges by Oct. 1.

In addition, the benefit mandates due to come online in 2014 are still on track. For example, caps on out-of-pocket maximums under nongrandfathered plans, 90-day limits on waiting periods and a ban on pre-existing condition restrictions have not been delayed.

The delay will not impact employers' duty to provide a Summary of Benefits and Coverage for 2014. Ironically, even though an employer plan does not have to meet the minimum value standard or pay a penalty in 2014, employers will have to revise SBCs to include a statement regarding whether their plan meets the minimum value standard.

It must be noted that an individual potentially still will need to have a minimum value standard plan. Thus, the determination as to whether the plan meets this standard still will be relevant to include on the SBC for 2014.

Likewise, in the DOL's Model Notice of Coverage for employers that offer a health plan, the employer will need to provide to all its employees basic information about the employer-provided health coverage. A check box on the notice states, "This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages." This and other requirements for 2014 cannot be ignored.

But Maybe We Should Be Worried

When employers heard the news on the employer mandate delay, they celebrated, but the news may not really be so great.

Because the delay does not affect the individual mandate, employees will need to secure coverage for themselves by 2014 or pay a penalty. That means employees will look to their employers to offer affordable, robust health plans — as employers have done for years, and many still plan to do under reform.

This desire by employers to play rather than pay caught the Obama administration by surprise. It assumed employers would drop their plans, pay the small penalty and run to the exchanges. The exchanges then would be flooded by low-risk, healthy lives that would build up the risk pool and enable the exchanges to bear the cost of insuring a previously uninsurable population.

Instead of buying into that faulty proposition, employers across the nation worked harder to implement cost-effective health plans in 2014, thereby ensuring their employees would enjoy affordable, robust benefits through self-funding.

Now, however, these innovative employers are being told to hold off and spend 2014 planning for 2015. I urge you not to fall for this trick. Now, more than ever, the innovative cost-containment and benefit plans are needed.

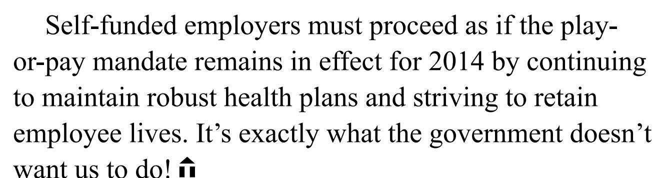
The fact is that employees subject to the individual mandate now will be looking to their employers for their health benefits in 2014. If they are not satisfied with employer offerings in comparison with what they can purchase in the exchanges — guess what, folks — they will go to the exchanges. Once they go, they may never turn back to employer plans.

(**Note:** Another issue to consider: As employers with healthy, low risk populations still chose to self-fund their health plans, regulators, the administration, state insurance commissioners and proponents of a single payer system have been trying to to build a case against self-funding. This has taken the form of state insurance commissioners and legislators trying to limit small employers' ability to obtain stop-loss protection. Restricting stop-loss access increases the self-funding risk for employers and may convince some employers to send their healthy lives to the exchanges.)

What You Need to Do Next

In 2014 employers need to focus on offering affordable, attractive coverage to their employees. Why is this so important? Because if employees purchase coverage via the exchanges in 2014, employers will have a difficult time shifting those lives back to their plans in 2015.

If the momentum to self-funding built over the years is lost due to 2014 reform implementation, these healthy lives will not return. As a result, in 2015 and beyond, employer plans will face great difficulty in securing lives for their plans, maintaining affordable programs and avoiding the play or pay penalties.



Self-funded employers must proceed as if the play-or-pay mandate remains in effect for 2014 by continuing to maintain robust health plans and striving to retain employee lives. It's exactly what the government doesn't want us to do!

Subject Index, Vol. 20

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