Employer's Guide to
Self-Insuring Health Benefits

Employee Benefits Series | THOMPSON | December 2013 | Vol. 21, No. 3

TPAs Will Administer Birth Control As Fiduciaries Under Reform

The issues relating to health care reform's contraceptive mandate have become complex for self-funded plans and third-party administrators. The health care reform law requires all plans to cover contraceptives by classifying them as preventive health benefits that cannot involve any cost-sharing to the patient. Religious plans objected and earned an exemption that enabled them to avoid offering contraceptive coverage in their plans. The government wanted to provide free contraceptives anyway, only not through these plans. Therefore it tacked the task onto insurers and TPAs. In the self-funded plan world, this creates new administrative burdens, financial obligations and fiduciary concerns for TPAs. Contributing Editor Adam Russo, Esq., explains how that is going to work. ***Page 2***

Rules Could Free Some Self-funded Plans From Reinsurance Fees

Self-funded plans that are also self-administered will be exempt from paying reinsurance contributions under the health care reform law for the 2015 and 2016 benefit years, the Centers of Medicare and Medicaid Services said in final program integrity rules. The promised relief will occur in future rulemaking, according to the preamble of the program integrity rules. The change will remedy an imbalance under which self-funded plans, which operate without an insurer to fund risk, would be paying into a fund they could not draw from. (Only insurers can draw payments from state reinsurance funds.) The program integrity rules were published in the Oct. 30 *Federal Register*. ***Page 3***

GHP Insurer Must Pay Large Sums For Poor Claims Review Process

An insurer for an employer-sponsored health plan governed by ERISA was ordered to pay benefits, interest and a $99,000 penalty for failing to deliver the guidelines it relied on to deny a claim, after a federal court found its claims and appeals process was riddled with delays, its denial letters failed to cite plan provisions and it disregarded evidence supporting payment of the claim. After eight years and three rounds of judicial review, allowing the payer to review the case one more time would have been futile, the court said. One improper tactic employed by the payer was basing its decision on coverage criteria for an inpatient hospital stay rather than for a stay at a residential substance-abuse facility. Another was explicitly telling an independent reviewer to disregard new evidence. The court overrode the independent reviewers' decision because its denial was identical to previous ones and it gave no reasons for overlooking — or other consideration to — the new evidence. ***Page 6***

Also in This Issue

Contributing Editor's Column

By Adam V. Russo

Update Pages

¶792 — Updated discussion on the Pregnancy Discrimination Act

Audio Conference Recording

Health Care Reform Myths and Facts: The Top 5 Things Employers Should And Should Not Worry About

Visit http://www.thompsoninteractive.com

Want Your News Faster?

Transfer your subscription to our digital version and get your news and updates as they happen. Visit www.thompson.com/suite for a 14-day free trial to the entire suite of HR and benefits products in Thompson's HR Compliance Expert.

Contact Us

Customer Service: 800 677-3789
Online: **www.thompson.com**
Editorial: 202 872-4000

What Now Makes Contraceptive Coverage Much More Complicated

By Adam Russo, Esq.

Adam V. Russo, Esq. is the co-founder and CEO of The Phia Group LLC, a cost containment adviser and health plan consulting firm. In addition, Russo is the founder and managing partner of The Law Offices of Russo & Minchoff, a full-service law firm with offices in Boston and Braintree, Mass. He is an advisor to the board of directors at the Texas Association of Benefit Administrators and was named to the National Association of Subrogation Professionals Legislative Task Force. Russo is the contributing editor to Thompson's Employer's Guide to Self-Insuring Health Benefits.

The issues relating to health care reform's contraceptive mandate are getting more complex by the day for self-funded plans and their administrators, and now yet another reform-related problem has emerged.

The problem is: The health care reform law requires all plans to cover contraceptives that require a trip to the doctor by classifying them as preventive health benefits that cannot involve any cost-sharing to the patient.

Employer's Guide to Self-Insuring Health Benefits

CONTRIBUTING EDITOR: **ADAM V. RUSSO, ESQ.**
THE PHIA GROUP LLC
BRAINTREE, MASS.
DIRECTOR OF PUBLISHING: **TRAVIS HICKS**
ASSOCIATE PUBLISHER: **GWEN COFIELD**
EDITOR: **TODD LEEUWENBURGH**
DESKTOP PUBLISHING SPECIALIST: **SHAWNE HICKS**

The *Employer's Guide to Self-Insuring Health Benefits* (USPS 011-926) is published monthly by Thompson Information Services, 4340 East-West Highway, Suite 300, Bethesda, MD 20814. Periodicals Postage Paid at Bethesda, MD and at additional mailing offices.

POSTMASTER: Send address changes to: *Employer's Guide to Self-Insuring Health Benefits*, Thompson Information Services, P.O. Box 41868, Austin, TX 78704.

This newsletter for the *Employer's Guide to Self-Insuring Health Benefits* includes a looseleaf update to the *Guide*. For subscription service, call 800 677-3789. For editorial information, call 202 872-4000. Please allow four to six weeks for all address changes.

THOMPSON
Insight you trust.

Religious plans objected and earned an exemption that enabled them to avoid offering contraceptive coverage in their plans. But the government still wanted plan participants to obtain coverage without cost-sharing, behind the backs of their health plans. This entailed a strange fix that tacked the task onto insurers and third-party administrators. In the self-funded plan world, this creates new administrative burdens, financial obligations and fiduciary concerns for TPAs. How is that going to work?

Policy Impacts Self-Insured Plans

Since the beginning of the Affordable Care Act, most health plans have covered recommended women's preventive services, including contraceptives prescribed by a health care provider, without cost-sharing. The independent Institute of Medicine provided recommendations to the U.S. Department of Health and Human Services about which preventive services help keep women healthy and should be covered without cost-sharing.

The IOM recommended covering all FDA-approved contraception for women available with a prescription, without cost-sharing because there are tremendous health benefits for women that come from using contraception. At the end of the day, these services reduce the cost of health care for everyone. Further, nearly 99 percent of U.S. women have relied on it at some point in their lives, but more than half between the ages of 18 and 34 have struggled to afford it.

But religious objections arose, and the administration carved out exceptions for religious organizations. Objections from religiously guided organizations that weren't churches or schools arose and the government broadened the exception. Final rules (on Coverage of Certain Preventive Services Under the Affordable Care Act) issued on June 28, 2013, by the U.S. Departments of Treasury, Labor and HHS, allowed nonprofit organizations that object to contraceptive coverage on religious grounds to skirt such coverage for their employees or students, provided they certify that they qualify for an accommodation on the newly created EBSA 700 form.

Exemption from Coverage

The June 28 rule simplified the earlier definition of a religious employer. It eliminated the requirement that a religious employer have religious values as its purpose,

See *CE Column*, p. 14

Future Rules Could Free Some Self-funded Plans From Reform's Transitional Reinsurance Fees

Self-funded plans that are also self-administered will be made exempt from paying reinsurance contributions under the health care reform law for the 2015 and 2016 benefit years, the U.S. Department of Health and Human Services said in final program integrity rules.

The promised relief will occur in future rulemaking, according to the preamble of the program integrity rules. The change will remedy an imbalance under which self-funded plans, which operate without an insurer that funds the risk, would be paying into a fund they could not draw from.

(**Note:** Only insurers can draw payments from state reinsurance funds.)

The program integrity rules (78 Fed. Reg. 65045) were published in the Oct. 30 *Federal Register*. They deal with systems for financial integrity and oversight for participants in health insurance exchanges and how states must operate risk adjustment and reinsurance programs.

Remedies an Imbalance

In announcing the upcoming reinsurance program relief for certain self-funded plans, HHS noted that there will be caveats. The change will only be applied if the major medical component of the plan is self-insured, HHS states in the integrity rule preamble. It would not be applied if the plan carves out, say, a prescription drug benefit, to be self-insured and self-administered, while keeping a fully insured policy for major medical coverage, the preamble added.

HHS agreed to develop a more specific definition of "major medical coverage" for this purpose, which would add certainty for entities unsure whether they will need to contribute or not.

Those self-funded plans would be required to pay the first-year fee for the program in 2014, and that fee is $63 per plan life that is covered for all 12 months of the year.

For more information on the transitional reinsurance fee and other health care reform taxes, see Section 795 of Thompson's *New Health Care Reform Law: What Employers Need to Know*.

The surprise proposal is couched in the preamble of the larger rule. A fact sheet from HHS describes the purpose of that rule:

> The overarching goal of the provisions in the final rule is to safeguard federal funds and to protect consumers by ensuring that issuers, [exchanges], and other entities comply with federal standards meant to ensure consumers have access to quality, affordable health insurance.

For example, the final rule requires that states reinsurance methodologies will have to be certified by third-party accrediting organizations. States will have to account for their risk-adjustment and reinsurance programs, and give reports on operations to HHS and the public to ensure the soundness and transparency of the programs. Records pertaining to risk adjustment, reinsurance and enrollment must be maintained for 10 years, the rule states.

Individual Subsidies

The rules also set program integrity standards to verify the financial need of individuals who use premium tax credits to buy subsidized insurance coverage on exchanges (known as Marketplaces).

The issue of individuals being issued subsidies without verification of need was a point of contention raised by House Republicans in their opposition to the health care reform law. In turn, the Obama administration pledged to strengthen its income-verification measures to ensure that individuals do not use fraudulent means to obtain subsidies.

See *Program Integrity*, p. 4

Many Employers Overstate Health Coverage Rules Under Reform, Benefits Attorneys Say

Employers are subject to misinformation about the coverage and reporting requirements of the health care reform law, even as they work to ensure that their health plans are in compliance. It's a bit of a tight rope: Employers should not "over-implement" rules they don't like to prove a point, but neither should they ignore provisions just because compliance penalties have been stayed by the government.

The problem is being made more difficult because (due to no fault of employers), they have to make decisions without sufficient information from the government, which has consistently lagged in issuing needed guidance, two legal experts told a group of employers on Oct. 15.

Attorneys Paul Hamburger and James Napoli of the Washington, D.C., firm Proskauer Rose LLP identified and dispelled a number of common misconceptions among employers at a Thompson Interactive webinar.

Key misconceptions result from a widespread lack of clarity on the difference between minimum essential coverage and essential health benefits, they explained.

Misconception 1: My Plan Must Cover All 10 Essential Health Benefits in Order to Qualify

Nearly all employer-sponsored group health plans will be offering MEC even if they cover few, if any EHBs, Hamburger said.

- Employer-provided group health plans by definition are MEC.
- Coverage sold on exchanges and on the individual market has to cover EHBs.
- Fully insured plans will need to cover EHBs as defined by the state in which the insurance is offered.

Self-funded employer group health plans need not cover EHBs in order to qualify as MEC.

However, MEC health plans do have to cover preventive care without cost-sharing; and for whatever EHB they do cover, they have to eliminate annual and lifetime dollar limits. Further, starting in 2014, out-of-pocket limits will apply to the entire set of essential health benefits that employer plans cover. Employers may not pick and choose which EHBs will be subject to those rules.

See *Myths and Facts,* p. 5

Program Integrity (continued from p. 3)

One of HHS's key goals with respect to the oversight of advance payments of the premium tax credit and cost-sharing reductions is ensuring that eligible enrollees receive the correct tax credit and cost-sharing reductions. In order to achieve this goal, HHS establishes timeframes for refunds to eligible enrollees and providers when an issuer or Marketplace incorrectly applies advance payments of the premium tax credit or cost-sharing reductions, or incorrectly assigns an individual to a plan variation (or a standard plan without cost-sharing reductions). HHS also establishes general standards necessary for the oversight of these payments, including standards governing the maintenance of records, annual reporting of summary statistics and audits.

The rules also include standards for insurer participation in individual and small business exchanges. Insurers will have to show they comply with requirements, such as the maintenance of records and participation in investigations, the fact sheet states.

In addition, the rule directs for exchanges to do the following:

- **Set up an enrollee satisfaction survey system**. The rule sets standards for survey companies working on behalf of health plans on exchanges. The surveys will compare satisfaction levels among comparable exchange plans.
- **Charge insurers user fees** in order that exchanges remain self-sustaining.
- **Certify insurance products** as qualified health plans. The final rule also sets up procedures for exchanges to decertify QHPs and appeal processes insurers can follow to challenge decertifications.
- **Ensure the privacy of data**, and ensuring insurers use data only for exchange enrollment, eligibility determinations, efficient operations, and applications for tax-credits and cost-sharing reductions. At a minimum, they will have to comply with the HIPAA privacy and security rules and standards.

CMS and the HHS are authorized to oversee the financial integrity, compliance, efficiency and nondiscriminatory administration of state exchanges, the rule states. CMS/HHS may levy fines on states to enforce its exchange-integrity rules. The feds expect individual exchanges to have separate design, structure

See *Program Integrity*, p. 5

Myths and Facts (continued from p. 4)

MEC is what individuals must maintain for themselves or face a fine or a penalty

An individual cannot get a subsidy on an exchange if he or she doesn't have MEC. The definition of MEC includes: employer-provided coverage; individual health coverage; grandfathered health plans; self-funded student plans; Medicare and Medicaid; COBRA coverage; and retiree medical coverage.

EHB is a group of benefits defined as essential under the health care reform law

EHB encompasses 10 categories, including hospital, maternity, ambulatory services and prescription drugs. The categories are very broad and it's nearly impossible to capture every service under the umbrella of an EHB with certainty. So when it's uncertain, employers need to defer to their state's definition. Each state may have different definitions of EHBs, defined through the insurance markets.

Definitions may be different for ambulatory service; or what is a prescription drug. So employer plans may have leeway putting limits on say, fertility, which is composed of various EHB categories, including prescription drugs, outpatient procedures and counseling services. Some states treat some aspects of fertility treatment as EHB and some define others out (often based on well-accepted, established, versus more experimental or elaborate). Some states may define as EHB just the drug aspect of fertility treatment. Another treatment that may be subject to selective limits based on being a composite of EHB and non-EHB services is bariatric surgery, Hamburger said.

Which aspects of such compound borderline services are EHB — and which are not — varies from state to state. So employers and insurers will have to know these variations in the event a subscriber tries to invoke the law to get coverage for (or challenge a limit placed on) such services, Hamburger added.

Furthermore, self-funded plans have a say in deciding which services (or service components) fall inside and outside the EHB definition. Thus, they should reserve discretion in the plan document beforehand in order to have an advantage in the courts if a plaintiff tries to invoke the law to get coverage for (or challenge a limit placed on) the totality of such services, Napoli said.

Misconception 2: I Have to Use EHB Definition From the State Where My Company Is Headquartered in Order to Qualify as MEC

Current guidance permits employers to choose any available state-law benchmarks for EHBs, but employers may not "cherry pick" various coverage terms among states; for example by using Utah's rules for fertility; and Texas' rules for bariatric surgery, Hamburger said.

Reporting Requirements

Employers are required to give all employees notice of the availability of coverage on exchanges, and whether the employer offers affordable/minimum value coverage. The U.S. Department of Labor issued model notices for employers offering coverage and not offering coverage.

Misconception 3: If Employer Gave Notices of Exchange Coverage Availability to All Existing Employees by Oct. 1, 2013, It Is Done

That of course is not true, Hamburger said. Employers must also give the notices to all new employees upon hire (within 14 days of employee's start date, for 2014). Normal ERISA delivery methods are permissible, including hand delivery, first class mail and electronic delivery under DOL rules. More recent guidance specified that there is no fine or penalty under the law for failing to provide the notice. Good-faith compliance is required, however, because you could get complaints from employees, or it could damage your attestation that you're in full compliance with all laws.

See *Myths and Facts,* p. 11

Program Integrity (continued from p. 4)

and governance from small-business (known as SHOP) exchanges.

States that run their own exchanges have a bit more flexibility in running their own audit and compliance verification programs over individual and small-business exchanges. The rules are more prescriptive when exchanges are in partnership with the feds, and when exchanges are run by the federal agencies. The rules will take effect on Dec. 30, 2013.

Public Frustration

This rule comes against the backdrop of criticism leveled at the exchanges due to the healthcare.gov website's lack of preparedness and inability to handle consumer traffic. People attempting to sign up for coverage have been frustrated not only by wait times and pages that would not load, but also because of the site's inability to give price quotes before an individual puts in an application for coverage.

Oct. 1, 2013 was the official start date for individuals to be able to buy health coverage through exchanges. Policies sold on exchanges begin taking effect as soon as Jan. 1, 2014.

GHP Insurer Must Pay $99K in Disclosure Penalties And Benefits Due to Poor Claims Review Process

An insurer for an employer-sponsored health plan governed by ERISA was ordered to pay benefits plus interest (and a $99,000 ERISA penalty for failing to deliver guidelines relied on to deny a claim) after a federal court found its claims and appeals process was riddled with delays, its denial letters failed to cite plan provisions and it disregarded, without explanation, evidence supporting payment of the claim.

As a result, the court found the insurer did not provide a "full and fair" review.

After eight years and three rounds of judicial review, allowing the payer to review the case one more time would have been futile, the court said in *Butler v. United Healthcare of Tennessee*, 2013 WL 5488644 (E.D. Tenn., Sept. 30, 2013).

Coverage Guidelines

John Butler and his then-wife Janie were covered by a plan sponsored by John's employer and insured by United Healthcare. United has discretionary authority to determine eligibility for benefits.

The applicable guidelines for coverage of residential substance-abuse treatment was from United Behavioral Health, an affiliate of United, and were not part of the employer's plan document. To pay benefits, they required: (1) severe substance abuse that hasn't responded to lower levels of care; (2) risk of harm to self and others; (3) risk of withdrawal symptoms; (4) living conditions subversive to abstinence; (5) a high risk of dangerous behavior induced by substances.

Rehab Coverage Denied

United rejected Butler's claim for coverage for his ex-wife's residential rehabilitation treatment at Sierra Tucson Hospital during February and March 2005.

Before the 2005 residential treatment occurred, Ms. Butler got one month of intensive outpatient treatment that the plan paid for, was approved by the plan for partial hospital/day treatment but left against medical advice; was treated by a psychologist for addiction; and participated in Alcoholics Anonymous meetings.

In February 2005, she entered the inpatient treatment program at the Sierra Tucson Hospital, and the health plan authorized two days of detoxification treatment. Her physicians recommended residential treatment at Sierra Tuscon and Ms. Butler sought coverage.

Without referencing to the medical record, United's medical director denied the request for residential rehab treatment, saying her substance abuse had not caused severe enough health conditions and she could be managed at the "intensive outpatient" level of care. She stayed there 30 days anyway. After being discharged, her appeal was rejected again on the grounds that her problems stemming from abuse were not severe enough. Again, the medical records were not cited.

Mr. Butler requested a third review be performed by an independent reviewer (Dr. Clemente), and he asked for a copy of the guidelines in February 2006. UBH ignored his request for the guidelines, and it was not until July 2008 that he saw the guidelines, 900 days later. Meanwhile, the independent reviewer also rejected the claim, but his rejection, it was later discovered, was based on different stricter guidelines than those used in previous reviews by United officials. He had reviewed the case using UBH's more restrictive inpatient substance abuse criteria, rather than the applicable residential substance abuse criteria.

Participant Seeks ERISA Penalties

Butler filed suit under ERISA's enforcement provisions in July 2008 alleging that United's denial of Janie's claim for residential addiction treatment was arbitrary and capricious. As a result of the action, Dr. Clemente had to embark on a second review of the claim under the effective guidelines. Ostensibly using the right guidelines, he nevertheless upheld United's denial.

Over five years, the court twice sent the case back to United for flaws in its review process. On reviewing the case a third time, the court considered United's latest review and denial.

Full and Fair Review

Butler contended that United failed to give his claim a full and fair review. He argued that a third remand would be futile. He asked the court to: bypass another remand; review the plan's decision *de novo*; award benefits due under the plan plus interest; tack on attorney's fees; and impose ERISA penalties.

In September 2010 the court issued a memo supporting Butler's claim that United withheld full and fair review, because nothing in United's records indicated that it had considered letters from Butlers' physicians. United responded by sending the letters back to Dr. Clemente,

See *Review Process,* p. 7

Review Process (continued from p. 6)

who re-issued an identical denial, merely adding that he had looked at the letters.

The court rejected the idea that this was sufficient to prove the review was full and fair.

> *The point was for United to consider the letters, not just provide them to the Court.* It was not merely the omission of those letters in the Administrative Record that made the review process procedurally defective. United did not *explain* why it disagreed with the medical opinions of Plaintiff's treating physicians and psychiatrist. United has attempted to cure that.

The court in August 2011 granted Butler's request for a new independent reviewer, and remanded the claim to United. The court noted that United had delayed the claim for one year, warning that any further delay from United might result in sanctions.

In September 2011, Butler submitted new recommendation letters from his physicians, which were updated based on the guidelines that were received finally in 2008. United initially tried to block admission of the new letters but court said new evidence was allowed.

In November 2011, when the third and final appeal went to an independent reviewer, United explicitly instructed the reviewers to disregard the new evidence. United also failed to include Butlers' corrections to deficiencies United had objected to.

The appeal went to two reviewers from the Medical Review Institute of America, who upheld United's denial. They determined that the treatment was not medically necessary and United again denied the Butlers' claim.

In April 2012, Butler requested the court to review the record *de novo*, award benefits, attorney's fees and impose ERISA penalties on United. United filed cross motions. A year later, arguments were heard and additional briefs were filed.

The Administrator's Biggest Mistake

The court agreed that the instructions telling MRIA reviewers to disregard additions to the record tainted the review.

> [B]y giving such an instruction, United essentially nullified the district court's order that the external reviewer consider additional documents submitted by Mr. Butler.

United told the reviewers that the new materials were too general, shouldn't be included because they postdated the claim and they were irrelevant. But the court said the material was "very relevant" and the lateness of the material was justified.

Revised physician letters were justified because United withheld the applicable guidelines for 900 days, which hurt his ability to get relevant letters from his physicians, the court said.

Its failure to forward two revised pieces of evidence in November 2011 also had no support in the record, the court said.

Court Overrides Independent Reviewers' Conclusion

The court decided that United had run out of excuses, and at this stage any further remand would be futile and "serve no purpose because the administrative record provides clear support for granting of benefits."

The court disregarded the MRIA's review supporting United's denial. It did so because MRIA review contained factual inaccuracies about Ms. Butler's treatment and did not discuss or refute the reasons given by Butler's physicians in favor of covering the treatment. Merely that they were part of the record was not enough, it said. Citing *Elliott v. Metropolitan Life Ins. Co*., 473 F.3d 613 (6th Cir., 2006), the court said:

> [A] plan may not reject summarily the opinions of a treating physician, but must instead give reasons for adopting an alternative opinion.

The MRIA physicians denied that lower levels of therapy had been tried and not worked, but the court said just four months before the residential care admission, she had been treated at a lower (intensive outpatient) level of care, and United knew about that because it paid for it, the court continued. Finally, there was no proof either of the doctors were certified in substance abuse, it said.

Court Decides for the Plaintiff

The court awarded benefits for the rehab stay, holding that Ms. Butler satisfied the criteria set forth in the guidelines: She had a history of severe substance abuse despite motivation and treatment in less intensive care settings, which failed to work. The record chronicled the extreme nature of her drinking and the harm she was doing to her own health. The court also said her drinking habits were subjecting her to danger. She was motivated to stop drinking, but intensive outpatient treatment had failed.

Treatment at Sierra Tucson was medically necessary, the court concluded. She had relapsed four times at lower levels of care; and it was time to use a more intense and structured level of care to achieve sobriety. That level

See *Review Process*, p. 8

Plan Blocks Provider's ERISA Claim as Assignee; Domestic Partner Was Ineligible for Coverage

The 10th U.S. Circuit Court of Appeals affirmed that a hospital lacked standing as an assignee to pursue an expensive claim of a domestic partner deemed ineligible for coverage under a group health plan. The domestic partner's coverage, which had been effective for almost a year, was rescinded when the plan discovered the individual misrepresented his own marital status.

In *Denver Health and Hospital Authority v. Beverage Distributors Co.*, 2013 WL 5539624 (10th Cir., Oct. 9, 2013), the provider's quest for payment failed because it was rooted in an assignment of benefits from someone who never met the plan's definition of "dependent."

The plan's definition of "dependent" was clear, and an "extrinsic document" — a domestic partner declaration form — issued by a plan's claims processor failed to cloud it; therefore, the hospital lacked standing to force the plan to pay benefits.

The Facts

Junnapa Intarakamhang was employed by Beverage Distributors Co., and enrolled her domestic partner, Terrence Hood, in Beverage Distributors' health plan. Beverage Distributors was the plan administrator. The plan allowed two types of "dependent:" a spouse and/or minor children. It defined "spouse" as someone "of the opposite sex" to whom the member is "legally married."

In June 2008, Principal Life — the plan's claims processor — gave Intarakamhang a "Declaration of Domestic Partnership" form to enable her to enroll Hood. The form included Principal's logo and a space listing Beverage as the employing company. She made regular premium payments to the plan for Hood's coverage.

On March 21, 2009, Hood was injured in a motorcycle accident and incurred $750,000 in expenses while being treated at a hospital operated by Denver Health.

Denver Health called the claims processor, and Principal sent the provider 14 authorizations for 48 days in the hospital. However, the plan discovered that Hood never qualified for benefits as the plan participant's legal spouse because he was married to someone other than Intarakamhang. As a result, the plan rescinded Hood's coverage. Beverage Distributors informed Intarakamhang of the rescission of coverage which was to apply retroactively to June 2008.

Denver Health attempted to use an assignment of rights it obtained from Hood to seek payment for its

See *Assignment of Rights*, p. 9

Review Process (continued from p. 7)

of treatment was the residential stay at Sierra Tucson, in spite of the plan's refusal to admit it, the court concluded.

Pre-judgment Interest

United's problems were due to a "bureaucratic, perfunctory and scattered" claims and appeal process "that was a product of United's underlying conflict of interest," but it was not bad faith, the court said. Nevertheless, it awarded pre-judgment interest because of the length of the litigation, the multiple remands and the long time during which Butler fought for payment of the claim.

Statutory penalties

ERISA authorizes courts to levy fines of up to $110 per violation per days for failing to furnish, guidelines, rules, etc., used to make an adverse determination, and it hit United with the full force of that provision. United failed to respond for 900 days and that delay had a negative effect on Butler's appeal. Therefore, the court levied the maximum fine of $99,000.

The court withheld a decision on Butler's request for attorney's fees pending additional hearings on the issue.

Lessons Learned

This case reminds us of a very basic concept in a somewhat confusing and convoluted way. Health plans are generally afforded a deferential standard of review by courts, unless they act in an arbitrary and capricious manner.

Plans are entitled deference, as long as they exercise their authority with care and reason. To avoid a *de novo* review, plans must review medical claims in conformity with plan terms. They must make reasoned decisions after looking at all available evidence.

But to simply ignore the facts and medical records without providing an alternative analysis or application will subject the plan to a substantially higher standard of review and, as we saw here, heavy penalties.

An outcome like this one can be avoided by simply not processing claims in an arbitrary and capricious manner. Having clear plan terms and using those terms as well as relevant available evidence to form a reasoned opinion that is communicated to the plan beneficiary is imperative to ensure a deferential standard of review.

Assignment of Rights (continued from p. 8)

services. It sued the plan for ERISA benefits and made two claims under Colorado law. In February 2012, a district court decided that state-law charges were not preempted (*DHHA v. Beverage Distributors Co*., WL 2012 400320 (D. Colo., Feb. 8, 2012)), but that the provider lacked standing to pursue benefits under ERISA.

On Nov. 4, 2011, Beverage filed a motion for judgment on the pleadings for the ERISA claim. The district court determined that Denver Health lacked standing to pursue an ERISA claim, because Mr. Hood was never a plan "participant or beneficiary." The state-law charges were not part of the appeal.

The Appeal

Denver Health appealed, saying that the district court erred by holding that it did not have standing to sue the plan under ERISA. Beverage disagreed and argued that even if the appeals court reversed the standing determination, Denver Health failed to exhaust the plan's administrative remedies. The appeals court would agree that Denver Health lacked standing to sue, so it did not have to address exhaustion of remedies arguments.

Standing

The court backed the plan by affirming that Denver Health had no standing to sue the plan for benefits, because (1) only participants and beneficiaries have standing to enforce rights ERISA benefits; (2) providers generally are not participants or beneficiaries, and therefore lack standing to pursue ERISA benefits unless they have a written assignment of benefits from an eligible participant of beneficiary; and (3) the assignment conveys whatever rights the purported beneficiary has; if Hood had no rights as an eligible beneficiary, neither did Denver Health.

The appeals court agreed that Hood was not a beneficiary under ERISA because plan terms provided that a spouse must be "of the opposite sex" from and "legally married" to the member to be considered an eligible beneficiary.

Denver Health never alleged that Intarakamhang and Hood were legally married.

But for the first time on appeal, the provider argued that the phrase "legally married" was an ambiguous term that the Beverage Distributors defined to include domestic partnership by asking Intarakamhang and Hood to complete a domestic partnership form and accepting the completed form from them.

The appeals court rejected this because: (1) it refused to accept new arguments on appeal when they are directed to reversing the district court; and (2) the plan plainly required spouses to be legally married, and there were no two ways to interpret that.

Extrinsic document excluded

A court can look outside of the plan's written language to refine the meaning of plan terms, but not when the plan is unambiguous and has a clear meaning under the law. However, the court would not allow issuance of the "domestic-partner" form from the claims processor to cloud the plan's clear definition of legally married as a requirement for becoming a beneficiary. The court stated:

> An "extrinsic document," like the domestic partnership form "do not themselves constitute the terms of the plan for purposes of § 502(a)(1)(B)" and do not trump the actual language of the plan).

Hood was married to someone other than Intarakamhang from February 2001 to November 2010 and therefore could not be legally married to her while married to another woman.

Furthermore, even if the court entertained Denver Health's arguments, the domestic partner form asked Hood to certify that he wasn't married to or legally separated from anyone else. Hood lied on that form (attesting that he wasn't), because he was still married to another person and so he failed to meet the plan's definition of domestic partnership.

Accordingly, the court issued a judgment on the pleadings in the plan's favor.

Lessons Learned

This case illustrates a very basic concept that is of utmost importance: An assignment of rights or benefits to a third party conveys only rights or benefits that existed in the first place.

Much like a health care provider has no claim to benefits above benefits that have been granted to the patient under plan terms, a provider can only obtain remedies that would have been granted to the patient.

Since the patient in this case was never actually a participant of the plan, he had no right of action against the plan. He was ineligible thanks to unambiguous plan terms and he misrepresented his marital status. Logically, then, he had no right to assign any litigation rights to the provider.

The health care provider in this case expended valuable time and resources, and wasted the plan time and resources as well, for this reason. Health plans and those who represent them must understand this basic assignment concept otherwise they will continue to be susceptible to litigation like this.

Indiana Challenge Says Reform Exchanges Unfairly Penalize States and Employers

A state that rejected operating a health insurance exchange under the health care reform law is arguing that current reform regulations unfairly hurt employers and governments in states that declined to set up the exchanges for the sale of health insurance.

An IRS rule that expanded the definition of "exchanges" to include federally run as well as state-run exchanges contradicts the statute and should be void, a lawsuit by the state of Indiana contends, citing its constitutional opposition to the health care reform law.

Subsidies should be available only if individuals purchase insurance through an exchange established by a state — not both state *and* federal exchanges as the IRS rule provides, the lawsuit contends.

A rejection of Obamacare's: (1) system of exchanges; (2) subsidies to individuals; (3) new 30-hour definition of full-time employee; and (4) penalties on employers — would be synonymous with preserving jobs, keeping business costs low, preserving state rights and keeping covered lives in employer plans, the lawsuit *State of Indiana et al v. IRS*, No. 13-1612 (S.D. Ind., Oct. 8, 2013) argues. It was brought by 15 Indiana school districts and the state of Indiana.

In addition to injuring state sovereignty, removing the state's ability to reject Obamacare exchanges takes away the state's ability to control its own business climate, the filing says.

If the federal government had not tinkered with the letter of the law through rules and sub-regulatory guidance, Indiana citizens purchasing coverage from a federally facilitated exchange would be ineligible for subsidies. Employers in Indiana (which opted not to run its own exchange) would not have to pay health care reform penalties for failing to offer minimum essential coverage to all employees working 30 hours or more per week.

By giving the same subsidies for purchases on federally facilitated exchanges as are available for purchases on state-run exchanges, IRS contravened the text of the health care reform law and thwarts Indiana's ability to execute state policies that protect employers from penalties, the complaint says.

Therefore, the state and school districts are suing IRS and HHS to block federal subsidies to Indiana citizens to purchase coverage from a federal exchange. That in turn would shield employers in the state from penalties for failing to offer "minimum essential" health coverage to all employees who work more than 30 hours a week.

The plaintiffs also seek a ruling that the employer mandate violates the 10th Amendment to the U.S. Constitution preserving state powers from federal encroachment, and want to permanently bar the mandate's enforcement.

> [B]y *not* creating an Exchange, the use of which may trigger financial penalties for employers, a State can create a more hospitable business environment for large employers.

IRS proposed a new definition of "exchange" in August 2011 (76 Fed. Reg. 50931) and finalized it on May 23, 2012, to include federally run exchanges. Before that time, the statute itself referred only to *state-established* exchanges.

Injuries Done to the Schools

Previous lawsuits of similar ilk have failed in federal court because they argued that states and businesses have not been injured by health care reform provisions that do not take effect completely until 2014. State sovereignty arguments have not done well in federal courts, which have said that residents of states are also U.S. citizens subject to federal law.

As an employer, the state of Indiana has had to spend time and resources on compliance, and may have to reduce capacity and cut work hours because of the mandate. The Indiana lawsuit argues that the reform law has harmed school districts by forcing them to cut workers' hours to keep them part-time. According to the complaint:

1) The school districts have had to reduce the hours of cafeteria staff, instructional aides, coaches, substitute teachers and bus drivers to fewer than 30 hours per week so those employees would be considered part-time.

2) The mandate harmed public schools' ability to comply with other federal education mandates (such as the No Child Left Behind and the Individuals with Disabilities Education Acts) by reducing the hours of instructional aides who help children with learning disabilities.

3) The mandate nullified the advantages a state would seek by opting not to run an exchange and not to participate in Obamacare, and that it constitutes a federal theft of authority that should belong to the state. Therefore, the employer mandate is an unconstitutional exercise of federal power.

See *Indiana Lawsuit*, p. 11

Myths and Facts (continued from p. 5)

Other health care reform-related reporting requirements for employers include:

- **Summaries of benefits and coverage.** Hamburger noted that material modifications have to be recorded on the SBC 60 days before the effective date of the change.
- **W-2 reporting** of the cost of health coverage.
- **Section 6055 and 6056 reporting** to the IRS about the scope and nature of coverage offered and participants covered by that coverage. Government and employer unpreparedness for this reporting is what caused enforcement of the employer mandate to be suspended in July 2013.

These reporting burdens overlap very significantly and it's important to ensure that communications do not contradict each other, Hamburger said.

Keep Communications Unbiased

Employers should try not to criticize the health care reform law when communicating these requirements to workers. Employees may be in favor of the law, and a company's criticism could hurt its standing with workers. Communications should stick to the legal requirements, and the legal standard, as determined by whether the matter implicates the employer under the Fair Labor Standards Act, ERISA or state law. Trying to politicize it or give it a slant is not a good idea, Napoli said.

Politicizing the health care reform issue in communications to workers is not a good idea especially in the context of workforce realignments, such as moving workers from full- to part-time status. If an employer writes in a letter that workers hours are being cut because of "Obamacare," the employee might file a complaint under the Affordable Care Act's nondiscrimination provisions, Napoli said.

New Limits

Starting on Jan. 1, 2014, new deductible limits will apply to small group plans. Deductibles cannot exceed $2,000 single and $4,000 family, and there will be a limited exception for plans that cannot meet stated actuarial value, the presenters noted.

On the same date, new out-of-pocket limits will apply to all non-grandfathered plans, tied to limits for high-deductible health plans with qualified health savings accounts, and those limits in 2014 will be $6,350 single and $12,700 family. In spite of ambiguity in the statute, employers can assume essential health benefits, in-network benefits and major medical coverage are what count toward the out-of-pocket limit, Napoli said.

Indiana Lawsuit (continued from p. 10)

Reporting Requirements Allegedly Unconstitutional

The law's reporting requirements about whether minimum essential coverage is offered and who has accepted it also violates the Constitution, by being an inappropriate expansion of federal power, an unnecessary incursion into the state's right to control the terms it offers its own employees and a state's right to control its own business climate, the complaint says.

> [T]he terms of employment for those providing governmental services is essential if Plaintiffs are to exercise their sovereign rights to choose what services to provide and to what extent they will fund those services. Plaintiffs have a legitimate sovereign interest in retaining a certain measure of control over the type and amount of compensation they offer their employees.

The government's decision to suspend until 2015 the reporting provisions in 26 U.S.C. Sections 6055 and 6056 (and with them the enforcement regime underpinning the entire employer mandate) did not affect their obligation to comply with the employer mandate. They were not promulgated through rulemaking with comment periods; they were merely announced in a blog post on the White House website. As such they have no legal force, the complaint says. Large employers are still under the requirements as a matter of law, in spite of the blog post's pledge not to initiate enforcement actions for violations.

Similar State Challenge

A similar challenge to the employer mandate survived dismissal in federal court a few months earlier. The state of Oklahoma is also an employer, and as such it may be subject to the employer responsibility penalty if an employee gets premium tax credits through the exchange, the U.S. District Court for the Eastern District of Oklahoma ruled.

The court on Aug. 12 denied the federal government's motion to dismiss *Oklahoma v. Sebelius*, CIV-11-30-RAW (E. Okla., Aug. 12, 2013). The state originally filed the suit in 2011; it was one of many cases brought by state attorneys general to challenge the law. The court rejected many of Oklahoma Attorney General Scott Pruitt's arguments attempting to block subsidies for individuals to buy insurance. but while the anti-injunction provisions of the Constitution prevented the state from suing the federal government, the state as an employer may have standing to file suit, that court concluded.

Health Care Reform Briefs

The U.S. Supreme Court indicated that it will choose from among four cases attempting to broaden the range of employers that can opt out of health care reform's mandate to provide contraceptive services free of charge. Organizations acting on behalf of church plans sued the agencies implementing health care reform to stop enforcement of the contraceptive mandate, citing their objections to having to cover drugs and devices they say cause abortions. They complained that non-religious grandfathered plans are exempted, and that they are not classified as religious employers.

Supreme Court to Choose From Four Contraceptive Mandate Cases

The U.S. Supreme Court will choose from four cases contesting the Affordable Care Act's contraceptive mandate in a Nov. 26 conference. It announced on Nov. 4 that it will examine all four pending cases together in order to determine whether the cases will be formally heard before the Court. The government issued briefs related to three of the four cases on Nov. 5. The cases are:

Sebelius v. Hobby Lobby. The 10th U.S. Circuit Court of Appeals ruled that the owners of a national retailer had a religious freedom case and had a chance of persuasively arguing that it would suffer an irreparable harm if the government enforced the mandate. The government appealed to the High Court to prevent the Religious Freedom Restoration Act from interfering with the mandate.

Conestoga Wood Specialties Corp. v. Sebelius. The 3rd Circuit (ruling contrary to the 10th Circuit) rejected a claim that the RFRA shields a Pennsylvania cabinet-making company from having to comply with the mandate, and it also refused to allow the individual owners to object on their own.

Autocam Corp. v. Sebelius. The 6th Circuit ruled that a corporation cannot exercise religion and thus cannot make a challenge for itself, and it also barred the religious owners of two companies that make precision instruments from pursuing their own complaint, finding that the mandate only applies to the company.

Liberty University v. Lew. The 4th Circuit rejected a religious school's challenge to the contraceptive mandate, and decided that the employer mandate is a valid use of Congress' constitutional power to regulate interstate commerce. The Lynchburg, Va.-based school objects to the mandate on religious grounds.

The conflict within the circuit courts on this issue increases the odds that the High Court may agree to hear at least one of the contraceptive mandate cases. This would make it the second challenge to health care reform to reach that level.

Church Plans Sue HHS Over Contraceptive Mandate

The Southern Baptist Convention's health and financial benefits entity has filed a putative class-action lawsuit against the health care reform law's contraceptive mandate on behalf of church plans.

The suit contends the religious liberty of the organizations covered by GuideStone Financial Resources (which arranges health coverage and retirement benefits for clergy and others) is violated by the mandate requiring employers to pay for contraceptives and drugs they say cause abortions.

The lawsuit (*Reaching Souls Int'l et al., v. Sebelius*) cites 16 counts, including violations of the First Amendment's free exercise and establishment clauses and the 1993 Religious Freedom Restoration Act.

It was filed on Oct. 11 at the U.S. District Court in Oklahoma City. Joining GuideStone in the suit are Oklahoma City-based Reaching Souls International and Truett-McConnell College in Cleveland, Ga.

The suit seeks a preliminary injunction blocking enforcement of the mandate until the judicial process is complete. The mandate, based on final rules issued June 28, 2013 (78 Fed. Reg. 39870), will take effect Jan. 1, 2014.

"GuideStone plans do not cover drugs or devices that can or do cause abortions," GuideStone President O.S. Hawkins said in a written release on Oct. 14.

Drugs covered by the reform mandate include Plan B and other "morning-after" pills that possess a post-fertilization mechanism preventing embryo implantation.

The administration "wants to tell us that we not only have to provide [abortifacients], but without cost to anybody that wants them," Hawkins said on Sept. 16.

The complaint was raised in opposition to the mandate and what it calls its lack of adequate conscience protections for religious employers.

The groups note that church plans are left out of exemptions that grandfathered health plans and religious organizations are entitled to.

[The plaintiffs'] religious beliefs forbid them from participating in the government's scheme to provide abortion-inducing drugs and devices.

See *Reform Briefs*, p. 16

IRS Eases Health FSA 'Use-it-or-Lose-it' Rule

Employers now have the option of allowing plan participants to roll over up to $500 in unused flexible spending account funds at the end of each plan year, under a new regulatory interpretation on health FSAs, the U.S. Treasury Department and IRS said on Oct. 31. Employers are free to change their plan designs accordingly for any plan year beginning in 2013 or later, but they don't have to. The new carry-forward provision is optional, just as the current rules' grace period for spending is. IRS announced the change in Notice 2013-71.

A senior Treasury official said employers now have three options:

1) offer the $500 carry-forward to employees;

2) offer the grace period available under the current rules; or

3) offer neither.

The official said employers may not offer both the carry-forward option and the grace period option at the same time — they must choose one or the other. Employers have until the end of 2014 to decide whether they will adopt the change, which they can apply as early as Jan. 1, 2013. He said employers still have the option of making no change at all.

"This is designed to help consumers, to make it easier for people to consider participating in a flexible spending account without the same degree of concern that many people have today that if they guess wrong about their medical expenses for next year — the types of expenses that qualify under [their] FSA — that they might have ended up contributing too much and having money leftover that will get forfeited. The risk of that forfeiture would be dramatically reduced with this $500 carry-forward," the Treasury official said in a briefing to reporters. He said that based on informal conversations with employers, most forfeitures are less than $500, so the change would address most of the situations in which employees have to give up unused FSA funds.

Asked by a reporter for the dollar amount of a recent year's worth of forfeitures nationally, the official said that information is kept by employers and the federal government does not track it.

The carry-forward option retroactively applies to Jan. 1, 2013, in order to counter balance the effect of Congress' decision to halve the annual health FSA limit to $2,500, also effective Jan. 1, 2013, the official said. Providing an optional carry-forward was within the Treasury's and IRS' statutory interpretive authority. The Patient Protection and Affordable Care Act's reduction of the annual limit prompted their action, he said.

Under the "use-it-or-lose-it" rule, funds set aside in a health FSA for a plan year must be used by the end of that plan year; any that are not are forfeited and could not be carried over, at least until IRS issued Notice 2013-71. IRS allows employers to give health FSA participants a grace period of up to an additional 75 days after the end of a plan year in which to use FSA funds from the plan year that ended to cover eligible expenses incurred during that plan year but that may not have come due until after it ended, as well as eligible expenses incurred during the grace period. For example, an employer that allows a grace period and has a plan year that ends Dec. 31, 2013 will allow participants to continue to use 2013 health FSA funds to cover eligible expenses through March 15, 2014.

The annual limit works along with the longstanding "use it or lose it" rule to limit the availability of funds that employees set aside tax-free. If there were no downside risk to over-estimating one's medical expenses for the coming year, the rationale goes, employees would be likely to divert more money than necessary to cover potential future medical expenses, maximizing the amount of money that goes untaxed.

But the Treasury official, as well as employers and others in industry, said that strategy has had drawbacks. The "use it or lose it" rule triggers unnecessary purchases of eligible items as the end of the plan year approaches, as employees try to spend down their unused funds to avoid forfeiting them, the official said. "There is a fair amount of anecdotal [evidence] of people loading up on various items that they're permitted to purchase under these FSAs that they might not otherwise purchase. This change will reduce the amount of that potentially unnecessary spending," he said.

Orrin Hatch, R-Utah, the ranking minority member of the Senate Finance Committee, said the rule change was a good start but more needs to be done. "This was a good decision by the Treasury Department," Hatch said in a prepared statement Oct. 31. "Allowing Americans who have one of these accounts to roll $500 over to the following year just makes sense and will give people more help to pay for out-of-pocket health care costs," he said. "I'd like to see more done to expand these critical accounts that empower the individual to make informed health care decisions using money they saved."

CE Column (continued from p. 2)

primarily employ persons who share its religious tenets, and primarily serve persons who share its religious tenets. It merely required a plan sponsor to be a nonprofit that attests it has religious objections to contraceptives, to avoid having to cover them.

Under the exemption, such organizations do not have to contract, arrange, pay or refer anyone for contraceptive coverage. At the same time, the federal rule provides that separate payments for contraceptive services be available for women in the health plan of the organization, at no cost to the women or to the organization.

The New Definition

The simplified definition of religious employer for purposes of the exemption 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. This change is intended to clarify that religious entities are not excluded from the exemption because they provide services to (or employ) persons of different religious faiths.

Certification Goes to TPA

The question remains as to how, under a typical self-funded arrangement, is the TPA supposed to certify an organization's objection to the mandate when a TPA is neither a fiduciary nor a payer of claims? The TPA is supposed to be processing claims with the plan's money.

The first step is that a self-funded plan must self-certify to its TPA that it objects to the contraceptive mandate and it will not act as a plan administrator for contraceptive services. (Insured plans provide the certification to their insurer.)

The form includes a declaration that the organization is eligible and a certification that it will not administer or fund contraceptive coverage. It cites specified provisions of the ERISA regulations, which explain the TPA's obligations.

Although it is not the TPA's responsibility to ensure that the plan completes this form, if the TPA is aware that the plan will not cover contraceptive services, it may be wise for the TPA to ensure that the plan does self-certify to prevent any future complications.

Notification

For each plan that has an exemption, the TPA must provide written notice of the availability of payments for contraceptive services to members separate from any application materials distributed in connection with enrollment or re-enrollment in group health coverage. The notice must specify that the plan does not administer or fund contraceptive benefits, but that the TPA provides separate payments for contraceptive services and must provide contact information for questions and complaints.

In addition, if an employer wants to exclude one form of contraceptive services but not others, the TPA must honor that request.

Normally, self-insured religious organizations pay for all covered services and are fiduciaries for how they are paid. But here the TPA provides payment for contraceptive services and it becomes an ERISA plan fiduciary for that purpose. The TPA must undertake the responsibility of serving as plan administrator for these limited contraceptive services. The TPA also must ensure that none of the money collected by objecting self-funded religious organizations will be used to cover contraceptive services.

Every TPA may decide whether it wants to handle the contraception services for its exempt plans. But if it does so, it becomes responsible for notifying employees of this coverage. To do so, a TPA should use DOL's model language. The notice must be provided independently of other plan materials.

The TPA Must Arrange Coverage

In providing the coverage, the TPA can directly provide payments for contraceptive services for participants and beneficiaries from its own general assets, or it can arrange for an insurer to provide the payments. In either case, the payments are not health insurance policies and the TPA can make arrangements with an insurer through a federally facilitated exchange to obtain reimbursement for its costs. The participating insurer and TPA also receive an allowance for administrative costs and a margin around the drugs and services themselves.

Reimbursement

The costs of such payments can be offset by adjustments in FFE user fees paid by a health insurer with whom the TPA has an arrangement.

The insurer offering coverage through the FFE can receive an adjustment to the FFE user fee, and the insurer is required to pass on a portion of that adjustment to the TPA to account for the costs of providing payments for contraceptive services.

This allowance will be at least 10 percent and will be specified in the annual notice of benefit and payment parameters. The user fee adjustment normally will be

See *CE Column*, p. 15

CE Column (continued from p. 14)

shared between the insurer and TPA, to compensate the TPA for its use of the insurer's services. If the user fee adjustment exceeds the amount of user fees owed, the insurer will receive a credit.

Note: Beginning in 2014, insurers may be subject to a 3.5-percent fee to pay for the insurer's access to FFEs. This fee is a percentage of the insurer's exchange-based sales. This fee is not applicable to a TPA.

Here is the tricky part for most TPAs: (1) they don't have these arrangements in place; and (2) they are being asked to set up arrangements with their competitors. There isn't this beautiful and loving relationship between most TPAs and fully insured carriers, yet now they are being asked to get together for this limited service.

In order to do so, the insurer must advise HHS of its intention before Jan. 1, 2014, or within 60 days after it receives a self-certification from an eligible organization, and it also must report to HHS the actual amount spent on contraceptive services during a given calendar year, by July 15 of the following year.

The insurer then must report to HHS the actual amount that has been spent on contraceptive services on an annual basis by July 15 of the following year. The user fee adjustment will begin on the following Oct.15.

Although the health care reform law imposes the responsibility of providing contraceptive services on the TPA, it is the insurer that must report its intent to provide contraceptive services and the amount spent to HHS. Therefore, I would suggest that the agreement in place between the TPA and the insurer should require the insurer to provide this information to HHS.

There are three conceivable arrangements by which the TPA would be reimbursed.

1) If the TPA offers a qualified health plan through the FFE or contracts with an insurer that offers a qualified health plan through the exchange, the insurer's own fee for using the exchange will be adjusted.

2) If the TPA or an insurer contracted to provide contraceptive services for the TPA does not offer a qualified plan through the exchange, a related insurer that is part of the same insurer group as the TPA or its contracted insurer can claim the adjustment. The user fee adjustment can then be passed down to the insurer providing the contraceptive services or to the TPA.

3) If neither the TPA nor an insurer covering contraceptive services for the TPA, nor a related insurer, offers a qualified plan through the exchange, the TPA can contract with an unrelated insurer that does participate in the federal exchange to receive the benefit of a user fee adjustment to cover the cost of services provided by the TPA.

   This unrelated insurer can claim the user fee adjustment and pass it down to the TPA, even though that unrelated insurer had no part in the TPA's offering contraceptive services.

Confused yet? Well, we were advised that HHS will inform TPAs of the various insurers that offer separate contraceptive-only policies.

Most importantly, unless the TPA offers a qualified health plan through an FFE, the TPA must contract with a fully insured insurer in some way to obtain reimbursement.

Exempt Plans Cannot Pay For Contraceptive Claims in Any Way

Let me make this point very clear. TPAs may not offset the cost of providing contraceptive coverage by increasing the administrative fees for these plans, as the relevant regulation specifies that a TPA must ensure that no fee or other charge in connection with such coverage is imposed on the eligible organization or its plan. I am aware that many TPAs were thinking this would be the approach that they would take, but the fact remains that they cannot do so.

TPAs May Not Raise Rates to Cover Birth Control

It appears that some TPAs may, however, attempt to offset this cost by raising their administrative fees for all their clients. It is unclear, however, whether a general increase in administrative fees would violate the current regulations, if the rise in fees were partially contributed to by the cost of contraception coverage, and if the fee increase applied universally to all the TPA's clients.

Conclusion

While the overall approach for handling the contraceptive process may look good on paper, it may prove to be unworkable in the real world. The industry must come up with innovative ways to handle this process or some self-insured religious nonprofit organizations may have persistent troubles relating to contraceptive issues.

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-3. 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 "21:3/2" indicates Vol. 21, No. 3, page 2.

Index by Subject

Index of Court Cases

Reform Briefs (continued from p. 12)

Yet the government refuses to exempt Reaching Souls and Truett-McConnell as "religious employers."

More than 1 million pastors and church workers depend on church plans for their health benefits, the lawsuit says.

"We reluctantly take this step because we are committed to protecting the unborn and preserving the religious freedom that is guaranteed under the laws of this nation," he said.

In a related development, Sen. Mark Pryor, D-Ark., cosponsored the Church Health Plan Act (S. 1164), which would help church health plans regain some protections lost under the health care reform law.

Employer Owners Have Case Objecting To Contraceptive Mandate Case

On Nov. 1, the U.S. Appeals Court for the District of Columbia ruled in favor of an employer that raised religious objections to the health care reform law's requirement that companies provide birth control coverage.

The court said that Freshway Foods and Freshway Logistics did not have First Amendment rights to press a claim, but the owners as shareholders did. The owners, Francis and Philip Gilardi, do not want to provide insurance coverage for contraception, sterilization and abortion.

The appeals court reversed a lower court ruling that denied the owners a preliminary injunction.

As a result of the regulation, Judge Janice Rogers Brown wrote that the owners are in an impossible dilemma, either: (1) adjust their companies' plans to provide the mandated contraceptive services and "become complicit in a grave moral wrong"; or (2) pay a penalty amounting to more than $14 million per year, and "cripple the companies they have spent a lifetime building."