Employer's Guide to
Self-Insuring Health Benefits

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Never Overlook Your Administrative Services Agreement

Employers wanting to benefit from the advantages of self-funding will usually end up signing administrative services agreements with third-party administrators or preferred-provider organizations. So when you get that administrative services agreement to sign, what do you do? Contributing Editor Adam Russo explains what to be watching for and what to do. For example, on many occasions employers have great ideas on how to save their plan money — such as PPO replacements, physician-only networks, specialized carve-outs and Medicare-plus pricing — only to only find that they cannot do so based on their ASA. If your ASA hasn't been revised in the past two years, chances are that it is already outdated. Plans need to realize that the decision on how much of a fiduciary role the TPA has will be vital in determining who has the final say on plan terms. Many employers do not realize that when they decide to become self-funded, there is much responsibility outside of just paying for the claims. ***Pages 2, 7, 8***

Court Blocks Putting Self-funded Plans Under Ga. Prompt-pay Law

Self-insured ERISA health plans and their administrators should not face enforcement of Georgia's prompt-pay statute, a federal court decided after determining that the statute interfered with the core ERISA concern of claims adjudication. The court did not accept the state insurance commissioner's arguments that the state's maximum times for claims payments was a ministerial plan duty that does not touch core ERISA concerns. The state's prompt-pay law would have taken effect Jan. 1, 2013. In spite of this and other rulings of its kind, self-funded plans often are bound to prompt-pay timeframes through their PPOs. ***Page 3***

Plan's Misstatements Cause Contract Rewrite, Retroactive Payment

A recent case outlines potential new liabilities plan sponsors face when they misrepresent the impact of plan amendments and other decisions. In *CIGNA v. Amara*, plan members were entitled to benefits in addition to those provided by plan terms because of misrepresentations that occurred in plan newsletters, a summary of material modifications and summary plan descriptions. The U.S. Supreme Court supported contract rewrite and money damages and remanded the case for specific remedies. The district court ordered CIGNA to: provide updated notices to beneficiaries about their plan options and benefits; and restore plan funds to bring plan members to the same funding levels they would had if the the plan had not misrepresented the impact of its changes. And it denied CIGNA's motion to decertify the class. ***Page 5***

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Never Overlook Your Administrative Services Agreement

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You have seen your fully insured premiums go through the roof over the past five years. You don't want to give up insuring your workers and let them go to the health insurance exchanges — not in 2014 anyway. So you have been reading a lot about the advantages of self-funding.

In looking at various self-funding options, you've seen the benefits of working with the large, network-owned third-party administrators and administrative-services-only vendors that give you great provider networks but not much freedom. You have reviewed the smaller, independent TPAs where you have much more control but you have concerns regarding claim discounts and provider access.

> If your ASA hasn't been revised in the past two years, chances are that it is already outdated.

After speaking with your broker, your human resources team and your executive team, you finally decide to self-fund. The trouble is that your in-house counsel isn't an expert in self-funding and just recently learned what a TPA even does. So when you get that administrative services agreement to sign, what do you do? Well, hopefully this article will begin to lead you down the right path.

Beware of Automatic Renewal Clauses

Typically, an ASA will be between the claims administrator and the plan sponsor and last for a year with the potential for annual renewals. Be careful of any annual renewal policies that kick in unless you opt out of the agreement. You do not want to be stuck in a relationship that you want to get out of. Generally, the plan sponsor creates a program of health benefits under the plan and funds the plan with the employer's general assets and employee contributions.

Be Careful of TPA Fiduciary Functions

The main question for plans to decide is whether they want to take on the fiduciary role in its entirety or to share fiduciary responsibilities with their TPA and other vendors.

The decision regarding fiduciary responsibility is a vital one that you as the plan must make since the responsibility and potential liability will fall squarely on the party that is the named fiduciary as well as the party (if not the same) that acts as the fiduciary.

While self-funded plans usually take on all fiduciary responsibilities, increasing numbers of TPAs and plans agree that the TPA is a plan fiduciary and has discretionary authority and final determinative capability.

See *CE Column*, p. 13

Employer's Guide to Self-Insuring Health Benefits

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Federal Court Blocks Amendment Subjecting Self-funded Plans to Ga. Prompt-pay Law

Self-insured health plans and their administrators should not face enforcement of Georgia's prompt-pay statute, the U.S. District Court in Northern Georgia ruled, after it determined that the statute interfered with the core ERISA concern of claims adjudication.

In *AHIP v. Hudgens*, 2012 WL 6738768 (N.D. Ga., Dec. 31, 2012), America's Health Insurance Plans challenged provisions of Georgia's prompt-pay statute, after that law was amended in 2011 to include self-funded health plans as covered entities. The change was scheduled to take effect Jan. 1, 2013. AHIP is a trade association for large insurers; its members also perform third-party and administrative-only services for self-funded plans.

Georgia's insurance commissioner Ralph Hudgens defended the prompt-pay statute, saying that imposing maximum times for claims payments was not preempted because achieving time periods is a ministerial plan duty that does not touch core ERISA concerns. AHIP argued that ERISA preempts the statutes and protects self-funded plans from the law.

Law Targets Self-funded Plans

The goal of prompt-pay statutes is to prevent abuses by insurance companies delaying and underpaying health claims.

Georgia's 1999 prompt-pay statute originally applied to insured ERISA plans but not to self-funded ERISA plans. It required that:

- Health plan benefits were payable by the "insurer" obligated under the plan.
- "Insurers" had 15 working days (after a clean claim is received) within which to process claims and mail payments or denial letters.
- Failure to process and pay (or deny) the claim on time obligated the "insurer" to pay 18 percent per annum interest on the outstanding balance.

However, the growth of self-funding (it grew from 44 percent to 60 percent of workers nationwide between 1999 and 2011) brought with it significant erosion in the number of plans subject to the state's prompt-pay requirements, the court opinion noted.

Accordingly, the state passed the Insurance Delivery Enhancement Act in April 2011, which extended the prompt-pay statute's requirements to self-funded health plans. It also lowered the interest payment for noncompliance to 12 percent per annum. Gov. Nathan Deal (R) signed the bill and it was scheduled to take effect on Jan. 1.

The law expanded the definition of health benefit plan to include self-funded plans. It deleted the express exemption for self-funded plans from the definition of "insurer," and added "the plan administrator of any health plan" to that definition.

On Sept. 14, 2012, AHIP moved to enjoin Commissioner Hudgens from enforcing the challenged IDEA provisions. On Oct. 12, 2012, the commissioner filed a motion to dismiss the plaintiff's complaint.

Preemption Arguments

The commissioner put up a series of reasons why the state law should not be preempted. Hudgens argued that ERISA did not preempt the challenged provisions of IDEA because:

1) AHIP lacked standing to file a claim because: the group had not suffered a cognizable injury; its claim was not ripe, and the court lacked subject matter jurisdiction;
2) Third-party administrators and not self-funded ERISA plans themselves were subject to the law and its penalties (because TPAs are not ERISA

See *Prompt-pay Law*, p. 4

Prompt-pay Law (continued from p. 3)

fiduciaries and not directly governed by ERISA, Georgia may regulate their claims processing, he said); and

3) the law governs only a ministerial function; that is, the required timing for paying or denying claims.

The court rejected the commissioner's argument that TPAs could be regulated without impermissibly affecting self-funded plans themselves. The court said the text of the amendments evinced a clear intent to reach self-funded health plans, without regard to the specific entity processing the claim. It also noted the amendment's deletion of the exemption of self-funded plans.

The court rejected the concept that the timing of claims payments is a mere ministerial — not a fiduciary — function. While avowing that many TPAs perform ministerial duties only and most do not perform fiduciary functions, the court rejected focusing an analysis on the regulated entity and instead looked at whether the *functions regulated* by the law's amendments "related to" ERISA plans. And it found that the timing of claims payment restricted plans' claims eligibility rulings, which the court said was central to ERISA plan administration.

> Although not explicit, the statute necessarily requires that benefit eligibility determinations (i.e., determinations as to whether the claim is covered) also be made within 15 or 30 days, in time to satisfy the payment or notice timing requirement. These requirements, when applied to ERISA plans, have at least a "connection" with the plans. These requirements, while not "alter[ing] the incentives" for ERISA plans to pursue certain actions, do compel certain action — "prompt" benefit determinations and payments — by plans and their administrators.

The court cited a number of cases showing a state law is preempted when it governs a "central matter of plan administration" or affects "national uniformity of benefits determinations" and claims.

AHIP argued that the provisions "relate to" ERISA plans. AHIP further argued that it was not saved by the saving clause or, alternatively, that, if the saving clause applied, the deemer clause should also apply to preempt the provisions. (**Note:** The saving clause blocks preemption of state laws designed to regulate insurance, and the deemer clause prevents self-insured plans from being deemed to be insurers.)

> The practical effect of the Saving and Deemer Clauses is that a state law may regulate insured ERISA plans, by regulating the insurance policies that the plans purchase, but it may not regulate self-funded plans, which do not purchase insurance and which cannot be "deemed" to be insurers for purposes of the law.

The interplay between the savings and deemer clauses results in insured ERISA plans being subject to state insurance laws (based on the savings clause), while self-funded ERISA plans are not (based on the deemer clause), the court noted. As a result, the amendments were preempted by Section 514 of ERISA, thereby invalidating the commissioner's motion to dismiss based on non-preemption.

Accordingly, AHIP's complaint survived and the court issued a temporary injunction enjoining the commissioner from enforcing the new provisions of the state's prompt-pay law.

In granting it, the court held that AHIP members would suffer "irreparable injury" from the amendments; they would have to carry the cost of changing their claims processing systems; and they would have to monitor compliance with the law. If self-funded plans ignore the law, the court noted, they would face the 12-percent penalty imposed by the commissioner. "Absent an injunction, AHIP's members [would] be forced either to incur the costs of compliance with a preempted state law or to face the possibility of penalties," the court said.

Implications

This decision shows that despite some history of animus toward self-funded plans and their cost containment tactics, core ERISA arguments still protect benefit plans from much state regulation. By rejecting the commissioner's argument, the court affirmed that the amendments were clearly intended to affect the underlying benefit plan, not the claims administrator. In applying a "relate to" standard, the court deemed that timing of claims payment is an issue central to ERISA plan administration, and as such, is protected by ERISA preemption.

This case shows that despite the recent attempts by many states to indirectly regulate self-funded benefit plans, through entities such as their TPAs and stop-loss insurers, health plans continue to successfully use basic theories underlying ERISA; and that self-funded plans must have the ability to administer claims uniformly and in accordance with plan terms. As the court stated, preventing a plan from doing so could bring about "irreparable injury."

Enthusiasm Tempered

While we can clearly place this case in the win column for ERISA self-funded plans in the state of Georgia, plans still must be careful in how their claims are processed.

See *Prompt-pay Law*, p. 5

Case Highlights New Liabilities of Expanded Equitable Relief

ERISA Plan's Misleading Disclosures Result in Contract Rewrite, Retroactive Payment

A recent case outlines potential new liabilities plan sponsors face when, in plan communications to their members, they misrepresent the impact of plan amendments and other decisions. The ruling underscores the consequences of expanded equitable relief under theories of surcharge, unjust enrichment and contract reformation.

The U.S. District Court for the District of Connecticut held that a class of 25,000 CIGNA retirement plan members is entitled to benefits in addition to those provided by plan terms because the plan intentionally miscommunicated the impact of a change in retirement plan offerings in communications such as a plan newsletter, summary of material modifications and summary plan descriptions.

The district court: (1) ordered CIGNA to provide updated notices to beneficiaries about their plan options and benefits based upon its ruling; and (2) reformed the plan in order to restore funds to beneficiaries who made harmful choices based on the plan misrepresentations, to bring them to the same funding levels they would have if the plan had made correct representations.

It stayed these remedies to allow the parties to pursue an appeal; nevertheless it ordered CIGNA to post bond of $40 million to ensure that the plaintiffs could be paid. It also denied CIGNA's motion to decertify the class.

Prompt-pay Law (continued from p. 4)

While self-funded ERISA plan claims are not subject to the Georgia statute, if the claims are in-network and subject to a network or PPO agreement, the rules in that agreement still apply. Many PPO and network agreements have prompt payment rules that are even stiffer than the state statute. For example, while a plan's out-of-network claim in Georgia may not be subject to a 30-day prompt-pay rule, the network agreement may state that claims must be paid within 20 days in order to receive a discount.

In addition, the penalties for not paying as stated means that the plan will lose the discount as well as have to pay interest and other fees on the claims in question. Many plans will read this case and believe that they are in the clear, but that just isn't so. If they signed a PPO agreement, they have agreed to those payment terms and the laws of the state that the agreement uses.

The case is *Amara v. CIGNA Corp.*, 2012 WL 6649587 (D. Conn., Dec. 20, 2012).

While this case involved a retirement plan, it is relevant for health plans as well. For example, the expansion of remedies in response to misrepresentation is already being tested in cases involving health plans, such as in *Gearlds v. Entergy Services Inc.*, 2012 WL 1712441 (S.D. Miss., 2012), now before the 5th U.S. Circuit Court of Appeals.

Ruling Bolsters New Remedies

The district court was ruling on remand after an earlier decision by the U.S. Supreme Court in *CIGNA v. Amara*, 131 S.Ct. 1866 (2011), which ruled (8-0) in favor of the plaintiff class. It held that reformation and surcharge were not available remedies under ERISA Section 502(a)(1) (benefits due under the plan) but suggested that, after remand, the district court might award such relief under Section 502(a)(3) (appropriate equitable relief).

Reformation

The court affirmed the remedy of reformation (rewriting), based on contract, and not trust, reformation standards, which say that if there is "mistake on one side and fraud … on the other," then reformation is the appropriate remedy. This was true in this case, the court noted, because "deficient or misleading communication led employees to misunderstand the content of plan amendments." Further, court said, CIGNA knew that if it issued an honest statement of the impacts of its plan change, it would experience backlash from participants. As a result, it affirmatively misled them and did not try to correct its mistake.

CIGNA suggested that ordering reformation would be inappropriate because it would alter a contract in response to a third party's misrepresentations — not those of a party to the contract. The SPD is not part of the ERISA plan, it was not written by the plan's sponsor, and ERISA carefully distinguishes between the plan administrator and the employer, the company argued.

But the district court disagreed, finding that distinction to be artificial because CIGNA was acting as both sponsor and administrator.

The court also held that it didn't matter whether the plan document itself was the vehicle through which the

See *New Remedies*, p. 6

New Remedies (continued from p. 5)

misrepresentations were made (they were made in an information kit and three SPDs), and that CIGNA failed to articulate why that should make a difference in determining whether to order reformation of a contract.

Surcharge

Generally, the court noted that an ERISA fiduciary that breaches its statutory duties may be surcharged for the amount of the benefit to the trustee personally as a result of the breach.

CIGNA could be surcharged if the plaintiffs showed that the company breached its fiduciary duty, and the plaintiffs suffered a related loss, under both make-whole and unjust enrichment theories.

CIGNA was the *de facto* plan administrator and breached its fiduciary duty by materially misleading its employees, according to the court.

Regarding the make-whole surcharge, once the plaintiffs demonstrate the company breach and participant loss, CIGNA (in in order to avoid being surcharged) would have to show that their loss would have happened even if the misrepresentation had never happened. CIGNA failed to prove this; therefore, the plaintiffs were entitled to surcharge, the court ruled. Essentially, CIGNA failed to demonstrate that its fiduciary breach was not a factual cause of the diminished retirement benefits:

> CIGNA has not convinced the Court that, had its disclosures been proper, Plaintiffs would have still suffered the same losses.

Regarding the unjust enrichment surcharge, the question was whether, but for CIGNA's deficient notices, CIGNA would not have obtained the cost savings that it did. In comparison, the inquiry for make-whole surcharge was whether but for CIGNA's deficient notices, each plaintiff would not have received diminished retirement benefits. However, for procedural reasons — mainly the fact that make-whole surcharge was deemed available — the court declined to expand upon the unjust enrichment surcharge inquiry. In doing so, it noted that the parties will likely seek the 2nd Circuit's guidance. If the appellate court disagrees with the application of reformation and make-whole surcharge, the district court said it is likely to allow a further hearing to determine whether an unjust enrichment surcharge theory is applicable unless foreclosed by the 2nd Circuit.

The court also rejected CIGNA's attempt to decertify the class, saying the company applied the disadvantageous terms to all class members equally and sent out identical notices and disclosures to the members of the class. As a result, any relief could be applied uniformly.

> **Note:** A lack of surcharge relief in the health plan context has led to participants paying premiums for coverage, only to have the plan cancel coverage when the first big claim comes in, citing "ineligibility." In those cases, the only remedy for years of misrepresentation about the existence of coverage is for the plan to return premiums paid, leaving the participant to pay his or her own medical bill.

> **Note**: Concerning reformation in the health plan world, the implication of this case would mean that a plan could be forced to restate its plan document and retroactively have to cover claims that were inaccurately denied based on plan provisions. In an example involving reimbursement rights from a member, a plan has a provision allowing it to recover money on a subrogation case but the law does not allow the plan to do so. This case means that a plan could be told by a court to change its provision as the remedy going forward.

Lessons Learned

Although discomforting because this case shows the court's willingness to impute equitable limitations on an employer-sponsored health plan, it is important to note the narrow scope in which the opportunity to reform arose. Federal courts have historically ruled against benefit plan administrators for failing to administer the plan in conformity with the terms as set forth. In this case, the plan willfully misrepresented the impact of plan changes causing damage to the plan beneficiaries. As a result, the plan was not acting in complete conformity with its terms and the court used remedies available to remedy the breach.

This case re-enforces the importance of clear, concise language as well as the need to follow those terms strictly. Plans must ensure that all of their communications with plan beneficiaries, as well as their processes and procedures, are consistent with the terms of the plan. Courts have shown that when the action is a plan attempt to enforce its terms, the court will defer to the plan's action. However, when there is a breach of fiduciary duty, the court will take a much more aggressive approach in providing relief to beneficiaries for any damages.

Claims Process Involves More Than Writing Checks Under an ASA

By Adam Russo, Esq.

Many employers do not realize when they decide to become self-funded that there are many responsibilities besides just paying claims. Key decisions need to be made about the *whole* claims process.

For example, administrative services agreements become more complicated when plans deal with insurer-owned administrative-services-only providers, third-party administrators owned by large networks or TPAs that own their own regional PPOs. Many of these ASAs are so complex that they actually have the look and feel of plan documents. The reason is that these ASAs often include many more rules about how claims must be paid compared to independently run TPAs.

The entire process of how claims are to be reviewed, adjudicated, processed, paid and potentially audited are outlined in the ASA regardless of what the plan document may state. These agreements often state that claims must be paid according to network agreements and that no other arrangements can be made with any provider in the network. Often you have to agree to these terms even though you may not be allowed to review these outside contracts.

Therefore, if the plan wants to carve out claims, negotiate directly with a hospital or use specialty networks, there is a great chance that it will be prohibited by the TPA through its ASA agreement. So, if you plan on using a TPA or ASO because they have their own network or have unique access to a large physician organization, be sure you are fine with the fact that your ability to carve our claims or negotiate directly with physicians may be greatly compromised.

A Panoply of Potential Services

In many cases, the TPA will provide utilization review services for the plan, including pre-certification of hospital stays, concurrent review of hospital stays, discharge planning or retrospective reviews, hospital bill audits, large case management and many other managed care programs. Again, as the plan sponsor, you need to decide if you want the option to select a vendor to provide UR services for the plan or at least have final approval in doing so. You should at least require to be given a copy of the applicable agreement between the UR vendor and the TPA, detailing all of the services and fees to be provided, so that you know exactly where those fees are being applied.

Access to the Claims Data

One of the main benefits for self-funded plans in using a TPA is having access to the claims data.

It is important that your ASA state that you, as the plan, own and shall own all rights, title and interest in the underlying plan data and records of claims of all plan participants and beneficiaries. The plan sponsor is to have access to all plan data and is to be delivered to the plan at no cost and upon termination of the ASA. This way, if the plan chooses to work with another TPA or a stop-loss insurer that it has chosen on its own, you will have access to the claims data needed for the insurer to make coverage and premium decisions. This is one of the major advantages of working with a TPA versus an ASO.

In order for the TPA to know what employees and dependents are eligible for coverage you will need to maintain current and accurate plan eligibility and coverage records for the TPA. Typically, this information includes the following for each plan participant: name and address, social security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends and any other information necessary to determine eligibility and coverage levels under the plan.

I would advise that your contract specifically state that on a weekly basis the TPA provides you with a standard set of reports detailing claims processing for the previous week. This should include claims payment denials and appeals. These claim activity reports will include current period and year to date information and should include those data elements requested.

Be Ready When TPA Uses Discretion

If a TPA makes an initial determination that a claim is not payable and the claimant requests a review of the claim determination, it is advisable for the ASA to state that the TPA must refer such request to the plan administrator, along with the relevant records in the TPA's possession.

However, just like with the fiduciary responsibility, you may decide that the TPA will be responsible for the final decision. In such situations, the ASA should provide that the TPA will review the request, make a full and fair review of the claim denial as required by ERISA and notify the claimant in writing of its decision in accordance with ERISA's time limits.

What's the Scope of Your TPA's Duties?

By Adam Russo, Esq.

Most administrative services agreements state that the third-party administrator is not obligated to disburse more in payment than the plan sponsor shall have made available. This is an important provision as it shows that the TPA is not the payer of claims. The ASA typically will go on to state that the ASA is not a contract of insurance under any laws or regulations and that the TPA does not insure, guarantee or underwrite liability.

Not Legal Advice

One of the typical statements that most plans ignore is that the TPA does not offer legal advice or guidance. In this day and age of health reform, there is no way a self-funded plan can be successful for long if it doesn't have legal expertise on its side. So if the TPA is telling you that you are on your own from a legal standpoint, then protect yourself. Most TPAs, unless they are the large ones, do not have in-house counsel. Most TPAs rely on outside law firms and attorneys to assist them with legal and compliance issues. It is important that you reach out to your TPA and ask it for recommended attorneys with self-funded expertise.

Authority to Hire Vendors

There is an important decision that plans must make. Who will have the final say on whether a vendor should be used and if so, then who will be chosen? The plan can decide to retain final authority regarding who is used or not. There are pros and cons to both sides but the recent trend is allowing TPAs to make these decisions since this is their area of expertise.

Depending on the state you are in, it will be important to verify that the TPA you plan on working with is licensed in your state and the state where your employees reside. Some states require that the TPA be licensed even if only one plan member resides in that particular state. Again, there are many different rules as they relate to licensing and state requirements, so it's best if you ask your TPA up front.

Eligibility and Recordkeeping

It is vital that the plan also knows specifically what the TPA will do for the plan sponsor. Typically, the TPA can:

- administer eligiblility determinations, enrollment and termination of plan participants as directed by the plan sponsor;
- maintain plan records based on the dates on which a plan participant's coverage starts and ends, based on data from the plan sponsor; and
- maintain plan records of coverage applicable to each participant, based on information from the plan sponsor.

The TPA should maintain records regarding payments of claims, denials of claims and pending claims. In addition, it should adjudicate claims incurred by participants according to plan document terms. But just who is designing the plan document? Did you as the plan have any options in regards to plan terms or did you leave it up to the TPA? Again, this can be outsourced to the experts in the industry or you can rely on your TPA to do it for you. When it comes to plan documents, not all lawyers are the same. While an experienced ERISA attorney may assist you with compliance needs for your plan document, he or she will offer little when it comes to cost containment measures. Your best bet is to seek referrals from those in the know.

You may also want to have the TPA capture and provide data for IRS form 5500 filings on behalf of the plan sponsor. Preparation of the form itself may or may not be included but more and more TPAs are making this service available based on the new health reform rules.

Reform Opens New Doors for TPAs

Based on the new reform requirements, more and more TPAs are handling the Summary of Benefits and Coverage preparation. Under reform, the plan sponsor must provide participants with an SBC. You can choose to have the TPA provide SBC preparation services for a modest fee. We have seen fees anywhere from $300 to $1,000 per plan with a 90-day notice of plan changes before the applicable plan year. In keeping with reform, TPAs can also handle your external reviews and choose the independent review organizations. Your chosen TPA should have already contracted with four URAC-accredited IROs.

It Needs to Be in the Plan Document

Remember that the plan document is basically your instructions on how TPAs should process your claims. You are telling them what to pay and how much should be paid. When I'm speaking at conferences across the country directly to employers, I like to show a slide that I call my wife's "shopping plan document." Basically I state that when my wife goes shopping with my credit card, she is acting like the TPA and I am the plan! The shopping plan document tells my wife where she can shop (covered expenses) and what's excluded. For example, Nordstrom's is excluded from coverage but Wal-Mart is covered at 100 percent with no copay or deductible! When I explain it this way, people realize that the plan document is basically a list of instructions to the TPA. Unless the TPA is taking on a fiduciary role, the TPA should just be doing exactly what you have told it to do within the terms of the plan document. This is why it is so vital that you as the plan fiduciary decide plan terms.

Cost Control Strategies and Self-audits Are Essential During 2013 Reform Implementation

Employers can't be instantly ready for how health reform will transform their health plans in 2014; they have to do all the heavy lifting in 2013 in order to achieve preparedness.

Attorneys from the Epstein Becker & Green law firm on Dec. 19 discussed health-reform compliance duties for employers in 2013, including what are reform's most pressing requirements, how certain benefit design changes could complicate collective bargaining agreements, and how compliance self-audits might help ensure reform implementation. They also explained how employers can mitigate reform's costs and burdens by implementing wellness programs, using value-based purchasing, increasing employee engagement and engaging with other employers to create health purchasing consortia to increase market heft.

The attorneys first discussed health reform's salient compliance duties for employers in 2013.

- **Counting full-time equivalents.** There's a new method of counting full-time equivalents under health reform (based on a 30-hour definition of FTE) that you have to follow. Employers have to calculate FTEs for one or more of the following reasons: (1) to see whether they meet the large-employer definition, which is 50 or more FTEs, which triggers the shared responsibility requirements; and (2) to calculate their liability if they fail the no-coverage, unaffordable-coverage or inadequate-coverage tests. Most plans existing today do not use a 30-hour definition of full-time, and they don't provide any coverage at all for part-time employees, so plans will have to be changed to comply, said attorney Frank Solander, in EBG's Washington office. Reform also has elaborate rules to smooth out the variations of seasonal workers, and other rules for new hires.
- **Providing notice of state insurance exchanges.** By March 1, 2013, plans must provide notice to employees and new hires of the upcoming existence of state insurance exchanges. Employers are waiting, because the feds have issued no guidance on the content of this notice, and state exchanges are not operational in any state yet.
- **Increasing FICA and Medicare tax withholding**. For tax years beginning after Dec. 31, 2012, the FICA tax will increase by 3.8 percentage points and the Medicare tax rate will increase by 0.9 percentage points for wage earners over $200,000 ($250,000 for married couples filing jointly).
- **Health flexible spending account annual limit.** Employers will have to adjust the maximum dollar limit for health FSAs to $2,500 annually.
- **Patient-centered outcomes research.** For plan years ending on and after Oct. 1, 2012, self-insured health plans and insurers must pay $1 per covered life, increasing to $2 per covered life. The first possible payments are due in July 2013.
- **Generating and distributing disclosures,** Summaries of Benefits and Coverage and revisions to summary plan descriptions that reflect the changes that must be implemented under reform in 2013.

Coordinating Plan Changes with CBAs

Employers that have FTEs under a union contract will have a trickier task, because health reform's new definition of FTE probably doesn't fit in the framework used in CBAs, Frank C. Morris, Jr., an attorney in EBG's Washington office, said. He said coordinating health plan changes with CBAs will be important for some employers.

Some plans are going to lose the ability to tailor benefits for the goal of recruitment, retention and union demands. Others will need to scale back extras in order to comply with new areas of coverage required by reform, or to keep health costs under control. But they'll have to do so in a way that does not alienate employees or galvanize unions.

In such instances, employers may reopen CBAs (rather than making unilateral changes), meet with union reps and discuss targeted changes to the CBA that are limited to just provisions required to comply with health reform, without disturbing the other areas (wages and hours, etc.) worked out with the union.

Morris said one option is a short-term CBA, in effect during 2013 only, during which employers resolve the issues, and come into compliance with health reform rules in 2014.

Be Careful of Unions When Eliminating Excess Coverage

Employers that are mulling over whether to drop health coverage (or if they have to change or modify coverage to decrease plan costs) might want to let the union know whether they can achieve concessions in the CBA if all sides agree that it is necessary to maintain the health plan.

However, employers need to be careful about moves to either drop or scale back coverage, Morris continued.

See *Self Audits*, p. 10

Self Audits (continued from p. 9)

Unions could galvanize around this issue to increase organizing. If employers lessen the benefits in their plans, or drop health coverage altogether, unions may become emboldened to recruit members.

He said he expects this will be the case with lower-paid workers, presenting unions with an opportunity to go after part-time employees who don't have coverage: "If you drop coverage, higher paid employees who would not typically perhaps be as fertile ground for organizing efforts can again become more fertile ground because of the fact that they are very unhappy over the loss of employer provided coverage, as a result of the decision that may be best cost decision but not the overall most sensible decision for the employer."

Morris also mentioned (outside the union context as well) other risks of dropping coverage: (1) the loss of employees to competitors; (2) a decrease in the work productivity from workers who no longer have quality health care; and (3) the loss of tax-preferred status of benefits.

What Employers Can Do

If employers choose to maintain benefits, costs are likely to increase, because: (1) more members will probably enroll; and (2) the insurance mandates inflate the cost of coverage. To keep plans sustainable in the long term, employers will have to move to keep health cost growth under control, Solander said. Here are some of his suggestions:

- **Wellness programs.** The reform law allows employers to offer incentives of up to 30 percent of health premiums for progress on health indicators. Plans should identify, then target their cost drivers, and implement wellness programs to reduce the health risks to the extent possible. An example is obesity.
- **Value-based purchasing.** Today, the health system pays based on services provided, and that approach is unsustainable, Solander said. Plans that can find a way to pay providers for better, quicker outcomes and for engaging patients and getting their health under control will have a better chance of reining in their health costs over time.
- **Employers might consider teaming up** with other employers in purchasing consortia, to increase market heft and achieve economies of scale when setting up wellness, disease management and value-based approaches.

Perform a Reform Compliance Self-audit

U.S. Department of Labor audits of employer health plans are already being modified to check on the implementation of plan elements required by reform, such as dependent coverage to age 26, an elimination of coverage rescissions and ending pre-existing condition exclusions for children, New York City-based EBG attorney Gretchen Harders noted.

A very smart way to prevent the DOL audit from ending in tears is to perform a self-audit of all health plans sponsored by the employer. (Faults in one plan can trigger penalties calculated based on your entire workforce, Harders said.) Even though penalties do not start until 2014, Harders said employers should:

- Review and ensure compliance with 2012 mandates already implemented — including claims and appeals procedures; how the employer stands in relation to the preventive care mandate; and the raft of new notification documents.
- Determine whether they are subject to 2014 pay-or-play penalties; are a large or small employer; how many full-time employees they have; ensure that they have minimum actuarial value of group health plans; and calculate or project potential penalties.
- Ensure compliance with reform's affordable-coverage and adequate-coverage goals, and if not, then calculate exposure to penalties.

New IRS Rule Consolidates and Clarifies Guidance On Employer Play-or-pay Mandate

Employers trying to comply with health reform's play-or-pay mandate — and calculate their exposure to penalties — now have more insight based upon a new notice of proposed rulemaking and a new set of questions and answers from the IRS.

Under reform, employers have to calculate full-time equivalent employees for one or more of the following reasons: (1) to see whether they meet the large-employer definition (50 or more FTEs), which subjects them to reform's "shared responsibility" (play-or-pay) requirements; and (2) to calculate their liability if they fail no-coverage, unaffordable-coverage or inadequate-coverage tests.

Employers must pay penalties under health reform if they fail to offer coverage to 95 percent of workers; or offer coverage that (1) is unaffordable; or (2) fails to meet minimum value standards, the proposed rule states.

The proposed rule is built on, and invokes Notices 2011-36, 2011-73, 2012-17, 2012-58, and 2012-59. These notices describe how employers will: (1) determine whether a worker is full-time or does not have enough hours to be entitled to coverage; (2) count new hires when it is not clear whether they will work full-time or part-time; and (3) set a stable period during which the worker is assumed to be full-time and require health coverage (or part-time and *not* need coverage). All the guidance describes how employers can determine whether they offer unaffordable or insufficient coverage, and thus are subject to penalties.

The IRS Q&A answers several practical questions that are central to employers trying to maximize compliance and minimize exposure to penalties, by tailoring the scope of plan coverage and complying with the law.

The relevant employer shared-responsibility provisions are in Section 4980H of the Internal Revenue Code.

Counting Full-timers

The IRS' definition of FTE appears designed to prevent companies from avoiding their responsibility through restructuring workforces into part-timers.

> Employers are subject to the coverage mandate when they employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50. (For example, the IRS says, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees).

The agency also heads off attempts by owners to split companies in subdivisions that would enable several subsidiaries with fewer than 50 FTEs to skirt the coverage requirement.

> Consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 [FTEs]. If the combined total meets the threshold, then each separate company [is subject to health reform's coverage requirements].

Employers are not allowed to exclude paid leave from calculations to arrive at the average number of hours worked per week. For employees paid on an hourly basis, employer calculations of hours of service must include vacation, holiday, illness, incapacity and jury duty, the proposed rule states.

Representatives from business requested special methods (rather than a mere hour count) to calculate full-time status for workers in their fields, including adjunct professors and airline pilots. The government said it would consider adding safe harbors for jobs in such fields, the proposed rule states.

The rule also addresses a wide range of other issues, including:

- whether a large foreign corporation with a small U.S. presence (under 50 employees) would be subject to section 4980H;
- how to apply the seasonal worker exception for purposes of determining whether an employer is an applicable large employer;
- special issues related to reform's look-back measurement method presented by educational institutions, under which work schedules are based on an academic year;
- the rules' applicability to various categories of employees, including new, ongoing and commission-based employees; and
- a clarification that minimum essential coverage must be offered to employees' dependents.

Safe Harbors

The rule also establishes several safe harbors in determining affordability of coverage. For example, a

See *IRS Guidance*, p. 13

Feds Propose Varying FTE Definition by Industry In Reform's Play-or-Pay Rules

Federal agencies will accept alternate definitions of full-time employee for purposes of health reform's play-or-pay mandate, to allow for industry-specific labor norms and seasonal workers.

Some business owners and workers requested special methods of calculating hours for employees: (1) whose compensation is not based on hours, such as salespeople on commission; and (2) whose work hours are subject to safety-related limits, such as airline pilots.

Other changes were requested by employees who did not want their "off the clock" work not counted for health coverage. And still others were driven by the government anticipating schemes by employers to split worker hours to avoid their coverage responsibilities.

This all appears in proposed rules on health reform's "shared responsibility" requirements for employers (see http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf). Employers become subject to the requirements in January 2014, so the rules are expected to be finalized before then. The public has until March 18 to submit comments on the proposal, and IRS will hold an April 23 public hearing at IRS headquarters in Washington, D.C.

> **Note:** Full time employees are counted on an aggregated basis, to determine whether a company is a large employer, triggering reform's coverage responsibilities; and on a worker-by-worker basis to see whether an individual: (1) gets coverage; or (2) triggers penalties by getting a subsidy and getting coverage on a state exchange.

FTE Variations Must Be Reasonable

The feds suggested that some leeway when counting FTEs would be allowed, but that modifications had to be reasonable. For instance, not counting travel time for a traveling salesperson, or counting an adjunct professor's classroom teaching time only, while leaving out class preparation time, would be unreasonable, IRS said.

Seasonal Employees

The rule requires employers to use a "reasonable, good faith" interpretation of the term seasonal employee when counting FTEs under health reform.

> **Example:** It would be unreasonable and not in good faith to decide that an employee at a school who works during the active portions of the academic year is a seasonal employee, the rule proposes.

The agency is contemplating adding a six-month limit to the definition of seasonal employee, which would bring the safe harbor in line with rules of that kind for self-insured health plans.

Educational Institutions

Commenters said employees at institutions with nine-month academic years could lose full-time status, if health reform's 12-month look-back measurement period is used.

In response, the rule proposes excluding school employees' three-month summer break from the calculations, and treating spring and winter breaks as paid leave. Therefore, the average hours worked while school is in session must be taken to be the average for all 12 months of the year. As a result, employees who work full-time during the active portions of the academic year would be counted as full-time employees.

> **Note:** The rule states that employers may not exclude paid leave to lessen the number of hours worked. Employer calculations must include holidays, sick days, vacation days, incapacity and jury days.

Temporary Staffing Agencies

The government still has to work out how new employees of temporary staffing agencies are to be counted. Many such workers are expected not to be FTEs, because the agency might not provide them with continuous employment at 30 or more hours per week, and there is much potential for significant gaps between assignments.

Therefore, the IRS expects many temp employees to be counted as variable hour workers, and not as FTEs. But it still wants employers to count temp workers on long-term, full-time assignments, as FTEs.

The IRS said it would add "anti-abuse" provisions to the final rule, to prevent employers from using staffing agencies to avoid their play-or-pay duties. There is potential for a temp agency client to split workers between itself and a temp agency, thereby making appear that neither the client nor the temp agency employs them full-time, the IRS noted.

Further, staffing agencies said it is often unclear when workers terminate employment with them, so agencies have a hard time determining separation dates. The agency asked for comments on sorting that out.

CE Column (continued from p. 2)

The reason we see this shift of responsibility is the growth of the self-insured marketplace. In contrast to the old school mentality of self-insurance, where plans knew that they were responsible for everything from plan design to claim appeals, the new self-funded plan wants everything done for it. Many plans that were fully insured for years and have now switched to self-funding did so because of the cost savings. Many of them didn't realize they had to create a plan document or decide what type of exclusions they wanted. So, when they became self-funded, many weren't aware of their fiduciary responsibilities.

Widespread Ignorance of Fiduciary's Importance

To be quite honest, many times lack of awareness about fiduciary duties occurred because health insurance brokers didn't know either. So plans turned to their TPA and asked it to handle some, if not all, of these decisions for them. TPAs have been charging extra for the added responsibility and have outlined the same in their ASAs. The fact remains that while most plan contracts do state that the plan makes all decisions, for the most part TPAs truly do make the claim decisions. I have personally seen on many occasions, when instead of bothering the plan, the TPA will just make a decision when necessary.

Therefore, the decision on how much of a fiduciary role the TPA has will be vital in determining who has the final say on plan terms. However, even the best written plan documents will encounter situations where it is just too difficult for the TPA to know what the plan's intentions would be in a rare and unique circumstance. These do happen on occasion and you as the plan need to be informed when this does occur. Make sure you advise the TPA that you want to be involved in these decisions. Thus, you want the ASA to specifically state that the TPA will refer any doubtful or disputed claims to the plan sponsor for a final decision.

Unless you delegate all or some of the fiduciary responsibility to the TPA, the ASA will include a provision stating that: (1) unless otherwise agreed upon, you acknowledge that you, the plan sponsor, serve as the plan administrator and fiduciary, and shall have discretionary authority and control over plan management, and all discretionary authority and responsibility for plan administration; (2) the plan sponsor will resolve all plan ambiguities and disputes relating to the plan eligibility of a participant, plan coverage, denial of claims or any plan interpretation questions; and (3) the TPA will administer and adjudicate claims in accordance with the plan document but will have no discretionary authority to interpret the plan.

Note: For more information on the scope of TPA duties and how the ERISA plan document must spell it out explicitly, **see the story on page 7**.

PPO Rules Can Straightjacket Plans

We have all heard about the good, the bad and the ugly when it comes to preferred provider organizations and their potential alternatives in the marketplace, whether it be PPO replacements, smaller physician-only networks or specialized carve-outs. There's also the option of Medicare-plus pricing, on which we could write a book when we have more time.

The rarely discussed mystery question is whether your ASA even allows you to do these things. On too many occasions an employee plan and its broker have great ideas on how to save the plan money, only to only find that they cannot do so based on its ASA. A plan may spend thousands of dollars having attorneys set up these new programs and negotiate deals with specified providers, only to realize that none of it is allowed. So before spending your hard-earned time and money, make sure that you have the right to do so in the first place.

See *CE Column*, p. 14

IRS Guidance (continued from p. 11)

W-2 safe harbor would allow employers to assess unaffordability for each employee with reference to the employee's W-2 wages only. The employer would not need to collect data on household income.

If an employee's share of the premium for (the lowest-cost) employer-provided coverage (that also meets the minimum value requirement) would be more than 9.5 percent of the employee's household income, the coverage is not considered affordable for that employee. Employers can avoid a payment if the cost of the coverage to the employee would not exceed 9.5 percent of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2.

The rules also provide for transition relief for certain types of plans: (1) large employer-sponsored plans based upon a calendar (fiscal) year; and (2) cafeteria plans with plan years beginning in 2013.

Comments on the proposed rule will remain open until March 18, and a public hearing will be held on the proposal on April 23. Employers can rely on the proposed regulations for guidance pending the issuance of final regulations or other guidance. Final regulations will be effective as of a date not earlier than the date they are published in the *Federal Register*.

CE Column (continued from p. 13)

So think about the liabilities and responsibilities involved in the self-funding space as it relates to PPO issues. For example:

> **Example:** A self-funded plan does not pay its claims within 30 days as required under a PPO agreement, not because it deems the claims to be overcharged but simply because it is a bit short on cash this month and could not fund the claims. The provider repeatedly calls the TPA demanding payment and eventually sues the plan and TPA when payment is not received six months later.

In this example, the plan loses its discount, and is liable for full charges and interest on the bills. The question is whether the TPA can be held responsible for payment of the claims. Court cases have gone both ways on this. This can only be resolved by looking at two potential contracts: the PPO agreement and the ASA.

The decision as to how much of a fiduciary role the TPA has will be vital in determining who has the final say on plan terms.

Spell Out Stop-loss Coverage Issues in ASA

One of the biggest areas for litigation between a TPA and a plan sponsor involves excess-loss insurance or as we like to call it "stop-loss coverage." It is vital that the responsibilities involving stop-loss maintenance and coverage issues be spelled out in the ASA. Many times the ASA will state that the plan must maintain excess loss insurance with a company approved by the TPA and promptly notify the TPA of any termination, expiration, lapse or modification of this insurance. Be sure that the responsibilities and duties are clearly defined as they relate to stop-loss.

Include Incentives for Cost Containment

As health reform rules take hold and more creative cost containment approaches are entering the industry, more and more TPAs and ASOs are revising their ASAs. If your ASA hasn't been revised in the past two years, chances are that it is already outdated. About a year ago, we here at The Phia Group asked our clients to email us their current ASAs so that we can compare and contrast the results and see what is being offered across the country. What we saw was a growing trend to change the way TPAs are paid for services. Instead of just being paid for processing claims, TPAs are now focusing on partnering with plans and being rewarded for cost containment.

What to Do About Overpayments?

One of the deep, dark secrets of the self-insured world involves overpayments. Typically, these are claims paid in good faith but in error by TPA. As you can imagine, TPAs are not going out of their way to talk about their mistakes. These ASAs usually state that the TPA will make a good faith attempt to recover any overpayments and that if it fails to do so, the TPA may refer the recovery to a collection agency or other organization at the plan's expense. Yes, you have read that correctly. You will be paying for the recovery by the overpayment recovery firm. Although you may think that this is not right, you are probably much better off receiving 75 percent of your money than none of it. At least by referring the issue to a vendor once the TPA tries to recover the funds at no cost to you, the vendor will have an incentive to recoup the funds since it is the only way for it to make money. The TPA does not make money attempting to recover overpayments; in fact it loses money, and based on my experience most TPAs do not do a very good job in recouping these funds. Overpayments are a fact of life so as long as they are not excessive. Be reasonable in how they are recouped.

It pays to remember you will be responsible for any erroneous disbursement of benefits by the TPA in the event of error or neglect on the plan sponsor's part of providing eligibility and coverage information.

Note: For a story on ASA issues impacting your claims process and claims data, **see the story on page 7**.

Claims Run-out Periods

All good things can come to an end. And when it comes to termination of the plan-TPA relationship, you need to spell out what happens with the remaining claims, otherwise called the claims run out. Often, there are issues relating to the roles of the parties when the relationship is coming to a halt. There may be bad blood between the parties as the relationship ends, so it's vital to set forth the duties of each party. It must be agreed by the parties how long the TPA shall pay the claims run out following the ASA's termination date. The TPA must agree to forward any claims received after the run out period to the plan sponsor or other entity designated by the plan.

The bottom line is that although the ASA may seem like a routine part of the self-insurance process, the reality is that it is a complicated piece of work that truly needs to be digested and understood. Hopefully, the last time you have to look at it is when you sign it!

Final HITECH Rules Tighten Breach Notification

Sept. 23 is the compliance deadline for most of the latest HIPAA privacy and security rule changes.

A whole litany of tighter privacy and security requirements were finalized Jan. 17 by the U.S. Department of Health and Human Services, and most of these will have to be met by this Sept. 23.

Also of note are HHS' changes to the HITECH breach notification rules that have been in effect since 2009. As many suspected, the agency tightened the controversial "risk of harm" standard for determining what is a "breach" requiring notice to affected individuals.

The final rules do stop short of "requiring notification for all impermissible uses and disclosures without any assessment of risk," as some privacy advocates had urged. But such a disclosure will be presumed to be a breach unless the health plan or other entity can demonstrate "a low probability that the protected health information has been compromised."

The omnibus rules were published in the Jan. 25 *Federal Register*, with an effective date of March 26. The compliance deadline for most of the rules is Sept. 23, 2013, except that covered entities have until Sept. 23, 2014, to reopen and amend contracts with business associates.

The new rules also include privacy rule changes mandated in the Genetic Information Nondiscrimination Act (originally proposed in 2009), and the HITECH enforcement rules issued as an interim rule in October 2009. The final rules strongly impact business associates. The HITECH Act extended HIPAA's security and enforcement provisions, and certain privacy requirements, directly to business associates for the first time

Privacy and security enforcement applies to subcontractors, sub-subcontractors "and so on, no matter how far 'down the chain' the information flows," HHS said.

If HITECH enforcement were imposed only on business associates that contract directly with the covered entity, privacy and security protections would "lapse once a subcontractor is enlisted" to perform any of the delegated services, "while at the same time potentially allowing certain primary business associates to avoid liability altogether," HHS said. Thus, subcontractors will be directly liable for HHS penalties just as business associates are, and many of HIPAA's requirements affecting the covered entity-business associate relationship will be imposed on business associates and their subcontractors. However, covered entities will not be required to have business associate contracts directly with subcontractors.

Subject Index, Vol. 20

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