Employer's Guide to
Self-Insuring Health Benefits

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Health Plan Cannot Arbitrate Then Try to Backpedal, Court Rules

Submitting to arbitration has benefits such as accelerated resolution, fewer costs than litigation and new opportunities to resolve disputes with providers. But it may result in unforeseen consequences for ERISA plans. In one illustrative case, a self-funded health plan in a benefits dispute failed in its effort to strike allegations it did not like from an arbitration proceeding in order to put the allegations before a federal court. The court, however, decided that the plan had been intimately involved in the arbitration and appeared to be endorsing the arbitrator's authority, up until the moment the process yielded an unwanted result for the plan. ***Page 5***

Employers Should Eye Standards Set by New Reform Rules

New reform standards for health plan value and coverage are important for employers, first because they will determine the kind of insured coverage that small employers buy, but also because grandfathered and self-funded employer health plans also need to know the rules to avoid penalties under health reform. Proposed rules, unveiled by the U.S. Department of Health and Human Services on Nov. 20, include standards on how states will define a core set of "essential health benefits" that exchange plans, small group plans and issuers of individual policies must cover. The proposed rules include an actuarial value calculator for health plans, which helps users measure the actuarial value of health plans and compliance with actuarial value standards required by health reform. ***Page 9***

DOL: Aetna's Recoupment Actions Against Provider Breached ERISA

Aetna's actions recovering overpayments from a durable medical equipment provider failed to comply with ERISA, DOL argues in a recent *amicus* brief, because: 1) retroactive changes in coverage as a means of recovering overpayments are ERISA denials; and (2) the providers in this case were entitled to ERISA explanations of benefits and ERISA appeal rights. DOL wrote the brief supporting plaintiff providers in *Tri3 Enterprises v. Aetna Inc.,* being heard by the 3rd U.S. Circuit Court of Appeals. Tri3 provided pneumatic compressors to Aetna-administered ERISA health care plans. Tri3 enjoyed a pattern of reimbursement from Aetna for a while, but the payer apparently saw a spike in utilization and questioned the necessity of the compressors. Its special investigations unit looked and said Tri3's claims were improper. Then Aetna started recovering what it now termed overpayments. ***Page 13***

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In *McCutchen*, Supreme Court Faces Complicated Decision on Scope of ERISA Plan Recovery Rights

A victory by the health plan participant in *US Airways v. McCutchen*, now before the U.S. Supreme Court, may erode ERISA plans' ability to enforce plan terms as written, a legal expert recently surmised.

The expert further noted that in *McCutchen*, the Court has a very difficult balancing act to answer whether: (1) an ERISA health plan administrator is entitled to full reimbursement of plan payments from a participant who received a damage settlement from a third party; or (2) that by arguing that a plan would be unjustly enriched, the participant will be able to override clear plan language and refuse to reimburse a plan for all benefits paid. The High Court heard oral arguments on Nov. 28.

According to Charles Seemann, an attorney in Proskauer Rose's ERISA litigation group in New Orleans, this case will be difficult for the Court to rule on for three reasons:

1) **More exceptions to recoveries could hurt plan participants as well as plans.** In this case, the US Airways plan is trying to recover, and the defendant is invoking an "equitable defense," namely unjust enrichment. But in most ERISA cases those roles are reversed, Seemann says. And when the shoe is on the other foot, and plan participants seek equitable relief under ERISA, plans may be able to use the same equitable defenses that shielded McCutchen in this case. Therefore, the justices may have to be careful: A ruling that recognizes too many defenses to recovery could be used to block participants seeking recoveries for plans in the future. "If they help the participant here they may find they're hurting the participant in future cases," Seemann says.
2) **The case pits the common-fund doctrine against clear plan language.** If attorneys who achieve a tort recovery can lose their fee to the plan, that could discourage victims of wrongdoing from seeking recoveries from the parties that caused damage, Seemann says. On the other hand, a patchwork of judges allowing various equitable defenses would have major implications for ERISA plans nationwide. "If you allow judges to deviate from plan rules to satisfy the concept of fairness, then what does that do to uniform, nationwide law governing administration of ERISA plans?" he asks.
3) **The justices focused on whether the plan established a reimbursement agreement or merely a right to subrogation.** Some justices seemed to say the plan document lacked a section on plan reimbursement, but instead based its recovery right on the plan document's "Subrogation" section. The two are different: Subrogation entails plan involvement in the lawsuit (and a division of proceeds with the plaintiff's attorney) while reimbursement does not.

Plan Sponsor's Position

During oral arguments before the High Court, Attorney Neal Katyal for US Airways contended that: (1) the plan had clearly stated its reimbursement rights (reimbursement of all costs the plan paid); (2) it had no agreement with McCutchen's attorney; and (3) McCutchen "double-promised" his money — first to the plan and then to his personal injury attorney.

Katyal said the key conditions for recovery set forth in *Sereboff v. Mid Atlantic Medical Services, Inc.*, 2006 WL 1310754 (U.S. 2006) were met: the action was not seeking personal liability; it specified a particular fund traceable to the settlement; and the parties had an equitable lien by agreement. That was enough.

See *Supreme Court*, p. 20

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Another Big Year for Self-insured Plans Who Knows What Will Happen

By Adam Russo, Esq.

My office and I have had to deal with the many complexities of the health reform law for a few years now, but I don't think the rest of the industry understands the enormity of what is coming down the pike. What we will see in 2013 and beyond is night and day when compared to the current environment. The days of sitting on the couch and griping are over; the time to act is here. As with your new year's resolution, it's time to get on the treadmill and move on reform implementation!

Upcoming Reform Challenges

For the past few months, regulators such as the U.S. Department of Health and Human Services, the Labor Department and the IRS were laying low, waiting to see what was going to happen. Between the Supreme Court decision and elections, they weren't going to waste their time and resources creating rules to flesh out a law that could be revoked. But now the dust has settled and we know what the law will be for at least the next two years.

Therefore, be prepared for a tidal wave of regulations and guidance from all the agencies. My office has been prepared for a while to receive a barrage of calls. We enjoyed the calm before the storm, but the clouds are rolling in and I'm trying to be the first forecaster to get it right!

There are many challenges for the self-funding industry as we enter 2013, from the National Association of Insurance Commissioners with its stop-loss model law; counting full-time employees for health reform purposes; new fees and disclosures; and the proliferation of state-based insurance exchanges.

Insurance Exchanges

One of the biggest issues for 2013 is the health insurance exchanges. It was reported Dec. 17 that 18 states and the District of Columbia will set up exchanges. In the week before, governors for Pennsylvania, Tennessee and New Jersey announced they would not run their own exchanges. Newspaper articles are predicting that most states will opt not to run exchanges, allowing the federal government to do so instead.

HHS will determine by Jan. 1, 2013, whether a state will have an exchange operational by Jan. 1, 2014.

States also may elect after 2014 to begin or cease operation of an exchange and cede responsibility to the federal government. The federal government is in the midst of approving state exchanges that meet HHS standards, and it was reported on Dec. 14 that HHS had approved the exchanges of eight states (Kentucky, New York, Colorado, Connecticut, Massachusetts, Maryland, Oregon and Washington) and the District of Columbia.

Each state must have an insurance exchange by Jan. 1, 2014. The exchanges will be used to help individuals and employers purchase qualified health plans. As you may know, states have the option of having separate exchanges for individual coverage and employer sponsored group coverage. Plans offered in an exchange will receive ratings from HHS based on their quality and price. The exchanges will receive federal start-up funds, but must be self-sufficient no later than Jan. 1, 2015.

Reinsurance-fund Payments

Looking ahead to the years 2014, 2015 and 2016, states must establish a temporary reinsurance program. They are meant to help stabilize premiums for coverage in the individual and small group markets in a state during the first three years of operation of the exchanges. The reinsurance program will make payments to issuers that cover high-risk beneficiaries in the individual market.

Contribution amounts will be based on number of enrollees in self-insured health plans. Fees will be collected through a national collection based on a

See *CE Column*, p. 4

CE Column (continued from p. 3)

determined percent of premiums for fully insured plans and on a plan participant basis for self-insured plans.

When a self-insured plan uses "administrative services only" to run its plan, the insurer is responsible for making the payment. Self-insured plans that process their own claims are responsible for making the payments. Payments by insured plans will be made to the state or to HHS if their state doesn't run the program. Payments by self-insured plans will be made directly to HHS.

New Disclosures to Members

As of March 1, 2013, employers will be required to disclose many items to each of their employees at the time of their hiring. They must inform the employee that (1) state insurance exchanges exist; (2) describe the services exchanges provide; (3) explain how employees can ask exchanges for help; and (4) note that if the employer's share of the total allowed costs of benefits provided is less than 60 percent of such costs, the employee may be eligible for a premium tax credit and a cost sharing reduction if he or she buys a qualified health plan through the exchange.

Measuring FTEs

The toughest issue that we are beginning to tackle relates to the definition of full-time employees. Employers with more than 50 full-time employees that do not offer affordable health coverage to their full-time employees may be required to make shared repsonsibility payments. The shared provisions for those payments are at 26 U.S.C. 4980. In order for an employer to determine its liability under this statute, the employer must be able to calculate how many "full-time" employees it has.

Recent IRS guidance can help employers determine their number of full-time employees. Of particular importance is IRS Notice 2012-58, which provides the most recent guidance for employers to use in defining full-time employees under the law. Employers are not required to follow the procedures outlined in the notice for determining full-time employee status at this time. However, because the forthcoming regulations are likely to reflect the methods and guidance provided in the notice, employers would be well advised to proactively implement the suggested measures. Employers that follow the guidance are granted a safe harbor.

A safe harbor would allow employers to use a defined period of three to 12 months (called the look-back measurement period) to determine whether an employee was full-time, (working an average of 30 hours per week). If an employee was determined to be full-time during the look-back measurement period, then an employer must treat him or her as a full-time employee for a subsequent stability period. This is regardless of whether the employee averaged 30 hours of service per week or at least 130 hours of service per calendar month during the stability period. The stability period must be at least six consecutive months in length, but not shorter than the look-back measurement period.

If an employee was determined not to be full-time during the look-back measurement period, then an employer does not have to treat the employee as a full-time employee during the stability period, provided the stability period used by the employer was not longer than the look-back measurement period.

It is important to note that employers may use measurement and stability periods that differ either in length or starting and ending dates depending on the category of employee. For purposes of determining whether a newly hired employee is full-time, there are many factors to consider, for example:

> If a new employee is reasonably expected to work full-time on an annual basis and works full-time during the first three months of employment, the employee must be offered coverage under the employer's group health plan as of the end of the initial three-month period.

If it cannot reasonably be determined that a newly hired employee is expected to work full-time, then if the employee works full-time during the first three months of employment and it is representative of the average hours the employee is expected to work on an annual basis, the employee will first be considered a full-time employee as of the end of the initial three-month period.

May I Be Taxed More, Sir?

If you do not feel like you have been taxed enough already, soon self-insured plans will be assessed a fee to contribute to the Patient-Centered Research Outcomes Trust Fund that will be responsible for comparative effectiveness research. Fees on self-insured and fully insured accident and health insurers providing coverage in the large group market will be $1 per covered life for any plan year ending in 2013 and $2 per covered life for the plan year ending in 2014.

Conclusion

So in the upcoming year we face a series of challenges from DOL, HHS, the insurance companies, the exchanges and state insurance regulators, all operating under the assumption that what's good for self-funding is bad for health reform implementation.

But in spite of these new obligations, the fact remains that firms with lower than average cost workers will be more likely to save money by self-funding in 2014. If a

See *CE Column*, p. 23

Health Plan Cannot Arbitrate, Then Try to Backpedal Based on Unwanted Result, Court Rules

Submitting to arbitration may have its benefits (such as accelerated resolution, less costs than litigation and a new potential opportunity to resolve disputes with providers), but it may result in unforeseen consequences for ERISA plans. The following case illustrates this dilemma.

A self-funded health plan in a benefits dispute failed in its effort to strike allegations it did not like from an arbitration proceeding in order to put the allegations before a federal court. The court, however, decided that the plan had been intimately involved in the arbitration and appeared to be endorsing the arbitrator's authority, up until the moment the process yielded an unwanted result for the plan.

Further, while courts often take precedence over the arbitrators themselves when deciding the scope of arbitrators' authority, if a contract vests that authority with the arbitrator, then the presumption of court jurisdiction is removed, the U.S. District Court for the Southern District of California decided in *Jeld-Wen v. Tri-City*, 2012 WL 5944215 (S.D. Calif., Nov. 27, 2012).

Pre-existing Condition Exclusion

In November 2008, Patient S, a Jeld-Wen employee, indicated on a plan questionnaire that he had a pre-existing heart condition. A plan provision held coverage would be excluded 12 months for any pre-existing condition treated six months before the member's first day of enrollment.

Patient S had not opted into coverage until Jan. 1, 2009, and therefore under plan rules he could be excluded from coverage for heart-related treatment during the entire 2009 calendar year.

The Jeld-Wen health plan was under a participating hospital agreement with Tri-City. In July 2009, Patient S went to the emergency department at Tri–City, was admitted to Tri–City and underwent a heart-related procedure. His medical bill was about $159,000.

Denial in Spite of Preauthorization

Between the time he was admitted and underwent the procedure, Tri-City called Shasta Administrative Services (the plan's third-party administrator) to verify coverage. The TPA indicated the patient did not require precertification because he arrived through the ER, and indicated that the plan would pay 80 percent of billed charges after the patient paid a $500 copay. Tri-City contacted Innovative Care, Jen-Weld's utilization review company, to obtain further authorization. Innovative Care authorized the hospital stay.

On Sept. 18, 2009, however, Shasta informed Tri-City for the first time that the claim was pending for a pre-existing condition. Soon the TPA denied the claim, citing the pre-existing conditions exclusion.

Based on the authorization and verification of coverage, on Dec. 29, 2010, in accord with the provider agreement, Tri-City filed a demand for arbitration seeking reimbursement at rates found in the provider agreement. It served the demand with the American Arbitration Association, asking for a ruling to redress its allegations that:

> The claim [was improperly] denied and inappropriately unpaid [because the] services were authorized and patient's benefits were verified and no pre-existing condition exclusions were communicated.

The health plan argued that the patient was suffering from a pre-existing condition within the exclusionary period and Tri-City's claims were preempted by ERISA. After hearing oral argument, however, the arbitrator denied Jeld-Wen's summary judgment motion.

At the arbitrator's request, Tri-City filed a "detailed specification," embellishing on the claims being arbitrated, including breach of contract, negligence, negligent misrepresentation, estoppel, violations of California Code and *quantum meruit*. The plan in turn argued that these were "additional claims" that the arbitrator should be barred from considering.

Plan: Table Arbitration Until Court Decides

The plan asked the arbitrator to table the proceedings, arguing that: (1) the claims did not arise from the provider agreement and were not subject to the arbitration clause; (2) only a court of law could determine the scope of conduct that should be covered by arbitration; and (3) the new information about the preauthorization and TPA's statements could not be entered into arbitration. The provider countered that the arbitrator had the authority to determine what it should cover, that the entire dispute fell within the arbitration clause and it was not preempted by ERISA.

The arbitrator issued an order saying it has power to rule on its jurisdiction, including objections to the scope of the arbitration agreement. Then it denied Jeld-Wen's request for a stay, saying at issue was the plan's perfor-

See *Arbitration*, p. 6

Arbitration (continued from p. 5)

mance of the "authorization" and "verification" functions under the agreement and were not preempted by ERISA.

Jeld-Wen then sued in federal court seeking declaratory relief (that a court of law and not the arbitrator determines the scope of conduct covered in an arbitration hearing) and an order staying arbitration proceedings until its demand for relief was resolved. The court denied the application for a stay. Tri-City filed a motion to dismiss the plan's motion, which the court converted to a motion for summary judgment.

The Court Weighs In

The court said the plan lost its ability to challenge the dispute's arbitratability by participating in the arbitration, citing a 1964 case saying:

> A claimant may not voluntarily submit his claim to arbitration, await the outcome, and, if the decision is unfavorable, then challenge the authority of the arbitrators to act.

It said the Jeld-Wen plan began arguments about the scope of the issues only after arbitration resulted in an outcome it did not like. Further, Jeld-Wen waived its right by being intimately involved in the proceedings up to that point. A right to challenge the arbitration's scope is valid only if the litigant has minimal involvement in the allegations, and the involvement is procedural only and involves the merits of the claims. The case history, however, showed the Jeld-Wen plan was far more involved than that; and therefore, it was barred from challenging the arbitrator's authority.

The court then held that the plan was wrong to argue that the additional causes of action listed in the "detailed specification" amounted to an amended demand. The new material laid out the legal causes of action based on the facts alleged in the original arbitration demand, the court said.

It also noted that courts, not arbitrators, determine the scope of arbitration, unless the parties clearly and unmistakably provide otherwise. The court saw that the arbitration agreement vested authority with the arbitrator.

Since that clause existed, the presumption of court jurisdiction over arbitration's scope was removed, the court held.

Conclusion

The court gave the providers a victory on all counts, holding that: (1) the arbitrator, not the court, decides on the propriety of the claims for arbitration; (2) the arbitrator had the authority to declare that the claims in the "detailed specification" were not new claims; and (3) ERISA did not preempt, because ERISA claims are arbitrable and the court gave the arbitrator control over those claims.

Implications

This case illustrates the significance of the initial statements about Patient S. When he arrived to the ER, the TPA indicated that pre-certification was not required. Then the utilization review company indicated that associated hospital stay was authorized.

The provider argued that the claims denial was improper because benefits were verified and the plan vendors did not advised it of any pre-existing condition exclusions.

Arbitration

By agreeing and participating in the arbitration, with the hopes the issue will be resolved faster, plans must be aware of the consequences.

In this case, the arbitrator's decision was not on par with the plan's decision, thus creating an issue for the plan and the potential to question the arbitrator's jurisdiction. The court, however, deemed that the arbitrator had the proper authority. Further, in this case, the arbitrator's scope was valid and unable to be challenged since the plan participated in the arbitration.

Plan Limitations

It is interesting to consider whether (and how) this case may have been different if it was not a pre-existing limitation issue. For example, if the patient in this case had incurred the claims as a result of an illegal act, but at the time of the admission the plan was not aware of the circumstances of the illegal act, would the same allowances have been granted?

In the case of an illegal act situation, the provider may not have been so successful. For example, the claims would have been subject to the other limitations and exclusions within the plan document (that is, the illegal acts exclusion).

A plan and its administrator must ensure that they capture all relevant information surrounding pre-existing conditions and other potential plan limitations to avoid authorizing claims that should not be. Also, it is important to remember that many plans attempt to prevent issues such as these by providing that this is "not a guarantee of payment."

See *Arbitration*, p. 7

Solid Documentation/Procedures Shield Plan From Expensive ERISA Benefits Claim

A self-insured health plan's clear terms, as well as repeated communications with the plan participant pertaining to its denial of claims and its appeal options, protected the plan from an ERISA claim challenging the benefits denial. In the case, a plan participant sued the plan to recover $600,000 in medical expenses. However, she had refused to sign the plan's subrogation agreement as required by the terms of the plan. This requirement was clearly set out in the plan's summary plan description, which also set forth the consequences of refusing to sign the agreement.

As a result of the plan's due diligence and strict compliance with plan terms, the participant's refusal to sign the subrogation agreement backfired. A federal appeals court affirmed a lower court decision that the plan participant failed to exhaust administrative remedies under the terms of the plan, thereby leaving her holding the bag for a $600,000 hospital stay. The case is *Florida Health Sciences Center v. Total Plastics*, 2012 WL 5416539 (11th Cir., Nov. 6, 2012).

On appeal, the 11th U.S. Circuit Court of Appeals ruled that she *did* fail to exhaust the plan's remedies, and therefore it did not need to consider whether the denial was correct.

In doing so, the circuit court rejected the notion that an attorney's letter objecting to the signing of a subrogation agreement constituted an administrative appeal for exhaustion-of-remedies purposes. Further, it ruled that the participant failed to appeal the matter within the 180-day limit provided for by the plan and rejected her arguments that an appeal would have been futile.

The Facts

Kristy Schwade, an employee of Total Plastics, Inc., was covered by its self-funded ERISA health plan. Total Plastics was also the plan administrator. In May 2007, Schwade's 5-month old son became the victim of shaken baby syndrome, suffering profound brain damage. His daycare provider pleaded guilty to aggravated child abuse. The child was hospitalized for more than two months in Tampa General Hospital and required continuous medical attention until his death at the age of four.

Subrogation Right

Total Plastics' SPD included a provision entitling the plan to recover up to the full extent of benefits paid by the plan from third-party tortfeasors. It also required the plan participant to "execute documents (including a lien agreement) ... and do whatever else is necessary to protect the Plan's [subrogation] rights."

If a plan participant refused to sign the subrogation agreement, "the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of [the plan participant]," the SPD stated.

Administrative Appeals

The Total Plastics SPD set out the procedures to be followed before a participant may take legal action against the plan. First, the plan provides notice of the denial was as the rationale from which it rose, namely through an explanation of benefits. This notice also informs the plan participant of the steps one can take to correct the denial or challenge the determination. Participants have 180 days following receipt of an EOB form to file an appeal.

The plan paid the child's medical expenses for about two months. It then requested that Schwade sign the required agreement and complete a questionnaire about her son's injury. In doing so, it included a warning (in solid capital letters): "Failure or refusal" to execute the

See *Solid Procedures*, p. 8

Arbitration **(continued from p. 6)**

Note: Due to provisions in the health reform law, pre-existing condition exclusions may no longer be applied to enrollees who are under age 19. Plans with years starting on or after Jan. 1, 2014, may no longer impose pre-existing condition exclusions on any enrollees. For more information on health reform's bar on pre-existing condition exclusions, go to Section 350 of *The Health Reform Law: What Employers Need to Know* (See http://hr.complianceexpert.com/hcrl/chapter-3/350).

Lessons Learned From *Jeld-Wen v. Tri-City*

- **Act now.** By participating within the arbitration, the plan should not later try to challenge the authority of the arbitrator.
- **Accuracy of information.** Ensure that all relevant information about participants and potential exclusionary periods is up to date to avoid miscommunication. As noted below, this may be irrelevant as it relates to pre-existing conditions in 2014 under the health reform law.

Solid Procedures (continued from p. 7)

agreement would "relieve[ ] the plan of any and all ... obligation" to pay her benefits.

Participant Refuses to Sign Agreement

When she did not respond, the plan administrator stopped paying benefits and kept contacting her for updated information. It sent 54 EOBs between August and December 2007. Each form said "amount not payable," gave a reason for the nonpayment and included a form letter with ways for her to get more information about the denial, and an explanation of how to appeal the denial. Most of the EOBs said denials resulted because Schwade had failed to respond to information requests.

In June 2008, Schwade's attorney asked the plan about her claim, and was told that she had to sign the subrogation agreement before the plan could "determine benefits." The plan again warned about the consequences of her failing to sign a subrogation agreement, but nothing further happened.

In July 2008, Schwade's attorney notified the plan of Ms. Schwade's refusal to sign the agreement, complaining that the wording was "totally unacceptable."

Then, in November 2008, Schwade's attorney proposed that the plan split any net recovery after payment of costs and attorney's fees, and continued to question the validity of the subrogation requirement. The plan ignored this and similar letters.

In March 2010, Tampa Hospital sued Schwade for $600,000. She removed the case to federal court and filed a third-party complaint against Total Plastics for more than $1.4 million in plan benefits.

The District Court's Ruling

The federal court remanded the hospital's claim to the state court, but retained the action against Total Plastics. It then considered the employer's motion for summary judgment.

In *Schwade v. Total Plastics, Inc*., 2011 WL 5459649 (M.D. Fla., Nov. 10, 2011) the federal district court agreed with Total Plastics that Schwade's failure to execute the agreements allowed the plan to deny benefits, and that in any event, she failed to exhaust the plan's administrative remedies.

The Appeals Court Weighs In

Schwade argued that the district court's grant of summary judgment was wrong because she actually appealed though her attorney's letters disagreeing with the denial of benefits.

The 11th Circuit, however, rejected the notion that an attorney's letter objecting to the signing of a subrogation agreement constituted an administrative appeal. It also said the letters were sent far after the plan's 180-day window for appeals had closed. Schwade attempted to argue that the tolling period for that window was unclear, because of ambiguities in communications from the plan.

The court, however, said she had not provided any examples of such ambiguity. On the contrary, the appeals court decided that the letters from the plan constituted unambiguous notice, citing the all-caps warning, reasons for the denial and instructions for an appeal, on the EOB forms.

Schwade also argued that her failure to exhaust the plan's remedies had to be excused because: (1) the plan failed to follow its own claims procedures; and (2) an appeal would have been futile.

The court said a failure to follow claims procedures does not excuse a failure to exhaust remedies; it only authorizes a court to remand the case back to the administrator for an out-of-time appeal. But in the years leading up to the case, she never sought an administrative appeal. The court therefore rejected the first prong of her argument.

Responding to second prong of Schwade's argument (that is, that appeal attempts would have been futile), the court said because Schwade never tried to appeal, there was nothing to indicate that the plan would not give her a fair hearing. Accordingly, the appeals court upheld the lower court's decision.

Implications

This case is a great example of what can happen when a plan sets clear terms and is disciplined in its claims administration. By establishing clear terms and following through, the plan in this case secured its determination. The case makes clear that when plan documents have appropriate appeal procedures, those exact procedures must be exhausted before a suit can be brought against the plan. Alternative attempts that could be construed as appeal, such as the letter submitted to the administrator here, will not suffice.

It is important to note, however, that the appeals' court did not review whether the decision to deny was correct. Therefore, this appeals decision should not be construed to affirm the validity of subrogation agreements in and of themselves, rather simply that the attempts that were made to request reconsideration did not rise to the level of an appeal as set forth by the plan.

Employers Should Eye New Reform Standards On Essential Health Benefits and Actuarial Value

New reform standards for health plan value and coverage are important for employers, first because they will determine the kind of insured coverage that small employers buy. But grandfathered and self-funded employer health plans also need to know the rules to avoid penalties under health reform.

The proposed rules, which the U.S. Department of Health and Human Services announced on Nov. 20, include standards on how states will define a core set of "essential health benefits" that exchange plans, small group plans and issuers of individual policies must cover.

Read about the rule at http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html; see the rule itself at http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-0001.

The June 2010 health reform law requires that all policies sold on the individual market and to small groups (inside or outside the state exchanges): (1) cover the 10 categories of EHBs; (2) meet annual cost-sharing limits when covering EHBs; and (3) meet actuarial value limits for EHB coverage, starting with plan or policy years beginning Jan. 1, 2014.

The law does not require large or self-funded plans either to cover all 10 EHBs, or adhere to cost-sharing rules when covering EHBs. However, EHBs are important for large, self-funded employers because they bear on other reform mandates, such as lifetime limits. For example, if a self-funded plan does cover all 10 EHBs, it may not impose limits on them.

Plan Actuarial Value

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

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

The proposed rule includes an AV calculator for health plans. The proposed tool allows users to measure the actuarial value of health plans and compliance with actuarial value standards required by health reform. Go to http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-methodology.pdf for a Nov. 20 memo describing the steps insurers and plans will use to calculate AV.

The proposed rules allow for variations in AV of plus or minus 2 percent to be called *de minimis*.

They also suggest ways of calculating the AV of EHBs that are not generally represented in current policies; namely, pediatric oral and vision, and habilitative services. The lack of these two categories also makes it difficult to select state benchmark plans as models for qualified health plans on exchanges.

State Benchmark Plans

The rules propose an accreditation process for states to follow when certifying "qualified health plans." New previously unaccredited insurers will be able to sell policies on an exchange starting Jan.1, 2014, if they are scheduled to get reviewed by a recognized accrediting agency. For their second year, insurers will have to have their plans accredited as a precondition to selling on an exchange.

The rule proposes that states select a benchmark plan from among several options, and all plans that cover EHBs must offer benefits substantially equal to those offered by the benchmark plan.

A "base-benchmark" plan may be: (1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefits plans by enrollment; or (4) the largest insured commercial non-Medicaid HMO in the state.

If a benchmark plan is missing any of the 10 statutory categories of benefits, the proposed rules would have the state or HHS supplement the benchmark plan in that category. The proposed rules also include a number of standards to protect consumers against discrimination and ensure that benchmark plans offer a full array of EHB benefits and services.

If a state does not make a selection, the largest small-group product offered in the state, by enrollment, would be the benchmark. If a "base-benchmark" plan does not cover all 10 categories of EHBs required by the reform law, or failed to meet other requirements, it would have to be augmented.

The proposed rules also would:

See *Essential Benefits*, p. 10

Essential Benefits (continued from p. 9)

- prohibit benefit designs that could discriminate against potential or current enrollees;
- include special standards for benefits not typically covered by individual and small-group policies, such as pediatric oral and vision, and habilitative services; and
- add standards for prescription drug coverage.

The appendix of the proposed rules include the proposed list of state-selected EHB-benchmark plans, as well as the default benchmark plan for a state that does not select a benchmark plan, for public comment. States can make an EHB-benchmark selection until the close of the comment period. Further information on the benchmark plans can be found at http://cciio.cms.gov/resources/regulations/index.html.

Background

Public comments on the proposed rule had to be submitted by Dec. 26.

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

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

The feds say their guiding principle is that the EHBs' scope will be equal to the scope of benefits provided under a typical employer plan, on a state-by-state basis, as HHS described in the government's Health Benefits Bulletin on Dec. 16, 2011.

See http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

Employers Will Bear Burden of Filling Reform Fund to Stabilize Individual Market

Employers that sponsor health plans are bracing themselves for a significant tax hit under health reform.

Health reform's transitional reinsurance program, which will require insurers and self-funded plans to pay billions of dollars to partly reimburse commercial insurers writing individual policies for patients with very high costs, imposes large costs to further the federal health reform agenda.

Proposed rules (see http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf) by the U.S. Department of Health and Human Services describe a regime under which reinsurance funds would be transferred from states with healthier populations and fewer people in individual policies, to sicker states with more individual policies.

Self-insured employer health plans and insurers are on the hook for the fees. Employers estimate that the first-year assessment for the three-year program, which begins in 2014, is expected to be in a range of $60 to $90 per health plan participant. As a result, the largest employers are looking at bills in the millions of dollars.

The goal of the program is to make the individual market more affordable and to combat the uninsured problem in the United States, HHS says in the proposed rules. It is intended to alleviate the need to build into premiums the risk of enrolling high-risk, unhealthy individuals.

Starting in 2014, the reinsurance program will reduce premiums in the individual market by between 10 and 15 percent below what premiums would be without reinsurance, HHS says. The agency also predicts that 50 percent more people will join the individual market as a result of the reinsurance fund and other reform provisions.

Third-party administrators will make contributions on behalf of self-funded plans, but those plans are ultimately liable for reinsurance contributions, and TPAs and administrative-services contractors are to be used to administer the fee payments.

Traditional Reinsurance Fund

HHS proposes a uniform national contribution rate to go into the fund, and a uniform method to calculate reinsurance contributions by employer health plans and insurers in all states. (States will not be allowed to collect less than HHS requires, but they will be allowed to collect more, the proposed rules state.) HHS, not states, would collect contributions from insurers and self-insured plans. HHS proposes that it distribute reinsurance payments based on each state's need for them. Collections would be made annually instead of quarterly.

In addition, HHS proposes a national, uniform calendar under which: (1) reinsurance contributions would be collected from self-funded plans and insurers; and (2) reinsurance payments would be disbursed to issuers of individual policies.

The health reform law says the rate to be collected for the reinsurance pool (and to refund the U.S. Treasury the $5 billion used by the Early Retiree Reinsurance Program) will be $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016. How much this will cost employers will vary by number of lives covered, and HHS is working on a national per capita reinsurance rate in upcoming rulemaking.

Exclusions for Non-major Medical Policies

Health coverage that is not major medical coverage will be excluded from reinsurance contributions, including: privately run Medicare and Medicaid plans; health reimbursement arrangements, health savings accounts and flexible spending accounts; employee assistance, wellness and disease management programs; stop-loss and indemnity coverage; military health benefits; and coverage for American Indian Tribes.

There is no indication that HHS will drop fees for retiree-only plans for former employees. Employers hoped the government would institute this exception as a means to encourage employers to sponsor such plans.

There is also nothing in the proposal indicating that COBRA-qualified beneficiaries would not be included in calculating the fee paid by employers.

The rule also proposes rules on maximum cost-sharing amounts and out-of-pocket limits on essential health benefits that apply to non-grandfathered individual and small group health plans.

Visit us online at http://hr.complianceexpert.com/hcrl to get more information on health reform.

Reform's PCORI Fees Must Be Paid for Retiree-only And COBRA Plan Members, IRS Says

Employer sponsors of health plans must count members in retiree-only plans and COBRA-eligible plans for purposes of paying into health reform's Patient-Centered Outcomes Research Institute. Furthermore, employees covered under two or more "specified" policies can be counted (and taxed) more than once.

The IRS final rule on employer payment of PCORI fees disregarded employer requests to exclude retiree-only plan members, COBRA enrollees and to limit the tax to one per employee. The final rule contains few changes from the April 2012 proposed rules and Notice 2011-35, which the IRS released in June 2011. See the final rule at http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/html/2012-29325.htm.

The IRS rule was issued on Dec. 6, 2012, but its effective date is Oct. 1, 2012. Therefore, plans with plan years that started after Oct. 1, 2012, can use an alternative calculation method during the first year, the IRS rule provides. Plans that have calendar plan years can start counting on Jan. 1, 2013.

PCORI fees start at $1 per plan-covered life for plan years starting on or after Oct. 1, 2012. They double to $2 for plan years starting on or after Oct. 1, 2013. From the $2 level they increase in step with health inflation until they sunset for plan years starting after Oct. 1, 2019.

Plan sponsors and insurers must report and pay the PCORI fee no later than July 31 of the calendar year after the last day of the policy or plan year, the final rule says.

No Exception for Retiree-only Plans

The rule provides no exception for participants in retiree-only health plans when calculating the fee. The final rule applies the PCORI fee to retiree-only insurance policies and self-insured health plans, even though retiree-only employer sponsored coverage is exempt from HIPAA's portability, nondiscrimination and related requirements.

Similarly, the rule explicitly states that COBRA qualified beneficiaries must be included when employers calculate the fees they pay.

Individuals Can Be Counted More Than Once

Commenters to the proposed rule requested that the fee apply only once per covered life and not multiple times if coverage is provided to one individual through more than one policy or self-insured arrangement; for example, a fully insured insurance policy and a self-insured drug plan. The IRS rejected this proposal, saying in the final regulations that such a provision is contrary to the explicit statutory language applying the fee to each specified policy or plan. So if a beneficiary is covered by an insured major medical plan and by a self-funded health reimbursement arrangement, for instance, he or she will be counted twice when calculating the fee.

Excepted Coverage

Employee assistance programs, disease management programs or wellness programs (unless they provide significant medical or treatment benefits) are not included in the definition of a specified health insurance policy, so fees on those members do not need to be paid.

Further, health savings accounts and most health flexible spending accounts will be exempted.

However, HRAs are covered, so HRA beneficiaries must be counted when calculating the fee.

Four Ways to Count Lives

To count the fees (based on the average number of lives covered), employers can choose between four methods: (1) an actual count; (2) an average of quarterly snapshots; (3) a member-months method; or (4) data transferred from state forms.

For example, the snapshot method allows sponsors to tally the number of participants in each covered plan on a quarterly basis, but samples must be from the same day of the month (with three days leeway before and after the target date). Those samples are added together and divided by the number or snapshots included.

Special Rules for First Year

Plans with years starting after Oct. 1 but before the rules' effective date may use an alternative method of counting lives. These plans and insurers may begin counting lives covered under a policy as of May 14, 2012, rather than the first day of the policy year, and divide by the appropriate number of days remaining in the policy year to determine the fee amount.

The final rule also allows plan sponsors to use any reasonable method to determine the average number of lives covered under an applicable self-insured health plan for a plan year beginning before July 11, 2012, and ending on or after Oct. 1, 2012.

PCORI to Fund Evidence-based Research

PCORI is a private, nonprofit corporation designed to help purchasers and policymakers make informed health decisions by synthesizing and disseminating research

See *PCORI Fee*, p. 13

Aetna's Recoupment Actions Against DME Provider Violated ERISA Claims Denial Rules, DOL Contends

Aetna's actions recovering overpayments from a durable medical equipment provider failed to comply with ERISA — the U.S. Department of Labor argues in a recent *amicus* brief — because: (1) retroactive changes in coverage as a means of recovering overpayments are ERISA denials; and (2) the providers in this case were entitled to ERISA explanations of benefits and ERISA appeal rights.

The DOL wrote the brief supporting plaintiff providers in *Tri3 Enterprises v. Aetna Inc.,* an ERISA class action lawsuit being heard by the 3rd U.S. Circuit Court of Appeals, which is considering the lower court's decision.

DOL argued that Aetna's demand to return an alleged overpayment failed to follow ERISA's claims processing and administrative appeals procedures.

DOL also argued that Aetna's state-law fraud claims should not block federal ERISA procedural rules on denials.

Accordingly, the district court erred in ruling otherwise and its decision should be reversed, it pleaded.

Facts of the Case

Tri3 provided medical equipment — including two kinds of pneumatic compressors to relieve joint pain and swelling — to Aetna-administered ERISA health plans. It obtained a valid assignment of participants' benefit claims and billed from Aetna's reimbursement code book and was reimbursed, the brief states.

After sensing patterns of utilization it alleged were abusive, Aetna's Special Investigations Unit conducted a post-payment audit of payments for the pneumatic compressors and said Tri3's claims were improper. Subsequently it initiated a recoupment process that included a suspension of pending claims for the compressors.

The medical equipment provider submitted evidence that its claims were properly coded and Aetna had preauthorized the orders.

Aetna disregarded the billing code provided and prior authorization of payment, and demanded repayments based on a determination that the pneumatic compressors were excluded from coverage because they were "experimental and/or investigational" services, according to the court document.

Tri3 sued Aetna for health benefits due under ERISA section 502(a)(1) and for injunctive relief under ERISA section 502(a)(3). It did so as an assignee of the beneficiaries and participants, the brief stated.

Aetna argued that its actions were justified in a benefits abuse context, and that other circuits have held that overpayment recoupments like this had been upheld under state law without triggering ERISA preemption.

The district court sided with Aetna. First, it rejected the provider's argument that this was an ERISA

See *DOL Amicus Brief*, p. 14

PCORI Fee (continued from p. 12)

findings about evidence-based medicine. The health reform law imposed fees on self-funded plans and insurers to fund the institute. Paying the fee will be sponsors of accident or health insurance policies (including group health plans) covering people living in the United States (see box, this page).

Plans That Are Subject To the PCORI Fee

Employees in these plans must be counted when calculating the fee:

- Health plans
- Prescription drug plans
- Health reimbursement arrangements
- Retiree-only health plans
- COBRA qualified beneficiaries

Employees in these plans are exempt from the fee:

- Employee assistance programs, wellness programs and disease management programs that do not provide significant health benefits
- Most flexible spending accounts
- Health savings accounts
- Separately insured dental or vision plans
- Self-insured dental or vision plans, if subject to separate coverage elections and employee contributions
- Expatriate coverage for employees who work and reside outside of the United States

DOL Amicus Brief (continued from p. 13)

coverage dispute only, instead saying it saw state-law misrepresentation claims.

Second, the court found that the precedents "holding that an insurer may bring claims for fraud and misrepresentation outside the context of ERISA" applied to the current dispute. And while one might have to look at the ERISA plan, it was basically a state-law misrepresentation claim.

A plan's post-payment overpayment demand based on retroactive denials is an adverse benefit determination triggering ERISA claim and appeal rights, DOL said

DOL: ERISA Denial Rules Were Violated

DOL argued that the district court ruling should be overturned, first because this was not a case for benefits due; instead it was about the payer's failure to follow ERISA's claims and appeals rules; namely, communicating a denial and offering an opportunity to appeal.

> Under the statute and regulations, the beneficiary or participant is entitled to a claims procedure that "afford[s] a reasonable opportunity ... for a full and fair review by the appropriate named fiduciary of [a] decision denying [a] claim," 29 U.S.C. §1133, and can then appeal the denial in federal or state court.

Second, a plan's post-payment, overpayment demands based on retroactive denials of benefits is an ERISA adverse benefit determination triggering full and fair reviews guaranteed under ERISA. DOL said:

> [T]his Court has held: "'where 'plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) of ERISA is appropriate.'" (*citations deleted*). That holding squarely applies to this case.

That point that the case belonged squarely under ERISA was buttressed by the fact that the DME provider had been assigned benefits from ERISA plan beneficiaries, the brief said. The dispute was about plan coverage and the interpretation of plan terms, DOL said.

Third, Aetna violated ERISA's claims and appeals rules because the statute says claims and appeal processes are due after any "adverse benefit determination," (including overpayment recovery demands) without reference to whether they are pre- or post-payment, according to court documents.

DOL cited an agency question and answer saying that when a participant (or provider acting through assignment) demands ERISA plan benefits, the contract between the plan and provider is usually excluded from consideration, making it a case of enforcing an ERISA benefit plan, not a state-law case enforcing a contract.

DOL also argued that ERISA procedural protection applied equally to in-network and out-of-network providers.

The question whether the claims were clean, abusive or fraudulent involved plan interpretation and implicated ERISA, DOL said.

DOL said ERISA's claim and appeal rules are designed to protect providers from rescissions of previous approved services covered by plans DOL indicated.

> Insurers cannot retroactively deprive plan participants of valuable benefits and leave them fully liable for expensive medical treatment, without even providing a means of challenging the benefit denial or its legitimacy under the plan's terms.

The same protections should apply to providers under assignment, the department said.

Therefore, the district court should never have dismissed Tri3's ERISA case, DOL concluded.

Supreme Court Okays Rehearing of Liberty U.'s Challenge to Reform Law

The U.S. Supreme Court has ordered a federal appeals court to rehear a Christian university's challenge to the health reform law in *Liberty University v. Geithner*.

Reviving the case creates the possibility that the High Court may rule on the case itself sometime in 2013, which would make it the second challenge to health reform to reach that level.

On Nov. 26, the High Court vacated its earlier order denying reconsideration, and granted the school's motion for *certiorari*. It remanded the case to the 4th U.S. Circuit Court of Appeals for further consideration. Estimates are that the appeals court will render a ruling in early summer 2013.

The Lynchburg, Va.-based school objects to the health reform law's coverage mandates on religious grounds. But after the June 2012 *NFIB v. Sebelius* ruling upheld the individual mandate, the Court struck the university's lawsuit and denied the school's motion for a rehearing.

After the *NFIB* ruling, in October 2012, Liberty filed an amended motion for rehearing contending that its freedom-of-religion questions were not resolved in the June 2012 Supreme Court decision.

Importantly, the federal government dropped its opposition, saying that while it would oppose the university's arguments, those arguments had not been resolved in the June 2012 *NFIB* ruling.

Federal Opposition Dropped

In the brief, the Obama administration told the U.S. Supreme Court it will not try to block Liberty University in Lynchburg, Va., from seeking legal remedies to its religious objection to the health reform law's coverage mandates. The university recently petitioned the High Court for a rehearing of its case.

Liberty University argues that its religious objections to the law were not vacated in the Supreme Court's *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012) opinion upholding the individual and employer mandates.

Liberty's argument against the mandates as improper expansion of Congress' commerce-regulating powers were stricken in the *NFIB* decision, but Liberty's arguments that they violated constitutional provisions on religious freedom and due process were never heard.

University's Case Reemerges

Filing its case on March 23, 2010, Liberty challenged first the individual and employer mandates to buy (for self) or offer (to employees) health coverage, or pay a penalty. It argued that those mandates improperly expanded the federal government's authority to regulate interstate commerce.

But it also claimed the law violated the school's religious rights because funds from mandatory insurance payments would be used to cover abortions. The university's claims religious rights arguments were based on the First Amendment, protecting free exercise of religion, and the Fifth Amendment's due process clause.

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

The university petitioned the U.S. Supreme Court, arguing to reverse the appeals court's Anti-Injunction block on the case, and arguing against the two mandates as an improper expansion of the constitution's commerce-regulating powers. But it lacked arguments against abortion funding as violating free religious exercise.

In its June 28, 2012, landmark decision on *NFIB*, the Supreme Court ruled (1) that a pre-enforcement challenge to the employer and individual mandates was not barred under the Anti-Injunction Act; but in spite of that (2) the coverage mandate portions of the law were a legitimate use of Congress' taxation authority.

Liberty's petition was seen as resolved after the Supreme Court issued its decision, and the High Court dismissed all pending cases against the law, and denied Liberty's petition for *certiorari* on the day after the *NFIB* decision.

Liberty Resubmits Complaint

In an amended petition to the Supreme Court submitted July 23, Liberty asked it to reverse its denial of *certiorari*, contending that the university's allegations should get a new hearing, because the case was not barred under the Anti-Injunction Act (*Liberty University v. Geithner*, 2012 WL 3027174 (U.S., July 23, 2012)).

The government in its Oct. 31 brief said it agreed that the appeals court's anti-injunction ruling had been overturned and that the First and Fifth Amendment arguments had not been covered in the June 2012 ruling. And because of that, the government said it will not oppose the university's moves to pursue the case.

Religious Publisher Gets Reprieve From Contraceptive Mandate; Judge Grants Injunction

Tyndale House Publishers, a publisher of Christian literature, doesn't have to offer health coverage for contraceptives if it has moral objections under the Religious Freedom Restoration Act, a federal judge in the District of Columbia held, blocking the federal government from imposing a contraceptive mandate on that business.

Tyndale publishes a wide array of Christian books ranging from Bible commentaries to Christian family advice and fiction, and employs 260 workers.

The company and its CEO and trustee Mark Taylor filed suit against the government in October 2012, alleging the government's mandate violated the RFRA, and the First and Fifth Amendments to the U.S. Constitution. Under the mandate, if it fails to cover three kinds of morning-after pills (which end pregnancy after conception), the company argued, it will be subject to penalties that could put it out of business. The case is *Tyndale House Publishers, Inc. v. Sebelius*, Civ. No. 12-1635 (D.D.C., Nov. 16, 2012).

For-profit Companies Can Have Religious Objections

The court first found Tyndale made an adequate showing of standing, after rejecting initial government contentions that a for-profit corporation does not have standing for free-exercise of religion or First Amendment claims.

The court noted instead that companies can have standing to assert the free exercise rights of their owners. It referred to *EEOC v. Townley*, 859 F.2d 610, 620 (9th Cir., 1988)) and *Stormans, Inc. v. Selecky*, 586 F.3d 1109 (9th Cir., 2009). *Stormans* involved a pharmacy that objected to dispensing morning-after pills, and in *Townley* prayer at the workplace was upheld.

Tyndale submitted adequate evidence that it is religiously infused, and its directors, trustees, branches and most of its employees, share the same religious views, the court said.

The company is owned by a trust whose mission is evangelical Christian, and its trustee board must sign a statement of faith each year, which includes language opposing abortion. The court said:

> [T]the beliefs of Tyndale and its owners are indistinguishable. Tyndale is a closely-held corporation owned by four entities united by their Christian faith, each of which plays a distinct role in achieving shared, religious objectives. Christian principles, prayer, and activities are pervasive at Tyndale, and the company's ownership structure is designed to ensure that it never strays from its faith-oriented mission.

The court rejected the government's argument that the company and owners were not being hurt by its health plan's decision to furnish contraceptives.

Then the court found that the government's taxes and penalties on plans that don't provide contraceptive coverage are coercive enough to restrict the plaintiff's religious exercise. Penalties imposed for not providing contraceptives could put the company out of business, the court said. These coercions were stronger than, say paying Social Security and Medicare taxes, because they:

> [A]affirmatively compel the plaintiffs to violate their religious beliefs in order to comply with the law and avoid the sanctions that would be imposed for their noncompliance.

The court rejected the government's argument that the company and owners were not being hurt by its health plan's decision to furnish contraceptives. In doing so, the court held that because Tyndale is a self-funded health plan, and not fully insured, the objectionable act of providing birth control or the morning after pill was not being carried out by a third party such as an insurance company.

> Tyndale itself directly pays for the health care services used by its plan participants, thereby removing one of the "degrees" of separation that the court deemed relevant in [*O'Brien v. HHS*, 2012 WL 4481208 (E.D. Mo. 2012)].

See *Religious Reprieve*, p. 17

Religious Reprieve (continued from p. 16)

Government Fails on 'Compelling Interest'

The RFRA forbids the government from substantially burdening a person's exercise of religion unless the government can demonstrate that "application of the burden to the person: (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest."

The administration argued that allowing employers to be exempted from the contraceptive mandate would harm women's health and deprive women of equal access to health care with men.

The court said the questions were really whether the government needed to apply the contraceptive coverage mandate to the plaintiffs to achieve public health and gender equality, and why the disputed element of the law was necessary to achieve its broader goals. The court wrote:

> [T]he defendants must show that requiring the plaintiffs to provide the contraceptives to which they object — Plan B, ella, and intrauterine devices (as well as education and counseling regarding the same) — will further the government's compelling interests in promoting public health and in providing women equal access to health care.

The court looked at the Institute of Medicine's *Clinical Preventive Services for Women: Closing the Gaps 2* report, which was the basis of health reform's contraceptive coverage mandate. It recommended contraception coverage on public health and gender equalizing grounds (better prenatal care for babies, better women's health though better timed pregnancies, etc.). But those goals are not furthered by forcing Tyndale to cover morning-after pills, the court concluded.

The government argued that Tyndale was violating the rights of women who did not share the company's beliefs about birth control and religion. But this was not a strong enough argument to conclude the government had a compelling interest in enforcing the plan coverage mandate.

The government also said depriving the 260 employees of full coverage under reform was a public health obstacle, but the court noted that millions of people already belong to plans exempted from the new mandate. The government failed to show a compelling interest in the mandate, nor did it show any harm to the public in lifting enforcement of it on Tyndale, the court found.

Background

When the government mandated coverage of preventive services, including contraception, sterilization and morning-after pills, it created an exemption for religious employers, which was originally designed to be limited to houses of worship. It has expanded the exemption, but not enough to avoid litigation by non-religious organizations that are run by religious company officials.

Exempt employers were defined in August 2011 [76 Fed. Reg. 46621] rules as having each of the following characteristics:

1) Inculcating religious values is the organization's purpose.
2) Employing primarily employs persons who share the organization's religious tenets.
3) Serving primarily people who share its religious tenets.
4) Being a nonprofit organization as described in Code Sections 6033(a)(1) and 6033(a)(3)(A)(i).

The court said the questions were really whether the government needed to apply the contraceptive converage mandate to the plaintiffs to achieve public health and gender equality.

Religious proponents argued this exemption was too narrow, and in response, the government in February 2012 (see http://www.gpo.gov/fdsys/pkg/FR-2012-02-15/pdf/2012-3547.pdf) agreed to grant exclusions on ad hoc basis to a wider array of religious organizations. It left the mandate in place for non-religious organizations. Lawsuits have ensued from employers claiming exemptions and seeking to stay government enforcement.

Note: On Nov. 5, the government dropped its opposition to the Supreme Court hearing Liberty University's religious objection to the health reform law's coverage mandates. The university recently petitioned the High Court for a rehearing of its case.

Note: In a contrary ruling on Nov. 19, the U.S. district Court for the district of Western Oklahoma court rejected legal action by Hobby Lobby, a $3 billion arts-and-crafts chain, with 514 stores in 41 states and 13,240 full-time employees, to prevent the government from enforcing its mandate to provide morning-after pills in their group health care plan. The government gives exceptions to religious organizations, but Hobby Lobby is not such an organization, the government successfully argued in *Hobby Lobby v. Sebelius*, 2012 WL 5844972 (W.D. Okla., Nov. 19, 2012).

Employer Sues to Block State's Demand For Claims Data From Self-funded Health Plan

An insurance company recently sued the state of Vermont to block its attempt to get details on the employees and family members enrolled in the company's group health plan, and the actual claims they've submitted.

Vermont health and insurance regulators want this information for a database designed to measure and improve the quality of health care in the state. A state law directs the Department of Banking, Insurance, Securities and Health Care Administration to gather eligibility and claims data from all insurers, third-party administrators and pharmacy benefits managers registered to do business in Vermont.

But Liberty Mutual Insurance Co. says such information on participants in its own self-funded health plan is shielded by ERISA. The company is arguing that ERISA's fiduciary duty prohibits them from disclosing it, and that ERISA preemption precludes the state from demanding it.

The Vermont law and BISHCA's implementing rules "are an attempt to intrude upon the uniform and exclusive regulation of employee benefit plans that Congress provided under ERISA," the company argues in its lawsuit. ERISA already sets out the detailed reporting and disclosure requirements for self-funded plans like Liberty Mutual's, and gives the U.S. Department of Labor exclusive authority to collect and analyze data from these plans, according to the complaint filed Aug. 12 in federal district court.

Liberty Mutual cited the "deemer" exception to the insurance "savings clause" from ERISA preemption (see ¶820 of the *Guide*): "Vermont cannot impose additional reporting requirements not contemplated by ERISA simply by deeming the Plan to be an insurance company."

Moreover, providing participants' confidential health information would violate ERISA's requirement to administer the plan solely for the benefit of its participants and beneficiaries, the complaint continues:

> The duties outlined in Section 404 of ERISA compel Liberty Mutual to safeguard against the type of detailed and intrusive reporting regime being imposed by BISHCA, particularly because BISHCA may release claims data to various third parties who request such data.

This dispute is part of a larger trend, according to the HR Policy Association. Many states are setting up similar databases, raising "concern that such states may attempt to require employers to turn over similar sensitive and confidential plan participant information," according to a statement from the group, which comprises large companies' senior human resources officials. "This trend, if left unchallenged, will likely continue and become even more aggressive as state health care exchanges are established" under health reform.

BISHCA General Counsel Clifford Peterson downplayed the privacy concerns raised by Liberty Mutual. The participant information the state is gathering is not personally identifiable to begin with, is encrypted in transit and is safeguarded "zealously" once the state has it, he said. The state also disputes the ERISA preemption claim, he added, because "we're not interfering with the ERISA plan at all."

The state agreed to drop its immediate demand for the information from Liberty Mutual, pending the ultimate outcome of the lawsuit. BISHCA had issued a subpoena for this data, and Liberty Mutual in turn had sought a court injunction to block it. The dispute only involves data on 137 individuals anyway, Peterson noted. The case will now be litigated on a regular schedule.

The disputed records are actually held by Blue Cross Blue Shield of Massachusetts, Inc., which acts as the Liberty Mutual plan's TPA. BCBSMA already has turned over data on thousands of Vermonters enrolled in other plans that it insures or administers, Peterson said.

SIIA Petitions 6th Circuit to Block Michigan's Tax on Health Plans

A Michigan tax on health claims violates ERISA's goal of uniform administration of group health plans, the Self-Insurance Institute of America argues in an appeal filed Nov. 20. Therefore, SIIA has asked the 6th U.S. Circuit Court of Appeals to declare that ERISA preempts the claims tax and overturn a lower court's ruling to the contrary.

Suing the state though its governor, insurance commissioner and treasurer, SIIA's petition to the 6th Circuit contends that the 2011 Michigan Health Insurance Claims Assessment Act (Pub. Act 142) triggers ERISA preemption by directly regulating ERISA plans and plan administrators and imposing state-specific administrative burdens on them.

Preemption Facts

For a law to be preempted, it must be "related to" an ERISA plan, which that means it must "refer to" or "have a connection with" an ERISA plan, U.S. Supreme Court precedent mandates. If either standard is met, ERISA preempts the offending law.

The Assessment

The Michigan state tax on health claims imposes a new 1-percent claims assessment on insurers and third-party administrators (and by extension one must presume, self-funded health plans) for health medical services provided to a Michigan resident in Michigan.

Because self-funded plans have to pay it, SIIA says the Michigan health claims tax clashes with one of ERISA's core concerns — universal administration, by creating new state-specific obligations.

- ERISA plan administrators must adjust plan procedures and record-keeping to comply with Michigan-specific record-keeping and reporting requirements.
- Plans have to analyze plan documents, contracts with claims administrators and providers, and coverage and eligibility for compliance with the state law.
- The state can unilaterally hike the tax estimate, leaving the onus on the plan to refute the state's estimate.
- The law subjects ERISA plans to state regulation, audit, enforcement and fines.

The district court did not see it that way. In September 2012, it ruled the state law did not "relate to" ERISA plans in the meaning of ERISA Section 514. It was a law of general application, and had a tenuous effect on benefit program operation, so it was not preempted, that court said.

SIIA's Case

SIIA is appealing the conclusion that the law does not have a "connection with" ERISA plans, arguing instead that it does, because it mandates state-specific administrative requirements that prevent uniform administrative practice.

SIIA does not argue about whether the law "has a reference" to ERISA plans.

The assessment, the processes and the new state powers of inspection all constitute an impermissible connection with an ERISA plan, SIIA says.

The imposition of new recordkeeping requirements in particular clashes with ERISA goals of uniform national administration, the group argued, citing the U.S. Supreme Court in *Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) and case law from various circuits.

Citing from several Supreme Court rulings, SIIA argues that Congress' intent when it passed ERISA is that ERISA plans should not be faced with conflicting state rules.

New Definitions Imposed

New duties imposed on ERISA plans include: the state's reliance on residency for the tax to apply; the requirement that a service be rendered in Michigan; and its definition of "paid claim" — all of which destroy uniform administration and warrant preemption, according to SIIA.

The state had successfully argued to the district court that because the tax was paid after the claims decision had been made, the law was not interfering with plan operations and governance. SIIA vigorously counters that in its appeal petition:

> ERISA does not distinguish between preclaim and post-claim administrative burdens and, assuming it did, the Act does not merely impose post-claim burdens.

New Recordkeeping Burdens

In particular, the recordkeeping regime to support the Michigan tax imposes burdens on plan operations in general, SIIA's filing says.

See *SIIA Appeal*, p. 21

Supreme Court (continued from p. 2)

He said agreements between participants and plans trumped the common-fund doctrine in most circuit courts recently. ("A valid contract … [displaces inquiries] into unjust enrichment," he said, quoting case law.) Justice Scalia supported that.

Justices Express Skepticism

Justices Sotomayor and Breyer critiqued the idea that the plan should trump the common fund doctrine in this case. Without the common-fund doctrine, an accident victim pays for litigation to generate a fund and then turns over the settlement to the plan even if he or she has to pay attorney's fees out of pocket. That requires very clear language (best achieved by a direct abrogation of the common-fund doctrine), which they said wasn't in the US Airways plan.

Several justices, notably Ginsburg and Kennedy, said US Airways did not have adequate language in the plan document to give its lien precedence over McCutchen's attorney's lien.

They said the employer's subrogation clause (on which its recovery claim was based) was in the summary plan description only and not in the plan itself. They noted that the plan document takes precedence over the SPD when the two conflict. The plan document did directly refute the common-fund doctrine, and the plan did not distinguish between subrogation and reimbursement. The plan included a section on subrogation, and based its recovery claim on that section.

Questions posed by Breyer and Sotomayor expressed skepticism that the common-fund doctrine should be trumped in general, just because a plan provision reserves 100 percent of its expenses.

The discussion of what should take precedence — an agreement under the plan or the common-fund doctrine — continued as the federal government's attorney (appearing as a friend of the court) supported the idea that courts could enforce equity though the common-fund doctrine in order to avoid a negative recovery scenario like McCutchen had. Scalia and several others critiqued that standpoint.

US Airways complained that no matter how clearly written the document is about full recovery, and even if the plan is honest and forthright, a participant who is not made whole because the third party is broke or underinsured still has exceptions (equitable defenses) to full recovery.

Matthew Wessler, attorney for McCutchen, said a subrogation agreement is subject to the common-fund doctrine and other equitable defenses; McCutchen signed a subrogation agreement with the plan; however, US Airways is seeking reimbursement.

Ginsburg asked what the plan was doing wrong by collecting a full recovery as provided in its agreement with the participant.

We have an agreement here, and the plan is asking for what the agreement gives

See *Supreme Court*, p. 22

US Airways v. McCutchen

The case began with a U.S district court decision in *US Airways Inc. v. McCutchen*, 2010 WL 3420951 (W.D. Pa., Aug. 30, 2010) that ordered James McCutchen to repay US Airways' self-funded ERISA health plan all of the $66,866 it paid for health expenses arising from an auto accident.

McCutchen settled his tort claim for only $10,000 due to very limited liability coverage of the other driver. He also collected $100,000 from his own underinsured motorist auto policy.

After paying his attorney's fees with 40 percent from the settlement, McCutchen's net recovery was less than $66,000. It was then that US Airways sought reimbursement for the entire $66,866. McCutchen's attorneys responded by placing $41,500 in trust, but when McCutchen did not pay the difference, the airline sued him.

When the district court ruled that McCutchen had to pay the plan the full amount based on summary plan description language calling for complete reimbursement of plan benefits, this meant McCutcheon would have emptied $41,500 from the trust account and paid $25,366 from his personal assets.

McCutchen contended that outcome would be unfair and inequitable, and that the plan would be unjustly enriched if it was able to collect from him without any allowance for the costs incurred to achieve the recovery.

On appeal, the 3rd U.S. Circuit Court of Appeals ruled the reimbursement remedy sought by the plan was not "appropriate" because McCutcheon would have to go into his personal funds to completely reimburse the plan, even though plan terms called for reimbursement of all costs a plan paid from third-party awards. In *US Airways Inc. v. McCutchen*, 2011 WL 5557411 (3rd Cir., Nov. 16, 2011), the circuit concluded that US Airways' claim for reimbursement was subject to equitable limitations and vacated the district court's judgment, remanding the case for further proceedings.

The 3rd Circuit's ruling conflicted with the 5th, 7th, 8th, 11th and D.C. Circuits (which have supported full plan recover regardless of what the plaintiff received from the tortfeasor).

Reform and Price Hikes Forces Help Drive Larger Employers to Self-funding

The number of workers covered by self-funded health plans in 2011 reached its highest level in the last 15 years. But while health reform and skyrocketing insurance premiums may be pushing large employers into self-funding, those factors are not leading smaller employers down the same path.

In 2011, the most current year surveyed, 58.5 percent of U.S. workers with health coverage were in self-insured plans, up from 40.9 percent in 1998, according to research by the Employee Benefit Research Institute. See http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd1.pdf.

Large employers (1,000+ workers) have driven the upward trend in overall self-insurance. In 1998, 55.4 percent of workers in firms with 1,000 or more employees were in self-insured plans. By 2011, 86.3 percent were in self-insured plans, the institute said.

But the proportion of workers (covered by self-funded plans) at firms with fewer than 50 employees decreased from 12.5 percent to 10.8 percent between 2010 and 2011, EBRI found. The percentage of workers covered by self-funded plans sponsored by companies with 100 to 999 workers also has dropped to just 35 percent.

EBRI's findings undercut concerns that passage and implementation of health reform is causing an increasing number of smaller employers to adopt self-insured plans as a means of avoiding coverage mandates.

Reform Isn't Driving Small Firms to Self-funding

Many experts predicted that the passage of health reform would increase the number of firms that self-insure, because reform's insurance mandates (the minimum-creditable-coverage requirement; the breadth of essential health benefits; the taxes on insurers, medical-device makers and drug companies; stricter coverage rules; and reinsurance fees) are causing increases in health insurance premiums.

This can be inferred from EBRI's research, but only among the entire working population. In the final four years of the study (2008-2011), during which health reform was either in effect or being debated, self-funding among all employers grew from 55.2 percent to its current level of 58.5 percent.

However, the reform law apparently does not incentivize small companies with 50 or fewer employees to choose self-funding. That rate was close to 12 percent in most years of the survey; it peaked at 18.1 percent in 1997 and reached a low of 10.8 percent most recently in 2011.

Small employers have long been better served by buying insurance. Due to their small number of participants, they cannot accurately predict fluctuations in claims frequency and severity and lack the financial resources to assume the risk of loss on any one employee who exceeds the premium historically charged to the employer by a commercial insurer.

What's more, under health reform, starting in 2014, small employers will be allowed to buy group health insurance on state-run exchanges, whereas large employers will not eligible until 2017 to do so (and then only in states that decide to offer that privilege).

State-by-State Variations

The percentage of participants in self-funded plans varied by state, from a low of 30.5 percent to a high of 73.8 percent.

Massachusetts, the only state that has enacted health reform like the Affordable Care Act, has seen an increase in the percentage of workers in self-insured plans among all firm-sizes, except for firms with fewer than 50 employees. But apart from that state, the study found no correlation between prescriptive state coverage mandates and the prevalence of self-funding in individual states.

For more information on health reform's impact on self-funding, visit us on line at http://hr.complianceexpert.com/self/100/150.

SIIA Appeal (continued from p. 19)

According to SIIA, ERISA plans must: (1) determine whether the claim constitutes a "paid claim" within the meaning of the law; (2) determine when and how "recoveries" must be credited against payments; (3) keep reports based on their state-law determinations; (4) subject themselves to audits of their state-law determinations; and (5) collect assessments from other ERISA plan entities or explain to the state why they did not do so. All of which impinge on plan administration before, during and after health care claims are paid, the group says.

Because of their nature and their extent, the burdens imposed by the Michigan claims tax encroach on the core competencies of ERISA plans, make uniform national administration impossible, and therefore the law should be preempted, SIIA concludes.

The Commonwealth Fund's Hostile Report Promotes Putting Shackles on Self-funding

by Adam Russo, Esq.

The Commonwealth Fund seems to believe self-funding should not be part of a high-performing health system. The group focuses its entire November 2012 *Issue Brief* on self-insurance by small firms under the health reform law, essentially finding that they should be discouraged from self-funding in order to better support the post-reform market.

In the issue brief, it simulates small-employer coverage decisions under reform and found that low-risk stop-loss policies lead to higher premiums in the fully insured small group market.

It focused on the belief that small employers with healthier workers and dependent profiles will avoid participating in the broader-based insurance pools and instead take advantage of experience rating as a self-funded plan. In addition, since the fully insured small-group markets will be guaranteed issue with limited waiting periods, small employers could self-insure during good times and enter the fully insured market during bad times, it posited.

The report expressed the position that if the states or federal government do not regulate or restrict access to stop-loss policies for small employers, then coverage in fully insured small-group insurance will be substantially lower and premiums will be significantly higher. Without such action, they believe that under the reform law, self-funding will draw many of the healthier firms out of the fully insured market and increase the premiums for those who remain.

However, if the stop-loss parameters recommended by the National Association of Insurance Commissioners are uniformly adopted, the report suggests, such adverse selection would be prevented. The NAIC recommends that stop-loss deductibles (also known as attachment points) be set at a minimum of $60,000 per insured individual. These parameters would expose small employers to significant financial risks when self-insuring and would dissuade most small employers from doing so.

It is important to note that before health reform took effect, most states defined small group markets as including employers of 50 workers or less. Beginning in 2016, the law requires the small group threshold to be set at 100 workers or fewer; however, the law allows states to set the threshold anywhere from 50 to 100 in 2014 and 2015.

It also is important to know that currently, slightly less than 12 percent of firms with fewer than 100 workers offer health coverage under at least one self-insured plan, according to the Commonwealth Fund report. But while self-funding among small employers is not widespread today, health reform changes the incentives to self-insure beginning in 2014 by exempting self-insured plans from many provisions. Under the law, fully insured plans will be priced according to modified community rating and claims-experience rating will not be allowed. Self-insurance will provide an experience-rated option to healthy small employers post-reform.

The reform law includes an insurer fee based on covered lives that self-funded plans will not have to pay, which will be a premium surcharge of 2 to 4 percent on fully insured plans, another incentive to self-insure. Read the report online at http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Nov/Small-Firm-Self-Insurance.aspx.

Supreme Court (continued from p. 20)

it. Why is the plan unjustly enriched by receiving exactly what the plan entitles it to receive?

The hearing concluded with Katyal describing the impact of weakened subrogation and reimbursement rights on millions of insurance policies, many of them backed by Medicare and Medicaid. Then Breyer described a scenario where the tort victim spends 98 percent of a settlement just proving its case, only to have an insurer swoop in and take the entire amount, leaving the victim paying to enrich the plan.

Visit us online at http://hr.complianceexpert.com/self/700/720 for a description of subrogation and reimbursement.

Common-fund Doctrine

If a self-funded ERISA health plan is subject to the common fund doctrine, both the attorney and the plan have to share the client's attorney's fees, as well as the settlement proceeds (that is, the common fund).

On the other hand, if the plan's subrogation provision states that it is entitled to full reimbursement from any tort settlement proceeds without application of the common-fund doctrine, the plan would be entitled to full reimbursement before the plan participant's attorney can be paid from the proceeds.

PPO Tells Plans to Shun Medicare-plus Payment

By Adam Russo, Esq.

An Ohio-based PPO called HealthSpan is warning the self-insured industry against paying claims based on a percentage of Medicare, in a Nov. 20 memorandum. But many believe it's an effort to pull the wool over the eyes of the self-funded community.

Many self-funded plans consider Medicare-plus reimbursement to be a way of limiting reimbursement to a certain percentage above Medicare, and it is used by many plans and consultants. But HealthSpan cautions that such an approach exposes plans and their members to balance billing. The memo states that using Medicare-plus reimbursement (and I quote):

1) Exposes the plan and its members to being billed the difference between plan payment and the *full amount* of billed charges.

2) May have balance billing occur after the end of the plan's stop-loss year exposing further risk to the employee, employer and stop-loss insurer.

3) May require patients to pay up front for care in order to get treatment.

4) Further limits access to those providers who will accept this form of payment in a market where physician shortages are already restricting access to care.

PPOs are popular because they eliminate balance billing. When a PPO secures a "discount" for a health plan, the provider agrees to accept payment per the network fee schedule as payment in full, with no balance billing. View the memo here: http://blog.riskmanagers.us/wp-content/uploads/2012/12/Letter-to-HealthSpan-customers-brokers-and-TPAs_Nov-2012.pdf.

CE Column **(continued from p. 4)**

small self-insured group's claim costs rise, the firm can move to the fully insured market at any time, as the exchanges will have rolling enrollment. The fully insured market could end up being a magnet for bad claims risk, while healthier lives are diverted to self-insurance.

For that reason, reform proponents (including the Commonwealth Fund, *see story, page 22*) support far-reaching state and federal regulation of stop-loss reinsurance.

However, we have not lost this fight for one main reason — people love self-funding and the options it gives. We need to focus on this as we enter the New Year. The facts are on our side so let's take advantage of that.

Plans and PPOs

We have seen the average cost per family enrolled in a PPO hit an all-time high in 2012. We think current large PPO arrangements have limited network power to secure high discounts and lower rates for services. We think they result in one-sided contracts in favor of providers. Such contracts present major issues when administered alongside self-funded plans.

Many of the agreements deprive plans of their right to perform audits, which are meant to ensure that charges are fair and reasonable. The result: improper charges can go undetected and undeterred.

HealthSpan suggests instead paying through traditional PPO models. PPOs need to be used because networks protect patients from balance billing, it says. It states:

> Our PPO network contracts do not permit balance billing and assures protection of the patient/consumer and the employer. Not only does HealthSpan credential its in-network providers to verify their qualifications, insurance coverage and licensure, our PPO contracts also address regulatory compliance requirements, compliance with your plan documents, quality and other performance standards.

We Beg to Differ

If the lack of balance billing is your best attribute, there may be a problem in your business model, my staff at the Phia Group and I believe. Balance billing is a way to achieve "price transparency" and consumer "skin in the game," and everyone is clamoring for these things.

This is why we expect to see growth in alternative pricing methodologies in 2013. There is an enormous uptick in "Medicare plus" pricing, cost-plus payments, out-of-network pricing and smaller network or direct provider agreements between a facility and a self-funded plan or its third-party administrator.

What PPOs fail to mention is that plan sponsors have a duty to prudently manage plan assets, and pay claims in accordance with their plan document — not a network contract. Most self-funding experts view the lack of transparency within PPO contracts as a major hindrance to prudent plan management.

It's easy to pay what the network tells you, avoid conflicts and spend no time auditing claims. It's a tough decision to take the hard road, when the alternative is so much easier. More and more self-funded employers, however, are taking that road. They are adopting systems of reimbursement that assess providers' actual cost to deliver services and allowing for a fair payment above that cost.

Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-4. Entries are listed alphabetically by subject and the name of the court case. The numbers following each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "20:4/2" indicates Vol. 20, No. 4, page 2.

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