Employer's Guide to
Self-Insuring Health Benefits

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You Were Smart Enough to Self-fund, Now Try Some Innovation

Employer-sponsored health plans that want to control their own claim dollars and the destiny of their costs have some intriguing new methods they may not be aware of. Certainly, emphasizing prevention and maintenance care for chronic diseases are already proving their effectiveness. But beyond that, one-on-one contracts with select providers for select procedures can be a clear "win" for plan and provider. Consider arrangements for dialysis, joint replacement and emergency services. Dovetailing such arrangements around larger provider networks is not without pitfalls for the unwary. Large savings are also available to plans and participants through medical tourism arrangements for select procedures. Contributing Editor Adam Russo, Esq., explains how all this can work. ***Page 2***

6th Circuit Multiplies Award, Saying Insurer Profited from Benefits Denial

Rather than merely finding that an individual was entitled to benefits due, a federal appeals court ordered an insurer to pay a large monetary award under ERISA based on a theory of disgorgement of ill-gotten profits. The 6th U.S. Circuit Court of Appeals held that the insurer used money it should have paid out in benefits to generate profits. The decision flies in the face of long-standing precedent that the aim of ERISA is to make plaintiffs whole, not to give them a windfall. Plaintiff's attorneys will undoubtedly use this decision to add disgorgement actions to their benefits suits. In the aftermath, employer-sponsored plans will feel compelled to pay benefits even when coverage is dubious, for fear of subjecting plans to sizeable new awards. ***Page 3***

High Court to Rule on Obamacare's Contraceptive Mandate

The U.S. Supreme Court on Nov. 26 agreed to rule on an appeal of health care reform's contraception coverage mandate. The cases that will be heard were brought by Hobby Lobby Stores and Conestoga Wood Specialties. The question revolves around whether corporations have the right to personal religious freedoms; and whether the owners of corporations have religious rights that can be violated when the government forces them to manage their companies in certain ways. A reversal on contraceptives would be another in a long string of health care reform setbacks, including an embarrassing roll-out of the health insurance exchange enrollment websites, the termination of thousands of low-cost, low-coverage individual and small-business policies and the suspension of the employer pay-or-play mandate ***Page 5***

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You Were Smart Enough to Self-fund, So Try Some Innovation

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The best part of self-funding a health plan is that you control your own destiny in many ways. While you cannot control who needs medical care in most situations, you have a better ability to manage your own plan. Many options exist when it comes to managing a self-funded plan, and I plan to share some intriguing options of which you probably are not aware.

Employer's Guide to Self-Insuring Health Benefits

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Who Should Keep Reading

This article is not for self-funded plans that don't want any control. It is for plans that want to control their own claim dollars and the destiny of their plan costs.

While self-funding allows plan sponsors more flexibility to deliver quality health benefits in a more cost-effective way, sponsors must commit the necessary time and focus to design and manage their plans in order to achieve the desired results. If you rely on your claims administrator to do it for you, then your plan will not be as successful in reining in costs. The final simple statement is that if you are not willing to make this commitment, you will likely be better off in a traditional, fully insured arrangement.

The Many Aspects Of Self-funding

There are many ways to self-fund a health plan. For example, when you self-fund with a large entity, self-funding is handled no differently than the fully insured options available, except that you pay for each individual claim instead of a monthly premium cost. Everything else is eerily similar to the fully insured product. You do not decide what claims are paid, how much is paid, who your stop-loss insurer is or what the plan language states. You do not have any discretion over the plan. You just write the checks and hope for the best.

On the other end of the self-funding spectrum, you can control it all. You design the plan, the benefits, the networks, the carve-outs, the special little things that your plan may need. Everything is in your control, and while the above two scenarios are extremely different; they are both categorized as self-funded plans.

Federal law provides self-insured plans greater flexibility in designing benefit packages that better meet the specific needs of plan participants. For example, organizations with a labor-intensive workforce can structure their plans to incorporate more robust health benefits that would be used by these plan participants. Self-insured plans also can structure more innovative reimbursement arrangements with health care providers.

See *Featured Columnist*, p. 18

6th Circuit Says Insurer Profited from Benefits Denial, So Allows ERISA Monetary Award

Rather than merely finding that an individual was entitled to benefits due, a federal appeals court ordered an insurer to pay a large monetary award under ERISA based on the equitable theories of unjust enrichment and disgorgement of ill-gotten profits. The 6th U.S. Circuit Court of Appeals held that the insurer used money it should have paid out in benefits to generate profits.

In *Rochow v. LINA*, 2:04-cv-73628 (6th Cir., Dec. 6, 2013), the appeals court awarded the plaintiff not only relief under Section 502(a)(1) (ERISA benefits due), but a three times greater amount under Section 502(a)(3) (other equitable relief, for a fiduciary breach) to compensate for profits the company allegedly generated using the unpaid benefit.

Although the case involved a long-term disability plan, it has larger implications, as noted by a dissenting opinion. There, a 6th Circuit judge said the decision bordered on compensatory and punitive relief, and that it expands the scope of ERISA remedies.

The Facts

Daniel Rochow, an executive with the Gallagher Insurance Co., fell seriously ill and applied for long-term disability benefits, which were denied. He sued, and both a lower and appeals court found that LINA's denial was arbitrary and capricious.

After Rochow died in 2008, his estate sued for attorney's fees and argued LINA unjustly enriched itself with the money it should have paid to Rochow. It sought disgorgement of profits the company thus gained. The $3.78 million award sought consisted of $910,629 in denied benefits and $2.8 million more in earnings based on LINA's rate of return on equity.

In the March 2012 ruling on *Rochow v. LINA*, 851 F. Supp 2d 1090 (E.D. Mich. 2012), the district court based its outsized award on the fact that the plan had comingled the funds it should have paid in benefits and used them for business purposes.

In response, LINA argued that permitting disgorgement was outside the scope of ERISA's mandate, but the court refused to consider this. LINA appealed. The 6th Circuit said it would look at whether the disgorgement order and the method of calculating the disgorgement amount clashed with ERISA norms.

The Appeals Court Weighs In

Writing for the appeals court, Circuit Judge Arthur Tarnow said the district court was right to impose the double liability on the plan to deprive the company of illicit profits it made.

> After this ruling, employer health plans will feel compelled to pay benefits even when coverage is dubious for fear of being subjected to the one-two punch of a sizeable equitable award on top of a benefit recovery.

Propriety of remedy under ERISA

Initially, LINA argued that disgorgement was inappropriate because equitable relief under Section 502(a)(3) (for "other relief available in equity") should be available only where Section 502(a)(1) (for "benefits due under the plan") solutions do not provide an adequate remedy. (See *Varity v. Howe,* 516 U.S. 489 (1996) and *Wilkins v. Baptist Healthcare System, Inc.*, 150 F.3d 609 (1998).)

U.S. Supreme Court precedent led courts to routinely deny relief beyond reimbursing benefits due as prescribed in Section 502(a)(1).

See *Double Award*, p. 4

Double Award (continued from p. 3)

If a plaintiff received such relief, further relief under Section 502 (a)(3) (under alternative theories of equity) most often was rejected as double relief.

ERISA remedies not always mutually exclusive

But the court saw no complete bar to simultaneous awards under Sections 502(a)(1)(B) and 502(a)(3), Tarnow stated.

Bifurcated awards can be allowed if the extra relief:

1) is not a repackaged claim for benefits, as when an ongoing business-wide practice must cease in order to prevent further losses to participants; and

2) responds to plan misconduct (for example a misrepresentation) that damages the victim in ways that are not remedied by restoration of benefits alone.

The appeals court noted the lower court gave two awards: (1) restoration of benefits denied under Section 502(a)(1)(B); and (2) equitable relief to prevent the plan from profiting from its own fiduciary breach, under Section 502(a)(3).

Amount of disgorgement

In many cases, the supplemental award is scaled to the damage to the plaintiff, and not to an improper windfall gained by the defendant. However, nothing limits Section 503(a)(3) remedies to the extent of plaintiff injuries, Tarnow wrote.

An accounting for profits is typically available in equity and therefore is appropriate under Section 503(a)(3), Tarnow said. Nor could the disgorgement be looked at as "punitive," because it left the company no worse off than it would have been had it paid benefits when the law required, Tarnow added.

LINA argued that a double award would undermine ERISA's goal of a consistent system of benefit determinations.

But the court said ERISA had another purpose: ensuring that plans act in participants' interest and only for providing benefits to them. It wrote:

> If no remedy beyond an award of benefits were allowed, insurance companies would have the perverse incentive to deny benefits for as long as possible, risking only litigation costs in the process.

Dissent Calls this an Impermissible Expansion of ERISA Remedies

In a dissenting opinion, Circuit Judge David McKeague said the ruling diverged from ERISA's remedial purpose of making plaintiffs whole, because it focused its remedy on the size of profits made, not on the damage to the participant.

Being paid disability benefits and attorney's fees would have made Rochow whole.

Allowing him to recover "profits" above and beyond denied benefits was "an improper repackaging of the benefits claims" and "a second recovery for the same injury."

Implications

This decision marks a major victory for plan beneficiaries and a significant blow to employer-sponsored benefit plans. According to the 6th Circuit, disgorgement of profits is appropriate as an additional remedy under ERISA Section 502(a)(3) where a plan administrator's decision to deny benefits is held to be arbitrary and capricious.

The 6th Circuit's determination seems to fly in the face of long-standing precedent that, to borrow from Judge McKeague's dissenting opinion, the aim of ERISA is to make plaintiffs whole, not to give them a windfall.

However, by providing plaintiffs with an award for the denial of benefits that includes both benefits due and equitable relief under Section 502(a)(3) in the form of disgorgement of profits, the plaintiffs are being made whole and then some, which in the Rochow case amounted to $2.8 million.

Proponents of this decision will maintain that allowing plan beneficiaries to recover not only the benefits

See *Double Award*, p. 5

U.S. Supreme Court Will Rule on Health Care Reform's Contraceptive Mandate

The U.S. Supreme Court on Nov. 26 accepted an appeal of health care reform's contraception coverage mandate. The cases that will be heard are *Sebelius v. Hobby Lobby Stores, Inc.* and *Conestoga Wood Specialties v. Sebelius*. (Kathleen Sebelius is named in her capacity as U.S. Health and Human Services Secretary.) The cases were consolidated and one hour was allotted for oral argument.

The question revolves around whether corporations have the right to personal religious freedoms; and whether the owners of corporations have religious rights that can be violated when the government forces them to manage their companies in certain ways.

The case will be argued probably in March, and a ruling issued in the summer of 2014. The Supreme Court took up the appeal partly because there was a split among federal appeals courts.

In June, the 10th U.S. Circuit Court of Appeals in *Hobby Lobby v. Sebelius*, No. 12-6294 (10th Cir., June 27, 2013), temporarily lifted the requirement that the craft-store chain provide contraceptive coverage for their workers, sparing them from having to pay penalties. The owners argued that their company should not have to observe the health care reform requirement because it imposed on their (the owners') personal religious rights.

In the *Conestoga* case, the Mennonite owners of a Pennsylvania company were told by the 3rd Circuit that they could not avoid the contraceptive coverage mandate by arguing that avoidance is an exercise of their religious beliefs. The latest opinion was *Conestoga Wood Specialties Corp. v. Sebelius*, 2013 WL 3845365 (3rd Cir., July 26, 2013).

The health care reform law requires employers with 50 or more workers to cover preventive care (including contraceptive services for women) without cost-sharing, which generated religious objections from some employers.

This is the second time the Supreme Court will hear a dispute stemming from the health care reform law. On June 28, 2012, a 5-4 majority concluded that the mandate that individuals be covered by health insurance or pay a penalty is congressional power authorized by the U.S. Constitution. A negative outcome in that case would have had far more crippling effect on the law as a whole than a reversal of the administration's contraceptive policy. It did, however, negate the law's mandate that states expand Medicaid programs and as a result, 25 states have refused to expand that form of coverage.

A reversal on contraceptives would be another in a long string of setbacks, which includes an embarrassing roll-out of the health insurance exchange enrollment website; the termination of thousands of low-cost, low-coverage individual and small-business policies; the suspension of the employer pay-or-play mandate; and opposition to the law from Republican lawmakers and low approval ratings from most businesses and the voting public.

Supreme Court Rejects Liberty U. Challenge to Health Care Reform

In an order dated Dec. 2, the U.S. Supreme Court rejected *Liberty v. Lew*, which involved several challenges to the law that had already been defeated in other cases, particularly in its June 2012 decision on *National Federation of Independent Business v. Sebelius*, in which it upheld the individual mandate under the government's taxing power.

Liberty University challenged the constitutionality of the employer mandate, using arguments that had already been covered in the June 2012 decision. The University also contended that the mandate to pay for contraceptives violated the Religious Freedom Restoration Act and the First Amendment.

Liberty University was one of the first litigants to challenge the new health care reform law. It sought Supreme Court review earlier, but the High Court also declined to hear that case, although the court did agree to allow Liberty to return to the 4th Circuit to press its claims. That review by the 4th Circuit rejected all of Liberty's challenges.

Double Award (continued from p. 4)

that were improperly denied but also the profits earned on those withheld benefits will strongly discourage plan administrators from making unwarranted adverse benefit determinations.

On the opposite end of the spectrum, employer-sponsored plans will feel compelled to confer benefits even where coverage is dubious for fear of subjecting the benefit plan to the one-two punch of a sizeable equitable award on top of benefit recoveries, the inevitable consequence of which will be premium and contribution increases for the other plan participants.

Employee benefit plans will need to be on guard as plaintiff's attorneys will undoubtedly use this decision as an opportunity to add disgorgement actions to their benefits suits going forward.

Government Proposal Refines Reform Fees On Self-Insured Plans and TPAs

A proposed rule published in the Dec. 2 *Federal Register* adjusts reinsurance rules and tries to put out fires left burning by the ever-moving target of health care reform.

For example, it proposes a lower contribution level insurers and self-funded plans would pay in 2015 to a transitional reinsurance fund, and gives employers the ability to pay in two installments. It would make it easier for insurers to qualify for risk payments in 2014. Also, it would set up reinsurance funding for third-party administrators that have to pay for contraceptives.

The Centers of Medicare and Medicaid Services rule (78 *Fed. Reg.* 72322) was open to public comment for 30 days after Dec. 2.

Lower Reinsurance Fees in 2015

The government proposes lowering the transitional reinsurance fee to $44 per insured life per year in 2015, down from $63 per person per year in 2014. The fees for the Transitional Reinsurance Program will be used to partially reimburse commercial insurers for individuals with high health care costs. They will be paid annually over a three-year period.

> The health care reform law established a program to enable states to set up reinsurance funds to cover insurers' losses in the individual and small-group markets. Insurers and self-funded group health plans must fund pay into the fund in proportion to the number of lives they cover.
>
> The program is designed to stabilize premiums in the face of significant new coverage obligations the law requires. These include the full panel of 10 essential health benefits, automatically renewal of policies, the elimination of pre-existing condition exclusions, and compliance with other reform-law coverage mandates.

Employers would be able to pay the transitional reinsurance fee in two installments under the proposed rules.

The first-year assessment remains, as stipulated in earlier regulations, at $63 for each health care plan participant. However, employers could make a payment of $52.50 per participant then, an additional $10.50 per participant payment late in the fourth quarter of 2015.

For the 2015 plan year, the $44-per-participant reinsurance fee could be paid in two installments: $33 in January 2016 and then $11 per covered life in the fourth quarter of 2016.

Funds for TPAs

In another fix, TPAs would receive funds to pay contraceptive claims on behalf of participants in objecting health plans.

The rule would authorize funding to reimburse TPAs that provide payment for contraceptive services for enrollees in self-funded health plans. Money would be raised through a user fee adjustment allowance that would cover costs in the 2015 benefit year to TPAs working for plans that object to providing contraceptive services in 2014.

Under health care reform's scheme, TPAs would have to administer (and fund) such claims outside of the plan. But most TPAs lack funds apart from what their sponsors make available, and so would have to coordinate with insurers, which can in fact get reinsurance money for that coverage.

Note: As a practical matter, insurers are not cooperating in this endeavor, according to the Self-Insurance Institute of America. In a Nov. 26 letter, SIIA wrote:

> SIIA TPA members are taking every conceivable action to comply with the final contraceptive mandate rule, so this is not a matter of opposing the rule for some political or ideological reason. At issue is that there are no health insurance carriers willing to partner with TPAs to provide contraceptive service coverage for self-insured religious organizations. It is also important to confirm that most TPAs do not maintain reserves sufficient to fund claims in anticipation of reimbursement on some uncertain future date, which has been suggested.

For more information on religious objections to contraceptive coverage, see Section 370 of Thompson's *The New Health Care Reform Law: What Employers Need to Know*.

Lower Attachment Point for Insurers in 2014

Under the proposal, the government would make it easier for insurers offering plans on health insurance exchanges to qualify for risk payments in 2014. At the moment, the government's reinsurance plan will pay 80 percent of claims above a $60,000 attachment point. Under the proposed rule, the government would pay insurers 80 percent (the coinsurance rate) of claims greater than $45,000 in 2014.

This is in response to the government's announcement that it will allow insurers to renew cheap insurance

See *Review Process*, p. 7

Review Process (continued from p. 6)

policies in the individual and small group market that would have been cancelled due to noncompliance with the reform law's coverage mandates, but now can be renewed between Jan. 1, 2014, and Oct. 1, 2014. If the healthy people who had the cheap policies get to remain in a separate risk pool and don't join the government's risk pool, then insurers that comply with the 2014 market rules will experience a higher proportion of expensive claims. The lower attachment point is designed to address this, the proposal stated.

The attachment point would jump back up to $70,000 in 2015; there would be a $250,000 reinsurance cap; and the coinsurance rate would drop to 50 percent in 2015, under the agency proposal.

Also, if transitional reinsurance fees levied exceed the amount of claims, the government would increase its coinsurance rate to more than 80 percent in 2014 (and more than 50 percent in 2015) to ensure that all contributions collected are spent on insurers' claims that year, the agency said.

Cost-sharing Parameters

The rule proposed new ways of estimating average premiums and calculating premium percentage changes, to monitor compliance with health care reform's limits on cost-sharing and deductibles in the small group market. The statute required that limits be updated annually based on the percent increase in average per capita premiums. CMS proposes calculating the increases with projections from the National Health Expenditure Accounts and the CMS Office of the Actuary.

For 2015, it proposed a premium adjustment of 6 percent, which would result in a maximum annual limit of $6,750 for self-only coverage in 2015, and a maximum $2,150 deductible for self-only coverage in small-group health plans in 2015.

Revised Actuarial Calculator

On CMS' Center for Consumer Information & Insurance Oversight website, it includes a new actuarial value calculator; a proposed 2015 guide to its new AV calculator; and describes changes to the AV calculation methodology.

Small-business Exchange Rules

CMS proposed provisions relating to Small Business Health Options Programs, namely:

- employers in the federally facilitated SHOPs would make premium payments according to a timeline and process set by the U.S. Department of Health and Human Services;
- employers would be charged only for the portion of the month for which they are enrolled in a SHOP policy;
- they could get standalone dental plans from SHOPs, and offer only one or many to workers; and
- they would be allowed to contribute differently to the premiums of full-time and non-full-time employees.

Finally, CMS would not allow composite rating in the FF-SHOPs when an employer elects to offer employees a choice of plans at one AV level since that would make composite rating complex.

Implementation of these rules will have to wait until 2015, when insurers are officially required to offer all four levels of health coverage (namely 60, 70, 80 and 90 percent AV). A final rule published in June 2013 suspended that requirement and allowed insurers selling on SHOPs to offer only one level of coverage, and employers to offer the same one level of coverage to their workers.

For more information on health care reform's fees on self-funded plans, see Section 795 of *The New Health Care Reform Law: What Employers Need to Know*.

Health Care Reform Briefs

Firms that cut workforces or reduce full-time employees' hours to avoid health care reform's employer mandate could have to defend against allegations of ERISA violations, a prominent law firm explains. A survey shows that many franchises expect to lessen working hours and fill full-time positions with part-time workers to avoid health care reform's pay-or-play mandate.

In other news, U.S. Department of Health and Human Services Secretary Kathleen Sebelius ordered an Office of Inspector General investigation into the problems contributing to the poor early phase launch of the health care reform website healthcare.gov. She also appeared before a house committee on Dec. 11 to argue that the website had turned a corner, enrolling much more people in November than it had in the previous month.

The ERISA Industry Committee asked the government to make health care reform reporting less onerous on large businesses. Meeting the requirements for reporting about coverage to the IRS and participants will cost large business thousands of work-hours, the group said.

And criticism of reform came from patient advocates, who pointed out that health plans sold on federal- and state-run exchanges are skimping on drug benefits for serious chronic illnesses like AIDS, multiple sclerosis and cancer. The result is higher out of pocket costs for people with the worst illnesses, advocates say.

Workforce Realignments to Skirt Employer Mandate Might Violate ERISA

A strategy of reducing employee hours potentially exposes employers to liability under ERISA Section 510, which prohibits interfering with employees' rights to present and future benefits, the law firm Epstein Becker & Green reports.

Some employers report that they are cutting workers hours so those workers will not fall under reform's 30-hour definition of full-time worker, and the employer will not have to offer health coverage to those workers. But employers may face discrimination and retaliation complaints for following such a strategy, attorneys Kara Maciel and Adam Solander write.

Employees who averaged 30 hours or more a week previously and whose employer reduced their workload below 30 hours per week in response to the employer mandate might argue that the change was intended to deny them health coverage they are entitled to under ERISA.

It is important for employers to understand the claims that may be brought against them and the steps that maybe taken to reduce the chance of such claims succeeding. ERISA Section 510 is enforced through the civil enforcement framework laid out in ERISA Section 502. Depending on the nature of the action, Section 502 allows for private parties as well the U.S. Department of Labor to bring civil actions to enforce ERISA.

Typically, plaintiffs bringing ERISA Section 510 (nondiscrimination, no retaliation) claims seek redress under the first and third options above. Under these options, monetary relief is limited. The first option restricts potential monetary relief to benefits due under the plan. However, Section 502(a)(3), the provision for "other appropriate equitable relief" in cases where benefits due under the plan do not cover claimed losses, is also available. The interpretation of the third option has been the subject of considerable legal debate. In *CIGNA Corp. v. Amara*, the U.S. Supreme Court indicated that such equitable relief may include monetary relief, which would not necessarily be limited to the value of a lost plan benefit. Enforcement actions could involve:

1) A participant or beneficiary may bring a civil action to recover benefits due to him under ERISA's enforcement provisions.

2) The DOL, a participant, a beneficiary or a fiduciary may bring an action against a fiduciary for breach of fiduciary duty.

3) A participant, beneficiary, fiduciary or the DOL may bring an action to: (a) enjoin any act or practice that violates ERISA or plan terms; or (b) obtain other appropriate equitable relief to redress violations or enforce any provisions of ERISA or the plan terms.

To read the report, see http://www.ebglaw.com/files/58687_Where-ERISA-And-The-Affordable-Care-Act-Collide-Kara-Maciel-Adam-Solander.pdf.

Health Care Reform Leading Businesses To Reduce Full-time Positions

Even though the Obama administration has delayed implementation of the employer mandate until 2015, employers are cutting hours and reducing the number of full-time employees to fewer than 50, the threshold above which employers face taxes for not providing coverage. This is particularly strong among franchisees, according to a survey sponsored by the U.S. Chamber of Commerce (http://www.uschamber.com/sites/default/files/reports/IFAChamberFinal.pdf).

See *Reform Briefs*, p. 9

Reform Briefs (continued from p. 8)

Sixty-four percent of franchise owners said they expect to be harmed by health care reform; and 31 percent of franchisees have already reduced worker hours to reduce the number of workers being counted as full-time. Twenty-seven percent had replaced full-time with part-time workers, because of the health care reform law. And about 60 percent of franchisees with 40 to 70 workers said they would restructure workforces to avoid having 50 full-time workers. Fifty-eight percent of franchisees said the reform law was a "strongly bad idea."

Many respondents said they would drop offering coverage altogether, and opt instead to pay extra taxes to the government.

HHS Secretary Sebelius Orders OIG Investigation of HealthCare.gov

After taking stock of the flawed launch of healthcare.gov, HHS Secretary Kathleen Sebelius announced that the agency has launched an OIG investigation into the problems.

In a Dec. 11 blog post (http://www.hhs.gov/healthcare/facts/blog/2013/12/three-initial-steps.html), Sebelius said the investigation would delve into the managerial and contractor performance that led to the flawed launch of healthcare.gov. She ordered HHS Inspector General Dan Levinson to investigate the acquisition process, overall program management, and contractor performance and payment issues. The Centers for Medicare and Medicaid Services will create a new risk officer to address risk management in large-scale contracting and IT acquisition projects and take action to ensure best practices for vendor management, she said.

House Chairman: More Coverage Lost than Gained

More people lost coverage so far due to policies not complying with essential health benefits and other coverage requirements, than have signed up for new coverage, said Health Subcommittee Chairman Joe Pitts, R-Pa., during a Dec. 11 House Energy & Commerce hearing.

Sebelius said 365,000 Americans enrolled in through the end of November, but under questioning from Pitts, she said that number was rough; premiums had not been paid, because those do not have to be paid until mid-December. CMS released the news in a Dec. 11 enrollment report (http://aspe.hhs.gov/health/reports/2013/MarketPlaceEnrollment/Dec2013/ib_2013dec_enrollment.pdf).

Sebelius said the government is implementing "hundreds of software fixes, hardware upgrades and continuous monitoring" to improve website performance. She said site capacity was improved, responses to traffic were faster, and the site created far fewer errors. The website can handle 50,000 concurrent visitors and 800,000 people per day, she said.

Pitts countered by citing the government's target enrollment number of 3.3 million by the end of December. Pitts claimed saying 5.6 million people in small-group and individual policies had their "skinny" policies cancelled, because they didn't match health care reform tests. Sebelius and her allies on the committee, including Henry Waxman, D-Calif., said that having to change plans to include more coverage is not the same as *losing* coverage.

Sebelius said four times more people enrolled in Obamacare in November 2013 than did so in October. The website also helped up to 2 million people get eligibility determination for ultimate enrollment in Medicaid or children's health insurance program coverage, she said.

Large-employer Group Calls for Less Reporting about Employer Coverage

Facing the likelihood that large employers will have to toil for thousands of hours to set up systems to report information about health coverage to the IRS, the ERISA Industry Committee asked the government to make the rules less onerous on large businesses.

To comply with health care reform's employer mandate, large employers must return information reports to IRS under Sections 6055 and 6056 of the tax code. They must attest whether the company offered minimum essential coverage to full-time employees and their dependents; the months during which coverage was available; the monthly cost to employees for the lowest self-only minimum essential coverage, and information about each full-time employee who was covered and the months they were covered. The requirement includes providing health coverage information to participants. The requirement was first to take effect on Jan. 1, 2014, but IRS deferred it until Jan. 1, 2015.

Some employers will have to spend thousands of man-hours building and testing systems to extract the required information from a benefits recordkeeping system and create the necessary files, ERIC remarked in Nov. 14 comments to the IRS. Add to that printing and mailing costs, and the cost is fairly substantial. ERIC had the following suggestions to make the burden less onerous.

- Companies should only have to provide information to individuals on request, particularly given the fact that most employees are already enrolled and know about company's coverage.
- The reporting and disclosure requirements should simply certify that they offer minimum essential

See *Reform Briefs*, p. 10

Failure to Proactively Disclose Provider Status Leads 7th Cir. to See ERISA Possible Fiduciary Breach

A plan's failure to disclose important coverage information (even though the plan participant did not directly ask for it) might have been a fiduciary breach that warranted an award for breach of fiduciary duty, a federal appeals court held, reversing a lower court decision that no fiduciary breach existed.

Fiduciaries are required to volunteer pertinent facts once they understand the participant's situation and interest, an *en banc* panel of the 7th U.S. Circuit Court of Appeals ruled. The fact that the participant failed to directly ask whether the provider was in-network did not absolve the fiduciary (reversing the district court opinion). As a result, the plan may have to pay debts owed to the provider, in addition to statutory penalties for not responding to a request for plan documentation (ordered by the district court), a majority opinion written by Circuit Judge Kenneth Ripple said in *Killian v. Concert Health Plan*, No. 11-1112 (7th Cir. Nov. 7, 2013).

Facts of the Case

Royal Management Corp. sponsored a health plan, and used Concert Health as its claims review administrator. Concert Health was a named plan fiduciary.

In February 2006, plan participant Susan Killian required immediate brain surgery and aggressive cancer care after her lung cancer spread to her brain. Susan began care with a brain surgeon who was not in Concert's open access network.

In April 2006, on the day of Susan's surgery, her husband James Killian called the number on the back of his insurance card to obtain pre-approval. In two conversations, James Killian never directly asked Concert's customer help representatives whether Rush University Hospital was in network. When Killian told the customer representative that his wife was admitted, the claims

See *Poor Responses*, p. 11

Reform Briefs (continued from p. 9)

coverage to 95 percent of employees and post notice on the company website that employees can request complete Section 6055 and/or 6056 information.

- In order to save money on paper delivery, employers should not need consent to use electronic delivery.
- Companies should have to provide names, but no other identifying information for dependents.
- Other requested changes involve less frequent reporting, simplified reporting and giving companies the flexibility to design their own reporting.

For more information on Section 6055 and 6056 reporting, see Section 530 of Thompson's *The Health Care Reform Law: What Employers Need to Know*.

Exchange Plans Could Be Shortchanging Chronically Ill on Drug Coverage

Health care reform is drawing the ire of advocates for patients with chronic diseases, who complain that health plans on the exchanges charge these patients higher out-of-pocket costs for treating chronic conditions than their previous employer plans and don't cover important drugs used in disease-specific care.

On the one hand the health care reform law will insure millions more Americans and guarantees coverage of essential health services, but to pay for this expansion of coverage, some insurers are trying to keep chronically ill patients away from their plans. They are doing this by limiting reimbursement for a number of specialty drugs to treat chronic conditions, such as AIDS, MS, rheumatoid arthritis and cancer. (Patients said also that the doctors working on their chronic conditions are not in-network with many exchange plans.)

In a new letter, HIV Health Care Access Working Group voiced concern about exchange policies not covering some of the most effective and accepted drug treatments for HIV. "[They] are not covering HIV medications recommended by the HHS, including the single tablet regimens that promote adherence and result in lower medical costs." (See http://www.hivhealthreform.org/2013/12/09/hiv-advocates-continue-to-push-feds-for-effective-implementation-of-the-aca.)

In an Oct. 18 letter, the group argued that many exchange insurance plans did not cover single-tablet-regimen pills and other standard treatments for HIV.

A Dec. 9 article in the *Washington Post* described nonmonetary drug plan policies designed to curb utilization of expensive drugs: "The plans are curbing their lists of covered drugs and limiting quantities, requiring prior authorizations and insisting on 'fail first' or 'step therapy' protocols that compel doctors to prescribe a certain drug first before moving on to another — even if it's not the physician's and patient's drug of choice."

Poor Responses (continued from p. 10)

servicers merely said "okay," and "go ahead with whatever has to be done."

In June 2006, Susan needed a nine-day hospital admission to treat pneumonia. After discharge, she went on chemotherapy, but she died in August 2006.

Concert Health held that the physicians and Rush University Hospital were not in network with Concert and rejected Killian's internal appeals in two letters.

In August 2007, James sued in federal court alleging improper denial of benefits totaling $80,000 and breach of fiduciary duty.

The district court upheld the denial of benefits and saw no breach of fiduciary duty because no evidence showed detrimental reliance by Killian and the plan's denial letters complied with ERISA requirements.

However, after a new district judge looked at the case, the court awarded Killian statutory damages of $10 per day (one-tenth the statutory maximum) for the plan's failure to provide a summry plan description. But that was only $5,880. He appealed, seeking payment for the denied services.

The First Appeals Court Ruling

In April 2012, the 7th circuit upheld the plan benefits denial, because explanations of benefits told the Killians that Susan's physicians and hospital were out of network, and the plan's decision to deny payment was neither arbitrary nor capricious. Plan directions to call a number to check for provider network status were sufficient to escape fiduciary-breach claims. Killian didn't directly inquire about Rush University Hospital's status, and the call center's failure to volunteer network information did not *per se* create a fiduciary violation. Nothing in the record indicated that Killian believed the providers were in-network, and it appeared the Killians would have started treatment from them whether they had an SPD or not.

The first appeals court ruling said that ERISA does not require a fiduciary to set out on a quest to uncover some kind of harm that might befall a beneficiary. *Killian v. Concert Health Plan*, 2012 WL 1357703 (7th Cir., April 19, 2012).

On the other hand, the court would consider imposing higher statutory penalties for the plan's failure to deliver plan documents.

In the second *en banc* ruling, *Killian v. Concert Health Plan*, No. 11-1112 (7th Cir., Nov. 7, 2013), the circuit court upheld the denial of benefits but found that failure to provide an SPD plus the call center's failure to provide essential information warranted an order to pay more benefits.

Poor Call Center Responses

Circuit Judge Ripple saw a breach of fiduciary duty in the conversation with the call center. Citing *Kenseth v. Dean Health Plan, Inc.*, 610 F.3d 452 (7th Cir., 2010), it said once a beneficiary has requested information and the fiduciary is aware of the beneficiary's situation, then:

> [the] fiduciary has an obligation to convey complete and accurate information material to the beneficiary's circumstance, even if that requires conveying information about which the beneficiary did not specifically inquire.

And quoting from a 2003 case:

> Regardless of the precision of his questions, once a beneficiary makes known his predicament, the fiduciary 'is under a duty to communicate … all material facts in connection with the transaction which the trustee knows or should know.'

If the plan had clear documents and if it had properly trained ministerial personnel to apprise members about coverage policies, then the plan would be shielded from the mishaps of a ministerial, non-fiduciary agent.

But the Killians never received an SPD, which was supposed to contain the composition of provider networks. Instead, the group master policy merely directed participants to call a toll-free number before starting treatment to find out whether providers were in-network. That was a problem, because without the SPD serving as a backstop, the plan became susceptible to the customer service agents' poor responses.

The situation appeared to be distinct from one in which a ministerial, non-fiduciary agent gave mistaken advice to an insured person, the court stated.

After reviewing Killian's first April 2007 call, the court said that a reasonable trier of fact could conclude the plan failed "to convey complete and accurate information." Killian had called the number on the plan's benefit identification card, and the call center had told him to "do whatever you have to do." Killian took that response as an authorization because the customer service agent did not affirmatively tell him the facility was out of network.

Killian made a second call the next day to a different number to certify she was authorized for an admission. A different agent on that call said "okay." Here also, it could be argued that the agent was obligated to volunteer information about the facility's network status, the court held.

See _Poor Responses_, p. 12

Plan's Failure to Provide Meaningful Review Derails Exhaustion Defense; ERISA Claims Proceed

Exhaustion of remedies cannot be used as a defense against ERISA claims when an ERISA plan fails to provide meaningful access to appeal and review procedures. In *Mitchell v. AseraCare Home Health*, 2013 WL 5797610 (D. Neb., Oct. 28, 2013), a self-funded plan's third-party administrator attempted to derail a benefits denial case by arguing that the plaintiff had not exhausted plan remedies.

Those arguments failed, however, and exhaustion was not required because the plan failed to give notice of the plaintiff's appeal rights; the plaintiff received no explanation of her denial on appeal; and her request for plan documents was not timely fulfilled by the plan.

The Facts

Sarah Mitchell worked for AseraCare Home Health Care in Omaha, Neb. and was covered by the company's self-funded health plan. She was hired in September 2008, and before accepting the job offer warned her supervisor that she anticipated having surgery in November of the same year.

Prior to the procedure, Mitchell called TPA Anthem Blue Cross, which told her all she needed was a certificate of insurance. After she got the surgery, however, Anthem denied most of her claims. She claims she asked for further information about the denials, but that Anthem did not respond. She filed an administrative appeal and later a workers' compensation case, which was dismissed by the court.

Anthem asked for information from the doctors and hospital, but did not ask Mitchell for anything. Ultimately, Anthem justified denial of benefits to the hospital and two of three doctors because there was a waiting period for pre-existing conditions.

In September 2009, Mitchell's lawyer asked Anthem for the basis of its denial as well as copies of its policy and coverage booklet. Through September and October 2009, Mitchell herself made the same request to plan sponsor Golden Living (AseraCare's parent corporation). Finally, in late November 2009 Mitchell's lawyer sought review and a response to the situation from the CEO of Blue Cross of California. The CEO did not respond other than to provide a copy of the company's plan description, which Anthem finally delivered in December 2009. As a result, Mitchell filed suit.

Suing the TPA, her employer and the parent company, Mitchell sought benefits due under an ERISA plan, breach of contract, breach of fiduciary duty, negligent misrepresentation, estoppel. (Claims for ERISA penalties, attorney's fees and remedies were ultimately dismissed.)

Anthem filed a motion to dismiss Mitchell's claims, saying Mitchell failed to exhaust her plan's administrative remedies. Anthem also argued that it was no more than a TPA and therefore not liable as a fiduciary. District Judge Joseph Bataillon from the U.S. District Court in Nebraska heard the case but ruled on the TPA's motion only.

Judge: Further Appeals Were Futile

If an ERISA plan clearly requires that a claimant exhaust administrative remedies, he or she will be barred from seeking relief in federal court for failing to do so, unless that exhaustion would be wholly futile, or if "there is a lack of meaningful access to review procedures."

See *Meaningful Review*, p. 13

Poor Responses (continued from p. 11)

While ERISA does not require a fiduciary to set out on a "quest to uncover some kind of harm that might befall a beneficiary," this case did not require a quest, the *en banc* appeals court said. ERISA does not allow plans to defeat breach-of-fiduciary-duty charges by claiming they were unaware of what a participant was looking for when he called phone banks designed to answer those kinds of questions.

Accordingly, the court remanded the case to determine whether: (1) Killian's questions should have prompted the fiduciary to disclose material information; (2) Concert breached this duty; and (3) whether Killian was harmed by the breach.

Dissent

Circuit Judges Daniel Manion and Diane Sykes issued a joint dissenting opinion arguing that Susan's breach of fiduciary duty and denial of benefits claims were moot because the Killians never paid the Rush providers and there was no longer a legal obligation to pay those bills (relevant statutes of limitations having expired). Thus, there was no longer any legal harm to Susan's estate.

The dissenting opinion also disagreed with placing the blame for the situation on the plan fiduciary rather than the Killians themselves. While James Killian deserved sympathy, the mistake was really his, because he didn't consult with or consider the terms of the health plan, the dissent stated.

Meaningful Review (continued from p. 12)

Judge Battalion noted that one of the reasons an insurer's failure to respond can short-circuit an exhaustion-of-administrative-remedies defense is that it deprives the claimant of sufficient information to prepare adequately for further administrative review or an appeal to the federal courts.

Mitchell appealed to Anthem on Oct. 22 and Nov. 7, 2009, and claimed that Anthem did not process her appeals.

When plans reject claims, ERISA requires them to include: (1) the provisions on which the denial was based; (2) a statement about participant rights; and (3) added materials needed to perfect the claim. Mitchell said she received some of that information for one of her doctors, but none for the remaining care providers.

As a result, the court agreed with Mitchell: Any further pursuit would have been futile, because:

- **Notice of rights was withheld.** It did not appear that proper notice of the denial and appeal rights were given to Mitchell.
- **Her appeal went unprocessed.** Mitchell attempted to appeal, through her lawyer and on her own, but her appeal was not processed.
- **Her document request was unfulfilled.** Mitchell and her attorney tried to obtain the documents guaranteed under ERISA, but those documents took a very long time to make their way to her.

Confusing Plan Language

In response to Anthem's argument that it was no more than a TPA and had no responsibility for the denials, Mitchell argued that both Golden Living and Anthem were administrators and operated the plan jointly, both exercised discretion and both met the definition of fiduciary.

Anthem was not a named fiduciary; the plan named AseraCare and its parent company as fiduciaries, and Anthem said it did not belong in this allegation.

An ERISA fiduciary is one who "has or exercises any discretionary authority or discretionary control" over the ERISA plan or its assets, the judge said.

Mitchell said the plan was written in such a way that it intertwined and overlapped plan sponsor, plan administrator and claims administrator.

For example, the plan named Golden Living as sponsor. The plan administrator was "the committee," and put Anthem (known then as BC Life and Health) was on the committee (presumably giving it discretionary roles and fiduciary duties). However, later it said Golden Living was the plan administrator and Anthem was the claims administrator.

But elsewhere, the plan gave Anthem "complete discretion and authority to construe and interpret the plan, decide all questions of eligibility and benefits, make underlying factual determinations, and adjudicate all claims and appeals."

Court Refuses to Strike Fiduciary Charge

Mitchell argued the plan gave Anthem duties to interpret and administer the plan and that it did have the fiduciary duties of performing plan work prudently and in participants' interest. The judge agreed that that this was a viable argument and refused to dismiss that charge. It agreed with Mitchell that plan language was ambiguous on Anthem's fiduciary status, and said that Mitchell had arguments that Anthem and the plan were unified and entwined.

It also remarked that the plan made Anthem responsible for denying payment (duties to construe and interpret the plan), thereby meeting the plan's own definition of fiduciary. It rejected the motion to dismiss this count.

Breach of contract claim survives; State estoppel claim doesn't

Bataillon also rejected the payer's argument that the statute of limitations had run out on Mitchell's breach of contract charge, adding later that breach of contract could be argued under ERISA. However, the court said it would reject any estoppel claims brought under state law; those would be preempted by ERISA. She could reargue that claim but only if raised under ERISA, the judge ruled.

Misrepresentation charge against TPA stricken

Bataillon agreed with Anthem that nothing in the complaint showed Anthem was responsible for the negligent misrepresentation alleged by Mitchell. The employee who made statements about insurance payments and start dates never represented Anthem, and therefore there was nothing that tied Anthem to Mitchell's negligent misrepresentation charge.

Implications

Some of the most basic tenets of administering employee benefit plans can often be the most important. This case illustrates how failure to comply with them can greatly prejudice a health plan.

While not a novel concept, the courts commonly rule against plans if administrators fail to comply with the simplest of requirements that must be followed when

See *Meaningful Review*, p. 14

ERISA Disclosure Penalties Cannot Be Used To Impose Sanctions on Claim Procedure Failures

Statutory penalties for violating ERISA's general disclosure provisions cannot be used to punish a plan's service provider's alleged delays in responding to inquiries related to claims procedure rules.

In *Curran v. Aetna Life*, 2013 WL 6049121 (S.D. N.Y., Nov. 15, 2013), the court disallowed the penalty on procedural grounds, making a distinction between enforcement under different statutory and regulatory language.

In another part of the ruling, the U.S. District Court for the Southern District of New York denied the plaintiff what amounted to compensatory damages because a payment of benefits would completely extinguish her problem, and rejected calls for the service provider to be deemed a *de facto* plan administrator.

The Facts

Bridget Curran and her minor son were participants under TriNet's "Open Access Managed Plan." The plan was insured and underwritten by Aetna Life Insurance Co., and TriNet Group Inc. was the plan administrator.

Meaningful Review (continued from p. 13)

issuing adverse benefit determinations. First, a plan that wants to benefit from the terms in the plan document must comply with those terms strictly, uniformly and without any hint of being arbitrary or capricious. Otherwise, as we have seen time and time again, courts will impose their will on the plans and thus undermine the very core benefit of self-funding.

Second, plan sponsors and administrators must clearly set forth the terms of their agreement in order to ensure that fiduciary responsibility is apportioned based on the expectations of their relationship. Even still, simply have well drafted administrative services agreements! Courts repeatedly have held that a party's actions determine whether it can be held liable as a fiduciary and have seemingly been attempting to stretch that burden, even to those who advise the plan. Plans and administrators must exercise diligence when establishing their relationships. Crafting effective administrative services agreements and plan documents is the most important aspect of self-funding benefits. Following the terms of those agreements is undoubtedly a close second and is an area where applicable parties can ensure more control over their destiny in the life of actions brought under ERISA.

Curran's son underwent scoliosis surgery in January 2011, at Stamford (Conn.) Hospital by Dr. Rudolph Taddonio, an out-of-network physician.

Taddonio billed the plan through Aetna $168,500 for the surgery. At first, Aetna indicated on its website that it had approved a payment of $119,658, with the proviso "to be paid by plan."

Instead, Aetna paid two installments to Taddonino totaling only $4,444, the final one arriving in December 2011. Aetna advised Curran that the previous approval was a mistake and the claim had a new case number.

Curran made a written request for documents about the approval and subsequent withdrawal of the $119,658 payment, in which she referenced ERISA and U.S. Department of Labor rules. Between April 2011 and January 2012, she sent seven such letters to Aetna. She sent two more letters to TriNet in March and May 2012, in which she asked for documents describing the claim denial. TriNet responded that it was not a fiduciary and that it had delegated all claims administration duties to Aetna. Curran never got the documents about the claims denial.

She sued in January 2013 and amended her complaint in August 2013, seeking:

- benefits due under ERISA;
- declaratory and injunctive relief and to impose sanctions on Aetna and TriNet for failure to provide documents explaining her claim denial;
- damages for breach of fiduciary duty from Aetna; and
- damages for breach of fiduciary duty from TriNet.

Aetna and TriNet moved to dismiss the case. District Judge Nelson Roman partly dismissed her claims.

Aetna Escapes *De Facto* Administrator Trap

ERISA Section 502(c) allows for statutory penalties of up to $100 a day for failing or refusing to furnish certain information, like summary plan descriptions. But, the court noted, only the plan administrator can be assessed such penalties. Because TriNet was the plan administrator, only TriNet was subject to ERISA penalties for failing to provide required documents. Therefore, such penalties could not be imposed on either the plan, or on Aetna, the ruling said.

See *ERISA Penalties*, p. 15

ERISA Penalties (continued from p. 14)

Curran argued that Aetna should be considered the *de facto* plan administrator because it held itself out as such. But the court refused to apply a *de facto* test for Aetna under ERISA. Although some courts have granted *de facto* status when non-administrators held themselves out as administrators, most rulings by the district held that only designated administrators can be held liable for such penalties.

What *Should* Be in a Denial Letter

Curran sought statutory penalties under ERISA Section 502(c) for failure to provide information under separate DOL claims-appeal rules (see ¶718 of the *Guide*). Under those rules, notifications of claims denials are supposed to include:

1) The specific reason or reasons for the adverse determination.
2) The specific plan provisions on which the determination is based.
3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The court threw out the claim for statutory penalties, noting that this distinct enforcement mechanism could not be used to remedy violations under the separate claims appeals rules. The statute authorizes statutory penalties only for failure to provide documents like a summary plan description, which Curran had been furnished with. However, it would not strike a claim (for mandamus relief) to deliver documents relating to Curran's claim for coverage because the defendants had not countered Curran's claim for that relief in their motion to dismiss.

Benefits Due Is Only Relief Available

Curran then argued that Aetna violated its fiduciary duty to act solely in the interest of plan beneficiaries. Because it was both an insurer and fiduciary, it took actions out of self-interest and not in accordance with Curran's best interests, she said.

Curran therefore demanded "compensatory damages" of $168,500 — the providers' billed amount. But the court held that a $119,658 payment of plan benefits would render this claim unrecoverable.

The court dismissed this claim after determining that there was no "appropriate equitable relief" available under Section 502(a)(3), apart from a simple payment of plan benefits due under Section 502(a)(1)(B).

Focusing her fourth charge on TriNet, Curran complained that she put it on notice about Aetna's fiduciary breaches, and TriNet did nothing about them. Under ERISA Section 405(a), one fiduciary can be held liable for a breach of fiduciary duty by another fiduciary.

Curran sought $168,500 from TriNet for that alleged malfeasance. But the court rejected that claim for the same reason: total relief would be achieved by a payment of benefits and anything apart from that would be a money fine not authorized by ERISA.

Conclusion

The court left standing the claim for ERISA benefits; and it allowed claim for injunctive and declaratory relief to remedy the failure to adequately respond for requests for documents, while rejecting statutory penalties for that same failure. It also dismissed the claims against Aetna and TriNet for "appropriate equitable relief" relating to their alleged fiduciary breaches.

Implications

The court in this case took care to differentiate between things required by ERISA and things required under separate rules and guidelines.

Plan participants routinely use ERISA as a sword against benefit plans and their claims administrators. Here, however, the plan participant tried to use ERISA in a manner the court deemed inadmissible.

The court in noting that ERISA Section 502(c) does not provide penalties for failure to comply with claims appeals rules issued by the DOL, provided the benefit plan with some possible arguments against the imposition of ERISA penalties when the failures are not explicitly deviations from the statute.

Additionally, the court also deviated from a recent trend by failing to extend *de facto* administrator status to Aetna. Recently courts have been determining parties act as fiduciaries will be subject to fiduciary liability regardless of whether their agreement with the plan administrator establishes them as one.

It would not have been a stretch, then, for the court to determine that Aetna should be deemed a plan administrator when it held itself out to be one for the purpose of ERISA penalties. Instead, however, the court relied on the party designations to determine responsibilities for ERISA penalties. This decision again illustrates the importance of clarity in the contracts between plans and their administrative vendors.

TPA May Not Be Sued for Mental Health Parity Violations, Court Rules

A third-party claims administrator may not be sued for violating the Mental Health Parity and Addiction Equity Act because the law by its terms applies only to group health plans and their insurers, a federal district court ruled. Related ERISA claims against the TPA were also dismissed because the company was not the "plan administrator" for ERISA purposes. The case is *N.Y. State Psychiatric Ass'n v. UnitedHealth Group*, No. 13 Civ. 1599 CM (S.D.N.Y., Oct. 31, 2013).

Facts of the Case

The case's principal plaintiffs were three beneficiaries of different employers' self-funded group health plans whose claims were administered by UnitedHealth Group.

Denbo

Jonathan Denbo, an employee of CBS Sports Network, received psychotherapy for depressive and anxiety disorders and submitted the claims to UHG, which processed them through subsidiaries UnitedHealthcare Insurance Co. and United Behavioral Health. UHG subjected his claims to concurrent and prospective review, rather than strictly retrospective review as called for by the terms of the CBS medical plan, Denbo alleged.

UHG allegedly informed Denbo and his therapist that it would no longer cover their sessions because the ongoing treatment plan "does not meet UBH criteria for benefit coverage at this time," given Denbo's "adequate reduction/resolution in clinical symptoms." Denbo and his provider appealed this decision to no avail. Denbo then sued UHG, alleging that the company had violated the CBS plan's terms by conducting prospective and concurrent reviews and refusing to grant him a second level of appeal.

Smith

Brad Smith, an employee of SYSCO Corp., has a son who has been treated for severe mental illness since 2005. UBH terminated coverage for "Daniel's" inpatient residential treatment, explaining that "treatment could be safely and effectively delivered" on an outpatient basis. According to Brad Smith, however, no such outpatient treatment is available in their community, and UBH later denied coverage for Daniel's outpatient treatment as well.

UBH violated MHPAEA, Brad Smith alleged, by assessing mental health claims with a definition of "medical necessity" that gives it "far greater discretion to deny care" than the definition used by the claims administrator of SYSCO's medical/surgical benefits. UBH also allegedly imposed a "fail-first" policy under which it refused to reimburse for a particular level of mental health care unless less intensive levels were tried first, and failed.

Olin

Jordan Olin, an employee of Oracle Corp., also has a son who was treated for severe mental illness. UHIC allegedly refused to authorize coverage for "Sean's" residential treatment, based on its determination that he "could be treated safely and effectively at the mental health/dual diagnosis partial hospital level of care."

After Jordan Olin's initial appeal was denied, UHG referred his second-level appeal to an external "independent review organization," but this entity allegedly delayed its review and gave the plan's original decision too much deference.

In Jordan Olin's lawsuit, he alleged that these procedural shortcomings violated plan terms and federal law, and that UHIC violated MHPAEA by applying strict treatment limits like fail-first to mental health claims that it did not apply to medical claims.

Plaintiffs' Legal Theories

Denbo, Smith and Olin alleged that UHG violated its ERISA fiduciary duty by:

- imposing financial requirements and treatment limitations on mental health coverage that violated MHPAEA;
- violating the plans' own terms by improperly reviewing and under-reimbursing mental health claims; and
- failing to provide an appeals process that complies with the Patient Protection and Affordable Care Act.

MHPAEA

The court acknowledged that the conduct alleged by the plaintiffs would violate MHPAEA, but dismissed their claim "because, in its capacity as a claims administrator of self-insured ERISA plans, United is not a party to which the Parity Act applies."

By its terms, MHPAEA applies to a "group health plan (or health insurance coverage offered in connection

See *TPA Escapes*, p. 17

TPA Escapes (continued from p. 16)

with such a plan)," the court noted. "An entity that is processing claims and making coverage determinations that will be paid with someone else's money is not an entity that is 'offering' coverage 'in connection with' that Plan."

Therefore, the court dismissed the claim that UHG breached its fiduciary duty under ERISA Section 404(a)(1) to abide by "the documents and instruments governing the plan."

And while this claim could also be characterized as a claim for violating plan terms under Section 502(a)(1)(B), "any such claim would have to be brought against a proper §502(a)(1)(B) defendant — the Plans, Plan trustees, or their designated §1002(16)(A) Plan Administrators," U.S. District Court Judge McMahon wrote in the court's opinion. "United cannot be sued on such a claim."

Plan Terms

Denbo, Smith and Olin also sued under the plan terms, alleging that UHG had denied them benefits due under their respective plans and breached its fiduciary duty to follow plan terms. Again, however, the court ruled they were "suing the wrong party" because UHG was not an ERISA plan, plan trustee or plan administrator.

While some courts have ruled that third-party claims administrators may be sued for denial of benefits if they actually made the decision, "the larger number of judges on this and other Second Circuit courts adhere to a bright-line rule that only entities that have been formally designated as 'plan administrators'" may be sued, McMahon wrote.

And while other entities may be deemed fiduciaries if they have discretionary authority to administer the plan, as UHG allegedly did, the U.S. Supreme Court in *Varity v. Howe* allowed "appropriate equitable relief" against these other entities only when "adequate relief" is not available elsewhere, the district court stated.

"Courts have consistently rejected claims for equitable relief under §502(a)(3) that would effectively order the provision of benefits, on the grounds that adequate monetary relief is available to plaintiffs under §502(a)(1)(B)," McMahon wrote.

Therefore, these plaintiffs' claims fail because denial-of-benefits claims "against the statutorily-designated defendants would provide adequate relief."

Appeal Process

The PPACA procedural claims also were brought against the wrong defendant, the court determined. The plaintiffs alleged that UHG failed to use independent reviewers in appeals or provide continuing coverage pending their outcome. However, like MHPAEA, the relevant PPACA requirements (29 U.S.C. §1185d) only apply to "group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans," the court indicated.

These appeal rights, "like Parity Act requirements, become implicit terms incorporated into every ERISA plan," which participants can enforce "by suing an appropriate party or parties," McMahon wrote. "As with all §502(a)(1)(B) claims, however, the only appropriate defendants are Plans, Plan trustees, or §1002(16)(A) Plan Administrators."

The court therefore dismissed the claims brought by Denbo, Olin and Smith, as well as the related claims brought by health care providers, and declined to exercise supplemental jurisdiction over their state-law claims.

Implications

McMahon emphasized that the 2nd Circuit has held that only ERISA plans, ERISA plan trustees and ERISA *plan administrators* may be sued under ERISA Section 502(a)(1)(B). The majority of 2nd Circuit judges adhere to a bright-line rule that only entities formally designated as "plan administrators" can be considered proper "administrator" defendants in Section 502(a)(1)(B) actions.

The claims administrators in this case, UnitedHealth Group and its subsidiaries, were not formally named as plan administrators.

So although plan participants may bring breach of fiduciary duty claims under ERISA's "catchall" provision (Section 502(a)(3)) against fiduciaries not formally designated as plan administrators, such claims involving the wrongful denial of benefits will normally be dismissed if they can be adequately remedied under §502(a)(1)(B).

Takeaway: Employers acting as plan administrators will remain on the hook for the benefit determinations made by their claims administrator or TPA when such entities have not been formally designated as a plan administrator. Moreover, even when a claims administrator exercises discretionary authority to qualify as a "fiduciary" under ERISA, employers serving as plan administrators still remain liable for the benefit determinations made by their claims administrators.

Featured Columnist (continued from p. 2)

Access to Data

Health claims data is extremely valuable for plan design purposes, but under traditional insurance arrangements and many self-funded programs with the large insurers, insurers maintain that they own this data and employers cannot get access to it. By contrast, self-insured organizations can have control over this data and can use it to help deliver benefits more efficiently and control costs.

Instituting Prevention and Wellness

As medical costs have skyrocketed, self-insured plan sponsors have been taking steps to reduce them by emphasizing prevention and maintenance care for chronic diseases. Employers have the flexibility to design strategies such as health risk assessments, as well as prevention and wellness programs tailored to the employer's specific employee demographics and needs. However, employers can do even more and I have seen it implemented across the country with effective results. It's a revolutionary approach of less provider network focus and more direct access to specified doctors and facilities.

Across the country, one of the fastest growing trends is direct provider contracts. The Phia Group has two such agreements in our self-funded plan while we still have access to a well-known national provider network. This plan may not work for everyone, but if you care about your claims dollars, you should spend some time analyzing the options.

Here's an example of what The Phia Group is able to do within its own plan. Let's say that one of our employees must have corrective shoulder surgery in the next few months. Unlike a traditional health plan where he chooses a facility from our vast network of hospitals and makes an appointment, he also has the option of using a facility in Oklahoma City that publishes its actual rates for services on its website. Now, why would anyone living in Boston choose to fly to Oklahoma for shoulder surgery? Well, in our plan document, we added a provision stating that if you choose to visit this facility, with which we have a direct agreement, then out of the actual savings the plan gains on the final cost of the entire procedure, the employee will get reimbursed 20 percent. In addition, the employee has no copays.

In our traditional network, if the procedure costs $40,000 after the network discount at a local hospital, the out-of-pocket expense for the employee is $150. The published price in Oklahoma City is $15,000 and based on our plan document terms, there is no out-of-pocket cost to the employee. However, $150 doesn't seem like enough savings for our employee to decide to fly to the Midwest and deal with the hassle. So in our plan, The Phia Group pays for the surgery, the flight for the employee and his family to go to Oklahoma, the hotel accommodations and all meal costs and incidentals. In addition, the employee gets a paid week off to recover from the surgery. After all is said and done, the entire cost is $25,000. The plan has saved $15,000 due to the employee deciding to travel, and the employee ends up receiving a check for $3,000 for doing so. The final savings to the plan is $12,000 and the employee, by having skin in the game, made a decision that will also benefit the plan.

Cost Transparency

If the plan didn't have this option, as most don't, the employee would not have decided to have the surgery far away based on the cost of care since in the employee's mind, the cost is $150 — the copay. Even though the Obama administration has pushed the idea of cost transparency, unless a patient actually has a reason to care about the cost, he or she *won't* care about the cost. We need to incentivize employees to have some skin in the game and this is a great way of doing it. All we had to do was contact the facility and negotiate an agreement, as well as ensure that by doing so we were not violating any of our existing administrative and network contracts.

I would highly recommend that before implementing an idea like this you contact an experienced attorney to assist in drafting the plan document amendments, as well as ensure there are no contractual breaches to existing agreements. Unfortunately, I have seen on too many occasions self-funded plans and their third-party administrators implement innovative programs without first seeing if they violate their existing network or administrative service agreements. For example, I have seen this occur with dialysis facilities with some bad results for the well-meaning self-funded plan. As we all know, good intentions don't always have good outcomes.

Mind Pre-existing Contracts

Typically, a national provider network will have dialysis providers as part of their network of specialists. A self-funded plan will use these providers as needed without any issues. However, after a while the plan, its TPA, or its stop-loss insurer will begin to get upset about the high cost of these dialysis claims. Eventually, somebody wants another solution because costs have begun to pile up. Some plans decide to have dialysis claims paid at Medicare-plus rates and do so by amending their plan documents, but without reviewing or amending the current network contracts. The dialysis vendor expects

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plan member claims to be paid based on the network discount, yet it ends up getting a check from the TPA based on Medicare reimbursement rates. The vendor is unhappy and complains to the network, as it should. While the plan is following its newly updated ERISA plan terms, it is violating the state law contractual provisions of the network agreement as well. Oops. Nothing positive comes out of this.

With that being said, the next plan with the same issue is a little smarter. It decides to contract with a specialized dialysis network to ensure the same thing doesn't happen. Under this new arrangement, the discounts it gets from the dialysis providers are much better than under the original national PPO network it uses. The trouble is that the dialysis vendor is a participating provider of both networks. The national network isn't happy that the plan is undercutting its contract (and its fees) and threatens the plan and the plan's TPA with losing access to all the other providers in the network.

Great, you can access the dialysis providers in the dialysis network, but you have no national network for the typical medical needs of the plan. So, what do you do when you are strong armed? You eliminate the specialized network. Ouch!

While the employer may attempt to directly contract with the dialysis provider, the facility may balk because it knows that it will be paid much more if the claims go through the national network. The best way around this is to proactively work with networks that allow you flexibility with specialty claims, or arrange contracts with dialysis providers or other providers that are not in your network, and therefore would not be in violation of any contract. This is exactly what we can do in our self-funded plan.

Plans Can Do Steerage

The second proactive direct provider agreement we implemented was much closer to home. I met with a local urgent care facility to discuss our plan's options. After much research, it seemed clear to me that urgent care facilities needed to be promoted to my staff. Most people go to the emergency room when they need stitches or have a broken arm. Not only is this more expensive for a self-funded plan, but it also costs the patient a $150 copay and needless hours waiting in the emergency room. Urgent care facilities can treat these injuries quickly with no cost to the employee and at a quarter of the emergency room rate.

Here is a great example of one of our claims. An employee's child needed stitches after getting hurt during a football game. The local hospital charged $3,000 for the service and after the network discount, our plan paid $1,500. The patient paid $150 out of- pocket and spent four hours at the facility. The urgent care facility would have charged $350 and after the network discount, our plan would have paid $300 with no out-of-pocket cost to the employee as stated in our plan document. A simple thing that you should do regardless of whether you have a direct contract with a provider is to waive the copay for all urgent care facilities to incentivize your staff to use them.

Take Prompt Pay to Another Level

We didn't stop there. I realized that the self-pay, no insurance, or cash option at this urgent care center was only $150. So, while my plan was paying $300, if I just walked in there with cash, I would have paid half of that. So why couldn't I just make a deal with the owner of the facility through a direct provider agreement? After a moment of thinking it over, I called the man and took him out to lunch. While he could have received $300 from my plan after submitting the bill to my TPA and waiting at least 30 days for payment, I made a deal to immediately pay his facility $200 for any of my employees who entered his facility. He saved hours of paperwork and received the payment immediately — not 30 days later. The plan saves money and he receives payment sooner. In addition, he receives added steerage from my employees since they know that our plan has a direct contract with his facility. If they are happy with the results from his facility, they will share their goodwill with others.

The question people always ask me is why more companies don't use these arrangements. The answer is that they just don't know they can. Self-funded plans assume that their TPA and/or network have already arranged the best possible deals on their behalf. Unfortunately, this is not usually the case. You know your employees and their needs better than anyone. After reviewing your claims data, you should know which facilities your staff uses, or at least know if there is a location nearby that they typically visit. You can't begin to save serious money for your health plan unless you get creative and start thinking outside of the box.

Not only will your plan save money and offer additional savings to your members, but you will also end up establishing better relationships with your doctors, hospitals and other local providers. By having all the parties in the system working together instead of being adversarial as they are now, we can create a better health care system both for your bottom line and the well-being of our employees. Isn't that what health care reform really should be about?

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, 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 "21:4/2" indicates Vol. 21, No. 4, page 2.

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