Employer's Guide to
Self-Insuring Health Benefits

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Skinny Plans Adhere to the Letter (But Not the Spirit) of Health Reform

An increasing number of employers are examining providing a low-benefits health plan that covers only preventive health services but not high-price major medical claims. Offering this type of low cost or "skinny" plan is allowed under the health reform law. The question is: Will skinny plans trigger a large-employer exodus to *de minimis* coverage, and if so, will the federal government rewrite the reform rules to disallow them? Under health reform, employers with large workforces must offer health insurance to workers. Given that fact, it is possible that many large employers will offer skinny plans, because they feel they have to comply with health reform at the lowest possible cost, according to Contributing Editor Adam Russo, Esq. ***Page 2***

Employer Can Recover Plan Funds From Special Needs Trust

A special needs trust set up by a plan participant's attorney will pay the plan first, in monthly installments, until the plan recovers the entire amount it is owed under the plan's recovery provisions. This is the outcome after the 5th U.S. Circuit Court of Appeals determined that the attorney created the trust with the primary goal of putting the the settlement proceeds out of the plan's reach. The appeals court decision corrects a district court ruling that blocked the employer's claim because it found the participant and attorney were seeking legal, rather than equitable relief. The district court said the participant did not have possession or control of the settlement funds. But the circuit said the participant had fleeting posession of the funds, because he acted to set up the trust from which he would receive monthly payments. ***Page 3***

Wellness Rule: Employers Must Offer Choices Among Health Goals

Rules newly issued by the federal reform agencies say if employers offer to give a reward to workers who accomplish some kind of biometric goal (a contingency standard), then employers must have a standing 'reasonable alternative' to the contingency-based standard. The employee should not need to get a note from his or her physician to opt for the alternative wellness goal. An alternative should be available to anybody for any reason, regardless of the requestor's health status, senior officials said. Also, workers who feel that the employer's contingency-based standard doesn't work for him or her can see a physician to work out a biometric goal that the employee can use to replace the employer's contingency-based standard. Agency officials denied that the requirement could make wellness programs much more complicated for employer sponsors. ***Page 9***

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Skinny Plans: Adhering to the Letter (But Not the Spirit) of Health Reform

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An increasing number of employers are examining a low-benefits health plan that covers only preventive health services but not high-price major medical claims. Offering this type of low-cost or "skinny" plan is allowed under the health reform law. The question is: Will skinny plans trigger a large-employer exodus to *de minimis* coverage, and if so, will the federal government rewrite the reform rules to disallow them?

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For the first time under health reform, employers with large workforces must offer health insurance to workers (even if they earn minimum wage or not much more) or pay a penalty. Large employers can avoid a no-coverage penalty if they offer minimum essential coverage to at least 95 percent of their full-time equivalents and dependent children under age 26.

Given that fact, plus the fact that health services are often unreasonably expensive, it is possible that many large employers will offer skinny plans, because they feel they have to comply with health reform at the lowest possible cost.

Offering a low benefits plan shields larger employers (defined by health reform as those with 50 or more employees) from the reform law's expensive no-coverage penalty ($2,000 per year, times the entire number of workers employed, minus the first 30 full-time equivalents). While such plans may expose such employers to an inadequate- or unaffordable-coverage penalty, that tax is levied only in proportion to the number of workers who actually apply and qualify for, subsidies and get coverage on a health insurance exchange. That triggers a far less expensive penalty for employers.

The prospect of offering "some plan any plan" to employees to avoid the prospect of massive health reform liabilities makes economic sense.

How is this possible? Let's start by looking at the definition of "minimum essential coverage."

Definition of Minimum Essential Coverage

The health reform law generally requires that all individuals and their dependents maintain "minimum essential coverage" each year, as provided by entities that include employer-sponsored health plans.

Employees are free to go to a health insurance exchange if their employer offers them a plan they do not like. Further, they can get a premium subsidy if their employer fails to offer coverage that: (1) is affordable; or (2) provides minimum value. A plan's minimum value is measured with reference to benefits covered by the employer that also are covered in any one of the essential health benefit benchmark plans adopted by a state.

See *CE Column*, p. 14

5th Circuit Confirms Employer Can Recover Plan Funds Despite Special Needs Trust 'Ruse'

In *ACS Recovery Services, Inc. v. Griffin*, 2013 WL 1890258 (5th Cir., May 7, 2013), a plan participant played a shell game with his third-party settlement proceeds by setting up a special needs trust, paying his attorney and splitting the money with his divorced wife to avoid paying back an ERISA health plan.

However, the U.S. 5th Circuit Court of Appeals held his approval of that settlement was sufficient to allow the plan to establish an equitable lien.

The 5th Circuit *en banc* decided that the plan would be compensated from a trust with an annuity set up to pay the beneficiary. The trust fund had to remit each monthly payment to the plan, rather than the beneficiary, until the plan recovered the entire amount it was owed for reimbursement of medical expenses it paid on his behalf.

The ruling further defines remedies ERISA health plans may seek while ensuring that relief sought remains "equitable," and not "legal."

The ability to trace funds belonging to a benefit plan as a result of a third-party settlement is essential for a successful claim for relief under ERISA where holding a plan beneficiary personally liable for money that is not in his possession has been found to be inappropriate. As a result, although the court was careful not to charge the beneficiary or his wife personally with reimbursing the plan, the court was still able to fashion a scenario wherein the plan could be reimbursed in equity from the trust fund where the money had been placed.

The Facts

Larry Griffin was injured in an automobile accident while employed by FK Industries and receiving benefits through its self-funded ERISA health plan. The plan paid more than $50,000 for his health expenses. Griffin and his wife sued the tortfeasor, and ultimately settled the claim with an arrangement under which they would receive "cash and periodic payments with a present value sum" of slightly over $294,000.

The FKI plan provided for "a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation" to repay the medical expenses it paid, and ACS Recovery Services was the plan's benefits-recovery vendor.

However, Griffin's attorney "devised an artful attempt to insulate the settlement proceeds from reimbursement provisions," according to the majority opinion. He even admitted that he structured the settlement "in an effort to legally avoid any equitable lien asserted by [FKI]."

He divided the settlement into amounts to cover his own fee, some additional medical expenses and an amount payable to Griffin's wife under their divorce settlement.

The remainder of the settlement (about $148,000) was used to set up an annuity under a special needs trust, whose trustee was Griffin's brother. The special needs trust would make monthly payments to Griffin from those proceeds of $843.42 for 20 years.

A state court approved the settlement, and the special needs trust was set up, except FKI did not approve it.

ACS and FKI brought a lawsuit against Griffin, his ex-wife, the trust and the trustee seeking "appropriate equitable relief" under ERISA; that is, the establishment of a $50,000 constructive trust to reimburse the plan.

The district court blocked ACS and FKI because it found they were seeking legal, rather than equitable, relief, because neither Griffin nor the trust had possession or control of the settlement funds held by the annuity. The district court also found that the trust had no possession or control over the annuity; Griffin himself had no control over the trust; and the trust could not be liable as Griffin's agent.

See *Special Needs Trust*, p. 4

Special Needs Trust (continued from p. 3)

Appeals Court Weighs In

Following an unfavorable ruling from a 5th Circuit panel, ACS sought *en banc* review. All 5th Circuit judges considered whether the remedy sought by the plan — drawing from the annuity-based trust fund — was in fact a legal or equitable remedy.

The definition of equitable relief was strongly influenced by the U.S. Supreme Court decision in *Great–West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002). In that case, Great-West Life & Annuity Ins. Co. sued its plan beneficiary after a settlement was reached, however, it failed to file a suit against the special needs trust which had possession of the settlement funds. The court noted that to sue the beneficiary under these circumstances would be to attempt to hold them personally liable through a legal remedy, rather than to seek equitable relief as allowed under ERISA. The plan could only bring a claim for equitable relief against the party in possession of the settlement funds. Plaintiff's counsel across the country proceeded to interpret this case to mean that a benefit plan could not recover money if the plan participant was not in possession of funds. As a result of this case, a split in the courts developed in many federal jurisdictions across the country.

Preexisting Duty to Plan Creates Lien

However, in *Bombardier Aerospace v. Ferrer, Poirot & Wansbrough,* 354 F.3d 348 (5th Cir. 2003), the 5th Circuit ruled that the plan's claim could take precedence over an attorney's fee if the beneficiary's obligation to the plan predated its agreement with the law firm and thus precluded him "from contracting away ... that which he did not own himself, namely, the [money] that rightfully belonged to the Plan."

Three years later, *Sereboff v. Mid Atlantic Med. Servs., Inc*., 547 U.S. 356 (2006) further evolved the view of equitable relief, holding that a plan participant is deemed as having controlled assets paid by the tortfeasor in the settlement, even if that control is fleeting; that is, just transferring the proceeds to a special needs trust, or paying fees to an attorney. A similar post-*Sereboff* ruling in *Comm. for WalMart v. Horton,* 513 F.3d 1223, 1226 (11th Cir. 2008), stated:

> Where property is held by one person upon a constructive trust for another, and the former transfers the property to a third person who is not a *bona fide* purchaser, the interest of the beneficiary is not cut off. In such a case, he can maintain a suit in equity to recover the property from the third person, at least if his remedies at law are not adequate

The appeal court held that the funds were in Griffin's "constructive possession and control" despite the firm's claimed contingency fee arrangement because the client, had a pre-existing agreement with the benefit plan, likening the situation to *Wal-Mart Stores H&W Plan v. Shank,* 500 F.3d 834 (8th Cir. 2007).

Because Griffin had a pre-existing agreement with ACS to reimburse the plan in the event of a third-party recovery, the court decided that his signature on the settlement agreement triggered an equitable lien by agreement for ACS. It also said Griffin was in constructive possession and control of the assets when he set up the annuity and completed the settlement, adding that Griffin's attempt to shunt away the settlement did not change his ownership and control.

> Griffin's attempt to divorce himself from the origin of the fund and its disposition is no more persuasive than if he had directed the money to a close relative. But the most important point ... is that he could not give away that which he did not possess.

Griffin's right to receive money from the settlement was subordinate to the plan's lien.

> Both the annuity and its monthly payments to the Trust, which accrue to Larry's benefit, are an identifiable fund to which the Plan's lien attaches. The money belongs "in good conscience" to the Plan to the extent of the costs it incurred.

On the other hand, the court ruled that ACS could not recover anything from Griffin's ex-wife because it was not demonstrated that whatever she received from the settlement was attributable to Griffin's injuries rather than her personal claims arising from the accident. Likewise, the plan could not recover anything from the Hartford annuity because, like Knudson, Griffin had no possession or control of the settlement proceeds. However, because Griffin consented to the disposition of the settlement funds, the Court said that he "had at least constructive possession and control of the fund to facilitate the settlement."

It was important that the plan bring suit against the trust fund as well as the beneficiary. If the plan sued Griffin alone, he would not be in possession of the proceeds; that was the case in *Knudson*, and the recovery was blocked for being legal relief. The trust is what holds proceeds traceable to the settlement.

> Larry Griffin's Trust could have been funded by an annuity reduced to satisfy his reimbursement obligation to the Plan. He and his attorneys chose instead to disregard the Plan's equitable lien by agreement, as they attempted to divorce Larry and the Trust from possession and control

See *Special Needs Trust*, p. 8

TPA Hid Improper Fees in Spite of Plan Due Diligence; Must Repay $5M

In *Hi-Lex Controls Inc. v. Blue Cross Blue Shield of Michigan* Case No: 11-12557 (E.D. Mich., May 23, 2012), a federal district court ruled that a third-party administrator's scheme to charge improper administrative fees — for nearly 15 years — was so well-hidden that a self-funded plan sponsor had done due diligence when it performed audits and other methods to uncover the problem even though it failed to do so for several years.

Therefore, the court rejected TPA arguments that ERISA self-dealing and fiduciary breach claims were subject to a three-year statute of limitations period, which would have reduced the $5 million of improper fees the TPA had to repay.

The court reviewed the TPA's long pattern of misleading statements about the fees and concluded that such fraud and concealment necessitated a six-year limitations period. Thus, the TPA was obligated to repay the $5 million along with interest and attorney's fees.

Facts of the Case

BCBSM began charging network access fees after 1987 when the organization was under financial duress. It initially called the surcharges "plan-wide," "other-than-group" and "retiree" subsidies, and they were out there for everyone to see. Problem was, self-insured plans rejected the fees. Efforts to explain them fell on deaf ears, and plans either refused to pay them or cancelled doing business with BCBSM, costing the payer hundreds of thousands of covered lives in 1989.

In 1993, BCBSM responded by tacking the surcharges onto hospital bills. They were not itemized, and the company changed its disclosure language, vaguely alluding to "certain charges … for provider network access" being included in hospital charges.

BCBSM became Hi-Lex's TPA in 1991. From 1994 until 2011, the hidden fees were undetected by Hi-Lex Controls' self-insured plan. BCBSM's claims reports, quarterly and annual statements, renewal documents and Forms 5500 made its administration fees appear lower than they actually were while making claims paid to providers seem higher.

The hidden network access fees made BCBSM seem more economical than competing TPAs, because the other TPAs portrayed the fees separately.

Note: "Access fees" are not uncommon in the industry because many third-party claims administrators lack their own network; they lease one that causes them to incur access fees. BCBSM, however, owns its own network, and BCBSM was thus presumed not to have such fees, brokers later testified.

Court Rules BCBSM Violated ERISA

After ultimately determining that BCBSM was charging hidden fees, Hi-Lex sued BCBSM for breach of fiduciary duty and self-dealing under ERISA.

On Sept. 7, 2012, the U.S. District Court for the Eastern District of Michigan found that BCBSM was an ERISA fiduciary; and the plan could avail itself of relief under ERISA, ruling in *Burroughs Corp. v. Blue Cross Blue Shield of Michigan,* 2012 WL 3887438 (E.D. Mich., Sept. 7, 2012).

The district court observed that ERISA defines a fiduciary in functional terms of control and authority. For example, in *Briscoe v. Fine*, 2006 WL 947189 (2006), the 6th Circuit concluded that a TPA was a fiduciary because it had the power to write checks.

Similarly, the court held that BCBSM violated ERISA when it engaged in the prohibited transaction of self-dealing (unilaterally determining its own fees and acting to collect them).

The case proceeded to determine damages for the self-dealing violation, and to address the merits of the fiduciary breach claim. BCBSM had raised a statute of limitations defense that could affect the amount it would need to refund Hi-Lex. The plan would be entitled to less if it knew or should have known about the fees earlier than it contended. To do this, the court looked at how BCBSM responded when Hi-Lex asked about the fees.

Full Payback Required

In the current case, regarding the damages to be assessed for self-dealing, the disputed fees charged by BCBSM to the plan from 2002 until 2011 were found to be more than $4 million. BCBSM had no records for amounts it took between 1994 and 2001. The court accepted Hi-Lex's estimate of damages for the period from 1994 until 2001 to be more than $1 million. The court ruled that Hi-Lex was entitled to recover all the hidden access fees charged between 1994 and 2011, for a grand total of $5,111,431, with additional payment for interest.

The court also found three ways in which BCBSM violated fiduciary duties: (1) failing to disclose informa-

See *Improper Fees,* p. 6

Improper Fees (continued from p. 5)

tion about its compensation — it should have proactively explained the disputed fees even without a specific request for information from the plan; (2) supplying false and misleading information about the fees and as such about its administration of the plan; and (3) supplying false information on Form 5500s.

Limitation Period

ERISA's statute of limitations applies: (1) six years after the date of the last violation or breach, or (2) three years after the plaintiff first knew of it. In cases involving fraud and concealment, the limit becomes six years after the plaintiff first knew of it.

BCBSM claimed the plan knew or should have known about the fees in 1994 (when the BCBSM account manager spoke to the Hi-Lex CFO) and if not then, in 2003 (when Marsh got ambiguous answers about the fees from the claims administrator). Under that, the six-year limit would have expired in or before 2009.

The plan argued that it did not know about the disputed fees until 2007. Hi-Lex executives persistently asked about them, but never knew their true nature because they were listed as hospital charges and not as TPA administrative fees.

Court Considers Responses to Questions About Fees

BCBSM contended that the way it disclosed the fees put the Hi-Lex plan on a sufficient level of notice. The court disagreed, saying instead that BCBSM reports and disclosures about the fees were consistently misleading until 2007. The payer intentionally downplayed the fees and avoided explaining them to Hi-Lex on several occasions.

1) BCBSM repeatedly assured brokers that 100 percent of its discounts were passed on to plans. It said that its administrative fee was "all-inclusive," meaning, network access fees were not being billed separately.
2) Internal emails indicated that decision-makers at BCBSM knew the fees were controversial, and intentionally kept them secret.
3) Around 2000, a BCBSM competitor started telling brokers there were hidden fees in its plans. That prompted one broker to call a meeting with BCBSM sales manager Steve Hartnett. Hartnett denied the fees were being added to hospital charges, and told the broker (who testified to the court) that 100 percent of hospital discounts were returned to clients.
4) Around 2003, Hi-Lex's auditor Marsh asked BCBSM about hospital charges in Schedule A documents and the TPA did not reply. Later, Marsh expressly asked whether BCBSM charged network access fees. BCBSM answered "N/A." Hi-Lex and Marsh reasonably took this as a denial that access fees were charged.
5) In 2004, a major client (Grand Rapids, Mich.) insisted to know about the fees and the company obliged, but it did not include the disclosure for any other clients.
6) Emails indicated that in 2004, an internal debate arose over transparency of the fees, with a few executives in favor of explaining them honestly. Senior management, however, decided to keep them a secret, and developed communication strategies that downplayed the access fees and hid how much they really were.
7) In 2007, BCBSM analyzed which of its customers would be surprised to learn that TPA fees were in-

See *Improper Fees*, p. 7

Improper Fees (continued from p. 6)

cluded in their hospital charges. It found that Hi-Lex, most brokers and most of its clients, did not know about the fees.

The court agreed that BCBSM intentionally misrepresented to Hi-Lex that it charged no hidden access fees, because:

1) No one could tell from the monthly claims reports, quarterly reports, annual settlements and Form 5500 certifications that BCBSM kept part of the money reported as hospital claims, the court held.
2) A BCBSM account manager testified that he told Hi-Lex CFO Tony Schultz in 1994 about the fees, but the court pointed to inconsistencies that made that testimony unbelievable.
3) *The fees were kept a secret even from BCBSM's own employees*. An account manager testified she did not understand anything about the disputed fees. If BCBSM's trained account managers did not understand the contracts, then Hi-Lex could not be expected to proactively figure them out, it ruled.

Plan Exhibits Due Diligence

The court ruled that a hypothetically diligent company would not have discovered the improper fees before 2007.

- None of the six brokers (each with years of experience dealing with BCBSM) who testified understood the fees until around 2007 or 2008.
- Form 5500 Schedule A's and administrative service contracts were intentionally misleading, hid the fees and stifled inquiries into their true nature.
- Hi-Lex did not have a broker who might have advised them about BCBSM's hidden fees.

According to the court, the so-called disclosures made in 1994 did not give Hi-Lex actual knowledge of the disputed fees; nor did the audit and information requests by Marsh in 2003. Additionally, contracts, renewal packages and years of Forms 5500 Schedule A consistently failed to unambiguously disclose the fees.

Accordingly, the court held that Hi-Lex lacked actual knowledge of the breach or violation until Aug. 21, 2007, when the payer finally presented its Value of Blue chart. That included a pie chart portraying the extra fees as a percentage of hospital charges. It was presented first in August 2007 and it portrayed the exact amount of the disputed fee for 2006. But the chart did not admit the existence of, or present amounts for, the disputed fees that were charged from 1994 through 2005.

Court Sees Fraud and Concealment

The fraud/concealment rule applied and allowed the plan to recover the entire amount of damages from the self-dealing claim along with interest.

> The court agreed that BCBSM deliberately misrepresented that it charged no hidden fees partly because internal emails showed BCBSM executives were concealing the true nature of the fees.

The court said the evidence presented by the health plan proved that BCBSM actively concealed their knowing misrepresentations and omissions in the contract documents in order to allay the plan's suspicion and prevent inquiry into the fees.

Finally, the court ruled that the payer failed to reasonably argue that Marsh should have figured out the fees based on its answers to Marsh's 2003 inquiries.

> BCBSM violated ERISA's prohibition against self-dealing and also breached its fiduciary duties. It also engaged in fraud and concealment to hide its violations from Plaintiffs. BCBSM exhibited bad faith that precludes imputation for the purpose of its statute of limitations defense or otherwise.

The company would have to pay an amount (to be determined) for the plan's attorney's fees, too.

Implications

This case highlights the importance of clear and open communication, as well as the notion that courts will punish TPAs and advisers that fail to effectively advise a health plan client of its rights and obligations under administrative services agreements (executed between the parties) and under plan terms.

While certainly not on par with the seemingly intentional nature of the situation above, benefit plan advisers routinely fail to: (1) adequately explain certain aspects of the plan to the plan sponsor; or (2) adequately define the roles and responsibilities of all in the relationship. They thereby become liable for breach of fiduciary duty under ERISA. Advisers must be cautious to provide clear communications and disclosures to avoid breaching their fiduciary duty.

Special Needs Trust (continued from p. 4)

of the settlement funds. Against this ruse, ACS asserts an equitable claim for restitution and seeks the equitable remedy of a constructive trust over the proceeds of the settlement fund as they come into the Trust's possession. As we have explained, this claim is well supported in law

Accordingly, the court remanded the case back to the district court so that it could impose equitable relief upon the special needs trust through its trustee; that is, to order the trustee (Griffin's brother) to pay the monthly proceeds from the annuity to the plan for about five years until the plan was fully reimbursed for the benefits it paid.

A majority ruled the trust had to remit each monthly payment to the plan. Since the plan paid benefits of about $50,000 and the special needs trust would receive monthly payments of about $843, it would take about 60 months to reimburse ACS and FKI. None of the individual parties to the lawsuit had any liability to the plan.

The Dissent

Four dissenting judges concluded in one opinion that none of the defendants in this case had possession or control of the settlement, and so none of them could have been subject to the order of the court to turn those proceeds over to the plan.

They said that Congress did not provide ERISA plans with a "first money" right to funds recovered by a plan participant from a third party. They explained that a "first money" right is a doctrine in many states that provides a statutory first right to any funds recovered by beneficiaries from third-party tortfeasors, but that such a "first money" right was not adopted by Congress for use in ERISA cases.

Suing special needs trusts and their trustees, even though Griffin's may have been set up not in good faith, the dissent warned, could have unintended consequences.

Finally, the majority opinion fails to account for a significant aspect of this case. The need to give effect to Section 502(a)(3)'s provision of equitable relief for ERISA plans must be balanced with the need to give effect to the protections afforded to special needs trusts by Congress and the states. This is not a case in which the plan seeks to recover from only the beneficiary (see *Knudson*), a lawyer's IOLTA account (see *Longaberger v. Colt*), a state court's registry (see *Bauhaus)*, a court-sanctioned investment account (see *Sereboff*). Instead, the Appellants seek to recover, *inter alia*, against a special category of trusts — special needs trusts. Permitting such recovery requires disregarding the special nature of these trusts, which the majority opinion does not consider apart from a short discussion at the end of the opinion. Giving special needs trusts appropriate consideration, however, leads to the inescapable conclusion that we must respect the protections afforded to them by Congress and the states.

Implications

This case serves as one of the first cases heard since the U.S. Supreme Court ruling in *US Airways v. McCutchen*, 133 S. Ct. 1537 (2013), which directly challenges a health plan's right to equitable relief under ERISA.

On the other hand, it serves as confirmation that an ERISA plan with the right language that takes the appropriate legal action can recover funds it pays for injuries caused by a third party. But although the language here was not at issue, it is interesting to note that four dissenting judges still argued against a benefit plan's recovery, despite the Supreme Court's seeming slant in favor of health plan recovery.

In addition to courts interpreting the exact language that will be considered sufficient to ensure a self-funded plan is reimbursed under ERISA, arguments focusing on congressional intent likely will become more prevalent in an effort to strip away plan rights. Health plans must be diligent when drafting their reimbursement language and follow case precedent to ensure that procedures are followed correctly to obtain a successful recovery.

Final Wellness Rule: Employers Must Offer Choices Among Health Goals, If Rewards Are Offered

At a background media call, senior administration officials from the U.S. Departments of Treasury, Labor and Health and Human Services said their agencies had new rules for contingency-based wellness program goals in final wellness rules under health reform on May 29.

If employers offer to give a reward (such as discounted health insurance premiums) to workers who accomplish some kind of biometric goal (a contingency standard), then employers must have a standing 'reasonable alternative' to the contingency-based standard.

"Standing" implies, among other things, that the employee should not need to get a note from his or her physician to be excused from the employer's contingency-based wellness goal: at least one alternative should be available to anybody for any reason, regardless of the requestor's health status, a senior official from the DOL's Employee Benefits Security Administration said.

Note from Physician Can Set Wellness Goal

Secondly, the final rule then states that a worker who feels that the employer's contingency-based standard doesn't work for him or her, can see a physician to work out a biometric goal that the employee can use to replace the employer's contingency-based standard.

Employers with contingency-based incentive programs will have to provide notice of their right to an alternative standard for gaining the employer's reward; but the notice also has to inform workers of their right to get a second opinion for an alternative standard that the employer will adopt if possible.

The officials said the rule was not going to force undue changes on wellness programs, in spite of the new requirements on reasonable alternatives and physician recommendations.

The officials said their agencies decided against requiring wellness standards be evidence-based (which would have been an extra burden on wellness program sponsors), opting instead to give employers the flexibility of setting wellness goals, against a "reasonableness" standard.

Rules Include 30-percent Incentive Limit

Financial wellness incentives of up to 30 percent of coverage costs will be permitted as of Jan. 1, 2014, for calendar-year plans, under final rules issued May 29 that apply the health reform law's changes to HIPAA's wellness program rules.

Like the HIPAA rules' previous 20-percent limit, the 30-percent threshold (50 percent for tobacco cessation) applies only to "health-contingent wellness programs" that require individuals to meet a specific health-based standard. Like the version proposed in November 2012, the final rules largely retain the HIPAA nondiscrimination framework for evaluating wellness incentives, but with a few new wrinkles.

Wellness programs that are merely "participatory" remain exempt from most of these requirements. Such programs include not only reimbursements for gym memberships and health classes but also rewards for completing a health risk assessment, if no further action is required, under the final rules published on June 3 in the *Federal Register* [78 Fed. Reg. 33157]. Both health-contingent and participatory wellness programs must be made available to all similarly situated individuals.

"The intention of the Departments in these final regulations is that, regardless of the type of wellness program, every individual participating in the program should be able to receive the full amount of any reward or incentive, regardless of any health factor," according to the preamble. "The reorganized requirements of the final regulations explain how a plan or issuer is required to provide such an opportunity for each category of wellness program."

The final rules take effect in plan or policy years beginning in 2014, for grandfathered and non-grandfathered coverage alike. DOL, HHS and Treasury restructured the rules from the November 2012 proposed version to address what they called "some degree of confusion regarding the HIPAA and Affordable Act rules governing wellness programs."

Specifically, the rules do not apply to "all types of programs or technology platforms offered by an employer, health plan, or health insurance issuer that could be labeled a wellness program, disease management program, case management program, or similar term," according to the preamble. Instead, like the wellness provisions of HIPAA's 2006 nondiscrimination rules, the new rules explain how to qualify for an exemption from HIPAA's general prohibition on health-based discrimination.

New Requirements for 'Outcome-based' Programs

The Patient Protection and Affordable Care Act codified HIPAA's wellness rules into statute, largely without change, including the five major requirements that health-contingent wellness programs must meet. The new final rules further subdivide health-contingent programs into "activity-only" and "outcome-based," and

See *Wellness Rule,* p. 10

New Reform Rules Explain Monitoring Of Exchanges, Adjust Employer Plan Provisions

How health insurance exchange money is spent, which private insurance products may be offered on exchanges, who advises exchange consumers on plan choices and how well exchanges handle personal data will be under federal scrutiny, as explained in proposed program integrity rules issued by the U.S. Department of Health and Human Services June 19. The rules also propose tweaks to existing regulatory language to better address certain employer plan designs and to reconcile some definitional inconsistencies affecting employer plans.

The proposed rules determine how federal government agencies will oversee the integrity of state, federal and mixed health insurance exchanges and premium stabilization programs under health reform.

Wellness Rule (continued from p. 9)

require outcome-based programs to offer a reasonable alternative to a broader set of individuals than is required for activity-only programs:

1) *Activity-only wellness programs.* A reasonable alternative standard for obtaining the reward must be provided to any individual for whom it is unreasonably difficult or medically inadvisable to meet the otherwise applicable standard. (This is similar to the existing HIPAA rules.)

2) *Outcome-based wellness programs*. A reasonable alternative must be offered to *all* individuals who do not meet the initial numerical standard (that is, a medical excuse is no longer needed).

"This approach is intended to ensure that outcome-based programs are more than mere rewards in return for results in biometric screenings or responses to [an HRA], and are instead part of a larger wellness program designed to promote health and prevent disease," DOL, HHS and Treasury indicated in the final preamble.

This expansion of the reasonable alternative requirement is meant to be same as proposed in November 2012, but the agencies sought to clarify the terminology. "The requirements that the alternative be reasonable taking into account an individual's medical condition, and the option of waiving the initial standard, remain the same," according to the preamble.

The officials stressed that final rule, issuing from the health reform statutes of 2010, are in no way a safe harbor for nondiscrimination rules being enforced by other agencies, such as the EEOC, which continues to impose uncertainty on wellness programs incentives and rewards.

The rules include: (1) oversight and financial integrity standards; (2) proposals on insurer participation in individual exchanges and small business health option programs; (3) new standards on guaranteed availability and renewability, among other things (see bullet list below).

Enforcement Priorities

Starting Oct. 1, 2013, qualified individuals and qualified employers can buy health coverage through exchanges or marketplaces. Coverage starts as soon as Jan. 1, 2014, and states must certify that such coverage meets certain standards.

An exchange may be run: (1) by a state alone; (2) by a state in partnership with the federal government; or (3) by the federal government alone (in cases where states refuse to set up an exchange).

The feds expect individual-market exchanges to have separate design, structure and governance from SHOP exchanges, where small businesses can buy coverage for their workforces. But states have the option of merging the two together, and the proposed rules would set parameters for doing that.

The rules encourage flexibility of program integrity measures when a state is running an exchange or a SHOP program. The rules are more prescriptive when state exchanges are in partnership with the feds and when exchanges are run by the federal agencies.

The rules propose exchanges to do the following:

- **Set up an enrollee satisfaction survey system**.
- **Charge insurers user fees** in order that exchanges remain self-sustaining. (**Note:** User fees must be administered properly and not wasted.)
- **Certify insurance products** as qualified health plans. (The decision whether coverage is a QHP must be based on the interest of consumers.)
- **Certify brokers** as being able to sell and give advice on coverage for sale on exchanges, and to help consumers get tax credits and cost-sharing reductions.
- **Set up transitional reinsurance and risk-corridor programs.**
- **Ensure the privacy of data**, and ensuring that data is used only for exchange enrollment, eligibility

See *Program Integrity*, p. 11

Program Integrity (continued from p. 10)

> determinations, efficient operations, and applications for tax-credits and cost-sharing reductions.

HHS is authorized to oversee the financial integrity, compliance, efficiency and non-discriminatory administration of state exchanges. HHS may levy fines on states to enforce its exchange-integrity rules.

Small Employer Definitions

The proposed rules would apply a slightly modified definition of "small employer," which needs to be imposed because it contradicts other federal definitions that define a small employer as having at least two employees. Under the proposal, small employer would be defined as a company with just one employee.

The definition would expand the number of businesses eligible for small-business coverage sold on a SHOP exchange and would reduce the number of individuals having to buy policies on the larger health insurance marketplaces, in order to satisfy reform's "individual mandate."

Large Employer Definitions

The rules also implement the statutory directive that until Jan. 1, 2016, states have the option of defining "large employers" as 50 employees or greater, not 100 or greater, which is the default listed in the statute. That also would determine the upper end of "small employer."

> Small employer means, in connection with a group health plan …, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before Jan. 1, 2016, a State may elect to define small employer by substituting "50 employees" for "100 employees.

This matters because small-employer policies, such as the ones purchased on the SHOP exchanges, must provide all essential health benefits. Large employer sponsors of group health plans need provide only the EHBs they choose (even though if they cover any EHB category, they may not apply annual or lifetime limits to it.)

> **Note:** The definition of "large employer," that must offer coverage in order to avoid a "no-coverage" penalty, is 50 employees.

In states that close off the SHOP to employers with 51 or more workers, employers with 50 to 100 workers will be more apt to sponsor their own plans with minimum benefits (so-called "skinny plans").

Partially Insured Self-funded Plans Would Pay Fees if They Fund Medical Benefit

One of the functions of the exchanges is to administer reinsurance and risk adjustment programs, which includes collecting funds from contributing entities (including insurers and self-insured group health plans). The proposed rules would clarify whether an exchange collects reinsurance payments from self-insured plans that are partially insured; that is, they self-fund one benefit (say, medical) and buy an insured policy to cover prescription drugs.

Under the proposed rules, if a group health plan self-insures the medical benefit, the plan would be liable for reinsurance contributions; and the insurer for the drug plan wouldn't be. If it is the other way around; that is, if the partially insured plan has an insurer covering its medical benefit but self-funds a drug benefit, then the insurer for the medical benefit would have to pay the fees.

10-year Record Retention Requirement For States, QHP insurers

On a related note, under the proposed rules, states would have to retain records relating to their reinsurance programs for 10 years, and make them available on request to HHS, its Office of Inspector General or its program integrity contractors. The level of detail would have to be sufficient to demonstrate compliance with federal standards.

They would have to keep records of all: (1) funding received from HHS; (2) payments received from insurers of reinsurance-eligible plans; (3) all reinsurance payments made to insurers of reinsurance-eligible plans; and (4) all administrative expenses incurred for the reinsurance program. They also would be required to self-audit and submit the results to the federal agencies.

A similar 10-year recordkeeping requirement would be in place for risk adjustment programs run by states.

States also would have to ensure that their contractors, subcontractors and agents follow similar standards for maintaining relevant documents and records and making them available.

QHP insurers in the individual market on a state exchange would have to follow the 10-year record retention requirement as those records pertain to cost-sharing reductions and advance payments of the premium tax credit.

For more information on state-based health insurance exchanges, see Section 810 of the *New Health Care Reform Law: What Employers Need to Know*.

SHOP Insurers Can Offer One Choice Of Coverage in 2014, Final Rules Confirm

A health reform requirement that all insurers offer four levels of health coverage to small businesses will be delayed until 2015. Under a final rule from the U.S. Department of Health and Human Services that is published in the June 4 *Federal Register* [78 Fed. Reg. 33233], many small employers will get one choice of health coverage in 2014.

The rule also states that if a prominent seller of small-group coverage fails to offer policies on the Small Business Health Options Program, it will lose the opportunity to sell on the mainstream health insurance exchanges.

Finally, it reduces the special enrollment period from 60 days to 30 days after a qualifying event to align health reform's special enrollment rules with HIPAA.

Background

Starting in 2014, small businesses with up to 100 employees will have access to state-based health insurance exchanges (also known as marketplaces). The levels of coverage are connected to actuarial value: bronze (60 percent), silver (70 percent), gold (80 percent) and platinum (90 percent). Facilitating employee choice at a single level of coverage selected by the employer — bronze, silver, gold or platinum — is a required SHOP function.

HHS said that delaying that requirement until 2015 would provide stability to the small-group insurance market as insurers gain their footing in SHOP marketplace, the agency said in the rule.

Employers with plan years starting before Jan. 1, 2015, may have just one choice of coverage, but starting Jan. 1, 2015, insurers will have to start offering all four coverage options on the SHOP.

The final rule incorporated comments received on, and finalizes guidance from, these proposed rules:

- a March 27, 2012, proposed rule (77 Fed. Reg 18310);
- CMS's March 11, 2013 rule on Notice of Benefit and Payment Parameters (78 Fed. Reg 15410); and
- a separate March 11, 2013 proposed rule on qualified health plans and exchanges (78 Fed Reg 15553).

The final rule also requires that if an insurer offers coverage on the main exchange for individuals, but also has 20 percent or greater share of that state's small group market, it must offer gold and silver coverage on the SHOP exchange.

Insurers that do not offer small group market products in a state will not have to offer the required SHOP coverage as a condition for selling on the larger exchange.

Harmonizing with HIPAA

The agency finalizes another provision from the proposed rule. Namely, the special enrollment period for the SHOP will be set at 30 days for most applicable triggering events, so that it aligns with the special enrollment periods for the group market established by HIPAA.

Also, if an employee or dependent becomes eligible for premium assistance under Medicaid or the Children's Health Insurance Program or loses eligibility for Medicaid or CHIP, these are now triggering events, and the employee or dependent would have a 60-day special enrollment period to select a qualified health plan.

Availability of SHOP coverage is limited by statute to employers with 100 or fewer employees. In 2016, states will have the option to reduce this threshold to 50.

For more information on emerging health reform rules, see *The New Health Care Reform Law: What Employers Need to Know* and Section 150 of the *Guide.*

EEOC Urged to Align Wellness Standards With HIPAA and Health Reform Rules

The U.S. Equal Employment Opportunity Commission's failure thus far to issue clear guidance on permissible wellness incentives threatens to undermine employers' development of wellness programs at a time when their importance is growing, business groups warned the EEOC at a May 8 hearing.

"We urge you to recognize the comprehensive regulatory framework that already exists" under HIPAA's nondiscrimination rules, as amended by the Patient Protection and Affordable Care Act, Tami Simon of Buck Consultants told the EEOC. Otherwise, wellness programs' uncertain status under the Americans with Disabilities Act will discourage the implementation of programs that are clearly beneficial and would meet the detailed HIPAA and PPACA standards, she said.

EEOC members acknowledged the need for additional guidance on wellness incentives, but no such clarification seems imminent. "It is the commission's duty to let the regulated community and all stakeholders know what our positions are," said Commissioner Victoria Lipnic. "We haven't given that kind of certainty." This meeting was called to gather input so the EEOC can craft such guidance, she said.

A majority of employers now offer some sort of wellness program: 94 percent of employers with over 200 workers, and 63 percent of smaller ones, according to Karen Pollitz of the Kaiser Family Foundation, which researches issues relating to health care. Many of these programs offer some sort of financial incentive for participation, which can range from gift cards to higher employer contributions for insurance premiums, or penalties like additional surcharges to employees for health insurance.

What's Voluntary?

The most common intersection of these programs and the laws the EEOC enforces occurs when the programs require medical exams or ask disability-related questions, both of which would ordinarily violate the ADA, said Christopher Kuczynski, EEOC acting associate legal counsel. While the ADA allows employers to ask for medical information in connection with voluntary wellness programs, the meaning of "voluntary" remains fuzzy, he explained.

The EEOC has declined to specify whether and how great a financial incentive would render a program involuntary. Meanwhile, the three HIPAA agencies have forged ahead with detailed numerical thresholds and procedural safeguards against health-based discrimination (see ¶150 of the *Guide*).

In PPACA, Congress ratified and actually loosened the HIPAA standards for wellness programs, said Amy Moore, an attorney with Covington & Burling, on behalf of the ERISA Industry Committee.

EEOC members acknowledged the need for more guidance on wellness incentives, but no such clarification seems imminent. The meeting was convened to gather input EEOC could use to craft such guidance.

"Since Congress has determined that an incentive up to 30 percent of the annual cost of coverage does not prevent a wellness program from being voluntary for purposes of HIPAA, the commission should acknowledge that the same incentive does not prevent a wellness program from being voluntary for purposes of the ADA," Moore argued. "The Commission should also confirm that an incentive is permissible under the ADA regardless of whether it is presented as a reward or as a penalty."

However, representatives of consumer groups, while agreeing on the need for more clarity, argued that the ADA's "voluntariness" standard safeguards certain rights distinct from those contemplated by HIPAA or PPACA.

Programs that "penalize people with disabilities for not being as 'well' as others … make it even more difficult for individuals with disabilities to obtain employment on fair and equal terms," said Jennifer Mathis on behalf of the Consortium for Citizens with Disabilities. And an incentive that falls within the HIPAA/PPACA thresholds can still end up penalizing an employee thousands of dollars a year for refusing to disclose information that the ADA entitles him or her to keep private, she said.

For More Information

Details on the May 8 meeting, including copies of written testimony, are available on the EEOC's website at http://www.eeoc.gov/eeoc/meetings/5-8-13/index.cfm.

CE Column (continued from p. 2)

(**Note:** If employees buy coverage through an exchange they lose their employers' contribution. And if they do so, they will pay for that coverage with after-tax dollars.)

An employer-sponsored welfare benefit plan is defined under ERISA (29 U.S.C. 1002) as "any plan, fund, or program … established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise." This includes medical, surgical or hospital care benefits.

A skinny plan would be considered a plan, fund, or program established and maintained by an employer for ERISA purposes (and similarly for purposes of the Public Health Services Act). As such, it also would be considered an employer-sponsored health plan under reform.

Accordingly, an individual employee and their dependents covered under this type of arrangement would satisfy the individual mandate requirement and would not have to pay a penalty for the year.

The reality is that many workers, especially the young and healthy ones, would accept this type of "minimum essential coverage." They probably would stick with the skinny plans until they actually get sick and need real care. If large numbers of employees are enrolled in skinny health plans, reform will have produced an unanticipated outcome.

Who Would Buy These Skinny Plans?

Skinny plans could become an option for restaurant and retail chains that are too big to fit in any small employer category. Employers that up until now have offered no coverage also might like skinny plans.

Young and healthy workers may find the bare bones option more attractive from a financial standpoint. A typical waiter at a chain restaurant probably fits the mold of an employee who wouldn't think he or she needs more health coverage.

For example, Dallas-based Tex-Mex restaurant chain El Fenix says that it will offer limited insurance coverage to its 1,200 workers — covering prescription drugs, preventive care and physician visits —in order to avoid the no-coverage mandate, *Forbes* reported.

An article in the May 20, 2013, *Wall Street Journal* reported that:

> San Antonio-based Bill Miller Bar-B-Q, a 4,200-worker chain, will replace its own mini-med with a new, skinny plan in July. … The new plan will have no dollar limits on benefits, but will cover only preventive services, six annual doctors' visits and generic drugs. X-rays and tests at a local urgent care chain will also be covered. It wouldn't cover surgeries or hospital stays.
>
> Because the coverage is limited, workers who need richer benefits can still go to the exchanges, where plans would likely be cheaper than a more robust plan Bill Miller has historically offered…. The chain plans to pay the $3,000 penalty for each worker who gets an exchange-plan subsidy.

What About Attracting the Best and Brightest?

Few employers now offering full self-funded benefits to their employees would take the opportunity to switch to skinny plans. That's because businesses trying to attract and retain high skill employees for long-term positions have an economic incentive to offer generous and attractive health insurance.

That's what most already do. Otherwise, they would lose good employees to competitors. But the kind of businesses mentioned in the aforementioned articles — restaurants, retailers, assisted-living chains — tend to employ low-skill workers who typically work temporarily and are offered no health benefits. These skinny plans may very well be better than what they currently receive. In a high unemployment economy, they do not have to offer great health insurance to get the workforce they need.

It's Cheaper to Pay the Unaffordable-coverage Penalty

The skinny plan would shield not only the individual workers from penalties but also the employer. As noted above, skinny plans can trigger unaffordable-coverage or inadequate-coverage penalties if a full-time employee applies for and receives a premium subsidy to get exchange coverage.

Under the inadequate/unaffordable-coverage rules, if coverage is unaffordable or does not provide minimum value, the employer will be subject to a $3,000 penalty tax for every full-time employee who purchases an individual market health plan through an exchange and accesses a premium subsidy for health insurance.

Offering skinny plans under this scenario is still far cheaper than failing the no-coverage test and paying a penalty for every member of the workforce (less the first 30).

Skinny plans may cost an employer only $40 to $100 a month per employee, much less than the $167 per month-per employee penalty for providing no insurance.

See *CE Column*, p. 15

CE Column (continued from p. 14)

Please keep in mind that this strategy is very uncertain. Eventually, skinny plans may not pass muster if the government rewrites the definition of minimum essential coverage to eliminate them. But currently, nothing prohibits employers from using such plans.

Not So Great for Workers and Consumers

The real question that must be posed is whether this really is health insurance? In my opinion it's not.

Instead it is a payment plan for small maintenance care. Insurance is needed to protect people from expensive needs that befall the unlucky insured party. Skinny plans don't provide that because they exclude surgeries, hospitalizations, mental health, maternity care and the like, from coverage. That means such insurance policies are not a very good option for employees who might actually get sick.

This also means health reform is actually encouraging large companies to drop true insurance in favor of maintenance plans. That seems at odds with the government's intent for employers to continue to sponsor full health benefits, and to prevent consumers from being stuck with catastrophic bills that force them to declare bankruptcy.

Skinny plans do nothing to solve the dilemma of lowering health inflation so health care is more affordable and more accessible. This cannot be what President Obama envisioned when it came to reform. However, because the reform law was passed by Congress so quickly, seemingly without anyone parsing through the fine print of the bill, I predict we will continue to have more and more loopholes.

Undesired Outcome: Premium Hikes on Exchanges

Widespread adoption of skinny plans may have dire implications for reform. Workers who had hoped for employer-sponsored insurance may find themselves having to choose between anorexic employer coverage and a pricey plan on a health insurance exchange.

Low-income hourly workers who health reform was supposed to help would be disproportionately affected. For the sector of the economy that employs such workers — which has employers with an economic incentive to save money wherever possible — these skinny plans may become the new normal.

Skinny health coverage does not mean workers get healthy. It means that their health insurance leaves them holding the tab if they get really sick. The problem of people going bankrupt due to high-priced hospital care will not be resolved.

To the extent reform pushes firms to offer *de minimis* plans, premiums for plans offered through exchanges will rise. The healthiest workers will enroll in their employers' skinny plans, but workers or dependents who have expensive illnesses will seek more comprehensive coverage through the exchanges. This influx of sick consumers will increase premiums for the exchanges.

[**Note:** Employers are also renewing their health benefits contracts before Jan. 1, 2014, which allows them to avoid many of reform's regulatory costs for several months. Major insurers, including UnitedHealth Group, Aetna and Humana are offering small companies a chance to renew year-long contracts toward the end of 2013. Early renewals of plans could yield significant savings because plans typically do not need to comply with many reform-law provisions that could raise costs after January 2014. That move could also increase premiums for exchange-based plans by encouraging workers with high-cost illnesses to seek coverage through exchanges while healthy workers stick with their employer's plans. It is adverse selection across the board.]

The Future of Skinny Plans

Federal agency officials have expressed surprise at the possible expansion of skinny plans. But will they try to shut them down?

If skinny plans thrive and the exchanges begin to go bust, federal agencies may conclude that skinny plans violate the new nondiscrimination rules that apply to fully insured health plans.

We will eventually find out whether the Obama administration will attempt to use nondiscrimination arguments to put a stop to skinny plans. Until then, it appears that offering a low-cost, skinny plan is a possible strategy when it comes to an employer's overall approach to offering health insurance to its employees and complying with the new reform requirements, including the employer mandate.

Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-10. 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 "20:10/2" indicates Vol. 20, No. 10, page 2.

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