Employer's Guide to
Self-Insuring Health Benefits

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Broker Liable for Failure to Explain Stop-loss Coverage Gap to Plan

A health plan sponsor has sued its broker and claims administrator for failing to preemptively tell it about differences between the plan document and its stop-loss insurance policy. The plan sponsor was unaware that it would have to pay in-network services without limit, but the plan's stop-loss coverage had a $1-million cap that included payments for in-network services. Although the plan failed to make the claims administrator liable, the broker failed to quash a host of state-law charges relating to its failure to foresee the problems and allegedly neglecting to harmonize the plan's and the stop-loss policy's lifetime benefit maximums. ***Page 5***

Employers' Results Mixed Obtaining $1.3M From Insolvent TPA's Insurers

Employers trying to recoup a $1.3-million judgment against an insolvent TPA had mixed success because insurance policies designed to cover TPA malfeasance did not sufficiently cover the loss. On the one hand, the court upheld an errors-and-omissions insurer's exclusion for intentional acts. On the other hand, the TPA's surety bond insurer was found liable because its attempt to argue that the TPA's misconduct was not theft by an employee was foiled by ambiguous plan language. However, the surety bond policy limit does not make the employers whole, the court noted. The losses occurred because the TPA mismanaged plan assets, then could not refund $1.3 million of plan funds it allegedly wasted and misallocated. ***Page 7***

Health Reform: DOL Finally Issues Model Exchange Notice Language

The U.S. Department of Labor recently issued model language for the exchange notice that self-insured group plans will be required to send to plan participants. DOL also issued guidance explaining what employers are required to send; when the notice must be delivered; to whom it must be delivered; and in what form. An employer that employs one or more employees and has at least $500,000 in annual revenue is required to send a notice. Hospitals, health and mental institutions, schools, institutions of higher education and federal, state and local government agencies are subject to this new requirement. The exchange notice must be sent to all employees, whether part- or full-time. The notice does not have to be sent to dependents. The notice may be provided by first-class mail or electronically, but only if the electronic delivery is made in accordance with DOL's electronic disclosure safe harbor rules. ***Page 10***

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Possible Exchange Problems May Help Boost Self-funding

By Adam Russo, Esq.

In this world of uncertainty, the self-funded industry needs to establish that our products and services are the best option to reduce the cost of health care and expand coverage to all. This has added importance because if the health insurance exchanges do not do well and insurers begin to pull out, the public's knee-jerk reaction may be that the country needs a government-run single-payer system, since everything else has failed.

Many in the self-funded industry say such a system seems to be the administration's ultimate goal. Maybe the government would even welcome failure of state-level exchanges (the speculation goes) because that way a single-payer model becomes more appealing. Let's see if this hypothesis comes to pass.

This summer, the government plans to mount a public relations and recruitment effort to educate the nation about the health reform law and the exchanges, in order to sign up as many people as possible when open enrollment begins this fall.

The application for individuals to get exchange coverage had to be reduced to less than five pages for a single applicant not needing financial support (to make it easier to fill out), it was announced around May 1. The form for individuals to get into an exchange was initially 21 pages, embarrassing the government with complaints that it was not user friendly.

Insurers have much riding on the success of the summer recruiting effort and subsequent fall enrollment in the exchanges. If the recruitment is successful in luring millions of young, healthy enrollees into exchanges, insurers stand to acquire a large chunk of subsidized new customers. On the other hand, if primarily the sick take the time to sign up, it might become an unsustainable and costly disaster — and it's doubtful that insurers will want to continue participating in the exchanges. However, this would come with a heavy consequence: If insurers decide to not offer exchange coverage, states may prohibit them from selling any insurance in the state in retribution.

What's bad news for employers seeking exchange coverage — in 2014 at least — is the fact that national insurers are absolutely swamped just trying to prepare coverage options for numerous state exchanges. Insurers say they are so battered by the health reform law that they predict 50-percent to 200-percent premium increases for 2013.

The good news is that employers, including small employers, are not planning to take the easy way out and simply dump their employees into exchanges and pay the fine. Employers have realized that their employees would be unhappy with losing their employment-based benefits. Therefore, employers are being loyal to their employees and will continue to offer health benefits while the state and federal governments desperately enroll individuals into the exchanges.

The other good news is that the insurer's problems in getting ready for the exchanges is a huge boost to employers choosing to remain self-funded or looking at this option for the first time. In the world of self-funding, there are no profit margins and the industry has had strict transparency of fees and reporting since ERISA was enacted in 1974. Self-funding allows greater custom design of benefits offered in order to meet the specific needs of each workforce. Thus, it gives the most

See *CE Column*, p. 4

Employer's Guide to Self-Insuring Health Benefits

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Stop-loss Proposals Still Advancing In Several States

By Adam Russo, Esq.

Due to fast-moving events at the state level, it's already time to give an update on state proposals aimed at making it harder for smaller groups to self-insure. These bills would regulate stop-loss by putting power over self-funding in the hands of state commissioners and as result, would make it expensive for employers to self-insure.

Seemingly with these bills, state insurance commissioners and legislators are trying to force small plan sponsors to give up self-funding and choose between: (1) a fully insured plan controlled by the state commission; or (2) a policy purchased through a state insurance exchange, in an effort to strengthen health reform by sending lives to those programs.

For example, last month, we reported on a new Utah law that now requires stop-loss insurers to cover incurred and unpaid claims if a small employer plan terminates — an unprecedented requirement. And California's stop-loss regulatory proposal has advanced to a full Senate vote. Even though its sponsor agreed to reduce the bill's minimum specific attachment point to $65,000, (down from $95,000) that minimum still would be one of the most onerous on self-funded plans in the country.

Minimum attachment points like those in the California bill would make it impossible for my company to self-fund. If we could not purchase stop-loss coverage at a $35,000 specific deductible and had to be at risk for the first $65,000, we could not remain self-funded — even though we are self-funding experts!

ERISA Cannot Stop These Proposals

Stop-loss insurance falls under state purview; therefore ERISA plans will have difficulty arguing preemption to avoid increased stop-loss regulation by the states.

Anyone who thinks his or her stop-loss policy can enjoy ERISA preemption because it's part of a self-funded plan needs to be reminded: Preemption will not stop many of these stop-loss laws. ERISA preemption will likely fail to stop laws that are remote from ERISA plan administration, and high attachment points have frequently been seen as not dictating benefits administration.

The Inexorable March

On May 14, **California** stop-loss control legislation (S.B. 161) with a small-group minimum specific attachment point of $65,000 was approved by a Senate health and appropriations committee. As noted earlier, it is now slated for a full-Senate vote. As that vote looms, Senate Committee Chairman and bill sponsor Ed Hernandez (D) indicated a willingness to lower that attachment point further, but that was still being debated as of press time.

As part of the legislative testimony, Hernandez and other proponents made several statements that indicated they want to influence ERISA plan administration. And that might support a legal challenge on ERISA preemption grounds should it be enacted. The real question is whether the self-funded industry can successfully argue that such stop-loss proposals would in fact be preempted.

On May 5, the **Colorado** Senate Committee on Health and Human Services approved H.B. 13-1290, which would:

- create a $30,000 minimum stop-loss attachment point;
- force stop-loss insurers to report the size and number of small health plans they insure; and
- empower the insurance commissioner with additional rule-making authority to further regulate stop-loss insurance.

While the stop-loss attachment point requirements are not as punitive as California's, they still reflect the view

See *Stop-loss*, p. 4

Stop-loss (continued from p. 3)

that the state commissioner should have power to unilaterally alter self-funded plans.

In **Idaho**, H.B. 0199 has been signed into law and extends certain regulatory and reporting requirements currently imposed on multiple employer welfare arrangements operating in Idaho to single employer self-insured group health plans. This includes the mandate that claims be funded and paid through a separate trust and that those trusts maintain minimum reserves. The law, most self-funded plan sponsors would agree, should be preempted because it imposes direct state regulation on single-employer self-funded plans.

In **Rhode Island**, stop-loss legislation that had stalled due to industry opposition was quickly revived, to our surprise and dismay. The House passed a substitute bill (H.B. 5459) and it now moves to the Senate. The substitute bill contains a minimum specific attachment point requirement of $20,000 (down from $60,000 in an earlier version). However, it would give authority to the insurance commissioner to create new rules affecting stop-loss insurance.

In the never-ending saga in **Michigan**, the state has proposed amendments to the Health Insurance Claims Assessment Act. S.B. 335 was recently introduced to: (1) repeal the sunset provision of the act, which is set to expire at the end of this year; and (2) increase the 1-percent tax in future years by tying it to a floating rate designed to ensure the state gets a stable funding level. That amount would be three times the amount raised by the 1-percent tax last year.

The Self-Insurance Institute of America has challenged the HICA Act in federal court on ERISA preemption grounds.

The U.S. District Court for the Eastern District of Michigan held that the state law did not "relate to" ERISA plans intimately enough to trigger preemption, because it did not "mandate any particular benefit structure or bind administrators to certain benefit structures."

SIIA's appeal is now pending before the 6th U.S. Circuit Court of Appeals.

I will keep you updated as new developments occur, but it seems I would have to set up a Twitter feed to keep up with all the activity.

CE Column (continued from p. 2)

bang for the buck for both the employer and employee. Even many doctors and other providers are now beginning to see self-funding as a great way to be paid reasonable fees in light of health reform. In the not-so-distant past, they did not like self-funding, because they were so comfortable with the large insurers.

Now, if only the federal government, instead of attempting to eliminate self-insurance, would look at our industry as the blueprint for the nation.

N.C. Stop-loss Bill Would Promote Medical Home Model

Legislation in North Carolina would impose new restrictions on stop-loss policies sold to groups with 20 or fewer employees. However, these restrictions would not apply if employers reimburse for outcomes, embrace the medical home model and adopt wellness program elements.

Under H.B. 934 (not yet scheduled for a hearing), aggregate policies would be prohibited and specific attachment points could be no lower than $60,000.

The bill's restrictions however, would not apply to employers that provide access to a medical home that provides health care screenings, is focused on outcomes and key performance indicators, is reimbursed on outcomes and curtails fee-for-service reimbursement.

H.B. 934 conflicts to some extent with existing state statutory language that applies health insurance regulations to stop-loss insurance if contracts are issued to groups with 50 or fewer employees. Due to this existing statute, very little stop-loss insurance is written for groups of 50 or fewer employees.

Therefore, the proposed additional restrictions for 20-employee groups seemingly would not affect the small group market in North Carolina.

Plan/Stop-loss Conflict Caused Costly Coverage Gap, So Employer Sues Broker and TPA for Poor Disclosure

A health plan sponsor has sued its broker and claims administrator for failing to preemptively tell it about expensive differences between the plan document and its stop-loss insurance policy.

The case illustrates why it is important to compare plan documents to applicable stop-loss policies when securing new vendors.

Lifetime benefit maximums were not harmonized between the plan and stop-loss policy. The plan sponsor was unaware that it would have to pay in-network services without limit. It bought stop-loss that counted in-network services toward the plan's comprehensive $1 million lifetime benefit limit. When expensive claims came in, the plan sponsor was unexpectedly stuck with the shortfall.

In *Express Oil Change, LLC v. ANB Ins. Serv., Inc*., 2013 WL 1245748 (N.D. Ala., March 27, 2013) the employer failed to hold the claims administrator liable because the disputed language, albeit not "a model of clarity" was not onerous enough to overturn the benefits payment decision. But the court refused to quash a host of state-law charges against the broker for failing to foresee the problems.

The Facts of the Case

Express Oil instituted a self-funded plan in 2003. It hired ANB Insurance and ANB employee Alan Wood (who had "expertise" on stop-loss insurance) to design, transition to, and to procure stop-loss insurance for the new plan. Express Oil CFO Greg Glover worked with Blue Cross to develop the plan. Express Oil was already fully insured with Blue Cross. It quickly reviewed a benefits comparison chart and two off-the-shelf self-funding packages, and chose one of them.

Express Oil contracted with Blue Cross to administer the plan and use its provider network. The administrative service agreement designated Blue Cross as the claims administrator that would be held harmless for anything other than the specified administrative services.

As a self-funded plan, Express Oil allegedly believed that the plan had a $1 million lifetime maximum regardless of whether services were provided in-network or out-of-network. In 2003 Glover and Wood thus procured stop-loss insurance from stop-loss insurer Monumental Life Insurance Co. (which changed its name to Unimerica around 2007) covering both kinds of member claims from $75,000 to the $1 million lifetime maximum.

The 2003 summary plan description actually had a $1 million lifetime cap, *only for out-of-network providers*. Specifically, it defined the $1 million lifetime maximum as applying only to:

> Other Covered Services, Non–PPO Outpatient Hospital Services, Non–PPO Physician Services, Mental Health and Substance Abuse Physician Services unless otherwise stated.

This lifetime maximum also was detailed in benefits summaries.

The plan was bound to pay in-network providers without limit, but that left a gap in coverage between the plan and the stop-loss coverage, which ran out after $1 million.

From 2003 to 2008, Express Oil renewed its self-funded plan with Blue Cross. Each time, Blue Cross reissued SPDs without changing the lifetime maximum. Glover signed letters saying he read and approved each SPD. When Blue Cross updated its 2007 SPD, it sent a letter to Express Oil noting that the employer has the responsibility to ensure the SPD accurately reflected plan terms. Blue Cross also updated its ASA in 2007 to provide that it would exercise discretionary fiduciary authority to process and adjudicate claims, and that the employer is responsible for securing suitable stop-loss insurance.

In 2005, Blue Cross suggested that the plan increase its stop-loss limit to $2 million. Glover turned this down because he assumed a comprehensive $1 million lifetime limit per member was in place.

Claims Start Rolling In

In the 2006 plan year, catastrophic claims totaling $378,000 started coming in due to a premature birth. The plan exhausted its $75,000 deductible, and stop-loss reimbursed $303,000. The plan renewed the stop-loss policy with the same $75,000 attachment point and $1 million lifetime cap.

In the 2007 plan year, claims continued to accrue, and the Express Oil plan paid $850,972 for the child. Unimerica provided $627,003 in stop-loss reimbursement.

Express Oil renewed its stop-loss insurance with Unimerica for the 2008 plan year as well, with the same lifetime limits per member.

Stop-loss Benefit Runs Out

During the 2008 plan year, Express Oil paid $1.5 million for the child. Under the stop-loss policy, Unimerica had

See *Coverage Gap,* p. 6

Coverage Gap (continued from p. 5)

exhausted its $1 million lifetime maximum stop-loss reimbursement benefits for the claim, and could pay no more.

Glover emailed Blue Cross, and the administrator quoted from the SPD and explained that that the maximum did not apply in-network providers. Apparently this was the first time Glover learned that Express Oil's plan did not have a comprehensive lifetime maximum.

Glover hired an auditor to check Blue Cross' payments, but the auditor disputed only $110,000, not $1.4 million. The auditor found ambiguities in the "covered services" that would be subject to the cap. A more favorable reading for Express Oil would have put all physician services under the cap, resulting in a $110,000 refund to the sponsor. A 2007 revision clarified that out-of-network physician services only were subject to the lifetime cap.

Express Oil dropped self-funding in 2008 and stopped doing business with Blue Cross. It then sued Blue Cross and brokers ANB/Wood for failing to spot the lifetime maximum discrepancy.

Court Testimony

An expert brought by Express Oil said capping out-of-network claims but not in-network claims was unusual, and that Blue Cross and the brokers should have explained it to Glover. Glover said the Blue Cross benefits comparison chart failed to indicate that the $1 million caps were for out-of-network charges only. He added that he never discussed the lifetime maximum with either Blue Cross or Wood and did not remember looking at either the SPD or benefits summary.

Blue Cross said it had no need to explain the lifetime benefit caps to Express Oil: the $1 million cap was already in the fully insured policy Blue Cross had provided.

Claims Administrator Absolved

The court cleared Blue Cross of all charges. Bad faith dealing and improper payment of claims were preempted by ERISA or nullified by statute of limitations. Allegations of fiduciary duty violations were invalid as well, because Blue Cross had reasonably interpreted the plan. The court decided that:

1) Express Oil's state-law **breach of contract** claim directly related to its poor reading of the ERISA plan, and was preempted.
2) Express Oil's state-law **negligent wonton design** claim exceeded the state's two-year statute of limitations for negligence (Express Oil took more than four years to recognize something was wrong).
3) A **fraudulent suppression** (Blue Cross failed to explain how the lifetime maximum operated and point out its limitations) claim was "abandoned" for procedural reasons. However, the court noted that the claim was directly contradicted by the fact that Express Oil received SPDs with relevant plan rules.

The court noted that:

> A plaintiff who receives documents in connection with an allegedly fraudulent transaction has the duty to read those documents and investigate facts that should provoke inquiry. ... If one receives from a defendant documents that put him on notice of the very facts alleged to have been suppressed, then that defendant cannot have suppressed those facts.

ERISA charges of breach of fiduciary duty against Blue Cross (for misapplying benefit caps relating to the disputed claims) centered around whether Blue Cross properly read the plan document.

Express Oil said problems over the ambiguous "covered services" that would be subject to the cap should be resolved by reading the plan in a way that favored Express Oil. Insurance law requires ambiguous policies to be read in a way that benefits the insured, but Express Oil wanted an interpretation that would have harmed the insured. The court noted that the 2003-2006 SPDs were not "a model of clarity." However, in its *de novo* review of those SPDs, it concluded that the "perceived ambiguity" was not as blatant as Express Oil contended and was not *de novo* wrong. Because Blue Cross was given limited discretionary authority in the 2007 SPD, the court used an arbitrary or capricious standard of review to find that Blue Cross had a reasonable basis to interpret that SPD to exclude in-network services from the lifetime maximum.

Charges Against Brokers

In contrast, the court refused to drop breach of fiduciary duties charges against ANB and Wood. Insurance brokers are not usually fiduciaries, but under Alabama law, any adviser that is in a close advisory relationship with a client, and purports to be trusted adviser, can be held to that standard.

Further, the plan sponsor produced evidence that the brokers breached their duty to adequately explain the coverage gap, and that their losses resulted from that breach. So the court upheld the plan's fiduciary breach charges against the brokers.

The court did, however, quash the allegation that the brokers negligently failed to procure appropriate stop-loss coverage, because Express Oil didn't prove the

See *Coverage Gap,* p. 7

Employers' Results Mixed in Seeking $1.3M From Business Insurers of Insolvent TPA

Employers trying to recoup a $1.3 million judgment against an insolvent TPA had mixed success because insurance policies designed to cover TPA losses did not sufficiently cover the judgment.

In bad news for the employers, a court upheld an errors-and-omissions insurer's exclusions for the TPA's intentional acts. On the other hand, the TPA's surety bond insurer was found liable because its attempt to argue that the TPA's misconduct was not theft by an employee was foiled by unclear plan language. However, the surety bond policy limit does not cover the judgment, the court noted.

The backdrop against which these two developments occurred was the TPA's mismanagement of plan assets, and its inability to refund $1.3 million of plan funds it allegedly wasted and misallocated. The case is *Guyan International v. Professional Benefits Administrators v. Federal Ins. Co., and Gotham Ins. Co.*, 2013 WL 1338194 (N.D. Ohio, April 16, 2013).

Background

Guyan International and several other companies signed contracts with Professional Benefits Administrators to administer their self-funded health plans. Their contracts prohibited PBA from intermingling funds from segregated bank accounts with its own operating funds and from using the monies in that account for its own purposes.

Guyan International's subsidiary Permco soon learned that PBA was not paying plan claims and that plan funds were unaccounted for. PBA apparently failed to pay claims, and used plan funds for general operating expenses and to pay other plans' claims. As a result, health care providers went unpaid, and some providers stopped treating Permco employees.

Permco sued PBA. In January 2011, a federal court concluded that PBA was an ERISA fiduciary because it exercised control and authority over plan funds, and its breach of fiduciary duty caused the plans' losses. See *Guyan International v. PBA*, 2011 WL 53105 (N.D. Ohio, Jan. 7, 2011). It awarded Permco $501,380. Three other companies had already intervened in its case with similar complaints. In April 2011 the court ruled in their favor as well, and awarded them money equal to the claims that PBA had not paid. (See the March 2011 *newsletter*.)

See *Insolvent TPA*, p. 8

Coverage Gap (continued from p. 6)

brokers could find coverage for their losses. New stop-loss insurance might not have covered the premature-birth claims; those probably would have been excluded during underwriting, the court agreed.

In addition to breach of fiduciary duties, the brokers still must contend with charges of: (1) breach of contract (to properly advise the plan); (2) fraudulent suppression (of material facts); and (3) failure to properly monitor Wood.

Implications

- When buying an off-the-shelf self-funding package from a major insurer, awareness of important areas of future risk is not a duty that plan sponsors can delegate away.
- The plan sponsor failed to argue that a claims administrator that issues an off-the-shelf product had a fiduciary duty to design a plan with the sponsor foremost in mind.
- Coverage policies take on a different meaning when a plan is fully insured than when it is self-insured, so converting terms from a fully insured policy into a self-funding arrangement requires close review.

Lessons Learned from *Express Oil Change v. ANB Insurance*

Avoid Gaps in Coverage. This case illustrates why it is so important to compare plan documents to applicable stop-loss policies before claims are incurred. From exclusions with differing meanings to varied interpretations of what is usual, reasonable and/or customary, these days stop-loss insurers are toughening up on enforcement of their language, and gaps in coverage will prove fatal for everyone involved.

Brokers Beware. The court deemed the broker in this case to be a fiduciary because of the Alabama law stating that an broker or other professional purporting to be a trusted adviser can be held to be a fiduciary. This holding will have implications on brokers in Alabama, who will now have to be mindful of their potential fiduciary status as advisors to health plans.

Insolvent TPA (continued from p. 7)

Four ERISA Plans Still Not Made Whole

In the aftermath of the rulings, PBA was unable to pay, citing insolvency. Three of the four plans filed supplemental complaints under Ohio insurance law to collect their judgments against PBA from PBA's insurers, Federal Insurance and Gotham Insurance. The plans initiated a subrogation action under Section 3929.06 of the Ohio Revised Code, which allows an "injured party [to stand] in the shoes of the insured against his or her insurer."

The insurers invoked coverage exclusions to avoid paying the plans' losses.

Gotham, the issuer of PBA's E&O policy, defended its refusal to cover the plan losses because the TPA's liability related to its own improper conduct. Gotham argued that its policy exclusions applied for two reasons:

1) The TPA *expected the damages to occur*, because it initiated the fraud. For the E&O coverage to work, losses must be unexpected.

2) The TPA's misconduct triggered the policy's fraud exclusion.

Federal argued that PBA's fraud was a general business practice, and that PBA's diversion of plan assets did not meet Federal's definition of "theft."

Because of clear contractual language, the court found that Gotham's exclusion applied. However, ambiguous language doomed Federal's argument, as explained below.

E&O Policy Not for Intentional Acts

Gotham's E&O policy was in effect in August 2012, when PBA lost the money judgment. PBA filed a claim with Gotham, but it refused to pay, arguing that PBA triggered the E&O policy's exclusion for willful creation of the losses.

Gotham's E&O policy said it would pay damages and associated expenses arising out of a negligent act, error or omission. However, the policy had exceptions:

- prohibiting coverage of claims that originated from willful acts and fraud;
- for damages coming from judgments and settlements finding that the losses resulted from an error or omission that was fraudulent, intended, willful, criminal, malicious or dishonest;
- for losses that originated from "the return, restitution, disgorgement, forfeiture or rescission of any personal profit, remuneration or financial advantage, or monies to which an insured was not entitled;" and
- for claims resulting from a TPA's commingling and conversion of a plaintiff's plan funds.

PBA argued that: (1) negligence caused the losses — it was possible that it did not understand what it was doing; (2) the court order was to restore plan funds, not ill-gotten gains; (3) commingling funds did not cause the loss — it was the misallocation of plan funds; and (4) its *acts* were intentional, but the harm to its clients was not intentional.

These arguments were unavailing, the court concluded. The failure to pay providers and the use of plan money for PBA's own use were intentional, the court held. This was demonstrated by the fact, for example, that provider checks designated for payment by the plans were withheld. Instead, they accumulated in PBA's file cabinets to the point that more cabinets had to be purchased to hold all of the unmailed checks. Therefore, Gotham had properly invoked its exclusions.

ERISA Bond Issuer Ordered to Cover

The Federal policy covered theft by employees, but it also defined directors, officers and members of the board as "executives," and outside of the definition of employees. ERISA's bonding requirement requires

See *Insolvent TPA*, p. 9

Insolvent TPA (continued from p. 8)

entities that handle ERISA funds to have surety bonds to prevent dissipation through fraud.

Federal argued that its employee theft provision was inapplicable because: (1) no employee stole assets; rather that it was the company's general business practice to use assets fraudulently; (2) the prime mover of the fraud was PBA's chairman and majority owner, who was not an employee under the policy's definition; and (3) no PBA employee took money for his own benefit, but instead, the purloined money was used for PBA operations.

PBA argued that several of its employees were parties to the mismanagement, and as a result those losses were covered theft by employees.

The court identified three employees who were engaged in the theft. That activated a payment obligation under the policy's employee theft provision.

Federal's strategy failed because its policy did not define the word "theft" in a way that excluded fraudulent, dishonest or criminal conduct, and as such the court ruled that its sketchy definition of "theft" did incorporate such conduct. As a result, the court concluded that PBA's misconduct did constitute "theft" that triggered a payment obligation under the Federal policy.

Although mentioned only in passing, the fact that surety bond payment would go to refund the plans, and not to PBA itself, was a factor in the court's decision.

However, the court noted that the monetary judgment against PBA exceeded the limits of the Federal policy.

Implications

This case shows us once again that in certain circumstances, the judgment is not worth much if the defendant does not have the resources to satisfy it. While we were all initially relieved to find that the plaintiffs prevailed, it is unfortunate that they cannot be made whole for their losses because the TPA is insolvent and because the surety bond is too small to cover the losses created by the TPA.

Ambiguous Policy Language

While we are accustomed to seeing the negative effects of ambiguous health plan language, it is interesting to see how an ambiguous term affects other policies. Here, the plans were able to prevail because the term "theft" was open to interpretation. This serves as a reminder that all contracts and insurance policies must be carefully reviewed before signing, and all definitions must be clear and unambiguous.

Insurance Policies and Intentional Acts

E&O insurance policies, like most other insurance policies, contain exclusions for intentional acts. It comes as no surprise that the E&O insurer denied coverage based on such an exclusion. As the name implies, E&O policies are meant to protect against errors and omissions, and not intentional bad acts or mistakes that were caused by bad faith.

Lessons Learned

E&O Insurance. Although the E&O insurance did not apply in this case due to an exclusion, this case serves as a reminder of the importance of adequate insurance coverage and bonding. Health plans should verify that prospective TPAs carry an adequate amount of E&O insurance as legitimate mistakes are likely to occur from time to time. Self-funded health plans also should carry E&O insurance to protect themselves from — not their own fraud — but from vendors that might misappropriate and lose funds.

Vendor Performance Reviews. This case illustrates the importance of conducting thorough research when hiring vendors such as TPAs. Plans have a duty to prudently manage plan assets. As such, health plans should research vendors and ask for references and/or recommendations from other plans before hiring a vendor in order to limit the possibility of hiring a dishonest vendor.

For more information about the importance of monitoring TPA performance and service agreements, go to ¶540 and ¶550 of the *Guide*.

Fiduciary-acts Insurer Held Liable, but Not Commercial-loss Insurer

The employers also had mixed results in an earlier court ruling. In *Guyan Int'l v. Travelers Casualty and Surety*, 2011 WL 6225398 (S.D. W. Va., Dec. 12, 2011), the Permco plan sustained its claim against Travelers, the issuer of Permco's fiduciary acts insurance policy, because of the court's earlier determination that PBA was acting as a fiduciary. (See the February 2012 *newsletter*.)

On the other hand, Phoenix Insurance defended its claim denial because its commercial loss policy would provide coverage only in the event of a negligent act, error or omission, the court held.

Reform Agency Requires Employers to Use Model Exchange Notice Starting Oct. 1

Employers wanting to get an early start on providing a required notice to employees of coverage options under health insurance exchanges can use belated, but new, model language from the federal government. On May 8, the U.S. Department of Labor issued a model notice for employers *may* use now — but *must* use beginning Oct. 1, 2013.

There are two model notices: (1) a notice for employers that do not offer a health plan (see http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf); and (2) another model (see http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf) for employers that offer a health plan to some or all employees.

DOL also issued issued temporary guidance in Technical Release No. 2013-02 (http://www.dol.gov/ebsa/newsroom/tr13-02.html), which explains notice distribution procedures.

Background

Beginning Jan. 1, 2014, individuals and employees of small businesses will have access to coverage through health insurance exchanges (officially called Health Insurance Marketplaces). Open enrollment through the marketplaces begins Oct. 1, 2013.

The health reform law amended Section 18B of the Fair Labor Standards Act to require that employers provide employees at the time of hiring (or regarding current employees, initially no later than March 1, 2013), a written notice: informing employees of a marketplace coverage options.

In January 2013, DOL delayed the notice requirement, but received several requests from employers seeking a model notice much earlier so they can inform employees now about their marketplace options. As a result, it issued the model notice and the guidance.

As the statute provides, the notice must: (1) include information on the existence of a new marketplace, contact information and a description of services provided; (2) inform employees that they may be eligible for a premium tax credit if they purchase a QHP through the marketplace; and (3) include a statement informing employees that if they purchase a QHP, they may lose any employer plan contribution and all or a portion of that contribution may be excludable from income for tax purposes.

Employers must provide the notice to each new employee at the time of hiring, beginning Oct. 1, 2013. For 2014, DOL will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. Regarding workers who are current employees before Oct. 1, 2013, employers must provide the notice not later than that date. The notice must be provided automatically, free of charge, and can be distributed via first-class mail or electronically.

Employers that employ one or more employees and have at least $500,000 in annual revenue are required to send an exchange notice. Hospitals, health and mental institutions, schools, institutions of higher education and federal, state, and local government agencies are subject to this new requirement. The exchange notice must be sent to all employees, whether part- or full-time. The notice does not have to be sent to dependents of the employees.

Exchange notices may be provided by first-class mail or electronically but only if the electronic delivery is made in accordance with DOL's electronic disclosure safe harbor rules.

DOL also updated the model election notice for COBRA coverage purposes to reflect alternatives offered through the exchanges.

Reductions in Transitional Reinsurance Fee Are Possible but Unlikely, Says DOL Official

Employers might pay less than $63 per covered life per year under health reform's transitional reinsurance fee rules, but that would require a surplus in the fund, a U.S. Department of Labor official told an employer plan industry group on April 18 in Washington, D.C.

Even though possible, such a reduction would be contingent on: (1) collections exceeding claims; and/or (2) the government collecting more than $10 billion in the first year. The official with DOL's Employee Benefits Security Administration, who asked to remain anonymous, made the statements after her prepared remarks during a question-and-answer session at a legislative/regulatory conference sponsored by the Self-Insurance Institute of America.

The official also described what the situation would be if the reverse happened. That is, if employers fail to contribute enough money to cover reinsurance claims, then the rate of $63 per covered life will remain, but outgoing claims will be paid on a diminishing *pro rata* basis.

Fee Reduced Only if Collections Surpass Claims

The fee is designed to prevent issuers of individual policies from having to build in the risk of sick individuals into premiums, since underwriting of individuals was drastically curtailed by reform's guaranteed issue rules. The government aims to collect $12 billion in 2014 ($10 billion for the fund and $2 billion for the U.S. Treasury), $8 billion in 2015 ($6 billion for the fund and $2 billion for the U.S. Treasury) and $5 billion in 2016 ($4 billion for the fund and $1 billion for the U.S. Treasury).

U.S. Department of Health and Human Services rules on the notice of payment and parameters (78 Fed. Reg. 15410) require self-funded health plans to pay into the transitional reinsurance fund. The rules added language specifying that administrative-only services and third-party administrators may arrange payment of the fee on behalf of self-funded plans, but the employer or plan sponsor is ultimately responsible for the cost.

Employers and insurers would welcome the news that the government might lighten this new tax burden; however, the official did not make a direct promise about a future lessening of the per capita amount. She said there were two scenarios in which the fee would be reduced.

If the government collects more than $10 billion in the first year, it will carry forward the excess to 2015, and in that case, the 2015 contribution rate will go down. However, the official said the likelihood that the government would collect more than $10 billion in 2014 was slim.

If reinsurance claims do not exhaust the fund, the government will roll anything left over to 2015, and the contribution rate would be reduced. But health reform's other transitional reinsurance program, the early retiree reinsurance program, ran out of money after spending $5 billion far quicker than anticipated, leaving thousands of claims unpaid, said Rep. Tom Price (R), who spoke earlier in the day.

The official did not make a direct promise about a future lessening of the per-capita amount. She said there were two scenarios in which the transitional reinsurance fee would be reduced.

The official also described what would happen if not enough money was collected into the fund.

If the government collects less than $10 billion, it will not come back the next year to fill that in 2015. In other words $63 per year is the most per covered life the government will collect.

But if claims surpass incoming contributions, claims payments will be reduced on a *pro rata* basis, based on rate of collection and projection of claims. The net result would be, of course, insurers getting less money for their claims.

The official noted that payouts made from the fund would be triggered at relatively low attachment points: "below industry standard," as she put it. Attachment points are $60,000 per individual, and a cap will be applied at $250,000; the fund will pay 80 percent of claims (but that percentage could drop if the fund becomes depleted, as described above). This also supports the idea that payouts will be relatively liberal under the rules, meaning the fund might be exhausted and collection rates will have to remain high.

She did say no change in contribution amount or in reimbursement amount would be possible until after June 30, 2014.

For more information, see ¶150 of the *Guide,* and *The New Health Reform Law: What Employers Need to Know.*

Reform Penalties May Become Stricter For Failing to Cover Seasonal Workers

Around this time of year, many employers are hiring seasonal workers and may be wondering how those workers will impact their obligations under health reform's play-or-pay provisions. For the time being, seasonal workers create far fewer obligations and potential for penalties than full-time and even part-time workers … but that might change during or after 2014.

The reform law requires employers with more than 50 full-time employees to provide a certain level of coverage to employees or pay a penalty to the federal government. But seasonal workers who are *employed 120 days (four months) or fewer* need not be the factor that pushes an employer over 50 workers.

Seasonal Workers

December 2012 proposed regulations spelled out how the employer must count seasonal employees for play-or-pay purposes. See http://www.irs.gov/pub/newsroom/reg-138006-12.pdf.

Accordingly, the employer will not be an "applicable large employer" if: (1) it employed 50 or more full-time employees for no more than 120 days in the preceding calendar year; and (2) the employees causing it to reach or exceed the 50 full-time employee threshold were seasonal workers who worked fewer than 120 days during the preceding calendar year. The seasonal worker exception does not apply if the number of an employer's full-time employees (including seasonal workers) and FTEs equals or exceeds 50 employees for more than 120 days during the calendar year.

> **Example:** An employer employs 40 full-time employees for all of 2013. It also has 80 seasonal full-time workers who work from September through December 2013. The employer has 40 full-time employees for the first eight calendar months of 2013, and 120 full-time employees (including seasonal workers) during the last four calendar months of 2013, resulting in an average of 66 full-time employees (rounding fractions down). However, the employer's workforce equaled or exceeded 50 full-time employees (including seasonal workers) for no more than four calendar months in 2013, and the number of full-time employees would be fewer than 50 during those months if seasonal workers were disregarded. Accordingly, the employer is not an applicable large employer for 2014.

In contrast, the hours worked by part-timers (even if they work less than four months a year) are included in the average and can bring an employer above 50 FTEs.

While seasonal employees may not figure in the "large" employer count, they must be counted when calculating penalties. But the 120-day count need not be used; employers may use their own reasonable good-faith decision on whether a worker is seasonal and not counted in penalty calculations.

However, the agencies implementing health reform say they may impose a stricter definition of seasonal employee to include a specific time limit or time period under which seasonal employees will be counted for purposes of calculating penalties.

Also, the agencies gave specific examples — one being teachers with their long summer, spring and winter breaks, but also a lot of work outside of the classroom — of employees they did not want to see being classed as seasonal workers.

CRS Report Describes Nuances

This and other essentials to calculating employer penalties are described in a new Congressional Research Service report. Nuances apply not just to employers of seasonal and part-time workers, but also franchise owners. See http://assets.opencrs.com/rpts/R41159_20130403.pdf.

Franchise Owners Will Aggregate

Employers that operate at multiple addresses are expected to aggregate the number of employees. These employers will have to follow tax Code Section 414, which regulates employees of business entities that are under common control by one owner or group of owners. Therefore, if franchise owners own more than one entity, they must count all employees across the entities.

Part Timers

As noted above, the requirement to offer coverage is for employers that employ an average of 50+ FTEs. Both full- and part-time employees are included in the calculation. Employers cannot escape the requirement by spreading the hours worked by a few full-timers onto a greater number of part-timers. The CRS gives this example of a mix of full- and part-timers being counted together to surpass the 50+ FTE threshold.

> **Example.** A firm has 35 full-time employees (30 or more hours). Assume the firm also has 20 part-time employees who all work 24 hours per week (104 hours per month). These part-time employees' hours would be treated as

See *Seasonal Workers*, p. 13

As Early Retiree Program Winds Down, CMS Sets Data Cut-off Dates for Sponsors

The government's work is nearly done on the early retiree reinsurance program; it's been winding down for two years now. Taking that process a step further, in an April 23 *Federal Register* notice (78 Fed. Reg. 23936), the feds announced the cut-off dates for submitting data on new claims and last-minute fixes it wants ERRP recipients to make, if needed, before the program ends.

The ERRP was implemented under the health care reform law. Its purpose was to address the lack of affordable health coverage for the "early retiree" population (age 55 to 64) who are expensive and not eligible for Medicare. Employers were dropping coverage for that group, and the ERRP provided $5 billion of funds as an incentive for employers to keep that coverage available.

The U.S. Department of Health and Human Services stopped accepting applications for the ERRP after April 30, 2011, based on projected exhaustion of funds. By Jan. 1, 2012, 90 percent of ERRP funds had been paid out and no new claims were processed after that date.

The program sunsets on Jan. 1, 2014, and on or soon after that date, its online secure website (for data correction and claims and appeal submission) will be taken offline. Therefore, ERRP fund recipients have until Dec. 31, 2013, to use the ERRP secure website to:

- correct out-of-date information on their application, including contact and banking;
- report changes of ownership and/or plan sponsor; and
- appeal adverse reimbursement determinations.

Seasonal Workers (continued from p. 12)

equivalent to 16 full-time employees for the month, based on the following calculation, bringing the total number of FTEs to 51.

In spite of this, there are still advantages to moving to a part-time workforce. Part-time workers are not counted in penalty calculations, even though they are counted when deciding whether an employer is "large." Further, if a part-time worker seeks coverage on an exchange, employer penalties are not triggered (they are triggered only if a *full-timer* goes to an exchange).

For more information on calculating penalties under health reform's shared responsibility provisions, go to Section 410 of *The New Health Reform Law: What Employers Need to Know*.

Fund recipients have until July 31, 2013 to:

- submit reimbursement requests; and
- report and correct data inaccuracies on claims.

The notice contains a slightly accelerated reporting calendar of data inaccuracies on reimbursement claims.

> [A] sponsor that knows or should know, before or on April 30, 2013, of any data inaccuracy contained in a reimbursement request for a plan year for which a reimbursement determination was made, must submit a reimbursement request with corrected data by July 31, 2013, rather than by no later than the end of the next calendar quarter after the sponsor knows or should know of the data inaccuracy.

Hang on to Those Records

The sun-setting of the program does not invalidate the requirement that recipients of ERRP funds: (1) maintain and furnish records that HHS asks for; and (2) retain records connected to their ERRP disbursements for six years after the expiration of the plan year in which the costs were incurred.

ERRP Recipients May be Audited

Plan sponsors that get ERRP funds must maintain to same level of dollar contribution to support the early retiree plan as they did before the reinsurance program. They cannot accept ERRP funds and then use those funds to lower the amount they contribute toward the plan.

Feb. 27, 2013 guidance from CMS illustrated that the government has embarked on a campaign of claw-back auditing related to ERRP, basically to ensure that funds were spent properly and if not, returned to the federal government.

Therefore, plan sponsors that received ERRP funds must demonstrate that they:

- maintain the same level of contribution to support their early retire plan;
- do not use ERRP reimbursement as general revenue; and
- use ERRP reimbursement properly.

They must return unused and improperly used reimbursements to HHS. See http://www.errp.gov/download/Ban_on_Using_ERRP_Funds_as_General_Revenue.pdf.

For more information on the early retirement fund, see Section 790 of *The New Health Reform Law: What Employers Need to Know*.

Employers Get More Guidance On MV Coverage in New Reform Rules

Determining whether group health coverage provides "minimum value" is key to avoiding penalties under health reform's premium tax credit program, so employers will likely welcome new proposed rules that further explain MV criteria. The proposal, published May 3 by IRS (78 Fed. Reg. 25909), would complement language in final rules issued in February on how reform's MV and affordability provisions apply to health savings accounts, health reimbursement accounts and wellness programs.

Background

Beginning in 2014, individuals who meet certain income thresholds and purchase coverage under a qualified health plan through a health insurance exchange may receive a premium tax credit. They are not eligible for "affordable coverage" under an eligible employer-sponsored plan that provides "minimum value." Eligible-employer coverage is affordable only if an employee's required contribution for self-only coverage does not exceed 9.5 percent of household income. A plan fails to provide MV if its share of the total allowed costs of plan benefits is less than 60 percent of the costs. An applicable large employer may be liable for penalties if a full-time employee receives a premium tax credit.

In February 2013, HHS published final regulations (78 Fed. Reg. 12834) that defined total allowed costs and described several options for determining MV, such as using a MV Calculator or a safe harbor established by HHS and IRS. The rules requested comments on issues to be addressed in further guidance. Those comments are reflected in the new proposed rules, which would apply for taxable years ending after Dec. 31, 2013 (however, taxpayers "may" apply the rules for taxable years ending before Jan. 1, 2015, according to IRS).

Health Benefits Measured in Determining MV

The proposed regulations refer to the proportion of the total allowed costs of benefits provided to an employee that the plan pays as the plan's MV percentage.

The MV percentage is determined by dividing the cost of certain benefits the plan would pay for a standard population (which reflects the population covered by self-insured group health plans) by the total cost of certain benefits for that population, including amounts the plan pays and the employee pays through cost-sharing. That result is then converted to a percentage.

Commenters to the final HHS rules sought clarification on the health benefits to be considered in determining the plan's share of benefit costs. For example, should MV be based on the plan's share of the coverage cost for all essential health benefits, or only those categories of EHBs the plan covers?

To that end, the proposed regulations would not require employer-sponsored self-insured and insured large group plans to cover every EHB category or conform their plans to an EHB benchmark that applies to QHPs. In stating so, the proposed rules noted this conforms to language in the final HHS regulations.

Health Reimbursement Arrangements And Health Savings Accounts Credited

Some commenters to the HHS rules questioned the extent to which HSA and HRA contributions should count toward the plan's share of costs in calculating MV. They also questioned how HRA contributions should be counted in determining the affordability of eligible employer-sponsored coverage.

The proposed regulations would provide that:

1) All amounts contributed by an employer for the current plan year to an HSA would be considered in determining the plan's share of costs and would be treated as amounts available for first dollar coverage.

2) Amounts newly made available under an HRA integrated with an eligible employer plan for the current plan year: (a) count for MV purposes in the same manner if the amounts may be used only for cost-sharing and not used to pay premiums; and (b) are taken into account only in determining affordability if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost-sharing. This prevents double counting the HRA amounts.

Upcoming rules are expected to address the HRA integration issues in more detail.

Wellness Program Incentives

Opinions from commenters also differed on how nondiscriminatory wellness program incentives that may affect an employee's cost sharing should be taken into account for MV and affordability purposes.

See *MV Guidance*, p. 15

MV Guidance (continued from p. 14)

To clarify matters, the proposed regulations would provide that:

1) A plan's share of costs for MV purposes would be determined without regard to reduced cost-sharing available under a nondiscriminatory wellness program. However, if those programs are designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the program terms relating to tobacco use.

2) The affordability of an employer-sponsored plan is determined by assuming that each employee fails to satisfy the requirements of a wellness program (excluding a nondiscriminatory wellness program related to tobacco use). Thus, the affordability of a plan that charges a higher initial premium for tobacco users will be determined based on the premium charged to non-tobacco users, or tobacco users who complete the related wellness program, such as attending smoking cessation classes.

The proposed rules state that this affordability language will only matter in limited circumstances: When the employer sets the level of the employee's required contribution to self-only premium and establishes a wellness program that provides for a level of premium discount, so that the contribution would exceed 9.5 percent of household income (or wages, under a proposed affordability safe harbor) but for the potential premium discount.

> **Example.** If the employee's household income was at least $25,000, and the employee's required contribution for self-only coverage did not exceed $2,375 (9.5 percent of $25,000), the coverage would be affordable whether or not a wellness premium discount was taken into account to reduce the $2,375 required contribution.

Forthcoming regulations will provide more specifics on how nondiscriminatory wellness programs that affect premiums will be treated for purposes of the affordability exemption.

The proposed rules would give employers with wellness programs transition relief from penalties that typically will be assessed when an employee receives a tax credit for coverage deemed not to be affordable or to satisfy MV. This relief would only apply for plan years beginning before Jan. 1, 2015. Here, relief would apply when the coverage *would have been deemed* affordable or satisfying MV had it been based on the total required employee premium and cost-sharing applicable if the requirements for *any* wellness program had been satisfied by the employee.

The relief only would apply to the extent of the reward in place as of May 3, 2013, expressed as either a dollar amount or a fraction of the total required employee contribution (or cost-sharing, as applicable), and only if:

1) the terms of a wellness program were in effect on May 3, 2013; and

2) the employee was in a category eligible under the program terms in effect on May 3, 2013 (regardless of hiring date).

Methods for Determining Minimum Value

As noted earlier, MV can be determined several ways, including through a safe harbor. Upcoming guidance will propose certain safe harbor plan designs, and the proposed rules noted what is being considered thus far:

1) a plan with a $3,500 integrated medical and drug deductible, 80 percent plan cost-sharing and a $6,000 maximum out-of-pocket limit for employee cost-sharing;

2) a plan with a $4,500 integrated medical and drug deductible, 70 percent plan cost-sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to an HSA; and

3) a plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit, and drug copays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75-percent coinsurance for specialty drugs.

Continuation Coverage, Retiree Coverage

The final regulations had provided that an individual who may enroll in continuation coverage that provides comparable continuation coverage is eligible for minimum essential coverage only for months that the individual is enrolled in the coverage. The proposed rules would apply this rule only to former employees. As a result, active employees eligible for continuation coverage as a result of a reduction in hours would be subject to the same eligibility rules for affordable coverage offering MV as other active employees. A comparable rule would be added for retiree coverage. Accordingly, an individual who may enroll in retiree coverage is eligible for minimum essential coverage only for the months he or she is enrolled in the coverage.

Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-9. 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 "20:9/2" indicates Vol. 20, No. 9, page 2.

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