Employer's Guide to
Self-Insuring Health Benefits

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What is Fueling the Fear of Stop-loss?

Government studies showing that self-insured plans function well and play an important role in health care don't seem to matter. Neither do data showing very small companies seldom self-fund. Nor does research indicating that stop-loss insurers are not writing policies for very small groups. Heedless of all that, states are going ahead with proposals to raise stop-loss attachment points, so as to increase the amount of risk that self-funding employers have to bear on their own. Contributing Editor Adam Russo, Esq. says this is because the states aren't so sure their exchanges will enroll enough lives to remain viable. On April 1, Utah enacted a law that imposes onerous duties on stop-loss by requiring stop-loss insurers to cover incurred and unpaid claims if a small-employer plan terminates. This is unprecedented and will have a chilling effect on the market, Russo says. ***Page 2***

Supreme Court: Clear Plan Terms Defeat Broad Equitable Remedies

Clear plan document terms in ERISA group health plans are the best defense against legal claims asserting board equitable remedies, the U.S. Supreme Court reinforced in an April 16 decision. Make-whole, common fund, unjust enrichment and double-recovery doctrines should not be allowed to override a plan's clear language reserving its right to full reimbursement of benefits it paid when all other contractual conditions are met. The decision in *US Airways v. McCutchen* reversed a 3rd Circuit decision and affirmed that the plan document had special force. But it also ordered a reduction of the company's claim because the plan document lacked language disavowing the common-fund doctrine, under which plan recoveries can be reduced by the percentage retained by an attorney in securing the settlement. ***Page 3***

Reform Rule on Maximum Waiting Period Details 90 Day-plus Scenarios

Employer group health plans must eliminate waiting periods of more than 90 days before enrolling otherwise eligible employees. Under proposed rules published by the federal agencies in charge of health reform, if it takes more than 90 days to determine whether a variable-hour worker is full-time or part-time, the maximum waiting period could be lengthened to accommodate the time it takes to make that determination. The longest that can take is 13 months from hire to enrollment offer. Employers may use criteria that are not based on a tally of days. These include meeting certain sales goals or earning a certain level of commission. A minimum number of cumulative hours of service may be imposed as a condition for eligibility without triggering the 90-day rule, provided the cumulative hours of service requirement does not exceed 1,200 hours. ***Page 14***

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What in the Stop-loss World Is Happening?

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Recent government studies largely confirm that self-insured health plans function well and play an important role in the health care marketplace. But will health reform contribute smaller employers seeking self-funded status if stop-loss insurers respond to more expensive group health insurance by offering cheap stop-loss with low attachment points? If that happens, the concern is that such a migration will compromise the exchanges' viability by filling them with too many unhealthy lives. Self-funded employers need to know what is already occurring in the states to address that concern, and what they need to do to counteract it.

What Is Fueling the Fears?

A prevalence of stop-loss with low attachment points allowing too-small groups to self-fund in unstable arrangements is not supported by current data. However, fears this might change are being fed by uncertainty over the impact of exchanges, and of the rising cost of insured plans brought on by health reform's insurance mandates.

An example of this is a recent study by The Urban Institute (see related story, p. 5), by its nature suspicious of self-funding. On April 9, it issued a report with no damning evidence on stop-loss. The Institute had to admit tiny companies aren't self-funding, and most reinsurers aren't interested in writing health insurance with low attachment points. Its study did find some attachment points of $5,000 and $10,000, but it said those were out of the norm. However, the study still portends the day when self-funding threatens the viability of reform's exchanges.

Other reports, however, indicate that low attachment points are becoming more widely available. We have seen over the past few years that more marketing materials and insurers are beginning to offer these low attachment point policies for the small self-funded marketplace.

And if attractively priced reinsurance providing coverage at low attachment points became widely available, then there would likely be substantial movement of small employers to self-insurance. And the incentives to move to self-funding for small employers with younger and healthier workers may increase after 2014.

New Data Should Be Taken Into Account

Based on new data from consulting firm Milliman, it would appear that the questions about low attachment points were answered. Currently, only an extremely small number of self-insured employers maintain stop-loss policies with specific attachment points lower than $25,000. In this regard, adverse selection concerns are unfounded and do not need further regulation.

Specifically, in 2013 Policy Characteristics in the Employer Medical Stop-loss Market, Milliman said that employers with 100 or fewer covered employees represent approximately one quarter of the employer stop-loss market (if measured by count of employers). If measured by covered employees, however, that same segment

See *CE Column*, p. 10

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Supreme Court: Clear Plan Terms Prevail Over Broad Equitable Remedies

But Plan Omission Left Opening for Common-fund Reduction

Clear plan document terms in ERISA group health plans are the best defense against legal claims asserting board equitable remedies, the U.S. Supreme Court reinforced in an April 16 decision.

In its holding, the Court affirmed that equitable theories, such as make-whole, common fund, unjust enrichment and double-recovery doctrines, should not be allowed to override a plan's clear language reserving its right to full reimbursement to benefits it paid when all other contractual conditions are met.

The reason cited by the High Court in its 5-4 decision is that the plan's reimbursement agreement is mutual, whereas after-the-fact carve-outs to protect a plan participant from equitable defenses such as windfall, unjust enrichment, etc., are unilateral.

Employer Failed to Disavow Common-fund Rule

But in *US Airways v. McCutchen,* No. 11-1285 (U.S. Ct., April 16, 2013), the US Airways plan document was not air-tight, and when less than perfect plan language is used, courts can insert a beneficiary's "equitable" rules as gap filler.

The plan document failed to include language disavowing the common-fund doctrine, under which plan recoveries can be reduced by the percentage retained by the plan participant's attorney in securing the settlement.

The majority opinion, written by Justice Kagan and joined by Justices Kennedy, Sotomayor, Ginsburg and Breyer, ordered application of the common-fund doctrine and a reduction of US Airways' claim.

A dissenting minority opinion written by Justice Scalia joined by Chief Justice Roberts, and Justices Thomas and Alito, said that "full reimbursement" was understood as the funds the plan spent, and since the plan said that its reimbursement could be reduced by any amount, then no allowance should be made for attorney's fees.

The Case

Plan participant James McCutchen was injured in an auto accident due to a third party. The plan paid $66,866 for his care. McCutchen hired an attorney and secured a $110,000 award from the third part, of which McCutchen received $66,000 after paying his lawyers a 40-percent fee.

US Airways demanded reimbursement of the full $66,866 it had paid; more than the total amount actually received by McCutchen, based on the following plan language:

> If [US Airways] pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, …. [y]ou will be required to reimburse [US Airways] for amounts paid for claims out of any monies recovered from [the] third party, including, but not limited

Resolving the Circuit Split

The federal circuit courts have been split on whether "equitable defenses" such as unjust enrichment can override an ERISA plan's reimbursement provision. The 3rd and 9th Circuits have ruled yes, while the 5th, 7th, 8th, 11th and D.C. Circuits have held no. The Court decided to hear *McCutchen* to resolve this split.

Part of the conflict results from the Court's holding in a similar case, *Sereboff v. Mid Atlantic Medical Services, Inc*., 547 U. S. 356 (2006). In that case, the plaintiffs asserted that a "parcel of equitable defenses" were available in certain subrogation actions. The Court had held that argument was "beside the point." However in *McCutchen*, the Court conceded that a footnote entry in *Sereboff* "left a narrow opening" for future litigants like McCutchen to raise equitable defenses claims.

See *US Airways v. McCutchen*, p. 4

US Airways v. McCutchen (continued from p. 3)

> to, your own insurance company as the result of judgment, settlement, or otherwise.

When McCutchen did not comply, US Airways filed suit against McCutchen under Section 502(a)(3) of ERISA, which authorizes health plan administrators to obtain appropriate equitable relief to enforce plan terms.

Clear Plan Blocks Made-whole Arguments

McCutchen raised two arguments opposing US Airways' attempt to recoup funds from the recovery.

First, he argued that he was not being made whole: his injuries were worth far more than $110,000; he should not be left with nothing, especially since the plan's subrogation and reimbursement provisions are designed to prevent "double recovery" by a participant, which he clearly was not getting.

McCutchen added that US Airways' recovery should be limited to the percentage of his settlement that went to medical expenses only, leaving out the portion of the award for loss of future earnings, and pain and suffering, for example.

Second, he argued that the common-fund doctrine must be applied, reducing any award to US Airways by a percentage amount equal to the contingency fee paid to his attorneys.

The district court in *US Airways, Inc. v. McCutchen*, 2010 WL 3420951 (W.D. Pa., Aug. 30, 2010) rejected this, concluding that plan provisions were sufficiently clear and unambiguous to entitle it to full reimbursement of the benefits it paid. The court rejected the argument that McCutchen was not made whole from the settlement. It also held that no deduction for attorney's fees (or any other non-medical expense) was needed.

But in a reversal (*US Airways, Inc. v. McCutchen*, 2011 WL 5557411 (3rd Cir., Nov. 16, 2011)), the 3rd U.S. Circuit Court of Appeals decided that full recovery would be inequitable because it would constitute unjust enrichment for the plan. That was because: (1) the plan participant's recovery ended being less than what the plan paid after attorney's fees were deducted; and (2) the plan never intervened in the third-party recovery. In other words, the equitable theories of made-whole, common-fund, unjust enrichment, double recovery, windfall, etc., should be allowed to override the contract language the plan designed to protect itself.

High Court Backs Clear Plan Allowances

The Supreme Court disagreed with this view, saying:

> In a §502(a)(3) action based on an equitable lien by agreement — like this one — the ERISA plan's terms govern. Neither general unjust enrichment principles nor specific doctrines reflecting those principles — such as the double-recovery or common-fund rules invoked by McCutchen — can override the applicable contract.

In other words, enforcing a "lien by agreement" took precedence above all else because that constituted holding both parties "to their mutual promises." US Airways had a right to the funds because its beneficiary had promised to turn them over. The outcome would have been different in the absence of a contract.

> McCutchen identifies a slew of cases in which courts applied the equitable doctrines invoked here, but none in which they did so to override a clear contract that provided otherwise.

Mutually agreed-upon written terms trump equitable court-created rules. According to the High Court, this means:

> [D]eclining to apply rules — even if they would be "equitable" in a contract's absence — at odds with the parties' expressed commitments.

For US Airways, this meant that language asserting a first right to the money in the tort settlement recovery was binding, regardless of McCutchen's attempt to separate out non-medical expenses.

Equity Has a Special Place for Common-fund Rule

However, the court noted that the plan document was silent on the issue of attorney's fees, and when omissions like that occur, equitable rules advanced by a plan participant may be used as a "gap filler." That approach has prevailed in many other cases. The majority opinion stated:

> The plan is silent on the allocation of attorney's fees, and in those circumstances, the common-fund doctrine provides the appropriate default. …
>
> In other words, if US Airways wished to depart from the well-established common-fund rule, it had to draft its contract to say so — and here it did not.
>
> Without the [common-fund] rule, the insurer can free ride on the beneficiary's efforts, and the beneficiary, as in this case, may be made worse off for having pursued a third party. A contract should not be read to produce these strange results unless it specifically provides as much.

The majority explained how the plan's allocation formula could be open to different interpretations:

> To be sure, the plan's allocation formula — first claim on the recovery goes to US Airways — might operate on every dollar received from a third party, even those covering the beneficiary's litigation costs. But alternatively, that formula could apply to only the true recovery, after the costs of

See *US Airways v. McCutchen*, p. 5

Urban Institute Touts Strong Stop-loss Limits To Dissuade Small Employers From Self-funding

If small companies self-insure their health plans and in doing so can get stop-loss coverage with very low attachment points, they could siphon healthy lives away from the new insurance market designed by health reform to insure millions of new lives, the Urban Institute warned in a April 2013 report. The Institute explained that low attachment points would allow those employers to replicate full insurance for significant savings.

In theory, such an uptick might happen, but has not been observed yet, according to the Institute, and probably will not happen until well into 2014, when the health insurance exchange markets have been operating for a while. Stop-loss insurance officials and producers who were interviewed for the report said they are not interested in selling policies to companies that are too small to handle self-funding's risks and responsibilities. However, the Institute is concerned that might change.

To protect health reform in the event stop-loss insurer attitudes change, the Institute touts state laws imposing on stop-loss insurers minimum attachment points of $60,000 to $100,000. Such attachment points may be easily handled by a large employer, but they would put self-funding out of reach for employers with fewer than 200 employees, which the Institute says would be a good thing.

The Institute surveyed stakeholders in 10 states, including small employers, insurance producers, health insurers, stop-loss insurers, state insurance regulators and exchange representatives. The report showed that not much self-funding among smaller companies. Most insurers and producers do not sell stop-loss to small groups, the report found. But officials from all sides said they would be concerned if groups with fewer than 50 covered lives did self-fund.

Institute Wary About Small Business Self-funding

Self-funding is not appropriate for groups of 100 and fewer, the report stated. Self-funded plans carry more risk than fully insured employer plans. The report noted that smaller companies that self-fund are more susceptible to that one or two catastrophic claims, such as premature childbirth, major trauma or conditions like AIDS, hemophilia and cancer. Such charges can outstrip premium receipts and push a plan into extraordinary loss.

Many observers are taking a wait-and see approach to whether health reform will prompt smaller businesses to

See *Stop-loss limits,* p. 6

US Airways v. McCutchen **(continued from p. 4)**

> obtaining it are deducted. … The plan's terms fail to select between these two alternatives: whether the recovery to which US Airways has first claim is every cent the third party paid or, instead, the money the beneficiary took away.

The majority opinion said equity held a special place for moneys spent securing recoveries that means common fund allowances can supersede a plan's contractual rights in the absence of a direct plan disavowal of the common-fund doctrine.

> "When it comes to the costs incurred" by a beneficiary to obtain money from a third party, "the terms of the plan do not control." [the United States wrote in an *amicus brief* to *Sereboff* v. *Mid Atlantic Medical Services, Inc.*, 547 U. S. 356 (2006), citation omitted] An equity court, the Government contends, has "inherent authority" to apportion litigation costs in accord with the "longstanding equitable common-fund doctrine," even if that conflicts with the parties' contract.

Dissenting Opinion

The dissenting opinion by Justices Scalia, Thomas and Alito, and Chief Justice Roberts, said that "full reimbursement" was written in the plan as not being reducible by any amount, including attorney's fees, and that McCutchen was aware of that.

> Respondents interpreted "full reimbursement" to mean what it plainly says—reimbursement of *all* the funds the Plan had expended. In their brief in opposition to the petition they conceded that, under the contract, "a beneficiary is required to reimburse the Plan for any amounts it has paid out of any monies the beneficiary recovers from a third-party, *without any contribution to attorney's fees and expenses*."

Therefore plans take note: In order to maximize your recovery rights, it is necessary to include language in the plan expressly disavowing the common-fund doctrine and refusing to reduce recoveries based on that doctrine. Your rights are only as good as your language.

For more information on the history of ERISA plans' subrogation and reimbursement rights, including important Supreme Court rulings, go to ¶720 of the *Guide*.

Stop-loss limits (continued from p. 5)

opt for self-funding health benefits. Producers have been reticent to promote self-funding arrangements to small businesses, preferring to sell HMO and PPO products. But if the market changes after 2014 they would be prepared to follow demand, the Institute reported.

The Institute listed several factors that could provide new impetus for small businesses to self-fund and/or avoid sending workers to exchanges to get their health benefits.

- **Avoiding select reform mandates.** Self-funded plans are exempt from two insurer mandates. They are not obligated to cover all 10 essential health benefits like plans sold on the exchanges are, and they are not obligated to hew to the $2,000 (single) and $4,000 (family) annual limits on cost sharing that other plans must follow.
- **The availability of stop-loss policies with low attachment points.** The Institute lauds the two states (Oregon and New York) that completely ban the sale of stop-loss to small companies, and recommends bringing the minimum specific attachment point to $60,000. The report did not find many policies with very low attachment points being written by insurers and producers. But it pointed to a few statements by insurers that they might follow the market if it requested policies with low attachment points.
- **Alternatives to self-funding** the Institute also doesn't like include (1) high-deductible health plans backed by a health reimbursement arrangements; (2) stop-loss captives, pooling several small groups together under one stop-loss policy; and (3) dropping insuring workers altogether, and allowing workers to get coverage on an exchange. The last option is particularly attractive to small businesses because they will not have to pay a penalty under reform's play-or-pay provisions for doing this.
- **The definition of small employer will change** from 50 employees to 100 in 2016. This means that more workers can go to get (possibly subsidized) coverage on an exchange without the employer being penalized.

Part of the reason the potential for more self-funding exists is the fact that insurers are raising premiums in response to reform mandates like guaranteed issue, guaranteed renewal, elimination of annual and lifetime limits, dependent care to age 26, preventive services without cost-sharing, and the elimination of pre-existing condition exclusions. Self-insured plans are subject to most, but not all of these requirements.

Insured plan premiums are expected to rise as much as 30 percent as a result of reform, and insurers front-loaded much of those increases in anticipation of the new reform provisions.

Further, reform's new rating bands for age and tobacco are narrower than industry standards used to date. Rate restrictions (such as job category, gender and medical history) can no longer be used by either insured or self-funded groups.

Stakeholders predicted interest to rise in 2014 particularly in companies from 80 to 100 employees. For instance, Rhode Island officials told the Institute that younger groups may self-fund to avoid premium increases associated with reform's rating reforms.

Insurers predict the new rating bands will raise premiums on younger, healthier groups. Small self-funded groups inhabited by healthy lives will not be affected by the new rating bands because their younger, healthier groups do not have to float the claims of any older, sicker insured lives outside of the group.

One producer in New Mexico told the Institute that groups of over 50 individuals are used to being underwritten, confronting lasering (a practice whereby stop-loss insurers stop covering a specific individual's condition, usually after that person has incurred substantial losses) and coverage denials, so "they might as well take on more risks to avoid the taxes and fees in fully insured coverage."

More on Self-funding

For more information on the advantages of self-funding, see ¶110 of the *Guide*. Advantages include:

- not having to pay commissions to insurance companies;
- not having to pay state taxes on insurance premiums;
- being able to design more efficient coverage without permission from an insurance company or state regulator;
- potential revenue from plan financial reserves; and
- ERISA preemption of many state health insurance/health plan rules.

Companies with fewer than 250 employees are less reasonable candidates for self-funding, because these plans (1) have smaller cash flow for handling claims; (2) a smaller employee base to spread risk; (3) a greater risk of being rendered insolvent because of one or two major claims; and (4) most smaller companies do not have the in-house legal capabilities to self-fund.

HHS: Stop-loss Insurers Not Invited To Help With Exchange Market

The health reform law provides that entities called "Navigators" will assist consumers and small businesses in researching health insurance exchanges — but stop-loss insurers for self-funded health plans won't be one of them. Those insurers, as well as individuals and other entities with too close a financial relationship to such insurers, would be excluded from being Navigators under proposed rules issued April 4 from the U.S. Department of Health and Human Services (78 Fed. Reg. 20581). The agency said Navigators must be "fair and impartial," and stop-loss insurers would have a financial incentive to encourage small employers to self-fund.

Under the Patient Protection and Affordable Care Act, individuals and small businesses will be able to purchase health insurance through affordable insurance exchanges (also known as the health insurance marketplaces). States can establish such exchanges; federally facilitated exchanges will exist for states that choose not to operate an exchange or won't have one operational by Jan. 1, 2014.

Consumers can receive assistance from a variety of sources when seeking access to exchange coverage. Under the reform law and its exchange regulations, exchanges are to give grants to Navigators that are to provide:

1) "fair and impartial" information to consumers about health insurance, the exchanges, qualified health plans, insurance affordability programs such as premium tax credits, Medicaid and the Children's Health Insurance Program; and

2) referrals to consumer assistance programs and health insurance ombudsmen for enrollees with grievances, complaints or questions about their health plan or coverage.

Agency Says S-L Insurers Would Steer Small Employers to Self-funding

Navigators are not to not make eligibility determinations and will not select qualified health plans for consumers or enroll applicants into QHPs. They will, however, help consumers through the eligibility and enrollment process. HHS said in the preamble:

> Navigators may play an important role in facilitating a consumer's enrollment in a QHP by providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application, clarifying the distinctions among QHPs, and helping qualified individuals make informed decisions during the health plan selection process.

Exchanges also are to perform certain consumer service functions through a "non-Navigator consumer assistance program." State-based exchanges may, but are not required to, establish such a program, however.

The reform law directed HHS to establish standards for Navigators, to include certification, licensure training and the avoidance of conflict of interest. The proposed rules provide details on these standards and build upon the conflict of interest provision by excluding stop-loss insurers, as explained below.

Stop-loss Excluded From Definition of Navigator

The health reform law provided that Navigators are not to be: (1) health insurance issuers; (2) a subsidiary of such issuers; or (3) an association that includes members of, or lobbies on behalf of, the insurance industry. Furthermore, Navigators are not to receive any direct or indirect compensation from any insurer in connection with the enrollment of any qualified individuals or employees of a qualified employer in QHPs.

The proposed rules would take this a step further by providing that a Navigator cannot be a stop-loss insurer or a subsidiary of such an insurer. As well, Navigators could not receive any direct or indirect compensation from any stop-loss insurer in connection with the enrollment of individuals or employers in a QHP or non-QHP.

In HHS' view, a Navigator must distribute fair and impartial information on QHP enrollment and must not have a conflict of interest when presenting information on coverage choices to individuals or small employers that receive its assistance. They cannot have a personal stake in consumer choices.

"More specifically, with respect to the assistance offered by a Navigator to a small employer, a Navigator should not have a personal interest in whether a small employer chooses to self-insure its employees, or chooses to enroll in fully-insured coverage inside or outside the Exchange," according to HHS.

To that end, HHS believes that stop-loss insurers and any related entities would have a conflict of interest that "would compromise the ability of a Navigator to provide information and services in a fair, accurate, and impartial manner." The agency explained that Navigators affiliated with stop-loss insurers could have "a financial incentive to encourage small employers towards self-funding and might not present all coverage options, including insured options, to small employers."

See *Exchange Navigators,* p. 8

One State Passes, Several Others Propose Laws Restricting Stop-loss For Self-funded Plans

Bills that would make self-funding less attractive by raising specific deductibles on stop-loss policies and introducing tough provisions on stop-loss insurers have been advancing in state legislatures. Such measures are intended to rein in self-insured plans, which fall outside the purview of state regulators, the self-insurance industry says. (See related column, p. 2.)

On April 1, Utah enacted a law that requires that stop-loss insurers cover incurred and unpaid claims if a small employer plan terminates — an unprecedented requirement. However, legislation restricting stop-loss was ultimately removed in Minnesota and Rhode Island. A California proposal, with draconian attachment points, is still in play. And most recently, Colorado's House passed a bill to scrutinize and restrict stop-loss.

Since state efforts to regulate self-funded plans are preempted by ERISA, states have gone after stop-loss as an indirect means of limiting self-funding, according to Mike Ferguson, chief operating officer of the Self-Insurance Institute of America. SIIA's position is that such legislation should be preempted by ERISA, and states are confusing stop-loss insurance with health insurance when regulating it.

Also, reducing the ability to self-insure is seen by some legislators as necessary to making health reform work. "The common denominator is an effort try to push as many individuals and small businesses into health-reform exchanges," Ferguson said.

Utah Enacts Tough Plan-termination Provision

Utah's H.B. 160, which was signed into law by Gov. Gary Herbert (R) on April 1, institutes new stop-loss limits. While the attachment points are less onerous than those proposed by most other states, the law has another requirement that is having a chilling effect on the stop-loss market.

See *Stop-loss States,* p. 9

Exchange Navigators (continued from p. 7)

Conflict-of-interest Standards

Entities that do meet the criteria of Navigator and non-Navigator assistance personnel would have to follow conflict-of-interest standards that would require them to disclose any interaction with health insurance issuers and stop-loss insurers. Specifically, Navigators would have to disclose to exchanges and consumers:

1) any existing and former employment relationships they have had within the last five years with any health insurance issuer or stop-loss insurer, or their subsidiaries;

2) any existing employment relationships between any health insurance issuer or stop-loss insurer, or their subsidiaries; and

3) any existing or anticipated financial, business or contractual relationships with one or more health insurance issuers or stop-loss insurers, and their subsidiaries.

"These types of conflict-of-interest relationships with issuers of health insurance or stop loss insurance should be disclosed because these relationships may confer benefits or indirect financial gain that would compromise a Navigator's objectivity," according to HHS.

Navigators also would have to disclose any other lines of insurance business — other than health insurance or stop-loss insurance — they intend to sell while serving as a Navigator (for example, auto, life and homeowners' policies).

The rules noted that agents and brokers could operate as Navigators as long as they could satisfy the standards — to include being prohibited from receiving compensation from stop-loss insurers.

The rules also would provide that the prohibition on receipt of compensation would apply to the entire organization and staff:

> While a Navigator could retain staff members who serve as agents and brokers, those staff members — and the organization itself — could not receive compensation from health insurance or stop loss insurance issuers for enrolling individuals or employees in QHPs or health insurance plans outside of the Exchange.
>
> Such staff members, however, could continue to be compensated for selling other insurance products (for example, auto, life, and homeowners' policies).

Comments

HHS is accepting public comments on the rules through May 6, 2013.

Stop-loss States (continued from p. 8)

The new law outlaws specific attachment points below $10,000. It also requires that aggregate attachment points may not be less than 90 percent of expected claims.

In spite of the not-onerous $10,000 minimum attachment, Utah's law requires that stop-loss contracts include provisions to cover incurred and unpaid claims if a small employer plan terminates. This is creating a chill factor in the market, according to Ferguson. The problem is this unprecedented provision adds a whole new form of risk and turns stop-loss into health insurance, commenters say. At least one insurer has suggested that it may stop writing stop-loss policies in Utah as a result, Ferguson said.

Utah's law further outlaws lasering, an insurer practice of carving out coverage for a specific individual in the employer group. The law only applies to groups with 50 or fewer employees.

Self-funded plans will benefit from the elimination of lasering, which left them exposed to unforeseen health expenses. The elimination of lasering also is in step with health reform's no rescission rule, with which all self-insured plans must comply.

The law requires that stop-loss benefit limitations and exclusions be aligned with the small employer health plan's limitations and exclusions. This will reduce situations in which plans are caught paying unexpected claims because stop-loss insurer and plan exclusions do not align.

California's Draconian Attachment Points

California's stop-loss bill, S.B. 161 would impose draconian rules on stop-loss policies written for small employers with 50 or fewer employees. It would prohibit stop-loss policies written after Jan. 1, 2014, from having an individual attachment point for a policy year that is less than $95,000. It would require aggregate attachment points to be no lower than the greater of: (1) $19,000 times the total number of covered lives; or (b) 120 percent of expected claims.

Last year, the same high levels were in legislation (S.B. 1431) but were removed and the bill was not passed.

California's bill also would outlaw lasering, bringing stop-loss in line with plans' obligations under reform's prohibition on rescissions and removing additional risk to self-funded plans.

Colorado House Passes S-L Restrictions

On April 22, the Colorado House of Representatives passed legislation regulating stop-loss through minimum attachment points, and requiring stop-loss insurers to give the commissioner information about their self-insuring clients with 100 and fewer full-time equivalents. The insurance commissioner could unilaterally raise minimum attachment points in line with health inflation. The bill was reported to the Colorado Senate on the same day.

If the bill passes, stop-loss insurers will have to report on all policies written for clients with 100 and fewer FTEs: the number of covered lives for each group, the mean and median attachment points for each group, and the source of prior coverage for each group, including whether they migrated lives from the Colorado insurance exchange.

The specific attachment point would be $20,000 and the aggregate attachment would be no less than 120 percent of expected claims or $20,000. These limits would apply only to companies with 50 or fewer FTEs.

Attachment points could not vary by individuals within the group and the policy could not exclude any eligible employee or dependent from the stop-loss insurance coverage. Thus, no lasering of individuals.

Rhode Island's H.B. 5459 would have prohibited stop-loss policies with annual specific attachment points of lower than $60,000 per individual. That legislation would have barred aggregate attachment points for small employers below the highest of $15,000 times the number of group members, or 130 percent of expected claims. On March 12, Rhode Island's House Committee on Corporations tabled the measure in response to opposition from employers, Ferguson told the *Guide*.

A stop-loss bill in Minnesota (included in a Feb. 18 version of H.B. 647) would have barred new stop-policies with specific deductibles below $60,000 (up from the previous downward limit of $20,000) or annual aggregate attachment points of less than 120 percent of expected claims for employers with 50 or fewer workers. The provisions were removed from the bill.

Federal Stop-loss Rules Might Be in the Offing

Beyond the states, the federal agencies with jurisdiction over ERISA may re-characterize stop-loss policies with a low attachment point as health insurance.

HHS may attempt to expand the definition of health insurance coverage to say stop-loss with an attachment point of $25,000 or lower would be considered as providing health insurance benefits under a policy offered by a health insurer as defined under Section 2791(b)(2). For this purpose, HHS would argue that the stop-loss issuer is a health insurer and therefore is subject to state insurance law, says attorney Adam Russo, president of the Phia Group in Braintree, Mass.

That would be more likely than Congress enacting a law amending the definition of health insurance under ERISA to include stop-loss insurance with low attachment points.

CE Column (continued from p. 2)

represents only 2 percent of the market. Milliman found that the median specific attachment point was $80,000. For groups with 50 or fewer covered employees, the median deductible was $35,000. For groups of 51 to 100 employees, the median was $45,000. Less than 0.2 percent of specific stop-loss policies had specific deductibles of $10,000 or less. About 0.3 percent of specific stop-loss policies were written with specific deductibles of less than $20,000.

So why are state insurance commissioners so concerned with raising the attachment point when so few employers have such stop-loss policies in effect?

The simplest way to regulate stop-loss and thus self-funding as a whole is through the states. I have been saying this for years. Just wait and see what happens when certain state exchanges have high costs but not enough members in their ranks. Those states will be looking for ways to secure more members in the exchanges. What easier way than by limiting stop-loss coverage for self-funded employers, thereby almost ensuring that employers will have to send their employees to the exchanges.

A Review of State Activity

Attempts to restrict on stop-loss at the state level are already beginning to occur. Utah enacted a stop-loss law with unprecedented burdens on stop-loss. California is trying to impose draconian attachment points for the second year in a row. Minnesota and Rhode Island attempted but failed to pass stop-loss legislation; Colorado introduced its own bill, which was approved by its House of Representatives on April 22.

Commissioner Powers Threaten Self-Funding

Some state legislation would allow the insurance commissioner to simply change the rules for purchasing stop-loss. Under the failed Rhode Island bill, for example, in order to ensure employers join the exchange (in response to anemic enrollment), the commissioner would have been allowed to raise the minimum from $60,000 to say, $200,000. Now, a $200,000 attachment point would prevent most employers from self-insuring and force most of them in the exchanges or to become fully insured. It would be an easy way to increase the lives on the exchange and lower the overall risk to the state without any additional legislative interaction.

This is what we need to be concerned with: Not just what the drafted bills state now but what power would be placed in the hands of the insurance commissioners. The potential damage this could cause is extremely worrisome for self-funding proponents.

New Utah Law Prohibits Lasering

On April 1, a law was enacted in Utah that sets a specific attachment point at $10,000 (unlike measures introduced in California, Minnesota and Rhode Island, which would preclude stop-loss insurers from issuing policies with specific deductibles below $60,000.) Before you breathe a sigh of relief, you will soon realize that there are bigger issues than the attachment point. Overall, an employer's ability to self-fund in the state is now extremely limited. The fact that the law was enacted so quickly and with so little fanfare in a Republican state makes it even more unnerving.

The Small Employer Stop-Loss Insurer Act (H.B. 160): (1) requires both specific and aggregate coverage; (2) requires the stop-loss to provide gapless coverage; and (3) prohibits lasering of individuals. Lasering is a practice by stop-loss insurers of setting higher specific deductibles on plan members with pre-existing conditions or excluding coverage altogether.

The law only applies to groups with 50 or fewer employees. But as I stated before, it won't be long until this number is 100, 200 or even 500.

The insurance commissioner now has the ability to create a standard stop-loss application form for small groups. The stop-loss policy has to guarantee rates for 12 months with the only exception being a change in plan benefits.

Therefore, a stop-loss insurer cannot exclude any plan member from coverage. As a result, the cost of the stop-loss policy will be extremely expensive if the plan chooses to self-fund. This almost ensures that such plans will either join an exchange or become fully insured.

After speaking to various stop-loss experts, I realized this is not even their biggest concern with the Utah law. What scares them the most is that it requires stop-loss insurers to pay claims incurred but not reported if the plan terminates — they are expected to pay claims directly if the plan ceases to exist. The insurers essentially will become health insurance companies in Utah. This will basically shut down self-funding in the state by many of the large insurers.

To make matters even worse, and to show the true intent of the law, stop-loss benefit limitations must be aligned with a small employer's benefit limitations, including any annual or lifetime limits. Since most plans cannot have annual or lifetime limits, neither can the stop-loss policies. This is meant to ensure stop-loss insurers are regulated as health insurers, which they are clearly not.

The goal of Utah lawmakers was to restrict the availability of medical stop-loss insurance to small employers

See *CE Column*, p. 15

DOL Survey Results Show Financial Strength Of Self-funded Health Plans

Companies that self-fund insurance benefits are larger than companies that fully insure health benefits and their solvency is just as good as companies that fully insure, a government report required by the health reform law indicates.

The reform law requires reports on the prevalence, solvency and quality of self-funded plans, with the stated goal of seeing whether such plans are solvent and as dependable as fully insured plans. The third such *Annual Report to Congress on Self-funded Health Plans* since 2011 was issued April 1 by the U.S. Department of Labor and derived its data from 2010 Forms 5500.

The findings seem to indicate that self-funding remains financially viable and the companies that do self-fund tend to be larger and richer than companies that do not.

Data on the relative financial health of companies that self-fund versus those that fully insure were mixed. On the one hand, fully insured firms had more cash flow relative to total debt than self-insured and mixed-insured firms. On the other hand, fully insured firms had lower operating income relative to debt.

Details

About 75 percent of self-funded plans provided ancillary benefits in addition to health benefits. Just 4,753 of 19,772 self-funded plans provided health benefits only; the other 15,019 provided health and other benefits such as dental, vision and non-health coverage. Companies with totally self-funded plans filing Forms 5500 and for which complete financial data was available had median employee counts at around 3,000.

Mixed insured plans were partly self-insured but assumed to have at least one contract of insurance, often to cover ancillary benefits, such as dental, vision and non-health. Just 270 mixed insured plans offered only health benefits; the other 3,752 offered a range. Companies with mixed insurance plans filing Forms 5500 and for which the most financial data was available had median employee counts at around 11,000.

In 2010, 48,544 private sector employer-sponsored group health plans filed a Form 5500. Of those, 19,772 were totally self-insured, 4,022 were mixed-insured and 24,750 were fully insured.

Earlier Reports Understated Self-funding

Previous reports understated the number of self-insured plans, DOL said. As a result, the most recent count should not be compared to previous reports to observe an upward trend, DOL said.

The Form 5500 Series is part of ERISA's overall reporting and disclosure framework, to see to it that plans comply with prescribed standards, and that they ensure participant rights and benefits.

Assets

About 30 million group health plan participants (out of a total of 68 million) were covered under self-insured plans.

Self-funded plans keeping assets in trust recorded assets of $57.8 billion. Mixed-insured plans keeping assets in trust recorded assets of $136 billion. The assets they held were, in order: cash, direct filing entities, mutual funds, debt instruments and stock.

Trusts owned by self-funded and mixed-insured plans posted investment income gains of more than $22 billion, of which approximately $4 billion was gained by self-insured plans and $18 billion by mixed-insured plans, according to the latest report.

Where Does the Money Go?

The survey had more details from plans that had trust funds, but not when plans paid out of general assets. DOL had no data on plan assets, contributions and paid benefits from plans that paid out of general assets. Of totally self-insured plans, 5,400 paid benefits out of a trust and 14,400 paid out of general assets.

The 5,400 self-insured plans keeping assets in trust had annual contributions of $51.8 billion and benefits payouts of $49.1 billion. They also paid nearly $3 billion in administrative expenses, which breaks down to $500 million in professional fees, more than $1 billion in administrator fees, $100 million of investment advisory and management fees, and more than $1 billion in other administrative expenses.

The 1,700 mixed-insured plans keeping assets in trust had annual contributions of $87 billion and paid benefits of $88 billion. They paid approximately $4 billion in administrative expenses, comprising $400 million in professional fees; $3 billion in administrator fees, $200 million in investment advisory and management fees, and $1 billion of other administrative expenses.

For more information on health reform and self-funding, see ¶150 of the *Guide*.

Court: Expansive Amara *Remedies Don't Apply*

Enrollee Fails to Evade $30K Medical Necessity Denial; Sought Impermissible Legal Remedy

In the recent case *Plambeck v. The Kroger Co*., 2013 WL 943735 (D. S.D., March 11, 2013), a plan participant unsuccessfully sued an ERISA health plan for refusing to pay a $30,000 bill for laser surgery she received. She was under the impression that the plan would pay based upon her health care provider's comments, and when the plan cited medical necessity and refused to pay, she sued and sought payment of the bill.

However, a federal court in South Dakota would not allow that, finding that she was seeking a "legal" remedy that is not available to litigants suing ERISA plans.

Background

Under longstanding precedent, courts applying ERISA can: (1) compel a plan to pay benefits that are due; or (2) impose "equitable" remedies on plans. Equitable remedies are limited to restoration of assets that can be traced to the plaintiff and that are in the defendant's possession. Courts may not impose legal remedies, which punish a perpetrator or make a victim whole, in such cases.

Therefore, under equitable relief, if an enrollee misunderstands plan rules behind an adverse benefit determination, the plan is not held liable for the cost of the enrollee's misunderstanding.

But the newer Supreme Court ruling in *CIGNA v. Amara*, 131 S. Ct. 1866 (2011) seems to have expanded equitable remedies. And that apparent expansion emboldened the employee in *Plambeck.* She tried to argue that plan misrepresentations led her to make a detrimental choice about her care, a similar logic that made money awards available to plaintiffs in *Amara*.

The federal district court in South Dakota refused to let that logic proceed: the discussion of new remedies in *Amara* was *dicta* and was not meant to override the traditional distinctions between equitable and legal relief, the judge ruled.

The Facts of the Case

Marcia Plambeck was covered under the self-funded health plan sponsored by her employer, the Kroger Co., which was administered by Anthem Blue Cross Blue Shield.

Plambeck suffered from chronic back pain and she sought surgery to alleviate her pain from Laser Spine Institute (LSI), a nationally advertised provider. She learned of LSI from a TV advertisement.

LSI required her to deposit $30,000 of her own money up front before getting surgery.

LSI called Anthem to ask about the plan's policy on out-of-network outpatient surgery. Anthem advised LSI that Plambeck had to satisfy a $6,000 out-of-pocket limit and that she would file a claim with Anthem and the plan. Coverage was verified, but the provider did not mention the particular surgery being performed.

The provider conveyed this information to Plambeck, but apparently also advised her that that once the plan covered her surgery she would be reimbursed, after meeting her out-of-pocket limit. The provider portrayed to her that the most she would pay would be $6,000.

On a second occasion — this time right before Plambeck's surgery — LSI called to verify benefits, and was told medical necessity was needed for payment, but that the three CPT codes LSI gave Anthem to describe the procedure were not showing up on the payer's pre-certification list.

Plambeck received the surgery, which was ineffective. Later, Anthem denied the claim after determining that the service was medically unnecessary.

Expanded Definition of Equitable Relief

Plambeck sued, demanding equitable relief under ERISA §502(a)(3), saying Anthem represented that her out-of-pocket expense would be $6,000, and that she detrimentally relied on this representation before undergoing surgery.

1) She pleaded under the theory of estoppel that the plan should be stopped from denying her claim because of Anthem's misrepresentation.
2) She also pleaded under theories of surcharge or unjust enrichment that she should be "made whole" and her funds restored to what they would have been if Anthem's misrepresentation had been true.

In doing so, she was attempting to equate her situation to *Amara*, in which a plan's failure to disclose the limitations of its benefits enabled harmed beneficiaries to get new forms of relief under ERISA §502(a)(3), for remedies "typically available in equity."

Plambeck said she understood that the plan did not cover the surgery due to its medical necessity exclusions,

See *Laser Spine Surgery*, p. 13

Laser Spine Surgery (continued from p. 12)

and therefore a remedy under ERISA §502(a)(1) for "benefits due under the plan" would not be available. The question was whether her facts enabled relief under an expanded reading of ERISA §502(a)(3).

Defendant Says Relief Was Legal

Anthem moved for summary judgment, contending that Plambeck's claim was legal in nature, because it attempted to impose personal liability on Anthem in the amount she paid to LSI for the surgical procedure. Only equitable relief is available under ERISA; legal relief is precluded.

The longstanding definition of equitable relief in *Great-West Life v. Knudson,* 534 U.S. 204 (2002), holds that for relief to be equitable it should restore assets that belong to the plaintiff but are in the possession of the defendant. Relief is not equitable if the claim is based on a plaintiff's losses and if he or she seeks money in the value of harm without identifying assets in the defendant's possession that came from the plaintiff.

Under 8th Circuit precedent, equitable relief restores the defendant's ill-gotten gain, and only if that gain belongs in good conscience to the plaintiff, the court noted. In contrast, legal relief focuses on the plaintiff's losses and restores money the value of harm done to the plaintiff.

Plambeck contended that the plan withheld funds that rightfully belonged to her. She said because Anthem withheld payments that LSI was going to refund to her, Anthem possessed funds that rightfully belonged to her.

The court found that to be too much of a stretch.

> It is clear … that [Anthem] does not possess any money which can "clearly be traced to particular funds or property" rightfully belong to Plambeck. Plambeck does not value her damages based on any gain made by the defendants but on the amount of her loss.

Does *Amara* Override *Great-West*?

Plambeck argued that the limitations on equitable relief in *Great-West* and in subsequent 8th Circuit rulings were superseded by the ruling in *CIGNA v. Amara*.

The court rejected this, saying that the previous rulings still stand, because: (1) *Amara* held that that money damages may be rewarded relief in response to unjust enrichment in an ERISA case was mere *dicta*; (2) it was contingent on a trustee with control over a fund violating its fiduciary duty; and (3) it was not intended to override the old distinctions between equitable and legal relief.

> Notably, [*Amara*] did not overrule any prior Supreme Court precedent as it relates to §502(a)(3). Justice Scalia, in his concurring opinion, noted:
>
> The Court's discussion of the relief available under §502(a)(3) and Mertens is purely *dicta*, binding upon neither us nor the District Court. The District Court need not read any of it — and, indeed, if it takes our suggestions to heart, we may very well reverse. Even if we adhere to our dicta that contract reformation, estoppel, and surcharge are " 'distinctively equitable' remedies," it is far from clear that they are available remedies in this case. The opinion for the Court does not say (much less hold) that they are and disclaims the implications.

The 8th Circuit would continue to rely on earlier Supreme Court cases limiting relief sought under §502(a)(3) to equitable.

Implications

Fortunately, the Court in this case refused to expand on the established remedies available to participants under §502(a)(3). This case serves as a reminder of why so many employers decide to self-fund in the first place. In addition to avoiding many rigorous state laws, self-funded ERISA health plans can generally avoid having to pay for punitive or other damages to plan participants.

Patient Relations

Although the plan prevailed and the patient-plaintiff was unsuccessful in seeking "legal" relief, this case demonstrates that patients often misunderstand information provided by customer service representatives and/or providers. As such, employers must ensure that precertification policies and procedures are clearly communicated to plan participants.

In this case, the patient may have been less likely to bring an action against the plan if she had fully understood that the treatment was not going to be covered under the plan. Her sole argument was grounded in detrimental reliance because she believed that her treatment would be covered.

Based on the facts, it appears that this patient was actually misled by the provider and not the plan. As such, plans must advise participants and providers alike that verifying coverage over the phone is not a guarantee of payment.

Plan Language

While the specific plan language was not an issue, employers and health plans should be aware that key exclusions such as treatment outside of "medical necessity" are

See *Laser Spine Surgery*, p. 16

Reform Rule on Maximum Waiting Period Details Some 90 Day-plus Scenarios

Employer group health plans must eliminate waiting periods of more than 90 days before enrolling otherwise eligible employees (or dependents) into health coverage, under a proposed rule published on March 21 (78 Fed. Reg. 17313) by the agencies implementing health reform.

For Clear Full-time Hires, It's 90 Days

Group health plans and health insurers in the group plan setting may not apply any waiting period that exceeds 90 days, the rules jointly issued by the departments of Labor, Health and Human Services and Treasury say. Plans and insurers are not required to have any waiting period. They could obviously have shorter waiting periods without violating the requirement, the proposal states. And if a worker failed to enroll within 90 days of his or her own accord, that would not count as a violation.

Waiting Period May Last 13 Months When FT Status Unclear

The proposed rule provides that if it takes more than 90 days to determine whether an variable-hour worker is full-time or part-time, the maximum waiting period could be lengthened to accommodate the time it takes to make that determination.

> **Note:** The rules on measuring full time employees allows for measurement periods of three to 12 months to determine average hours per week worked. The full-time/part-time distinction is key to health plan eligibility, because larger employers are required to offer health coverage to full-time workers, defined as 30 hours per week or more under the health reform law.

Employers even could get 13 months and a few extra days under the following scenario: The employee is hired after the first day of the month, for example on the 7th or 15th. Then the employee is seen as joining the company on the first of the next month. Then (provided the full-time status of the worker is to be determined, and the employer chooses to use an 11- or 12-month measurement period), the employer can make an offer of coverage as many as 13 months from the first day of THAT month, the proposed rule stated.

Some Non-Time-based Criteria Allowed

The proposal is meant to regulate restrictions that are based solely on the lapse of time. If a plan's reasonable eligibility rules (not time-lapse based) take the date beyond 90 days, the rule would permit this, as long as the plan's rule is not designed to skirt the 90-day requirement.

> **Example:** Meeting certain sales goals or earning a certain level of commission, can be seen as eligibility provisions that do not trigger the 90-day waiting period limitation.
>
> A minimum number of cumulative hours of service may be imposed as a condition for eligibility without triggering the 90-day rule, provided the cumulative hours of service requirement does not exceed 1,200 hours. Once the employee satisfies the cumulative hour minimum, the employer can tack on the 90-day waiting period without violating the requirement. But the employer may not repeat the process on the same employee.

Expanded Regulatory Purview

The rule would expand provisions to insured group health plans and insurers that previously applied only to ERISA-governed self-insured plans. They would apply for plan years beginning on or after Jan. 1, 2014, and they would apply equally to grandfathered and non-grandfathered plans.

Technical Changes

The newly applicable consumer protections were incorporated in Title XXVII of the Public Health Service Act.

The 90-day requirement is based on earlier guidance issued by the agencies implementing health reform in February 2012 and in August 2012. The proposed rules coincide with the August 2012 guidance closely enough for the agencies to say compliance with that guidance will be considered compliance with the 90-day waiting period rule through to the end of 2014, the rule states in a footnote.

The proposal is open for comments for 60 days after its publication in the March 21 *Federal Register*.

Ancillary changes to the PHS Act are included in the proposed rule; in particular, it would eliminate the requirement to issue a certificate of creditable coverage after Dec. 31, 2014. It would also formally overwrite HIPAA's 2004 portability rules allowing some preexisting condition exclusions, to implement health reform's total ban on such exclusions starting Jan. 1, 2014.

Pre-existing Condition Examples

The proposal includes the following examples illustrating reform's ban on exclusions for pre-existing conditions. The following exclusions would be prohibited because

See *Waiting Period Rule*, p. 15

CE Column (continued from p. 10)

that self-insure their health plans. They clearly accomplished their mission, and then some.

California's Draconian Attachment Points

The Golden State has proposed the most draconian stop-loss bill in the country. Its restrictions would be limited to policies sold to employers with 50 or fewer lives. However, they would have to have an individual attachment point greater than $95,000, and aggregate attachment points greater than either $19,000 times the total lives or 120 percent of expected claims. These insane attachment points were put down in 2012 only to reappear in 2013 in the same form.

The newly revived bill requires that stop-loss coverage include all employees and dependents, and they could not be excluded based on an actual or expected health-related risk factor. Basically this means no lasering of employees in stop-loss contracts. The bill does not discuss whether the insurers could make the deductible higher for certain individuals. In addition, insurers would have to renew, at the small employer's option, all stop-loss policies written, issued, administered or renewed on or after Jan. 1, 2014.

The most amazing piece of this bill is that the state insurance commissioner could adopt regulations as necessary to carry out the law. This basically means that the commissioner could do whatever he or she needs to do to ensure that the exchanges get enough lives. This bill would clearly ensure that enough people go to the exchanges. California might become the first state to enact legislation with the highest attachment points in the country.

A Minnesota bill died without too much of a battle. It would have barred stop-loss insurers from issuing to any self-funded employer new stop-policies with specific deductibles below $60,000; with annual aggregate attachment points of less than 120 percent of expected claims. That state already limits specific attachment points at $20,000.

Rhode Island's bill would have prohibited stop-loss policies with annual specific attachment points of lower than $60,000 per individual. It would have barred aggregate attachment points for small employers below the highest of $15,000 times the number of group members, or 130 percent of expected claims. (See story, page 8 for more information.)

On March 12, Rhode Island's House Committee on Corporations recommended that the measure be held for further study. This was in response to testimony from one of the state's largest self-funded employers.

A Rallying Cry

Record numbers of employers are choosing to self-fund even, with specific deductibles for stop-loss coverage required to be more than $60,000. Based on the innovative cost containment options and plan language, self-funded employers are lowering their costs compared to the fully insured world, and such cost savings will continue as the insurance exchanges are rolled out.

As the exchanges begin to lose money and have lower-than-expected membership, states will need to find ways to raise revenues and get additional members on the exchanges. The simplest way to do this is by limiting stop-loss coverage. It will start with the smaller employers and slowly make its way to bigger and bigger companies. Before we know it, self-funding will be in the history books unless we stop the madness now.

Waiting Period Rule (cont. from p. 14)

they operate to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy.

1) An exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage.
2) A plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan.
3) The requirement to be covered under the plan for 12 months to be eligible for pregnancy (this is a subterfuge for a pre-existing condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage).
4) The exclusion of coverage for treatment of congenital heart conditions.
5) A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance. This is prohibited.
6) A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage.

   Counting benefits for a specific condition provided under prior health coverage against a treatment limit for that condition is prohibited.
7) An exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth.

Subject Index, Vol. 20

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Laser Spine Surgery **(continued from p. 13)**

constantly being scrutinized by plan participants and providers. As such, plans must have clear and effective plan language and interpret this language consistently.

Lessons Learned

1) **Communication.** This case demonstrates the importance of communication. The specific details of this treatment, such as the ICD9 codes, were relevant to determining if the procedure was covered, and yet this important information seemed to have been left out of the conversation.

2) **Accuracy of information.** Ensure that all relevant information and procedures concerning covered and excluded charges is up to date and accurate to avoid miscommunication.