Employer's Guide to
Self-Insuring Health Benefits

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Carving the Employee Health Plan Is an Essential Move to Control Costs

One of the biggest benefits of being a self-funded plan is the ability to carve out benefits. Carve-outs involve removing some benefits from your main insurance plan's account and providing them through another vendor with a separate contract. As health care costs have risen, so too have the number of carve-outs, as plans increasingly seek innovative ways to reduce costs and craft their own benefit packages. The obvious carve-out is the prescription drug benefit, provided through a pharmacy benefit manager. Other carve-outs are for mental health, durable medical equipment, chronic disease management, dialysis and specialty pharmacy. The plan administrator should retain the right to perform audits of carve-out vendors to ensure they administer rebates properly and stick to contract terms, Contributing Editor Adam Russo advises. ***Page 2***

Government Shutdown Accord Doesn't Change Obamacare Much

A bipartisan accord to fund the federal government until mid-January and raise the government's debt ceiling until early February was reached by leaders in the U.S. Senate but the final agreement did virtually nothing to change the health care reform law. The only part of the compromise affecting health care reform was income verification of individuals before they obtain federal premium subsidies to buy coverage in state-based health insurance exchanges. Successive attempts by Republicans to: defund the law; postpone the individual mandate; expand exceptions to contraceptive coverage; suspend the transitional reinsurance tax; and remove taxes on medical devices — were countered by Democrats and President Obama, who issued veto threats. ***Page 5***

California Law Restricting Stop-loss Approved

Legislation designed to make it more difficult for smaller employers to self-insure by restricting their ability to obtain stop-loss insurance with very low attachment points was signed into law on Oct. 1 by California Gov. Jerry Brown. S.B. 161, which takes effect Jan. 1, 2014, will prohibit stop-loss insurers in California from issuing policies with specific deductibles below $35,000 for self-funded employer plans. After Jan. 1, 2016, the law increases the minimum specific attachment point to $40,000. Stop-loss insurers will have to report to the California Department of Insurance the number of small employer stop-loss policies they issued. The law also bans pre-existing condition exclusions, rescissions and annual and lifetime limits. ***Page 10***

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Carving the Employee Health Plan Like a Turkey on Thanksgiving

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One of the biggest benefits of being a self-funded plan is the ability to carve out benefits. This doesn't mean that you don't cover things you normally would, but rather that you cover them in a more innovative and cost effective manner.

This article will outline the best options for carve-outs and how they work, but also things to watch out for in your attempt to be proactive and cost effective.

Employer's Guide to Self-Insuring Health Benefits

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Carving out is not without risk. It needs to be handled in a cautious manner.

Carve Out What?

Carve-outs are an arrangement in which some benefits are removed from your main insurance plan's account and provided by another vendor through a separate contract. They are usually reimbursed under a different arrangement or rate formula than they would be under the main plan.

Carve-outs include services or benefits provided to a smaller segment of an employee population, or used to offer additional benefits under a different insurer. They are frequently done for prescription drugs, mental health, specialty pharmaceuticals, disease management, durable medical equipment and dialysis.

There is no question that in past years, carve-outs have grown into a world of their own. As health care costs have gone up, so too have the number of carve-outs as more and more plans seek innovative ways to reduce costs and offer self-funded solutions.

Service vs. Provider-based Carve-outs

When it comes to carve-outs, I've generally seen attempts made based upon one of two factors: service type and provider.

The first question you should ask when choosing between these two approaches is whether you want treat a particular service type in a unique fashion regardless of who the provider is, or are you looking to treat a particular provider in a unique fashion regardless of what the service is.

Service-based Carve-outs

Service type refers to the type of service being provided. In a service-type carve-out, the plan:

1) ensures that the carved-out service is not included in any description of its standard, network-eligible covered services; and

2) includes a section dedicated to the carved-out service, where it sets forth the rules and benefits applicable to that service.

It is vital that whatever you attempt to carve out of your plan does not have a conflicting outside third-party agreement. Thus, you need to ensure that if the plan is attempting to carve out certain service claims, the providers

See *CE Column*, p. 17

Plan's Silence on Anti-assignment Clause Constituted Waiver, So Provider's ERISA Claim Advances

A recent federal court ruling shows that anti-assignment clauses should be invoked early in the game if a plan wants to use them to block legal claims for ERISA benefits brought by providers. If a plan entertains disputed claims with an assignee through its appeals process and makes a final determination, it may lose the ability to use its anti-assignment clause to dismiss a legal case.

"Better late than never" didn't work for one employer. Instead of invoking the clause, the claim administrator of the employer's group health plan processed the claims, processed an appeal and exhausted plan remedies by giving a final determination. Working on the employer's behalf, the claim administrator's failure to invoke the clause led the court to consider the plan's anti-assignment language to be waived.

So even though the anti-assignment clause was "unequivocal" and could have been enforceable if it were invoked at the right time, the court said the provider had standing, and could continue its legal claim for ERISA benefits. The case is *North Jersey Brain & Spine Center v. St. Peter's University Hospital*, 2013 WL 5366400 (D. N.J., Sept. 25, 2013).

The Facts

Patient W.R. worked for St. Peter's University Hospital and was covered by its health plan. Horizon Blue Cross Blue Shield was the plan's claims administrator. W.R. received emergency surgical and medical treatment from the North Jersey Brain and Spine Center in Oradell, N.J.

NJBSC, an out-of-network provider, submitted bills to the plan under an assignment of benefits signed by W.R., but alleged that the plan arbitrarily and capriciously underpaid it by: (1) skewing the appropriate reasonable and customary charges that should have been paid; and (2) failing to process the procedures in accordance with the emergent nature of the procedures.

The provider appealed the payment decisions with Horizon BCBS and alleged that it had exhausted the plan's remedies; and that the plan and the administrator gave a final decision that no further benefits would be paid. The provider sued the employer under Section 1132(a) to recover benefits due under an ERISA plan and to recover attorney's fees.

St. Peter's attempted to dismiss the provider's complaint for lack of standing, because: (1) there was no valid assignment of plan benefits; (2) the plan's anti-assignment provision barred any assignment; and (3) the plan did not waive its right to enforce the anti-assignment clause.

> Plans need to realize that acts performed every single day by administrators, such as appeals or even discussing claims with a provider, can act as a waiver of anti-assignment provisions.

The Assignment

St. Peter's first tried to argue that the assignment gave the providers the right to pursue an internal appeal with Horizon BCBS, but not to pursue legal claims against St. Peter's in court.

While the 3rd U.S. Circuit Court of Appeals has not addressed the question directly, the district court acknowledged that virtually every other circuit has ruled that providers can use benefits assignments to pursue ERISA benefits in courts. Recent rulings by lower courts have relied on that acknowledgement as an indirect affirmation of such derivative standing, the court said.

See *Anti-assignment Clause*, p. 4

Anti-assignment Clause (continued from p. 3)

Beyond that, a 2011 case pitting the same plaintiff against CIGNA resulted in a similar refusal to dismiss the case. A magistrate's ruling accepted by the court held that the assignment to collect reimbursement "logically included the right to judicially enforce the reimbursement" and created a valid assignment under ERISA, the court held in *North Jersey Brain & Spine Ctr. v. Conn. Gen. Life Ins. Co.,* 2011 WL 4737067 (D. N.J., June 30, 2011).

The Anti-assignment Clause

St. Peter's said its plan included an anti-assignment clause that would block the broader interpretation of assignment. It read: "Subject to applicable health law, the Health Care Program does not permit you to assign, sell, transfer, or pledge your benefits."

The court held that that sort of language can indeed be enforceable, even though the 3rd Circuit has not directly ruled on that issue.

So, the court noted, the only way the practice could retain standing would be if St. Peter's waived the right to enforce the plan's anti-assignment clause. While its anti-assignment clause could have blocked litigation, St. Peter's actions constituted a waiver of the clause, as discussed below.

Don't Use It and It Goes Away

Anti-assignment clauses can be waived by written instrument, a course of dealing, or even passive conduct; such as taking no action to invalidate the assignment, the court said.

In a previous case, the court found that "discussions of patient coverage under health care policies, direct submission of claim forms, direct reimbursement of medical costs and engagement in appeal processes" amounted to a waiver of an anti-assignment clause.

In this case, the plan's involvement with the reimbursement claims constituted such a waiver. In relation to these services Horizon BCBS: processed bills; took phone calls to discuss claims; appealed denials; and sent letters explaining the adverse determination, all on behalf of the plan:

> BCBS interacted voluntarily and repeatedly with Plaintiff without once invoking the anti-assignment clause. Such "passive conduct, i.e., taking no action to invalidate the assignment vis-à-vis the assignee," is sufficient to waive the right to invoke the Plan's anti-assignment clause.

Therefore the provider was eligible to pursue not only payment but also legal remedies under ERISA against St. Peter's on the plan participant's behalf.

Implications

This case highlights an issue of great importance, especially as an increasing number of employer-sponsored health plans seek innovative ways to reduce the cost of providing robust health coverage to their employees. More plans are using AOBs and their benefits (quick payment and ease of administration), to secure provider discounts, thereby ensuring cost-effective health care to their employees. The legal effect of the AOB, and its ability to protect both the plan and plan participant from the pain of balance billing is an issue that is gaining tremendous momentum.

But health plans that use the AOB as leverage need to realize that acts performed every single day by administrators, such as appeals or even something as benign as discussing claims with the provider, could be serving as a waiver of applicable anti-assignment provisions. It is imperative that plans and administrators talk to providers about the limits of AOBs and the enforceability of anti-assignment provisions to ensure that claims and all dealings with providers are handled in accord with the plan's wishes.

Agreement to End Government Shutdown Lacks Major Changes to the Health Care Reform Law

A bipartisan accord to fund the federal government until Jan. 15 and raise the government's debt ceiling until Feb. 7, was reached by leaders in the U.S. Senate on Oct. 16, but the final agreement did virtually nothing to change the health care reform law.

The only part of the compromise affecting health care reform was income verification of individuals before they obtain federal premium subsidies to buy coverage in state-based health insurance exchanges.

The U.S. House of Representatives voted just before midnight on Oct. 16 and approved the Senate bill that would reopen the government and avert a catastrophe over the debt ceiling. Questions arose over whether the country would find itself in the same bind just a few months later, but in signing the measure, President Obama said there would not be a repeat of the situation.

Demands to change the reform law that were not included in the compromise agreement include: (1) a postponement of the individual mandate; (2) an expansion of exceptions to contraceptive coverage; (3) a suspension of the $63 per-year per-life payment into the transitional reinsurance fund; (4) a provision cutting health subsidies for congressional officials; and (5) the new excise tax on medical devices. The movement started as an attempt to defund Obamacare as part of the government spending bill. Successive attempts by Republicans were countered by Democrats in both houses of Congress and President Obama, who issued veto threats.

Republican House Majority leader John Boehner, R-Ohio, said his side had "fought the good fight" over Obamacare, but allowing the government to reopen on Thursday would enable his team to "fight another day" in the future to reduce the size of government and balance the budget. He directed members of his caucus to vote for the Senate agreement.

Pundits observed that the GOP made a strategic blunder holding the economy hostage to extract changes in the health care reform law. They said Obamacare is currently embarrassing itself through the non-performance of exchange websites; therefore, the law would have collapsed under its own weight and it might fail of its own accord.

Health Care Reform Spurs Government Shutdown

House Republican efforts to postpone, block and repeal the health care reform law were key reasons for the federal government-shutdown crisis, under which 800,000 federal employees stayed home beginning Oct. 1.

The House Republicans, whose opposition to the reform law paralyzed spending bills, at that time were demanding that the administration acquiesce on two demands:

1) postpone the "individual mandate" that individuals have federally approved minimum essential coverage or pay a penalty for one year; and

2) take away federal subsidies the administration gave to members of Congress and their staffs, after it became apparent the members and staffs would lose their employers' contribution to exchange coverage (the law mandated that Congress members and staff obtain coverage on exchanges instead of through a federal employee benefits plan) without a fix. GOP called the fix "special treatment."

Chaos at the Top

During the budget negotiations, House Republicans also touted not raising the debt ceiling unless concessions are made to delay or repeal parts of health care reform. In response, President Obama said that he shouldn't have to offer anything to Republicans to avert the crisis. Obama said he would consider ways of changing the law in negotiations, but without connecting them to this budget cycle.

The Senate proposed keeping the government open for six weeks while the two parties discuss policy. Senate Majority Leader Harry Reid, D-Nev. argued that the House had tried and failed to repeal health care reform in 40 separate votes over the last three years; and that the effort would not pass the U.S. Senate because a veto-proof majority in the Senate would require 67 votes. The House refused.

Representing the House Republicans in an interview on CNN, Rep. Jason Chaffetz, R-Utah, said delaying the individual mandate is in line with a host of employer-mandate delays to accommodate business compliance that Obama instituted in the past two months. That included a suspension of pay-or-play penalties under the large-employer mandate to cover employees or pay a penalty.

Note: The penalty for violating the individual mandate is $95 or 1 percent of salary (whichever is greater)

See *Government Shutdown,* p. 6

Calif. Law Restricting Stop-loss Becomes Law; Likely to Hamper Small Business Self-funding

Legislation designed to make it more difficult for smaller employers to self-insure by restricting their ability to obtain stop-loss insurance with very low attachment points was signed into law on Oct. 1 by California Gov. Jerry Brown.

S.B. 161, which takes effect Jan. 1, 2014, will prohibit stop-loss insurers in California from issuing policies with specific deductibles below $35,000 for self-funded employer plans. After Jan. 1, 2016, the law increases the minimum specific attachment point to $40,000.

Also under the law, starting Jan. 1, aggregate attachment points cannot be less than $5,000 times the total number of group members, 120 percent of expected claims, or $35,000 ($40,000 after Jan. 1, 2016).

Note: The bill as introduced in May 2013 had a minimum specific attachment point of $65,000. During debate, bill sponsor Sen. Ed Hernandez (D) agreed to lower that minimum to $35,000.

Starting April 1, 2014, and each April 1 thereafter, stop-loss insurers will have to report to the California Department of Insurance the number of small employer stop-loss polices they had issued that were in effect as of Dec. 31 of the previous year.

S.B. 161 brings stop-loss policies in line with health care reform rules banning pre-existing condition exclusions, rescissions and annual and lifetime limits for health coverage.

It also prohibits stop-loss insurers from denying coverage for individuals who were very sick and costly the year before, a practice called "lasering." It prohibits them from excluding any employee or dependent based on actual or expected health status-related factors.

It prohibits stop-loss insurers from refusing to reissue policies to employers. Instead it requires them to renew all stop-loss insurance policies (if asked by the employer), except: (1) in cases of non-payment of premiums or intentional misrepresentation by the self-funded plan; (2) if the insurer ceases to issue stop-loss policies; or (3) if the insurer is determined to be "financially impaired" by the state insurance commissioner.

In so doing, S.B. 161 tips the scale against self-funding by making companies assume more risk of paying

See *Stop-loss California*, p. 7

Government Shutdown (continued from p. 5)

in 2014; it increases to $395 or 2 percent of salary in 2015 and to $695 or 2.5 percent of salary in 2016.

Also, GOP legislators wanted to reverse a federal decree that allowed congressional staffers to remain under their current federal health plan and not to go onto exchanges. Rep. Chaffetz said this constituted "special treatment" that Congressional members and staff should not get.

On the evening of Sept. 30, a subset of House Republicans staged a mini-rebellion, trying to shear off 17 GOP votes that would have allowed the government to stay open. But they failed, getting only six votes.

House GOP Focuses on Contraceptive Mandate

As of Oct. 12, the U.S. Congress remained far from resolving the budget crisis and government shutdown, as House Republicans refused to adopt a deal cut in the Senate, because their goal remained one of dismantling the health care reform law. GOP hardliners demanded stronger opt-outs from contraceptive coverage as a condition of resolving the budget impasse and government shutdown.

By that time, President Obama had given up negotiating with the House and had placed his faith in talks between Senate leaders Mitch McConnell, R-Ky., and Harry Reid, D-Nev., with the expectation that whatever bipartisan agreement emerged would need to be approved by the House. The White House rejected a House deal because it did not include a reopening of the government. In an Oct. 12 leadership meeting, the House GOP leaders said they could not accept either a debt-limit bill or a government-funding measure that lacked their priorities for the health care reform law.

According to published accounts, Rep. Paul Ryan, R-Wis., argued that the House had dropped the demand for a suspension of the individual mandate, but now required a "conscience clause" — allowing employers and insurers to opt out of birth-control coverage if they find it objectionable on moral or religious grounds.

Impact on Employer Plans

Employers in their role as health plan sponsors felt little immediate impact from the shutdown, but the agencies that oversee employee benefits (namely the DOL's

See *Government Shutdown*, p. 19

Tennessee Rule Scrutinizing Navigators Blocked

A federal judge stayed enforcement of a state regulation designed to limit the activities of "navigators" (who are supposed to help the public sign up for exchange coverage provided under the health care reform law) and subject them to background checks. A federal judge issued a temporary restraining order Oct. 10 blocking the Tennessee Department of Commerce and Insurance from enforcing part of emergency rules designed to block health law navigators who had not been vetted by the state. (See http://state.tn.us/sos/rules_filings/09-29-13.pdf.)

As a result, churches, unions and social service organizations can set up computer stations to help the uninsured sign up for coverage under the health care reform law.

The lawsuit challenging the state regulations was brought by Service Employees International Union Local 205 and two of its members. Other plaintiffs included a librarian who wanted to help library patrons sign up and an employee with Nashville social services who said she could help people sign up for food stamps and state Medicaid, but she could not do essentially the same thing for the exchange.

The plaintiffs said that the rules violate the First Amendment right to free speech and conflict with federal laws, including the health care reform law and the Americans with Disabilities Act. The attorney representing the local SEIU contended that the rules would prevent his clients from helping people sign up for coverage on the Internet, according to articles in *The Tennessean*.

U.S. District Judge Todd Campbell said he issued the two-week injunction because the language represented a prior restraint violation of the First Amendment.

Tennessee Compromise

Bill Young, Tennessee's solicitor general who also represented the state in federal court, signed an order that narrowed the entire scope of the emergency rules. The state agreed that the rules would only apply to people and entities that are required by federal law to be registered as navigators or certified application counselors.

Young asked the federal judge to let the Davidson County Chancery Court decide the issue and said negotiations were under way to resolve the dispute.

Campbell said he did not think it was appropriate for the federal court to be absent on an issue that involved First Amendment rights and a federal health-care program.

The Original Rule

The rule proposed prohibiting anyone from acting as a navigator in the state unless they had passed a criminal background check, including being fingerprinted. The proposal also stated that health law counselors and navigators may not discuss "benefits, terms and features of a particular plan over any other health plans" or "offer advice about which health plan is better or worse or suitable for a particular individual or employer."

The rule's preamble stated: "These rules are necessary for the Commissioner of Commerce and Insurance to establish criteria for registering navigators to ensure that individuals who are not of good moral character cannot act as navigators in this State, … and to ensure that navigators are not acting as insurance producers." The rules set a penalty of up to $1,000 per violation.

Tennessee in May 2013 promulgated Chapter 377 of the Public Acts of 2013 prohibiting navigators from selling, soliciting or negotiating any insurance policy, giving the insurance commissioner the ability to shut down errant navigators and directing the commissioner to write rules restricting them.

On Oct. 1, 2013, individuals began enrolling for health coverage in the health insurance marketplaces, also known as exchanges. In Tennessee, the marketplace is run by the federal government.

The state commissioner, Julie Mix McPeak, said the rules would ensure that people representing themselves as exchange experts "have completed federal training courses and related examinations, where appropriate, and that they have passed a criminal background check."

Stop-loss California (continued from p. 6)

members' health expenses, and potentially dissuading them from deciding to self-insure in the first place, the Self-Insurance Institute of America said.

Governor Says Bill Supports Reform

The Governor's office in Sacramento connected the passage of S.B. 161 to its support of the health care reform law. Earlier insurance mandates, such as no rescissions and no annual limits, raised the cost of coverage, but self-insurance is a way that employers can skirt compliance with federal and reform mandates, to the peril of consumers, reform proponents have argued.

S.B. 161 builds on earlier health care reform implementation efforts, including building a health benefit exchange, the governor's office said.

HHS Reminds Plans of ERRP Sunset Steps

HHS is phasing down ERRP website so that it can be taken offline during the first week of January 2014. And in an Oct. 3 notice, the agency described the final steps fund recipients should take because they won't have further access to the site. (See http://www.errp.gov/newspages/2013/20131003-plan-sponsor-duties-during-errp-phasedown.shtml.)

ERRP, part of the health care reform law, was intended to shore up the number of employers offering health coverage to certain retirees age 55 to 64, by providing temporary financial help to employers to keep providing such coverage. The ERRP is scheduled to close on Jan. 1, 2014.

Representatives, account managers and designees working for plans should assume they won't be able to access the ERRP's website on or after Jan. 1, 2014, HHS said in the memo. Therefore, HHS' Centers for Medicare and Medicaid Services asked plans that received ERRP funds to review information on the website "to determine what, if any, information or data should be printed and/or saved before the system is taken offline." Authorized representatives and account managers should ensure that their contact information (especially email addresses) is accurate. Also important to verify is that banking information on file with ERRP is up to date and that the latest change-of-ownership notifications are made.

The agency noted that plans' ERRP recordkeeping requirements do not end on Jan. 1, and that they are required maintain and furnish required records to HHS on request. For example, plans must supply documentation to auditors to demonstrate compliance with program rules.

After Dec. 31, 2013, plans will no longer be required to update their data, unless they are the subject of an audit.

HHS issued a notice on April 23, 2013 explaining the operational shutdown of the program that said: (1) July 31 was the last day plans could submit an ERRP reimbursement request; (2) Dec. 31 is the last day plan sponsors had to update information on the website; and (3) Dec. 31 is the last day plans can submit an ERRP reopening request. (See http://www.gpo.gov/fdsys/pkg/FR-2013-04-23/pdf/2013-09541.pdf.)

Note: HHS stopped accepting applications for the ERRP after April 30, 2011, based on the exhaustion of funds. In December 2011, it told plan sponsors that 90 percent of ERRP funds had been paid out and that no new claims would be processed after Jan. 1, 2012.

Exchange Websites Exhibit Flaws, Government Says, Due to High Consumer Interest

Droves of people flocked to comparison-shop or sign up for health coverage on newly operational health insurance exchanges, which started operating on Oct. 1. Unfortunately, many of them encountered various technical difficulties — especially on Healthcare.gov.

On Your Marks, Get Set, Fail

Despite the federal shutdown in Congress, federally facilitated health insurance exchanges (also called "marketplaces") opened as scheduled, on the morning of Oct. 1. But soon after the system opened for enrollment, exchange websites crashed in 24 of 36 states whose exchanges are run by the federal government.

"Consumers who need help can also contact the call center, use the live chat function or go to localhelp.healthcare.gov to find an in-person assistor in their community," the U.S. Department of Health and Human Services said in a statement.

Many people were denied access, encountering instead pages telling them that due to high traffic, sites were not operating. Some consumers said the exchange computer servers were unable to handle the process of scrolling through quotes, leading to computer freeze-ups.

"The federal site, Healthcare.gov, was sluggish and flashed error messages much of the day. The Obama administration said the delays were simply the result of an initial rush of people flocking to the site — 4.7 million unique visitors in the first 24 hours," the *Washington Post* reported.

Insurance companies selling on exchanges, now known as marketplaces, reported that they had gained few if any new customers from the new marketplaces. For example, Blue Cross Blue Shield, Louisiana's biggest insurance provider and one of four companies participating in that state's exchange, said in the first two days of operation that it had sold no policies at all through federal exchange websites.

On the other hand, some consumers said enrolling in Obamacare policies was far easier than facing the questioning insurance companies used to perform when underwriting individual policies before exchanges coverage became available. Policies regulated under the health care reform law are limited to asking underwriting questions related to age and tobacco only.

More Delays in Health-reform Implementation; Key Aspects of Exchanges Compromised

The federal agencies implementing health reform continued to delay aspects of roll-out, especially as they relate to state-based health insurance marketplaces (also called "exchanges"), which opened officially on Oct. 1.

The Obama White House announced on Sept. 27 that federally run health-insurance exchanges, required by health care reform, will not be able to handle Spanish-language online enrollment by Oct. 1 as planned. The announcement did not apply to the 14 states that run their own exchanges. It also told the public that the exchange program for small businesses will have no online component until Nov. 1.

On the same day, a prominent administration official described how responding to industry concerns played a role in implementation delays the public is seeing now.

Spanish Not Spoken Here

First, the Spanish-language version of healthcare.gov will not be able to enroll Spanish speakers online until Oct. 21, the administration announced.

Spanish speakers will still be able to enroll through a call center or enrollment specialists known as "navigators," the White House said. It added that this was not a delay, but rather reflected the administration's decision to unveil the online enrollment tool to coincide with Hispanic Heritage Month.

Another Delay

Second, small businesses (those with 50 or fewer workers) will not be able to sign their staff up for insurance on Small Business Healthcare Option exchanges until Nov. 1, the U.S. Department of Health and Human Services admitted, also because the SHOPs' online resources are not up and running. Online enrollment will commence on Nov. 1.

That means small businesses will not be able to access searchable coverage options with premium quotes, and the concept of "one-stop shopping" will not be available until Nov. 1. However, they can apply to establish their eligibility and to get subsidies to cover their workers, White House spokesperson Jay Carney said. He added the failure to have online resources ready on Oct. 1 would have no practical effect on coverage because policies sold on SHOP exchanges won't be valid until Jan. 1 in any event.

Carney further downplayed the delay, noting that the SHOP exchange is open year-round, while the larger state-based health insurance exchanges for individuals stop selling policies at the end of March.

But the delays add to expectations of a slow start to the landmark social program which remains under attack

See *Reform Delays*, p. 10

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D. Free Distribution by Mail *(Samples, complimentary, and other free)*		
1. Outside-County as Stated on Form 3541	20	20
2. In-County as Stated on Form 3541	0	0
3. Other Classes Mailed Through the USPS	0	0
E. Free Distribution Outside the Mail *(Carriers or other means)*	0	0
F. Total Free Distribution *(Sum of 15d and 15e)*	20	20
G. Total Distribution *(Sum of 15c and 15f)*	158	134
H. Copies not Distributed	59	26
I. Total *(Sum of 15g and 15h)*	217	160
J. Percent Paid and/or Requested Circulation *(15c/15g x 100)*	87%	85%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2013 issue of this publication.
17. I certify that the statements made by me above are correct and complete. Todd Leeuwenburgh, Editor.

Reform Delays (continued from p. 9)

by Republican leaders and faces formidable technical hurdles for both states and the federal government.

EBSA Explains About-face on Exchange Notice

Also on Sept. 27, Assistant DOL Secretary for the Employee Benefits Security Administration Phyllis Borzi described what complicates reform implementation: Some of it has been in response to disinformation generated in the market and in the media.

For instance, the agency had to do a "quick pivot" on the notice about exchange coverage employers are required to give all employees.

Employers were concerned that their participants were getting erroneous information from vendors offering to sign up people on exchanges, but that inaccuracies in their marketing would contribute to participants leaving employer plans, Borzi said.

In response, EBSA/DOL added an optional section to the two model notices EBSA/DOL issued (one for employees covered, and another for employees not covered by an employer plan) with its approved description of the exchanges, hoping that would correct misconceptions. Use of the language is optional, but the additional description helps employers accurately describe the exchanges to their workers, she said.

There was a second set of disinformation: one consultant issued statements that failure to distribute the notice of exchange would trigger $100-a-day penalties under ERISA Section 502. That mistake went viral and "that started a stampede of reports that failure to distribute the notice would trigger a $100-a-day ERISA fine." DOL/EBSA responded with another clarification that the notification requirement is authorized under the Fair Labor Standards Act and as such it does not carry with it the threat of ERISA administrative fines.

This clarification is found in the recent agency-issued FAQ (see http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html) saying that while the notices are required, there is no penalty for failing to distribute them. On the other hand, Borzi said, since the notifications are not incorporated in ERISA, but part of the FLSA, employers must give them to *all* employees, not just people covered by the company health plan.

DOL Objectives

In the first year, the government hopes to sign up as many as 7 million enrollees. Over the years after 2014, millions more people will sign up, making a real dent in the uninsured population, Borzi predicted.

Borzi said the government is doing a nice job persuading those less than 30 years of age, helping them understand the need for insurance.

The federal government focused more intense rollout plans for exchanges and individual enrollment particularly in states that refused to set up their exchanges, she said, expressing satisfaction that higher-than-expected numbers of insurers will be selling products on federally run exchanges, adding that in spite of some of the large carriers sitting out of certain markets, premiums for policies sold on exchanges were lower than previous estimates.

Delays to Section 6055 and 6056 Reporting

Section 6055 and 6056 reporting requires all employers, insurers, government payers and multi-employer groups to tell their covered lives that they are (or are not) covered with minimum essential coverage. Without this reporting, the federal agencies (IRS in particular) have no basis for enforcing the employer pay-or-play mandate.

The reporting is critical because of the connection between tax credits for individuals and penalties for employers. She cited three reasons:

1) Individuals need to know whether they have MEC, so they can know whether they are entitled to subsidies to buy coverage on an exchange.

2) Before awarding subsidies, the IRS needs to track whether employers have made an offer of MEC, because employee credits are contingent on the employer having fallen short in what they offer.

3) Employers needed an appeal process of adverse exchange determinations, because even if a worker shows all the signs of being otherwise eligible, an offer of affordable MEC normally renders workers ineligible from getting subsidies to buy coverage on an exchange, she said.

The difficulty of coordinating the implementing agencies — DOL, IRS and HHS — and harmonizing the guidance with all three agencies' rules was what led to delays in that sphere, said Helen Morrison, a former Deputy Benefits Tax Counsel for the U.S. Department of the Treasury now with Ernst & Young.

Are Employers Using Reform as a Scapegoat?

Some employers have cited Obamacare as one of the reasons that they are: (1) removing spouses from company coverage; (2) reducing work hours to less than 30 per week to avoid an obligation that they be covered by health insurance; and (3) removing part-time workers from health plans, and giving them a nominal fee to seek coverage on exchanges. Borzi contended that such companies could have done this regardless of Obamacare.

Exchange Data Show Wide Premium Variations For Health Coverage in Various States

New federally run health insurance exchanges started selling policies on Oct. 1, and officials from the U.S. Department of Health and Human Services disclosed insurance prices for exchange coverage. In doing so, they emphasized that policies sold on exchanges came in costing less than projected, consumers have choices from among scores of plan options and multiple insurers are operating in virtually every market.

On the other hand, observers noted that young, healthy buyers will lose low-cost bare-bones options that may not be sold after Jan. 1, 2014, and at least some individuals will be forced to pay more.

Employers may consider these data in the cost-benefit analysis when deciding whether to keep workers on the company plan or send them to exchanges. Employers can effectuate this by phasing out health coverage altogether; or by moving people from full- to part-time status. Part of this task is knowing how workers are impacted financially by going to exchanges.

Policies sold on exchanges (also called "marketplaces") are designed to be for people who don't get insurance through their employer or government program. They cover a fairly comprehensive range of benefits, and have to be paid in full by consumers who don't qualify for health care reform subsidies. Because the health care reform law requires individuals to buy relatively complete coverage, some consumers are complaining about it raising new costs.

- The HHS report can be viewed at http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm.
- Data on premium rates in 36 states can be viewed at http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.

Plans in the marketplace will be categorized as either "gold" (covering 80 percent of costs) "silver" (covering 70 percent of costs) or "bronze," (covering 60 percent of costs). Policies that cover less than 60 percent of costs may not be sold on exchanges. The data show that exchange premiums vary markedly from state to state.

Example: In one rating area in Alabama, monthly rates for a 21-year-old are: $132.22 for the lowest priced catastrophic only; $152.88 for the lowest priced bronze plan; $189.47 for the lowest priced silver plan; and $245.25 for the lowest-priced gold plan.

Example: In one rating area in Florida, monthly rates for a 21-year old are: $194.67 for the lowest priced catastrophic only; $225.00 for the lowest priced bronze plan; $249.97 for the lowest priced silver plan; and $287.19 for the lowest-priced gold plan. In the same rating area, the rates for a 49 year old were $383.85 for lowest-cost bronze; $426.45 for lowest-cost silver; and $489.95 for lowest-cost gold coverage.

Example: In New Jersey (which has only one rating area for the whole state), monthly rates for a 21-year-old are: $177.40 for the lowest priced catastrophic only; $208.70 for the lowest priced bronze plan; $240.95 for the lowest priced silver plan; and $289.43 for the lowest-priced gold plan.

The data set showing rating areas and the lowest cost options left out the 14 states that run their own exchange programs. HHS reported on Sept. 23 that 36 states will host exchanges that the federal government runs; and just 14 states will run their own exchanges. But HHS also included a chart with weighted average premium rates for 48 states, which reveal where premiums are the highest (see box).

States With Expensive Average Premium Rates

State	Lowest Cost Bronze	Lowest-Cost Silver
Wyoming	$425	$489
Alaska	$385	$474
Connecticut	$340	$397
Indiana	$304	$392
New Jersey	$332	$382

Source: HHS/ASPE

HHS also issued a weighted average premium for the entire nation, which turned out to be $249 for the lowest cost bronze policy and $310 for the lowest cost silver policy.

Premiums Skyrocket Less

The Obama administration said premiums for exchange coverage have come in significantly lower than expected. HHS found that the average premium nationally for the second lowest cost silver plan will be $328 before tax credits, or 16 percent below Congressional Budget Office projections.

See *Premium Variations*, p. 12

Premium Variations (continued from p. 11)

But a spokesman for Senate Republican leader Mitch McConnell (Ky.) told the *Associated Press* that premiums that are "lower than projected" are not the same as "lower than they are now."

Bare-bones Plans No Longer Sold

Some consumers will pay more due to the disappearance of low-cost skimpy plans favored by younger people, because reform mandates much more coverage than before.

The *Wall Street Journal* ran a chart comparing the lowest cost bronze plan on the exchange for a healthy 27-year-old to the current lowest premium for a "bare-bones" (high deductible or limited coverage) plan in that area.

In each of from 35 examples, premiums rose dramatically for the young consumers as they moved into fuller bronze coverage.

In Nashville, Tenn., a 27-year-old male nonsmoker could have paid $41 per month for a bare-bones policy but now has to pay $114 for the lowest-cost bronze plan offered under reform, and that constitutes a rate hike for those people, the *Journal* reported.

Subsidies may reduce some of those consumers' premiums, but the help is most pronounced for people earning $25,000 a year and less; the subsidies taper off somewhat rapidly after that. The sale of slightly cheaper catastrophic plans to people in their 20s also is not expected to offset much of that cost.

(**Note:** Health care reform exchanges are selling catastrophic only policies that are available mostly for individuals who are under age 30, and the new HHS data indicate those policies are about 80 percent as expensive as the required "bronze" coverage. In November 2012, CMS issued a proposed rule regarding catastrophic plans, and those rules were finalized in February 2013 (78 Fed. Reg. 13406). Those final rules describe minimum standards for policies sold on exchanges.)

Sign-up started Oct. 1 but many of the new policies won't take effect until Jan. 1, 2014, the day every individual must have coverage or pay a penalty. It lasts through the end of March for a six-month sign-up period, the administration says.

Individual Fines for Failing to Obtain Coverage

Although the exchanges opened Oct. 1, penalties for not having health coverage will not begin to be assessed until the end of March 2014, HHS said. The penalties start small and increase over time, as seen in the chart below. Affected individuals will be assessed either a fixed (applicable) dollar amount, or a specified percentage of their modified income, whichever is greater, but not to exceed the premium amount for the area's lowest-priced bronze plan.

Year	Applicable Dollar Amount*	Specified Percentage
2014	$95	1 percent
2015	$325	2 percent
2016	$695	2.5 percent
2017 and beyond	$695, as indexed for inflation	2.5 percent

Source: HHS

Coverage under a grandfathered health plan and recognized employer-sponsored group health plans ensure that employees do not run afoul of the individual mandate. For employers to keep protecting workers from individual mandate penalties, they have to continue to offer "minimum essential coverage." If an employer offers MEC that is affordable and 60 percent actuarial value or higher, full-time employees are not eligible for exchange coverage, under reform rules.

For more information on the individual mandate, go to Chapters 610 and 620 of *The New Health Care Reform Law: What Employers Need to Know*.

Health Care Reform Briefs

The government garnered a second victory against owners of for-profit companies opposed on religious grounds to health care reform's contraceptive coverage mandate, paving the way for it to petition the U.S. Supreme Court over the extent to which an individual can invoke the Religious Freedom Restoration Act of 1993 to gain an exemption from a federal requirement targeting corporations. Elsewhere, two employers ended health coverage for part-time employees, sending them to state-based health insurance exchanges, as two large retailers — Trader Joe's and Home Depot — ended health coverage for employees working fewer than 30 hours a week. And large employers in a survey overwhelmingly said they would send out notices supporting the exchanges to all their employees, even though the government just announced there would be no penalties for failing to do so.

Feds Ask for High Court in *Hobby Lobby* After Contrasting Rulings Delivered

On Sept. 18, three federal agencies — Health and Human Services, Labor and Treasury petitioned the U.S. Supreme Court to overturn 10th Circuit's decision in *Hobby Lobby v. Sebelius*, No. 12-6294 (10th Cir., June 27, 2013), after that court ruled in favor of the owner's right to project his RFRA rights not to comply with the contraceptive care mandate through to his corporation. The government framed the following question to the High Court:

> The question presented is whether the RFRA allows a for-profit corporation to deny its employees the health coverage of contraceptives to which the employees are otherwise entitled by federal law, based on the religious objections of the corporation's owners.

The 10th Circuit had ruled that Hobby Lobby, a for-profit, $3 billion arts-and-crafts store chain with 514 stores in 41 states and 13,240 full-time employees, could refuse to provide coverage mandated by the health care reform law based on its owners' religious objections. The circuit said that the case brought by Hobby Lobby's owners showed a likelihood of success, and that their rights under the RFRA were substantially burdened by the contraceptive mandate.

In its petition for a writ of *certiorari*, the government tells the High Court that the RFRA "does not allow a for-profit corporation to deny its employees the benefits to which they are otherwise entitled by federal law."

Review by the High Court was due because the circuits are split on the question, the government said in its cert petition. The 10th Circuit's position in *Hobby Lobby* was opposed to the decisions by the 3rd Circuit in *Conestoga Wood v. Sebelius*, 2013 WL 3845365 (3rd Cir., July 26, 2013), and the 6th Circuit's *Autocam v. Sebelius*, No. 12-2673 (6th Cir., Sept. 17, 2013) decision (see below). Similar RFRA claims are pending in the 7th, 8th, 11th and D.C. Circuits, the government said.

6th Circuit Denies Challenge to Contraceptive Mandate; For-profits Cannot Defend RFRA Rights

The owners of a Michigan company do not have legal standing to seek an exemption from health care reform's requirement that all health plans provide forms of contraception and sterilization, a a federal appeals court said in a Sept. 17 ruling.

The RFRA is designed to protect individual rights, the 6th Circuit reasoned, and the owner should not be allowed to assert his RFRA rights in an effort to avoid complying with a federal organization. In so doing, it unanimously upheld a decision from the U.S. District Court in Grand Rapids, Mich.

The court also concluded that only a corporation has standing to challenge health care reform's employer mandate, because only a corporation is subject to penalties under it.

Autocam Corp. is in the manufacturing business for the automotive and medical industries, and it self-insures its health plan. It employs 680 people in the United States and offers health insurance that includes no-cost preventative care.

The company owners, the Kennedys, opposed contraceptive coverage on religious grounds, and said the company's direct purchase of contraception and sterilization services made them morally responsible for their use. They argued that dropping health coverage would injure it by violating their religious beliefs around caring for employees, but also because it would expose Autocam to pay-or-play penalties.

But the court said a for-profit corporation is not a person capable of exercising the right to free exercise of religion, and that to allow the Kennedys to sue under a personal statute for harm allegedly happening to

See *HCR Briefs*, p. 14

Autocam would contradict one of the basic tenets of incorporation: shielding individuals by creating separate entities.

Incorporation's basic purpose is to create a distinct legal entity, with legal rights, obligations, powers, and privileges different from those of the natural individuals who created it, who own it, or whom it employs, the court said. In return for the shield from liability, the shareholder has to give up some privileges, including that of direct legal action to redress an injury to him as primary stockholder in the business, the court said.

Trader Joe's Cuts Health Insurance To Part-time Employees

Socially progressive Trader Joe's last month told employees it will move its part-time staff into state-based health insurance exchanges where they will be eligible for tax subsidies to buy health insurance, starting on Jan. 1, 2014.

The company said exchange coverage would be more affordable to the company and federal subsidies would help part-timers absorb the change with little or no pain. To help soften the blow, the company gave affected part-time employees a $500 stipend to pay for new coverage.

Trader Joe's CEO Dan Bane told employees in a memo that most employees affected by the change — part-timers earning less than $20,000 — would be eligible for substantial subsidies and that there would be no change in company-provided health coverage for more than 77 percent of its workers.

The grocery chain has long provided health coverage to its part-time employees, and the retailer was praised as having some of the lowest rates available for part-time workers.

In a similar move, Home Depot on Sept. 19 announced it was phasing out coverage for (about 20,000) part-time workers with 30 or fewer hours a week and sending them to exchanges to get coverage.

Home Depot employs about 340,000 people and will continue to offer health coverage to full-time employees, a Home Depot spokesman said.

In such situations, some employees undoubtedly will have to pay more after losing their employer contribution; particularly as their salaries approach and exceed the subsidy limit of 400 percent of the federal poverty level.

This may be indicative of a growing trend of large employers cutting back on benefits in response to subsidy and cheaper-coverage opportunities on exchanges, observers said. They also said that health care reform was not intended to prompt employers into cutting back on benefit offerings, but that's been one of the unintended consequences of the law.

Virtually all Large Employers Will Send Notices of Exchange Coverage Options

The vast majority of large employers will distribute exchange notices to employees on Oct. 1, 2013, even though the government promised no fines would be levied for failing to do so, according to a survey conducted by the ERISA Industry Committee this September.

The health care reform law provides that employers are to inform their employees about access to health coverage through the exchanges.

Under the requirement, employers must tell workers: (1) about the exchanges; (2) that employees may be able to get cheaper insurance on the exchange, and (3) that if employees buy insurance through an exchange, they may lose the employer contribution (if any) to their health benefits.

In ERIC's survey, 94 percent (47 companies) of ERIC members surveyed said they were ready to do that on the rule's due date of Oct. 1. See http://www.eric.org/uploads/doc/health/ERIC%20Findings%20from%20Exchange%20Notice%20Survey.pdf.

This comes directly after guidance from DOL said employers cannot be fined for failing to notify employees about alternate health coverage on a state-based insurance exchange. The poll also found that 92 percent of the companies planned to use the model notice created by DOL for exchange reporting purposes.

On the other hand, many respondents indicated they had to craft a cover letter to accompany the notice because of the confusion and concern it otherwise would have engendered in workers.

ERISA Remedies Unavailable to Decedent's Family For Plan Delay Approving Treatment

An attempt by a deceased plan participant's family to recover money from a plan was rejected because ERISA does not allow recovery of extra contractual damages or damages based on undue delay in administration of a disputed claim.

ERISA benefits were impossible to disburse after the participant had died, the 5th U.S. Circuit Court of Appeals held in *Hamann v. Independence Blue Cross*, 2013 WL 5227085 (5th Cir., Sept. 18, 2013), because no medical care was received, the court said.

The situation arose after the health plan failed to communicate that its denial could be reversed, leading to a three-month delay in treatment.

The Facts

Dean Hamann had chronic lymphocytic leukemia and had developed myelodysplatic syndrome. His physicians requested that the plan approve stem cell transplant therapy along with a trial study.

In its initial denial, the plan administrator (Amerihealth) refused to pay, but failed to state that the reason was that the transplant was part of a trial study. The plan excluded coverage for trial studies. Hamman's physicians made a second claim again tying the SCT to the trial study, and the plan issued a second denial, this time invoking the plan's exclusion for experimental procedures.

(**Note:** Health plans may define care given in a clinical trial as "experimental" or "investigational," and therefore deny payment.)

The patient's wife then contacted Amerihealth and was told that the SCT therapy would be approved if requested without the trial study. At that point Hamman's physicians requested SCT separate from the trial study for the first time, and the plan approved it. But that approval was more than three months after the initial claim.

And by the time the plan did approve the treatment, the patient had grown sicker and getting the treatment was no longer feasible. He soon died.

The Decision

The family sued under ERISA, alleging failure to fairly and timely approve benefits due under the plan. It sought payment of the full value of the SCT therapy under ERISA's enforcement provision at §502(a)(1)(B). They also asserted a cause of action for survival and wrongful death under Louisiana law.

But the district court dismissed their case, accepting the plan's argument that an individual cannot recover the value of benefits due when he or she never received the medical care.

They appealed, arguing that even though Hamann never got or paid for the requested treatment, ERISA still allowed them to recover the value of the therapy as a "benefit owed" under the plan.

Unfortunately for the Hamanns, the Supreme Court in *Mass. Mut. Life. Ins. Co. v. Russell,* 473 U.S. 134, 147 (1985), held that ERISA's enforcement provisions do not allow recovery of extra contractual damages or damages based on undue delay in administration of a disputed claim.

The High Court in *Russell* rejected using §502(a)(1)(B) as a damages remedy when undue delay causes harm to a beneficiary, holding that courts cannot "engraft a remedy on a statute … that Congress did not intend to provide." In other words, ERISA has no remedy for delays that result in harm to a beneficiary.

> While §502(a)(1)(B) allows beneficiaries and plan participants to recover benefits to which they are entitled, it does not provide that beneficiaries can recover benefits they did not, and now cannot, receive.
>
> While the Defendants' approval of the SCT therapy tragically came too late for Mr. Hamann, we are bound by the specific relief provided by Congress under §502(a)(1)(B) and, therefore, must AFFIRM the district court's dismissal of the Plaintiffs' claim.

Implications

Much like in the way a benefit plan can avoid assessments of punitive damages, this case reminds us of some of ERISA's unique attributes.

Clear, well-crafted plan documents that comply with applicable laws and regulations are the most important component of a benefit plan seeking to capitalize on ERISA's advantages.

Through use of effectively drafted exclusions, as well as ERISA-compliant appeals procedures, plan sponsors can ensure their plans are administered prudently in strict accordance with applicable terms. While this case highlights that ERISA does not provide legal remedies for delays in treatment incurred as a result of proper

See *Remedies Unavailable*, p. 16

HDHP, Health FSA Participation Growing, Study Says

Participation in high-deductible health plans and health flexible spending accounts has grown at a strong pace, according to a study by the National Center for Health Statistics. The findings in "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2013" suggest that employees' interests in consumer-directed health plans is growing, information employers may find useful in designing and administering their benefits plans.

To read the report, go to http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201309.pdf.

Enrollment in HDHPs by participants in employer-provided health plans nearly doubled in five years, growing from 17.1 percent in 2008 to 30.3 percent in the first quarter of this year, NCHS says. HDHP participation is necessary before an individual can establish a health savings account.

Participation in health FSAs has grown during that time as well, although not by as great a rate. NCHS found that 18.7 percent of health plan participants contributed to a health FSA, and 22.8 percent did so in the first quarter of 2013. This growth took place even though effective Jan. 1, 2013, the Patient Protection and Affordable Care Act limits the amount an employee can set aside in a health FSA annually to no more than $2,500.

NCHS suggests that these findings may be attributable to PPACA's extension of coverage through parental health plans to adult children through age 26. It found that in the first quarter of 2013, 56.9 percent of those ages 19 through 26 have health coverage, whereas 51 percent did in 2010. Other key findings included:

- 46 million persons of all ages were uninsured in the first 3 months of 2013; 57.4 million had been uninsured for at least part of the year prior to interview; and 34.5 million had been uninsured for more than a year at the time of interview.
- In the first 3 months of 2013, 5.2 million children under age 18 were uninsured.
- 26.7 percent of adults age 19–25 were uninsured in the first 3 months of 2013.

NCHS is a federal government health statistics agency that compiles information to guide actions and policies to improve public health.

To read more about high-deductible health plans, health savings accounts and health FSAs, see the *Employer's Handbook: Complying with IRS Employee Benefits Rules* and the *Flex Plan Handbook*.

These publications can both be found on http://hr.complianceexpert.com/.

Remedies Unavailable (continued from p. 15)

claim administration, it may impose penalties on a plan that fails to strictly comply with its own terms.

For that reason, clear language and communication with all those charged with proper plan administration is necessary to assist in avoiding the much harsher judicial intervention imposed on health plans administering claims in a way that that could be deemed to be arbitrary and capricious.

Additionally, plans must recognize jurisdictional variation in the appeal requirements. While some federal jurisdictions require that a plan participant exhaust all administrative remedies, others allow plan participants to file an action under ERISA before completing the plan's appeals process.

Understanding how a plan's relative jurisdiction provides a plan participant standing to bring an action under ERISA is of utmost importance when determining a plan's liability on a given claim or matter.

CE Column (continued from p. 2)

involved do not already have an outside network agreement that you must abide by. This can be tricky and may require help from experts, but if you don't check this out first, then you may be killing your carve-out program before it even starts.

Provider-based Carve-outs

When a plan implements a provider-based carve-out, the rules apply because of who the treating provider is and not because of the service provided. The plan document terms can be as mundane as adding specific rules that apply to in-network providers versus out-of-network providers, or as intense as refusing to allow assignment of benefits to a particular hospital.

Prescription Drugs

One of the fastest growing costs for self-funded plans relates to prescription drugs. Three main options exist for carving out high-cost prescription drugs from a health plan: (1) the entire prescription drug plan; (2) specific drugs; or (3) a particular disease.

Carve-out Examples: Durable Medical Equipment and Dialysis

Carve-outs directed at DME would pay charges in accord with the negotiated agreement currently in force between the plan and the provider or, if not applicable, covered charges would be limited to the lesser of: (1) invoice cost plus a percentage; or (2) the network allowable. By using this type of language, you avoid any network issues since the network rate prevails if the claim is in-network. For this to work, obviously you need to know what your network and provider agreements say.

One of the most popular areas for carve-outs is dialysis because of the high costs and specialized care involved. An example of dialysis carve-out language states that a provider contracted with the dialysis vendor will receive the lesser of the actual charge for dialysis services which, in some cases, will be a rate set by a regulatory agency or the amount negotiated for the dialysis service in effect on the date that the service is rendered.

Note: In my opinion, if your dialysis services are not carved out and you are not using a dialysis network or setting forth specified rates tied to Medicare reimbursement, then you are doing a disservice to your plan. Some of the most egregious charges in the medical world relate to dialysis providers. The carve-out is pretty easy to implement and the savings to your self-funded plan are enormous.

When carving out pharmacy benefits, an employer can save significant money without reducing benefits by separately leveraging this critical component.

To do so, employers contract directly with a pharmacy benefits manager for all or part of their prescription drug coverage, with the PBM managing the program rather than the self-funded employee health plan.

See *CE Column*, p. 18

Carve-out Examples: Prescription Drugs

Pharmacy benefit managers coordinate the sale and reimbursement of prescription drugs between consumers, plans, insurers, drug manufacturers and pharmacies. They provide negotiating power to secure rebates and discounts from drug manufacturers and pharmacies.

Since PBMs are accustomed to working with employers, they should be able to manage the carved-out pharmacy benefit without adding much cost.

The advantage for self-funded plans of managing a PBM instead of going through their insurer is that insurers charge plan sponsors middleman fees to manage the PBM relationship. By taking the middleman out, an employer can eliminate much unnecessary cost.

Companies can carve out the entire prescription drug benefit or only certain drugs. This gives employers more control over plan design and lets them tailor the benefit to the population being served.

The self-funded employer would have to determine what its goals are. Is the plan looking to reduce costs for a single drug used by a single participant or does it want to implement a complete overhaul of its drug benefit?

There may be pricing differences due to whether prescription drugs are billed by a PBM or health insurer. That could make it worthwhile to do a drug-by-drug analysis and carve out certain drugs for the PBM to handle.

Self-funded plans make a PBM part of their cost-management efforts by negotiating further discounts with the PBM, changing the formularies, requiring pre authorization, encouraging use of mail orders, varying copay amounts and using step therapy (in which covered drugs are organized in a series of steps).

However, one of the problems commonly faced with using a PBM is the lack of transparency. If a self-funded employer were to use a PBM then it would have to review the contracts in detail and negotiate with the PBM to achieve further cost savings. Plan sponsors have the fiduciary obligation to do this on behalf of their plans.

CE Column (continued from p. 17)

Specialty Pharmacy

Employers also can carve out specialty pharmacy from their health plan by building it into a tailored program with a plan design that puts specialty drugs (mainly cancer drugs and expensive biologics) in their own tier.

Specialty pharmacy managers offer medication discounts, drug utilization reviews, and research and reports from their experience in managing patients with rare conditions. The use of a specialty pharmacy may be voluntary or mandatory for plan participants and can be on a per-medication basis or based upon a class of medications.

From dialysis to disease management to wellness to implant devices, the need to carve out speciality networks or use different pricing mechanisms on specific treatments is growing.

The advantage to using a specialty PBM is its expertise in the types of drugs the company wishes to carve out. They require special handling delivery schedules and they often require physician participation in administration. Specialty PBMs put more emphasis on assistance programs to help patients administer specialty drugs and manage their cost. Companies may consider using a specialty pharmacy for certain diseases only.

As you can imagine with any innovative cost mechanism, there very well could be resistance from providers. As an example, if oncology drugs were carved out it may cause issues in patient care.

Providers (who are paid to acquire and administer oncology drugs) may be unwilling to accept deep discounts of oncology drugs through the carve-out.

Therefore, some employers keep physician-administered specialty drugs on the health plan but carve out oral and self-injectable ones.

Another option is step therapy, in which covered drugs are organized in a series of steps. First, prescriptions are filled with an effective, but more affordable medication, such as a generic drug. A more costly medication can be authorized if the first prescription is not effective.

Specialty drugs should be defined in the plan document by referencing to a list of such drugs, with the power to add new specialty drugs to the list as needed. The plan should require PBMs to provide pass through pricing on each retail, mail order and specialty drug. So what is the best way to obtain pass through pricing or as I like to call it, transparency? It requires the PBM to invoice the plan for a drug using its actual purchase cost, meaning the PBMs only profits are found in a flat per member, per month administrative fee. There is no more double or triple billing.

The plan should ensure that it has a contractual right to renegotiate all pricing and guarantees in the contract, which must be coupled with a right to terminate the contract, with or without cause, on anywhere from 30 to 90 days' notice. The contract should define rebates in order to distinguish between those rebates that are retained by the PBM and those that should be passed through to the self-funded employer.

Audit Rights Are Indispensable

The plan administrator should have the right to perform audits as they are important to determine if the PBM is administering the rebate contracts in accordance with the contractual terms. The plan must ensure that the PBM is not trying to limit the scope of the audit to a certain amount of contracts and data sets.

Disease Management

One of the growing areas is in disease management, which is a system of coordinated health care interventions for conditions in which patient self-care efforts are significant. It is the process whereby people with long-term conditions share knowledge, responsibility and care plans with health care practitioners. In order to be effective, it requires implementation with support networks — a range of clinical professionals willing to act as partners or coaches and relevant online resources. Knowledge sharing is integral to the concept of disease management.

Disease management and carve-out vendors can select and assemble the best specialists that treat large numbers of patients with the same conditions; adopt and evaluate the newest technologies, drugs and clinical guidelines; and conduct research.

On the other hand, problems with administrative functions, such as payment and oversight, can occur because some disease management services may be provided outside the health plan's usual network of providers.

See *CE Column*, p. 19

Government Shutdown (continued from p. 6)

Employee Benefits Security Administration) were running on a skeleton crew.

The shutdown slowed the development of health-reform guidance for employers, and raised the possibility of disrupting ongoing rulings, says attorney Paul Hamburger a partner with Proskauer Rose in Washington, D.C.

The shutdown was seen as not helping employers comply with new health benefit administration rules. To the extent the administration was not working, employers were not getting needed guidance, Hamburger said. Two big examples are: (1) the "post-*Windsor*" treatment of domestic partner benefits; and (2) health care reform.

Second, there were potential effects on employers that were awaiting rulings — such as a qualified plan determination or private letter ruling — pending before a closed government agency. "If you have such a matter, we hope the agency reaches out with an alternative plan," he said.

Hamburger expressed hopes that the government would accord flexibility for deadlines missed due to the shutdown.

Impact on Implementing Agencies

Impacts on the agencies that oversee employee benefits were outlined in a Sept. 25 DOL memo. According to the memo, EBSA normally had 986 employees, and was running on a staff of 46.

EBSA employees who worked in spite of the shutdown were the top dozen officials in the Assistant Secretary (for EBSA)'s office, and the remainder were investigators and prosecutors at EBSA regional offices.

Staffers were kept on because of their involvement in: (1) criminal cases involving ERISA plans; (2) pursuing civil cases that pose imminent threat to plan assets and other property; and (3) addressing situations where an ERISA benefits dispute could pose imminent threat to human life.

According to a Contingency Staffing Plan for Operations, the U.S. Department of Health and Human Services said the Centers for Medicare and Medicaid Services would "continue large portions of [health care reform] activities, including coordination between Medicaid and exchanges, insurance rate reviews, and assessing medical loss ratios by insurers." CMS normally employs 5,994 workers; under the shutdown 2,113 went to work.

CE Column (continued from p. 18)

Another potential drawback to DM carve-out programs is the administrative costs of achieving the necessary integration of information across multiple vendors, so that patients' care is coordinated. DM carve-outs, similar to wellness programs, are not extremely popular strategies for cost containment as it may take the plan years to realize any cost savings from such a program. The services typically provided with a DM carve-out program may include more services than what the plan really needs. However, in a world where we are seeing more proactive rather than reactive health care solutions coming to the table, DM carve-outs are making a splash.

Mental Health

Plan sponsors often carve out mental health coverage, delegating these benefits to specialized vendors with high levels of expertise in managing substance abuse, inpatient utilization and outpatient services, and negotiating with mental health providers and facilities.

High-risk Claims

Carve-outs for high-risk procedures or conditions allow employers to minimize their risk exposure to catastrophic health care claims. They transfer more of the financial risk to a third party, and help employers more effectively predict future health care costs. Health care services evolve rapidly and advanced medicine and technology change the way people use health care services. Accordingly, carve-outs can be a preventive strategy for unpredictable claims and new medical technology. Examples of high-risk carve-outs include transplants or premature infant care.

Conclusion

There are many potential carve-outs to choose from, but the truth is these additional, innovative programs and agreements can make your self-funded plan even more successful. If you are in a self-funded plan and you don't have the ability to carve out anything, you may want to rethink who is handling the processing of your claims. It makes sense on many levels, so spend some time looking at your options. From dialysis to wellness to implant devices, the need to carve out specialty networks or use different pricing mechanisms on specific treatment is growing. Jump on the bandwagon before it leaves the station.

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-2. Entries are listed alphabetically by subject and the name of the court case. The numbers following each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "21:2/2" indicates Vol. 21, No. 2, page 2.

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