Employer's Guide to
# Self-Insuring Health Benefits

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## CBO Quantifies Costs of Proceeding Without Pay-or-play Penalty Funds

The government's cost to implement health care reform is expected to rise by $12 billion as a result of the recently announced delay in the employer mandate and information reporting requirements, according to findings by the Congressional Budget Office. Further, the absence of the threat of penalties will result in 1 million fewer people enrolled in employment-based coverage in 2014 than would have otherwise, CBO predicted. The findings came one month after the Obama administration postponed: (1) employer reporting about coverage offered to workers; and (2) penalties for failing to offer required coverage. In a related development, the government scurried to explain that it afforded only very limited flexibility for state-run exchanges to verify income of individuals seeking subsidies for exchange coverage. In most cases, incomes would be checked to prevent fraud. ***Page 3***

## Health Reform Stumbles Forward In Spite of State, Insurer No-shows

A number of health insurers pulled out of state-based insurance exchanges for calendar year 2014, in most cases because the exchanges would not allow them sufficient freedom to raise rates. In another protest against health care reform, Texas became the sixth state to refuse to enforce reform's insurance mandates. The federal government will be forced to step into that role. Meanwhile legislators sought to change reform's definition of full-time employees as those working 30 hours per week, to bring it in line with most businesses 40-hour definition. Also, the government added implementation and compliance materials for employers to government websites. ***Page 5***

## ASO That Paid State Fee from Plan Assets Violated Bar on Self-dealing

A fee that an administrative service vendor tacked onto a self-insured plan's charges to fund its obligations to the state was a violation of its fiduciary duty to the plan under ERISA, the 6th U.S. Circuit Court of Appeals affirmed. Between 2002 and 2004, a nonprofit Blue Cross organization skimmed money from hospital discounts it negotiated with self-insured plans to shift the cost of its independent obligation to the state's Medigap program. Because the ASO vendor had discretion on how to pay the fees, the allocation was a fiduciary act. The fact that the fees were pulled from plan funds violated ERISA's prohibition on self-dealing and ERISA's requirement to use plan funds only in the plan's interest. The 6th Circuit affirmed a lower court ruling that agreed with the fund's argument, as well as an order of restitution of almost $400,000. ***Page 8***

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# Planning Ahead Through Your Plan Document

*By Adam V. Russo, Esq.*

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Self-funded employers, their brokers and third-party administrators always ask what they can do to reduce the overall cost of their health plans. The usual answers we hear from the self-insurance industry are to have a robust wellness program and review your claims data to identify problem areas. But we do not normally hear about something that I have been preaching for a decade: The best way to ensure that your self-funded health plan is running efficiently is through the plan document.

This two-part series will outline the way plan document design and wording can stop problems now ... before they turn into something that costs your plan a lot of money.

### Consider Taking Charge

The biggest advantage of being self-funded is the ability to design one's own health plan document.

The way a trucking company's plan with 300 lives is designed should be very different than how a school district's plan with 1,000 lives should be designed. Both plans have different needs and different risks. If the plans were fully insured, they would be pretty much identical. But a self-insured plan can be customized to best reflect the covered population.

But with such a privilege comes a dual challenge. Self-funded plan sponsors must: (1) ensure the plan complies with applicable laws (now including the health care reform law); and (2) control costs in the face of all the mandates and new rules that make the plan more expensive to operate. A forward-looking plan document handles both concerns — compliance and cost.

### Who Will Be the Fiduciary?

When determining what the plan document actually looks like, one of the first (and most important) things to be hashed out is: Who will be fiduciary of the plan and who has the discretionary authority to make plan decisions? This is the foundation of the plan. Will it only be the employer? Will the administrator make claim decisions at any point or might a third party have some fiduciary responsibilities?

*In the traditional TPA world***,** the plan holds all fiduciary duties, but the industry is beginning to see a shift where the TPA has the fiduciary responsibility on non-network claims, claim appeals or specific claim types.

In the TPA world, all questions regarding health claims should be directed to the TPA. The plan is ultimately responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with ERISA. Benefits under the plan will only be paid if the plan decides in its discretion that the participant or beneficiary is entitled to them.

This is a major difference from the "administrative services only" world of a health insurance company.

**See *CE Column*, p. 12**

**Employer's Guide to Self-Insuring Health Benefits**

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# High Cost of Employer Mandate Delay: Reform Costs May Rise by $12 Billion

The government's costs to implement health care reform is expected to rise by $12 billion as a result of the recently announced delay in the employer mandate and information reporting requirements, according to a July 30 letter by the Congressional Budget Office and the Joint Committee on Taxation. In addition, the letter to the House Committee on the Budget noted that roughly 1 million fewer people are expected to be enrolled in employment-based coverage in 2014 than what CBO had projected earlier this year.

### Background

On July 2, the U.S. Treasury Department announced that the federal government was suspending certain reform requirements that initially were scheduled to begin in January 2014: (1) employer reporting about coverage offered to workers; and (2) a play-or-pay mandate, which will require employers that employ 50 or more workers to offer health coverage to workers or pay a penalty. An official announcement on transition relief for employers from the reporting requirements and the play-or-pay mandate delay was issued July 9 in Notice 2013-45.

Subsequently, the administration announced that through 2014, state-run health insurance exchanges need not perform complete eligibility verifications on all individuals applying for federal premium tax credits, under final rules published July 15 from the U.S. Department of Health and Human Services. This means that HHS will not conduct follow-up verification on behalf of the exchanges until Jan. 1, 2015, one year later than expected. There was a brief maelstrom of criticism that unverified applicants would lead to fraud and abuse, which prompted the government to issue a clarification: the vast majority of applicants' income will be verified and the risk of fraud and abuse is limited (see *box* at end of this story).

### CBO's Updated Estimates

In May 2013 baseline projections, CBO had projected that the insurance coverage provisions of the reform law would have a net cost to the federal government of $1.36 trillion over the 10-year period from 2014 to 2023. However, CBO expects the delayed requirements will result in a higher estimated net cost of $1.3 trillion — $13 billion more than previously estimated. That amount represents a $10 billion reduction in 2014 employer penalties (that would have been collected in 2015), and a $3 billion increase in exchange subsidies. However, CBO and JCT stated this will be offset by $1 billion due to "other small changes," including an increase in taxable compensation resulting from fewer people enrolling in employment-based coverage. This will result in a net cost increase of $12 billion.

CBO and JCT noted that, other than the revenue loss from penalty payments, the budgetary impact primarily will stem from changes in how many people will obtain coverage and from what source:

- Some large employers that would have offered health coverage to their employees in 2014 will no longer do so as a result of the delay. However, CBO and JCT noted that most large employers currently offer health coverage to their employees, and because the delay is only for one year, few employers will change their decisions about offering coverage.
- As a result of the looser procedures for verifying offers of employment-based coverage, some additional workers with affordable offers from their employer will obtain subsidized coverage through exchanges in 2014.

However, CBO and JCT expect that the change in verifying procedures will have only a slight impact on the number of exchange enrollees and the accuracy of their income reporting because: (1) the IRS will be able to identify misreporting when it compares reported

**See *Cost of Delay*, p. 4**

## *Cost of Delay* (continued from p. 3)

income with tax returns at year-end; and (2) enrollees still will have to provide certain information and sign a statement that their answers are accurate to the best of their knowledge, and employers will be notified of employees who qualify for premium tax credits.

CBO and JCT added that the information reporting delay will have only a negligible effect on sources of coverage and on revenues collected through penalties for individuals who do not obtain coverage in 2014. Here, CBO and JCT explained that the projected effects on coverage and revenues from 2014 penalties (which will be collected in 2015) are already lower than projected collections in subsequent years to allow for initial implementation difficulties. In addition, the administration is encouraging insurers and self-insured employers to voluntarily comply with the reporting requirements and report the names of covered individuals to the IRS.

Finally, CBO and JCT noted that, as a result of the delay and the new final rules, roughly 1 million fewer people are expected to be enrolled in employment-based coverage in 2014 than the number projected in CBO's May 2013 baseline. This is primarily because of the one-year delay in employer penalties. CBO and JCT expect that roughly half of the individuals will be uninsured and the others will obtain coverage through the exchanges or will enroll in Medicaid or the Children's Health Insurance Program. "In particular, fewer than half a million additional people are expected to be uninsured in 2014 than the number projected in the May baseline," according to the letter.

### Current Reform Guidance

The July 30 CBO letter can be viewed at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44465-ACA.pdf.

Notice 2013-45 can be viewed at http://www.irs.gov/pub/irs-drop/n-13-45.PDF.

To view the rules on eligibility of individuals for subsidies on exchanges, go to: http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

### CMS: Subsidy-seekers' Income Will Be Verified

Responding to misunderstanding of eligibility rules for individuals seeking health coverage subsidies, the Centers for Medicare and Medicaid Services put out a memo saying specifically that in the vast majority of cases, health insurance exchanges (now formally referred to as "marketplaces") would verify incomes of consumers applying for health insurance subsidies, which come in the form of: (1) advances on tax credits for premiums; and (2) reduced cost-sharing.

> Marketplaces will always use data from tax filings and Social Security data to verify household income information provided on an application, and in many cases, will also use current wage information that is available electronically." [Unnumbered document dated Aug. 5, 2013.]

The agency caught heat after announcing in a final rule that state marketplaces could allow applicants to self-attest their revenue levels (apparently leaving the door wide open to fraudulent applications), but the government hastened to say this circumstance would arise rarely. For it to happen, the application filer would have to project income that is 10 percent below the applicant's tax return and Social Security data. Then data from credit watchdog Equifax would be requested, and the individual would be asked provide a reasonable explanation for the discrepancy. Only if Equifax data was unavailable, and the individual failed to provide an explanation, would the exchange have an option of granting coverage without additional documentation, CMS' Center for Consumer Information and Insurance Oversight wrote.

This dispensation applies only to the 16 states and the District of Columbia that have no federal involvement in running an exchange. In the other 34 states with a federal presence, exchanges will require full income verification, because, CCIIO said, there are sufficient resources to do so. The regulatory relief is for 2014 only, and federal anti-fraud laws remain in effect, CCIIO asserted.

# Health Care Reform Briefs

In spite of its one-year suspension of the employer mandate under health care reform, the government added implementation and compliance materials for employers to government websites. Meanwhile legislators sought to change reform's definition of full-time employees as 30 hours per week, saying it must become 40 hours a week, to bring it in line with most businesses.' A number of health insurers (including Aetna in Maryland, see below) pulled out of states' health insurance exchanges for calendar year 2014, in most cases because the state-based health-reform markets would not allow them sufficient freedom to raise rates. In another protest against health care reform, Texas became the sixth state to refuse to enforce reform's insurance mandates. The federal government will be forced to step into that role.

## Website Clarifies Reform's Play-or-Pay Rules

The year-long delay of the employer mandate will give employers time to figure out the rules, and large and small employers can spend that time studying the new instructional material on health care reform, on a website the U.S. government unveiled July 29.

The site compiles information from several government agencies and includes:

- A slide deck on the shared responsibility rules (from the U.S. Small Business Administration) for companies with 50 or more employees, which is mainly about calculating the number of full-time employees. It also covers how to tell if one's plan offers minimum value, and the rules on when employees can get subsidized coverage on health insurance exchanges (now "Health Insurance Marketplaces"), which exposes large employers to penalties.
- A link to documents explaining key reform provisions for employers with 50 or more employees.
- A link to www.hhs.gov/healthcare's consumer material on reform implementation.
- An explanation on whether and how a business needs to calculate employer shared responsibility penalties.

See http://business.usa.gov/healthcare for the new instructional material.

## Legislator Moves to Change Reform 30-hour Definition in Line with Federal 40-hour Week

Sen. Susan Collins, R-Maine, warned that the reform law will depress workers' earnings and inhibit job growth in the weekly Republican address on Aug. 3. Federal health care reform: (1) creates a perverse incentive for businesses to reduce the number of hours that their employees can work; and (2) has a chilling effect on hiring, Collins said.

Collins said the reform law incentivizes companies to reduce worker hours, so as to ensure that more workers remain part-time, because employers defined as "large" under the law are threatened with the burden of offering all full-time workers health insurance or paying heavy fees for not doing so.

"A school system in my state of Maine is already preparing to track and cap the numbers of ours that substitute teachers can work to ensure they cannot work more than 29 hours a week. Fewer hours means less money in the teacher's pay checks and more disruptions for their students," Collins said.

She cited a study by the University of California-Berkeley saying that 10 million workers are vulnerable to having their hours cut directly due to the reform law.

Along with Sen. Joe Donnelly, D-Ind., Collins sponsored S. 701, which would change reform's definition of full-time employee from 30 to 40 hours a week.

Reform will also chill hiring, Collins said on Aug. 3, because employers will avoid new hires that would put them over the 50-worker "large-employer" threshold. Having more than 50 employees defines a company as a large employer that must offer group coverage to workers. Companies that are not ready for that mandate will not make hires that put them above 50 workers, she said.

## Aetna Pulls Out of Maryland Exchange

Aetna Inc. pulled out of Maryland's health insurance exchange after the state pressed it to lower its proposed rates by up to 29 percent.

In an Aug. 1 letter sent to the Maryland Department of Insurance, Aetna said the state's requirement for rate reductions from its proposed prices would lead it to operate at a loss. The rate reductions include products from Aetna and Coventry Health Care, which it bought this spring.

"Unfortunately, we believe the modifications to the rates filed by Aetna and Coventry would not allow us to collect enough premiums to cover the cost of the plans, including the medical network and service expectations

**See *Reform Briefs,* p. 15**

# For-profit Company Cannot Use Religious Objections to Avoid Contraceptive Mandate

For-profit, secular corporations cannot argue that they are exercising religious beliefs to avoid the contraceptive coverage mandate under health care reform, the 3rd U.S. Circuit Court of Appeals ruled July 26. Such entities are "artificial beings" created to make money and cannot exercise religion," which is an inherently "human" right, the 3rd Circuit opined. Accordingly, the court affirmed a lower court's denial of a preliminary injunction request from Mennonite owners of a Pennsylvania company. They objected to the mandate based on their church's teachings. They are suing the U.S. Department of Health and Human Services, contending that complying with the mandate would violate their rights under the Religious Freedom Restoration Act and the Free Exercise Clause in the U.S. Constitution. The case is *Conestoga Wood Specialties Corp. v. Sebelius*, 2013 WL 3845365 (3rd Cir., July 26, 2013).

In its ruling, the 3rd Circuit noted that it "respectfully" disagreed with a recent federal appeals court decision holding that for-profit, secular corporations can assert RFRA and free exercise claims in some circumstances.

### Background

The Patient Protection and Affordable Care Act requires non-exempt group health plans of employers with 50 or more employees to provide coverage without cost-sharing for preventive care and screening for women or face statutory penalties. Such coverage includes contraceptive services, which has proved controversial for employers with religious objections. Grandfathered plans are exempt from this requirement, as are "religious employers," which are those deemed to be nonprofit organizations with religious objections.

### Facts of the Case

Five members of the Hahn family own 100 percent of the for-profit Conestoga Wood Specialties Corp., which has 950 employees. Conestoga became subject to the contraceptive coverage mandate as of Jan. 1, 2013. The Hahns are members of the Mennonite church, which teaches that terminating a fertilized embryo is evil and a sin. Conestoga's board of directors adopted a Hahn family statement on Oct. 31, 2012, articulating, among other things, that it is against the family's moral conviction to be involved in the termination of human life through abortion.

The contraceptive coverage mandate includes two "emergency contraception" drugs such as Plan B (the "morning after pill") and *ella* (the "week after pill") that the Hahns contend conflict with the church's teachings. The Hahns and Conestoga sued HHS, contending that forcing them to comply with the mandate violated the RFRA and several clauses in the U.S. Constitution, including the Free Exercise Clause. They sought a preliminary injunction, which requires a party to meet four factors, the first one being the likelihood of success on the merits. A federal district court found that they could not meet that first criterion and denied the injunction. Subsequently, the 3rd Circuit denied an expedited motion for a stay pending appeal. As a result, Conestoga is currently subject to, and complying with, the mandate. The current 3rd Circuit proceedings address the merits of the appeal.

The Free Exercise Clause is contained within the First Amendment and provides that "Congress shall make no law respecting the establishment of religion or prohibiting the free exercise thereof." The key issue in the case is whether in addition to individuals, Conestoga — as a for-profit, secular corporation — can exercise religion. The Hahns alleged that it could based upon two principles: (1) directly, under a 2010 U.S. Supreme Court ruling upholding the principle that the Court has a long history of protecting corporations' rights to *free speech* under the First Amendment; and (2) indirectly, under the 9th Circuit's "passed through" theory, under

**See *Reform Contraceptives,* p. 7**

## *Reform Contraceptives* (continued from p. 6)

which for-profit corporations can assert the free exercise claims of their owners.

### *Citizens United*

In finding that corporations have a right to free speech under the First Amendment, *Citizens United v. Fed. Election Comm'n,* 558 U.S. 310 (2010)*,* did not distinguish between the amendment's free exercise and free speech clauses. Accordingly, whether *Citizens United* applies to the Free Exercise Clause was a question of first impression.

The 3rd Circuit first categorized corporations as artificial beings, "invisible, intangible, and existing only in contemplation of law." It noted that while there is an "extensive list" of Supreme Court cases addressing the free speech rights of corporations, there is none (other than those relating to the reform mandate) addressing free exercise protection to corporations. Furthermore, the court noted that Supreme Court precedent and other case law have held that the purpose of the Free Exercise Clause "is to secure religious liberty *in the individual*."

"Even if we were to disregard the lack of historical recognition of the right, we simply cannot understand how a for-profit, secular corporation [created to make money] — apart from its owners — can exercise religion," which is an inherently "human" right," the 3rd Circuit indicated.

In a footnote, the court acknowledged that the 10th Circuit in *Hobby Lobby Stores, Inc. v. Sebelius*, No. 12-6294 (10th Cir., June 27, 2013), recently held that for-profit, secular corporations can assert RFRA and free-exercise claims in some circumstances. However, it "respectfully" disagreed with that analysis.

### 'Passed Through' Theory

The "passed through" theory was first developed by the 9th Circuit in *EEOC v. Townley Engineering & Manufacturing Co*., 859 F.2d 610 (1988), and affirmed in *Stormans, Inc. v. Selecky*, 586 F.3d 1109 (2009). Both cases held that for-profit corporations can assert the free exercise claims of their owners but declined to address whether corporations could exercise such rights independent of their owners, as follows:

- Townley was a closely held manufacturing company whose owners made a "covenant with God requir[ing] them to share the Gospel with all of their employees." Townley sought an exemption, on free exercise grounds, from a religious accommodation provision of Title VII of the Civil Rights Act. The court noted that, "Townley is merely the instrument through and by which Mr. and Mrs. Townley express their religious beliefs."
- In *Stormans*, a pharmacy brought a Free Exercise Clause challenge to a state regulation requiring it to dispense Plan B. The court emphasized that the pharmacy was: (1) a "fourth-generation, family-owned business whose shareholders and directors are made up entirely" of Storman family members; and (2) an extension of the beliefs of Storman family members, and those the beliefs were the beliefs of the pharmacy.

Upon review, the 3rd Circuit rejected passed through theory, which it found based on "erroneous assumptions regarding the very nature of the corporate form" as a distinct legal entity:

> The "passed through" doctrine fails to acknowledge that, by incorporating their business, the Hahns themselves created a distinct legal entity that has legally distinct rights and responsibilities from the Hahns, as the owners of the corporation.

The 3rd Circuit noted that since Conestoga is distinct from the Hahns, the mandate does not actually require the Hahns to do anything. All responsibility for complying with the Mandate falls on Conestoga.

> "We recognize that, as the sole shareholders of Conestoga, ultimately the corporation's profits will flow to the Hahns," the court noted, "but … The Hahn family chose to incorporate and conduct business through Conestoga, thereby obtaining both the advantages and disadvantages of the corporate form."

### RFRA and Individual Claims

Next, the court quickly disposed of the RFRA claim based upon its analysis of the Free Exercise Clause, further noting that the RFRA only applies to a *person's* exercise of religion.

"Since Conestoga cannot exercise religion, it cannot assert a RFRA claim," the court found. "We thus need not decide whether such a corporation is a "person" under the RFRA."

Finally, the court found that the Hahns do not have viable Free Exercise Clause and RFRA claims on their own, for the same reasons it concluded their claims could not "pass through" Conestoga.

Because the Hahns and Conestoga could not meet the first preliminary injunction factor — likelihood of success on the merits of the claims — the court agreed with the district court that a preliminary injunction was

**See *Reform Contraceptives,* p. 8**

# 6th Cir.: ASO That Paid State Fee from Self-funded Plan Assets Became Fiduciary, Violated Bar on Self-Dealing

A fee that an administrative service vendor tacked onto a self-insured plan's charges to pay the ASO's separate obligation to the state's Medigap program was both a fiduciary act and a violation of its fiduciary duty to the plan under ERISA, the 6th U.S. Circuit Court of Appeals affirmed.

The case*, Pipefitters Local 636 Insurance Fund v. Blue Cross & Blue Shield of Michigan*, No. 12-2265 (6th Cir., July 18, 2013), has been in litigation for nine years. Between 2002 and 2004, BCBSM, a nonprofit Blue Cross organization, skimmed money from hospital discounts it negotiated with self-insured plans to shift the cost of its independent obligation to the state's Medigap program.

The Pipefitters fund alleged that despite its administrative services only contract, BCBSM had to decide from whom and how it would levy the fee, a decision that was a fiduciary act. The fact that the fees were pulled from plan funds violated ERISA's prohibition on self-dealing and ERISA's requirement to use plan funds only in the plan's interest. The 6th Circuit affirmed a lower court ruling that agreed with the fund's argument, as well as an order of restitution of almost $400,000.

### Nonprofit Status Brings Privileges, Costs

Because BCBSM operates as a nonprofit in Michigan, it was exempt from paying state and local taxes, as well as from general laws governing for-profit insurers. However, the state required it to pay one percent of its earned subscription revenue to fund the state Medigap program, which pays copays and deductibles that seniors on Medicare cannot afford.

The state did not specify how insurance companies were supposed to collect the Medigap "cost-transfer" contribution. However, a separate section of the law precludes some cost transfers between self-funded subscribers and BCBSM.

### Facts of the Case

The Pipefitters Local 636 Insurance Fund was fully insured by BCBSM before becoming a self-funded plan under contract with BCBSM. BCBSM regularly charged the Medigap cost-transfer subsidy (also known as its "Other Than Group" fee), to insured group clients, but did not require all of its self-insured clients to pay it.

When Pipefitters' switched to a self-insured plan, it entered into an ASO contract with BCBSM under which BCBSM was to administer its health benefit fund, including claims processing, financial management and reporting, cost containment, customer service, record-keeping and provider utilization audits.

Under the contract, BCBSM disavowed plan administrator and fiduciary roles:

> BCBSM is not the Plan Administrator, Plan Sponsor, or a named fiduciary for purposes of [ERISA] and its obligations shall be limited to the processing and payment of Enrollees' claims as provided herein.

BCBSM stated in ambiguous terms that certain fees, including the OTG fee, could be passed on to the plan through higher hospital bills:

> the Provider Network Fee, contingency, and any cost transfer subsidies or surcharges ordered by the State Insurance Commissioner as authorized pursuant to Michigan law will be reflected in the hospital claims cost contained in Amounts Billed.

In January 2004, BCBSM stopped charging Pipefitters the fee.

In September 2004, the Pipefitters fund sued BCBSM, alleging that it breached its fiduciary duty by failing to disclose the OTG fee that it charged, and the fee violated the state law that prohibits some cost transfers between BCBSM and self-funded plans.

**See *Bar on Self-dealing* p. 9**

## *Reform Contraceptives* (continued from p. 7)

inappropriate and affirmed the lower court's order denying the Hahns' motion.

One judge did write a lengthy dissent, noting that:

> The government takes us down a rabbit hole where religious rights are determined by the tax code, with nonprofit corporations able to express religious sentiments while for-profit corporations and their owners are told that business is business and faith is irrelevant. … This is a controversial and, in some ways, complex case, but in the final analysis it should not be hard for us to join the many courts across the country that have looked at the Mandate and its implementation and concluded that the government should be enjoined from telling sincere believers in the sanctity of life to put their consciences aside and support other people's reproductive choices.

## *Bar on Self-dealing* (continued from p. 8)

BCBSM argued that it was not acting as an ERISA fiduciary when it assessed the fee; a federal district court agreed and dismissed the charge. The fund appealed and the 6th Circuit reversed, deciding that the fund had stated a valid claim for breach of fiduciary duty under ERISA.

On remand, the district court granted a motion for class certification, and ruled in favor of the fund on both the OTG fee imposition and disclosure claims. On appeal a second time, the 6th Circuit reversed on class certification and on OTG disclosure, but let stand the ruling on the OTG fee imposition. On remand a second time, the district court upheld the OTG fee imposition claim and ordered BCBSM to pay $285,000 plus $107,000 in interest. BCBSM appealed that ruling.

### Appeals Court: BCBSM Was a Fiduciary

The court rejected BCBSM's arguments that its method of collecting the OTG fee was merely a "pass-through" and not a fiduciary decision. It did so because BCBSM did not charge the OTG fee to all of its ASO customers, and that it decided to stop charging it in 2004.

The court also rejected BCBSM's argument that since the state set its fee at 1 percent, it had no discretion in collecting the fee because the state did not prescribe how (or even whether) BCBSM was supposed to collect its fees from its customers. More importantly, neither did the ASO between Pipefitters and BCBSM, which decided on its own among many options on how it would collect its obligation to the state.

The language in the BCBSM contract (see above), that cost transfer subsidies will be "reflected" in the hospital claims costs, was not explicit, nor did it change the fact that BCBSM was using its discretion to collect fee from its client.

> [BCBSM] negotiated discounts with healthcare providers such that if, for example, a provider would normally bill an individual $120 for a given procedure, it would only bill [its] customers $100. Defendant collected the OTG fee by not passing through the entire discount it had negotiated ($20) to its administrative services customers. Instead, [BCBSM] would bill administrative services customers, like Plaintiff, $101 for the procedure that it had only paid $100 for. The extra dollar would then be used by [BCBSM] to pay its Medigap obligation to the State of Michigan.

The 6th Circuit pointed to an earlier ruling where it held that "an entity that exercises *any* authority or control over disposition of a plan's assets becomes a fiduciary." (*Guyan Int'l v. Professional Benefit Administrators,* 2012 WL 3553281 (6th Cir., Aug. 20, 2012) Since BSBCM had discretion regarding the OTG fee, the court concluded, it was a fiduciary act to pass the fee onto Pipefitters.

### Bar on Self-dealing Violated

Pipefitters claimed that BCBSM violated fiduciary duties as explained in 29 U.S.C. Section 1106(b)(1), which bars self-dealing by a fiduciary, and Section 1104(a)(1), which requires a fiduciary to "act for the exclusive purpose of providing benefits to plan participants."

By discretionarily setting the OTG fee and using it to pay the Medigap obligation, BCBSM violated both ERISA sections, the court found.

The court said the situation was similar to an insurer (unbeknownst to the client) marking up premiums with an administrative fee, the amount of which was unilaterally set by the insurer based solely on its conception of what was "reasonable compensation" for itself. Such an instance was found to violate ERISA's bar against self-dealing by the 9th Circuit in *Patelco Credit Union v. Sahni,* 262 F. 3d 897 (9th Cir., 2001).

Then the court referred to its *Guyan* ruling where the third-party administrator failed to segregate funds, commingled plan funds with its own assets and used plan funds for its own purposes. This was an example of using plan funds for its own purposes

The court also concluded that BCBSM was using the plan's funds for its own purposes when it diverted the portion of hospital discounts to satisfy its Medicap obligation.

Therefore the appeals court affirmed the district court ruling in Pipefitters' favor.

### Implications

This decision should come as no surprise to those active in employee benefits, especially those familiar with the volume of ERISA material on service providers and their relationships to health plans and participants.

Fee disclosure and avoiding self dealings are two extremely important aspects that ERISA addresses. It is clearly established that a fiduciary is any party that makes decisions or exercises discretionary authority over the plan. Therefore, BCBSM in handling the OTG fee in a way it saw fit, exercised discretion over plan funds.

The case serves as a reminder that a party's actions are more important in determining fiduciary status than how it identifies itself. Disclaiming fiduciary status does not protect one who acts as a fiduciary from liability. Service providers seeking to avoid being fiduciaries must take care to make appropriate disclosures to their clients, otherwise, they themselves will be held to the very high standard of conduct levied upon those with fiduciary standing.

# Binding Arbitration Clause Does Not Void Judgment in $925K Stop-loss Dispute

Contractual arbitration provisions cannot be used to void a default judgment that found an administrator/multi-employer health trust liable for various state-law claims after it failed to purchase stop-loss insurance, resulting in a $925,000 loss for a self-funded employer.

In *Scott v. Louisville Bedding Co.,* No. 2012-CA-000252-MR (Ky. App. Ct., July 12, 2013), the employer had hired a trust to administer its plan and obtain stop-loss insurance. The contract provided that the parties agreed to settle disputes using binding arbitration. The employer suffered a steep financial loss as a result of the trust's failure to procure stop-loss coverage and sued the health trust, its president and the broker that had recommended the trust, for fraud, misrepresentation and breach of contract. A default judgment was entered against the trust and its president after they failed to answer the complaint. Several months later, the president sought to have the complaint dismissed or compel arbitration. Ultimately, a state appeals court in Kentucky affirmed a lower court decision that the contract between the trust and employer was an insurance contract and thus the binding arbitration clause was unenforceable under state and federal law.

### The Facts

Hugh Scott was the president of United Re AG, a company that purported to administer self-funded health plans. Louisville Bedding Co. had a self-insured health plan.

United Re and Louisville Bedding signed a contract under which the latter would participate in a trust administered by United Re. Louisville Bedding expected United Re to purchase stop-loss insurance with a $200,000 individual attachment point and a $1.87 million aggregate attachment point.

Louisville Bedding's health claims exceeded the aggregate attachment point and the self-funded plan submitted a $925,000 claim for stop-loss reimbursement. That claim was denied because, apparently, Scott and United Re failed to procure stop-loss, exposing the plan to a massive year-end charge.

In June 2010, Louisville Bedding sued United Re AG and its trust (United Re Entities), Scott and the broker, alleging: (1) fraud, misrepresentation and breach of contract; (2) that Scott exercised complete control over the trust, and that the trust was simply Scott's "alter ego"; (3) Scott's trust was merely a scheme to avoid insurance regulations; and (4) the broker and Scott concealed the trust's financial instability.

Scott answered that he was not the alter ego of United Re Entities and that the court lacked jurisdiction because disputes were subject to arbitration under the contract. United Re Entities did not file an answer to the complaint, so the court entered a default judgment against them.

### Enforceability of Arbitration Clause

In February 2011 Scott filed a motion to compel arbitration and in June 2011 the court granted that order, holding that the contract clause was valid and enforceable.

The plan filed to remove that protection from Scott. After a few orders addressing whether the court could compel arbitration, the trial court ruled that Kentucky law controlled, which deems arbitration clauses void if they are in insurance contracts. Importantly, the trial court ruled that the contract was for insurance. Therefore, Scott could not use the contract to compel arbitration.

Scott appealed, arguing that the agreement was enforceable under federal and state arbitration laws and he individually could compel arbitration. He said the administrative agreement was not an insurance contract, but if it was, then the federal law — which does not exclude insurance contracts — preempted Kentucky law.

### Contract Provision Applies to Executive

Louisville Bedding said it agreed in the contract to arbitrate disagreements it had with the trust, but not with Scott. The court disagreed, saying that if the plan alleged Scott and United Re Entities were "one and the same," then it could not bind him to carry out contractual reimbursement provisions while disavowing the arbitration provisions. Further, "[b]ecause the intent of the arbitration provisions is clear, and the alleged wrongful activity by Scott took place during and in the course of his employment, Scott is entitled to enforce the arbitration provisions in the Agreement."

### Contract Was for Insurance

The court moved on to the question of whether Kentucky's Uniform Arbitration Act would compel arbitration. That statute states that it does not apply to insurance contracts, unless such contracts were between two or more insurers.

Scott held that the contract was not for insurance; it mentioned insurance only at one point, where it promised

**See *Binding Arbitration*, p. 11**

## *Binding Arbitration* (continued from p. 10)

to obtain insurance coverage to protect the trust and to ensure that it could pay expenses and distribute income and principal.

The court decided that regardless of how few times the word insurance was mentioned in the contract, that it was for insurance. Employers participated in the trust to obtain protection from the risks of self-insuring. The trust operated by pooling several employers' funds and paying out claims from that pool. They would have excess claims covered by the trust (which would indemnify plans later) or by getting stop-loss insurance through the trust.

> Having reviewed the Agreement, we agree with the circuit court that it is an insurance contract. Bedding participated in the Trust in order to obtain indemnity for the risks of being self-insured. Pursuant to the Agreement, the Trust agreed to do so. Scott's argument that the Agreement is not an insurance contract because the only insurance mentioned is for the benefit of the Trust is not persuasive. The fact is that the Trust was obligated to pay the excess claims or to indemnify Bedding for the excess risk. Whether the money to make such payments came from excess Trust funds or from an insurance policy that benefited the Trust is irrelevant. It is the obligation to indemnify another for risk that is the hallmark of insurance, and that obligation was the Trust's. Therefore, we discern no error in the circuit court's finding that the Agreement is an insurance contract.

### State Law Stands

The federal arbitration statute, the court admitted, normally would preempt Kentucky's, had the contract not been for insurance. But the McCarran-Ferguson Act put matters of insurance in state hands. Therefore, federal preemption would not restore enforceability to an *insurance* contract's arbitration clause. The state arbitration rule controlled, thereby nullifying the contract's binding arbitration requirement, the court ruled.

Kentucky's exemption for arbitration clauses is lifted when both parties are insurers, so on appeal Scott attempted to argue that the Louisville Bedding, as a self-insured entity was itself an insurer, in order to bind it to arbitration. The court did not *need* to address this argument because Scott did not argue it at the trial court level, but it did so for the sake of "completeness."

The court dismissed this argument, relying on a federal appeals court ruling that said "individual self-insurance is not insurance because it does not involve the shifting of risk to another." Therefore the state law would control, with its carve-out of binding arbitration for the insurer-insured relationship.

Finally, the court rejected Scott's argument that United Re is headquartered in Switzerland, which Scott said made it subject to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards. However, the convention excludes corporations that are incorporated *or* have a principal place of business in the United States. While United Re did not meet the first criterion, the court noted that Scott testified that all decisions about United Re were carried out in his law office in Texas. Therefore, United Re's principal place of business was in the United States, and Louisville Bedding's contract with United Re Entities was not governed by the convention.

Plan administrators must be cognizant of their agreement terms and ensure that the provisions reflect their actual intent. Such awareness will help the plan avoid the costs of potential failed legal measures.

### Implications

While this case reaches its outcome through a somewhat convoluted maze of laws and exemptions, it illustrates a fairly basic tenet of law; contracts are generally considered to be within the jurisdiction of the states.

Make no mistake, this case was made complicated by federal provisions, namely the federal arbitration statue that seemed to suggest this Kentucky law invalidating arbitration clauses would be preempted, however, contracts between two parties traditionally are governed by state law. The concept is especially important for health plans that enjoy federal preemption.

Plans must remember that while questions of plan administration arising from the arrangement between the plan and the intended beneficiaries of a private, self-funded ERISA plan are typically governed by federal law, the contracts entered into for administering that plan do not enjoy the same protection. Those arrangements largely will be governed by state law.

Plan administrators must be cognizant of their agreement terms and ensure that the provisions reflect their actual intent. Such awareness will not only help streamline the relationship between the parties, but also help the plan avoid the costs of potential failed legal measures that may not be available by contract. Understanding the agreements you enter into, and law that governs them, is instrumental in ensuring effective health plan management.

## *CE Column* (continued from p. 2)

In that world, even though the self-funded plan's money is being spent, all the fiduciary responsibility lies with the insurer. In the ASO and insurer world, the plan delegates to the insurer the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. The ASO insurer decides whether a claim should be paid, how much to pay and when to pay claims. Such discretionary authority is intended to include, but not limited to, eligibility determinations for enrollees and claims payment decisions. The ASO insurer will decide whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. With an ASO, the plan administrator also delegates to the insurer the discretionary authority to perform a full and fair review of each claim denial that the claimant appeals.

The plan sponsor does not have any input in the process. Now while most of you may think this is crazy, there are plans that do not want any claims responsibility at all. In their minds, they do not want to be liable for claims decisions and do not feel comfortable deciding to pay or deny their employees' claims. (TPAs are beginning to offer the option of making these types of claims decisions for a fee.)

In my opinion, since it is the plan's money, the plan ought to be making the decisions, and the plan needs to have the authority to interpret specific and important plan provisions. In the end, the plan must have the final word on how it spends its money.

Vague terms can only get the plan and TPA in trouble, for example, if they interpret terms one way in one situation and differently in another.

Self-funded health plans are shown great deference by courts of law. To overturn a decision made by a health plan administrator, the court must be convinced that the decision was arbitrary and capricious — meaning, without any evidentiary backing or rationale at all. This favorable standard of review, however, is often shown only to plan administrators that reserve "discretionary authority" expressly to themselves in the plan document. That is a key reason why plan sponsors should not totally abdicate their discretionary authority.

### Definitions and Exclusions

In the plan document, the focus must be on how terms are defined and how certain things are excluded. The plan document must clearly define which expenses are and are not covered. This can include setting a maximum allowable amount for certain types of claims and reserving the ability to review that the claims are medically necessary.

In my years of consulting plans on claim issues, the one thing that keeps popping up relates to the wording of plan definitions and exclusions. In many instances the reason that a plan or TPA is unaware of how to process a claim is because the definitions and exclusions are impossible to interpret.

A great example is the definition of illegal acts. If the plan excludes coverage for an illegal act, would that include jay walking? What if a plan member is injured after being hit by a car while crossing the street and he did not cross in the crosswalk? Would the claim be excluded? Or what if the plan has a workers' compensation exclusion stating that if the patient is injured working for wage or profit, any injuries resulting from the activities would be excluded. Would this mean that a 17-year-old participant mowing his neighbor's lawn for $50 who cuts his hand while "working" would have his claims denied? Based on this exclusion, the answer would be yes. Even if the plan paid the claims, if the claims went to the stop-loss insurer and the stop-loss policy mirrors the plan language, wouldn't the insurer have the right to deny the claims?

This is why definitions and exclusions need to be extremely clear. The plan document is basically a guide telling the TPA what is payable under plan terms. It needs to be concise. Vague terms can only get the plan and TPA in trouble, for example, if they interpret terms one way in one situation and differently in another.

When something is ambiguous or left completely, and too generally, to the plan administrator's discretion, the risk is run that other entities — such as a court of law or stop-loss insurer — may interpret the language differently from the plan administrator. By identifying specific parameters upon which definitions are based and tethering interpretation to objective, third-party resources, the room for differing interpretations is limited and the plan is protected.

### Plan Limits You Won't Want to 'Exclude'

Let's list a set of exclusion that a self-funded plan really needs to survive. First it will need to deny claims

**See *CE Column*, p. 13**

***CE Column*** **(continued from p. 12)**

that result from work. A plan should deny any condition, illness, injury or complication arising out of, or in the course of, employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational injury medical coverage may be available. This is clear and to the point. Therefore, if a 16-year-old cuts his hand while mowing a neighbor's lawn for money, the plan will pay his claims since no workers' compensation would be available. However, if coverage is available then the plan is no longer responsible. This is simple and clear, yet so many plans fail to have coherent language on this topic.

*Illegal Act Exclusions*

Illegal act exclusions are also important to review because they occur so often. Plan language should state that any injury incurred while taking part or attempting to take part in an illegal activity is excluded from coverage (a possible definition is a misdemeanor or a crime for which a participant could be incarcerated). It is not necessary that an arrest occur, criminal charges be filed or a conviction result.

The language should not be so vague as to make it impossible for an administrator to know what to do on a particular claim. The plan document should become an instructional manual on how to process clams.

*Plan Exclusions Regarding Alcohol Use*

Claims should be excluded for injuries arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for injured patients other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for substance abuse treatment as the plan specifies.

Plans seem to always get it wrong when it comes to *alcohol-related injuries*. The best alcohol exclusion should bar coverage for injuries arising from taking part in any activity made illegal due to the use of alcohol. The key is *activities made illegal due to alcohol use*. You are allowed to walk home drunk and fall. Getting behind the wheel of a car in the same situation and crashing into a telephone pole is illegal. There is a difference, so make it known in your plan.

**See *CE Column*, p. 14**

## *CE Column* (continued from p. 13)

What also should be excluded are services, supplies, care or treatment to a participant for injury or sickness resulting from voluntary taking, or being under the influence of, any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician.

*Hazardous Activities*

Another widely misunderstood exclusion relates to hazardous activities. Injuries that result from engaging in a hazardous pursuit, hobby or activity must be excluded, but how is the plan sponsor going to define exactly what is a hazardous activity?

I often ask my audiences to give me their opinions on specific things people like to do for fun on the weekends, including jet skiing or rock climbing. Whether something is hazardous truly depends on what that particular person likes to do. For some people hiking a mountain is hazardous while for others skiing may be.

In most situations, a hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm. This may or may not include hang gliding; skydiving; bungee jumping; rock climbing; parasailing; use of all-terrain vehicles; use of explosives; automobile, motorcycle, aircraft, or speed boat racing; reckless operation of a vehicle or other machinery; and travel to countries with advisory warnings.

The plan must think about what its population's demographics are. A ski manufacturer probably has a different standard for a hazardous activity than a nursing home.

*Provider Errors*

The plan document also must clearly exclude treatments that arise due to provider errors. Injuries that are sustained or an illness that is contracted, including infections and complications, while the participant was under a provider's care must be excluded from coverage.

In addition, claims should not be paid for services deemed not to be reasonable or medically necessary, based upon the plan administrator's determination.

*Occupational Injuries*

The last widely misused exclusion involves *occupational injuries*. This again relates to what the employer feels is right. Some plans exclude any injury arising out of, or in the course of, employment, including self-employment, or an activity for wage or profit. That means anything you get paid to do. Others deny claims if workers' compensation or another form of occupational injury medical coverage is available. Some plans deny the claim only if the workers' compensation insurer actually accepts and pays the claim.

Most providers and networks contend that a clean claim means they submitted a bill. The plan must protect its right to audit and review those bills. If questions arise, the plan must be able to ask for more information.

**Rights of Audit and Review**

One of the most ignored definitions that should be addressed in the plan document is that of a clean claim. Just what is a clean claim? Most providers and networks contend that a clean claim means they submitted a bill to the TPA. The plan must protect its right to audit and review those bills. If any questions arise then the plan must be able to ask for additional information from the provider without the (30-day) prompt-pay rules kicking in. Before that 30-day clock starts ticking, the plan document must stipulate that the plan is to have all necessary information to ensure the claim is even payable, such as making sure the treatments are covered in the first place.

Stating what constitutes a clean claim also tolls the clock for the PPO discount. Such discounts for in-network providers are only available if the claim is paid within a certain amount of time. If the plan is trying to get information while the clock is ticking it risks losing a discount. By putting clean-claim language in the plan document, the clock is stopped and the plan can collect enough information to decide if it will even pay the claim.

The plan might say that a claim is filed when it receives a HCFA 1450/UB92 form. However, such a form does not necessarily provide enough information for the plan to determine if the service and/or charge is covered.

**Conclusion**

This may seem like a lot to process, but the plan document is a plan sponsor's most important weapon against the ever increasing cost of health care. The ability to draft a comprehensive plan document is the biggest advantage of being a self-funded plan and can no longer be ignored. We are always looking for new and innovative ways to keep the plan document evolving as the laws and self-insurance landscape change. Look to next month's column for more plan document terminology that will help protect your plan from various legal challenges — now and in the future.

of our customers," Aetna said in the letter to insurance commissioner Therese Goldsmith.

## UPS to Drop Dual-covered Spouses in 2014

United Parcel Service plans to remove thousands of spouses from its health plan because they are eligible for coverage elsewhere. The health care reform law requires large employers to offer coverage to employees and their dependents, but it does not require companies to cover spouses.

Some 15,000 working spouses eligible for coverage at their own employers will be excluded from the UPS plan in 2014, UPS said in a memo to employees. Rising medical costs, "combined with the costs associated with the Affordable Care Act, have made it increasingly difficult to continue providing the same level of health care benefits to our employees at an affordable cost." "[W]e believe your spouse should be covered by their own employer," the company said in the memo.

UPS expects the move will save the company about $60 million a year. UPS spouses who are not employed, whose job does not offer health insurance, or who are covered by Medicare will be allowed to stay on the UPS plan. It applies to non-union U.S. workers only.

## State Challenge of Individual Mandate Lives

Although many of its arguments were stricken, Oklahoma succeeded in preventing the federal government from killing a lawsuit challenging the health care reform law. Generally, the court noted that the state had yet to be harmed by the operation of the individual mandate; as a state, it could not sue the federal government to protect its citizens, but that as an employer it may have standing to mount a challenge.

U.S. District Court for the Eastern District of Oklahoma on Aug. 12 denied the federal government's motion to dismiss *Pruitt v. Sebelius*, CIV-11-30-RAW (E. Okla., Aug. 12, 2013). The state originally filed the suit in 2011; it was one of many cases brought by state attorneys general to challenge the law.

State Attorney General Scott Pruitt argued that the act's mandatory minimum-coverage provision exceeded Congress' powers.

Pruitt further argued that Oklahoma residents should be ineligible for premium tax credits, because the state opted to not to run its own exchange (the federal government will run Oklahoma's exchange). He argued that an IRS rule to the contrary should be invalidated. He said that the IRS rule deprived "Oklahoma of its authority under the Act to be the sole decision-maker regarding the availability of premium tax credits" under the reform law.

The court rejected these arguments, saying they were based on the incorrect idea that health care reform subsidies are available only for individuals who buy insurance through an exchange established by a state.

U.S. District Judge Ronald White held that Oklahoma could not sue the federal government on behalf of its residents. State citizens are also federal citizens, and a state cannot sue the federal government on behalf of their shared citizens.

The mandate that individuals obtain "minimum essential coverage" or pay a tax penalty was upheld by the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012), White noted.

He also held that Oklahoma as a state had not been injured by the IRS' decision to allow the federal exchange to issue premium tax credits in Oklahoma. Even had the state had a right to sue the federal government, it could not sue to challenge the IRS interpretation without having been concretely injured in any way by the IRS decision.

Judge White did recognize, however, that Oklahoma is also an employer, and as an employer may be subject to the employer responsibility penalty if one of its employees were to be denied affordable and adequate insurance and receive premium tax credits through the exchange.

## Texas Refuses to Enforce Insurance Reforms

Texas became the sixth state to refuse to enforce reform's insurance mandates, which include dependent care coverage to age 26, no coverage exclusions for preexisting conditions and preventive care mandates. The Texas Department of Insurance said it could not enforce regulations tied to federal law: "We can't act on anything that doesn't exist in state law," a TDI spokesman was quoted as saying.

Texas and five other states — Arizona, Alabama, Missouri, Oklahoma and Wyoming — have taken this path. In all such cases, the federal government will step into that role, reviewing insurance forms and responding to consumer complaints about health insurance; duties that are the purview of state insurance departments. Observers said this may: (1) increase confusion over whether the insurance commission or the federal government is protecting consumers; (2) weaken the authority of state insurance departments; or (3) or make it harder for insurers to do business, in those states.

# Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-12. Entries are listed alphabetically by subject and the name of the court case. The numbers following each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "20:12/2" indicates Vol. 20, No. 12, page 2.

## Index by Subject



## Index of Court Cases