Employer's Guide to
Self-Insuring Health Benefits

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Self-funding Under Attack

Texas Forces S-L Insurer to Pay State Taxes on Self-funded Policies

In a ruling that self-funding advocates view as a power grab by regulators, the Texas Supreme Court compelled a stop-loss insurer to pay a direct premium tax on stop-loss policies sold to self-funded health plans. The court upheld the Texas Department of Insurance's position that "reinsurance" can be defined as such only if the policyholder is another insurance company. The high court said TDI's interpretation of the term "insurer" (to not include ERISA health plans) was acceptable because the insurance code had several definitions with varying scopes. TDI used ERISA's deemer clause against self-funded plans. It reasoned that if a plan is not an insurance company, then it must be a consumer, and a consumer can only purchase a direct insurance policy when it purchases stop-loss. This is seen as a larger initiative by states to infringe on an employer's ability to self-fund its employee benefit plan. ***Page 3***

Contributing Editor: Patient Buy-in Is Necessary to Control Health Costs

The cost spiral for health care in this country is symptomatic of a patient population that's unconcerned how much care costs, says Contributing Editor Adam Russo. If a patient doesn't care about care costs, then he or she will skip health maintenance and wellness. The nation is beginning to wake up to out-of-control health costs. New rules regulate health plan/insurance premium increases, and a state or two is even keeping an eye on how much providers raise their charges. But weaker efforts are aimed at incentivizing patients to make better personal health choices. That's about to change, and employer-sponsored health plans can help by incentivizing healthy habits. ***Page 2***

Provider Overpayments

Indemnity Plan Does Not Bind Providers, So Lawsuit to Recover Overpayment Is Dismissed

ERISA can be the key to upholding benefit decisions based on plan language before money is paid, but it may be far less helpful once overpaid money goes out the door. In this case, the situation was worse because the plan had no contract with the provider. Plan provisions about recovering overpayments failed to spell out any duty for providers to return overpayments. Because the plan created no duties expressly for providers, the provider successfully argued it had not violated the plan. The plan unsuccessfully argued that accepting payment directly from the plan bound the provider to plan terms. ***Page 9***

Also in This Issue

Featured Columnist

By Adam V. Russo

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The Heavy Truth: Why We Must Have Patient Buy-in to Control Health Costs

By Adam V. Russo, Esq.

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Have you heard? Our nation is becoming progressively fatter. Recently, HBO launched a documentary series called "Weight of the Nation" addressing the obesity issue in America. The series discusses how "big" the problem is, who it affects and what needs to be done to fix it. Ladies and gentlemen ... it's not just about eating right to look good in a swim suit, it's about what all this excess weight is doing to the cost of health care and insurance. The lack of wellness in this country is one "symptom" of a larger condition. I call it: "patient-doesn't-care-about-the-costs-of-care-a-citis."

All Hands Must Be on Board

Health care consists of the "three P's": payers, providers and patients. You can't really fix health care without addressing all three. National health reform as it stands now addresses payers predominantly. It does little to require efficiencies, cost reductions, transparency and competition between providers, and does even less to promote preventive care, healthy lifestyles and patient wellness.

When Massachusetts passed its health insurance reform law (referred to as, Commonwealth Care and the Connector Plan) in 2006, a crucial piece was missing: how to control rising medical costs. The law did a great job of forcing people to obtain coverage, provided easy access to robust policies, capped expenses and ensured mandated benefits were available to all Massachusetts residents. What it failed to do, however, was make health care itself more affordable and efficient. Indeed, it dealt with the payer, but not the other two "P's" of health care.

Every politician involved with the process back then — including then-governor Mitt Romney (R) — has since acknowledged that they focused on access and payment for care and not on health care's actual costs. In response, Massachusetts lawmakers recently proposed cost control, tying growth in physician and hospital charges to economic growth and taxing the state's most expensive hospitals when they can't justify excessive prices.

Plans to Limit Provider Cost Growth

I never thought it would take several years to realize that forcing people to buy an expensive item doesn't make the item more affordable, but we are finally realizing that if you lower the price of an item and "shop smart," then more people can have access to it.

Massachusetts state representative Steve Walsh, chair of the Joint Committee on Health Care Financing, hit the nail on the head when he said that while this "frugal spending" plan would save $160 billion over 15 years, one of the greatest challenges is to contain costs while not undermining health care as an industry in the state. Indeed, 1 in 7 jobs are tied to health care.

While I'm thrilled that our lawmakers are expanding the scope of their reform from one of the "P's" (payer)

See *CE Column*, p. 12

Employer's Guide to Self-Insuring Health Benefits

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State Stop-loss Regulation

Texas Excludes Self-funded Plans From 'Insurer' Definition, Exposing S-L Policies to State Rules

In a ruling that advocates of self-funding view as a power grab by insurance regulators, the Texas Supreme Court compelled a stop-loss insurer to pay a direct premium tax on stop-loss policies sold to self-funded health plans.

Stop-loss insurance written in Texas for self-funded plans is not "reinsurance" and thus must observe pay state levies and follow state insurance rules, the court held.

American National, a stop-loss insurer, had been fighting to avoid paying premium taxes for stop-loss coverage it wrote in 2001, 2002 and 2003, because it said the policies were reinsurance and not subject to the direct tax. But the insurer's arguments would fail.

Instead, the court upheld the Texas Department of Insurance's position that "reinsurance" can be defined as such only if the policyholder is another insurance company. Since TDI's position that self-funded plans are not insurers was reasonable, American National would have to pay back taxes, the court held.

The court would support the department's position in *TDI v. American National Ins. Co*., 2012 WL 1759457 (55 Tex. Sup. Ct. 705, May 18, 2012).

Inconsistent Code Opens Door for Regulator

Direct health insurance is subject to state laws and levies, while reinsurance is exempt from those burdens. But the insurance code lacked consistent definitions.

In the absence of clear, consistent definitions for "reinsurance" and "stop-loss," and for the question of whether "insurers" include self-funded plans, the state high court deferred to TDI's constructions because it is the regulating agency that interprets the statute.

TDI maintained American National was not selling reinsurance to self-insured plans, and as a result, American National owed taxes on policies. TDI's refusal to consider self-funded plans as insurers was reasonable in the court's eyes, even though self-insured plans act like insurers in some ways, the court said.

The high court reversed an earlier Austin Court of Appeals opinion (2010 WL 1633170), which would have allowed stop-loss insurers to sell reinsurance to self-funded plans.

State Pursues Tax Revenue

The state claimed that American had not paid taxes or complied with state rules for insurers for several years. It said the payer improperly entered premiums it collected from self-insured plans as "assumed reinsurance" and not as "direct written premium." As a result, American National failed to contribute to the state's health insurance risk pool.

American sued to reverse TDI's actions and enjoin their enforcement. It argued that self-funded plans are "insurers" and "in the business of insurance," and if reinsurance is the transfer of risk from one insurer to another, then self-funding meets that test.

Conclusions in *TDI v. American National Ins. Co.*

1) A true reinsurer was defined as providing coverage to other insurance companies.
2) Stop-loss to a self-funded health plan is not reinsurance but instead, it's direct insurance to be regulated by the state insurance code.
3) The agency charged with a statute's enforcement should get special consideration as long as its interpretation is reasonable and doesn't contradict the statute's plain language. Courts should defer to a regulatory agency's interpretation as long as it's not plainly erroneous, particularly when: (a) the interpretation is formally adopted; (b) the statute was unclear to start with; and (c) the agency's view is reasonable.

See *Stop-loss Ruling*, p. 4

Stop-loss Ruling (continued from p. 3)

Appeals Court's Key Definition Jettisoned

The high court rejected the definitions of "insurer" and "business of insurance" (at Code Chapter 101) that the appeals court relied on. The expansive view in Code Chapter 101 was an attempt to spread a wide net when describing TDI's mission to rein in unauthorized insurance activity by all entities, it said.

> [U]nlike the court of appeals, we do not find Chapter 101's definitions to be determinative in this case, and we must look elsewhere for guidance.

The appeals court could have used the more restrictive definition of "insurer" found in the code's licensing rules, it added.

Self-funded Plans are Not Insurers

Reinsurance was limited to the redistribution of risk between sophisticated insurers, which self-funded plans are not, because the state code does not regulate them as such, TDI argued. Because stop-loss policies for health plans are designed to cover claims ultimately spent on hospital and medical expenses, they met the definition of health insurance, it continued.

In 1999, TDI issued a regulation that explicitly subjected stop-loss policies to self-insured health plans to regulation and levies, the court noted. It was based on longstanding agency policy, and a rule that had been officially announced and through a public comment period.

The court agreed with TDI, and said a ruling raised by American National, *Brown v. Granitelli*, 897 F.2nd 1351, 1354 (5th Cir., 1990), did not stop Texas from regulating stop-loss insurers.

State Uses Deemer Clause to Advantage

ERISA's saving clause stipulates that insurance laws that do not mandate ERISA plan terms are not preempted. ERISA's deemer clause creates an exception to the savings clause, by prohibiting states from regulating self-funded ERISA plans as if they were insurers.

Thus, under the savings clause, the state retains its right to regulate stop-loss insurers. Under the deemer clause, self-insured plans may not be seen as insurers, the high court said.

Since it was formally promulgated and not expressly contradicted in the insurance code, the agency's view that stop-loss coverage sold to a self-funded plan is not reinsurance, and therefore subject to state regulation, was reasonable.

Implications

As illustrated in other courts across the country, state insurance regulators are attempting to infringe upon an employer's ability to self-fund its employee benefit plan. These attempts to shackle the self-funded market may be a response to recent U.S. Department of Labor and Health and Human Services studies (required by the

See *Stop-loss Ruling*, p. 5

Plan Attorneys See Trend Against Self-funding

While ERISA plans themselves are not subject to state regulation, states are clamping down on stop-loss coverage as a way to discourage self-funding, say attorney Ron Peck and legal administrator Chris Aguiar at The Phia Group, Braintree, Mass. The Texas Supreme Court ruling in *TDI v American National Ins. Co.* and the passage by the California Senate of S.B. 1431 are examples of concerted efforts from state insurance commissioners and health reform proponents to indirectly regulate self-insured plans by clamping down on stop-loss insurance, they say. Self-funded plans are exempt from state insurance laws thanks to ERISA; but insurers that issue stop-loss policies can be regulated by states.

As those proponents see it, according to Peck, the new health system with the exchanges must take in as massive a risk pool as possible. A self-funding option could become more economical if premiums rose due to reform's insurance mandates. But that would divert premium-paying customers away from the exchanges, Peck says. Efforts to discourage self-insuring have resulted, he says.

The California stop-loss law, S.B. 1431, would set stop-loss attachment points at a minimum 120 percent of expected claims for employers with 50 or fewer employees (but the bill started out with more draconian rules that were dropped from the Senate version). S.B. 1431 was based in part on a model stop-loss bill developed by the National Association of Insurance Commissioners.

And the NAIC is considering updating that stop-loss model act to raise minimum specific attachment points to $60,000 and the minimum aggregate attachment point increased to 130 percent of expected claims, the Self-Insurance Institute of America reported on June 1.

In Spite of Review Flaws

Court Sees 'Sufficient' Appeal Process and Reasonable Obesity Repair Denial by Plan

Since an employer health plan gave a full and fair review resulting in a reasonable benefits decision, a federal court upheld the plan's lifetime limit on obesity services and its prohibition on payments to treat complications from earlier gastric bypass surgeries. The plan also weathered an allegation that it was not properly segregating plan funds.

In *Wesson v. Phillips Medical Center Employee Group Healthcare Plan*, 2012 WL 1536458 (N.D. Okla., April 30, 2012), the federal court said explanations of benefits and replies to plan appeals may have been sketchy, but did not fail to explain the reason for the denial and appeal options for the participant.

Discrepancies in plan communication were not given much weight because the plaintiff: (1) showed she understood the reasons for the denial in correspondence; and (2) failed to demonstrate she was harmed from any alleged plan mishap. The decision itself was upheld because she could not demonstrate that her need for gastric repair in 2008 was not caused by the 2005 gastric bypass surgery.

The Facts

Susan Wesson worked for Jane Phillips Medical Center and participated in its self-funded group health plan. In April 2005, she underwent "Roux-en-Y" gastric bypass surgery for weight loss.

The Plan's Obesity Limit

Under its benefits coverage for obesity, the plan would cover gastric bypass if: (1) a person's body mass index was 40 or higher (35 or higher if the patient had an additional comorbidity); (2) the patient was evaluated by a surgeon, psychiatrist and nutritionist; and (3) the patient selected an experienced gastric bypass surgeon. The plan stated that it would not pay to treat complications from a bypass surgery. It limited lifetime coverage for obesity services to $15,000.

The plan covered Wesson's 2005 surgery, and paid benefits up to the plan's lifetime limit for morbid obesity.

Medical Notes Cite 'Takedown of the Roux-en-Y'

In 2008, Wesson experienced health problems related to her bypass and needed surgery to reverse the 2005 procedure. The plan denied that claim, invoking the lifetime limit and the exclusion for complications from bypass surgery.

Operative notes from the July 2008 described the procedure as a "Takedown of the gastrojejunostomy with reconstruction."

Wesson appealed to JPMC, asserting that the repair procedures did not result from a complication of the original 2005 gastric bypass. She argued instead that stress and conditions that predated the 2005 surgery created her gastric obstruction and GERD.

See *Obesity Repair,* p. 6

Stop-loss Ruling (continued from p. 4)

health reform law) that indicated that self-funding is a viable, growing and effective method of providing health benefits to employees.

Here, TDI used the deemer clause to the detriment of self-funded plans. In its argument, it suggests that since you (employer plan) are not an insurance company, you (employer plan) must be a consumer. As such, you (employer plan) must be purchasing a direct insurance policy when you (employer plan) purchase stop-loss. Since a stop-loss policy relates to the provision of medical benefits, it must be similar to health insurance, and thus a policy we (TDI) can regulate.

This case illustrates a true mischaracterization of the relationship between a plan and a stop-loss insurer.

Lessons Learned From *TDI v. American National Ins. Co.*

1) *Define the relationship.* To preserve the relationship plans have with stop-loss insurers, the misunderstandings must be clarified. Remember, stop loss provides reimbursement, not payment of medical claims. When the plan pays medical bills, there is no guarantee that those funds will be available to them upon a claim for reimbursement from their stop loss policy.

2) *Consider the potential of a ripple effect.* If the relationship is not clarified on a broader and more expansive level, consider how this trend will continue (that is, other states may seek to consider stop loss coverage as "insurance").

Obesity Repair (continued from p. 5)

JPMC sought independent medical reviews from two experts, both of which determined the 2008 services were to cover complications from the 2005 gastric surgery.

Note: The plan failed to enclose the records of the 2005 procedure to both outside reviewers. (The plan's decision would be upheld in spite of this.)

On Aug. 31, 2009, after exhausting all plan remedies, Wesson sued for benefits due under the plan and breach of fiduciary duty.

The court found the plan's decision to be reasonable in spite of flaws in one reviewer's work. It said Dr. Freeman's review was too flawed to be the basis of a reasonable plan denial.

TPA Not Liable

On Sept. 30, 2011, the federal court granted a motion from BMI, the third-party administrator, to be removed as a defendant. BMI was a non-fiduciary that was not subject to suit for either recovery of benefits under ERISA or for breach of fiduciary duty, the court decided. As a result, the employer would be liable for any violative actions performed by BMI.

Plan Had Discretion

According to the court, the plan gave JPMC, as plan administrator, discretionary authority to determine eligibility and benefits, and to construe plan terms. As a result, the court would only overturn the plan's coverage decision if it deemed it arbitrary and capricious.

The court said any conflict of interest resulting from the plan being both final arbiter of and funding source of claim payments would be taken into consideration, but would not change the standard of review from abuse of discretion.

Plan's Claim Resolution Was Sufficient

Wesson first contended initial explanation of benefits and claim denial letters failed ERISA procedures.

Initial Review

Under ERISA, denial notifications must list the specific reasons for the adverse determination; and a description of material or information the plan member could use to perfect the claim.

Wesson complained she was unable to discern the reason for the denial on the letter. While some plan communications to Wesson did lack specifics, the court said, Wesson's legal argument was undercut by her own initial appeal letter to BMI and the plan. That letter showed she understood that the coverage limit was the operating factor for her denial.

Appeal

She then contended that in her Oct. 8, 2008 denial on appeal letter, BMI did not show her how it concluded that the 2008 procedures resulted from complications from her 2005 operation.

Under ERISA, BMI's correspondence was supposed to: (1) explain why it denied the claim; (2) identify the plan provision it based the denial on; (3) describe additional material the claimant can use to perfect the claim; and (4) describe plan time limits and the claimant's right to bring a civil action under ERISA.

See *Obesity Repair*, p. 7

Health Reform Increases Content Required in Denial Letters

Health reform rules issued in the June 24, 2011 *Federal Register* (76 Fed. Reg. 37208) set additional standards for employer-plan appeals and external reviews. Those rules do require plans to give participants: denial codes, the standard they relied on and copies of new evidence the plan relied on. Of course, those rules were not in effect in this case, and the court relied on existing ERISA (DOL) rules at 29 C.F.R. §2560.503-1.

What Plans Must Tell Participants When Rejecting Appealed Claims

ERISA rules at 29 C.F.R. §2560.503-1 require health plans to add the following to appeal-denial letters:

1) the specific reason or reasons for the adverse determination;
2) reference to the specific plan provisions on which the determination is based;
3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4) a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action.

Obesity Repair (continued from p. 6)

The court decided that the denial of appeal letter, while not particularly informative, did set out: (1) that the decision was arrived at after a review of the claims history; (2) the reviewer concluded the 2008 claim resulted from complications of the 2005 procedure; and (3) the plan prohibited that kind of claim.

Wesson said BMI's letter was improper because it failed to identify documents that "might help" her make her claim.

The court, however, rejected this. First, ERISA does not require plan administrators or TPAs to tell claimants about "documents that might be helpful," the court said. It requires them to identify "appropriate materials necessary to perfect an appeal" to the plan. Second, the plan had already requested, and Wesson had submitted, all there was in support of her case, and Wesson did not have any new information to submit in her favor.

Furthermore, the plan did not need to ask Wesson for more information because it had all it needed to make its determination. The fact it did not request more was not a violation of ERISA's requirement that a "meaningful dialog" take place between plan and claimant.

Finally, Wesson said the plan failed to remind her she had the right to representation when pursuing her next stage of review. The court rejected that too, because C.F.R. §2560.503-1 only requires that reminder when a claim is going for additional voluntary appeal or arbitration.

Plan's Decision Was Reasonable

The court then examined the plan's decision itself, and found it to be reasonable in spite of flaws in one reviewer's work. The plan probed outside reviewers on whether the symptoms that led to the 2008 procedure could have occurred in the absence of a Roux-en-Y procedure.

As a result of not having the 2005 records, one of the reviewers, Dr. Freeman, referred to the 2005 procedure as not a gastric bypass when it was a Roux-en-Y gastric bypass, and ignored the plan's question before ultimately concluding that the 2008 surgery "was done for a condition that was the result of the prior gastric bypass procedure." The court concluded that Dr. Freeman's review was too flawed to be the basis of a reasonable plan denial.

The plan, however, also based its conclusion on another reviewer's input and on other evidence. That reviewer, and notes and records from the surgeon who performed the 2008 procedure, showed they were designed to remove an implanted device and said it was a "takedown of the gastrojejunostomy with reconstruction." The device and the gastrojejunostomy were not naturally occurring; they resulted from the 2005 procedure, and therefore the plan had a reasonable basis for its denial, the court decided.

Wesson complained that the plan ignored six articles she submitted supporting her contention that her symptoms and conditions resulted from stress and pre-existing conditions. The court said the issues discussed in the articles were wholly irrelevant to her claims. For those reasons, the court held that the denial was reasonable. Since the denial was reasonable, no breach of fiduciary duty resulted from it.

ERISA requires that plan assets be held for the exclusive benefit of plan participants, but assets do not have to be segregated into a separate trust account, the court stated.

Breach of Fiduciary Duty Charge Fails

Wesson alleged that JPMC violated its duty as a fiduciary because it failed to segregate employee contributions to the plan in a separate interest-bearing trust account, and she alleged the plan was putting them in the corporation's general fund. JPMC's finance officer testified that plan funds were not being intermingled with general funds, so the court considered whether ERISA requires a separate trust account. It said ERISA doesn't create a duty to keep plan funds in a separate interest-bearing trust account.

ERISA requires employers to hold plan assets for the exclusive benefit of plan participants, but assets don't have to be segregated into a separate trust account, the court stated.

> JPMC's decision not to segregate plan funds into a separate trust account appears to comport with standard industry practice with regard to welfare plans, including healthcare plans like the one at issue here.

Furthermore, Wesson failed to demonstrate harm from the plan's failure to segregate funds.

> Ultimately, in order for an ERISA plaintiff to prevail on a breach of fiduciary duty claim under ERISA §409, "there must be a showing of some causal link between the alleged

See *Obesity Repair*, p. 8

Obesity Repair (continued from p. 7)

> breach and the loss plaintiff seeks to recover." In other words, JPMC cannot be liable for breaching its fiduciary duty unless Plaintiff can demonstrate both that JPMC breached its fiduciary duty and that losses to the Plan.

So, in addition to upholding the appeals procedure and claims denial, the court decided that JPMC needn't segregate employee contributions as Wesson contended. She also failed to show that her allegation caused her benefits denial or created ill-gotten plan gains.

The court upheld the plan's determination and denied Wesson's breach of fiduciary duty claim.

Implications

This case illustrates important issues for plans and administrators to consider.

Role of Wellness Programs

First, wellness and preventive care initiatives are playing an increasingly important role in employer health plans, particularly employers sponsor self-funded plans. The health reform law helped increase awareness about obesity by mandating 100-percent in-network coverage of obesity screenings and counseling for adults and children. Proactively addressing obesity issues may make financial sense for the employer seeking to maintain its self-funded plan.

Stricter Review Rules

Second, this plan sought outside and independent medical reviews. In this case, the independent reviewer was not provided with all the relevant materials. However, if this case had occurred post-reform implementation, the result may have been different. For example, reform rules require non-grandfathered plans to offer an external layer of review by an independent review organization. The IRO must be provided with all medical records and documentation relevant to claim. Further, the IRO's decision is binding on the plan.

Attention to How Claims Are Funded

Last, but certainly not least, this case focuses on a significant issue in our industry that relates not only to ERISA, but the agreements between the TPA and the plans.

Under ERISA, an individual is a fiduciary to the extent that person exercises discretionary authority or control over plan management, or over the management or disposition of plan assets. An employer that commingles plan assets with its general assets will be exercising discretionary authority or control over the management or disposition of plan assets and accordingly will be a plan fiduciary under ERISA.

A self-funded plan can be considered to have assets in various ways: (1) participant contributions (salary reductions); (2) separate account (a trust fund or bank account in the plan's name); or (3) funds related to the plan (including subrogation or reimbursement funds and stop-loss payments).

As illustrated here, an employer is not required by ERISA to segregate funds into a separate trust account. However, it is imperative that the employer holds plan assets for the exclusive benefit of plan participants. This distinction is key to ensuring plans are prudently managing the assets of the ERISA plan, as it is their fiduciary duty to do so.

Lessons Learned From *Wesson v. JPMC Employee Group Healthcare Plan*

1) **Preventive and wellness services.** Consider how implementation of wellness or preventive services, as required by health reform, will impact the plan population. Healthy plan participants may mean lower costs to the self-funded ERISA plan.
2) **PPACA external review.** For plans subject to the health reform law's external review requirements, ensure all plan and PPACA requirements are being adhered to. Further, remember that the IRO's decision is binding on the plan, and the plan participant.
3) **Commingling assets.** Use this case as a reminder to revisit how funds are separated and/or segregated. Third-party administrators and plans may want to review their administrative services agreements to ensure that claims-processing — and claims-funding — procedures are outlined.

Indemnity Plan's Recovery Provision Does Not Bind Providers, So Lawsuit to Force Pay-back Is Dismissed

ERISA can be the key to upholding benefit decisions based on plan language before money is paid, but it may be far less helpful once overpaid money goes out the door, particularly when the plan is indemnity-based with no provider contracts.

This situation became evident in *Int'l Longshore & Warehouse Union v. Sharp Surgery Center*, 2012 WL 1656921 (C.D. Calif., May 8, 2012), where a self-insured indemnity plan had no contract with a surgical practice, and plan provisions about recovering overpayments failed to spell out any duty for providers to return overpayments.

The plan attempted to enforce plan language to recover overpayments, but because that language did not create any obligations for providers (which had no contract with the plan), the provider successfully argued it had not violated the plan.

The court rejected plan arguments that accepting payment directly from the plan bound the provider to plan terms.

The Facts

The International Longshore and Warehouse Union Health Plan provided surgical, medical and hospital benefits on an indemnity basis to participants and beneficiaries. The plan provided that: (1) if the fund overpaid a medical provider, the plan could pursue recovery of the overpayments; (2) the plan only would cover medical care that is medically necessary; and (3) the plan pays no more than usual, customary and reasonable rates.

Sharp Surgery Center did not contract with the plan, but it did bill the plan directly through assignments of benefits it had from plan members.

After some time paying Sharp directly, the Longshore plan alleged: Sharp had millions of dollars of alleged fraudulent overbilling of medically unnecessary and unauthorized procedures; it billed for services not performed based on established treatment protocols; and plan members reported that they were billed for services to which they did not agree.

Asserting the plan had been cheated out of millions of dollars in plan assets by Sharp, the plan and its trustees sued under ERISA: (1) to recover outstanding overpayments; and (2) for declaratory relief. The surgery practice moved to dismiss the suit for lack of standing to state an ERISA claim.

Note: Sharp had sued the Longshore plan administrator under state law for breach of contract to compel the plan to pay amounts it said were due it for services performed, but the court remanded that case since the claims were not stated under ERISA. Less than one month later, the plan filed this overpayment case.

No Standing Under ERISA

The surgery center argued ERISA didn't authorize the kind of relief the plan was seeking, because: (1) such a recovery would be legal, and not equitable relief; and (2) it wouldn't relieve a breach to the plan because no breach of plan is identified.

Note: ERISA allows only equitable relief. Equitable relief includes specific performance, trusts and liens, restitutions, injunctions and declaratory relief. Examples of relief allowed in ERISA cases are orders to: (1) follow timeframes, procedures and coverage limitations as described in the plan document; (2) pay benefits due under the plan; and (3) restore benefits the plan paid to beneficiaries who were covered by another insurer, among others. Punitive or compensatory (legal) remedies — including payments for lost time and pain and suffering — are often disqualified under ERISA.

The U.S. District Court for the Central District of California said the second provider argument was enough to dismiss the case, so it would not need to determine whether the proposed relief was equitable or legal.

Failed Plan Arguments

The plaintiffs contended their claims were being brought in order to enforce the terms of a plan provision that said:

> If a third party provider of Benefits hereunder, through error, misrepresentation, or fraud, receives payment of Welfare Fund assets in an amount greater than the amount authorized under the Plan, the Trustees, in their sole, absolute, and unreviewable discretion, may collect the amount of any such overpayment(s).

The court agreed with the ASC that the plan did not impose any duties on the providers, and so they could not have violated plan terms. The ASC argued:

> [W]hile the Plan states that it will not pay bills that charge more than the reasonable value of services, it imposes no duties on the providers who submit the bills.

See *Indemnity Plan*, p. 10

Indemnity Plan (continued from p. 9)

The provision clearly authorized the plan to pursue its duty to recover overpayments, but it didn't create an obligation for providers to return funds the plan said were overpaid, the court agreed. Thus, the plaintiffs could not "enforce" plan terms as they were not bound by the plan's provisions.

Here, there could be no provider violation, because the plan's overpayment recovery provision created no duty for a provider, the court said.

Finally, the plan argued that by accepting benefit payments direct from the plan, by virtue of assignments from plan beneficiaries, Sharp agreed to be bound by plan terms. However, the court said this requirement was "far from the truth."

> [Sharp] addressed this argument in [its] reply, stating that [it was allowed to] submit benefit claims to the Plan — not by assignment — but based on a separate agreement distinct from the plan. … that [the plan] and [Sharp] entered into in 2009.

Therefore, the court dismissed the case with prejudice, because it said any effort to amend the complaint would be futile.

Implications

This case presents a classic provider versus plan overpayments case. These types of cases, unfortunately, are becoming more and more common. When plans inadvertently overpay claims and must seek reimbursements, they are often forced to seek legal interventions. However, courts are seemingly siding with the facilities in these cases. This presents a big challenge for plans and their administrators.

Assignment of Benefits

On a basic level, patients seek services from a provider, assuming their health plan will cover most of the treatment. The patient signs a form assigning his or her plan rights and benefits to the provider. The provider bills the plan and the plan pays the claims.

However, the provider's right to seek payment and receive funds from the plan is based solely upon this assignment of benefits from the patient. The patient may only assign to the provider the same limited rights available to the patient. As such, the provider is not entitled to anything beyond that which was also available to the patient.

In some circumstances, the plan document may have placed caps or maximum payable amounts on services (Example: No more than 20 visits covered). The plan administrator, as a fiduciary, is required to administer the plan prudently and in strict accordance with plan terms.

Using this example, assume the patient incurred a charge for a 21st visit. This charge is not covered under the plan. Even if the patient assigned his or her benefits, the provider is entitled to only the benefits available to the patient, and under the plan there is no coverage for this visit. Thus, the patient had no benefits to assign to the provider.

However, the services had been incurred and the provider was due payment … from someone (that is, the patient). It is important to remember that if services are incurred, someone should be responsible. That someone, however, may not always be the plan.

If the plan mistakenly paid claims for this 21st visit, courts may conclude that the plan should be pursuing the funds from the patient, and not the provider.

Potential Plan Responses

This case should motivate plans to investgate creative solutions for use in pursuing provider overpayments.

For example, consider how the provider "sought" payment. Was the provider making fraudulent claims? Wrongly inducing payment? If so, the plan may try to illustrate that the provider was fraudulent or induced payment to be made when it knew, or should have known, that the plan was not responsible for payment.

Also consider not allowing assignment at all under plan terms (that is, the anti-assignment avenue). The plan would stop allowing an assignment of benefits, start paying patients directly, and then if there was an overpayment offset against future claims.

To use this method, however, the plan would need an anti-assignment provision.

Lessons Learned From *Int'l Longshore & Warehouse Union v. Sharp Surgery Center*

1) **An assignment of benefits transfers benefits available to the patient under plan terms.** The assignment does not negate the fact that a provider is entitled only to the benefits the patient is entitled to. No more and no less!
2) **Consider whether an anti-assignment clause may work for the plan.** The insertion of an anti-assignment clause will render a patient's assignment invalid. If this is the intention, plan administrators must ensure the plan contains a clear and concise anti-assignment provision.

Self-Insured Employers Ponder Alternatives If U.S. Supreme Court Axes Health Reform

Regardless of how the U.S. Supreme Court rules on the federal health care reform, Humana and UnitedHealth Group on June 12 announced that they would continue several of health reform's insurance mandates.

The U.S. Supreme Court is considering whether the "individual mandate" (for everyone to get health insurance or pay a penalty) is unconstitutional, but also, whether parts of the law are inextricable from the individual mandate. Those parts include the law's "insurance reforms," and those could also be terminated in a Supreme Court ruling.

Starting 2010, plans and insurers have been implementing "insurance reforms," such as keeping dependents on policies longer, universal issue of policies and phasing out benefit caps on essential benefits.

Insurers: We'll Retain Reform-style Coverage

In similar June 12 releases to the public, UnitedHealth and Humana announced they will:

- cover preventive health services with no direct out-of-pocket costs;
- cover dependents until they turn age 26,
- eliminate lifetime policy limits and rescissions; and
- adhere to third-party appeals processes as mandated by health reform.

The coverage is "good for people's health, promotes broader access to quality care and contributes to helping control rising health care costs," said Stephen J. Hemsley, president and CEO of UnitedHealth Group.

"Humana believes its health plan members should have the peace of mind of knowing the company embraces and will maintain these common-sense provisions that add stability and security to health care coverage," that company said in a release.

Aetna has announced that it will cover dependents to age 26.

In contrast, Several Blue Cross companies — and CIGNA — would not commit to any course of action until the Supreme Court's decision is announced.

United said it would cover dependents up to age 19 regardless of pre-existing conditions, but only if the broader industry moved forward together on that.

The impact of this announcement applies to companies that buy full insurance directly.

Self-Insured Employers Still May Drop Provisions

Self-insured health plans do not have to follow suit. They create their own health care plans and set premiums and deductibles for their employees. They will be free to drop the insurance mandates if the Supreme Court strikes those elements.

These employers might turn to offering more high-deductible plans, with accompanying health savings accounts HSAs, and contract with narrower more restrictive provider networks.

Of the mandates United and Humana promised to keep covering, employers will have the easiest time offering free preventive care and eliminating lifetime limits, because those are rather cheap. On the other hand, plans may see more pronounced savings by dropping coverage of dependents up to age 26.

If self-insured employers found that most of their competitors continued to offer the insurance mandates, they'd probably conform, so as not to be at a competitive

See *Insurance Mandate*, p. 13

SIIA Develops Plan to Sue States That Improperly Regulate Stop-Loss

The Self-Insurance Institute of America, Inc. is setting up a legal defense fund and developing plans to sue California and/or other states that enact new laws regulating stop-loss attachment points. SIIA has concluded that there is a viable ERISA preemption argument, a SIIA official told the *Guide*. The group is seeking financial support to fight such legislation from its members and other industry stakeholders.

The California stop-loss law, S.B. 1431, would set stop-loss attachment points at a minimum 120 percent of expected claims for employers with 50 or fewer employees. The bill would have imposed a draconian $95,000 specific attachment point on all policies, but that requirement was dropped. "SIIA believes that such action(s) will have the effect of restricting the ability of many employers from self-insuring and the association's legal counsel has concluded that there is a viable ERISA preemption challenge that can be presented in federal court."

The particular state law(s) to be challenged will be dictated by future developments and analysis of the potential for success, the group said.

CE Column (continued from p. 2)

to two of the "P's" (payers and providers), there should be greater oversight on the contracts between health insurers and medical providers when the state's money is at stake. There also should be a global payment system placing doctors and hospitals on a glide path away from frivolous choices about care and exorbitant billing. I suggest applying smart consumer practices to both payer management and provider selection and billing.

Rachel Zimmerman and Carey Goldberg report in their "A New Approach to Cutting Massachusetts' Health Costs: Throw Spaghetti," that there will be a new, quasi-governmental agency called the Division of Health Care Cost and Quality. This sounds like a great way to save money! This agency would oversee the transition to the new payment and delivery system with a board that includes consumer, government and industry representatives.

The plan establishes a specific cap for health care spending that would be linked to the gross state product minus .5 percent. The state could impose a 10-percent tax on hospitals if they charged more than 20 percent of the state median price for a given service and couldn't justify that higher price. Hospitals would pay this penalty into a distressed hospital fund for institutions that serve a high proportion of poor and vulnerable patients. This means that providers with more Medicaid and Medicare patients would get the funds they actually do need to operate.

Providers Corralled on Cost

Two earlier reports by Massachusetts Attorney General Martha Coakley found certain hospitals exploited their market clout to charge higher than justified prices.

Goodness! Are we now addressing both payers and providers? Indeed we are. This is precisely what's missing under the current PPO model. Presently, providers can charge whatever they want without any justification of their charges. Trust us when we tell you that they get offended when we ask them to justify their bills.

So ... is this new plan perfect? No, it is not. You might recall that health care is composed of not two, but three "P's." Massachusetts' gaze now takes in payers and providers ... but patients: We are still getting away with our cake … and eating lots of it, too.

Patients Have No Skin in the Game

If I gave you my credit card and told you to go have a good time, would you be incentivized to spend wisely, cut costs and trouble yourself on my behalf? Of course

See *CE Column*, p. 13

CE Column (continued from p. 12)

not! Consider your car. You deal with the monthly hassle of changing your oil, getting a tune up, inflating tires, etc. You spend the time, spend the money and deal with the grind that is automobile upkeep. Why? Because you know that if you don't maintain your ride, you will be dealing with a much more costly repair down the line.

Auto insurance protects you only against unforeseen accidents, so foreseeable issues (arising over time due to a lack of care on your part) is entirely your responsibility. If your auto insurance paid for engine replacements arising from a failure by you to obtain oil changes, would you waste your time and money getting oil changes? … Not so much.

When consumers have skin in the game, they act responsibly, shop around for the best prices and spend a little now to avoid a big expense later. That's why we take better care of our cars than we do our own bodies: We pay to fix our cars; our insurance pays to fix us.

The Complexity of Motivating Patients

Dan Bowman with FierceHealth reports about online health care price-comparison tools that employees of self-insured companies are encouraged to use to shop around. While this is great, my earlier concern still applies. Why would plan participants go through the effort, if the savings don't trickle back to them? Indeed, if my plan participant doesn't care about the costs of care, what incentive is there to log in and find a deal?

Furthermore, as they say, it takes two to tango. Despite a 2006 law in California requiring hospitals to post their average charges for common procedures on a state-run website, very few hospitals actually post such prices. And I have heard no uproar from patients trying to save their insurance carrier or benefit plan some dough.

One solution bandied about involves high-deductible plans. Unfortunately, increasing how much patients pay often only impacts their decision to obtain care in the first place, rather than incentivize them to find the best deal.

Prevention Is Better Than Cure

So, when dealing with the third "P," transparency is a great place to start, but clearly the best way to lower health care costs is to avoid the need for care in the first place. I'm not the first to propose this and as a result, wellness programs are appearing in the headlines with more frequency these days. Whether it's watching the "Biggest Loser" on television or attending employer-sponsored wellness events, getting in shape hasn't been this cool since Jane Fonda donned her first spandex leotard.

On April 30, 2012, the California Public Employees' Retirement Systems and the Service Employees International Union Local 1000 announced a pilot state government workplace wellness program that will show how investing in health improves lives and saves money.

Evidently, the Urban Institute, in partnership with CalPERS, found that 22.4 percent of CalPERS' medical expenditures in 2008 were spent treating chronic diseases that could be prevented through changes in diet and increased physical activity. That's a lot of money. It was then proposed that wellness programs could result in at least a reduction of 5 percent in preventable conditions, potentially resulting in annual savings of $18 million; just a 1-percent reduction in such costs could net CalPERS an annual savings of $3.6 million.

This pilot program will be examined closely, since if it can work on a large state plan, it clearly can be used as a model for the private sector as well. Look west!

California isn't the only one realizing the potential R-O-I on being F-I-T. MSNBC reported that obesity adds $190 billion in health costs. Yikes! We have been told for years that smoking is bad for our health and children learn in school all about the horrible effects of

See *CE Column,* p. 14

Insurance Mandate (continued from p. 11)

disadvantage in recruitment and retention, Joe McGinty, vice president for employee benefits at the Graham Co. in Philadelphia, tells the *Guide*.

Dependent Care Possible Target

Dependent care to age 26 took a hit in a report by Senate Republican staff (see http://healthblog.ncpa.org/wp-content/uploads/2012/06/26-Year-Olds.pdf), which said that the dependent-care mandate loads into employer plans more than 4 million young lives that could have gotten coverage somewhere else.

It also reported that more twice as many young beneficiaries sought coverage than were expected, increasing employer health plan rolls by 6 million, instead of 3 million, young folks.

Beyond the insurance mandates, self-insured plans would also be free from reform requirements to field an independent appeals panel, and from the mandate to develop and distribute uniform summaries of benefits and coverage, McGinty notes.

CE Column (continued from p. 13)

smoking, but clearly the same isn't being said about fast food.

Worse, the cost of caring for less healthy individuals results in higher health insurance premiums for everybody. Everyone pays to cover those extra medical costs.

The parallel is clear. Only when scientists discovered that secondhand smoke was making nonsmokers sick, did policymakers get serious about fighting the habit.

Now, as economists put a price tag on body mass indexes, policymakers as well as the private sector are mobilizing to find solutions to the obesity epidemic.

U.S. obesity has soared from 13 percent to 34 percent over the last 50 years, while the percentage of Americans who are extremely or morbidly obese has rocketed from 0.9 percent to 6 percent. When we were in high school, nobody talked about wellness, but then again, back then, most kids went outside and engaged in physical activities. Today, there is no need to go outside or even interact face-to-face. You can have a chat or even date online and play games with your friends from the comfort of your couch, thanks to the Internet.

> It appears to fall on America's employers to motivate patients (their employees) to become more educated about their own health and take more proactive steps to improve it.

Employers Can Make a Difference

Health care reform allows employers to charge obese workers 30 percent to 50 percent more for health insurance if they decline to participate in a qualified wellness program. The law also includes carrots and sticks to persuade Medicare and Medicaid enrollees to see a primary care physician about losing weight and funds community demonstration programs for weight loss.

We can point fingers at the insurers, the networks and the providers ... but in the end ... costs will only come down when the people driving the costs need less care and obtain care with greater efficiency.

The Health Services and Systems Research Program at Duke's NUS Graduate Medical School forecasted results after simulating the savings that could be achieved through modestly successful obesity prevention efforts. Research published in the June 2012 *American Journal of Preventive Medicine* predicted that 51 percent of the population will be obese by 2030.

In essence, the new study estimates a 33-percent increase in obesity prevalence and a 130-percent increase in severe obesity prevalence over the next two decades. If we can hold obesity to 2010 levels, the combined savings in medical expenditures would be $549.5 billion over 20 years.

In the effort to make workers healthier, employers and insurers have dangled carrots. They've threatened with sticks. Now, they are trying games. My employees aren't allowed to have fun, but if you aren't like me, this might interest you.

Go to the Fitness Arcade

More success encouraging employees to take care of themselves is possible if an employer makes it fun and competitive. A growing number of workplace programs are borrowing techniques from video games in an effort to encourage regular exercise and foster healthy eating habits. The idea is that competitive drives, peer pressure, digital rewards and real world prizes can get people to improve their overall health, Anna Wilde Matthews of the *Wall Street Journal* recently wrote.

About 9 percent of employers are expected to use online games in their wellness programs by the end of this year, and another 7 percent plan to add them in 2013. By the end of next year, 60 percent said their health initiatives would include online games as well as other types of competitions between business locations or employee groups, according to a current Towers Watson/NBGH survey of employers.

Some offer weeklong walking contests, others attempt Olympic-style match-ups, which involve events such as relay races. Employers often award prizes and financial incentives to winners of the games, which typically also have digital rewards. Game companies say they've seen prizes as big as cars, as well as extra days off, preferential parking spaces and cash, but often employers offer health savings account contributions."

Premium Discounts

Inetico Inc., a Tampa-based health-costs management company, offers health insurance-premium discounts to employees for advancing through the levels of HumanaVitality, a game from Humana that takes players from "blue" to "platinum" status as they do wellness tasks. Partly because the financial value is significant, he likes that the game requires participants to back up fitness claims, typically with self-monitoring devices such as pedometers and heart-rate monitors.

See *CE Column*, p. 15

CE Column (continued from p. 14)

Matthews warns us, however, that "some researchers say workplace programs could create a backlash among workers who feel coerced to participate, either because of strong financial incentives or pressure from bosses and peers."

According to Michele Vana with payroll company ADP, wellness programs are part of a human resources strategy for many employers to improve employee health and control costs. But since most employers just recently started their wellness programs, the investment returns are too early to calculate, she said.

While 79 percent of large and 44 percent of midsized companies offer wellness programs, more than 60 percent of these companies do not measure their ROI, Vana's research indicates. Yet the majority of midsized and large companies report their wellness programs met or exceeded their senior executives' expectations in regards to reducing overall health care costs. The bottom line is that it's hard to predict savings on medical costs that don't occur due to being healthy.

This year, we here at The Phia Group expanded our wellness program to further our mission of providing cost-containment solutions to the health care industry. We hope that the program will further lower health care costs and increase employee goodwill and loyalty to the company. We expect that as employees become more educated about their health and proactively take steps to improve it, fewer absences from work and increased productivity will result.

Identify Your Workforce's Health Issues

The wellness program focuses on awareness and education, specifically nutrition and preventive care. Based on results from last year's biometric screenings, the health issues at our organization were smoking, blood pressure, high cholesterol, liver disease, metabolic syndrome (a group of risk factors [including fat around the waist] that increases the risk for coronary artery disease, stroke and type 2 diabetes) and drinking.

We kick-started our updated wellness program with a health fair. Our company's benefit vendors were there so that employees could ask questions, enroll and update benefit information. In addition, we had representatives from the American Cancer Society to offer a skin analyzer to detect sun exposure and educational materials and the American Lung Association offered educational materials on smoking.

For employees to earn a cash incentive at the end of the year, they must participate in 12 out of 16 wellness program events, including biometric screenings of blood glucose, total cholesterol, HDL, blood pressure and body mass index. In addition, the staff had meetings with educational specialist providing nutritional recommendations. Other events included charity walks, such as the March of Dimes WalkAmerica, the American Heart Association's Heart Walk, Avon Foundation's Walk for Breast Cancer, the Walk for Hunger, the Step Out: Walk to Stop Diabetes and the JDRF Walk to Cure Diabetes. We offered nutritionist seminars and lunch n' learn events with a nutritionist as well as healthy cooking competitions in the workplace.

The first step to a healthy workplace is awareness of your options and we hope that many of the employees that didn't take part in our past wellness activities will at least listen this year and meet with nutritionists. It's a start.

The Bottom Line

Our lawmakers attacked the first "P" of health care (payers), by requiring insurers and plan sponsors to offer coverage to all, eliminate caps, ignore pre-existing conditions and provide an exhaustive list of so-called "essential" health benefits for a capped cost. Now, legislators are starting to recognize the important of the second "P" of health care (providers), as reflected by new initiatives to expose fraud, excessive charges and shop-around for the best deals. Yet, it appears that it falls upon us — America's employers — to promote the third "P" of health care and drive our employees — the patients — to care about their own health and recognize that they do indeed have some "skin in the game."

Subject Index, Vol. 19

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 19, Nos. 1-10. Entries are listed alphabetically by subject and the name of the court case. The numbers following each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "19:10/2" indicates Vol. 19, No. 10, page 2.

Index by Subject

Index of Court Cases