Employer's Guide to
Self-Insuring Health Benefits

Employee Benefits Series | THOMPSON | November 2012 | Vol. 20, No. 2

ASO Vendor Breached Fiduciary Duty With Hidden Fees, Court Concludes

The issue of hidden or disputed fees has the potential to create serious concerns for employers and their claims administrators. This point is illustrated in a federal court ruling that a claims administrator breached its fiduciary duty under ERISA by charging hidden fees to self-insured health plans. Blue Cross Blue Shield of Michigan was found to have engaged in ERISA-prohibited self-dealing by unilaterally determining fee amounts it would take from plan assets without disclosing the amounts to plan sponsors. This case presents reasons for plans and claims administrators to closely and carefully examine their network and claims administration agreements for hidden or disputed fees. ***Page 3***

Health Reform: Agencies Develop Guidance, Promise Flexibility

Some feds will give compliance leeway in cases where plan sponsors cannot fit data into the narrow spaces prescribed in the summary of benefits and coverage mandated by the health reform law, U.S. Assistant Secretary of Labor Phyllis Borzi said. She and other administration officials described guidance that will tell employers: (1) how to determine which workers are full-time; (2) how plans and state-based insurance exchanges will communicate with each other; and (3) how plans will prove they meet the law's "minimum value" requirements. This would enable employers to determine their potential liability in relation to reform's play-or-pay provisions. Employers also will have new fees to fund the patient-centered outcome research institute and additional Medicare taxes for high-paid employees to contend with. ***Page 5***

DOL Wants More Ways for ERISA Plans to Pay Participants for Errors

In a recent brief, DOL agreed with the expansion of damage awards for plan participants and retirees when ERISA health and retirement plans are found to have violated fiduciary duties under ERISA. In an *amicus* brief filed with the 5th U.S. Circuit Court of Appeals, DOL argued money damages for a failed promise of health coverage are in fact "appropriate equitable relief" under ERISA and should not be blocked. It filed the brief in *Gearlds v. Entergy Services Inc*. Aaron Gearlds took early retirement and accepted health coverage in 2005. But five years later, his employer terminated his health coverage, saying he had not been eligible in the first place. He contended in court that his employer's promise amounted to misrepresentation that harmed him and sought remedies. The district court held he was seeking "legal" relief, which was impermissible under ERISA. He was seeking a reversal of that decision at the 5th U.S. Circuit Court. ***Page 8***

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Saving on Health Care Costs Takes Preparation!

By Adam V. Russo, Esq.

Adam V. Russo, Esq. *is the co-founder and CEO of The Phia Group LLC, a cost containment adviser and health plan consulting firm. In addition, Russo is the founder and managing partner of The Law Offices of Russo & Minchoff, a full-service law firm with offices in Boston and Braintree, Mass. He is an advisor to the board of directors at the Texas Association of Benefit Administrators and was named to the National Association of Subrogation Professionals Legislative Task Force. Russo is the contributing editor to Thompson Publishing Group's* Employer's Guide to Self-Insuring Health Benefits.

Once upon a time, the media reports regarding health care weren't about "care" at all. They centered on who should be responsible for making the payments. The focus wasn't on cost — it was on the number of uninsured Americans and insurance profit margins. It wasn't until, in Massachusetts (for instance), everyone became insured that we realized having insurance doesn't make health care any cheaper. Today, the biggest stories relating to health care aren't about the big, bad insurance companies. The main focus is going elsewhere: on providers, the cost of care and what we actually get for our money. We know that health care isn't getting any cheaper; in fact costs continue to grow. But why?

Recent political action has increased access to health insurance. But now, the federal government is beginning to learn that the *cost* of care really matters. Think about it: The main reason so few people own a brand new Mercedes is because they are expensive. The minute a Mercedes costs less than a Honda Civic, more people will buy them. The same holds true for health care. If you reduce the cost of the care, then demand for care grows. However, instead of identifying ways to make coverage cheaper, the politicians focus on giving coverage to all.

Insane Cost Variations

A study by the Robert Wood Johnson Foundation looked at 2009 data on 19,000 appendicitis patients. These were standard, uncomplicated cases with hospital stays of less than four days.

Check out the range of the bills in question. The smallest bill was for $1,529 from a rural northern California hospital. The largest bill came in at $182,955 from a hospital in California's Silicon Valley. The average bill came in at $33,000 while the national average is roughly $28,000 according to the Federal Agency of Healthcare Research and Quality and the International Federation of Health Plans.

Why am I bringing this up? It just shows you the problem with health care costs in the country. Most people with insurance that seek this particular service are looking at one thing: Their co-pays and out-of-pockets, but not the entire bill. The fact that the bill sizes can vary so much for the same service in the same state is shocking, but the consumer's not concerned about it. Clearly, one facility is charging much more than everyone else, but why? Are we getting more for the money? That's the question that must be answered. Nobody knows what the price of their health care is and it's as if providers throw up a random price hoping that somebody will bite.

The case of Massachusetts proves one thing. When people start to focus on the cost and not just who is paying their share of fixed co-pay and deductible costs,

See *CE Column*, p. 13

Employer's Guide to Self-Insuring Health Benefits

Contributing Editor: **Adam Russo, Esq.**
The Phia Group LLC
Braintree, Mass.
Director of Publishing: **Luis Hernandez**
Associate Publisher: **Gwen Cofield**
Editor: **Todd Leeuwenburgh**
Desktop Publishing Specialist: **Shawne Hicks**

The *Employer's Guide to Self-Insuring Health Benefits* (USPS 011-926) is published monthly by Thompson Publishing Group, 805 15th St. NW, 3rd Floor, Washington, DC 20005. Periodicals Postage Paid at Washington, D.C., and at additional mailing offices.

POSTMASTER: Send address changes to: *Employer's Guide to Self-Insuring Health Benefits*, Thompson Publishing Group, P.O. Box 105109, Atlanta, GA 30348-5109.

This newsletter for the *Employer's Guide to Self-Insuring Health Benefits* includes a looseleaf update to the *Guide*. For subscription service, call 800 677-3789. For editorial information, call 202 872-4000. Please allow four to six weeks for all address changes.

ASO Vendor Breached Fiduciary Duty By Assessing Hidden Fees, Court Rules

A claims administrator breached its fiduciary duty under ERISA by charging hidden fees to self-insured health plans, a federal court in Michigan ruled.

When the administrator was explicit about the fees, it lost the plans' business, but apparently hiding the fees allowed it to regain that business.

The court in *Burroughs Corp. v. Blue Cross Blue Shield of Michigan* 2012 WL 3887438 (E.D. Mich., Sept. 7, 2012) also found the administrator engaged in an ERISA prohibited transaction (self-dealing) by unilaterally determining fee amounts it would take from plan assets without disclosing the amounts to plan sponsors. BCBS of Michigan has been contending with several lawsuits over its fee-retention policies (see the June 2011 *newsletter*).

The vendor had reserved the right to add fees to hospital bills in its contracts with the self-funded plans, but the court denied that that obviated the vendor's fiduciary responsibility.

The U.S. District Court for Eastern Michigan ordered further proceedings to decide the extent to which the vendor made misleading statements about the fees, and how many of the claims were eclipsed by the statute of limitations.

ERISA Prohibited Transaction

Blue Cross was charging fees for claims services unbeknownst to its customers but it hid those fees under hospital claims. Initially (1989), the surcharges were explicit and called "plan-wide," "other-than-group" and "retiree" subsidies. Self-insured plans did not like the added fees, which were used to subsidize insured plans, and took their business elsewhere, costing Blue Cross hundreds of thousands of covered lives.

In response, Blue Cross restored the fees, but obscured them by tacking them onto hospital bills. The fees were not itemized, so they were unaccountable for self-insured plans. In this way, the administrator collected the fees while not losing customers.

From 1994 until 2011, the non-itemized fees were undetected by the self-insured plans of Burroughs Corp. and Hi-Lex Controls.

In June 2011, the company plans sued, alleging the company violated ERISA rules and engaged in illegal transactions by hiding the fees in the billing statements. They alleged that Blue Cross employed a "bevy of artifices" to hide the fees.

Blue Cross contended that its contract with the plans authorized it to add the fees to hospital bills, the fees were fully disclosed, the plans agreed to them and therefore, they breached no fiduciary duty. By and large, those arguments would fail.

Related State Court Ruling

On June 2012, the Michigan Court of Appeals issued an opinion in *Calhoun County v. BCBS of Michigan*, No. 303274 (Mich. Ct. App., June 5, 2012), one of the many cases against Blue Cross alleging hidden fees. It was brought by a county government plan.

The state court rejected the plan's allegations, saying the administrative services contract authorized collection of fees other than administrative and stop-loss fees, and therefore there was no fiduciary duty breach. But that case did not include ERISA claims, only state-law tort and contract claims.

The Federal Ruling

Blue Cross said the *Calhoun County* ruling disposed of the entire ERISA case brought by Burroughs and Hi-Lex Controls. Judge Victoria Roberts disagreed.

Roberts said the two cases were different because Calhoun County could not have brought its claims under ERISA — government plans are not ruled by ERISA.

See *ASO Vendor*, p. 4

ASO Vendor (continued from p. 3)

The ruling in *Calhoun County* was under state common law, whereas ERISA was at the core of the *Burroughs* complaint, the court said. While many elements of the *Calhoun County* case were similar, and that state-law ruling would control to the extent ERISA claims were found to be improper, Blue Cross' argument that *Calhoun County* disposed of Burroughs' and Hi-Lex' ERISA claims was wrong, Roberts said.

The court rejected the idea that Blue Cross acted as a nonfiduciary, saying it paid itself disputed fees and employed a deliberately opaque manner to determine those amounts.

To determine whether ERISA governed the case, the court first had to decide whether Blue Cross was acting as a fiduciary.

Roberts found that Blue Cross was a fiduciary under ERISA laws. Fiduciary status is granted not only when entities exercise discretionary control over distribution of plan assets (such as making claims determinations), but also when entities exercise other authority or control over plan assets.

Following 6th U.S. Circuit Court of Appeals precedent (*Briscoe v. Fine*, 2006 WL 947189 (2006) and *Guyan Int'l v. Professional Benefits Administrators, Inc.,* 2012 WL 3553281 (2012)), Roberts used a "functional test" to determine fiduciary status.

ERISA defines fiduciary not in terms of formal trusteeship but in functional terms of control and authority. For example, the circuit in *Briscoe* concluded that the TPA was a fiduciary because it had the power to write checks. In other situations, the functional test overrides contractual language specifying that a TPA was not a fiduciary.

Those examples featured mismanagement of TPA accounts that were replenished by the plan and used by the TPA to pay claims and expenses.

Roberts indicated that in *Pipefitters Local 636 Ins. Fund v. Blue Cross Blue Shield of Michigan,* 654 F.3d 618 (6th Cir., Aug. 12, 2011), 6th Circuit Judge Arthur Tarnow decided that Blue Cross' "other than group" fees imparted fiduciary status on the administrator.

Roberts concluded that Blue Cross was exercising fiduciary control over plan assets when it unilaterally decided the amount of fees it would pay itself. "The fact that Blue Cross was able to allocate to itself an administrative fee demonstrates its control over plan assets," and "as in *Pipefitters,* this case involves Blue Cross' unilateral allocation of a hidden fee from plan assets," she wrote.

Failed Efforts to Escape Fiduciary Status

She rejected Blue Cross arguments that it was involved in mere custody or possession of assets, or that it was performing just ministerial tasks.

Blue Cross said its contract gave it the right to unilaterally retain the fees. It read:

> The Provider Network Fee, contingency, and any other cost transfer surcharges ordered by the State Insurance Commissioner as authorized pursuant to 1980 P.A. 350 will be reflected in the hospital claims cost contained in the Amounts Billed.

That did not change the fact that Blue Cross was still acting as a plan fiduciary, Roberts said, because the contract did not specify dollar amount for the disputed fee, nor did it describe how they would be calculated. In other words, Blue Cross had discretion to decide how much it would pay itself.

The court also refused to allow Blue Cross to liken its situation to a nonfiduciary bank that stored fraudulently acquired benefit plan money and collected fees on that account, saying the situation was different because:

> Blue Cross was not merely collecting routine fees when it paid itself the Disputed Fees. It exercised discretion in a deliberately opaque manner to determine the amount of fees to pay itself.

Blue Cross tried to say plan assets were not involved because the accounts were housed in a Blue Cross account, and the contracts disclaimed the label of "plan assets." The court derailed that train of thought as attempting to "elevate form over function," and held that the funds deposited into its account were indeed "plan assets."

Bar on Self-dealing Violated

Section 1106(b)(1) of ERISA prohibits fiduciaries from using plan assets in their own interest or for their own account. Concluding this constituted a breach of fiduciary duty, Roberts said:

> This is plainly what Blue Cross did when it unilaterally determined the amount of Disputed Fees to keep as part of its administrative compensation and collected those fees from plan assets.

See *ASO Vendor*, p. 6

Agency Officials Promise Employers Flexibility In Complying With Health Reform

When it comes to health reform's new Summary of Benefits and Coverage, the feds will give some compliance leeway in cases where plan sponsors cannot fit data into the narrow spaces prescribed in the law, a prominent federal official told benefits attorneys in Washington, D.C.

Many in the industry say the health reform law was prescriptive to a fault on SBCs: dictating their page count, where information must go, how much space goes to each kind of information and even font size. The government maintains the format is important because it facilitates consumers doing uniform side-by-side comparisons.

However, to respect the nature of various employer plans, subregulatory guidance will probably follow the principle that getting all required information on your SBC is more important than making it fit exactly in the boxes and the page count prescribed in the law, Phyllis Borzi, head of the U.S. Department of Labor's Employee Benefits Security Administration, said in an Oct. 11 conference session sponsored by the ABA Joint Committee on Employee Benefits. But posting all required information is important.

For example, if a plan sponsor exceeds eight pages (including both sides of the paper) in their SBCs, or cannot fit a required element, like a coverage example, in an allotted space, it is more important to get in all the required information, she said. Minor overflows will be tolerated, especially in the first year, she added.

Calculating Play-or-pay Obligations

Important guidance for employers concerns calculating their obligation under reform's play-or-pay provisions. Several government officials described rules and guidance that will tell employers: (1) how to determine which workers are full-time; (2) how plans and state-based insurance exchanges will communicate with each other; and (3) how plans will prove they meet the law's "minimum value" requirements.

Counting Full-timers

IRS Notice 2012-58 is the latest guidance designed to help employers count full time employees for obligations under health reform. Employers will identify workers who worked on average 30 hours a week by referring to look-back periods (standard measurement periods). These can be between three months and 12 months in length — and employers will determine how many hours on average each employee worked per week, using that uniform period for all, to determine which are FTEs, and must be offered health insurance.

Having employees divided between full-time and part-time under reform's rules is a necessity when calculating employer play-or-pay penalties. The rules are complicated, said Kevin Knopf, an attorney with the Treasury Department, but they are flexible in order to deal with situations where workers move between full- and part-time status, and when workers are variable-hour or seasonal.

Enrollment Within 90 Days

EBSA is working through issues on calculating the 90-day period for automatic enrollment, because a determination of full-time status may clash with time limits on auto-enrollment, Borzi said. For new hires who are reasonably expected to be full time, a good way to avoid headaches is just to make an offer of coverage on hire, attendees (who were benefits attorneys) said.

In Technical Release 2012-01, DOL suspended enforcement of the employer responsibility payments for group health plan sponsors that don't cover an employee the first three months after his or her date of hire. Previous rules held that if an employer fails to make an offer of coverage within 90 days, a shared-responsibility payment can be assessed.

Rules on Plan-exchange Reporting

EBSA is working on rules to govern the exchange of information between state-run insurance exchanges and plans (starting 2014) on: (1) which employer health plans offer coverage that has "minimum value" and (2) which employees have used subsidies to purchase coverage on an exchange (both of which determine employer shared responsibility payments). Here again, the statute is unclear.

"This is not news: The statute is not a model of legislative crafting," Borzi said. Regarding this new reporting requirement, she said: "The tiny bit of statutory language we have is conflicting [and] contradictory."

Minimum Value

On April 26, 2012, Treasury and IRS issued Notice 2012-31, which provides information on determining whether an eligible employer-sponsored health plan provides minimum value. Starting in 2014, whether such

See *Reform Compliance*, p. 6

Reform Compliance (continued from p. 5)

a plan provides minimum value will be relevant to eligibility for the premium tax credit and application of the employer shared-responsibility payment.

The feds will provide three ways to demonstrate minimum value: (1) log into an online calculator, which will give you a determination based on your population, coverage and claims; (2) fill out a design-based checklist and submit it; or (3) hire an actuary and submit his or her report, Elizabeth Fowler, special assistant for health care policy from the National Economic Council said.

New Taxes

George Bostick, benefits tax counsel at Treasury said his office is trying to get guidance out as early as possible to enable plan sponsors to be ready by January 2014 (at which time, the employer shared-responsibility rules and state insurance exchanges take effect).

Bostick said his office is issuing rules on these reform topics in the next 12 months:

- **Fees to fund patient centered outcome research institute.** Most self-funded plans and insurers will pay $1 per the average number of covered lives for plan years ending on or after Oct. 1, 2012 and before Oct. 1, 2013. The amount will be $2 per covered life for years ending on or after Oct. 1, 2013 and before Oct 1, 2014. Plans years starting after Oct. 1, 2014 will pay $2 per covered life, plus health inflation, until 2019.
- **Medical device excise tax.** This is a 2.3-percent tax on all medical devices, which the government expects will bring in $29 billion over 10 years to fund health reform.
- **Additional Medicare tax.** Employers must withhold an addition 0.9 percent for Medicare for single filers making $200,000 a year, married filers making $250,000, and married filing separately making $125,000.

Perspective on Play-or-pay Penalty

Under IRS code rules on reform's shared-responsibility provisions at IRC Section 4980H, large employers are likely to face smaller penalties when offering "unaffordable" coverage than they will if they completely fail to offer coverage:

- **No coverage.** A penalty of $2,000 *times the number of full-time employees* is levied if the large employer offers no coverage and one or more employee enrolls in an exchange plan with a premium tax credit of cost-sharing reduction. This seems like a disproportional penalty if just one person gets the subsidy.
- **Minimum essential coverage is offered, but it is unaffordable.** In this case, if an employee qualifies for a tax credit or subsidy and gets exchange coverage, the plan faces a $3,000 payment, but that amount is *multiplied only by the number of employees* who actually got the subsidized exchange coverage.

A benefits attorney told the *Guide* that to reduce exposure to penalties, all large employers should offer minimum essential coverage, even if they require the worker to pay the entire premium, because penalties in that case will be far less than not offering it at all.

For more information, go to http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions.

ASO Vendor (continued from p. 4)

More Information Needed on Deception

The plaintiffs alleged Blue Cross breached its fiduciary duty by misleading them about the disputed fees. Roberts, however, said more discovery would be needed to determine:

- Whether Blue Cross lied in a Hi-Lex bid form when it wrote "N/A" in the row entitled "Network Access/Management Fees."
- Whether the various reports and disclosures Blue Cross issued to Burroughs and Hi-Lex Controls were misleading or false regarding the disputed fees.

The court dismissed seven state-law claims with prejudice after determining they were preempted. It ruled in favor of the plans on the self-dealing charge, but sent the remainder of the ERISA allegations to trial to determine how much Blue Cross must pay the plaintiffs (based on the deception v. transparency findings) and whether the lawsuit was filed before the statute of limitations ran out.

Implications

The issue of hidden or disputed fees has the potential to create serious concerns for employers and their claims administrators.

Here, the employer plans had direct contractual arrangements with Blue Cross to provide both claims administration services and access to the network. It was in the administrative services agreement between Blue Cross that the fees were not transparent to the plans. This agreement also outlined the process for Blue Cross

See *ASO Vendor*, p. 15

SIIA Fails in Preemption Bid Against Mich. Claims Tax on Self-funded Plans

The Self-Insurance Institute of America lost a major round in its challenge to Michigan's tax on health claims processed by third-party administrators and self-funded plans. The federal district court in Eastern Michigan refused to agree that the 1-percent per claim imposition on plans, TPAs and insurers was preempted by ERISA in *Self-Insurance Institute of America Inc. v. Snyder*, No. 11-15602 (E.D. Mich., Sept. 7, 2012).

Background

The Michigan Health Insurance Claims Assessment Act (Mich. Comp. Laws § 550.1731), which took effect Jan. 1, 2012, assesses a 1-percent tax on claims paid for health services performed by Michigan providers and on Michigan residents. It intends for the claims tax to generate $400 million to compensate for revenue lost by the lifting of another tax on Medicaid managed care organizations and Medicaid claims administrators. No one beneficiary can generate more than $10,000 in claim-tax payments to the state under the law. The claims tax phases out on Jan. 1, 2014.

TPAs, stop-loss insurers, health insurers and MCOs (all subject to the 1-percent tax) can pass the tax on to employer group plan sponsors, but they have to follow procedures to do so, see the state's description at: http://www.michigan.gov/documents/lara/Emergency_Rules_HICAA_383664_7.pdf. The state also issued this fact sheet: http://www.michigan.gov/taxes/0,4676,7-238-60726---F,00.html.

The Challenge

SIIA contended that the tax is preempted by ERISA because it: (1) refers to ERISA plans in its text; (2) imposes impermissible burdens on ERISA plans; and (3) interferes with their uniform nationwide administration. In its complaint, it named Gov. Rick Snyder (R), insurance regulation chief Kevin Clinton and state treasurer Andy Dillon as defendants.

The Michigan defendants countered that the tax has only an indirect economic influence on any ERISA plan choices and does not dictate plan benefits, structure or administration, or otherwise preclude uniform administration of ERISA plans.

According to SIIA, the state further said during June oral arguments that TPAs are in the insurance business (and that the tax only affected self-funded plans that self-administer claims), so taxing them is saved from preemption. SIIA argued that TPAs are agents of self-funded ERISA plans and as such, aren't in the insurance business. SIIA also contended that no state tax that directly taxed ERISA plans (not just the plan sponsor or TPA) has ever withstood an ERISA preemption challenge. SIIA's stance is outlined here: http://www.siia.org/i4a/pages/index.cfm?pageID=6171.

Court Dismisses SIIA Case

In the Sept. 7 ruling the federal court held that the claims tax does not "relate" sufficiently to ERISA plans for preemption to occur. One of the main criteria for if a state law is preempted is whether it interferes with the ability to uniformly administer a plan in several states. SIIA had not submitted adequate evidence that the tax would have such an effect on core ERISA plan competencies, such as enrollment, covered benefits and payment amounts, the court concluded.

The court told the litigants that an essential question when determining how a state law "relates to" an ERISA plan is whether the state law has an impermissible *effect* on it. Mere mention in the statute was not enough alone to warrant preemption, the court said, disregarding one of SIIA's arguments.

And although the tax does target ERISA plans (among a wide variety of other entities that process claims) by increasing their costs, it is not aimed at ERISA plans *per se*, and it does not treat ERISA plans differently from other entities, the court concluded.

> [C]ourts have found that laws that do not mandate particular structures for or decisions about the "processing of claims and disbursement of benefits," *Eglehoff,* 532 U.S. at 148, are not preempted, even if they may "impose some burdens on the administration of ERISA plans ... [or] increase [ ] the cost of providing benefits to covered employees."

The court also said that the claims tax is implicated and assessed only *after* claims had been decided on and paid, disregarding SIIA's arguments that its post-claims-administrative burdens also interfere with uniform plan administration. The court said perhaps they do, but:

> even assuming the Act results in some lack of uniformity in post-benefit-decision plan administration, this effect is unrelated to ERISA's concern of establishing [standard procedures for claims processing and benefits payments.]

See *Claims Tax*, p. 9

Plans Should Face Broader Damages For ERISA Violations, Says DOL Brief

In a recent brief, the U.S. Department of Labor agreed with the expansion of damage awards for plan participants and retirees when ERISA health and retirement plans are found to have violated fiduciary duties under ERISA.

In an *amicus* brief filed with the 5th U.S. Circuit Court of Appeals, DOL argued money damages for a failed promise of health coverage are in fact "appropriate equitable relief" under ERISA and should not be blocked.

Changing Landscape on Equitable Relief

Historically, the requirement that ERISA remedies must be "equitable relief" and not "legal relief" (which can result in monetary damages) has been a brake on many kinds of money awards from plans to participants. Earlier court rulings regarding "appropriate equitable relief" generally awarded a return of premiums in cases involving allegations of failed coverage promises.

However, the precedent set by the U.S. Supreme Court decision in *CIGNA v. Amara* expanded the remedies available to participants based on the conclusion that: (1) not allowing one party to profit from its own misconduct; (2) reforming a contract; and (3) imposing a surcharge on a party to remedy such profit, were relief "typically available [to courts] in equity."

In *Amara*, 131 S. Ct. 1866 (2011), the Court ordered CIGNA to rewrite provisions of the benefit plan which violated promises it made about enrollees' coverage. Then it had to retroactively pay the enrollees what they would have received, had the plan kept those promises.

Background

The 5th Circuit case, *Gearlds v. Entergy Services Inc.*, No. 12-60461, also involves court remedies for a plan's alleged failed promises. It is on appeal from the U.S. District Court for the Southern District of Mississippi.

Aaron Gearlds was employed by Entergy from 1976 through 1994, and he was on its employee benefit plans, including the health plan. In 1994, he stopped working and began receiving long-term disability benefits until 2002. In 2005, Gearlds took early retirement. Upon retirement, he accepted a reduced pension and full medical, dental and vision coverage. He paid premiums and received health coverage.

In 2010, however, Entergy terminated his health coverage, contending he had not been eligible for coverage in 2005.

Gearlds sued in federal district court, seeking money damages in the amount of his past and future medical expenses, interest, attorney's fees, court costs and other available equitable relief. He alleged: (1) Entergy induced him to take early retirement by promising retiree health benefits, but those benefits turned out to be impermissible; (2) he relied on those misrepresentations and, as a result, gave up the opportunity to be covered under his wife's policy when she retired.

His lawsuit argued that the plan violated its fiduciary duty under ERISA. He contended Section 502(a)(3) could equitably estop the plan from denying him benefits, and authorized the court to dislodge any profit that plan fiduciaries accrued by misrepresenting his coverage status.

The district court, however, held the award Gearlds was seeking was "legal relief" — not "appropriate equitable relief" — and he had failed identify any valid remedy under the circumstances.

DOL's Arguments

In its *amicus* brief, DOL seeks a reversal of that district court holding. It argued that:

- ERISA's enforcement provision for "other relief available in equity" at Section 502(a)(3) enabled the 5th Circuit to surcharge Entergy for the money of Gearld's health coverage.
- Gearld adequately pled a claim for fiduciary breach when he alleged he was harmed by the plan's misrepresentations and made a general request for equitable relief.

DOL said the more recent *Amara* case superseded the cases the district court relied on: (1) *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) and (2) *Amschwand v. Spherion Corp.*, 505 F.3d 342, 347 (5th Cir., 2007). Generally, those cases excluded money damage awards.

Amara, however, made it clear that courts have the equitable power to award make-whole monetary relief to plan participants and beneficiaries who are harmed by fiduciary breaches, DOL argued.

DOL added that two conditions for this kind of relief are met in *Gearlds*: (1) the recovery is being sought from the fiduciary responsible for the loss; and (2) fiduciary duty was breached:

See *DOL Amicus*, p. 10

Romney: Repeal and Replace Health Reform Law With More Consumerism, Tax-based Incentives

GOP presidential candidate Mitt Romney recently provided more details on his own health reform plan, stating that if elected, on his first day in office, he will issue an executive order for the federal government to issue health reform waivers to all 50 states, and immediately work on repealing the health reform law passed in March 2010.

His repeal strategy is based on these principles: (1) allowing states to craft their own specific health reform plans; (2) reducing health costs through pro-market measures; and (3) increasing consumer driven health options. His campaign charts out his legislative goals at http://www.mittromney.com/issues/health-care.

In the *New England Journal of Medicine*, Romney writes that he: (1) supports insurance exchanges; (2) would allow individuals to enjoy the same tax benefits that employer groups get when buying group coverage; (3) proposes a system of vouchers to seniors to pay for coverage instead of Medicare; and (4) would use block grants to fund state Medicaid programs.

Romney's campaign on Sept. 27 delivered a scathing assessment of President Obama's health reform law. It says that reform as actually implemented has fallen far short of several of Obama's and congressional Democrats' promises. In "Leaving the Obamacare Fantasyland," the campaign says, the reform law is: (1) forcing people to change out of the insurance they have; (2) ineffective on cost control; (3) generating huge tax increases on providers, device and drug makers, health plans and insurers; and (4) slashing Medicare, which would force many seniors to change the coverage *they* have.

In order to remedy the "rampant confusion," "disastrous design" and "broken Medicare" resulting from health reform, the campaign says if elected president, Romney would:

- **Lessen federal rules on private insurers and employer plans.** That would mean eliminating health reform's coverage mandates on insurers and employer plans. Potential changes include covering dependents to age 26, caps on annual and lifetime limits and the requirement to cover the government's list of essential health benefits.

  Note: Romney has said he does not want to change the no-rescission of coverage rules, and he wants to ensure that people with pre-existing conditions retain affordable coverage.

- **Promote public-private partnerships** in addition to health insurance exchanges and subsidies, to ensure that more people become insured and fewer remain uninsured.

  Note: In the 2010 reform law, exchanges were a way of achieving a uniform market and more access to coverage, by using companies from the private sector, while avoiding use of a "public option" plan sponsored and run by the government.

  Note: The Massachusetts Connector Plan is one such exchange program, which significantly cut the uninsured rate in Massachusetts. Romney signed that program into law in April 2006.

- **Help the chronically ill** by means of high-risk pools, reinsurance and risk adjustment.
  Note: Under reform, insurers and self-insured employers will face a reinsurance tax to fund individuals with very expensive needs. Insurers will get utility from their payments, because they sell individual policies; but self-insured employers do not sell policies, so they will see no benefit from their contributions, observers say.

- **Cap non-economic damages in medical malpractice lawsuits,** a measure absent from the health reform law.

- **Promote multi-small employer health insurance purchasing arrangements**.

- **Facilitate IT interoperability** to cut administrative costs and streamline service.

- **Give individuals who purchase health insurance the same tax deductions** as employees in group plans and employers get. This is an alternative to

See *Romney Plan*, p. 12

Claims Tax (continued from p. 7)

SIIA's efforts to invoke the deemer clause also failed. That clause prohibits any state law from deeming an ERISA plan to be an insurer in order to subject it to a mandate. But the court said that clause cannot be invoked if a statute is not seen as relating sufficiently to an ERISA plan in the first place.

> Here, where the Court has already determined that the Act does not impermissibly "relate to" an ERISA plan, the deemer clause is not triggered.

Accordingly, the court dismissed the case. SIIA said it will appeal the decision.

DOL Amicus (continued from p. 8)

> Contrary to the district court's conclusion, the *Amara* decision now makes clear that suits by plan participants and beneficiaries against fiduciaries for monetary redress of the losses caused by fiduciary breaches are fully consistent with the Supreme Court's decision in *Mertens*, and are thus permitted as suits seeking "appropriate equitable relief" under ERISA section 502(a)(3).

DOL said the plan breached its fiduciary duty "when it misled [Gearlds] about his health care coverage by making representations, both orally and in writing, that [he] was covered under the health care plan when Entergy knew or should have known that he was not covered."

Further, the 4th Circuit in 2012 overturned a district court's determination that ERISA authorized no more than a return of premiums in a similar misrepresentation-of-coverage case, in *McCravy v. Metropolitan Life Ins. Co.*, 2012 WL 2589226 (4th Cir., 2012).

DOL said Gearlds was entitled to equitable relief under post-*Amara* theories of contract reformation and surcharge, even though he did not name those explicitly in his lawsuit.

Dismissing Gearlds' claim because he had failed to adequately specify the remedies for the alleged violations was setting the bar for establishing fiduciary violations too high, DOL said.

Accordingly, DOL's Solicitor General M. Patricia Smith urged the 5th Circuit to reverse the lower court's order, and remand it for further proceedings.

Implications

Here, Gearlds was misled by Entergy. Whether this was intentional or negligent, it had far-reaching consequences. As a result, and relying on the information provided to him, Gearlds refused other health coverage that he otherwise would have elected … had he been properly advised by Entergy.

Under ERISA, the plan administrator interprets plan terms and provisions. The court must defer to the plan administrator's decision, so long as it is not arbitrary and capricious. As illustrated, knowing the impact of ERISA is critical. This is particularly true in light of recent case law.

The Supreme Court's decision in *Amara* has the potential to effectuate a departure in ERISA fiduciary breach remedies. It may be inferred from DOL's brief and in light of *Amara* that plan participants may seek monetary relief for failed promises under ERISA's "other relief available in equity" provision.

This has the potential to make employers vulnerable to lawsuits under which plan participants claim that they detrimentally relied on a promise the plan failed to keep and thus are entitled to "other relief available in equity" or monetary relief.

Statement of Ownership, Management and Circulation

1. Title of Publication: **Employer's Guide to Self-Insuring Health Benefits**	2. Publication No. 011-926	3. Filing Date: October 1, 2012

4. Frequency of Issue: Monthly 5. No. of Issues Published Annually: 12 6. Annual Subscription Price: $499
7. Complete Mailing Address of Known Office of Publication: 805 15th St. NW, 3rd Floor, Washington, DC 20005
8. Complete Mailing Address of Headquarters or General Business Offices of the Publisher: 805 15th St. NW, 3rd Floor, Washington, DC 20005
9. Name and Address of Publisher, Editor, Managing Editor:
(a) Thompson Publishing Group, James Still, President and CEO, 805 15th St. NW, 3rd Floor, Washington, DC 20005
(b) Todd Leeuwenburgh, 805 15th St. NW, 3rd Floor, Washington, DC 20005
(c) Gwen Cofield, 805 15th St. NW, 3rd Floor, Washington, DC 20005
10. Owner: Ableco, LLC, 299 Park Avenue, New York, NY 11201
GSC, LLC, 500 Campus Drive, Florham Park, NJ 07932
Natixis, 9 West 57th Street, 35th Floor, New York, NY 10019
NewStar Financial, Inc., 500 Boylston Street, Suite 1250, Boston, MA 02116
Fortress, 1345 Avenue of the Americas, 46th Floor, New York, NY 10105
PNC, 1600 Market Street, Philadelphia, PA 19103
11. Known Bondholders, Mortgagees, and Other Security Holders: None
12. Tax Status *(For completion by nonprofit organizations authorized to mail at special rates)*: None
13. Publication Title: *Employer's Guide to Self-Insuring Health Benefits*
14. Issue Date for Circulation Data Below: September 2012

15. **Extent and Nature of Circulation**	**Average No. Copies Each Issue During Preceding 12 Months**	**Actual No. Copies of Single Issue Published Nearest to Filing Date**
A. Total No. Copies Printed *(Net press run)*	279	260
B. Paid and/or Requested Circulation:		
1. Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	200	171
2. Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	0	0
3. Sales Through Dealers and Carriers, Street Vendors, Counter Sales and Other Non-USPS Paid Distribution	0	0
4. Other Classes Mailed Through the USPS	0	0
C. Total Paid and/or Requested Circulation *[Sum of 15b (1), (2), (3) and (4)]*	200	171
D. Free Distribution by Mail *(Samples, complimentary, and other free)*		
1. Outside-County as Stated on Form 3541	19	19
2. In-County as Stated on Form 3541	0	0
3. Other Classes Mailed Through the USPS	0	0
E. Free Distribution Outside the Mail *(Carriers or other means)*	0	0
F. Total Free Distribution *(Sum of 15d and 15e)*	19	19
G. Total Distribution *(Sum of 15c and 15f)*	219	190
H. Copies not Distributed	60	70
I. Total *(Sum of 15g and 15h)*	279	260
J. Percent Paid and/or Requested Circulation *(15c/15g x 100)*	91%	90%

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2012 issue of this publication.
17. I certify that the statements made by me above are correct and complete. Todd Leeuwenburgh, Editor.

Okla. AG Seeks to Upend Employer Mandate in Health Reform Law

Oklahoma's Attorney General has revived his state's challenge to the federal health reform law, this time targeting the law's employer mandate.

The state's amended complaint at the U.S. District Court for the Eastern District of Oklahoma seeks to overturn an IRS regulation allowing some consumers to get federal subsidies to buy insurance on health insurance exchanges in states that opted not to establish such exchanges.

Note: States may elect to set up and run their own insurance exchanges, or states may forgo that task, opting instead for the U.S. Department of Health and Human Services to establish and run their exchanges.

Pruitt: Employer Penalties Will Cost Jobs

In *State of Oklahoma v. Sebelius*, CIV-11-030-RAW (E.D. Okla., Sept. 19, 2012), Attorney General Scott Pruitt said large employers in states that elected not to run exchanges should not have to pay shared responsibility payments when a health exchange run by HHS gives a subsidy to a person living in one of those states.

The health reform law only authorized such applicability in states that actually establish health insurance exchanges, the AG contended. The IRS rule expanded the definition to include "federally-facilitated exchanges."

"Oklahoma has not established or elected to establish an exchange and does not expect to do so," according to the complaint. Thus, that state would have a "federally-facilitated exchange."

A large employer (defined as having 50 or more employees) is subject to the inadequate-coverage penalty if it offers health coverage to its full-time employees, but has one or more full-time employees certified as having enrolled in a federally subsidized exchange-based health plan.

If even one employee gets a premium subsidy, the large employer can face disproportionate penalties for offering no coverage, or coverage that is unaffordable or inadequate.

> Under Code Section 4980H(a), the annual assessable amount is $2,000 for each full time employee above 30 employed by the employer. Thus, if just one of an employer's 600 full-time employees is eligible for a Premium Tax Credit, the employer's annual Assessable Amount will be $1,140,000.

Note: Oklahoma in November 2010 amended its constitution in opposition to the individual mandate. "To preserve the freedom of Oklahomans to provide for their health care … [a] law or rule shall not compel … any person, employer or health care provider to participate in any health care system," the amendment states.

Background

State of Oklahoma v. Sebelius originated in January 2011 as a challenge the health reform law's mandate that all individuals buy health insurance, saying it was unconstitutional under the Commerce Clause.

In June 2012, the Supreme Court ruled that the individual mandate was authorized under Congress' powers of taxation (but not under the Commerce Clause).

> Pruitt amended the complaint to state that even though the mandate was valid, the feds still had no right to order anyone to buy health insurance.

A federal judge had stayed *State of Oklahoma v. Sebelius* in anticipation of the Supreme Court ruling. The state persuaded the judge to lift the stay to give it an opportunity to submit this amended complaint.

In light of the Supreme Court decision, Pruitt amended the complaint to: (1) say the individual mandate no longer conflicts with the Oklahoma constitutional provision; (2) state that even though the mandate was valid under Congress' taxing authority, the feds still had no right to order anyone to purchase health coverage; and (3) raise a new complaint about the IRS rule.

The Amended Complaint

The expanded definition in the IRS rule disadvantages employers in states that do not set up their own exchanges, Pruitt reasoned in his complaint.

> [U]nder the plain terms of the Act, employers in Oklahoma should not be subject to the Employer Mandate because of a determination that an Oklahoma resident employed by the employer in Oklahoma is entitled to advance payment of a premium tax credit because of enrolling for coverage through an Exchange established by HHS to operate in Oklahoma.
>
> [C]ontrary to the Act, [the IRS rule provides] that qualifying taxpayers are eligible for premium tax credits and "advance payments" if they enroll for health insurance through the

See *Reform Complaint*, p. 12

Romney Plan (continued from p. 9)

the proposal of eliminating the tax-exempt status of employer health benefits.

- **Allow consumers to purchase insurance across state lines,** which Romney says will create a more level playing field with fairer competition.
- **Allow health savings account holders to pay their health insurance premiums** with tax-advantaged HSA dollars.
- **Promote stop-loss and coinsurance products**.
- **Promote alternatives to the fee-for-service system** of billing and paying health services.

Backlash

The Commonwealth Fund on Oct. 2 issued a report critiquing Romney's plan, saying his plan would leave more people uninsured than the current law. In an hour-long teleconference on Oct. 1, Commonwealth Fund President Karen Davis and Vice President Sara Collins said Romney's plan would:

- **Increase the number of uninsured Americans** to 72 million in 2022. Under the current reform law, the number of uninsured would drop to 27.1 million in 2022, the group said.
- **Hurt small business** by depriving them of protections in the reform law against unfair denials, benefit limits and high prices due to pre-existing conditions. They say Obama's law contains protections against excessive premium hikes and coverage that spends too little on medical, as opposed to administrative, costs.
- **Stifle provider incentives to improve quality**, medical errors, patient care coordination, and the sources of cost growth. Romney, from his end, contends that reform's support of accountable care organizations is a failure because of low provider uptake.

Questions About Cost Control

Both Obama and Romney have similar proposals to slow health cost growth: Capping health inflation to the growth rate of per-capita GDP plus 1 percent (Romney) or 0.5 percent (Obama). The Commonwealth Fund officials took exception to that strategy. "We'd rather change [cost growth], by changing the way health care is organized and paid for, rather than just trying to shift costs."

Davis critiqued Romney's "premium support" strategy. The allowance would be set at a flat amount, but that amount very likely will be surpassed by inflation. People increasingly would be exposed to the gap between the flat premium support rate and health costs. The consumer would always absorb the difference, she said.

She preferred a strategy that would slow the growth of payments to physicians at the Medicare Payment Advisory Commission level and take steps to reduce hospital admissions. That way, cost control would be on the backs of providers, and there would be less cost-shifting onto consumers.

In general, Davis said, the group would like to see a quicker move away from fee for service, more linking reimbursement to comparative effectiveness, and more use of value-based insurance design.

Tax Treatment of Health Benefits

One of Romney's proposals is to equalize the tax treatment of individual and group policies. He would make individual coverage tax exempt by allowing individuals to take an "above-the-line" (meaning one would not have to itemize their deductions to take it) deduction from taxes.

Much has been made about Romney's apparent flip-flop: pledging to repeal a law that was closely modeled on the Massachusetts program he instituted. The Commonwealth Fund officials noted that Romney's state had substantial revenue sources including federal waiver funds, charity pools; and it had a relatively low uninsured rate to start with. Most other states in the union have less revenue and uninsured rates that are double or triple the Bay State's, they said.

Reform Complaint (continued from p. 11)

> Exchange where they live, regardless of whether it is a State-established Exchange or an HHS-established Exchange. … [F]ederal subsidies will be paid under circumstances not authorized by the Congress; employers will be subjected to liabilities and obligations under circumstances not authorized by Congress; and States will be deprived of the opportunity created by the Act to choose for itself whether creating a competitive environment to promote economic and job growth is better for its people than access to federal subsidies.
>
> [The IRS rule] expand[s] the circumstances under which an Applicable Large Employer must make an Assessable Payment unless it makes minimum essential coverage available under an eligible employer-sponsored plan as specified in the Act, with the result that an employer may be required to make an Assessable Payment under circumstances not provided for in any statute and explicitly ruled out by unambiguous language in the Affordable Care Act.

For more on health reform's employer mandates, see Thompson Publishing Group's *The New Health Reform Law: What Employers Need to Know*.

CE Column (continued from p. 2)

things change and outrage mounts. This is what happened in the Bay State as the Attorney General finally focused on transparency in hospital billing. The Bay State passed a law that created a special commission to report on variations in provider prices, and the attorney general will have increased authority to investigate potential anticompetitive practices by health care organizations.

Benefit plans profit from easier and more efficient claims processing with less hurdles. Presently, plans know what their discounts will be, but have otherwise been brainwashed into thinking that large discounts are great and applied to fair market prices. These are the same consumers, I suppose, that actually believe that when a garment store has a "buy one suit get one free" sale going, they are actually getting a "free" suit. Trust me; the markup on the one suit you pay for makes up for the so called "sale." Likewise, as the cost of care skyrockets, the pathetic discounts don't make up for it. In other words, a 30-percent discount on a 300-percent markup is no deal.

We Forfeit Our Right to Transparent Bills

Here's another way to illustrate the PPO scenario. If you walk into a supermarket and are told that you can either see the itemized bill and know the price of every item (as well as check for errors), or you can receive a 30-percent discount off the final price, but you can't see the receipt and will only see the final price, which would you choose? Many people would take the discount, trusting that the prices are fair and the cashier won't make any mistakes. At first, that may even be true. But over time, without checks and balances, what would stop the cashier from scanning the same item multiple times? What would stop the store from raising prices? Sacrificing our right to monitor our spending in the name of a discount is foolish.

This comes as no surprise to many. Most plans still using a PPO do not do so for the prices. They understand that they are receiving a small discount applied to an inflated price. Indeed, the fact is that the biggest reason plans still use networks is that they contractually prohibit providers from balance billing their plan members. Patients know that if they use an in-network facility, they will pay only a pre-arranged co-pay and deductible every time. They know exactly what they will have to pay regardless of what the actual cost is. This is the core of the issue! Employers, in an effort to avoid dealing with the cost of care, enter into abusive contractual relationships, divorce the consumer from the cost of what they consume and trigger the ultimate inflationary market. When the buyer doesn't care about the price of what they buy, the seller has no reason to cap their price.

Now, in the face of rising costs and health reform, employers and insurers are realizing that they can no longer afford to pay off providers, in an effort to hold off balance billing. We are seeing that more and more sponsors, insurers and brokers across the country are assessing the situation, and looking at self-funding as an option to avoid the status quo. More employers are beginning to see that discounts aren't everything — the net cost to their plans is what needs to be looked at. Self-funding offers alternatives to PPOs that result in real cost controls as far as the claims are concerned, as well as the ability to negotiate and thereby avoid balance billing.

The fact is that there has been a serious dilution of PPO value. The main reason for that reduction is the loss of exclusivity and steerage.

The fact that every consumer demands that every hospital, facility and doctor be included in the network means there is no exclusivity and therefore little to no steerage. How does anyone expect the networks to have any negotiation power or leverage when negotiating prices and discounts if every doctor and hospital is in the network? Networks will continue to have a hard time getting real discounts and an even harder time slowing down the meteoric rise of health care costs if payers aren't willing to kick facilities from their network.

Luckily, there is now an increased pressure on benefit plans to control premium growth from plan sponsors, brokers, plan participants, the government and stop-loss insurers. This is a great thing but the problem described still exists.

PPOs Going Back to Their Roots

We are starting to see the rebirth of PPOs as smaller limited networks. In addition, we are seeing a larger number of inquiries regarding carve-outs.

Through limited networks, the industry gets back to what networks were supposed to be and look like. Not every provider is in. Providers that are in are rewarded are promised true steerage, and plans get real discounts on fair market prices in exchange for more customers and prompt payment. The plans and networks thereby have negotiation power. Sure the plans give us access to all but they get true savings from those providers in their network. The plans can personalize terms and even create direct agreements with facilities. The hospitals benefit from an increase in consumer traffic (that their out of network competitors do not have), the networks benefit from being able to offer real savings, the plans

See *CE Column*, p. 14

CE Column (continued from p. 13)

benefit from receiving savings, and members don't see their premiums skyrocket.

So what is the best way to negotiate these network agreements? Many people in the industry will tell you that it is not possible, but we beg to differ. The most important thing if you do nothing else is defining clean claims as having all of the necessary information for the claim to be covered and payable under plan document terms, and covered services as not exceeding the maximum allowable amount, also according to plan terms. If you can do this then you have done your job as a plan fiduciary since basically everything flows based on whether or not a claim is payable and covered in the first place. Since the PPO applies only to covered services, it is vital that any claim be clean, and not in excess of coverage under plan terms. A clean, covered claim does not exceed the maximum allowable, includes the details needed to process the claims in accordance with the plan terms, and the claim has been reviewed for accuracy. When that occurs, the time line of 30 days to pay can then begin.

Plans Can Play Hardball

If you send payment to the facility and they cash the check but later want more or begin to balance bill the patient, then revoke the assignment of benefits and ask for the money back so that you can forward the funds to the patient and they can duke it out. Assignment of benefits, and the ability to receive payment direct from the plan, is valuable to providers. Take advantage of that value!

One of the most discussed options out there relates to carve-outs. Carve-outs, you may be asking? Isn't it a little early for Thanksgiving? Carve-outs are benefit types that are not included in the plan as a standard covered medical service. Instead, the plan addresses how claims for that service are treated, independent of the schedule of benefits. Classic examples include dental, prescription drugs and vision benefits. A plan may provide dental, drug and vision benefits, but it does so under a separate set of rules from other medical benefits. As a result, dental and vision are given their own sections in the plan document. Today, items like transplants, implants, and dialysis are being carved out from the general benefits as well.

Alternative Network Models

Many plans are beginning to have physician-only networks and paying all other claims though carve-out language and specialty programs. The growth of PPO alternatives and capped payment structures is hard to ignore. Whether it is medical tourism programs, Medicare plus payment options, MSRP and other pricing parameters, the sky is the only limit on options. But trust us, issues will remain if anything but a PPO option is used. The main issue with any type of program other than a network agreement is provider pushback resulting in balanced billing of members. Regardless of what anyone may try to tell you, the only way that you can stop balance billing is through a signed agreement with a provider that they will not balance bill in return for payment. That only occurs if you have a network in place, a direct contract between a provider and your plan, or a one-time signed agreement for a particular patient's claims. Under any other scenario you bear the risk of noise from your membership. The number one benefit of working with a PPO is not the discounts: It's the fact that your members will not get balance billed.

Anybody telling you that patients will not get balance billed is lying to you. Just like we cannot promise you that someone will not sue you regarding a fictional event, we cannot promise that a member won't receive a bill from a hospital. You can win, but you can't prevent the initial claim from being made, the balance bill from being sent, etc. You and your members can be protected if they are balance billed, through innovative language and use of experts; and this is a growing industry trend as well.

Not everything is so rosy when we look at what is happening to the self-insured industry. We like to advise the self-insured industry to "mind the gap" but sometimes it's not that easy. Sometimes a difficult gap occurs when two entities (the plan and the stop-loss insurer) are making decisions based on the same language; however, they interpret the same language differently. A great example of a soft gap relates to usual and customary charges. The plan may think a charge is usual and customary, and the insurer may think the claim exceeds the usual and customary rate — despite the two entities using the same definition of U&C. Ouch. The gaps here relate to interpretation, and cannot be spotted. You can identify potential places where differing interpretations "may" occur, but they're impossible to find with certainty.

PPOs Can Create Stop-loss Issues

Let's say, for example, that you have a well written plan document that allows you to audit any and all claims. It states that you will pay a facility the lowest of the following: 125 percent of what Medicare would pay, 150 percent of the implant invoice cost, the usual and customary charge in that particular county, or 140 percent of the average wholesale price. You then share

See _CE Column_, p. 15

CE Column (continued from p. 14)

the plan document with various stop-loss insurers. Each of them loves your language so much that they give you great rates and promise to reimburse your claims based on your language. They say that their policy mirrors your plan so if it's payable under your plan, it's payable by them. You can't beat that, right? Wrong. The insurer only asked for a copy of the plan document. This is standard across the industry. They are assuming that you are paying claims based on the plan document when in fact you are actually paying claims based on PPO contract terms. Per that network contract, you do not have the right to audit claims, you do not have the right to contact the facility directly and make a deal, you do not have the right to apply usual and customary rates, you do not have the right to ask for invoices, or do anything else other than close your eyes and pay the claims within 30 days. Since you are not obeying the terms of your own plan document, the insurer will not reimburse the payments. We see this every single day.

There is no super hero called ERISA Man who will come down from the heavens and save the day. It there were, I would hope that I could get an audition for the part!

So while it is great that plans and their third-party administrators are trying to find ways to save money with unique language and carve-out programs, you need to be sure that you haven't already agreed to other payment terms via some other contract.

One last piece of advice. Even when we advise plans that they have already agreed to not audit claims under their PPO agreement, they will tell us that they are self-funded ERISA plans, and ERISA trumps the PPO agreement. It does not. There is no super hero called ERISA Man who will come down from the heavens and save the day. It there were, I would hope that I could get an audition for the part! ERISA allows you to apply plan language nationwide and avoid state regulation of the plan. It doesn't allow you to execute independent contracts, and then avoid your part of the bargain.

Better yet, in many circumstances, the plan will advise that they want to carve out certain types of care and put the language in the plan document, but they prohibited from doing so by the agreement with their own third-party administrator. Yes, the very TPA that is supposed to process the plan's claims as the plan sees fit will state in their agreement that the claims must be processed through the network or not at all. The administrative services agreement between the plan and the TPA acts as a part of the plan document in many ways. TPAs that prioritize their relationship with their network may restrict your ability to rock the boat. The only thing that is certain is that the stop-loss insurer always supports cost containment, since they have skin in the game and really don't care about your relationship with the network.

The problem we see on a daily basis is that although many self-funded employers and their TPAs have great ideas regarding how to save money, they inevitably make the situation worse by not preparing their programs properly. If plans continue to do this, we will just take giant steps backwards instead of little steps forward. Every self-funded plan or broker that ends up dealing with a big mess due to not preparing properly will decide that self-funding is too difficult for them and will choose to take the safe and easy route — being fully insured or heading to the exchanges. This doesn't help anyone. This is not where we want to be so I urge all of you to act like the Boy Scouts and be prepared! In the end, we all benefit — plans, members, and all of our pocket books.

ASO Vendor (continued from p. 6)

to receive payment for these disputed fees from plan assets, unbeknownst to the plan.

An ASA is standard for plans and their claims administrators. ASAs commonly provide for network access. However, it is also typical for a claims administrator to enter into a separate agreement for access to a network for the plan. In general, this is intended to create an exchange: member steerage for discounted network rates.

Mindful that the claims administrator may be entering into this agreement for the plans, this creates the potential for creating an arrangement where a plan may become responsible for hidden or disputed fees. Should a plan be paying unknown or unrealized fees in an agreement established on its behalf by its claims administrator, this could be grounds for the plan to allege failure to disclose fees or misrepresentation.

This case presents reasons for plans and claims administrators to closely and carefully examine their network and claims administration agreements for hidden or disputed fees. In light of this case, participants may initiate ERISA claims. Participants may present misuse of funds or misrepresentation claims against their employer plans: that plan assets were improperly used to pay hidden fees and not their health claims.

Subject Index, Vol. 20

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

Index by Subject

Index of Court Cases