Employer's Guide to
Self-Insuring Health Benefits

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ERISA Plan Fails to Get Money Damages in Dispute With Vendors

Self-insured plans got interesting guidance about limits to their ability to extract ERISA remedies from specialty insurers and third-party administrators in a new federal court ruling. It found: (1) the specialty insurers were not plan fiduciaries, and (2) the funds they refused to pay were non-recoverable by the plan, because they did not meet the definitions of equitable relief available to ERISA plaintiffs. There was no specific fund or property in the defendants' possession from which to draw relief. Instead, Central States was seeking to impose personal liability on the defendants. Therefore, the plans demand was for "legal" relief, not available even under *CIGNA v. Amara*'s expanded definition of equitable relief. On the other hand, the court held that the plan's subrogation claim could proceed, because that was not limited to equitable relief. ***Page 3***

With Election Over, Employers Gear Up for Health Reform Mandates

President Obama's election victory cemented health reform by ending the threat of the outright repeal. So now self-funded health plans must begin to face implementation obstacles and financial burdens. Employers that delayed action pending the election's outcome will have to work extra to assume their expanded role, as they prepare for the pay-or-play mandates, which take effect in 2014. The first priority for many is finding ways of minimizing their exposure to penalties under the law. Highlights include: avoiding the no-coverage penalty at all costs; maybe changing your full-time/part-time ratio among workers. Low points include the traditional reinsurance program. That program is objectionable to many health plans because it helps to support the profitability of health insurers, with no direct benefit for non-insured, self-funded plans; plus it could cost self-funded plans as much as $60 per covered life. ***Page 5***

Employers Have More Options for Value-based Health Management

Self-insured health plans that want to adopt value-based benefits have at least three major tasks at hand: finding and purchasing from the high-performing provider in the area; designing a benefit that will steer employees to those high-performing providers. Speakers at a conference in Washington, D.C., told attendees how to achieve these goals. Points covered included: (1) the importance of data in guiding the design and construction of a value-based benefit; and (2) value-based changes require a multi-year strategic vision, and not just ad hoc changes every year. ***Page 7***

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Trying to Control Health Plan Costs? Don't Implement Without Proper Prep

By Adam V. Russo, Esq.

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One of the most important messages that I try to convey to readers is the importance of monitoring their claims dollars and focusing on cost containment. After all, it's every fiduciary's responsibility to prudently manage plan assets. Unfortunately, these days it seems like some overzealous entities are putting the "cost containment" cart before the "plan revision" horse. In other words, sometimes people get carried away and engage in more cost containment than their current plan document allows.

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Insight you trust.

Self-funded plans and their third-party administrators hear all sorts of great success stories, and dream of the dollars that can be saved by auditing claims, limiting payment to what Medicare pays, paying 50 percent or less of what a dialysis clinic charges and flying patients to faraway lands to have their gall bladder removed. But they don't pay attention to the details. They cut to the chase without setting the scene.

A hidden danger lurks that can cause their cost-containment dreams to run aground. **The problem:** Plans, TPAs and vendors are using cost containment techniques that aren't allowed by their plan documents.

> **Example:** Claims totaling $500,000 come in the door. The auditor slices and dices the bills and advises the plan to pay $100,000. The auditor asks for a small percentage of the savings; money well spent. However, a year later the hospital refuses to accept $100,000 as payment for its $500,000 bill, wants to know what the plan's legal basis is for the reduction and is balance billing the patient in the meantime.

When I'm called in a situation like this, I inspect the plan document. Sadly, I am often met with resistance upon requesting a copy. "Why do you need the plan document?" I am asked. "The auditor never needed it." Uh oh, that's a red flag.

More often than not, after this dialogue, I am shown a plan document with terms that do not support the audit. I always should be able to say, "Per page *x* of the plan document, the plan limits payment to $*x* when [blank] is the case. Because [blank] is the case here, $*y* is all the plan can pay." But if, for example, the plan document states that the "usual, customary, and therefore payable rate is equal to the PPO network fee schedule," paying half that amount (regardless of what Medicare pays) is a mistake.

By the way, the vendor charged 33 percent of savings and is long gone with the money. Whether you can actually use the result of its audit isn't its problem.

The Hospital Invasion

It's been a year since the audit when out of the blue the letters start arriving. The patient is being harassed and is worried his credit will be ruined and he won't be able to re-finance his home. The patient complains to his

See *CE Column*, p. 16

ERISA Plan Fails to Get Money Damages In Dispute With Insurers and TPA

Recently, the U.S. Supreme Court changed the previous legal landscape for health plans by authorizing money damages as ERISA equitable relief in certain circumstances, which experts predict almost certainly will increase litigation against plans.

But safe zones are coming into focus, giving plans clarity on how to know when the authority to get monetary relief will be precluded. A new federal court ruling denied relief based on the fact that two key conditions were missing: (1) fiduciary duty and (2) funds paid to the defendant that belong to the plaintiff residing in an identifiable account.

In *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Health Special Risk,* 2012 WL 5006054 (N.D. Tex., Oct. 18, 2012), an ERISA plan was seeking relief that was unauthorized under ERISA when it sought to compel payment from three specialty insurers and their third-party administrator, the federal court ruled.

In spite of the expanding view of equitable relief to include money damages, and the fact that the plan was allowed to amend its complaint in order to make ERISA relief possible, the court rejected all of its ERISA arguments, leaving just one state-law subrogation charge standing.

The Facts

The Central States, Southeast and Southwest Areas Health and Welfare Fund filed reimbursement claims to three issuers of accident medical coverage — Markel Insurance Co., Federal Insurance Co., and Ace American Insurance Co. — to pay the claims of 11 plan participants in the Teamsters Union. The vendors refused to pay, asserting that they had issued *excess* coverage only and were not liable.

The plan paid the claims on behalf of the Teamsters Union members, then appealed to the three insurers' TPA, Health Special Risk. HSR also refused Central States' reimbursement demand.

Central States then sued all four defendants to compel them to pay, seeking a declaratory judgment, an injunction prohibiting HSR and the insurers from violating plan provisions, and calling for money relief under theories of restitution, equitable lien and imposition of a constructive trust.

The district court (*Central States I*, 2012 WL 1570981 (N.D. Tex. May 4, 2012)) dismissed all of Central States' claims, holding that the plan was seeking "legal" rather than "equitable" relief, precluding it from an award under ERISA's enforcement provisions. However, the court allowed Central States to amend its complaint.

Comparison to *Amara* Disallowed

Central States repeated many of the remedies it sought in the initial complaint. Calls for restitution, equitable lien and constructive trust remedies were nearly identical to the original claims asserted in the first complaint.

But it amended its complaint to portray itself as having met the conditions for equitable relief spelled out in *Sereboff v. v. Mid Atlantic Medical Services*, 547 U.S. 356 (2006) that: (1) it asserted a separate identifiable fund that could be traced back to the insurers and TPA; and (2) the defendants were entities that owed fiduciary duties to the plan.

In its amended complaint, Central States specified that it asserted a lien on HSR to the extent of benefits Central States paid or will pay for the insured, "thereby establishing identifiable funds, … traceable to the Defendants." It also argued that the insurers and TPA were analogous to trustees, and that now entitled the plan to a monetary remedy, under the expanded definition of equitable relief validated by the U.S. Supreme Court in *CIGNA Corp. v. Amara,* 2011 WL 1832824 (May 16, 2011).

Note: The ruling in *CIGNA v. Amara* enlarged remedies available to plaintiffs under ERISA's catch-all equitable relief enforcement provision, §502(a)(3). In *Amara*, the

See *Money Damages*, p. 4

Money Damages (continued from p. 3)

> Justices for the first time said §502(a)(3) allows "compensatory," "make-whole" monetary relief to prevent situations in which one party gets a windfall (or unjust enrichment) by violating its ERISA fiduciary duties.
>
> (The High Court ruling upheld orders that the plan: (1) restore the plan to where it was originally; and (2) pay money to beneficiaries that would have been paid if the plan had not been changed from its original state.)

Central States also added a new subrogation claim, by which it sought health benefits that it paid for its insureds, "which they have a right to collect from the Defendants, under policies of insurance issued by the Defendants, providing coverage to them for accidental injuries." And it added another new claim for unjust enrichment under federal common law.

The defendants again argued that the plan had failed to state a claim on which relief could be granted.

Vendors Not on Hook

The court rejected the plan's central arguments. First of all, the plan's call for declaratory relief failed because the plan could not convert its claim into one for equitable relief merely by specifying "health claims" over "money."

Relief on restitution, equitable lien/constructive trust claims and a second declaratory claim (Counts II through IV) would not be appropriate, because Central States failed to show that the three insurers and TPA were plan fiduciaries. The court decided that *CIGNA v Amara* was inapplicable because Central States failed to plausibly allege a fiduciary relationship between itself and any of the defendants.

The situation in *Amara*, in contrast, involved beneficiaries suing their own plan that neglected its fiduciary duty, the court held. The court also rejected Central States' arguments that the lien it placed on the TPA changed the nature of the funds in dispute.

> The filing of notices of liens … does not convert [the insurers or TPA] into trustees such that [those vendors] would have owed a fiduciary duty to Central States.

The plan added arguments that the TPA and insurers' unjust enrichment justified money awards, either as equitable relief under the *Amara* precedent, or that failing, under federal common law, to prevent insurers from unjustly enriching themselves through improper actions even if ERISA precluded relief.

Central States argued plan provisions placed primary responsibility for providing benefits on the insurers, and because of that, the money Central States paid to the providers and patients should have been paid by the insurers.

But that didn't satisfy a key condition for equitable relief in the Supreme Court's *Sereboff* ruling: funds that belong in good conscience to the plaintiff must be paid to the defendants.

The insurers were never enriched with plan money, the court agreed. Plan money did go to pay providers, but the insurers were not in possession of plan funds.

There was no specific fund or property in the defendants' possession from which to draw relief. Instead, Central States was seeking to impose personal liability on defendants for their alleged failure to honor plan provisions. Therefore, Central States' claims against defendants were essentially claims for "legal" relief for money damages, the court held.

Central States' ERISA claim based on unjust enrichment was for *legal* relief, and not available under *Amara*'s expanded definition of equitable relief, the court therefore concluded.

The common law claim based on unjust enrichment independent of ERISA also failed. Courts are not allowed to fashion common law when ERISA is clear about a remedy, the court said. The court concluded the plan was seeking relief that is unavailable for all but its subrogation claim.

Subrogation Claim Lives On

The court allowed the subrogation action to ensue: As a subrogee, the ERISA plan is not suing as an ERISA plan fiduciary, but instead was stepping into the shoes of its insureds, and a limitation to equitable relief was not necessary, the court said.

> Defendants' sole basis for moving to dismiss Central States' subrogation claim is that this claim does not seek equitable relief. Because Central States is not limited to seeking equitable relief in asserting the claims of its Insureds as subrogee, defendants are not entitled to a dismissal of Central States' subrogation claim on this basis.

All federal claims having been dispelled, the court told Central States it would have to draw up a brief within 21 days to argue why the state subrogation claim should be heard in federal as opposed to state court.

Implications

This case illustrates the limitations that may exist when a plan pursues a subrogation or reimbursement claim against parties other than the actual plan participant. A plan must be wary of the circumstances under which a vendor or insurer may owe a fiduciary duty. Parties that do not hold plan

See *Money Damages*, p. 5

The Election Is Over, Now Employers Must Gear Up for Health Reform's Play-or-Pay Mandate

President Obama's election victory cemented health reform by ending the threat of the outright repeal promised by Gov. Mitt Romney. So now self-funded health plans must begin to face implementation obstacles and financial burdens, as the curtain is about to rise on the new health coverage market. Employers that delayed action pending the election's outcome will have to work extra to assume their expanded role, as they prepare for the pay-or-play mandates, which take effect in 2014. The first priority for many is finding ways of minimizing their exposure to penalties under the law.

Certain Employers Can Hedge Their Bets

Kathryn Bakich, a senior VP at The Segal Co. in Washington D.C., described fundamental ways employers can avoid health reform penalties, on the one hand for no coverage and on the other for "unaffordable" or "inadequate" coverage.

> **Note:** The penalty for failing to provide coverage is $3,000 times the number of full-time employees (excluding the first 30); the penalty for unaffordable or inadequate coverage is $2,000 times the number of employees who are eligible for a subsidy and get coverage on an insurance exchange, starting in 2014. For more information on the employer mandates, see Section 410 of the *New Health Reform Law: What Employers Need to Know*, published by Thompson Publishing Group.

She said the safest bet is to offer "adequate" and "affordable" coverage, and to try to prevent employees from getting a subsidy for: (1) low salaries; or (2) high premiums relative to salary. Specifically, employers may be able to ensure that:

Money Damages (continued from p. 4)

funds in an identifiable account do not owe a fiduciary. Because the vendors were never enriched with the money, the relief would amount to the imposition of personal liability on defendants. This relief would therefore be legal in nature and precluded under *Sereboff*. *Amara*'s expanded definition would also not provide relief where there is no fiduciary relationship between plan and defendant.

The Court did, however, allow the plan's subrogation claim to continue and relied on the basic concept of subrogation to do so. This decision re-affirms the notion that a plan enforcing its subrogation rights acts as the subrogee, and in so doing, has any and all rights of the plan participant. As a result, a plan acting as a subrogee is not limited to equitable relief.

- **No employee pays more than 9.5 percent of W-2 income for self-only coverage.** "As long as there are no employees paying 9.5 percent, then there won't be any penalties." To avoid an unaffordable coverage problem, an employer might have to consider increasing pay, she said.
- **No employee is eligible for premium tax credits.** If no one is eligible for a premium tax credit, that shields the employer from a penalty. A solution could be to increase wages so all full-time employees have income above 400 percent of the federal poverty level and/or eliminate full-time employees with wages below 400 percent of the FPL.

> The best way for employers to limit penalties is to provide coverage, then try to keep plan members from becoming eligible for subsidies because of unaffordable, or indequate, coverage.

Having a workforce that is 100 percent full-time employees would simplify matters, she continued. Some companies have considered eliminating all part-time employees and using temporary labor as necessary. Other options include:

- not letting part-time employees work more than 29 hours per week (**Note:** 30 hours a week is the level at which the reform law decides a worker is full-time and requires health coverage — furthermore, part-timers are not counted when calculating coverage penalties); and
- eliminating employees who work between 29 hours per week as well as the plan's eligibility standard (for example, 40 hours per week).

It is also important for employers to ensure that their health plan has minimum actuarial value of 60 percent, Bakich said.

Just Offering Coverage Limits Exposure

For large employers, it's important to know that just offering coverage will help them avoid penalties. The penalty for not offering coverage is a product of the entire number of employees in your company, while the "unaffordable/inadequate" penalty is a function of only the number of employees who actually apply and get subsidies.

See *Employer Mandate*, p. 6

Employer Mandate (continued from p. 5)

Therefore a basic compliance safeguard is to offer "all or substantially all" (to be defined) full-time employees coverage, Bakich said. Even if the coverage is inadequate or unaffordable, that employer will probably skirt the much larger penalty for not offering coverage. Bakich was speaking at a Nov. 8 webcast sponsored by the International Foundation of Employee Benefit Plans.

Reinsurance Program Belabors Health Plans

Self-insured health plans have expressed concerns about the costs of a reinsurance fund that looks likely to cost plans about $50 per covered life. This is far more onerous than the patient centered outcome research fund contribution of $1 or $2 per participant, attorneys for plans and employers say.

The transitional reinsurance program is objectionable to many health plans because it helps to support the profitability of health insurers, with no direct benefit for non-insured, self-funded plans, Mike Ferguson, CEO of the Self-Insurance Institute of America, said in an Oct. 23 blog entry.

> [A]n increasing number of large self-insured employers have been complaining directly to senior White House officials that the fee is fundamentally unfair.

The costs to self-funded plans could be $60 per covered life (it's not a fixed amount, but it could vary according to demand), according to Seth Perretta, an attorney at Crowell & Moring in Washington, D.C., who spoke to the *Guide* on Nov. 8. Employers will have to decide whether to bear the costs or pass them on to employees, he added.

The next question is who pays. The statute and a preliminary rule say third-party administrators on behalf of self-insured plans will be responsible for paying the fee. Ferguson says the feds he talked to implied TPAs would not be financing the fees, but only helping collect them from their clients.

The rationale from the insurers' and regulators' point of view may be that self-funded plans benefit from the individual market because the law allows employers to take waiting periods before enrolling new participants, and the company's part-time employees do get individual policies as opposed to group plan coverage. Thus, the individual market is where many of their employees may be getting covered, Perretta conjectured.

Guidance Employers Need to See Before 2014

It has been hypothesized that the government was holding back on issuing guidance until there was certainty Obama that would be reelected. What is clear now is that a significant amount of guidance is needed before the new elaborate system for health coverage (including the play-or-pay mandate) swings into action. Employers will need guidance to enable them to prove their health plans are creditable, and if not, to calculate their liability. Then they will have to adapt administratively. Perretta says employers should expect guidance from the administration on:

- whether health coverage under employer-sponsored plans provides "minimum value";
- whether employers must offer health coverage to spouses and dependents in order to satisfy the play-or-pay mandate — Perretta says he expects families will have to be covered;
- whether affordability is based on self-only or family — the regulators are leaning to requiring coverage for spouses and dependents, but basing affordability on self-only premium levels;
- automatic-enrollment rules for large employers; and
- notices to employees about the availability of coverage on the exchange; uncertainty persists on the specificity of the information, particularly at a time when exchanges may not exist in some states. Employer compliance on this obligation is required by March 2013.

Adam Russo, attorney and president of the Phia Group in Braintree, Mass., describes the implementation challenges for employers and health inflation implications nationwide in the following way:

> Over the next six months, the self-insured industry will see a flood of regulation that we have never seen in the past. The amount of guidance we can expect will be limited based on the time aspects. All the exchanges have to be put in place by 2014. Therefore all the guidance, all the issuances, the amount of hand-holding that the industry will get would be at a minimum. It seems we'll have to figure a lot of this stuff out on our own.

Purchasing Collectives Spearhead Value-based Health and Wellness Management

When a self-insured health plan adopts value-based purchasing and insurance design, its goal is to persuade workers to adopt a healthy lifestyle and go to the best performing providers. That's how plan savings occur, by catching cases before they become acute care cases that harm a self-insured health plan.

Self-insured health plans that want to adopt value-based benefits have at least three major tasks at hand: (1) finding and purchasing from the high-performing provider in the area; (2) designing a benefit that will steer employees to those high-performing providers; and (3) emphasizing effective preventive care, so chronic ailments don't become acute and costly. Two speakers at the National Business Coalition on Health's annual conference in Washington, D.C., on Nov. 12 told attendees how to achieve these goals.

Importance of Basing Strategies on Data

Before even starting, plans should collect and study data to identify which aspect of the benefit most needs work at improving performance and lowering costs. An understanding of the relevant health plan data must underpin all efforts to control costs. Frequent examples are programs to improve pharmacy benefits, diabetes management initiatives, and promoting physical exercise and nutrition, Gary Rost, executive director of the Savannah Business Group said.

> Self-insured health plans must do a health risk assessment to find out what their liability risks are for its population, stratify them, pick the one that's going to cost them the most, and make a program to address that cost. It's nice to have all these bells and whistle programs, but plans need to know the areas that are costing them the most money and address them.

Rost says there are four major things health plans must do to control health plan costs:

- Negotiate the best price you can get.
- Get the best quality you can, "and if you can't, then work with physicians to improve quality with the providers you have."
- Design your plan to drive at-risk patients to the better providers.
- Work on improving health in your community. "See what the community is working on and see if you can integrate that into what you're doing, so you don't have to redesign the wheel," Rost said.

Rost described the importance of data, identifying cost control targets and revising plan design to drive participation by the workforce.

> You can't do anything until you know what your utilization is, what your risks are, what your liabilities are, who's seeing what physicians, what they're seeing the doctors for. Start looking at your data.
>
> Then you decide what you want to go after, by asking: Where are our risks, where are the opportunities, what do we need to work on. You make a design with benefits and incentives; then you decide how are we going to provide that through your network, by deciding how do we structure programs to achieve that, how do employees access those programs.

Pursuit of value leads plan sponsors to creating a strategic process to decide how health benefits will be managed. Plans that want to implement VBD have to have a long-range vision about plan design.

Importance of Multi-year Strategy

And while employers can make quick progress on these four things, Rost says a value-based program really needs time to work: value-based changes require a multi-year commitment to strategic progress, and not just taking things as they come.

> [Pursuit of value] leads plan sponsors to creating a strategic management process designed to decide how health benefits will be managed. Many, many employers have no long-term strategic goals — they just go year to year … leading to consultant fees. Plans that want to implement VBID have to have a long range vision about plan design and what they plan to do about the productivity of their people.

A New Cost-quality Equation

The cost and quality equation is more complicated than it used to be, giving plans more levers to develop good value-based programs. In addition to cost and quality, plans now can and do track: (1) patient satisfaction; and (2) population health, as part of grading providers for value and quality.

See *Value-based Design*, p. 8

Value-based Design (continued from p. 7)

High patient satisfaction scores usually coincide with high provider quality, Rost said. A measure of patient satisfaction is patients' reports on physician empathy. Physicians with high empathy scores had better clinical outcomes than physicians with lower empathy scores, he said.

Thanks to the program, Rost said, the City of Savannah has seen the following outcomes:

- 13-percent increase in primary care physician visits;
- 5-percent reduction in specialist visits;
- 12-percent reduction in outpatient surgeries;
- 24-percent reduction in outpatient diagnostic;
- 18-percent reduction in intensive care admits; and
- 19-percent reduction in intensive care days.

Medicare: The 800-pound Payer

Medicare has launched the hospital value-based purchasing program, a large-scale effort at paying for performance and value-based benefit. The program clearly wants to take a more active role in what it is paying and it wants to pay differently, Rost said.

> **Note:** Starting Oct. 1, Medicare has been withholding 1 percent of its regular hospital reimbursements in the new Value-Based Purchasing Program, which was created by the 2010 health reform law. Over the course of the year, money will be returned to some hospitals based on how well they follow clinical guidelines for basic care and how they fare in patient satisfaction surveys. Some hospitals will get back some of the money that was held back, others will break even and some will end up getting extra. Medicare estimates about $850 million will be reallocated among hospitals under the program.

According to Rost, Medicare achieved a 2-percent improvement in quality and a $1,000 per case improvement in six key measures, namely: heart attack, heart bypass surgery, pneumonia, heart failure, hip replacement and knee replacement.

Medicare has the market clout to do this because 40 percent of hospitals are covered by Medicare: the program is working and providers are paying attention, he said.

Private plans should learn what Medicare is doing about VBID and replicate it.

> We now have the 800-pound gorilla behind us. We are not alone in the wilderness anymore. We have the standards; we have the ability to pull the data, we are able to report it, we can look at care delivered to employees, and we can look at how employees are using the system and the network. It's there.

Don't Entrust All Cost Control to Vendors

The Montana Association of Healthcare Purchasers is using value-based principles to negotiate health costs for several counties, the state university system and several professional associations. MAHP also has the endorsement of the state medical and dental associations. Mark Eichler, the group's director for pharmacy services, told attendees how it broke free from pharmacy benefit managers and got bigger discounts on drugs without losing savings to the PBM's hidden cost and profit centers.

Allowing PBMs to remain in the driver seat may not be in plans' cost-cutting interest, and even though they achieve impressive generic switchovers, for example, somehow that didn't translate into reduced drug spending for many Montana employers, he said.

"They do well but their overall business model is not meant to align necessarily with the financial and clinical needs of employers and employees," Eichler said.

His value-based purchasing alliance responded by setting up a system where the alliance can do everything a PBM can do without the middleman, he said. His purchasing coalition uncoupled all the financial relationships between the PBM and other services, and reconstituted them as separate, distinct contracts controlled by the alliance.

"We uncoupled all the financial relations between the manufacturers, the PBMs and the pharmacies, contracted with them separately with a separate vendor, and we gained control and transparency," he explained. The group made five or six contracts that enabled the group to "look and act like a PBM" but to be aligned with MAHP's incentives:

- A vendor provides evidence-based data, to analyze utilization.
- The rebate vendor is separate from the claim payer.
- The mail service vendor is not allowed to be owned by a PBM.
- Utilization incentives are designed by employers.
- MAHP still has a PBM to process and pay claims.

In spite of all this, drugs keep people out of the hospital and reduce complications. Use of prescription drugs prevents the need for more expensive hospitalizations, emergency visits and long term care. While drug spending may be wasteful without management, drugs can be a preventive trump card as long as they're used appropriately and their cost is managed, Eichler said.

Health Plans Can Expect Cost Reductions by Bundling Payments, AHRQ Indicates

Health plans and insurers long have been thinking of ways to compensate providers not for volume of care, but for value of care, as an important tool in curbing runaway health inflation.

Research over the last two decades recently compiled and reviewed by the Agency of Healthcare Research and Quality shows consistent reductions in what providers charge plans after they move to bundled prospective payments for health treatment.

The data is interesting because as health cost growth increasingly burdens health plans and insurers, they more actively support bundled payment systems that pay for care on an episodic basis, often contingent on quality outcomes and practices.

AHRQ's overview, however, does not suggest how the best ways plans and payers can deploy bundled payments to achieve cost control and quality.

Plans, Payers Call for Payment Reform

Payment reform is frequently cited as one of the most important steps to bringing health costs down for commercial health insurers and employer-sponsored group health plans. Using more bundled payment methods is seen as key to giving employer plans a system in which they will compensate providers only for effective, efficient care. Bundled payments would give plans more reliability in what they are paying, allow them to avoid paying for unnecessary visits and strengthen their hand in avoiding payments for complications and errors, advocates say.

A bundled payment system covers all services needed to get a sick patient well. It creates incentives for providers to streamline care processes and eliminate waste. Many of today's bundled payment models include quality measures and required hospital protocols to ensure patients are not getting shortchanged on care (in response to incentives to do less), according to this 2009 article by Harold Miller, president and CEO of the Network for Regional Healthcare Development in Pittsburgh, published in *Health Affairs*.

Outcome-driven reimbursement (of which bundled payment is a part) is widely regarded as important for health payers, and most plan analysts support more bundling and linking payments to quality outcomes.

Data Does Not Portray Blazing Efficiencies

In its report, AHRQ said bundled payment is a promising strategy for reducing health spending. However, effects may not be the same in future programs that differ from those included in this review.

The evidence clearly suggested that the transition from fee-for-service to a bundled payment method was generally associated with a decline in spending of 10 percent or less.

> Bundled payment was associated with a decrease in utilization of services included in the bundle … reductions in length of stay or utilization of specific services.

However the impact on quality was uncertain. Some payment changes caused some quality measures to improve, but worsened others. There were inconsistent conclusions about the effect of bundled payment on related quality measures, AHRQ reported.

See *Bundled Payments*, p. 10

Problems With Fee-for-service

In order to control rampant health costs, health plans, insurers and health systems replacing fee-for-service reimbursement with an overall per-diagnosis payment is widely accepted as a promising approach, because the current system is wasteful in many contexts.

The FFS system does not give providers financial incentives "to get care right," or to minimize billing of unnecessary visits and procedures. In the FFS system, follow-up visits increase the provider's revenue per patient. The system permits widely disparate payments to achieve the same result, Robert Mechanic, senior fellow at the Heller School for Social Policy and Management at Brandeis University in Waltham Mass., said in an article published in the March/April issue of *Health Affairs*.

> **Example:** To cure a simple ailment, plans using an FFS system would indifferently pay either: (1) $1,000 for five follow-up visits after a not-very-careful administration to the patient, or (2) one effective care visit at $200 — to cure the same illness.

Worse, the FFS system leaves plans on the hook for hospital readmissions and surgeries for preventable complications and errors by providers, a situation illustrated by the frequency with which plans have to go to court to avoid paying providers to repair complications and errors. Payers and plans have had to bite the bullet and pay in many cases for provider errors.

Bundled Payments (continued from p. 9)

The agency said the studies did not offer useful guidance on deploying bundled payment systems. For example, most of the studies looked at the effect of bundled payments on a single provider; only four looked at multiple providers. Data was lacking on the impact of bundle design; impacts on quality were not measured.

> When implementing a bundled payment system, it is important to ensure that such systems do not result in a decrase in quality of care or shifting of utilization to other settings of care.

In order to get more helpful results on the effects of adopting bundled payments, the agency suggests using: (1) standardized measures of quality and cost impacts; (2) better measures for quality outcomes; (3) longer time horizons; and (4) measurements of different impacts on various strata of patients.

That said, the data may be useful for plans that are working closely with a local hospital on streamlining care processes in an effort to curb costs and make them more predictable, AHRQ said in its report.

Bundling Has Risks for Plans Too

In spite of their benefits, bundled methods are susceptible to their own forms of misuse that are dangerous and costly to plans. Those may include underuse of effective services within the bundle, AHRQ said, and the avoidance of high-risk patients. Providers may upcode diagnoses in order to use a higher billing code. Component parts of a diagnosis-related group of services may be billed separately, another source of waste.

The takeaway for plans and payers is: when implementing a bundled payment system, it is important to see to it that such systems do not result in a decrease in quality of care or provider shifting of utilization to other settings of care.

AHRQ compiled results from 58 studies, most of which showed costs going down less than 10 percent after an institution moved to bundled payment systems. AHRQ looked at data from public payers that have long adopted such systems for hospitals and nursing homes. It included data on system adoption in facilities in Europe and Asia as well. AHRQ is an agency within the U.S. Department of Health and Human Services.

Wal-Mart to Pay Workers' Costs at Six Centers of Excellence for Big-ticket Medical Procedures

"Centers of excellence" is part of a trend to limit health costs associated with creating incentives for providers to perform more efficiently. Wal-Mart, the nation's largest private employer, is getting in on this concept. Wal-Mart health plan participants are now covered for their heart, spine and transplants, and the company also will pay travel costs to send them to one of six health centers, selected on the basis of quality and care coordination, the company announced earlier this month.

Spine procedures such as cervical and lumbar spinal fusion, total disk arthroplasty, spine surgery revisions and others will be performed by Mercy Hospital Springfield (Mo.), Scott & White Memorial Hospital in Temple, Texas, and Virginia Mason Medical Center in Seattle. Transplants will be provided by the Mayo Clinic in Rochester, Minn.

The Cleveland Clinic, Geisinger Medical Center in Danville, Pa., Scott & White and Virginia Mason will treat patients for cardiac surgery including open-heart surgery, heart valve replacement/repair, closures of heart defects, and thoracic and aortic aneurysm repair.

Wal-Mart will pay travel and expenses for patients to get the procedures at one of the six facilities; the treatments will be covered with no copay or deductible to the worker, the company said.

Wal-Mart operates approximately 3,400 stores and employs more than one million people.

About Centers of Excellence

One of the principles behind "centers of excellence" is: Facilities that perform elaborate procedures with regularity produce more practiced staff and streamlined protocols, which improves outcomes and reduces cost through fewer readmissions and preventable errors. By steering plan members to facilities they expect will do the job correctly and without waste, self-funded health plans can offer workers faster recoveries, less time spent in the hospital and fewer complications.

Health plans may be able to use Leapfrog Group data on hospital quality when considering such options. Leapfrog's quality measures include performance in cardiac and gastric procedures, as well as pneumonia and childbirth. But many hospitals decline to send data and there are holes in the Leapfrog data.

Center-of-excellence approaches like Geisinger, Cleveland Clinic and Mayo's are often mentioned in discussions about limiting spiraling spending on health care. Similar cost control ideas include payment reform, targeting chronic care cases and preventing readmissions.

Lowe's Also Has a Deal

Another large company is paying to send patients to centers of excellence for serious procedures, even if that means transporting them across the country.

Hardware retailer Lowe's in February 2010 reached such an agreement with the Cleveland Clinic for heart procedures. Lowe's concluded that it would pay airfare and lodging; and waive copayments and deductibles to induce full-time workers to go to Cleveland for valve repairs, coronary bypasses and the like.

Wal-Mart's Litigious History

For Wal-Mart, this may be a step in the direction of trying to counter its reputation as being skimpy on benefits and pay for workers. Not surprisingly for a large retail employer, it has been in litigation over wage and hour compliance and gender discrimination. It has also strongly defended its position as self-funded health plan sponsor. Here are some examples.

Last summer, Wal-Mart had to pay for overtime violations at stores nationwide, according to the U.S. Department of Labor. According to the agency, various managers and coordinators were not paid proper overtime wages, because Wal-Mart allegedly misclassified them as exempt from the Fair Labor Standards Act's overtime provisions.

In *Walmart v. Dukes,* 131 S. Ct. 2541 (2011), the U.S. Supreme Court blocked a massive gender discrimination lawsuit against *Wal-Mart,* but only after Wal-Mart had lost rounds in district and appeal courts.

In *Huber v. Wal-Mart*, 486 F.3d 480 (8th Cir., 2007), cert. denied, 128 S. Ct. 1116 (2008), the company defended its decision to not give an injured employee the position she requested after being injured, but instead transferring her to position where she was paid almost half of what she was making before. The appeals court decided that even though the plaintiff could no longer perform the essential functions her former job, the Americans with Disabilities Act did not require Wal-Mart to reassign her to the vacant position she wanted

See *Centers of Excellence*, p. 12

Feds Won't Block Liberty U.'s Challenge to Reform Law; Employer Wins Stay on Contraceptive Mandate

Religious objections to the health reform law are continuing in the courts, with the reemergence of a constitutional challenge to the reform law (the second such challenge that might reach the U.S. Supreme Court), and elsewhere, a nonreligious employer gaining a stay of enforcement of the law's contraceptive mandate.

Gov't Drops Opposition

In this brief, the Obama administration told the U.S. Supreme Court it will not try to block Liberty University in Lynchburg, Va., from seeking legal remedies to its religious objection to the health reform law's coverage mandates. The university recently petitioned the High Court for a rehearing of its case.

Liberty University argues that its religious objections to the law were not vacated in the Supreme Court's *NFIB v. Sebelius* (132 S. Ct. 2566 (2012)) opinion upholding the individual and employer mandates.

Liberty's argument against the mandates as improper expansion of Congress' commerce-regulating powers were stricken in the *NFIB* decision, but Liberty's arguments that they violated constitutional provisions on religious freedom and due process were never heard.

University's Case Reemerges

Filing its case on March 23, 2010, Liberty challenged first the individual and employer mandates to buy (for self) or offer (to employees) health coverage, or pay a penalty. It argued that those mandates improperly expanded the federal government's authority to regulate interstate commerce.

But it also claimed the law violated the school's religious rights because funds from mandatory insurance payments would be used to cover abortions. The university's claims religious rights arguments were based on the First Amendment, protecting free exercise of religion, and the Fifth Amendment's due process clause.

In November 2010, the district court dismissed both claims on the merits, in *Liberty University v. Geithner*, 2010 WL 4860299 (W.D. Va., Nov. 30, 2010). Then the 4th U.S. Circuit Court of Appeals shot down the school's appeal to that outcome, but it based that on the Anti-Injunction Act, holding that Liberty's action could not proceed until the penalties started being assessed, in *Liberty University v. Geithner*, 671 F.3d 391 (4th Cir., Sept. 8, 2011).

The university petitioned the U.S. Supreme Court, arguing to reverse the appeals court's Anti-Injunction block on the case, and arguing against the two mandates as an improper expansion of the constitution's commerce-regulating powers. But it lacked arguments against abortion funding as violating free religious exercise.

In its June 28, 2012, landmark decision on *NFIB*, the Supreme Court ruled: (1) that a pre-enforcement challenge to the employer and individual mandates was not barred under the Anti-Injunction Act; but in spite of that (2) the coverage mandate portions of the law were a legitimate use of Congress' taxation authority.

Liberty's petition was seen as resolved after the Supreme Court issued its decision, and the High Court dismissed all pending cases against the law, and denied Liberty's petition for *certiorari* on the day after the *NFIB* decision.

Liberty Resubmits Complaint

In an amended petition to the Supreme Court submitted July 23, Liberty asked it to reverse its denial of *certiorari*, contending that the university's allegations should get a new hearing, because the case was not barred under the Anti-Injunction Act (*Liberty University v. Geithner*, 2012 WL 3027174 (U.S., July 23, 2012)).

See *Contraceptive Mandate*, p. 13

Centers of Excellence (continued from p. 11)

and was qualified for, because Wal-Mart successfully argued that another worker was more qualified.

In *Administrative Committee of the Wal-Mart Stores, Inc. v. Shank*, 2007 WL 2457664 (8th Cir., 2007), it successfully asserted its right to subrogated money even though the proceeds were in a special needs fund held by the defendant, who was an invalid. (The company later dropped its claim after negative publicity).

In 2006, Maryland enacted the Fair Share Health Care Fund to force Wal-Mart to spend at least 8 percent of payroll on workers' health insurance. That law was promulgated by groups that alleged the retailer was not paying "its fair share" on employee health. In *RILA v. Fielder*, 2007 *WL* 102157 (4th Cir., 2007), the 4th U.S. Circuit Court of Appeals found the law was preempted by ERISA.

Contraceptive Mandate (continued from p. 12)

The government in its Oct. 31 brief said it agreed that the appeals court's anti-injunction ruling had been overturned and that the First and Fifth Amendment arguments had not been covered in the June 2012 ruling. And because of that, the government said it will not oppose the university's moves to pursue the case.

This case could reach the Supreme Court, making it the second challenge to the reform law to be ruled on by that body.

Mich. Firm Relieved From Contraceptive Mandate

In a separate development, the government was temporarily blocked from enforcing the health reform law's mandate to include contraception coverage in its health plan. The injunction in *Legatus v. Sebelius*, 2012 WL 5359630 (E.D. Mich., Oct. 31, 2012) was at the request of Weingartz Supply, a for-profit outdoor power equipment company with 170 employees, and the ruling from the U.S. District Court for the Eastern District of Michigan.

Weingartz is a member of Legatus, a non-profit organization whose mission is to strengthen Catholicism. Both organizations had designed their health plans to exclude contraception coverage.

District Judge Robert Cleland ordered a preliminary injunction in favor of Weingartz even though, he said, the government might eventually win the lawsuit. He expressed doubts that the company had suffered an actual harm yet.

Cleland denied associational standing for Legatus, saying the final rule was being amended to accommodate companies like Weingartz and other Legatus members, making the expected injuries not inevitable.

> **Note:** Another district court found that non-profit organizations protected under the safe harbor did not have standing because safe harbor is being amended, making their injuries hypothetical. *Wheaton Coll. v. Sebelius*, 2012 WL 3637162 (D. D.C., Aug. 24, 2012).

But he said a temporary stay for Weingartz was appropriate, because while the government might suffer comparatively minimal harm if the injunction is granted, the employer could experience far greater harm through infringement of its religious beliefs.

Weingartz said the contraceptive coverage mandate was harmful because it forced the company to choose between violating its religious objections and paying fines of $2,000 for all but the first 30 of its employees.

The court said that was a plausible argument.

> The court assumes that [Weingartz is] likely to show at trial that the HRSA Mandate substantially burdens the observance of the tenets of Catholicism.

The government argued that the contraceptive mandate was of high importance because: (1) control over pregnancy improves women's and newborns' health; and (2) it furthers gender equality in the workplace. Weingartz said these reasons had a "tenuous" and "generic" connection to health outcomes, and that contraceptive medical risks outweigh the benefits.

The government also reasoned there would be a slippery slope if it granted religious exemptions to secular, for-profit companies. That would open the door for owners of other secular businesses to request religious exemptions and permit them to impose their religious beliefs on their employees.

The government might show that its arguments are compelling, but further proceedings will be needed, the court said.

Open questions included: whether female employees have easy cheap alternatives to obtaining contraception; and whether the government has chosen the least restrictive means of achieving its public health goals, the court noted.

The court said it also will have to consider the limits to how religious observance can constrain the regulation of commerce.

> … [E]very person cannot be shielded from all the burdens incident to exercising every aspect of the right to practice religious beliefs. When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity.

But the biggest reason for the stay is that the mandate takes effect on Jan. 1, 2013, a date that comes before litigants could collect and organize arguments responding to each open question:

> No ruling on the merits can occur, therefore, until well after January 1, 2013, the date on which [Weingartz Supply] will be required to abide by the [contraceptive] Mandate absent an injunction.

See *Contraceptive Mandate*, p. 14

TPA's Pre-Approval Also Okayed Medical Necessity, Providers Argue in ERISA Case

A third-party administrator that began denying medical services as medically unnecessary after paying such claims in the past is now facing a variety of ERISA claims, and its pre-authorization process may become a sticking point.

The providers are legally challenging the denial based on either an improper reading of plan terms or the TPA's general practice of issuing pre-approvals, which they say gave the impression the TPA was attesting to both providers and enrollees that the services *were* medically necessary.

Contraceptive Mandate (continued from p. 13)

Because each side shows some, but not *strong*, likelihood of successfully arguing their case, the preliminary injunction is warranted, the court concluded.

Backlash to Required Contraceptive Coverage

When the government first implemented reform's contraceptive mandate, it ran into opposition from religious groups.

In response on Aug. 3, 2011, the U.S. Department of Labor created a rule (76 Fed. Reg. 46623) exempting non-profit religious employers (defined as having inculcation of religious values as its primary purpose, staffed with religious employees and serving people with similar religious orientations).

And in response to comments from concerned non-religious employers, on Feb. 10, 2012, the U.S. Department of Health and Human Services set up a temporary safe harbor for non-religious non-profit organizations that had religious objections. It was amended on Aug 31, 2012, to admit more employers. However, those employers had to be non-profit organizations.

In cases such as these, the government argues that it is expanding existing safe harbors to accommodate non-exempt, non-grandfathered religious organizations' religious objections, making challenges to the contraceptive mandate premature.

Note: In July, a federal judge in Colorado temporarily prevented the government from requiring the Catholic owners of Hercules Industries Inc. from covering birth control in its health plan. It held that a stay of enforcement would not hinder the government in pursuing an important public health goal. (See the September 2012 newsletter.)

Because the plans seemed to admit a degree of ambiguity as it pertained to the connection between pre-approvals and medical necessity, a federal district court found it premature to dismiss most of the claims. The case is *Sanctuary Surgical Center v. UnitedHealth*, 2012 WL 5199611 (S.D. Fla., Oct. 22, 2012).

The Facts

Sanctuary Surgical brought suit against claims administrator UnitedHealth to recover ERISA benefits allegedly due under employer health plans. After initially pre-approving and paying for chiropractic manipulations under anesthesia, United abruptly began denying the disputed procedures, saying they were: (1) unproven, experimental and investigational; (2) not medically necessary; or (3) not covered under the particular plan.

Note: The claims arose from a variety of different plans, and the MUAs at issue were administered to treat a variety of different conditions.

Sanctuary alleged: (1) failure to pay amounts due under an ERISA plan; (2) breach of fiduciary duty; (3) failure to provide plan documents; and (4) equitable estoppel under ERISA common law. Claims for approximately 500 patients in 300 plans were at issue.

United argued that all claims should be dismissed because the surgeons did not submit each of the 300 plans as evidence or analyze patient cases in relation to specific plan terms.

To survive a motion to dismiss, a complaint must contain factual allegations that "raise a reasonable expectation that discovery will reveal evidence" in support of the claim and that plausibly suggest relief is appropriate."

The court did quash the wrongful denial of benefits claim [under ERISA Section 502(a)(1)] due to the lack individualized evidence about the 500 payments, noting that grouping them together in a single legal complaint was impermissible.

But the court rejected United's motion to dismiss the claims for equitable estoppel, breach of fiduciary duty and failure to provide plan documents. Those claims survived based on language from the eight sample plans about the effect a pre-authorization would have on the medical necessity determination.

See *TPA's Preapproval*, p. 15

TPA's Preapproval (continued from p. 14)

Ambiguous Terms

Regarding the estoppel claim, the providers argued that certain plan terms were ambiguous.

The providers contended, and the court agreed, that "medical necessity" could be one such ambiguous term. Beneficiaries cannot be expected to know by reading their plans whether a given service is medically necessary, the court remarked.

Specifically, the providers argued that United's preauthorizations were an admission that the MUAs were medically necessary. Sample plan language indicated that a medical necessity determination would be made before authorization, and that the authorization contained a positive medical necessity determination. One plan excerpt told subscribers to:

> call UnitedHealthcare to obtain a predetermination of benefits by phone ... UnitedHealthcare will … determine the medical necessity of your proposed surgery before making a predetermination of benefits.

Saying such arguments could turn out to be plausible, the court remarked:

> These excerpts demonstrate that the pre-approvals granted in the case of each MUA represented United's own interpretation of the medical necessity of the MUAs.
>
> … United issued pre-approvals of every MUA at issue. Based on the language of the plans, United would not have issued pre-approvals if it did not find the MUAs medically necessary, which provides sufficient factual support for the conclusion that the MUAs were, in fact, medically necessary …

The court added that United's own history of granting pre-approvals and then denying coverage supported a finding of ambiguity, and concluded that further inquiry could lead to a conclusion that estoppel relief may be available, the court said.

Other Available Relief

The court said the surgeons might have a claim for "other relief available in equity" because United represented through its pre-approvals that the MUAs were covered services when they would eventually be denied. However, it was duplicative of the estoppel claim. But since the ambiguity issue in that claim had to be resolved, the court said it was premature to dismiss the fiduciary breach claim.

Fiduciary Breach

United countered that the surgeons could not assert an action for breach of fiduciary duty because they lacked standing. While a provider's assignment of benefits can transfer standing from a beneficiary to a provider, United said its plan language limited assignments to receiving payment only, and assignments did not give providers the right to sue for ERISA fiduciary duty breaches. The court would decide on the scope of United's assignments later, it said.

United also argued that the breach of fiduciary claim was duplicative with claims for "benefits due under ERISA plans" and "other equitable relief." It was "merely a repackaged claim for wrongful denial of benefits," and therefore should be dropped, United argued.

The court rejected this argument, noting that the fiduciary breach claim was not premised on whether or not MUA was a covered service. Rather, it was about whether United breached its duty of care.

The provider's case was allowed to continue and United was given time to respond to their amended complaint.

Implications

This case highlights that it is imperative for a benefit plan to avoid terms that may be ambiguous. Further, once a plan has defined a term so as to clarify its meaning, it is equally important that the administrator consistently follow plan terms.

That the term "medically necessary" was ambiguous in this case was certainly important; however, it was the pre-authorization followed by the subsequent denial of claims by the TPA that proved detrimental. By preauthorizing those claims the TPA may have highlighted the ambiguity, and in so doing, undercut the plan's ability to exercise its discretionary authority. That fact that the claims had been authorized, and the language made representations that a medical necessity determination would be made before authorization, may indeed have removed the plan's ability to change course on that determination in future claims determinations.

Further, the court's decision to leave the door open to establish that a provider, via an assignment of benefits, may also have standing to bring a suit against a benefit plan for breach of fiduciary duty opens the possibility of a an expansion of possible plaintiffs withstanding to bring such a claim. This may, of course, center on the ability of a plan to limit the scope of that assignment. A decision on that issue is still to come.

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

human resources department about why weren't the bills paid. He's been paying his premiums for years!

Your back is now against a wall. Maybe a year ago, had you paid what the provider expected, at least you'd have the PPO discount. Now, a year later, the provider wants 100 percent. As for stop-loss, that policy expired a year ago. You can hang the patient out to dry, and ignore the complaints. The plan, after all, pays what it pays. Except now the provider is also accusing you of breaching the contract. What contract, you may ask? Providers will claim that the PPO contract is not an agreement by which benefit plans access discounts. No, PPO contracts are payment agreements whereby you agree to pay a certain amount by a certain date, no questions asked. The PPO contract overrides the plan document; and failure to pay per its terms constitutes a breach.

Once the TPA refers the case to my office, I immediately ask for copies of all the contracts involved. I need the plan document, the administrative service agreement between the plan and the TPA, the stop-loss contract, and of course the applicable network PPO agreement. After reviewing everything, I almost fainted. I thought to myself, how did all this happen? Who let this happen? How are all these companies still in business?

It is vital that you pay attention to this story, which I see every day; people blinded by the promise of big savings and failing to set a proper plan-document-based foundation.

The Details of a Case Gone Bad

I like the idea of reining in costs. However, I advocate for either applying programs that fit the plan document language or adjusting that language to fit the program.

The plan document isn't the only issue, however. As already mentioned, the PPO contract may hinder you as well. Usually, as in the cases I deal with, the PPO agreement specifically states that no in-network claim may be audited. The claim must be paid within 30 days; the only reduction allowed is the percent discount.

> **Another issue:** The patient went to the hospital and gave the admissions officer his member ID card, which had the PPO logo right on it. This is an inherent way of representing to the provider that the network is being accessed, and PPO rules apply.

Between plan documents that base allowable pricing on their network, network agreements that limit their right to audit and dictate the payable amount, ID cards that trigger detrimental reliance by providers and audits that are in no way related to the actual plan terms, I am usually left thinking that there was no reason why the plan and TPA could avoid paying the claim in accordance with the terms of the PPO agreement.

It all comes back to the auditor and the promises it made. What gave this vendor any reason to think that it could do what it did? You may think that the auditor is responsible to defend the results of its own audit and bases his or her review on the existing plan document; and everything is prepared ahead of time and fully defensible. You'd be wrong.

During my "post-mortem" conference call with the TPA, I ask the questions that should have been asked before the claims repricing: What did the vendor see in the plan document that allowed it to proceed, and how exactly did it reprice the claim in accordance with those terms? Did the vendor agree to reimburse fees for savings that don't stick? Did it negotiate with stop-loss to keep contested claims open? Will it defend against balance billing?

The vendor never looked at the plan document, never asked if this was an in-network claim, never promised to get sign off on the claim or defend the patient or plan in cases of pushback from the provider, never mentioned stop-loss, and never told the TPA exactly how the claims were repriced. Amazing!

I had to set up a call with the vendor to see what in the world it was thinking. The vendor said it processed the claim at Medicare reimbursement rates. I asked it to repeat its statement numerous times, because I just couldn't believe what I was hearing. Why would any hospital agree to be paid at Medicare rates when it has an agreement to receive 70 percent, 80 percent and even 90 percent of charges? How, I ask the vendor, can it interpret the plan document as allowing the plan to so base payment upon Medicare?

The answer: "Medicare rates are usual and customary."

"Based on the definition of U&C in the plan document?," I ask.

"No," the vendor answers, "Based on our data."

Basically, the plan and the TPA had no right to do what they did and had actually agreed in writing *not to do* what they had done. I immediately realized I had very few, if any, ways to defend these actions.

As for stop-loss, in some cases the stop-loss insurer actually refers the audit vendor to the plan and TPA. What has it got to lose? Regardless, in any case, any additional

See *CE Column*, p. 17

CE Column (continued from p. 16)

payment that I could negotiate would need to be paid entirely by the plan, because by the time this whole mess is cleaned up, the stop-loss policy has expired.

Stop-loss insurers and auditors can tell plans and TPAs what to pay, and what to deny. It's up to the plan and TPA, however, to decide if that amount is actually defensible through the use of plan document provisions.

In my opinion, the vendor was responsible for what happened. There was no way it should really earn $250,000 for an hour's worth of work that wasn't even relevant to this plan and wasn't defensible. I immediately reviewed the vendor's agreement and of course my bad day got worse. The agreement specifically stated that the plan and TPA had 90 days to audit the vendor's results and claim any payment issues. Not a bad deal for this vendor when the reality is that nobody gets any push back within 90 days. I am sure this vendor was aware of that!

I knew that the best option I had was to talk to this vendor and explain what it is doing is killing the industry and unless it did right by this plan and reimburse most of its fees I would advise the plan to sue it. I'd also make sure that I tell everyone (like all of you) that they should never do business with this vendor.

To make an already long story a bit shorter, let's just say that the vendor agreed to reimburse all its fees, which made some funding available to negotiate with the hospital.

Become a Boy Scout and Be Prepared

So what is the point of this story other than just scaring you? First, create a cost containment program in the plan document. To have a great cost containment program: prepare, prepare, and prepare some more. All the parties involved had the right intention of saving money but went about it the wrong way. This entire situation never would have happened if the plan and vendor had:

1) reviewed the plan document with an expert before implementing the audit;
2) ensured that the stop-loss insurer's policy matched the plan document;
3) agreed how contested claims would be treated;
4) ensured that plan participants understand how the plan works; and
5) not done anything that would lead the provider to believe some other arrangement trumps the plan document.

The key decision with cost containment vendors is whether their program complies with your plan document terms. If they don't ask for your plan document, then stay away! It's better to know off the bat that they don't really care what your plan document says. Likewise, do they want to know about the presence of a PPO network? Do they want to review the contract? I hope so. You would think that any obligation you have under some other agreement — like a PPO contract — will impact their work, and may be something they want to know about.

I would have told the TPA and the plan to run away from this vendor. I would have stated that the plan document specifically states that the plan must pay this claim per plan document and PPO agreement terms. Even though it would be expensive, they would learn their lesson and make much-needed changes to the terms of their agreements going forward; plus they would secure their network discount and stop-loss reimbursement.

Find Out Who Your Friends Are

So what is the best process to use when deciding cost containment options?: (1) the best cost containment programs have the best plan language to defend the plan and the process; (2) review the terms of the PPO agreement and see what it allows or prohibits; (3) review the terms of the stop-loss contract; (4) review your ASA to see what you and your TPA can and cannot do when it comes to your claims process; and (5) analyze the audit program.

Have the best plan language to defend the plan

The plan should have the ability to audit every claim and apply various parameters on what shall be deemed — per the plan — an allowable expense. This is vital since this is only way you can get out from under PPO agreement terms is to state that the claim isn't for a covered expense.

Review the terms of the PPO agreement

The worst provision in a PPO agreement is one that doesn't allow the plan to audit in-network claims. If you approve such terms, you will be signing an agreement knowing that you will be paying claims blindly.

Review the stop-loss contract

If the stop-loss contract has a stricter definition of what is usual, customary, reasonable and appropriate than what's in the plan document, chances are you'll be required to pay something stop loss isn't required to reimburse.

See _CE Column_, p. 18

CE Column (continued from p. 17)

Even if a stop-loss insurer mirrors your U&C language, it may still allow itself to interpret your plan document language independent from the plan's own reading. This means that the same U&C definition can be read two ways: the plan paying, and the stop-loss insurer denying the claims as excessive. For these reasons, plans should beware of auditors introduced to them by their insurer. The insurer and auditor may agree that a claim is excessive, which the plan is required to pay regardless.

When attempting to create an aggressive cost containment program, make sure you approach the insurer and create a savings partnership. Explain your program in detail, and that if you can save money for the plan, you are actually saving money for them as well. The key is to execute an agreement stating that if any claims are paid using the cost containment program, particularly large hospital claims, the insurer will keep the claim open after the stop-loss contract expires until you can obtain sign off or the matter is otherwise resolved.

Review the ASA

Will the TPA agree to process claims outside the terms of the PPO agreement?

Analyze the audit program

How does the firm audit its claims, what are the parameters used and do the methodologies match those within the plan document? If the plan document says that the U&C rate is the prevailing rate in that provider's particular state or county, but the vendor is using national cost factors, then we have a major issue.

Will the audit firm agree to obtain sign off before it earns its fee? If not, will it agree to defend and handle any and all balance billing issues that occur? Will it refund fees taken on savings that aren't defensible? Today, many vendors are even willing to take on a fiduciary duty so that if there is any pushback by a provider, they would be responsible for defending their actions and paying any additional costs.

It's a Scary World Out There

There are many options in today's self-funding universe. The great news is that more individuals in our industry are looking at new and innovative ways to reduce the cost of care for their plans without reducing the benefits given to plan members. The problem is many options are not fully vetted before being implemented by plans and TPAs. This leads to bad results and horrible precedents. If you follow a well-designed game plan, you can win in the fourth quarter with a comfortable lead rather than punting it to me and crossing your fingers.

Employer Health Plans Could Face Unpredictability as State Responses to Reform Differ

Time will soon tell how many states will run health exchanges and expand Medicaid as directed in the federal health reform law. But for employer plans, the waiting game just draws out the inevitable confusion that may occur as those plans anticipate being impacted in different ways on a state-by-state basis, speakers explained at a Nov. 14 health policy conference.

States now face a political decision about the extent to which they will adopt the health reform law, including whether they will opt to expand their insurance programs by: (1) expanding Medicaid coverage to 133 percent of the federal poverty level; and (2) running their own health insurance exchanges as suggested in the health reform law.

Alternatives that states are considering include: (1) making eligibility something less than 133 percent of FPL; and (2) allowing the federal government to step in and run the exchange, Matt Salo, executive director for the National Association of Medicaid Directors told attendees at the National Business Coalition on Health's annual conference.

Weaker Medicaid expansion could shift lives into employer plans, Salo said. As a result, employers might have to help insure more full-time low-paid workers in states that opt out of the federal 133-percent requirement.

Note: Under the landmark U.S. Supreme Court decision last June otherwise upholding the law, Medicaid expansion was the sole element of the law to be reversed. As a result, the federal government cannot enforce the reform provision that would have completely cut off all Medicaid matching funding if a state failed to expand enrollment to 133 percent of FPL.

Because of the High Court's ruling, states can safely limit the expansion of Medicaid eligibility. And many may consider 100 percent of FPL as the benchmark, because the federal subsidies are available to buy insurance on the exchanges to applicants between 100 percent and 400 percent of FPL, Salo noted. Keeping eligibility at 100 percent of FPL would interface with the federal program, he added. Thus, states have the option to shift more covered lives into exchange plans, and more costs to the federal government.

State-by-state Variations

There will be important state variations and employers are well-advised to know the fiscal, ideological and policy factors that are driving reform implementation in their states, Salo told the group.

> How every individual state goes about making that decision is going to be different, but I recommend that you figure out what that process is. … Not only the governor[s] but state legislatures will have an impact on reform implementation, [and] those legislatures could be influenced by [for example] business or hospital associations, and [a state's business climate, state budgets and economic model] can have very wide-ranging impact on how reform is implemented.

Will States Run Their Own Exchanges?

And while many states may opt out of Medicaid expansion, they may be more willing to run their own exchanges. Here is the impending timeline for states to get the ball rolling on exchanges.

- **January 2013:** Federal certification of exchange plans
- **Oct. 1, 2013:** State-exchange open enrollment begins

See *Health Plans*, p. 20

Subject Index, Vol. 20

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 20, Nos. 1-3. 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 "20:3/2" indicates Vol. 20, No. 3, page 2.

Index by Subject

Index of Court Cases

Health Plans (continued from p. 19)

- **Jan. 1, 2014:** Effective date of coverage
- **March 31, 2014:** Open enrollment closes

Before the election, states including California, Colorado, Connecticut, Kentucky, Hawaii, Massachusetts, Maryland, Minnesota, New York, Oregon, Rhode Island and Vermont and the District of Columbia signaled their intent to run their own programs, according to Alan Weil, executive director of the National Academy of State Health Policy. Sixteen were still in the "no" column, with the remainder still sitting on the fence.

The picture on where states will fall on exchange administration will become clear between now and February 2013, he said.

Employer Plans Must Be Vigilant

The exchanges will influence employer plans because the market atmosphere will change in states that run their own exchanges. Looking forward, Weil said employer plans need to be vigilant in determining whether reform requires them to adjust eligibility requirements in the state where the employer plan operates. Employers will want to be on the lookout for effects on provider networks, access to providers and health costs. Attention should be focused on benefit design issues and care coordination among exchange, public health and employer plans, he added. And employers should look for opportunities in reform's population health goals, he said.

One such opportunity may be in payment reform. States and employers increasingly will jointly design and implement payment reform and quality improvement initiatives, he predicted. And the federal government seems interested in seeing such efforts work.

For example, as part of health reform, HHS is selecting state projects for improving health care payment and delivery. See innovation.cms.gov/initiatives/State-innovations to learn more.

Through this competitive process, the government is seeking payment reform and quality improvement initiatives like these:

- Patient-centered medical home for chronic conditions (federal)
- Primary care infrastructure (Maine)
- Multi-sector payment reform (Minnesota)
- Bundled payment introduction (Arkansas)