Employer's Guide to
Self-Insuring Health Benefits

Employee Benefits Series | THOMPSON | February 2014 | Vol. 21, No. 5

Will Self-funding Drown or Soar in 2014?

Self-funding can be expected to grow over the next few years, because regulatory burdens imposed by health care reform are making it relatively more price-competitive. Growth will happen if people see that it enables innovations like flexible pricing and charges, medical tourism, new networks and benefit carve-outs. But that's not a guaranteed outcome. Self-funding will not grow if reform-related laws and rules at federal and state levels are allowed to harm self-funding, a goal many supporters of health reform seem to have. Contributing Editor Adam V. Russo, Esq., explains how federal and state regulatory detractors are using stop-loss restrictions, anti-subrogation laws and other methods to slow or stop the progression entirely. ***Page 2***

ERISA Plan Can Set and Enforce Limits on Lawsuits, SCOTUS Holds

ERISA generally doesn't have a statute of limitations period for filing suit regarding various claims. However, a recent U.S. Supreme Court decision held that a plan's contractual limit on bringing disputes to court *is* enforceable, provided it is of reasonable length and does not conflict with a "controlling" statute. ERISA Section 413 includes a specific statute of limitations for actions alleging a breach of fiduciary duty. However, other types of ERISA claims, such as for civil enforcement or involving certain COBRA rights, do not include a specific limitation. In such instances, courts generally apply the most analogous state statute of limitations as a guide. The ruling resolved a circuit split over whether plan-imposed limits were enforceable in ERISA civil enforcement actions. The ruling may provide a level of legal security for ERISA plans that already have limitations language in place, as well as an opportunity for other ERISA plans to consider incorporating such language in their plan documents. ***Page 3***

Last-minute Stays on Enforcing Contraceptive Mandate Granted

On Dec. 31, just hours before it was scheduled to take effect, Justice Sonia Sotomayor of the U.S. Supreme Court stayed enforcement of the mandate to cover female contraceptives for one objecting employer, a group of nuns running nursing homes in Denver. At the appellate level, the 6th U.S. Circuit Court of Appeals stayed enforcement of the mandate, saying it was mindful of guarding a Catholic group's rights, and maintaining that a stay would not impede the government in achieving its public health goals. And on Jan. 8, the High Court set a late-March date on which it would debate two cases (*Sebelius v. Hobby Lobby Stores, Inc.* and *Conestoga Wood Specialties Corp. v. Sebelius*) challenging the contraceptive mandate. ***Page 11***

Also in This Issue

Featured Columnist

Adam V. Russo, Esq.

Update Pages

¶784 — Updated section on ERISA plans' ability to limit lawsuits

Webinar Recordings

- The IRS and DOL Have Spoken: Same-gender Partner Benefits in a Post-Windsor World
- The Ever-changing World of Health Care Reform: Planning Ahead for 2014

Visit http://www.thompsoninteractive.com

Want to Get Your News Faster?

Want Your News Faster? Transfer your subscription to our digital **HR Compliance Expert** platform and get your news and updates as they happen. Visit www.thompson.com/suite or call 800-677-3789 for a 14-day free trial to the entire suite of HR and benefits products.

Contact Us

Customer Service: 800 677-3789
Online: **www.thompson.com**
Editorial: 202 872-4000

Will Self-funding Drown or Soar in 2014?

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 Information Services' Employer's Guide to Self-Insuring Health Benefits.

Everybody wants to know whether health care reform will create a nourishing or a hostile environment for self-funded health benefits. My educated guess is that we will see employers self-funding in record numbers over the next few years, but that outcome is not guaranteed. Self-funding will soar if people see that it enables sponsors to implement the innovations that are quite advantageous to participants. Examples include new approaches to pricing and charges, medical tourism, new networks and carve-outs of benefit categories to make them more affordable. Self-funding will not flourish, however, unless the federal government and state insurance commissioners try to slow it down or stop the progression entirely.

The Threats

Discussions in state and federal government backrooms and federal and state court decisions are attempting to erode the special preemptions of self-funded ERISA plans. These negative movements are bound to intensify as regulators get concerned that too many small employers might opt to self-fund, frustrating their regulatory and health-reform related goals. Ironically, the better self-funded plans perform, the harder opponents will fight to eliminate them and the worse off the self-funding industry may be in the long run.

Why are self-funded plans scaring state and federal regulators? These plans are innovating by realizing that the best way to offer health coverage to all is by making it more affordable. So how do you make it more affordable? By lowering health care costs and finding ways to improve patient health so that claims don't occur in the first place.

I have been closely monitoring the Obama administration's interest in regulating stop-loss insurance. A rule instituting Section 9010 of the Affordable Care Act's health insurance tax was published, and the section related to stop-loss insurance shows that the administration believes that stop-loss is not health insurance.

On the other hand, a complete reading of the rule clearly indicates that the administration has not taken this interpretation off the table. Therefore, the prospects for future regulatory action remain uncertain, and even though I would not expect any new regulatory action at this time, a dreaded "white paper" could raise the specter of new mischief.

The White Paper

Employers that self-insure their employees' health benefits frequently purchase stop-loss coverage to mitigate risk. The stop-loss insurer assumes the risk of claims above a certain threshold. Some have suggested including stop-loss coverage in the definition of health insurance for purposes of Section 9010, whereas others want to exclude it.

The U.S. Departments of Labor, Health and Human Services and the Treasury are concerned that more employers in small-group markets with healthier employees may pursue self-insured options with stop-loss with low

See *Featured Columnist*, p. 9

Employer's Guide to Self-Insuring Health Benefits

CONTRIBUTING EDITOR: **ADAM V. RUSSO, ESQ.**
THE PHIA GROUP LLC
BRAINTREE, MASS.
DIRECTOR OF PUBLISHING: **TRAVIS HICKS**
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 Information Services, 4340 East-West Highway, Suite 300, Bethesda, MD 20814. Periodicals Postage Paid at Bethesda, MD and at additional mailing offices.

POSTMASTER: Send address changes to: *Employer's Guide to Self-Insuring Health Benefits*, Thompson Information Services, P.O. Box 41868, Austin, TX 78704.

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.

ERISA Plan Can Set, Enforce Its Own Limitations Period, Supreme Court Holds

ERISA generally doesn't have a statute of limitations period for filing suit regarding various claims (except for fiduciary breaches). As a result, courts reviewing ERISA claims tend to define limitations periods using the most analogous state law. In some cases, ERISA plans have crafted their own limitations period language, using state laws as a guide, and added it to the official plan document. But this has had mixed results legally.

However, a recent U.S. Supreme Court decision cleared the air by holding that a plan's contractual limitations provision *is* enforceable. It just has to be of reasonable length and not conflict with a "controlling" statute. Although this case involved a long-term disability plan, the Court's opinion seems to have wider applicability. Thus, it may provide a level of legal security for ERISA plans that already have limitations language in place, as well as an opportunity for other ERISA plans to review whether such language should be incorporated in their plan documents. The case is *Heimeshoff v. Hartford Life & Accident Insurance Co. et al.*, No. 12-729 (S. Ct. Dec. 16, 2013).

Background

Generally, a statute of limitations is a defined period within which a claim may be brought to court; that period tends to run when the cause of action "accrues;" that is, when "the plaintiff can file suit and obtain relief."

Under ERISA, courts have generally required participants to exhaust the plan's administrative remedies before filing suit to recover benefits. ERISA Section 413 includes a specific statute of limitations for actions alleging a breach of fiduciary duty. However, other types of ERISA claims, such as for civil enforcement or involving certain COBRA rights, do not include a specific statute of limitations.

Therefore, courts have adopted rules on how to determine an applicable statute of limitations under federal law. In these instances, they generally apply the most analogous statute of limitations under state law. Also, under ERISA, courts have approved reasonable plan-imposed statutes of limitations to limit the time that an aggrieved individual may sue for benefit claims. But a split developed in the circuit courts over whether a contractual statute of limitations in ERISA civil enforcement actions is enforceable. The U.S. Supreme Court agreed to rule on *Heimeshoff* to resolve this split.

The Facts

Hartford Life & Accident Insurance Co. is the administrator of Wal-Mart Stores, Inc.'s group LTD plan. The plan terms require any lawsuit to recover benefits under ERISA Section 502(a)(1)(B) to be filed within three years after "proof of loss" is due. This language was based on state law providing for a limitations period expiring "[not] less than one year from the time when the loss insured against occurs." (2 Conn. Gen. Stat. §38a–290 (2012)).

Wal-Mart employee Julie Heimeshoff filed a claim for LTD benefits with Hartford in August 2005. After she exhausted the mandatory administrative review process, Hartford issued its final denial in November 2007.

On Nov. 18, 2010, almost three years after that final denial but more than three years after the proof of loss was due, Heimeshoff sued Hartford and Wal-Mart to recover benefits under ERISA Section 502(a)(1)(B). Hartford and Wal-Mart moved to dismiss on the ground that the statute of limitations for the claim had expired. A federal district court ruled in their favor, finding that while ERISA does not provide a statute of limitations, the contractual three-year limitations period was enforceable under applicable state law and precedent from the 2nd U.S. Circuit Court of Appeals (which held that a three-year limitations period set to begin when proof of loss is due is enforceable). Therefore, Heimeshoff's claim was deemed untimely.

Upon appeal, the 2nd Circuit affirmed. That court concluded that it did not offend ERISA for the limitations

See *Supreme Court*, p. 4

Supreme Court (continued from p. 3)

period to commence before a plaintiff could file suit under Section 502(a)(1)(B). The plan language clearly provided that the three-year limitations period ran from the time that proof of loss was due under the plan. Heimeshoff filed her claim more than three years after that date, so her action was time-barred, the appeals court held.

Heimeshoff petitioned the U.S. Supreme Court, which agreed to hear the case. Her main argument was that because proof of loss is due before a participant can exhaust internal review, the plan's limitations provision runs afoul of the general rule that statute of limitations periods begin upon the accrual of the cause of action. (The U.S. government submitted a brief in support of Heimeshoff.)

The High Court's View

The unanimous opinion written by Justice Clarence Thomas focused on earlier Court precedent. In *United Commercial Travelers of America v. Wolfe,* 331 U.S. 586, 608 (1947), the Court held that a contractual limitations provision is enforceable as long as the limitations period is of reasonable length and there is no controlling statute to the contrary. Thomas noted that the principle that contractual limitations provisions should be enforced as written is especially appropriate in the context of an ERISA plan.

"Heimeshoff's cause of action is bound up with the written terms of the plan, and ERISA authorizes a participant to bring suit 'to enforce his rights under the terms of the plan,'" he wrote. "This Court has thus recognized the particular importance of enforcing plan terms as written in §502(a)(1)(B) claims … and will not presume from statutory silence that Congress intended a different approach here."

Thomas further noted that the *Wolfe* criteria were met because the plan's period is not unreasonably short. As acknowledged by the federal government in its brief, ERISA regulations for "mainstream claims" mean for them to be resolved in about one year, he pointed out. "Here, the Plan's administrative review process (internal review) required more time than usual but still left Heimeshoff with approximately one year to file suit," Thomas wrote.

Heimeshoff and the United States contended that even if the plan's limitations provision was reasonable, ERISA is a "controlling statute to the contrary." However, Thomas noted they did not allege that the limitations period for fiduciary breaches applied, or that ERISA's statutory language or regulations contradict the plan language. Instead, they argued that the plan's limitations provision will "undermine" ERISA's two-tiered remedial scheme, a theory that Thomas rejected.

He explained that enforcing the plan's limitation period is unlikely to shortchange the internal review process for several reasons:

1) The record for judicial review generally is limited to the administrative record, so participants who fail to develop evidence during internal review risk forfeiting the use of that evidence in district court.

2) Since plan administrators have discretion over benefit determinations, courts ordinarily review such determinations only for abuse of discretion.

3) If a plan administrator attempts to delay resolving claims in bad faith, the plan participant can seek immediate judicial review.

4) In "rare cases" when internal review prevents participants from bringing Section 502(a)(1)(B) actions within the contractual period, courts can apply traditional doctrines that may assist the plan participant, like equitable tolling, estoppel and waiver.

"The evidence that this 3-year limitations provision harms diligent participants is far too insubstantial to set aside the plain terms of the contract," Thomas wrote in affirming the 2nd Circuit's opinion.

Reform Agencies Clarify Triggers and Safe Harbors Related to Cost Sharing and Essential Services

With the health care reform law adding to the regulatory maze of health plan portability, mental health parity and ERISA, plans need help ensuring that they correctly count participants' out-of-pocket expenditures; that wellness program rewards are properly administered; and whether "carved-out" benefits somehow frustrate compliance with the health care reform law.

And in their latest set of Frequently Asked Questions, the U.S. Departments of Labor, Health and Human Services and Treasury provide some answers and promise they will be working on clear-cut rules that may help in the future.

Out-of-pocket Costs

Starting in 2014 plan or policy years, out-of-pocket costs must be limited to $6,350 for self-only coverage and $12,700 for self-plus or family coverage, to comply with Section 1302(c) of the Affordable Care Act.

The tricky part is when the benefits are spread among two or more benefits administrators; for example, between major medical coverage and a pharmacy benefits manager.

For the first year of implementation (that is, the plan year beginning on or after Jan. 1, 2014), the annual limitation on out-of-pocket costs will be satisfied if the major medical coverage complies with the out-of-pocket limits; and if the carved-out benefit also does not exceed the out-of-pocket maximum, the agencies stipulated in Question 2 of FAQ series XII.

But after that first year, starting in 2015 plan and policy years, plans must observe reform's out-of-pocket limits on all essential health benefits even if they are spread over more than one benefits administrator, the agencies said in the current FAQs, which are posted on the website of DOL's Employee Benefit Security Administration (see http://www.dol.gov/ebsa/faqs/faq-aca18.html).

To do this, plans and insurers may use different out-of-pocket limits for different benefit categories, provided that the total of all out-of-pocket limits for all EHBs combined does not exceed Section 1302(c)'s limits for that year (the limits are indexed for medical inflation).

Of course, some components of an EHB may be experimental, unproven, cosmetic or dangerous, and plans retain the right to restrict those services. Plans' interpretations of which services fall in and which fall out of the EHB definition will be respected if plans and insurers use definitions aligned with those of HHS, which will be working with plans on aligning such definitions, the agencies said.

Out-of-network Services

Plans may refuse to count participants' out-of-pocket expenses for services and items that are performed or supplied by out-of-network providers, one FAQ says. Under HHS rules, cost-sharing requirements for EHBs from non-network providers need not be counted toward the annual limitation on out-of-pocket costs.

> Plans are advised to cover medications for reducing the risk of breast cancer in women, to align coverage with recommendations just revised by the U.S. Preventive Services Task Force.

But the agencies urge qualified health plans being sold on state-based health insurance exchanges only to make allowances for out-of-network providers (and drugs not on formularies) if they're missing because updated networks (and formularies) have not been issued or finalized.

Similarly, premiums, balance billing amounts for non-network providers and spending for non-covered services need not be counted in out-of-pocket totals.

Nothing, however, prohibits a plan or issuer from counting such expenses toward the plan's annual maximum out-of-pocket limit, particularly by QHP issuers on state-based exchanges.

Cancer Treatments Added to Preventive Care

Plans are advised to cover medications (such as tamoxifen or raloxifene) for reducing the risk of breast cancer in women. The U.S. Preventive Services Task Force revised its recommendation for breast cancer screening and prevention in September 2013. Non-grandfathered group health plans and insurance policies will be required to cover such medications for applicable women without cost sharing subject to reasonable medical management. Plans are advised to cover these

See *Agency FAQs*, p. 6

Agency FAQs (continued from p. 5)

medications without cost sharing by September 2014 to comply with the new recommendations, the new FAQ said. Health plans and policies must cover — without cost-sharing — items or services that have a rating of "A" or "B" from the USPSTF in order to comply with health care reform's preventive care mandate.

Wellness Incentives

The agencies addressed some questions that have been raised on the final HIPAA/ACA wellness program rules since their issuance in June 2013.

If a participant is given a chance to enroll in a tobacco cessation program at the beginning of the plan year and declines, the plan may deny that participant his or her reward for wellness program participation (for example avoiding the tobacco premium surcharge) even if he or she enrolled in the cessation program in the middle of the year. Plans may give participants another chance to avoid the tobacco premium surcharge in the event of midyear enrollments, but they do not have to do so, they say.

If a participant's physician says a plan's outcome-based wellness incentive is medically inappropriate, the agency notes in another FAQ, the plan must provide the same reward if the individual satisfies a reasonable alternative standard, as suggested by his or her physician — even if the alternative is an activity-only program not based on a health outcome. However, the government suggests, if the physician recommends a weight reduction program, the plan still has a say in choosing the program, because many different ones could be reasonable for this purpose.

The final rules included sample language for notifying participants that a reasonable alternative standard is available, but plans may modify this language to reflect the details of their wellness programs as long as their notice includes all the required content, they added.

Fixed Indemnity Insurance

Fixed indemnity insurance provided by plans is an excepted benefit under government rules, and it is generally exempt from HIPAA's portability requirements and the ACA's creditable coverage rules. But in order for a fixed indemnity policy to be considered an excepted benefit, it must pay on a per-period basis, and not on a per-service basis, the agencies said in Question 7 of FAQ series XI.

But even if a fixed indemnity plan pays on a per-service basis, it still might qualify as an excepted benefit. It can do so by qualifying as supplemental to major medical coverage. It can do this by meeting the following conditions:

1) it is sold only to individuals who have minimum essential health coverage through the plan;
2) there is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
3) the benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided by any other health coverage; and
4) a notice is displayed prominently in plan documents that the coverage does not meet the definition of minimum essential coverage and by itself, will not satisfy health care reform's individual mandate.

HHS needs to go through formal rulemaking to implement this safe harbor. Until then, it will treat fixed indemnity coverage as an excepted benefit if it meets the four conditions above.

MHPAEA and the ACA

The agencies also clarified the ACA's effect on the Mental Health Parity and Addiction Equity Act, which prohibits plans that offer mental health or "substance use disorder" benefits from applying stricter financial or treatment limits on these benefits than on medical/surgical benefits. Final MHPAEA rules were issued Nov. 13, 2013.

Mental health and substance use disorder services are among the ACA's 10 EHB categories, and the EHB rules require non-grandfathered plans in the individual and small-group markets to comply with MHPAEA rules, they stated. ACA Section 1563 also extends MHPAEA requirements to the entire individual market (grandfathered or not).

This FAQ details the timetable for meeting the EHB and MHPAEA requirements. The final MHPAEA rules do not take effect until plan or policy years beginning July 1, 2014, or later, but the EHB rules must be met in plan or policy years beginning *Jan.* 1, 2014, or later. So, for example, non-grandfathered calendar-year plans in the individual and small-group market must comply with the 2010 interim final MHPAEA rules in 2014 and the permanent rules in 2015.

For more information on health care reform's employer mandates, go to ¶150 of the *Guide*.

Agencies Propose Expanding Scope Of 'Limited Excepted Benefits'

Employee assistance programs and certain "limited wraparound coverage" would be added to the set of "limited excepted benefits" exempt from most of the requirements of the Affordable Care Act, under proposed rules in the Dec. 24 *Federal Register* (78 Fed. Reg. 77632), The proposed rules also would make it easier for dental and vision benefits to qualify as "excepted."

The U.S. Departments of Labor, Health and Human Services and the Treasury proposed guidance and sought comments in three areas, about which questions arose in the context of health care reform. Comments must be submitted by Feb. 24.

HIPAA rules already excepted certain benefits from its coverage-related requirements. Under 2004 guidance, dental and vision benefit plans are considered excepted benefits if the benefits offered are limited in scope and are either issued under a separate policy, or not otherwise considered integral to the health plan.

Excepted benefits have taken on new meaning because they are exempt from newer insurance market requirements under health care reform. The proposed rule expands those exemptions and applies them to: (1) limited-scope dental and vision benefits; (2) employee assistance plans; and (3) "limited wraparound" plans.

Employee Assistance Programs

The status of EAPs has long been ambiguous, and the potential effects of health care reform have given the question a new urgency.

"Since enactment of the Affordable Care Act, various stakeholders have asked the Departments to treat EAPs as excepted benefits for reasons analogous" to those that apply to dental and vision benefits, according to the preamble to the proposed rules. "Specifically, some employers represented that compliance with the prohibition on annual limits could be problematic as such benefits are typically very limited, and that EAPs generally are intended to provide benefits in addition to those provided under other group health plans."

Therefore, the proposed rules would treat an EAP as excepted if:

- it does not provide "significant benefits" in the nature of medical care;
- its benefits cannot be coordinated with another group health plan;
- no employee premiums or contributions are required to participate; and
- no cost-sharing is involved.

Limited Wraparound Coverage

The addition of certain limited wraparound coverage to the list of excepted benefits was to address a predicament employees may face if their employer offers "minimum essential coverage" but they still have to seek coverage on the exchanges because the employer's coverage is "unaffordable" (as defined by the ACA).

Large employers' group health plans often cover more items and services than are now defined as "essential health benefits" under the ACA. "Some group health plan sponsors have asked whether wraparound coverage could be provided for employees for whom the employer premium is unaffordable and who obtain coverage through an Exchange," according to the preamble, so these employees still could have coverage comparable to the group health plan's.

Therefore, the proposed rules would treat as excepted benefits coverage that:

- wraps around individual health insurance that is not grandfathered under the health care reform law and does not consist solely of excepted benefits;
- is specifically designed to provide benefits beyond those offered by this individual coverage;
- is not otherwise "an integral part" of the group health plan;
- costs no more than 15 percent (including employer contributions) of what the primary plan costs; and
- does not discriminate by health status or income.

Dental and Vision Benefits

To qualify as excepted benefits under the existing rules, dental and vision benefits must either be offered under a separate insurance policy or charge an additional premium or contribution from participants who elect them.

ACA requirements such as the 90-day maximum waiting period and the phaseout of annual limits have made it harder to keep offering dental or vision benefits, so more plan sponsors are interested in getting them classified as "excepted," and are questioning some of the

See *Excepted Benefits*, p. 8

New York Bars Insurers from Subrogating Settlement Proceeds, But Not Self-funded Plans

New York State has amended its anti-subrogation law in the wake of a ruling that held that ERISA preempted it. In changes enacted by Gov. Andrew Cuomo (D) on Nov. 13, 2013, the Empire State focuses the law's prohibition on health or disability coverage, and on payments for lost wages, that are fully backed by an insurer. The amended law does not apply to self-funded ERISA health plans, leaving them free to pursue recovery claims.

Background

In 2009, the New York legislature enacted a new section to Section 5-101 of the New York General Obligations Law that was intended to protect parties to the settlement of tort claim from "certain unwarranted lien, reimbursement and subrogation claims."

In *Wurtz v. Rawlings Co.*, 2013 WL 1248631 (E.D.N.Y. 2013), a federal district court held that this legislation was preempted if applied to any ERISA health plan. The ruling held that the law was not "saved" from ERISA preemption because it was not specifically directed toward insurance entities.

To get around that ruling, New York enacted the new law, S5715/A7828, which amended Sections 5-101 and 5-335 to state that it was intended:

> to ensure that insurers will not be able to claim or access any monies paid in settlement of a tort claim whether by way of a lien, a reimbursement claim, subrogation, or otherwise so that the burden of payment for health care services, disability payments, lost wage payments or any other benefits for the victims of torts will be borne by the insurer and not any party to the settlement of such a victim's tort claim. This law is specifically directed toward entities engaged in providing health insurance, thus falling under the "savings" clause contained in ERISA, which reserves to the states the right and ability to regulate insurance.

The amendment makes it clear that the prohibition on subrogation is directed at any "insurance company or other entity that reimburses health care expenses, health care services, disability payments, lost wage payments or any other benefits under a policy of insurance or an insurance contract with an individual or group." Clearly, the amended law does not apply to self-funded ERISA health plans. The key operative provision of S5715/A7828 states:

> When a person settles a claim, whether in litigation or otherwise, against one or more other persons for personal injuries, medical, dental or podiatric malpractice or wrongful death, it shall be conclusively presumed that the settlement does not include any compensation for the cost of health care services, loss of earnings or other economic loss to the extent those losses or expenses have been or are obligated to be paid or reimbursed by an insurer.

It goes on to state:

> No person entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by an insurer and an insurer shall have no lien or right of subrogation or reimbursement against any such settling person or any other party to such a settlement, with respect to those losses or expenses that have been or are obligated to be paid or reimbursed by said insurer.

The substantive provisions of the law conclude by stating that:

> This section shall not apply to a subrogation or reimbursement claim for recovery of benefits provided by Medicare or Medicaid or pursuant to a policy of insurance or an insurance contract providing workers' compensation benefits.

Law Is Now Under ERISA's Saving Clause

S5715/A7828 pulls New York's law directly under the purview of ERISA's saving clause. It also removes the terminology exempting insurers with "statutory rights to reimbursement" and now limits this exemption specifically to Medicare, Medicaid and workers' compensation liens. This change removes any confusion on

See *N.Y. Anti-subro Law*, p. 9

Excepted Benefits (continued from p. 7)

current prerequisites for doing so, especially the additional employee contribution.

Some employers argued that if dental or vision benefits "are provided on a self-insured basis and without a contribution from employees, employers should not be required to charge a nominal contribution" that might be less than the cost of collecting it, according to the preamble. "Moreover, they pointed out that employers providing dental and vision benefits through a separate insurance policy are not required to charge a participant any premium in order for the dental or vision benefits to be considered excepted benefits."

The agencies agreed "to level the playing field between insured and self-insured coverage" by eliminating the requirement that participants pay extra for dental or vision benefits in order for them to qualify as "not an integral part of a plan."

Featured Columnist (continued from p. 2)

attachment points as an alternative to a fully insured health plan. As a result, the three agencies issued a Request for Information regarding such practices, with a focus on the consequences of stop-loss coverage at low attachment points. Section 9010 will not apply to stop-loss coverage until such time and only to the extent that future guidance addresses whether stop-loss coverage constitutes health insurance.

The administration (and large insurers) have expressed concern about self-insurance in the small-group market and continue to collect information that could influence negative action against it. Specific reference was made to any new information put out by the National Association of Insurance Commissioners, which is developing the self-insurance white paper I just alluded to. The ERISA (B) Working Group of NAIC's Regulatory Framework Task Force met in August 2013 to focus on drafting its white paper about self-insurance and the small group market.

The working group plans to draft the paper and vote on it at NAIC's March 2014 spring meeting, and move it to the full (B) Committee for next summer's NAIC meeting. The white paper will discuss: (1) how self-funding options may affect small employers and the small employer group market; (2) the ACA's impact on small employers, self-funding, the "Small Business Health Options Exchange" marketplace and stop-loss products; and (3) the nature of stop-loss and how it functions and whether self-funding options offered to small employers differ from those offered to large employers.

Self-funding Has Different Faces

What the administration may not understand is that not all self-funding is the same. Different ways to self-fund exist. On one end is the "ASO option," which resembles a fully insured plan except that the plan pays the claims instead of premiums and everything else looks like a fully insured plan. In an ASO option, most if not all control is in the administrative service provider's (insurer's) hands.

Under the "third-party administrator" option, however, the plan has most if not all of the control over plan functions.

In the TPA space, more employers are looking at alternative pricing methodologies. As the self-funding industry evolves, plans are coming up with new ways of defining covered charges in their plan documents, including redefining allowable charges, and using reference-based pricing for specific benefits, non-network plans and physician-only network plans.

Plan structures are also beginning to drastically change as self-funding evolves to include not only new models, but also variations of traditional self-funded plans, including skinny plans, minimum-essential coverage plans, minimum-value plans, carve-out plans, medical tourism plans and direct provider agreements. The growth of self-funding is being seen through new models cropping up with consumer-driven health care, captives, multiple employer welfare arrangements and other innovations that present new opportunities and challenges.

Major Network Reformation

I expect there to be serious changes in PPO and provider network arrangements in the aftermath of the Sutter settlement. In November 2013, Sutter Health Systems settled whistleblower charges in a complaint joined by the California Insurance Commissioner alleging crooked anesthesia billing. The California Hospital

See *Featured Columnist*, p. 10

N.Y. Anti-subro Law (continued from p. 8)

whether an insured ERISA claim fell under the definition of a "statutory reimbursement right."

The new law applies to tort settlements entered into on or after Nov. 12, 2013.

Implications

Some of the language defining "insurer" in the New York law could be read to apply to self-funded ERISA plans administered by "insurers." However, some of the legislative history documents accompanying the law indicate that it is inapplicable to self-funded plans even if they are administered by insurance companies.

It remains to be seen how liability insurers and attorneys representing injured participants of self-funded ERISA plans will draft their settlement agreements to ensure that they constitute full release of all further claims by the injured parties.

In many cases, insurance proceeds paid to plan participants do not include deductibles, coinsurance or copayments and the cost of excluded services. Of course, this won't matter in most cases because the settlement proceeds usually come from the tortfeasor's liability insurance. In many instances, that insurance is insufficient to fully reimburse the injured person for loss of income and pain and suffering. And since it is impossible to put a definite monetary value on paid and suffering, it is easy to allocate most of the settlement as compensation for the injured person's pain and suffering.

It will be interesting to see if any other states adopt similar legislation.

Association has stated that 90 percent of hospitals use the same billing procedures. Therefore, be aware of lawsuits in the coming year that challenge hospital billing practices.

Based on the awareness of abusive billing, demand for transparency and the fact that self-funded plans are looking at alternatives to PPO networks, I expect major network self-reformation. Network agreements will be written dramatically differently than they were in the past. New models such as small networks and specialty networks are arising, and plans are implementing them with varying degrees of success. In the wake of the Sutter settlement, be on the lookout for increased network transparency.

State Legislation

Expect more anti-ERISA legislation. States such as New York (http://open.nysenate.gov/legislation/bill/A7828A-2013), are enacting laws designed to prevent plans from intervening in tort lawsuits. States are doing their best to make subrogation more and more difficult, thereby making health coverage for self-funded employer-based plans more expensive. In the coming year, we expect to see more anti-subrogation laws drafted and enacted as powerful state personal injury lawyer lobbyists push their agendas. Another area of state legislation that raises concerns for self-funded plans centers on restricting stop-loss insurance. Led by California (which passed SB-161), many new states laws would prohibit selling stop-loss policies unless they exceed the law's minimum specific deductible.

Website Wipeout

The recent problems with the rollout of the health care reform website, healthcare.gov, raises issues on what this ineptitude means in the bigger debate about Obamacare. The administration spent almost four years and more than $700 million of taxpayers' money to develop this website. The administration has known since early in 2013 that the system wasn't ready to support the rollout of the health insurance exchanges. Yet it proceeded anyway, apparently unconcerned about its faulty software costing Americans millions of hours of frustration and lost productivity. This same bureaucracy continues to assume more and more control of our health care system.

As we all know, the health care reform law will expand Medicaid and with that expect increased cost burdens for taxpayers. Obamacare will add another 20 million new Medicaid dependents. According to the Kaiser Family Foundation, that expansion will add 13 percent to state Medicaid spending in 2014 alone. Even though Medicaid was designed to help the poor, studies have consistently shown that Medicaid recipients receive worse medical care than people without any health insurance at all. Medicaid patients have longer waits to see a doctor, fewer specialists to choose from and poorer medical outcomes. Essentially, Obamacare is forcing 20 million more Americans into second-class medical care with Medicaid.

In 2014, expect to see further destruction of Medicare, including higher premiums for supplemental policies; fewer kinds of supplemental policies; more cutbacks in covered services; longer delays to see doctors; more doctors dropping out from Medicare. These are just a few of the changes to expect.

What Else?

In the last year HIPAA was given a major overhaul. So in 2014, be on the lookout for updates in federal regulations designed to take the focus off the provision of health care and place it on implementation.

There are constantly new developments in health care reform in the form of Technical Releases and other documents published by DOL, HHS and the IRS. The interpretations and implications of many federal statutes have not been clarified by the relevant agencies, so be mindful of new interpretative guidelines in the coming year. If the past few years have showed us anything, it's that many current rules are hard to understand and honestly don't make much sense in the real world. Just look at how the government attempted to fix the contraceptive coverage issue with religious organizations.

Is There Any Good News?

In spite of all these threats, there will be some positive state legislation. States such as Massachusetts are enacting laws designed to benefit self-funded plans, although such helpful legislation is not the norm. Pay attention to legislation that benefits all insurance, including self-funded plans. While many states are attempting to cripple self-funded plans' ability to properly contain costs, some states are accepting cost containment as an integral part of all health care. States like the Bay State, which have experience with state-run exchanges, understand that the best way to fix the health care problem is cost transparency.

But much more good will come after state and federal governments finally realize that self-funding works. All we can do is continue to innovate with creative cost savings and detailed wellness opportunities. The more success stories we have, the harder it will be for them to shut us down. So let's keep working and growing to ensure that nothing can stop our climb to the top.

Enforcement Stayed for Some Religious Employers Pending Ruling on Contraceptive Mandate

On Dec. 31, just hours before it was scheduled to take effect, Justice Sonia Sotomayor of the U.S. Supreme Court stayed enforcement of the mandate for one objecting employer, a group of nuns running nursing homes in Denver.

At the appellate level, the 6th U.S. Circuit Court of Appeals stayed enforcement of the mandate, saying it was mindful of guarding a Catholic group's rights, and maintaining that a stay would not harm the government attempts to achieve its public health goals.

SCOTUS Schedules Mandate Arguments

On Jan. 8, the U.S. Supreme Court set a late-March date on which it would debate two cases (*Sebelius v. Hobby Lobby Stores, Inc.* and *Conestoga Wood Specialties Corp. v. Sebelius*) challenging health care reform's mandate to cover female contraceptives. The Affordable Care Act requires plans and insurers to pay for birth control without cost-sharing from insured participants. Dozens of legal challenges have been filed over the contraceptive requirement. The High Court agreed to rule on the two cases late last November.

Sotomayor Stays Enforcement of Mandate

In an order signed on Dec. 31, Justice Sotomayor suspended enforcement of the requirement for health plans and insurers to pay for contraceptives, and prevented it from being applied to a group of nuns running non-profit nursing homes.

"The government has lots of ways to deliver contraceptives to people. It doesn't need to force nuns to participate," a spokeswoman for the law firm representing the plaintiffs in *Little Sisters of the Poor Home for the Aged, of Denver v. Sebelius* said.

The nuns reject the government's accommodation, which would require them to delegate the issuance of contraceptives to its third-party administrator, saying it increases their health costs and makes them complicit in providing goods and services they object to. The injunction applies only to the Little Sisters, which insures its workers through a self-insured church plan.

U.S. Justice Department Solicitor General Donald Verrilli issued a reply opposing Sotomayor's decision.

The Jan. 3 reply noted that the nuns are eligible for a religious exemption because they are a not-for-profit employer, unlike Hobby Lobby and Conestoga Wood Specialties, the two for-profit companies whose challenges will be considered by the High Court. "With the stroke of … [a] pen," Verrilli wrote, the nuns could:

> secure for themselves the relief they seek from this Court — an exemption from the requirements of the contraceptive-coverage provision — and the employer-applicants' employees (and their family members) will not receive contraceptive coverage through the plan's third-party administrator either.

The group sought the administrative stay after the U.S. District Court in Colorado refused to grant it (*Little Sisters v. Sebelius*, 2013 WL 6839900 (D. Colo., Dec. 27, 2013)). Now the Supreme Court must decide whether to extend the temporary injunction or dissolve it while the case goes through the lower courts.

6th Circuit Issues Similar Order

The 6th Circuit on Dec. 31 similarly blocked enforcement of the contraceptive mandate for Michigan Catholic groups. The court in *Michigan Catholic Conference and Catholic Family Services v. Sebelius*, No. 13-2723 (6th Cir., Dec. 31, 2013), said that it was unclear whether the mandate violated the Religious Freedom Restoration Act. However, the possibility that the group's constitutional rights may be violated weighed heavily in its decision, "particularly given that there does not appear to be a substantial harm to others."

The court stated that three very large constituencies — small employers, religious employers and grandfathered plans — can get exemptions from the mandate. Moreover, the government has already stayed enforcement of the mandate to the plaintiffs and similarly situated entities. Therefore, the harm of an injunction pending appeal is not great, the court said.

Catholic Archdiocese Earns Stay

The U.S. District Court for the District of Southern New York awarded a round to the Catholic Archdiocese of New York in its fight against having to comply with health care reform's mandate to cover female contraceptives, including "morning-after" pills.

U.S. District Judge Brian Cogan issued a preliminary injunction barring enforcement of the law against the archdiocese and affiliated entities, concluding that the contraception mandate likely violates the Religious Freedom Restoration Act even with the accommodation for religious employers (*Roman Catholic Archdiocese of New York v. Sebelius*, 1:12-cv-02542 (S.D.N.Y., Dec. 16, 2013). Under the accommodation, employers with religious objections must certify with the government and then use a third-party administrator to administer contraceptives without passing the costs on to the health plan.

See *Contraceptive Mandate*, p. 12

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-5. Entries are listed alphabetically by subject and the name of the court case. The numbers following each entry refer to the volume, issue number and page number of the *Guide* newsletter in which information on that topic appeared. For example, the designation "21:5/2" indicates Vol. 21, No. 5, page 2.

Index by Subject

Index of Court Cases

Contraceptive Mandate (continued from p. 11)

The archdiocese argued that the accommodation did not adequately shield the archdiocese affiliates from administering a benefit it objected to. The mandate, with or without the accommodation, violated the group's core religious beliefs. The archdiocese's employer entities would not have grandfathered health plans, and though they could apply for the Obama administration's religious employer exception and accommodation, it said the level of participation required to do so amounted to an endorsement.

Judge Cogan agreed in his opinion this was sufficient to establish the employer suffered an injury, thereby giving it standing to sue. It agreed that the health care reform mandate imposed a substantial burden on the groups' religious rights under the RFRA. Even though the processes of self-certifying and finding a TPA with which to administer the benefit is rather light, the court took the archdiocese at its word that arranging for contraceptive coverage is a heavy enough burden for the lawsuit to proceed and it stayed enforcement.

For its part, the government failed to demonstrate that its accommodation is the least restrictive way of achieving a "compelling interest." The interests listed by the government included "the promotion of public health and ensuring that women have equal access to health-care services." Because the government already granted exceptions causing millions of covered women not to have contraceptive coverage (grandfathered health plans, small employers, fully religious organizations), and the government's public health goals would not be advanced by forcing this one employer to cover contraceptives, Cogan wrote.

In granting the injunction, the government said the plaintiff satisfied the criteria, which were: (1) likelihood of success on the merits; (2) whether the archdiocese will suffer irreparable injury absent an injunction; (3) the balance of hardships between the parties; and (4) the public interest.

The archdiocese advanced enough arguments for the court to agree that more legal action is needed to spell out the extent and nature of injury to the archdiocese.

An injunction would not place any significant burden on the government, and enforcement against the archdiocese was not essential to advancing government health-promotion goals, the court concluded.