Employer's Guide to
# Self-Insuring Health Benefits

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## Treasury Gives Mid-sized Employers A Year-long Reprieve from Mandate

Companies with 50 to 99 employees that do not offer health insurance to their workers will not be subject to fines under health care reform for failing to provide coverage until 2016. This gives such mid-sized firms more time to prepare health coverage, and it is the second delay of the employer mandate, which was originally supposed to start in 2014. Hospitality, restaurant and retail industries as well as temp agencies are going to get the most out of the delay, observers note. Under the same U.S. Treasury Department final rules, large employers (with 100 or more workers) can offer coverage to just 70 percent of workers in 2015. That allowance is meant to give large employers time to convert to counting employees who work 30 hours per week as full-time workers, so offers of health coverage can be made in compliance with reform. ***Page 3***

## Self-insured Plan Wins Preemption Argument over Health Reporting Law

A Vermont law requiring "health insurers" such as self-funded health plans to report detailed claims data and similar information to the state interferes with ERISA's goals of allowing national administration of health benefits and violated a plan's fiduciary duty of keeping claims data confidential, the 2nd U.S. Circuit Court of Appeals held. The court based its ruling on the supposition that "recordkeeping, reporting and disclosure" are central ERISA functions that should not be impinged upon by conflicting and contrasting state laws. The state was collecting data on care provided to state residents and care provided by Vermont health care providers and facilities, in order to learn about resource allocation and to inform state policy. Because it required more data on a more frequent reporting schedule than ERISA did, the law should be preempted, the court concluded. ***Page 6***

## Handbook and Workbook Govern When No Plan Document Exists

A health care handbook and benefit workbook that collectively served as the summary plan description had equal authority as an ERISA plan document when no formal plan document existed; and their combined terms were enforceable when they did not conflict with other important plan coverage terms, a federal district court recently ruled. Also, an administrative service agreement was not to be considered to be an ERISA plan document, the court held, because it governs relations between a plan and administrator; not between the plan and participants. This finding prevented a plan beneficiary whose medical payments were covered once by an auto insurer from being able to recover double payments from the plan. ***Page 8***

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# What … Me Worry? The Backdoor Plan To Limit Self-funding

*By Adam Russo, Esq.*

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Many in our industry say that one of health care reform's goals is to funnel lives away from employer-sponsored plans and into the state-based health insurance exchanges. I'm persuaded that view surely is not amiss.

Nearly 90 percent of private health insurance is employer-based and almost 60 percent of individuals with employer-based insurance are covered by self-insured plans. Although self-funding poses a greater financial risk for employers, small businesses that have not traditionally offered self-insured plans are now considering this approach, especially if their employees are healthy and relatively cheap to insure.

The Affordable Care Act recognizes both insured and self-insured coverage as acceptable options for satisfying the employer and individual mandates. Because new coverage requirements have raised the cost of insured plans, many health insurance experts believe that self-insurance will increase as an option for more employers.

A small-employer shift to self-funding could increase costs for small businesses in the traditional fully insured insurance market and threaten the stability of the health insurance exchanges, reform proponents have stated. The administration is already creating policy options to discourage this, focusing specifically on stop-loss regulation.

Opponents of self-funding state that the absence of a strong regulatory framework for the self-insured market creates an incentive for small businesses with young, healthy workforces to self-insure. As long as these employee groups remain young and healthy, there are few incentives for employers to join the fully insured risk pool that includes older, less healthy individuals. But getting young, healthy people into exchanges is one of reform's goals, so the exchange risk pools remain able to pay for new benefits for the older, sicker general population.

If most small businesses self-fund, the fully funded market will get filled up by older, costlier employees, and the result will be substantially increased premiums in the fully insured group market.

They argue that without state and federal consumer protection, sicker employees in self-funded plans may also face higher out of pocket costs because of a process known as lasering, which allows stop-loss insurers to set higher attachment points for employees with costly pre-existing conditions or other health risks, which shifts liability for these employees' costs back to the employer. The ACA explicitly bans such behavior, but that protection does not apply to stop-loss policies.

**See *Featured Columnist*, p. 14**

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# Treasury Gives Mid-sized Employers An Extra Year Before Facing Pay-or-play Mandate

Companies with 50-99 employees that do not offer health insurance to their workers will not be subject to fines for failing to provide coverage until 2016. This gives such mid-sized firms an additional year to prepare health coverage for workers, and that delay adds to the one-year delay in enforcement of the Affordable Care Act's employer-mandate announced last July. The employer mandate was originally supposed to start in 2014.

Hospitality, restaurant and retail industries as well as temp agencies are going to get the most out of the latest delay to the employer mandate, a prominent benefits attorney tells the *Guide*.

The changes were published in the Feb. 12 *Federal Register* (79 Fed. Reg. 8544) by the U.S. Treasury Department. They are now effective.

### Impacts Larger Firms Too

Firms with 100 or more workers must still offer coverage, but they can satisfy the employer mandate by offering it to 70 percent of their workforce, as opposed to 95 percent, the percentage that was required before the change. Large employers that do not cover 70 percent or more of their workers will have to pay a fine in 2015. The percentage large employers will need to cover will revert to the statute's original 95 percent in 2016.

The smaller percentage requirement may help employers adjust to health care reform's new definition of a full-time worker as somebody working 30 hours a week, the Treasury Department stated. For example, employers might use the additional leeway to skip offering coverage to employees who work 30 to 34 hours until 2016, while offering coverage to employees with 35 or more hours.

Industries with low income, higher-churn work forces were able to make an argument that resonated: That the employer mandate is an administrative burden, said Chris Condeluci, a former U.S. Senate staffer now with the law firm Venable in Washington, D.C. Compliance with the employer mandate is very difficult for smaller employers to figure out, and even assuming an understanding of compliance, there are administrative activities, such as counting the number of hours people work, that most small businesses haven't done in the past, Condeluci stated. Third-party vendors are cropping up to do it for those companies, but that costs money.

Under the rule, large employers with non-calendar year plans are subject to the mandate based on the start of their 2015 plan year rather than on Jan. 1, 2015.

Employers still may not reduce their workforce to qualify for transition relief and they must maintain previously-offered coverage, the rule stated.

Small businesses with fewer than 50 employees still do not have to provide coverage or report on the coverage they offer their employees; such businesses will not have to offer coverage at any time under the reform law, Assistant Secretary for Tax Policy Mark J. Mazur said in a statement.

### Streamlined Employer Mandate

The rules were designed to make compliance with the health care reform law simpler and easier to navigate, Mazur said. A series of IRS questions and answers (see http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act) provides more information on the current state of the employer mandate.

According to a fact sheet from the Treasury Department (see http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf), other stipulations include:

- volunteer hours at government and municipal organizations, such as firefighters and emergency responders would not cause those workers to be considered full-time;

**See *Employer Mandate*, p. 4**

# CBO Triples Estimate of 'Jobs Lost' Due to Reform Law

In its latest report on the federal budget, CBO has tripled its earlier estimate of the reduction of labor force participation that will be lost due to health care reform — hiking it to 2 million in the next four years. Initially, CBO had predicted that reform would reduce the amount of work performed by the equivalent of 800,000 full-time equivalents.

Because of reform, more workers will "choose not to work" because: (1) reform subsidies disappear as low-earners' salaries rise; (2) state Medicaid programs take on more individuals; and (3) new taxes will be imposed on highly paid employees, the report said. It also notes that reform might soon act as a brake on employer job creation.

Obama administration officials tried to counter the findings by saying they were really about health care reform allowing workers to leave jobs they were trapped in to get insurance; that the unemployment rate would be unaffected; and reform would have a positive impact on the federal deficit.

Low-wage workers will choose to supply about 1.5 percent to 2.0 percent less labor, in order not to lose lucrative subsidies to purchase expensive health insurance, resulting in a loss of 2 million full-time equivalents after 2017, rising to a total loss of 2.5 million FTEs at the end of 2024, CBO said in Appendix C to its Budget and Economic Outlook 2014-2024.

By moving to part-time work, many workers would become eligible for lucrative subsidies to buy coverage, whereas if they stayed in full-time jobs at small companies that do not provide health coverage they would not receive such subsidies, CBO noted.

In 2010, the CBO had estimated that the reform law would mean workers would choose to supply about 1 percent less labor, costing the economy about 800,000 full-time jobs. It changed the multiplier it used to calculate responsiveness of the labor market to the law's tax-rate increases.

Impacts will not be felt during the next three years, CBO stated; they will be felt starting 2017, when major tax provisions under reform will take effect. Countervailing effects could be felt in the form of: (1) increased demand for health care services and more jobs in that sector; and (2) new opportunities that may arise out of the curtailed hours of other workers, CBO said.

### *Impacts on job creation*

Tax increases on employers to fund the subsidies could dampen job creation, CBO predicted, although it presented no evidence of that. Some employers will avoid hiring employees so they can stay below reform's large-employer definition of 50 or more full-time equivalent workers. By staying below that number of FTEs, an employer can avoid the mandate to provide health coverage or pay a fine.

Employers and employment experts have long said the reform law would prompt employers to restructure full-time work forces into part-time jobs and that its requirement that employers spend more on providing health insurance to workers would hamper job creation because money diverted to health premiums cannot be used to pay worker salaries.

### *Reduced incentive to work*

Labor force participation is expected to slip from more than 67 percent in 2000 to less than 62 percent in

**See *Reform Impact*, p. 5**

## *Employer Mandate* (continued from p. 3)

- teachers and aides would not be considered part-time because they do not work during the summer; and
- seasonal employees (those working fewer than six months per year) generally will not be considered full-time employees.

Other final rules will soon be issued to streamline employer reporting requirements for employers that offer "highly affordable" coverage to all or virtually all of their full-time employees, Mazur stated.

Duties related to the employer mandate involve: (1) setting up minimum essential coverage; (2) counting full-time equivalents to see whether the company is big enough to be subject to the requirement; (3) identifying full-time workers (who work 30 hours a week or more) who must receive an offer of health coverage; (4) distributing standardized summaries of coverage; (5) getting workers enrolled in coverage within 90 days; and (6) reporting to the IRS on the kind of coverage being offered and who is enrolled in such plans.

Last July, the government suspended penalties against employers that fail to provide health coverage through 2014, because reporting requirements had not yet been spelled out. Reporting requirements about the existence or non-existence of health coverage that were delayed in July 2013 will take effect on Jan. 1, 2015 for all applicable large employers, including those with 50 to 99 workers.

For more information on health care reform's employer mandate, see Section 410 of the *New Health Care Reform Law: What Employers Need to Know* by Thompson Information Services.

## *Reform Impact* (continued from p. 4)

2025 (projected): reform was seen as a contributor to that trend, which CBO said was primarily attributable to an aging of the workforce. Reform subsidies to buy health insurance are available to people only if they earn less than a certain threshold.

*Reactions and spin*

Republican legislators and news outlets said this vindicated their view that health care reform gives people an incentive to leave work and go on an entitlement program. They pointed to the fact that the CBO had tripled its estimate three years ago, saying that indicated how badly the law is performing.

"For years, Republicans have said that the president's health care law creates uncertainty for small businesses, hurts take-home pay and makes it harder to invest in new workers," House Speaker John Boehner, R-Ohio, was quoted as saying.

### ACA Won't Kill Jobs, CBO Chief Clarifies

In a clarification one week later, CBO director Doug Elmendorf stressed that reform would prompt some workers to work fewer hours, but that it would not cause employers to eliminate jobs, in a series of FAQs on the CBO report.

The report was being portrayed as saying the law would force employers to eliminate 2 million jobs and workers who wanted to work would be deprived of it. Elmendorf said CBO "would not describe [its] estimates in that way."

Instead, the report said reform would allow people to leave work to take care of their families, or to cut back on their hours to pursue other interests, which is an elective decision and an economic windfall for those individuals, according to Elmendorf.

> Because the longer-term reduction in work is expected to come almost entirely from a decline in the amount of labor that workers choose to supply in response to the changes in their incentives, we do not think it is accurate to say that the reduction stems from people "losing" their jobs. … [W]e think the language of "losing a job" does not fit.

On the other hand, reduced worker participation in the workforce would reduce total employment, investment, output and tax revenue. Further, many people believe the subsidies will be a drag on the economy, he said.

# Self-insured Plan Dodges Vermont's Health-data Reporting Law due to ERISA Preemption

*Reporting Is Core ERISA Concern, 2nd Circuit Says*

A Vermont law requiring "health insurers" such as self-funded health plans to report detailed claims data and similar information to the state interferes with ERISA's goals of allowing national administration of health benefits and violates the plan's fiduciary duty of keeping claims data confidential, the 2nd U.S. Circuit Court of Appeals held in *Liberty Mutual Insurance Co. v. Donegan*, 12-4881-CV (2nd Cir., Feb. 4, 2014). In overturning an earlier lower court decision, the court based its ruling on the supposition that "recordkeeping, reporting and disclosure" are central ERISA functions that should not be impinged upon by conflicting and contrasting state laws.

### The State Requirement

In 2008, the Vermont State Department of Banking, Insurance, Securities and Health Care Administration created the requirement that all "health insurers" (including self-insured plans and third-party administrators) submit data related to care provided to state residents and care provided by Vermont health care providers and facilities to Vermont residents and non-residents.

The state's goal in collecting the data included: determining resource capacity and allocation; informing health care policy; evaluating the effectiveness of care improvement efforts; comparing costs between various treatment settings and approaches; providing information to health care consumers; and improving the quality and affordability of health care.

The statute allowed the Department to require insurers, providers and others involved in health care to file reports, data, schedules, statistics, etc., in the manner, time and place dictated by it. Failure to comply is punishable with a fine of up to $10,000 per violation.

### Employer Objects

Liberty Mutual operated a self-insured health plan, and used a third-party administrator, Blue Cross Blue Shield of Massachusetts. Liberty Mutual had just 137 health plan participants in Vermont, and is considered a "voluntary reporter," because the law requires data reports from only health insurers with 200 or more covered individuals in the state. But the much larger Blue Cross is deemed a mandatory reporter, and must report Liberty Mutual's data.

In August 2011, the state of Vermont subpoenaed Blue Cross for files relating to Liberty Mutual's eligibility, medical claims and pharmacy claims. Liberty Mutual instructed Blue Cross not to respond, partly because the law interfered with plan administration and the plan had a fiduciary duty to prevent unauthorized disclosure of medical records. The employer sought: (1) a declaration that ERISA preempted the Vermont statute; and (2) an injunction to block the subpoena. Vermont stayed its subpoena pending judgment.

> ERISA preempts any and all state laws that create a multiplicity of inconsistent state laws and defeat streamlined recordkeeping, reporting and disclosure regimes. State laws that have sufficient connection with the conduct of the plan, and direct economic effects are preempted.

The state moved to dismiss the complaint, alleging that Liberty Mutual lacked standing. The district court (*Liberty Mut. Ins. Co. v. Kimbell*, 2012 WL 5471225 (D. Vt., Nov. 9, 2012)) ruled that the employer did have standing, but that ERISA did not preempt the state statute, thereby ruling in Vermont's favor. The employer appealed.

The appeals court affirmed that the employer had standing: Liberty Mutual had a choice between: (1) violating ERISA and its duties to plan members by handing over the data; and (2) paying fines for noncompliance. That dilemma was not changed in spite of the fact that the subpoena was issued to the TPA, because any penalty on Blue Cross for non-response would have been paid by the plan, the appeals court said.

### Appeals Court Reviews Preemption Question

The appeals court then gave a new review to the preemption question.

On that question, it concluded that Vermont's reporting requirement could be preempted because "reporting" is a core ERISA function that is shielded from inconsistent and burdensome state regulation. ERISA

**See *Plan Dodges State*, p. 7**

## *Plan Dodges State* (continued from p. 6)

was designed with uniform reporting and disclosure utmost in mind, it said. ERISA already had a comprehensive regulatory scheme, and ERISA plans are required to file data with the U.S. Department of Labor, the appeals court said.

ERISA was intended to: (1) eliminate a multiplicity of conflicting or inconsistent state laws; and (2) achieve streamlined recordkeeping, reporting and disclosure. And it preempts "any and all state laws" that create such a multiplicity, or interfere with the aforementioned streamlining, it said.

The appeals court cited case law such as the U.S. Supreme Court ruling in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 514 U.S. 645, 665-67 (1995), which reaffirmed that state statutes mandating benefit structures or plan administration (including reporting disclosure and fiduciary duty) are sufficiently related to ERISA plans to be preempted.

State laws that are insufficiently related to ERISA plans should not be preempted, such as laws that "have little to do with the conduct of the plan," or "taxes with only indirect economic effect[s]."

But state laws that force plans into sets of inconsistent state obligations and that control or supersede central ERISA functions should not be saved from preemption.

State reporting laws that the 2nd Circuit had in the past saved from preemption did not: (1) impede an employer's uniform benefit administration; and (2) prescribe a record-keeping regime.

But what kept the Vermont rules from posing a slight enough burden for it not to impinge on ERISA plans was that it: (1) extracts extensive information on medical claims, pharmacy claims and member eligibility; (2) imposes a reporting on a *quarterly* basis for plans with less than 2,000 covered lives and on a *monthly* basis for larger plans, in opposition to ERISA's *annual* reporting; (3) imposes a coding system under which data must be submitted; (4) imposes other requirements, including encryption, that are different from, or absent from, ERISA.

Also, Vermont's scheme would impair or reassign the plan's obligation to keep health records confidential, as well as the TPA's job of using the information only to administer the plan. Therefore, the court ordered the lower court to issue an order ruling in favor of Liberty Mutual, saying in parting:

> The trend toward narrowing ERISA preemption does not allow one of ERISA's core functions — reporting — to be laden with burdens, subjected to incompatible, multiple and variable demands, and freighted with risk of fines breach of duty, and legal expense.

### Dissent

A dissent on the preemption question (it concurred on standing), argued that the state law's reporting was different and separate from the reporting required by ERISA and therefore that Vermont's was not the kind of law Congress intended ERISA to preempt. The Vermont statute did not have an impermissible connection to ERISA plans, and should not be preempted, it stated.

Also, the statute did not interfere with national administration of ERISA plan benefits, the dissent said, alleging that the majority opinion exaggerated the importance of reporting as a core ERISA function.

The majority opinion also downplayed the "presumption against preemption" unless congressional intent is clearly perceptible, which was not the case here, it said.

Further, contrary to the majority opinion, the state law did not dictate how plans are to be run or how benefits are to be administered, the dissent asserted.

Liberty Mutual also failed to demonstrate, and the majority opinion failed to explain, the burden connected with the reporting imposed by Vermont. The burden could well be *de minimus*, and not cause the plan to change at all, the dissenting judge said.

### Lessons Learned

As the court acknowledged, ERISA is facing a trend toward narrowed preemption. As states work hard to obtain the ability to regulate self-insured plans — either directly through state laws and regulation or indirectly through stop-loss regulation — ERISA's core principles are still the rock relied on by those courts and lawmakers that choose to protect it and rebut that trend. Avoiding application of conflicting state laws, thereby allowing plans to provide consistent, uniform plans with streamlined policies and procedures, are important ideas that must be protected if self-insured plans are to continue to survive.

Through the "savings" and "deemer" clauses, and through the complex regulatory scheme provided by ERISA, Congress sought to both federalize and simplify the provision of employer-sponsored benefits. This scheme has done so since the 1970s, and its protections must continue to ensure that employers can still sponsor robust, cost-effective health plans.

# Handbook and Workbook Govern When No Plan Document Exists, So COB Exclusion Prevails

A health care handbook and benefit workbook that collectively served as the summary plan description can indeed also serve as the full ERISA plan document where no other plan documents exist; and SPD terms may in fact be enforced when they do not conflict with other important plan coverage terms, a federal district court recently ruled. Also, the court held an administrative service agreement should not be considered to be an ERISA plan document because it governs relations between a plan and administrator, not between a plan and participants.

The court in *L&W Associates Welfare Benefit Plan v. Estate of Wines,* 2:12-cv-13524 (E.D. Mich., Jan. 13, 2014) ruled on whether the employer's "Health Care Handbook" and its "Associate Benefit Workbook" were sufficient to constitute an ERISA plan document.

L&W Associates' self-funded plan sought a ruling from the court preventing the estate from recovering money that was already paid by Citizens Insurance Co., a no-fault auto insurer that was primarily liable for the health costs in the case due to applicable no-fault policies issued in the State of Michigan.

### The Facts

Terance Wines was seriously injured by an automobile when riding a motorcycle. He was enrolled in L&W's self-funded ERISA health plan. The claims administrator for the L&W plan was Blue Cross Blue Shield of Michigan. BCBSM also provided the plan with stop-loss insurance; a financial insurance policy that reimbursed the plan for any eligible claims incurred and paid after the plan exceeded $150,000 in medical losses.

Because the injuries resulted from an auto accident, the no-fault auto policy had to pay primary under Michigan law.

Initially, BCBSM paid the claims, but stopped doing so when it found out that Citizens was considered the primary payer, in accordance with the terms of the plan. Accordingly, Citizens took responsibility and issued payments to the Wines' health providers. Subsequently, BCBSM obtained reimbursement for the overpayments created as a result of the duplicate payments.

Wines' estate argued there was no plan document provision prohibiting double-dip payments in place until March 17, 2010, and such payments must be authorized before that date. As a result, it sought to enforce Terrance Wines' right to benefits under the plan.

### Claim: SPD Placement Invalidated Exclusion

L&W argued that its plan document did not allow a double dip recovery for health expenses paid by another insurer and sued to enjoin the estate from accessing such a recovery because, although it did not have a formal plan document until March of 2010, the prohibition on double payment was in the health care handbook and benefit workbook.

The handbook and the workbook contained all required indicia of an ERISA plan, including: (1) IRS Form 5500s from 2006-2009; (2) a statement that BCBSM was claims administrator, with contact information; (3) details about the types and levels of coverage available to employees; (4) a statement that ERISA governs the plan; (5) a statement of participants' rights and protections under ERISA; and (6) its plan number and tax ID number. (**Note:** The prohibition of double-dipping benefits resided in the handbook only; the workbook was silent on the matter.)

The estate argued that the handbook and workbook were not a plan document, relying on the following language to support that argument:

> This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

And even though the estate was not in debt at all to the providers and had nothing to pay, it argued that the SPD (that is, the handbook and the workbook) cannot constitute a plan document because either: (1) it conflicted with the administrative services agreement between L&W and BCBSM; or (2) there was no ERISA plan document in effect at the time of the accident.

The language barring double health payments appeared in the SPD, which cannot be a plan document, and not in the ASA, which lacked language barring double recoveries and was the only relevant coverage document, or in an official plan document. Therefore, the SPD-based exclusion did not bar the estate from obtaining double benefits, the estate contended.

The estate relied on *CIGNA v. Amara*, 131 Sup., 1866 (2011), which held that an SPD is not a plan document and not legally binding (in *Amara* however, the SPD was found to be intentionally misleading).

**See *No Plan Document*, p. 9**

## *No Plan Document* (continued from p. 8)

### In Spite of *Amara*, SPD Carries Authority

The court shot down the estate's argument, saying: (1) an SPD can serve as an ERISA plan document when no other plan documents exist; and (2) the ASA is not a coverage document and in any event does not conflict with the exclusion found in the SPD.

Amara was not meant to be interpreted to mean that an SPD never can carry the authority of a plan document. Just days after *Amara*, the 6th Circuit in *Shaffer v. Rawlings Co.*, 424 F. 422, 426 (6th Cir., 2011) ruled that the SPD is a fully incorporated part of the plan. The court also alluded to a 1998 case that said:

"[When] the relevant SPDs were issued, there were no actual 'plans' separate and apart from the SPDs themselves. Accordingly, the only relevant plan documents are the SPDs."

Also, in *Wal-Mart H&W Plan v. Gamboa*, 2007 WL 675472 (8th Cir. 2007), the court held that when "no source of benefits exists aside from [an employee benefits handbook], the handbook (or SPD) must become the formal plan document, regardless of its label."

Amara did not change the conclusion, and several cases back up that decision. Where the SPD does not conflict with any other coverage document, then the court needn't consider *Amara*:

> At the heart of *Amara* is the requirement that there be a conflict between the language of the SPD and the controlling plan document before the terms of the SPD can be ignored or overridden.

The estate produced no evidence that the SPD's prohibition clashed with any other document governing the plan.

The plan contained a provision saying that double coverage might be possible if the participant had purchased some form of medical coverage in his own name, but Wines had not done that. He was covered by a no-fault auto policy in the other driver's name, so the situation was inapplicable.

The court rejected the estate's attempt to invoke two post-*Amara* decisions, both of which stated that an SPD could not be enforced over the conflicting terms of a plan document. But that would have to be predicated on contradictions between the two, and the estate identified no such document or anything that conflicted with the SPD's ban on double payments.

### Court: ASA Isn't a Plan Document

The court said the estate got it wrong on yet one more thing: The ASA between the L&W plan and BCBSM could not assume the authority of a plan document. It applied only to those two parties, and it was not designed to govern relations between plan and participants.

It contained no benefit-defining language and did not apprise plan participants of their plan benefits or rights. So in this case, while the SPD could take the place of a plan document, that contract could not because it included no required ERISA indices, whereas the handbook and workbook did.

The plan document is supposed to be a place where participants read about their rights and duties under the plan and the ASA between plan and claims administrator was not that document, the court said. (But even if it were a plan document, that contract nowhere contradicted the handbook's prohibition on double-dipping, it noted.)

### Conclusion

In a case like this, where no plan document existed, the SPD (in this case, the handbook and workbook) *is* the plan document, the court stated. All medical services had been covered by Citizens, the handbook excluded double recoveries, the plaintiff had no debts to pay.

The duplicate coverage was not in Wines' name, so the only situation in which double dipping might have been possible didn't exist. Accordingly, the court declared, that the L&W plan could enforce the prohibition that was housed in the SPD only, and didn't need to pay anything for Wines' care, which was already covered by the no-fault insurer.

### Lessons Learned

Plan participants and beneficiaries rely on the Supreme Court's decision in *CIGNA* in an attempt to obtain benefits to which they believe they are entitled. They routinely argue that a plan must have a plan document, or risk losing its enforcement protections under ERISA.

In this case, the court provided that any interpretation of *CIGNA* relying on this posture is incorrect. *CIGNA* does not require a plan to have a plan document. A plan can rely on the SPD, as long as the SPD terms do not contradict the terms of other controlling benefit documents.

If such contradictions exist however, they create mayhem for plans attempting to enforce plan terms against beneficiaries in court. To combat this, plans routinely avoid establishing multiple documents, instead relying on the SPD. If multiple documents are necessary, plan administrators must ensure that those documents are uniformly written, because any contradiction can ruin the remedies the plan intended.

# Vague Appeal Letters Cost Plan In Overturned Denial of Dental Claims

The claims administrator of an employer-sponsored health plan abused its discretion when it rejected a health benefits claim because it: (1) denied it without an explanation or plausible support; (2) had a structural conflict of interest because it was also the insurer; and (3) violated ERISA regulations by merely reciting its policy without refuting the opinion of the participant's care provider, the U.S. District Court for the District of Oregon recently found.

This case (*Yox v. Providence Health Plan*, 3:12-CV-01348-HZ (D.C. Ore., Dec. 31, 2013)) shows the importance of complete and ERISA-compliant communication to participants in determining whether a plan denial can be overturned in court.

### The Facts

Kelly Yox was a beneficiary of her husband's employer's group health plan, which was administered and insured by Providence Health.

In March 2011, Yox went into a seizure, fell and broke her jaw. Dr. Brett Ueeck performed open reduction and internal fixation surgery to repair the jaw and two weeks later, performed another procedure to treat an infection that developed at the surgery site.

Months later, in August 2011, Dr. Mohammed Saleh, a dentist, performed a series of fillings, extractions, restorations, bone grafts and mandibular adjustments on Yox. Saleh submitted a pre-authorization request to the plan because, he claimed, these treatments were necessary due to the jaw fracture.

Providence issued a response in October 2011 refusing to pay for the work performed by Dr. Saleh because it determined the dental procedures were outside the scope of health plan. On second appeal, Saleh and Yox argued the newer work was a "direct, but late" consequence of the accident. In accordance with plan terms, the plan convened a grievance committee hearing in December 2011, after which it authorized payment for one tooth extraction and replacement implant, denying coverage for the rest of the services because her need for most of the work predated the accident.

The committee recommended that Yox go to the Oregon University's dental school for an evaluation of her teeth before the fall. Instead, her dentist sent the plan a letter describing her dental state before her accident.

In January 2012, the plan authorized payment for the one tooth and rejected payment for all other work performed by Dr. Saleh. In its final decision, it said Yox could appeal to an independent review organization, and enclosed a form setting out her "Grievance and Appeal Rights." Later that month, Yox appealed to an IRO.

On Feb. 22, 2012, the IRO upheld the plan's decision. Subsequently, Yox filed a motion for summary judgment with the court.

### Court: Plaintiff Had Right to Sue

The court determined that it would use an abuse-of-discretion, rather than a *de novo* standard of review, because the plan had reserved for itself discretionary authority in the plan document.

Yox said the court should review the denial with "additional skepticism" because Providence had a structural conflict of interest; that is, it both made claims decisions and acted as the funding source when paying claims. The court agreed to weigh the conflict of interest when seeing whether there was abuse of discretion.

### Court: Plan Abused Discretion

Yox asserted that Providence improperly: (1) relied on file reviewers rather than accepting the conclusions of Yox's doctors, or hiring its own expert examiner; (2) violated ERISA rules regarding full and fair review; and (3) failed to provide rational evidence supporting the denial.

Not only did Providence rely on a "paper only" review of the claim, it also failed to explain why it rejected Dr. Saleh's opinion that the dental work was needed because of the trauma of the fall. It did not rebut that opinion. In doing so, it arbitrarily refused credible evidence, the court said.

Secondly, the plan's review process failed to identify the specific medical policy on which it relied for the denial. Although Providence relied on medical experts, none of them had training or experience in dental

**See *Vague Appeal Letters*, p. 11**

# SIIA: 6th Circuit Should Find Michigan Health Care Claims Tax Preempted by ERISA

Lawyers for the Self-Insurance Institute of America on Jan. 31 faced off against Michigan in a federal appeals court over the state's Health Insurance Claims Assessment Act, SIIA reported. The Act imposes a one percent tax on all paid health care claims for Michigan residents for services incurred in the state. Self-insured group health plans and third-party administrators are subject to the tax.

SIIA has sued the state of Michigan contending that the law is preempted by ERISA. A federal trial court judge previously ruled against the association, setting up the Jan. 31 appeal before the 6th U.S. Circuit Court of Appeals.

### SIIA's Legal Argument

Michigan cannot supplement ERISA's federal reporting requirements with a "different scheme" for reporting purposes, SIIA argues. If it did so, the Michigan statute makes impossible uniform plan administration, SIIA says.

Referring to the U.S. Supreme Court decision in *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001), SIIA said when deciding whether the Michigan law has a forbidden "connection with" an ERISA plan, the 6th Circuit must look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the effect the state law would have on ERISA plans. SIIA says both controlling case law and the legislative history demonstrate that Congress intended ERISA plans to be subject to federal regulation only of ERISA's core functions, particularly reporting.

The preemption provision was especially intended to address the threat of conflicting and inconsistent state and local regulation, the group said, citing *Fort Halifax Packing v. Coyne,* 482 U.S. 1 (1987*)*. An ERISA plan is subject to a host of federal regulatory obligations, including "keeping appropriate records in order to comply with applicable reporting requirements." That is impossible if a health plan is subject to differing regulatory requirements in differing states, the ruling in *Halifax* stipulated. ERISA is designed to prevent a situation in which plans are required to keep certain records in some states but not others, SIIA said.

If every state required ERISA benefit plans to regularly report on their ERISA activities, plan administrators would have "to master the relevant laws" of more than 50 jurisdictions, SIIA said.

## *Vague Appeal Letters* (continued from p. 10)

reconstruction. Further, the plan failed to adequately inform Yox of her right to bring a civil action, as required by ERISA. Taken together, the facts tilted toward a finding of an abuse-of-discretion.

Finally, the plan's denial letters merely recited its policy of covering no dental services, but did not explain why Saleh's services were not medical or why they were medically unnecessary. Yox presented evidence from her dentist that many of her teeth had no problems before the accident, but the plan failed to weigh those in the second appeal or the hearing before the Grievance Committee.

Based on the totality of the facts (the conflict of interest, the reliance on file reviewers and the failure to explain its decision) the court granted summary judgment for Yox and rejected the plan's attempt to take the case to trial.

### Lessons Learned

A health plan must take care to comply with ERISA's requirements when issuing adverse benefit determinations. If it fails to do so, it eviscerates its most important power — discretionary authority.

The abuse of discretion standard used by courts in reviewing adverse benefit determinations affords an incredible advantage to health plans, and one that has been litigated *ad nauseam*. Plans must be careful to ensure that negative decisions are based clearly and squarely on established provisions within the plan. As illustrated in this case, those provisions also must be explained carefully and with specific reference to the applicable plan terms to demonstrate the due diligence performed by the plan in making its decision. In doing so, the plan acts in such a manner that avoids court findings of improper or abusive decision-making.

In this case, there were other important divergences from legal requirements, such as disregard of qualified expert review, the failure to base decisions on logic or research and a fair explanation of the decision to the plan member. All these problems are exacerbated when conflicts of interest are present, as was the situation in this case.

# EBRI: HSAs and HRAs Are Growing, But HSAs' Upward Path More Consistent

More employers are giving their employees the option of defined contribution health plans, and employees are increasingly taking advantage of this benefit, according to a recent survey from the Employee Benefit Research Institute. For the first time since EBRI started the survey in 2005, the number of health reimbursement arrangements fell — from 5.1 million in 2012 to 4.7 million the following year — while the number of health savings accounts actually increased from 6.6 million to 7.2 million during the same period. The survey also shows the direct connection to employer contributions and increased account balances.

### Growth through the Years

HRAs, which have been around since 2001, and HSAs, originating in 2004, have found favor with employees who want to exercise more control over their health care service funds. Last year, 23 percent of employers with one to 499 employees and 39 percent of those employing 500 or more employees offered either an HRA or HSA. Since the introduction of these plans, participation has increased, and in 2013, around 26 million participants, about 15 percent of those who are privately insured, were covered by these types of plans.

## Overview: HRAs and HSAs

**Health Reimbursement Arrangements** receive only employer funding. Employees cannot contribute to HRAs on a pre-tax, salary-reduction basis. Reimbursements under HRAs are excluded from an employee's income if they are exclusively used for medical expenses. (See the *Guide*, ¶450.)

**Health Savings Accounts** can receive contributions from any eligible individual, including employers, employees or others, as long as that individual is covered under a high-deductible health plan. Employer contributions to an HSA are excluded from income and wages and/or reduce adjusted gross income if made by an individual. (See the *Guide*, ¶460.)

According to the survey, HSAs have steadily grown in number of accounts and in assets since their inception. In 2007, there were 1.6 million accounts, and this figure grew to 7.2 million in 2013. Growth has been steady, with increases through the years, including the greatest increase from 2010 to 2011, growing from 2.8 million HSAs to 4.9 million. Similarly, total assets in these plans have also increased over the years. In 2007, there was $2.4 billion in HSA assets. This amount has grown to $16.6 billion in 2013.

While HSAs have been steadily growing, HRAs have experienced both growth and slowdown. After HRA assets increased by 282 percent and accounts grew by 101 percent in 2007, the number of these plans experienced a slowdown from years 2008 through 2010, although after this time, plan numbers did increase again. However, after growing 40 percent in 2012, HRA accounts grew only 1 percent in 2013. One reason for this slowdown, the survey notes, is that the number of HRAs available from employers decreased, with HRAs falling from 5.1 million to 4.7 million between 2012 and 2013. The survey notes that there also has been a drop in assets in such arrangements.

### Account Balances and Contributions

Account balances in HSAs are typically higher than those for HRAs, which mirrors the also-higher growth for HSAs. For 2013, the average HSA balance was $2,311, compared to HRA balances, which averaged $1,236. Participants with HRA balances are also more likely to report that they had a zero account balance or did not know their balance. The survey states that these differences have been consistent, and HSA balances have remained higher than HRA balances.

Two factors that affect the account balance amount are the length of time a participant has the account, as well as employer and individual contributions, according to EBRI. Participants who had either an HSA or HRA account for less than six months in 2013 had an average of $1,965 in their account. Those with accounts from three-to-four years averaged $2,703 in their account. Participants with at least five-year-old accounts had account balances averaging $3,491.

The survey found that whether contributions come from an employer or from individuals, such contributions have an important correlation to higher account balances. In 2013, participants who had employer contributions of less than $1,000 had an average of $2,140 in their accounts, while this number increased for those with employer contributions of at least $1,000 to $2,889. Similarly, those who individually contribute less than $1,000 averaged $1,569 in their accounts,

**See *HSAs Grow*, p. 13**

# Employers Take Tougher Line On Insuring Part-timers, Spousal Coverage

Target Corp. on Jan. 21 said it would stop offering health coverage for part-time employees after April 1, 2014, and it said health care reform was the reason behind its policy change.

In a post on the company's blog, executive vice president for human resources Jodee Kozlak justified the action, saying that moving to a state-based health insurance exchange (mandated by reform) might be better for Target workers.

"The launch of Health Insurance Marketplaces provides new options for health care coverage that we believe our part-time team members may prefer," she said, adding: "By offering [part-time team members] insurance, we could actually disqualify many of them from being eligible for newly available subsidies that could reduce their overall health insurance expense."

## *HSAs Grow* (continued from p. 12)

while employee contributions of at least $1,000 averaged $3,196 account balances.

### Rollovers in Accounts

The flexibility of accounts to permit rollovers also has an impact on account balances, and apparently, participants are taking advantage of this feature in HRAs and HSAs. Those account holders with rollovers have increased over the years, according to the survey. In 2006, 500,000 participants rolled over $276.2 million, and in 2013, 7.9 participants rolled over $9.2 billion. The survey found that in 2006, 26 percent of employees did not roll over money from a previous plan year to their HSA accounts. This decreased to only 10 percent of participants in 2013 that did not take advantage of a rollover.

Again, as the length of time that a participant has held an account increases, so does the size of the rollover. Those with accounts for one to two years in 2013 had an average rollover of $887, while those holding accounts from three to four years had an average rollover of $1,614.

Employer contributions also increase rollover amounts, with contributions of less than $1,000 in accounts averaging a rollover of $1,153 in 2013. Participants with employer contributions of $1,000 or greater had rollovers that averaged $1,440. This is a trend that EBRI believes will continue.

Kozlak also reasoned that loss of the company's coverage offering for part-timers would not harm many of them. Less than 10 percent of the company's 361,000 employees participate in the part-timers' health plan that is being discontinued, she said.

Target will pay $500 cash to part-time employees who lose access to the company's health coverage, Kozlak said. The company is encouraging workers to sign up on state-based exchanges between now and March 31, when open enrollment ends. It hired a contractor to "develop a personalized approach to provide one-on-one support to every affected team member"; primarily by helping them enroll in exchange coverage.

The retailer joins Home Depot and Trader Joe's in shifting part-time workers from a company health plan to the state-based health insurance exchanges.

### A Tougher Line on Spousal Coverage

There is another trend: health care reform is prompting employers to take a harder line on spouses who can get health coverage from their own employers.

For example, as many as three times the number of large employers could be dropping coverage for spouses who have alternative coverage options, the Employee Benefit Research Institute said in a report entitled The Cost of Spousal Health Coverage. In early 2012, just 4 percent of large employers excluded such spouses from plans. Just one year later, 12 percent of large employers said they planned to exclude spouses when other coverage was available, an 8-percent jump.

The number of large employers that said they planned to impose surcharges on spouses when other coverage is available increased from 20 percent to 33 percent. The number that said they would require spouses to enroll in their own employer plan before allowing them into their own plan increased from 7 percent to 18 percent. Expanding the number of coverage tiers was planned by 15 percent in 2012; by 2013 the number of employers deciding to use that strategy increased to 24 percent.

The health care reform law leaves the door open for employers to make these changes, because it does not require employers to provide health coverage to spouses.

**See *Tougher Line*, p. 14**

## *Featured Columnist* (continued from p. 2)

Instead of trying to knock down the bolted, reinforced front door of ERISA (by amending it), it appears to me that reform proponents are working to curb self-funding by entering the back door; that is, by imposing new restrictions on stop-loss insurance at the state level. A more remote, but more serious threat would be a federal law that classes stop-loss with low attachment points as health insurance, subject to the federal health care reform law.

### ERISA Preemption

As you know, self-insured health plans are regulated by ERISA, the federal law that regulates private pension and welfare plans, including group health plans. Insured group health plans are subject to the insurance and other laws of each state through regulation of insurance companies and coverage issued in that state. ERISA generally prevents state laws from directly regulating self-insured health plans.

The hardest way to block self-funding would be to amend the ERISA, a law that has been on the books since 1974. This would take years to do, and folks implementing the reform law do not have years to wait. So the simplest and fastest way of stopping the growth of self-funding is through the back door.

### Stop-loss Targeted

Employers and others that sponsor self-insured health plans rely on purchasing stop-loss insurance to manage their risk of both large individual claims as well as the aggregate or total amount of claims in a plan year. Most self-funded plans have some level of protection from catastrophic health claims to prevent them from imploding in the event of unexpected big-ticket expenses.

Without it, few employers of any size would self-insure and this would remove the option that covers the majority of individuals today with employer-based health insurance. This is exactly what the Obama administration and some state legislators would love to occur without having to take the blame for it.

While private, self-funded plans are protected by ERISA preemption, stop-loss insurance is not. In fact, states have the authority to regulate insurance companies that sell stop-loss insurance. Depending on the state, they also may have the authority to limit the coverage the stop-loss policies offer. Those rights are not preempted by any federal law.

While it may seem strange that a state would limit the amount of coverage an employer could buy to protect its financial well-being, restriction of stop-loss insurance is occurring in several states. It seems the sole reason it is happening is to restrict employers' ability to self-insure.

The point at which an employer has stop-loss protection depends on its risk tolerance. Employers with low risk tolerance will also want stop-loss insurance with low deductibles. To the extent that states raise minimum stop-loss attachment points, fewer employers will try self-funding, and more employees will remain on exchanges.

### NAIC Seeks More Restrictions

The National Association of Insurance Commissioners first showed interest in regulating stop-loss insurance in 1995, when it drafted its first Stop-loss Insurance Model Act. This model legislation stipulated that stop-loss attachment points for groups of 50 or fewer employees may not be less that the greater of: $4,000 multiplied by the number of members, 120 percent of expected claims, or $20,000 indexed for inflation.

NAIC's intent was ensure that the group plan shoulders an adequate proportion of its risk rather than passing too much of it to a stop-loss insurer. It was intended to prevent employers from evading state regulation by setting up self-insured plans that were indistinguishable from fully insured plans.

**See *Featured Columnist*, p. 15**

## *Tougher Line* (continued from p. 13)

Spouses on average cost about 7 percent more to cover than otherwise comparable policyholders, EBRI research found. This makes spousal coverage a target for employers seeking to control health plan spending.

The United Parcel Service and the University of Virginia recently decided to eliminate health benefits for spouses who were eligible for coverage through their own employer, and they said their actions responded to rising health costs aggravated by health care reform requirements.

The strategy could save money for plans acting early, but when other employers start implementing the same strategy, plans may become responsible for covering employees they don't cover now because they are covered as a spouse under other plans, report author Paul Fronstin said. So those early gains could be reduced or eliminated entirely, he said.

## *Featured Columnist* (continued from p. 14)

In 2012, an NAIC working group wanted to raise the minimum specific attachment point to $60,000 and the minimum aggregate point to either $15,000 per employee or 130 percent of the expected aggregate claims. Luckily for us, a motion to adopt the amendments failed.

But in the absence of a revamped NAIC model, several state legislatures enacted stop-loss legislation in 2013.

Most states that reject health care reform on principle do not operate their own health insurance exchanges, but instead allow the federal government to run them. Those states also tend to leave stop-loss alone. (North Carolina and Utah may be considered as possible exceptions.)

Colorado, Rhode Island, and North Carolina adopted new $20,000 minimum attachment points, while Utah adopted a minimum attachment point of $10,000. A more restrictive minimum attachment point of $35,000 was enacted in California, scheduled to rise to $40,000 in 2016.

Most states that reject health care reform on principle do not operate their own health insurance exchanges under the reform law, but instead allow the federal government to run them. Those states tend to leave stop-loss attachment points alone.

North Carolina is the only state without a state-based exchange to also pass an insurance bill lowering minimum attachment points. (**Note:** Utah, which passed a mildly restrictive minimum attachment point, allows the feds to run its main exchange, but it runs its own exchange for small business.)

### A Potential Federal Attempt to Stop Self-funding

The government may also set minimum standards for all states. There are several ways to realize that goal using the U.S. Department of Health and Human Services' rulemaking authority. HHS regulators could include in the regulatory definition of a health insurance issuer those stop-loss insurers that sell policies with extremely low attachment points.

The statute defines a health insurance issuer as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance. Stop-loss insurers that offer policies with maximum risk protection could be defined as meeting this broad definition. Treating them as insurers would require them to meet reform requirements such as offering all categories of essential health benefits, covering preventive services at no cost and eliminating annual and lifetime limits. These changes would limit stop-loss insurers from offering cheaper premiums to small businesses based on limited benefit packages.

Second, regulators could include in the definition of self-insured plans under the reform law only those self-insured employers that assume a certain minimum level of risk.

Federal guidance defining self-insured plans already excludes plans offered by employers that purchase 100 percent stop-loss coverage.

Regulators may expand this definition after carefully reviewing premiums in the fully insured market.

Requiring small businesses to shoulder more risk in exchange for meeting the definition of a self-insured plan could discourage many of these businesses from choosing this approach.

Again, this could limit the growth of self-funding that we are seeing today.

# Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-6. 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 "21:6/2" indicates Vol. 21, No. 6, page 2.

### Index by Subject



### Index of Court Cases