Employer's Guide to
Self-Insuring Health Benefits

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Agencies Finalize 90-day Max Waiting Periods but Add Exceptions

Eligibility conditions based solely on the lapse of a time period are permissible for no more than 90 days, under final rules from the federal agencies implementing health care reform. The rules establish a series of safe harbors meeting eligibility criteria that can stretch the time before enrollment beyond 90 days, provided those are not an underhanded attempt to skirt the 90-day maximum. Measurement periods to determine whether a worker is part-time or full-time can stretch the period out to as much as 13 months. Cumulative hours-of-service requirements are allowed if they do not exceed 1,200 hours. Also reasonable orientation periods may be imposed of up to 30 days before the 90-day clock starts ticking (although that aspect of the rule is still open to public comment). ***Page 3***

Dismissal of Contrary Opinion Costs Plan Ability to Enforce Denial

An association health plan's effort to invoke its exclusion for work-related illnesses and injuries was rejected by a federal court, in large part because it ignored the differing opinion of a physician in its internal claim process. The decision went against the plan in spite of the fact that evidence in the record indicated that the condition was work-related, and the plan enjoyed a favorable standard of review by the court. The decision was unaffected by the fact that the employee first argued to a workers' compenation court that his sickness was work-related, and later contended (after the WCC ruled against him) that it was unconnected to his job in his case against the plan. The ruling underscores the importance of a full and fair review of contrary evidence in internal claims and appeals determinations. ***Page 7***

Appeals Court Blocks Prompt-pay Law Application to Self-funded Plans

An appeals court sided with a national trade group representing large insurers performing administrative services in blocking the application of Georgia's prompt-pay statute to self-funded health plans. The 11th U.S. Circuit Court of Appeals said the state's prompt-pay law — specifically amended to include self-insured plans and their third-party administrators — was preempted because it related to ERISA plans and interfered with national administration of health benefits. The case was brought by America's Health Insurance Plans, whose members perform administrative services for self-funded ERISA plans as part of their business. AHIP withstood arguments that it lacked standing to file the claim for relief and earned an injunction because its case had a substantial likelihood of success on its merits. ***Page 9***

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Adam V. Russo, Esq.

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Know the Type of Self-Funded Plan You Want to Be

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

An unnerving fact of the self-insured industry is that most employers do not know what type of plan they actually are. Do they want to be innovative in the way they approach self-funding, or passive by allowing vendors to call all the shots? Do they choose an administrator because of cheap administrative fees and network access, or do they choose it to ensure they are being smart with their claim dollars? Did they choose the stop-loss insurer with the cheapest price on the spreadsheet or did they actually check to see what they agreed to reimburse in the 15-page agreement? The key to answering these questions is for the organization to do some soul-searching and decide the type of self-funded plan it wants to be. That can be linked to the level of involvement it wants to have in plan management.

Three Kinds of Self-funders

There are three types of self-funded plans. The first just send in the checks to get claims paid. Many employers fall into this category and to be honest, their third-party administrators are happy not to be bothered with too many questions.

The second are slightly involved in the self-funding process: they might speak to their administrator on a monthly basis and review claims paid every once in a while. Most self-funded plans fall into this category. They do enough to feel good about themselves, but not nearly enough to prudently manage plan assets. In my opinion, they risk failing to ensure that plan dollars are spent wisely.

The third is the super self-funded entity. These are the plans that spend the extra time to ensure they and their administrators are being efficient with claim dollars and realize cost reductions as fruit of their labors. While these plans may let their TPA handle claim processing functions, they are always looking for new and innovative ways to rescue the cost of their claims.

In my opinion, being an involved and innovative self-funded plan is the best option, and it's not a time-consuming commitment. A plan probably needs to spend only 10 hours a month to make a true difference in claim payments.

The Path to Cost-effective Strategies

So what do you need to do first? From my standpoint, the first decision the innovative plan must make is whether it wants to be the fiduciary. It's not an easy decision, but if you decide to be an innovative plan, I suggest you take on this fiduciary role so you can control the money. When you become a self-funded plan, you agree to pay the claims. It doesn't mean you get to decide how much you end up paying or when you actually pay, it just means you foot the bills.

See *Featured Columnist*, p. 14

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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**

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Agencies Finalize Max 90-day Waiting Period For Health Plan Enrollment, but Add Safe Harbors

Generally, waiting periods to enroll in health coverage cannot exceed 90 days, and eligibility conditions based solely on the lapse of a time period are permissible for no more than 90 days, under new final rules issued by the U.S. Departments of Labor, Health and Human Services and the Treasury. In addition, the employer has to count all calendar days beginning on the enrollment date, including weekends and holidays. No group health plan or group health insurer may prevent an otherwise eligible employee from being made an offer in that time.

The rules also formally overwrite HIPAA's 2004 rules on pre-existing condition exclusions, to implement health care reform's total ban on such exclusions that took effect for plan years starting Jan. 1, 2014. Most key, the rules finalized the elimination of the requirement to issue HIPAA certificates of creditable coverage, starting with plan years beginning on Dec. 21, 2014. The rules finalize other amendments to 2004 HIPAA regulations. However, plans and issuers are to still comply with the existing HIPAA rules until the new amendments become effective.

Both grandfathered and nongrandfathered group health plans and group health insurers must observe the final rules for plan years beginning on or after Jan. 1, 2015. Plan years with start dates later than that are still running out through to Dec. 30, 2014, the rule notes.

The final rules were put on public display on Feb. 20 and were officially published on Feb. 24 (79 Fed. Reg. 10296). They mainly affirm what was set out in proposed regulations on March 21, 2013 (78 Fed. Reg. 17313), which in turn implement a ban on waiting periods that exceed 90 days for individuals otherwise eligible to enroll in coverage because they have been the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements).

The rule allows a number of coverage eligibility tests that are not based on the counting of days. It permits safe harbors to account for situations in which 90 days would be "too early to tell" whether a worker is eligible for an offer of insurance. Examples include "measurement periods" (during which a worker's full-time status is not yet certain); "cumulative hours of service;" "orientation periods;" and "rehired employees."

Safe Harbors

The rule establishes a series of safe harbors meeting eligibility criteria that can stretch the time before enrollment beyond 90 days. But the feds circumscribe each one to make sure that eligibility conditions that are based on achieving a work-related quota or other requirement are not used to evade the waiting period limit.

- **Measurement periods** may be used if an employer cannot reasonably determine whether the employee will work the amount of hours he or she needs to work full-time. A 12-month measurement period would be acceptable, but the offer of insurance will have to be made 30 days (not 90 days) after that for a grand total of 13 months maximum time from hiring to offer. For variable-hour workers, as long as coverage is offered no more than 90 days after a determination is made based on the measurement period, and the total "hire-to-offer" period is under 13 months, that period likely will comply. And if the employee's start date is not the first day of a calendar month, the plan gets additional time remaining until the first day of the next calendar month.
- **A cumulative hours-of-service** requirement will not be considered as designed to skirt compliance with the 90-day time limit if it does not exceed 1,200 hours. On the day the cumulative service requirement is met the 90-day clock must start ticking.

See *90-day Rule*, p. 4

90-day Rule (continued from p. 3)

Note: The cumulative requirement may not be used twice on the same employee.

- **Orientation periods.** Requiring new hires to complete a reasonable and *bona fide* employment-based orientation period may be imposed as a condition for eligibility for coverage under a plan. But a separate proposed rule, also published Feb. 24, (79 Fed. Reg. 10320) would limit the maximum duration of orientation periods to one month. And the agency is taking public comments on that aspect of the rule until April 25.
- **Rehired employees.** Former employees who are rehired may be treated as newly eligible for coverage upon rehire and, the rule says, a plan or insurer may require that individual to meet the plan's eligibility criteria and to satisfy the plan's waiting period again. The same goes for workers who move to positions that are ineligible for coverage but then return to an eligible job.
- **Collectively bargained agreements.** CBAs' special rules governing eligibility, such as "hour banks" — in which workers' excess hours from one measurement period are credited against any shortage of hours in a succeeding measurement period, enable workers to prevent lapses in coverage. These are allowed under the rules, provided the employer and insurer apprise each other about them.
- **Multiemployer arrangements.** In a September 2013 set of questions and answers, the example is given of a multiemployer plan operating under a CBA that has an eligibility provision allowing employees to become eligible for coverage by working hours of covered employment across multiple contributing employers. That would be considered acceptable because it accommodates a unique operating structure and is not an attempt to avoid compliance with the 90-day waiting limit, the rules state.

Late or Special Enrollees

If an individual enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period. The effective date of coverage for special enrollees continues to be that in the 2004 HIPAA regulations governing special enrollment (and, if applicable, in HHS regulations addressing guaranteed availability).

Pre-existing Condition Examples

The final rule codifies examples in the proposed rules of exclusions that would be prohibited since they deny benefits in violation of health care reform's prohibition on exclusions for pre-existing conditions. Under the final rules, these must all be covered now. See the final rule for the full list of examples.

- An exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage.
- A plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan.
- The requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits.
- The exclusion of coverage for treatment of congenital heart conditions.
- A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance. This is prohibited.
- A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit benefits provided under prior health coverage. ❖

Final PPACA Reporting Rules for Employers Remain Complicated but Provide Guidance

On March 10, the IRS released final regulations to simplify the health care reform law's reporting requirements, which require employers to report health coverage information under Code Section 6055 and Section 6056 starting in 2015. Although the reporting remains extensive, at least plan sponsors have certainty now that the rules are finalized and can move forward with setting up the data collection and interfaces with IRS and their workforces need to comply with the rule. (79 Fed. Reg. 13231.)

- Section 6055 requires insurers and sponsors of coverage through an employer's group health plan to report information that will allow taxpayers to establish and the IRS to verify that the taxpayers were covered by minimum essential coverage and their months of enrollment during a calendar year.
- Section 6056 requires large employers and other health plan sponsors to report about the health coverage they offer and which employees are enrolled in their plans. Reports are to ensure that MEC was being offered to the requisite number of full-time workers.

The government is collecting this information to help administer subsidies for health insurance exchange coverage and to identify employers that have to make "shared responsibility" payments. The final rules were issued for public inspection on March 5 and were officially published on March 10. They took effect immediately thereafter. They are based on proposed regulations that were published in the *Federal Register* on Sept. 9, 2013 (78 Fed. Reg. 54996).

Note: It was the government's failure to have rules on these reports ready in time that led the IRS in Notice 2013-45 to defer these reporting obligations and by extension, to cancel enforcement of the pay-or-play mandate in 2014. The requirement was since suspended for midsize employers (50 to 99 employees) through calendar year 2015. Therefore, it takes effect for large employers (100+ employees) in 2015 and for midsize employees in 2016.

The agency said it was trying to balance: (1) minimizing cost and administration for reporting by entities and individuals; (2) providing individuals with information for their tax returns and for potential eligibility for the premium tax credit; and (3) providing the IRS with information needed for effective and efficient tax administration.

Large employers subject to the employer mandate under Code Section 4980(H) must make an offer of MEC to 95 percent of their full-time workers or face penalties proportional to: (1) the size of their workforce (if no coverage is not offered); or (2) the number of employees who got subsidies and bought coverage on an exchange (if coverage is offered). On Feb. 12, the IRS issued final rules on the employer mandate, which included the one-year delay for midsize employers.

Simplified reporting methods

Under the final rule (for Section 6056 reporting), large employers must report the following:

- its name, address, employer identification number and phone number;
- the number of full-time employees for each month of the calendar year;
- a certification whether it offered its full-time employees (and their dependents) the opportunity to enroll in MEC, by month;
- the name, address and tax ID of each full-time employee who got MEC coverage and the months each one had coverage;
- the share of each employee's salary that would have to go to buy the lowest cost premium for self-only coverage.

The agency said large employers continue to have the obligation of providing pre-enrollment information to employees, including the notice of coverage options and the employee coverage tool, which includes similar questions.

Reporting under Section 6055 is similar to under the other section, but it handles coverage issued by small business health option exchanges, smaller self-funded plans and local government plans.

The final rules do allow sponsors to send in a truncated version of the worker's identification number.

The Section 6056 returns can be made on Form 1094-C (a transmittal) and Form 1095-C (an employee statement), or other forms the IRS may designate.

Employees can get Section 6056 electronically, but they will have to elect to do so specifically. A request for an electronic W-2 form will not suffice.

Section 6056 reporting must be completed on or before Feb. 28 (March 31 if filed electronically) of the year after the calendar year to which it relates. ❖

Administration Allows Restoration of Canceled Policies to Satisfy Individual Mandate

In a memo dated March 5, 2014, the Centers for Medicare and Medicaid Services' Center for Consumer Information and Insurance Oversight told state insurance commissioners that health coverage that would be or had been cancelled because it did not comply with reform coverage minimums could be reinstated and (for a transitional period) will be considered to be "minimum essential coverage" that satisfies the individual mandate.

Small businesses that choose to re-enroll in such coverage will be considered as offering minimum essential coverage. The change is only valid if permitted by the state insurance regulators, and if the insurer reinstates the coverage.

Such restored policies do not need to comply with reform's rules on pre-existing condition exclusions, out-of-pocket spending limits, guaranteed availability and renewability, fair health insurance premiums, provider nondiscrimination and discrimination based on health status. Finally, they need not cover all 10 categories of essential health benefits.

But they must observe health care reform rules on certain provisions, including the ban on annual or lifetime limits of EHBs, the rule extending coverage to dependent children to age 26, the rule banning coverage rescissions and the rules on coverage of preventive care services.

The memo extended the transitional period for reinstated coverage to the end of policy years beginning on or before Oct. 1, 2016 (in other words, into 2017 in many cases). This extends the delay instituted in November 2013. The change is valid only if permitted by the valid state authorities, and if the insurer reinstates a previously canceled policy.

States may choose whether to adopt both the November 2013 transitional policy or the extended transitional policy, or both. States also may adopt the transitional policies for the individual market, small group market or both.

Insurers must use one of two letters provided by CMS to inform policyholders that policies will be re-instituted, which are included in the memo. Small business policyholders that received such policy restoration notices should consider passing the insurer's notice or letter onto affected workers.

This added fuel to the fire for Republican lawmakers opposed to the law, who said the delays are designed to hide how poor the law really is, and to shield Democrats from the political/electoral impacts that would happen if it were implemented as written.

House Energy and Commerce Committee Chairman Fred Upton, R-Mich., said: "The administration cannot run fast enough away from its broken promises. The administration's lack of accountability throughout this law's passage and implementation is cause for alarm. While the president assails Congress for voting to protect all Americans from the disastrous law, the administration has acted dozens of times over the last year to unilaterally delay or change the law because it was not ready for prime time." ❖

HHS Tweaks Transitional Fee Payments For Insurers, Self-funded Plans

In final rules issued March 11, by the U.S. Department of Health and Human Services further described how insurers and self-funded plans will pay health care reform's expensive transitional risk reinsurance fees. While the fees must be paid by self-funded health plans to support insurers in the individual market, self-funded plans cannot draw from the fund. (79 Fed. Reg. 13744.)

The "HHS Notice of Benefit and Payment Parameters" rule was based on proposed rules issued about three months earlier.

Transitional Reinsurance Program

The transitional reinsurance program is controversial because the fee will be assessed against all major medical insurance, including self-insured plans and their third-party administrators. Self-insured health plans must pay into the fund but they cannot draw from it. Meanwhile, only insurers in the individual market — inside and outside the exchanges — can draw payments from it. It was originally $63 per year ($5.25 per month) per participant.

Employers will be allowed to pay the fee in two installments. The first upfront payment, the larger of the two ($52.50 per year per covered life), would be payable soon after the contributing entity submits an enrollment count. The second payment ($10.50 per year per covered life) would be payable during the fourth quarter, about nine months later.

See *Fee Payments*, p. 7

Plan Loses Ability to Invoke Work-related Exclusion By Ignoring Contrary Workers' Comp Opinion

An association health plan's effort to invoke its exclusion for work-related illnesses and injuries was rejected by a federal court, which noted that the plan's determination ran contrary to decisions by a workers' compensation court and its reviewing physician. The plan also tried to argue that the settlement of a workers' compensation claim meant the condition was work-related. However, the court noted that settlement was insufficient when compared with the cost of medical bills and could not have suggested the employee won the claim. The case is *ManorCare of Oklahoma City v. Oklahoma Lumbermen's Association Health Plan,* 2014 WL 288830 (W.D. Okla., Jan. 24, 2014).

The decision underscores the importance of a full and fair review of contrary evidence in internal claims and appeals determinations.

The Facts

Gary Friggeri worked for Chickasa Lumber Co. and was covered by the self-insured Oklahoma Lumbermen's Association Health Plan through his employer.

After being sick with dizziness and headache for more than two months, in July 2011 he had to go to the emergency room. The ER doctor said heat stroke was a possible cause for his condition — noting that Friggeri had no air conditioning at home and worked in a lumber yard — as did a neurologist he saw afterward.

Friggeri filed a workers' compensation claim in Oklahoma Worker's Compensation Court, to determine whether his illness related to his employment. In the WCC process, three separate physicians evaluated his case and while one found his problems were work-related, two (including that of Dr. John Munneke) found they were not.

The WCC concluded that his problems were related to an underlying disease and not heatstroke; nor were they related to his work at the lumberyard. So it denied his claim, but it gave him a $5,000 settlement in return for his promise to release all claims and not appeal its decision.

Friggeri's attorney reported that to the Lumbermen's plan, saying it should pay the claim. But the claims were denied, with the plan taking the position that his injury or illness came from his job. All of Friggeri's internal appeals and reviews were denied. Friggeri assigned his rights to his provider, ManorCare, so it sued the plan, arguing that the denial was improper.

'Slight' Conflict of Interest Seen

The court's opinion, written by District Judge Joe Heaton, used the "arbitrary and capricious" standard of review. However, ManorCare contended that the plan operated under a conflict of interest because it both decided and paid claims.

The court agreed to consider the conflict of interest as a factor in whether the decision was improper. But it called the conflict "slight" because: (1) the plan was run by an association of companies, none of which directly benefited from any savings; and (2) the savings on any denied claim did not inure to the members' benefit but could be used for plan purposes only.

The Plan's Review Process

The plan had a three-step appeals process for denials. The level-one appeal was a review by a qualified person who was uninvolved with the initial denial. The level-two appeal was a review by the association's employee benefits committee. The third level was an external review.

The plan's work-related illnesses/injuries exclusion allowed the plan to reject Friggeri's claim regardless of whether the WCC called it work-related or not. "The Plan Administrator has sole discretion to determine if an Injury or Sickness is Occupational," plan terms stated.

ManorCare argued that: the denial failed to consider the decision of the workers' compensation judge and medical evaluation; it gave improper weight to Friggeri's

See *Contrary Opinion*, p. 8

Fee Payments (continued from p. 6)

A piece of good news for employers is the 2015 annual reinsurance contribution rate drops down to $44 per enrollee; that will be split into a $33 first installment, and an $11 second installment nine months later for the 2015 benefit year. Those amounts would be payable in January 2016 and late in the fourth quarter of 2016.

The rule also excluded employers that self-insure health claims while also self-administering its claim services without a TPA, from making reinsurance contributions for 2015 and 2016.

For more information on health care reform's fees on self-funded plans, consult *The New Health Care Reform Law: What Employers Need to Know*, from Thompson Information Services. ❖

Contrary Opinion (continued from p. 7)

settlement of the workers' compensation claim; and it incorrectly interpreted a medical evaluation that came from the WCC process.

The plan argued that it had substantial evidence in the record to support its decision; and that Friggeri's pursuit, then settlement, of his workers' compensation claim amounted to an admission that his condition was work-related.

The court sided with ManorCare and Friggeri, even though it was a close call, due to the deferential nature of the arbitrary/capricious standard of review.

Disregarding Opinions

The plan's treatment of the opinion of Dr. Munneke (who wrote a medical opinion for the WCC concluding Friggeri's ailment was unrelated to work) was damaging to the plan and led the court to conclude that the plan's denial was improper.

Even though Munneke's opinion was unequivocal that Friggeri had an underlying condition, the plan ignored his opinion. The second-level review mentioned Munneke's opinion, but simply listed it as something on the record. The third-level review was even worse: it characterized Munneke's opinion as saying the exact opposite of what it really said.

> The Letter from John A. Munneke, M.D. and the Medical records from St. Anthony's Hospital make clear that the treatment for which Mr. Friggeri requests payment by the Plan was a work related injury or sickness.

The review nowhere said how it concluded differently from Dr. Munneke, or why his opinion was incorrect.

The plan's continued attestation that it relied on Munneke's letter when in fact it disregarded, ignored then mischaracterized it, was enough to persuade the court to reverse the plan's denial.

The plan *did* have evidence supporting its position. It based its conclusion on the medical records of two hospitals that treated Friggeri.

Settlement Did Not Extinguish All Fires

The plan also took a position that Friggeri's pursuit of payment from, then settlement with, the WCC extinguished all claims that could be brought under the plan.

Heaton agreed that the settlement was broad, but it was clearly there to protect Friggeri's employer (Chickasa Lumber) and its workers' compensation insurer. He said it should not release his health insurer from claims Friggeri might have against it.

Estoppel argument

The plan set out an estoppel argument in its final denial letter, which stated that he was prevented from arguing that his condition was not work-related because of the settlement and receipt of proceeds:

> You sued your employer in the Oklahoma Worker's Compensation Court, you invoked that Court's jurisdiction, you affirmatively asserted that you were injured on the job, and you demanded occupational injury benefits for what you contended was an occupational injury. You successfully settled your lawsuit, and received and accepted proceeds for your occupational injury claim from your Worker's Compensation carrier.
>
> You are estopped from taking a contrary position, and from seeking non-occupational injury benefits for the same injury for which you demanded, received and accepted compensation from your occupational injury carrier.

The court analyzed whether "judicial" estoppel should be involved. But the court said judicial estoppel is meant only to protect the integrity of courts by prohibiting parties from arguing one position (when that profits them), then switching arguments to gain (or get protection) a second time.

For estoppel to operate, three factors must be met: (1) a party's later position must be clearly inconsistent with its earlier position; (2) the party must have succeeded in persuading a court to accept that part's earlier position so that judicial acceptance of an inconsistent position in a later proceeding would create the perception that either the first or the second court was misled; and (3) the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped.

Regarding those factors, the court noted that the WCC court would have had to *accept* Friggeri's initial position for judicial estoppel to operate. While Friggeri did argue two different positions (meeting factor 1), he *lost* his case while at the WCC court (not meeting factor 2).

The court also rejected the plan's argument that Friggeri acted unreasonably or was unfairly benefited by his change of position, because there was no other way for Friggeri to find out whether his condition was work-related than to go from one venue to the next. Oklahoma has no consolidated forum for answering that question.

Admittedly, the settlement complicated the picture: It was $5,000 — not a tiny amount, and yet still not nearly enough to cover all his expenses.

See *Contrary Opinion*, p. 9

ERISA Preempts Ga. Prompt-pay Law's Application To Self-funded Plans, Appeals Court Rules

An appeals court sided with a national trade group representing insurers performing plans' administrative services in blocking the application of Georgia's prompt-pay statute to self-funded health plans. The 11th U.S. Circuit Court of Appeals said the state's prompt-pay law — specifically amended to include self-insured plans and their TPAs — was preempted because it related to ERISA plans and interfered with national administration of health benefits. The case is *AHIP v. Hudgens*, 2014 WL 563604 (11th Cir., Feb. 14, 2014).

Facts

In May 2011, Georgia amended its prompt pay law to cover self-funded health plans and their third-party administrators. Under the original law, enacted in 1999, "insurers" were subject to interest charges and fines if they fail to pay health claims within 15 days (or explain why the claim was denied).

The Insurance Delivery Enhancement Act of 2011 expanded the law to include self-funded plans and TPAs. The amendment expanded the definition of: (1) TPA to bring those entities under the law; and (2) insurer to include ERISA self-insured health plans. It also removed a clause from the original law exempting self-funded plans from the law's application.

The reason for the expansion was between 1999 and 2011, there had been significant erosion in the number of plans subject to state regulation due to increasing number of employers choosing self-funding, the court opinion noted.

America's Health Insurance Plans is a trade group representing large insurers that also perform third-party and administrative-only services for self-funded ERISA plans. In September 2012, AHIP sued to invalidate those portions of the prompt-pay amendment, arguing they were preempted by ERISA. It also moved to stay enforcement of the challenged provisions. A month later, Insurance Commissioner Ralph Hudgens filed a motion to dismiss the AHIP's complaint.

On Dec. 31, 2012 (one day before the amendments' effective date), a federal district court in Georgia found that ERISA's Section 514 preempted the amendment, so it enjoined enforcement of the affected portions of the amendment. It said AHIP members would have been trapped between having to pay costs they should not have to pay to comply the prompt-pay law or pay penalties to the state. The commissioner appealed to the 11th Circuit.

The Appeals Court Ruling

The commissioner questioned AHIP's standing to file a claim for relief, alleging the group failed to demonstrate real injuries to its members. AHIP had no evidence other

See *Prompt-pay Law*, p. 10

Contrary Opinion (continued from p. 8)

But the court held that Friggeri's conduct was rational and not profit-seeking. He did not have a clear diagnosis, and so it was unclear to him whether his illness was heatstroke from his work, or an underlying condition.

The fact that he first pursued his claim saying that his condition was work-related was no doubt some evidence that it was work-related.

But because a layman is unable to discern his own diagnosis the court gave minimal weight to that evidence, and said it was an insufficient reason for the denial. It ruled that Friggeri and ManorCare were entitled to payment from the plan.

Lessons Learned

Health plans must be careful not to exhibit hubris when handling participants' appeals of adverse bene-fit determinations. Courts historically give plans due regard when plan terms are appropriate, consistently followed, and provide a full and fair review to claims appeals.

But when the plan fails in any of these areas, the courts can become fickle. In order to provide a full and fair review and avoid court reversals, health plans must review the available evidence and be sure to give it proper consideration.

Failure to review evidence, disregarding opposing opinions, or outright misstating their meanings are sure-fire ways to give courts ammunition they need to reverse a plan's decision.

This danger is even more present when a plan is determined to have a conflict of interest.

Plans should review all the evidence and address it reasonably even when they have discretionary authority. This is the most successful strategy and gives plans the best opportunity to retain control over benefits decisions. ❖

Prompt-pay Law (continued from p. 9)

than a declaration from its executive vice president, the commissioner complained. But the appeals court decided that the executive's declaration and the commissioner's intent to enforce the prompt-pay statute were enough to find that injury to AHIP members was imminent.

Hudgen's arguments that the challenge was barred by the tax anti-injunction act failed, because the provision was a regulation, and not a revenue raising measure, the appeals court said.

The appeals court then reviewed the district court's grant of injunction based on the conclusion that the amendment was preempted by ERISA.

A grant of injunction can occur only if: (1) the moving party has a substantial likelihood of success on the merits; (2) irreparable injury will result without the injunction; (3) the injury of the moving party clearly outweighs the damage to the other party; and (4) the injunction would not be harmful to the public interest. The commissioner's arguments focused on the first prong only, so the appeals court centered its ruling on a discussion of ERISA preemption.

Establishing the substantial likelihood of success, the court decided that ERISA preempted the challenged provisions because the provision impermissibly "related to" ERISA plans. Requiring ERISA plans to process and pay claims and issue claims-denials within state-mandated timeframes related closely to the plans, and the court rejected the commissioner's idea that the amendment was merely "procedural."

The timelines "[flew] in the face" of allowing employers to use a uniform administrative scheme and a set of standard procedures for claims processing and benefits payments.

> If these provisions were to go into effect, employers offering self-funded health benefit plans would be faced with different timeliness obligations in different states, thereby frustrating Congress's intent.

Hudgens argued that the provisions "could have no connection" to plans because it regulated not plans, but non-fiduciary TPAs and providers, so it should not be preempted. The court rejected that, holding that it was irrelevant that the law targeted non-fiduciaries when its impact was to interfere with core ERISA concerns like uniform national administration of plans. In any event, the amendment specifically referenced self-funded plans, by including them in the definition of "insurer." The text of the amendments evinced a clear intent to reach self-funded health plans, without regard to the specific entity processing the claim. It also noted the amendment's deletion of the exemption of self-funded plans.

Court Skirts Savings Clause Determination

The commissioner argued that the "savings clause" operated and saved the state law from preemption. However, the court ultimately found this argument moot because it decided that ERISA's "deemer clause" was invoked. This clause prevents self-funded plans from being deemed to be insurers and prevents them from being regulated as an insurer would be under state law.

Based on this, the court said the law should be preempted, and AHIP was likely to succeed on the merits of its case.

Injunction Upheld

The appeals court held that other factors supported the injunction. Hudgens had challenged that irreparable harm would result, while AHIP listed increased employee time, changing claims processing systems, monitoring compliance, and preparing quarterly reports as costs that constituted just that kind of harm.

The court agreed with AHIP and the district court that these did constitute harm that justified an injunction preventing Georgia from enforcing the law against self-funded health plans in the state. It concluded, saying the amendment was:

> … an impermissible encroachment upon federal law. When, as here, a state law relates to certain areas that Congress has explicitly determined are off limits, we must recognize that federal law prevails.

Implications

Despite a holding in support of ERISA preemption, this case illustrates a problem that will become more pervasive as health care reform becomes a reality for employers.

State regulators, fearful that self-funding may create adverse selection in the state health insurance exchanges, continue to seek methods to puncture the shield provided by ERISA's preemptive powers. Like in Georgia, states have tried to impose burdens and taxes on self-funded plans, and the TPAs that administer them.

Self-funding provides relief from burdens states impose on insurers for political reasons, such as pleasing the provider lobby or promoting health care reform. By trying to impose taxes, passing laws limiting stop-loss insurance, or raising fears about the effectiveness of self-funding, state and federal regulators appear to show that they favor less self-funding. Thanks to ERISA preemption, these attacks will likely continue to fail unless Congress decides to tinker with ERISA's preemption scheme. ❖

Plan's Time Limit on Lawsuits Holds Sway Over Longer State Limitations Period

A federal district court in Missouri granted summary judgment to an ERISA health plan trying to uphold its clause invalidating lawsuits for ERISA benefits if they come more than two years after the plan concludes its final internal appeal.

In *Kienstra v. Carpenters' Health and Welfare Trust Fund of St. Louis*, 2014 WL 562557 (E.D. Mo., Feb. 13, 2014), the court found that the plan's limit on lawsuits was not "unreasonably short" and the plan properly communicated it to Debra Munro-Kienstra in its letter notifying her that her internal appeal had been denied.

The court's ruling, which rejected Kienstra's argument that a 10-year limitations period under state law applied, rested on a December 2013 U.S. Supreme Court decision holding that reasonable plan-imposed statutes of limitations on legal claims for benefits written into benefits contracts (including ERISA plan documents) are enforceable.

The Facts

Kienstra was denied benefits in 2007 and she appealed internally with the plan, but in July 2009, the plan's appeals committee upheld its denial, saying her procedure was experimental or investigational. She waited until January 2012 — nearly two and one-half years after the plan's appeal decision — to file a lawsuit to recover ERISA benefits. But the plan would contend that she had surpassed the plan's two-year contractual statute of limitations.

Under the heading "How to Appeal a Denied Claim," the plan document gave participants two years from a final plan denial to file any civil action under ERISA Section 502(a)(1)(b). (**Note:** That section gives participants and beneficiaries (and plans) the right to: (1) recover benefits due; (2) enforce rights; or (3) clarify rights to future benefits, under plan terms.)

Statutes of Limitation and ERISA

ERISA generally doesn't have a statute of limitations period for filing suit in most situations except for fiduciary breaches. As a result, courts reviewing ERISA claims tend to use the most analogous state law when defining limitations periods.

ERISA plans often use state laws as a guide when crafting their own limitations period language and add it to the official plan document. But the courts were split on whether plans limit that chose a different limit would override the statutory time limit.

But the Supreme Court decision in *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S. Ct. 604 (Dec. 16, 2013), changed that. It held that a plan's contractual limitations provision is enforceable, provided it is not "unreasonably short" and does not conflict with a "controlling" statute.

Under *Heimeshoff,* contracting parties may provide for limits that are shorter than the statutory period, and the parties may select the date on which the contractual time limit begins to run.

The court in *Heimeshoff* said such limits are "especially appropriate when enforcing an ERISA plan" because ERISA gives employers "large leeway to design [plans] as they see fit."

The Court Weighs In

Kienstra asked the court to borrow a general 10-year statute of limitations under Missouri law. The court said it could not do that, because the ERISA plans' limit overrode the state's time limit.

It moved on to *Heimeshoff*'s dual questions of whether the period was too short or whether it conflicted with a controlling statute.

It noted that in *Heimeshoff*, the ERISA plan had a three-year limit, and Hartford hadn't completed its internal appeal for two of those three years. In spite of that, an effective one-year period was not considered unreasonable.

In this case, the final denial was issued in July 2009 and Kienstra filed suit two and one-half years later, in 2012. That left plenty of time to file suit, the court said.

As to the "controlling statute" question, Kienstra never pointed to any statutory provision prohibiting a plan from contractually reducing the statute of limitations.

The court also checked to see whether the plan did anything to cause Kienstra to miss her deadline, such as failing to provide a copy of its policy regarding time limits. But the denial letter described how to bring a civil action under ERISA, including the plan's limitations on that right. So, the plan did not conceal information, nor did its conduct cause Kienstra to miss her deadline for filing a lawsuit.

As a result, the plan's limit prevailed, and summary judgment favoring the plan was ordered.

See *Limitations*, p. 12

Notre Dame University Denied Contraception Injunction in 7th Circuit Ruling

The 7th Circuit in a 2-1 ruling refused to grant a preliminary injunction to Notre Dame University, a Catholic institution, that would have freed it from participating in reform's requirement to provide contraceptives at no cost to all women.

In so doing the court criticized the university's argument that signing an EBSA Form 700 — expressing objections to the contraceptive mandate and announcing that its third-party administrator and insurer would cover contraceptives — was a form of "enabling" and "triggering" contraceptive coverage it objected to (*Univ. of Notre Dame v. Sebelius*, 2014 WL 687134 (7th Cir., Feb. 21, 2014)).

Background

Notre Dame never covered contraceptives, either through the plan that it self-insures or through the insured plan it offers employees.

In 2012, Notre Dame sued the federal government, claiming that the contraceptive mandate infringed its rights under the First Amendment and the Religious Freedom Restoration Act. Since then, the government broadened the exception for organizations with religious objections to providing such coverage, but allowed them to opt out if they objected in a government form, which had a due date of Jan. 1, 2014. But because Notre Dame waited so long to file suit, it was unable to get an injunction before the end of the year. So, on Dec. 31, it submitted the EBSA Form 700 to ensure compliance with the reform law.

The Decision

In its lawsuit against the government, Notre Dame sought the preliminary injunction, which a federal district court denied. The appeals court said discovery had not been completed by the district court, so it limited its inquiry to whether the district judge abused his discretion in refusing to grant the injunction. "With the evidentiary record virtually a blank, everything we say in the opinion about the merits of Notre Dame's claim is necessarily tentative, and should not be considered a forecast" of the ultimate resolution, the ruling written by Circuit Judge Richard Posner said.

Posner said the court was bemused about the kind of relief the university was seeking. It had filled out the required government form — telling concerned parties it objected and wouldn't pay — so it already exempted itself from the regulation.

It would have been logical for the university to ask for an order forbidding its third-party administrator (Meritain) and the insurer of an alternative insured plan it offered (Aetna) from providing any contraceptive coverage to Notre Dame staff or students pending a final district court ruling. But Notre Dame failed to add either Meritain or Aetna as a defendant, so that was unattainable. If Notre Dame objected to the complicity involved in filling out the EBSA Form 700, it should have filed suit earlier, and it might have received a stay.

But the problem with a preliminary injunction is that Notre Dame failed to demonstrate that the accommodation imposed a "substantial burden" on it. The university failed to demonstrate a substantial burden: (1) the form is short and easy to fill out; (2) under the accommodation, federal law and not the university orders the TPA/insurer to deliver contraceptives; and (3) the federal government or the insurer, not the university, pays for the drugs. ❖

Limitations (continued from p. 11)

Lessons Learned

The court provides some guidance on what can be considered a reasonable plan-imposed time limit after which a plan participant can no longer sue for ERISA benefits. The court relied on the standard set in *Heimeshoff,* where the plan participant had a three-year limit to bring action, but the plan exhausted two of those years conducting its internal appeal. Even under those circumstances, the court held that allowing the plan participant one-third of the allotted period was reasonable. Here, the court had no trouble finding that two and a one-half years was reasonable.

This decision reminds plans that the key to success in these situations is compliance with plan terms. Plans must keep in mind the plan's time limit and ensure compliance with those limitations while still allowing the plan participant sufficient time to take action. Undue delays or compliance errors can bring time limits to the realm of unreasonable, and plans must ensure compliance with these standards to receive ERISA's protection. ❖

Attorneys Explain Key Tasks to Help Employers Comply with Pay-or-play Mandate

The latest delay to the employer mandate gave mid-size employers an extra year to get ready for the employer mandate but for employers with more than 100 workers, the clock is really ticking now on complying with new duties required under the health care reform law. The most salient of these are: determining one's own "applicable large employer" status; determining the number of full-time equivalents; identifying those workers who are full-time and who get an offer of insurance; setting up reporting mechanisms; and assessing whether coverage is good enough to avoid triggering penalties.

What Big Tasks Are Left Over?

On Feb. 25, two attorneys from the Washington, D.C. law firm Epstein Becker Green told teleconference attendees about the biggest compliance steps employers have to take.

Section 6055/6056 reporting regulations

Employers that are subject to the employer mandate will be required to report information about their coverage. The requisition includes: data on all covered lives; time periods they were covered; the employer's share in paying for the coverage; information on coverage offered; and the lengths of waiting periods before offers of coverage are made.

Most companies are concerned about their ability to collect the information, but also about the IT systems and the interfaces they will need to report the information to IRS, attorney Adam Solander said. Information reported will help to determine whether: (1) an individual in a health insurance exchange got a subsidy for purposes of the individual mandate; and (2) companies will be liable for penalties. The IRS released proposed regulations in September 2013. Final regulations are due sometime early in 2014.

Note: Employers will also have to be ready and know what to do when they get reports from health insurance exchanges pertaining to individuals who enrolled in exchange coverage and received a premium credit, Solander said. For more on the reporting and disclosure requirements, go to Section 630 of *The New Health Care Reform Law: What Employers Need to Know.*

Determining the value of coverage

If a large employer offers coverage to the required 95 percent of full-time employees, but the coverage does not provide minimum value, then it may still nonetheless be subject to a penalty. The IRS issued proposed regulations on determining minimum value of employer-sponsored plans in May 2013. Final regulations are expected to come out soon. There are several methods one can use: (1) the MV Calculator CMS developed; but plans also may (2) seek certification by an actuary who is a member of the American Academy of Actuaries. Also, plans in the small group market that meet any of the "metal levels" of coverage based on the MV Calculator will be considered as meeting MV requirements.

Employers may not use wellness incentives for purposes of calculating affordability or minimum value, *except for tobacco cessation programs*. Employers should contact regulators and suggest a broadening of this: if they could include amounts spent on wellness programs, such programs would appear more often, improving the health of employees and reducing the cost of employer-sponsored plans, Solander said.

The proposed rules also would provide that:

1) All amounts contributed by an employer for the current plan year to a health savings account would be considered in determining the plan's share of costs and would be treated as amounts available for first-dollar coverage.

2) Amounts newly made available under an health reimbursement arrangement integrated with an eligible health plan for the current plan year count for MV purposes if: (a) the amounts may be used only for cost-sharing and to pay premiums; or (b) the employee may use the amounts only for premiums and not for cost-sharing. This prevents double counting the HRA amounts.

Observing the 90-day waiting period rule

The Affordable Care Act prohibits group health plans from applying waiting periods that exceed 90 days. A proposed rule issued in March 2013 may be relied upon at least through the end of 2014. A final rule was just issued, saying waiting periods longer than 90 days are not allowed, unless an employer falls under one of several safe harbors, including: extra time during which the employer determines whether a worker is eligible for an offer of insurance or not. Examples include periods during which a worker's full-time status is not yet certain; "orientation periods"; "rehired employees" and "meeting cumulative service requirements." Here are some highlights of what the two attorneys told attendees.

See *Key Tasks*, p. 15

Featured Columnist (continued from p. 2)

Become a Fiduciary

When you are a true fiduciary, you control how your claim dollars should be spent, how much to spend, when to spend it and who gets it. If you just buy an off-the-shelf administrative product from a massive insurer, none of these decisions are yours and you are not a true fiduciary. This is what many employers want, especially those that are self-funded for the first time. I can understand the theory that one might want to get one's feet wet first before swimming a long distance. But while the lack of control over how plan dollars are spent may work for the first year, it might also result in the plan's last year of self-funding.

A truly self-funded employer/plan sponsor should serve as the plan administrator and the named fiduciary. This means the plan administrator has discretionary authority and control over plan management and sole discretionary authority and responsibility for plan administration. The plan sponsor agrees that it will resolve all plan ambiguities and disputes relating to the eligibility of a plan participant and beneficiary, coverage, denial of claims or any other plan interpretation questions.

Understand the Limits of Your TPA

I have worked on many lawsuits where self-funded employers with years of experience honestly believe that their TPAs are supposed to make all claim decisions, even though the administrative service agreement and the plan document explicitly state that the employer is to do that. If you are unsure about whether you're supposed to serve as a plan fiduciary, read your agreements!

Problems arise when self-funded employers assume that the TPA or ASO will handle certain advisory and/or fiduciary things for them as part of their administrative fees. Remember that the TPA is not deemed to be a legal or tax advisor as a result of the performance of its duties and makes no representation on federal or state laws applicable to the plan. The plan sponsor must seek its own counsel for legal advice and guidance.

Sadly, don't be misinformed on this aspect of your relationship. Your administrator will not make your claim decisions unless it is explicitly paid to do so, and it will never offer you legal opinions, as it does not want to be held liable. In all legal situations, you will want to obtain the services of a law firm or consultant to assist with complex legal or claim issues.

Set Out Roles in the Plan Document

Therefore, when contracting with a TPA, you must negotiate the ASA terms and decide whether you intend to be deemed a "fiduciary" for the plan within the meaning of ERISA, and have discretionary authority and final determinative capability with regard to benefit determinations. If you decide to take on the challenge, as I suggested above that you do, codify it in your plan document.

The plan document is the instrument that sets forth and governs the duties of the plan sponsor and plan eligibility and benefit provisions, which provide for the payment or reimbursement of covered services.

> **Note:** The term "plan document" includes the summary plan description. The SPD must be provided to plan participants under Section 102 of ERISA. It describes the terms and conditions under which the plan operates. A self-funded plan working with a TPA can not only craft plan benefits that comply with health care reform, but also meet the needs of the employer's workforce cost-effectively.

As I like to say, plenty of lawyers can get you a compliant plan document, but only a handful can also ensure the right cost-containment features are included.

Avoid Picking TPAs on Price Alone

As they contract with a TPA, innovative plans also will carefully consider their selection. Choosing one based on price alone may enjoy lower upfront administrative costs, but actual claim costs will probably be much higher than they would be with a higher-quality administrator. So don't go with the cheapest options; go with the best.

A cheap administrator could spell the difference between spending $100,000 on a particular claim, or $30,000. Do you think that the small increase in the monthly administrative fee will cover the difference in your payment amount on this claim? I don't think so.

The problem is blind payments for "discounted" services. Too many plan administrators, TPAs, employers and brokers focus all their energy on the discount amount when the real question should be on the plan's net claim costs:

> **Example:** You are told that you get a 25-percent discount if you pay the claim within 30 days and that it's a great discount, much better than any discount any other administrator could give you. Great, that may very well be true, but are you getting a 25-percent discount on a $100,000 bill and thus paying $75,000? Another administrator might take that same bill, identify overcharges, audit the claim for clinical issues and then get the claim re-priced and paid without any discount for $40,000. You end up paying $35,000 less even though the second administrator got you no so-called discount.

See *Featured Columnist*, p. 15

Key Tasks (continued from p. 13)

Counting Employees

Counting employees is very important for an employer: (1) to determine whether it is an applicable large employer; then (2) to pinpoint the full-time workers (defined as working 30 or more hours per week) to whom an offer of coverage must be made.

The tally of *full-time equivalents* (based on the combined hours of part-timers and full-timers) is relevant only for purposes of determining ALE status.

Penalties are based only on *full-time employees.*

Solander said: "You'll never get a penalty under the employer mandate for not offering coverage to a part-time employee." After it is determined a worker is full-time, then an offer of coverage has to be made 90 days.

Here are some basic indicators that an employer expects a worker will be full-time:

1) The worker is replacing a full-time employee.
2) The job was advertised as requiring 30 or more hours per week. If the job description says one thing and the result is different, trouble could result, Solander said.

Employers just starting business

An employer that was not in existence throughout the prior calendar year will make a determination of whether it is an ALE based on the average number of employees it reasonably expects to employ in its first year of existence. The employer must assiduously document the logic going into its estimate. To qualify, the employer must not have been in existence even one day in the prior calendar year.

Seasonal workers

If an employer uses seasonal workers, it might not be considered an ALE because of safe harbors to the mandate. To be eligible: (1) the company must employ 50 or fewer FTEs for 120 days or more; and (2) the period (**Note:** this must be fewer than 120 days) during which the employer used in excess of 50 employees was due completely to the influx of seasonal workers.

Independent contractors

EBG attorney Frank Morris noted that misclassifications of full-time workers as independent contractors could subject employers to employer mandate penalties.

To avoid this, employers ought to review the duties of people currently treated as contractors, asking: Do they really meet the IRS and U.S. Labor Department tests for independent contractors? If an employer is investigated by tax or employment authorities on misclassification, the revelations could easily turn into a health care reform compliance problem, Morris said.

Monthly measurement method

An employee can be counted as full-time if he or she provided 130 hours of service for a month (including vacation hours, sick hours, etc.). Employers using a monthly counting method can use 120 hours as a measure of full-time status in months with four weeks, and

See *Key Tasks*, p. 16

Featured Columnist (continued from p. 14)

Ride the wellness wave

For those crazy employers that really want to get on the wild side, the future craze is in customized wellness and healthy lifestyle initiatives. You have the ability to design, implement, monitor, and measure results for coordinated initiatives that can reduce plan costs and increase workplace productivity. You're better off doing this yourself rather than with an off-the-shelf product.

Get focused on claims processes

A great example of cost-containment by a super self-funded entity is high involvement in the selection of its utilization management team. This team handles the review and evaluation of medical necessity and appropriateness of the health care services, procedures and facilities used by a plan member.

Again, this is an area where most employers drop the ball. Imagine never approving the work that is about to be done by the contractor you hired for your home. You never actually reviewed the agreements or the work orders and instead you just sign checks whenever he asks for payment. You would never allow this to happen for $10,000 of work being done in your kitchen, yet a majority of plan sponsors do exactly that, even though they will be spending millions on health care claims. It is mind-boggling to me even though it's the reality when it comes to the health insurance industry.

Conclusion

I hope this article emphasizes that you as the employer must first decide the type of self-funded plan you want to be. There are many options available, but the fact is that the more involved the plan sponsor is, the better the chance of success for the long run. The decision is yours, not your broker's and not your administrator's. So make it carefully. ❖

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-7. 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 "21:7/2" indicates Vol. 21, No. 7, page 2.

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Index of Court Cases

Key Tasks (continued from p. 15)

in calendar months with five weeks, an employee with at least 150 hours of service is a full-time employee.

Look-back measurement method

An employer may apply different look-back periods for certain categories of employees. One example is workers under collective bargaining agreements versus those who are not. Another example is people who are hourly versus people who are not hourly.

But when using different measurement techniques, the employer must have a good rationale to defend the choice they made. The reasons for the decision must be well-documented, created at the same time as the measurement period started and not trumped up after the fact when you're asked about it. Employers must treat similarly situated employees the same, Morris said.

ERISA discrimination

Attempts to gerrymander calculations with regard who is an employee and who is entitled to coverage under the employer plan could lead not only to accusations under the health care reform law, but also to claims the employer tried to interfere with attainment of an ERISA right, Morris said. ❖