Employer's Guide to
Self-Insuring Health Benefits

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Contraceptive Mandate Insecure Based on Supreme Court Questions

Questioning from the conservative majority of U.S. Supreme Court Justices appeared to undermine health care reform's contraceptive mandate and support religious for-profit employers' position that they should not be required to pay for contraceptives through their health plans, as the law requires.

The U.S. Supreme Court on March 25 heard oral arguments in two cases challenging the federal government's authority to compel for-profit employers to provide contraceptive prescription coverage to their employees under the health care reform law.

The cases are *HHS v. Hobby Lobby* (No. 13354) and *Conestoga Wood Specialties v. Sebelius* (No. 13354). Lawyers for the employers said the law is interfering with their rights under the First Amendment and the Religious Freedom Restoration Act.

Background

Conestoga Wood Specialties of East Earl, Pa., and Hobby Lobby of Oklahoma City separately sued the federal government in 2012 over health care

See *Oral Arguments*, p. 9

Choose Wise Definitions to Perfect The Well-managed Self-funded Plan

By Adam Russo

The best way to ensure that your self-funded health plan is running efficiently is with strong definitions of key plan document terms. Forward-looking definitions can stop problems before they turn into major plan costs, and the right definitions make the difference between getting taken for a ride and keeping your hands on the steering wheel.

These definitions will not only save you time in processing claims, they will ensure that plan claims are being paid in accordance with the plan sponsor's wishes. In this column we will explain: clear assignment-of-benefit language; the right approaches to maximum payable amounts; and how to define a clean claim. Strong plan rights are rooted in language that has thorough explanations to cover more contingencies.

Ambiguous Definitions Will Hurt You

First, we assume that you have signed an administrative service agreement and decided to keep all fiduciary responsibility for the plan under your belt.

Unclear or ambiguous definitions in the plan document are the leading cause of claim processing errors and lawsuits. I could actually make a living

See *CE Column*, p. 2

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Adam V. Russo, Esq.
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CE Column (continued from p. 1)

doing nothing but litigating problems caused by unclear plan document definitions. Some provisions have five different interpretations. My attorneys and I disagree on what specific provisions mean all the time.

This leads to claims being processed differently by claims examiners, depending on the way they interpret the language. This can lead to discrimination lawsuits when the same types of claims are handled differently by various claim adjusters.

Clear, Concise Definitions

Think about it: you are the plan and the plan document is basically an instructional guide to the administrator telling them how to spend your money. You have a fiduciary duty to be prudent with plan assets and the right starting point is to ensure that everyone is on the same page when it comes to definitions.

Therefore your definitions must be clear and understood. The plan document should be a clear and concise guide on how money should be spent. Following are the most important definitions to focus on.

Reining in Providers: Assignment of Benefits

For plans and third-party administrators that either create a reference-based pricing model or want better options to fight against hospital and provider overcharges, it is vital to have a detailed definition for assignments of benefits. It means an arrangement by which the patient assigns his or her right to a provider to seek and receive payment of eligible plan benefits in strict accordance with plan document terms. If a provider accepts the arrangement, then its rights to receive benefits are equal to those of a plan participant, and are limited by plan document terms. A provider that accepts this arrangement indicates acceptance of an AOB as consideration in full for services, supplies and treatment rendered.

This definition arms the plan with a much better arsenal when attempting to reduce costs. *The ability to rescind the AOB* is crucial in any claim negotiation because if the AOB gets rescinded, the provider must return plan funds to the plan. Those funds would then be turned over to the patient, so the provider has the joy of dealing directly with the patient on any outstanding claim issues. Trust me, any medical facility would be crazy to allow a plan member to receive a check for $50,000 and then expect that he or she will just gladly send the funds to the facility. The risk that the member would use the funds to buy a new boat is just too big of a risk for the facility to turn that money over. The plan is in a much better bargaining position that way, so asserting that right in plan language and in the explanations of benefits is vital.

Definitions Relating to Fair Pricing

Provider pricing follows its own logic. There's new patient versus established patient, there's negotiated price versus non-negotiated price; there's Medicare (and the dreaded Medicaid) price versus the price on the provider's own fee list. Physicians bill based on their *own* assessment of the case's complexity. Hospitals seem to live in an alternative reality where items like an aspirin pill or a single serving of mouthwash can cost the same as a fine dining experience. Add to this the fact that providers don't like to talk about their prices, and plans and patients can be in for unpleasant surprises when bills turn up.

Maximum Allowable Charge

Understanding and explaining this is important. It should be defined as the benefit payable for a specific plan benefit that is the lesser of: (1) the usual and customary amount; (2) the allowable charge specified by the plan; (3) the negotiated rate established in a contractual arrangement with a provider; or (4) the actual billed charges for the covered services (as if *that* would ever be the lowest amount!).

As usual, the plan must have the discretionary authority to decide if a charge is U&C (and for a medically necessary and reasonable service).

See *CE Column*, p. 10

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THOMPSON INFORMATION SERVICES

Health Care Reform Briefs

White House Office of Management and Budget Director Sylvia Matthews Burwell was nominated to take over as Secretary of the U.S. Department of Health and Human Services in the wake of Kathleen Sebelius' resignation on April 11. Promoting a budget expert to this position was seen as a good choice for interpreting metrics relating to success or failure of the law. Health care reform could lower the cost of workers' compensation and liability coverage, while possibly raising medical malpractice premiums, a research study found. Nearly 8 million people signed up for health coverage on state and federal exchanges, the government announced, as open enrollment on the exchanges ended definitively on April 15. The RAND Corp. released findings that the share of the population that is uninsured dropped from 20.5 percent before health care reform, to 15.8 percent since the law's enactment. And pharmacy benefit manager Express Scripts released data showing more use of specialty drugs by people who bought coverage on public exchanges, as opposed to commercial health plans.

OMB Director Nominated as Replacement Sebelius Resigns HHS Secretary Post

White House OMB Director Sylvia Matthews Burwell was nominated to take over as HHS Secretary in the wake of the resignation of Kathleen Sebelius on April 11. Promoting a budget expert to this position was seen as a good choice for interpreting metrics relating to success or failure of the law, including whether: it increases or slows the growth of premiums; a new round of cancelled policies might occur in the next year; new subsidies under the program will be a drag on the federal budget; and the program will hinder job growth or hurt employers' ability to compete. She will have to be confirmed by the U.S. Senate.

Likewise, reports predicted that Burwell's confirmation hearings are likely to be more about the health care reform law than about the nominee. Republicans will likely use the Burwell hearings to spotlight problems with the reform law, including canceled policies, higher premiums and the administration's unilateral delays of some provisions, including the employer mandate, which was delayed twice.

Sebelius entered a firestorm of GOP criticism after implementing the health care reform law, and trying to defend the program after its embarrassing website rollout in late 2013.

Accepting her resignation, President Obama said in spite of the difficulties, Sebelius had successfully improved the health care situation in the United States. Obama gave Sebelius credit for keeping the growth in health care costs under control, for helping to promote digital health records and for combatting Medicare fraud and abuse.

On April 17, Obama announced that 8 million Americans have signed up for private health coverage on exchange websites set up under health care reform. He said 35 percent of those who signed up were younger than 35 years old, an important thing for the administration to emphasize because young inexpensive lives are seen as essential to keeping exchange health premiums affordable. Sebelius on April 10 told the Senate Finance Committee that 7.5 million people had enrolled, in hearings about the agency's 2015 budget request.

RAND: ACA Could Reduce Cost of Some Insurance Lines due to Substitution Effect

The Affordable Care Act will have contrasting effects on lines of insurance other than health, such as auto, workers' compensation and medical malpractice, the RAND Corp. found in a new study. The amount of claims formerly assigned to auto and workers' compensation insurers might decrease as health insurance treats more problems and more people have health insurance who lacked it before.

Patients might use liability insurance less often for treatment of health problems that health insurance would otherwise treat. The same goes for workers' compensation,

See *Reform Roundup*, p. 4

CMS Clarifies Coverage of Same-gender Spouses

New health care reform guidance released by The Centers for Medicare and Medicaid Services clarifies that same- and opposite-gender spouses must be treated the same when offered health coverage by group or individual health insurers. The guidance clarifies earlier reform rules to ensure health benefits are available to same-gender spouses.

CMS' guidance indicates that a health insurer must offer the same coverage to both same- and opposite-gender spouses, without discrimination. The guidance also provides that coverage for same-gender spouses will use the "state-of-celebration" rule for its guidelines, regardless of the rules in place in the state where the insurance policy is held, or where the individuals reside. It builds on final rules issued Feb. 27, 2013 (78 Fed. Reg. 13406), which require certain standards for health insurance, such as fair coverage and premiums.

The guidance further clarifies that insurance companies are not being required to cover same-gender spouses; however, the option of such coverage must be given to employers. CMS recognized that some confusion may have existed related to this information under the final rules, which may have been reflected in plan designs for 2014. Therefore, plans are encouraged to comply now with the guidance relating to nondiscrimination of same-gender spouses.

The March 14, 2014, guidance emphasizes that discriminatory plan designs that do not offer such an option would be deemed as noncompliant with the guaranteed availability requirements, and further clarifies steps that should be implemented under final rules.

Enforcement will start for plan years beginning on or after Jan. 1, 2015. ❖

Reform Roundup (continued from p. 3)

but the trend to watch involves whether increased utilization fostered by the ACA drives up the cost of medical treatment. On the other hand, insured individuals will have more contacts with physicians, and receive more procedures, so the number of medical malpractice claims could increase, driving up the cost of malpractice insurance, RAND researchers found.

The overall impacts are likely to be small (that is, a few percentage points) in the short run and likely to vary across states. Other impacts include: new payment models and health care organizational structures; more subrogation against liability awards; and more preventive care and possibly better health across the population, RAND concluded.

Another RAND study estimated that 9.3 million people gained insurance as a result of the law. Most of this increase, the researchers found, came from new Medicaid beneficiaries and enrollment in employer plans. Although a total of 3.9 million people enrolled in marketplace plans, only 1.4 million of these individuals were previously uninsured. Of the 40.7 million who were uninsured in 2013, 14.5 million gained coverage, but 5.2 million of the insured lost coverage, for a net gain in coverage of approximately 9.3 million. The share of the population that is uninsured fell from 20.5 percent before the law to 15.8 percent now that the first year of the program's open enrollment has ended.

Express Scripts: ACA Expands Utilization of Specialty Drugs

Pharmacy benefit manager Express Scripts released data showing increased use of specialty medication by people who purchased insurance plans on public exchanges (contrasted with regular health plan usage) through February 2014.

The phenomenon is easy to explain: the first enrollees were people who were sicker than the general public and flocked to get subsidized prices on expensive drugs: including drugs that fight the AIDS virus, specialty drugs to treat multiple sclerosis or rheumatoid arthritis. Contraceptives were prescribed less for people on exchange plans. Key findings from the report stated:

- More than six in every 1,000 prescriptions in the exchange plans were for a medication to treat HIV. This proportion is nearly four times higher than commercial health plan rates.
- The proportion of pain medication was 35 percent higher in exchange plans.
- The proportion of anti-seizure medications was 27 percent higher in exchange plans.
- The proportion of antidepressants was 14 percent higher in exchange plans.
- And the proportion of contraceptives was 31 percent lower in exchange plans.

These data, however, did not represent a loss to the insurance industry: Patients in exchange plans had 35 percent higher cost-sharing than commercial plans, so insurance plans paid less per member for medications in those plans than for members in regular commercial plans, the report stated. So the trend was not necessarily bad for insurer profits. ❖

Judge Mulls Jail for Enrollee and Lawyer Who Dissipated Fund to Prevent Plan's Recovery

In a lesson for benefit plans, enrollees and their attorneys, a federal appeals judge threatened an enrollee and her attorney with jail time for delays in resolving an ERISA subrogation case. The case is encouraging given the fact that enrollees sometimes take extreme measures to avoid reimbursing ERISA plans seeking to recover benefits from third-party settlement proceeds.

In this strongly worded opinion (*Central States Southeast and Southwest Areas H&W Fund v. Lewis*, 2014 WL 943412 (7th Cir., March 12, 2014), Judge Richard Posner illustrated that at least some courts will staunchly defend the right of ERISA health plans to pursue those rights asserted in the plan document by way of an equitable lien by agreement. It also rejects arguments that plan recovery claims can be defeated merely because a defendant spent the settlement proceeds.

The Facts

Beverly Lewis was covered by the Central States' self-insured ERISA health plan when she was injured in an automobile accident in Georgia. As a result of her injuries, the plan paid $180,000 in medical benefits. Lewis then brought a claim against the person responsible for the accident and obtained a $500,000 settlement.

The plan had claimed it was entitled to a subrogation lien against the settlement proceeds, which would require Lewis to reimburse the plan the $180,000 paid on her behalf from her $500,000 settlement. Lewis' attorney, David Lashgari, had been notified of the existence of the lien, but instead of satisfying it and reimbursing the plan $180,000, he divided the $500,000 between himself and Lewis, according to Posner.

Lashgari's rationale in avoiding the plan's lien in its entirety was that the settlement was intended solely to compensate Lewis for the driver's "post-accident tortious conduct" against her. Posner, however, dismissed the argument as "nonsense" because, he said, both the settlement agreement and the settlement check clearly stated that they encompassed "all claims."

In pertinent part, the settlement agreement said:

> [This settlement encompasses] all claims and demands whatsoever that were or could have been asserted ... [for] damages, loss, or injury ... which may be traced either directly or indirectly to the [accident] ... no matter how remotely they may be related [to the accident].

As a result of this refusal to reimburse the plan in accordance with its terms, the plan filed suit against Lewis and her attorney under Section 502(a)(3) of ERISA to enforce the lien.

Lewis said she bought a car and house with the settlement funds, and Posner questioned why those assets could not be used to satisfy the court's order to escrow the funds. Further, the court noted that Lashgari kept $298,000 — 60 percent of the settlement proceeds — in his trust account, and that that sum was fair game as well.

Lewis and Lashgari, however, argued in district court that because the settlement funds had been dissipated, the plan's claim actually amounted to a suit for damages; that is, a suit at law rather than in equity. Therefore, they argued, relief under ERISA's enforcement provisions was unenforceable against the plan participant.

> Judge Posner labelled the defendants' conduct "outrageous," advised the district court to consider referring the case to the Justice Department, and suggested that the defendants might be jailed.

Posner however rejected that argument, and stated that the plan wasn't required to trace the settlement proceeds; rather, the plan had an equitable lien that automatically gave rise to a constructive trust of Lewis' assets. This argument was supported by the U.S. Supreme Court ruling in *Sereboff v. Mid Atlantic Medical Services,* 547 U.S. 356 (2006), as well as subsequent rulings in *Longaberger Co. v. Kolt,* 586 F.3d 459 (6th Cir., 2009) and *Gutta v. Standard Select Trust Ins. Plans*, 530 F.3d 614, 621 (7th Cir., 2008).

In May 2012, the district court ordered Lewis and Lashgari to put the $180,000 into a trust fund pending resolution of the case but they refused to move any money at all. In response, the district judge held them in civil contempt, ordered them to produce records that would establish their financial situations, and ordered Lashgari to submit documents relating to possible disciplinary proceedings against him. In response, Lashgari submitted documents that Posner considered "absurdly inadequate," and raised his ire by dragging his feet further by appealing the civil contempt order.

The court went to great lengths to label the defendants' conduct "outrageous," advising the district court to consider referring the case to the U.S. Department of Justice

See *Dissipated Fund*, p. 7

Plan May Have Conflict of Interest If Unqualified Reviewer Used to Deny Claim

Allegations that a health plan administrator assigned an unqualified medical director to make coverage decisions in a specialized area of medicine as a way of generating claims denials led a court to order discovery beyond the administrative record, in *S.M. v. Oxford Health Plans Inc.*, 2014 WL 1303444 (S.D.N.Y., April 1, 2014).

Plans are normally protected from such extra scrutiny when they reserve discretionary authority in plan documents, and its removal can expose the health plan to extra expense for the disputed claim. In this case, the court ordered authorization reports after the initial denial to see whether a conflict of interest operated in the first denial.

The Facts

S.M., the unnamed plaintiff in this case, was covered by an employer-sponsored health plan administered by Oxford Health Plans. Unfortunately, she contracted non-Hodgkin's lymphoma.

In addition to being treated with Rituxan, a form of chemotherapy covered by Oxford, she asked Oxford to authorize one year of treatment with Gamunex, an intravenous immunoglobin treatment that helps fight against infection which is known to be a common side effect of chemotherapy.

Oxford's medical director, Dr. Bruce Lundblad, first denied the IVIG treatment as medically unnecessary. After consulting with S.M.'s treating physician, Dr. Janet Cuttner, Lundblad changed his mind and authorized three months of coverage for Gamunex.

After the three months had passed, in November 2011, S.M. asked the plan to authorize an additional 10 months of Gamunex. Lundblad requested three sets of information, each of which S.M.'s treating physician provided, but Lundblad denied the extension of coverage anyway. Cuttner contacted the medical director one more time, but Lundblad would not budge. She sought expedited-internal and external reviews of the claim. Then, the plan reversed and covered her Gamunex in 2012 and 2013.

S.M. contended that the pattern of changing determinations was evidence of the plan's attempt to manufacture a denial. Lundblad, a former family practitioner, was unqualified to determine whether Gamunex was necessary and Oxford deliberately put him on the claim in order to secure a denial.

S.M. sued to force Oxford to reveal: (1) the process it followed in changing its decision; (2) Oxford's contract with Lundblad; and (3) the number of patients with her disease who were denied Gamunex nationwide. A November 2013 district court ruling refused (2) and (3), saying it would admit no evidence beyond the date of the second denial, in November 2011.

In deposition, Lundblad said he was unaware S.M. was on chemotherapy during the time she said she needed Gamunex, and he did not believe Rituxan was relevant to his decision on covering Gamunex. S.M. contended that his ignorance was so striking that it warranted further discovery.

She sued again, this time to force Oxford to produce the reports authorizing her coverage for Rituxan and Gamunex through 2012 and 2013, but the plan refused, saying those documents were irrelevant and outside the administrative record. The court now considered that request.

> The court gave weight to the theory that in order to effect a denial, Oxford chose a physician who did not understand Rituxan's immuno-suppressant side effects and Gamunex's capabilities.

'Flawed Procedures' Cited

Normally if the plan reserves discretionary authority in its plan document, then it will enjoy a more limited scope of discovery when a decision is challenged in court. Oxford did in fact reserve such authority for itself; but since the U.S. Supreme Court decision in *Metropolitan Life Insurance Co. v. Glenn,* 554 U.S. 105, 108 (2008), courts have allowed for expanded discovery and review beyond the administrative record in cases where serious issues influence the administrator's decision. Examples include conflicts of interest and use of "flawed procedures," the court said.

If a plaintiff can demonstrate those issues, then a reasonable expanded discovery would delve into:

- the criteria of review by the administrator;
- the factual basis for the defendant's decision regarding benefits;
- the competent and complete evaluation of medical records; and
- the physician's report and testimony.

See *Improper Denial*, p. 7

Improper Denial (continued from p. 6)

Oxford resisted bringing in the 2012 and 2013 records because the administrator did not rely on those when making the 2011 coverage decision. The court, however, said they would be useful in deciding whether a conflict of interest operated in the 2011 decision.

Conflict of Interest Operated

A conflict of interest exists when the entity making the claim determination is the same as the entity that actually pays the claim. If the conflict is prevented from influencing claims decisions, it is called "structural" and does not change the standard of review. Here, however, the court decided Oxford was influenced by the fact that it had those dual capacities, and the savings it could achieve influenced them to ensure they denied the claim by skewing the method it used to review the claim.

The court gave weight to S.M.'s theory that in order to effect a denial, Oxford chose a physician who did not understand the interplay between Rituxan's immunosuppressant side effects and Gamunex's immune-boosting capabilities. The court said S.M.'s contention was feasible that:

> Oxford deliberately chose a non-specialist Medical Director and walled him off from pertinent information within Oxford's possession (such as the 2011 Rituxan coverage).

These theories were enough to admit evidence outside the administrative record, the court decided.

Time Restriction Cast Aside

The plan argued that S.M.'s authorization reports for 2012 and 2013 were outside the time frame ordered by the judge in November 2013, but the court ruled otherwise. Looking at Oxford's authorization reports related to S.M.'s Gamunex claims in 2012 and 2013 could be useful in seeing whether a conflict of interest animated her 2011 denial, and whether the record Dr. Lundblad acted on in 2011 was deficient.

> There is a demonstrated pattern of changing determinations of medical necessity that extends beyond the 2011 denial — whether or not justified, as the defendants contend — that bolsters the allegations of a conflict of interest.

Expanding the evidence to include the 2012 and 2013 authorizations would help a court decide whether Oxford repaired the deficiencies in the records it was giving to medical directors, so as to allow claims to be approved.

On the other hand, it could vindicate Oxford's position that S.M.'s condition had changed enough to justify Gamunex coverage in 2012 and 2013.

Therefore, the court ordered Oxford to produce S.M.'s authorization reports for Rituxan in 2011, 2012 and 2013, and for Gamunex in 2012 and 2013.

Implications

This case provides another in a long line of decisions that put the onus on benefit plans to provide a full and fair review of claims submitted for payment. Employer-sponsored health plans typically enjoy broad discretion in how they process and evaluate claims; however, the courts have reminded them time and time again that discretion is not unlimited.

As in here, when a plan has a conflict of interest or acts in an arbitrary and capricious manner, courts have gone to great lengths to use a more aggressive standard of review and, where applicable, do their part to right the wrong. It comes as no surprise then that the court in this case ordered production of the additional records. All plans must take care to ensure adequate review of claims; this onus is even more important for plans that both make benefit determination and issue benefit payments. These conflicts of interest shine a bright light on the plan and courts are aggressive in intervening where they exist. ❖

Dissipated Fund (continued from p. 5)

and to the General Counsel of the Georgia Bar. "In the meantime, we direct the district court to determine whether the defendants should be jailed," Posner said.

Finally, the court implied that Lashgari's appeal was frivolous and he would have no problem with making the defendants pay the plan's attorney's fees.

Implications

This opinion is a clear shot across the bow to attorneys representing holders of tort settlement funds that frivolous defenses against ERISA plan actions to recover subrogation monies will not be tolerated.

It clearly rejects the notions of tracing in subrogation recovery cases that were propagated by the U.S. Supreme Court's ruling in *Great-West Life v. Knudson,* 534 U.S. 204 (2002). It also holds that the plaintiff attorney, who is not a plan participant, possessed plan funds and should be liable for reimbursing them. The court did not hesitate to include the attorney as a defendant and order him to restore the funds until the case's merits could be decided. The court also rejected arguments that spending the settlement money somehow defeated the recovery claim.

Finally, this opinion quashed the argument that plans commonly encounter from opposing counsel that even when on notice of a subrogation claim, the settlement somehow did not include medical expenses. ❖

Employers Urge HHS to Ease Burden of HIPAA Certification Rules on Self-funded Plans

The requirements recently proposed for certifying compliance with HIPAA's transaction standards would impose a significant, unwarranted burden on self-funded group health plans that do not perform these transactions directly, employer groups warned in written comments to the U.S. Department of Health and Human Services.

"The approach taken in the proposed regulations would impose significant costs on self-insured plans that hire vendors to perform Covered Transactions without generating a corresponding benefit," according to comments submitted April 3 by the ERISA Industry Committee. "As these vendors typically deal with the Covered Transactions on behalf of self-insured plans, they are in the best position to make the kinds of attestations or certifications required by the proposed regulations."

A self-insured plan would be able to certify compliance "only through its arrangement with those third parties that actually carry out standard transactions in the administration of the plan, and the multiplicity of such arrangements could make the effort both time-consuming and burdensome," agreed the American Benefits Council.

Section 1104 of the Patient Protection and Affordable Care Act requires health plans to certify compliance with the transaction standards and related "operating rules," or face potentially substantial penalties. The rules proposed Jan. 2 (79 Fed. Reg. 298) set the certification deadline for the first round of transactions at Dec. 31, 2015 (a two-year extension from the statutory deadline), but also specified that health plans must obtain third-party accreditation.

The proposed rules would require all "controlling health plans," meaning all health plans not controlled by another plan, to obtain either a Phase III certification or an alternative "HIPAA credential" from the Council for Affordable Quality Healthcare's Committee on Operating Rules. Either alternative involves significant testing requirements, and the proposed rules seem to place this obligation directly on the plan, not its business associates.

"For the majority of self-insured plans, the Proposed Rule's requirements are impossible to satisfy," warned the U.S. Chamber of Commerce. "For example, documentation of testing with providers is something never done by self-insured plans that contract out all of their administrative services."

ERIC urged HHS to modify the rules so self-funded plans can comply simply by confirming to HHS that they conduct covered transactions exclusively through one or more entities that either:

- are themselves directly covered by HIPAA; or
- have agreed contractually to comply with the transaction standards.

"In relying on these entities and their documentation of certification of compliance, an employer should not be held liable or assessed a penalty for any misrepresentation or failure to satisfy the compliance requirements on the part of the entity performing the transactions," the Chamber added. "Similarly, it will be incredibly difficult for entities that perform these transactions to certify to a standard of perfect compliance," so HHS should allow them to attest simply to "substantial compliance."

Application to Limited Benefits

Another area of concern was the rules' applicability to limited-scope and account-based benefits. "The majority of these types of ancillary or limited benefits do not typically get processed using standard transactions and should be exempt from these certification requirements," according to the Chamber.

ERIC agreed that benefits treated as "excepted" under HIPAA portability and PPACA market reforms should be exempt: "Compliance with the certification requirement by these programs would be unlikely to generate any significant benefit that could outweigh the substantial burdens placed on these arrangements."

Privacy and Security

ABC also expressed concern about the inclusion of HIPAA privacy and security compliance certification in both of the alternative CORE credentials.

"Certifying compliance with the privacy and security rules as part of certification of compliance with transaction standards and operating rules would be redundant and burdensome," and would essentially create "an alternative enforcement mechanism for HIPAA privacy and security standards that appears to undermine and conflict with the official enforcement role of HHS Office for Civil Rights," ABC argued. ❖

Oral Arguments (continued from p. 1)

reform's provision requiring "large" employers to provide female health plan members with coverage for contraceptives. Their arguments were similar, so their cases were consolidated into a single hearing.

The companies, owned and operated by Christian families, asked for an injunction blocking the requirement, reasoning that the law was forcing them to choose between violating their religious beliefs and paying hefty fines for excluding contraceptives from their health plans.

Conestoga's arguments failed before the 3rd U.S. Circuit Court of Appeals in July 2013, and the company is seeking a reversal of that judgment. Meanwhile, HHS asked the Supreme Court to overturn the 10th Circuit's June 2013 decision favoring Hobby Lobby.

Stretching the Religious Freedom Law?

The lawyer for the private parties was Paul Clement, a professor at Georgetown University. U.S. Solicitor General Donald Verilli argued the government's case.

Justices Sonia Sotomayor, Elena Kagan and Ruth Bader Ginsburg asked whether the employers' claim could include anything a religious owner might refuse to fund in its health plan, including blood transfusions and vaccines. They then questioned whether the RFRA should have the ability to interfere with any federal law at any time.

Clement replied that the government's interest in promoting vaccinations was probably greater than its stake in contraceptives, but he also said the government had a very weak case on compelling interest in the contraceptive matter. He said the RFRA could be used on any existing statute at any point that it is found to violate peoples' religious rights.

Ginsburg said Congress passed the RFRA to protect individuals and not for-profit corporations.

Kagan said if this case prevails, objections might be used to block minimum wage, family leave, child labor and sex discrimination laws. Conservative Justice Samuel Alito stepped in and said the RFRA had never been used that way.

Clement replied the cases involve small, closely held corporations that have firmly held religious beliefs, and not large, publicly traded companies.

Chief Justice John Roberts appeared to agree with allowing a small tightly held company to have its way on this matter, while a large publicly traded corporation, such as Exxon, might get a different outcome.

Kagan suggested that Hobby Lobby stop providing insurance and pay the law's "no-coverage" tax for that. At that point, Roberts noted that the employer wants to provide health insurance as an employer, and as part of its religious beliefs. Roberts also stated that the cost of increased salaries and taxes could be greater than the cost of providing insurance.

Why Doesn't the Government Just Provide Them?

Kagan said Congress granted an entitlement to women across the country and a positive ruling on this matter would enable certain employers to frustrate that entitlement. That would amount to tangible harm to women in those companies, she said.

Alito asked whether there would be ways to deliver the entitlement without involving the employer. Justice Stephen Breyer suggested that getting these products out to the female public would be a simple matter of having the government itself provide contraception.

Justice Antonin Scalia said the plaintiffs objected only to the methods that interfere with the egg after it had been fertilized, which they considered to be "abortifacients."

Verrilli countered that the four methods are in fact the most effective, but also the most expensive: particularly the IUD, which is embedded once, and costs between $500 and $1,000.

After Verrilli stated that the 14,000 employees of Hobby Lobby were being deprived of an entitlement, Justice Anthony Kennedy noted that the government had already exempted grandfathered health plans, nonprofits with religious objections and churches, from the requirement. That undermines the government's argument that it has a compelling interest in total compliance with the mandate across the population.

Kennedy, often regarded as a potential swing vote in this matter, further undermined Verrilli and the government's position when he said under the solicitor general's logic, the government could compel for-profit corporations to pay for abortions.

Verrilli replied that no, indeed, the Affordable Care Act contains provisions against the payment for abortions, and said the government denies that the four methods the employers object to (including morning after pills and IUDs) are abortifacients.

Reading the Possible Outcome

While the mandate appears to be in danger, the outcome is not clear because many of the justices raised a variety of points — some that could be construed as supporting, and some as opposing, the government position.

The court is divided on conservative-liberal grounds. Overall, the three female liberal-leaning justices were

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For those not working with a network, the plan language must state that the plan can use Medicare and cost-based provider reimbursement data to establish the MAC.

First, the plan should state that facility and physician claims billed on UB92 or UB04 forms will be reimbursed at the greater of Medicare plus some percentage or cost plus an added percentage. If no Medicare pricing data or cost data is available, payment will be based on a percentage of a regional Medicare approximation provided by a third-party vendor. If a pre-negotiated maximum allowable rate is established with the provider, the pre-established rate will create the MAC. Having this language will provide immediate dividends to the plan as claim costs will reduce immensely.

Clean Claim

There's a gap between providers' and payers' view of what this is. To me, hospitals think a clean claim is no more than a bill without any explanation of what they are charging and why. Must be a nice world they live in. I wish I could just bill my clients any amount I want without any actual explanation behind it.

We should avoid situations where the plan has to pay large claims that do not have any information on the bills except for a few diagnosis codes. The fact that a facility won't give you an itemized bill should scare you a little bit. So what can a plan do? While the battle continues over what makes a claim clean, the least you can do is define what you feel should be the necessary information needed in your plan document

In your plan document, you should define a clean claim as one that can be processed in accord with plan document terms without obtaining additional information from the service provider. It is a claim that has no defect or impropriety and stands on its own. A clean claim does not include claims under investigation for fraud and abuse, or claims under review for medical necessity and reasonableness of charges. *The plan must retain the right to audit and review* any claim to ensure it is clean or else it won't be paid.

Covered Expense

After clearly defining what a clean claim is, a plan must rely on its definition of covered expenses. In my opinion, it means the U&C charge for any medically necessary, reasonable and eligible items of expense. The best language ensures that covered expenses mean a reasonable, medically necessary service, treatment or supply meant to improve a condition. When more than one treatment option is available, and one option is no more effective than another, the covered expense must be defined as *the least costly option that is no less effective* than any other option. This last piece guarantees that the plan fiduciary is acting in way that ensures the most prudent use of plan assets. This is vital in an age where costs and charges continue to rise and facilities are willing to share less and less to justify their fees.

Definitions that Stop Abusive Claims

Providers have their own view of what the patient needs. Some of them may see every patient who comes in their office as a candidate for the services they specialize in providing. That can put providers at odds with what a plan may be willing to cover.

Experimental and Investigational

This area creates its share of litigation. Just what do these terms mean and how much discretion should the plan have in interpreting them? These types of treatments are typically the most expensive and can drag stop-loss insurers into the party. The best language says experimental and investigational services are not widely used or accepted by most practitioners or lack credible evidence to support positive short- or long-term outcomes from those services.

Your plan should exclude services that aren't Medicare-reimbursable, and services, procedures and treatments that do not constitute accepted medical practice under

See *CE Column*, p. 11

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the only ones clearly opposing the employers' arguments. Clinton appointee Breyer was mixed: on the one hand he sounded concerned about an overextension of the RFRA, but he also suggested having the government pay for contraceptives instead of employers.

Conservative justices Alito and Scalia seemed dismissive of the government's arguments. Justice Clarence Thomas, who remained mute during the hearing, almost always turns out conservative rulings.

Potential swing vote Roberts, a GOP appointee who nevertheless cast the deciding vote preserving the individual mandate in June 2012, led a discussion pointing to the idea that the RFRA can indeed defend the religious position of a corporation, not just an individual.

Second potential swing vote Kennedy was also mixed: on the one hand he asked whether any corporation's religious view could "trump" the interests of its workers; but he also made the aforementioned point that the government's logic could be used to compel abortion funding by employers. ❖

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the standards of a reasonable segment of the medical community or government insurers.

A drug, device or medical treatment or procedure is experimental if:

1. it lacks approval from the U.S. Food and Drug Administration when the drug or device is furnished; or
2. the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials.

You should accept only published reports and articles from authoritative medical and scientific literature that a procedure is not experimental and investigational.

I see much concern surrounding plan documents and stop-loss policies that attempt to exclude an entire treatment plan from coverage if *any* of the treatment is experimental. So if there is a $200,000 hospital stay for two months and $2,000 of it is for an experimental drug, then the plan can deny the entire stay. I have seen the same thing happen with stop-loss insurers and their ability to deny claims based on this same issue and the gaps in coverage. As a sponsor of a self-funded plan myself, I care about the well-being of my employees, so I cannot believe that employers exist that would deny an entire treatment plan just because a small piece of it was experimental.

Coordination of Benefits

Another often ignored provision of a plan document that has a very important role in reducing the overall plan claim costs involves coordination of benefits and deciding whether your plan is primary or secondary.

This feature defines what the "other plan" is for COB purposes. It is vital that the other plan is defined as not being limited to any primary payer besides the plan; any other group health plan; or any other policy covering the participant. You want that definition to include any policy of insurance from any health insurance, workers' compensation or other liability insurance company, including personal injury protection and no-fault coverage, uninsured or underinsured motorist coverage. Rights should be asserted to cover any medical, disability or other benefit payments, including school insurance coverage. Even crime victim restitution funds must be included.

Provider Errors and Churning Are Unreasonable

I have left the best for last: The area of the plan document that can save you the most amount of money; the game changer.

Adding the term **reasonable charges** to a plan document has the most significant savings potential for a health plan. There is no doubt that this one term has changed the way claims are negotiated and paid. For charges to be reasonable, they first must be necessary for the care and treatment of the illness and injury not caused by the treating provider. As we have shown with other definitions, a determination that the fee and services are reasonable will be made by the plan administrator. This will take into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply.

To be reasonable, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. This ties right back into the definition of a clean claim. Services, supplies, care and treatment are not reasonable if they result from errors in medical care that are clearly identifiable, preventable and serious in their consequence for patients. A finding of provider negligence or malpractice can cause fees to be deemed not reasonable.

Therefore, the plan must state that charges and services that result from provider errors or facility-acquired conditions — deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration (but not limited to) Centers for Medicare and Medicaid Services guidelines — are not considered to be reasonable, and are not eligible for payment.

This is a good time to remind you that the plan must reserve the right to review and identify charges and services that are not reasonable and therefore not eligible for payment.

Nothing Unusual Here

When discussing reasonableness, the term U&C should not be far behind. It should be defined as covered expenses identified by the plan administrator, taking into consideration: the fees that the provider most frequently charges or accepts for most patients; the cost to the provider for providing the services; the prevailing range of fees charged in the same area by providers of similar training and experience; and Medicare reimbursement rates.

To be U&C, fees must be in compliance with generally accepted billing practices for bundled or multiple procedures.

The term "usual" refers to the amount of a charges made or accepted for medical service. However, the charge should not exceed the common level of charges made by other medical professionals with similar credentials or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

See *CE Column*, p. 12

Subject Index, Vol. 21

This subject index covers the *Employer's Guide to Self-Insuring Health Benefits* newsletter, Volume 21, Nos. 1-8. 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 "21:8/2" indicates Vol. 21, No. 8, page 2.

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The term "customary" should be defined as a service, supply or treatment provided in accord with generally accepted standards of medical practice, appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale. I would recommend that U&C charges be determined by a plan using normative data such as Medicare cost to charge ratios, average wholesale price for prescriptions and/or manufacturer's retail pricing for supplies and devices.

The right wording will reduce the overall cost of a self-funded plan. I have personally seen thousands of claims paid at a reduced amount just because a few words were outlined and defined in the plan document. Words are powerful in the world of self-funding, so choose them wisely. ❖

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