

## Peer Into the Future: Health Reform's 2012 'To-do' List for Plan Sponsors

Sponsors and administrators of employer-sponsored health plans will spend lots of 2012 in implementing the health reform law, because there's still a lot of uncertainty that will decide the fate of self-funded health plans in particular. Plans will have to raise annual limits on essential benefits (as defined by reform rules) to \$2 million starting next Sept. 23. Plans won't have to pay new fees to fund comparative effectiveness research in 2012. But 2012 will be the year plans learn the payment frequency of and the method used to calculate the fees they will start paying in 2013. Similarly, plans won't have to start issuing summaries of benefits and coverage (SBCs) to all participants, but they will be waiting and watching for rules about the SBC to develop, so they know how to satisfy that requirement. *Page 2*

## Appeals Court: Unjust Enrichment Limits Equitable Plan Recovery

In a surprising decision, the 3rd U.S. Circuit Court of Appeals used the concept of "appropriate equitable relief" to restrict an employer-sponsored health plan's recovery from a third-party settlement. Full reimbursement of what the plan paid out would have been "inappropriate and inequitable," even though the plan had asserted recovery rights over *any monies* collected from a third party. Full recovery would have been unfair because: (1) the plan participant's recovery ended up being less than what the plan paid after attorney's fees were deducted; and (2) the plan never intervened in the third-party recovery. The outcome diverges from many recent cases, which upheld plans' claims on total proceeds, regardless of whether the plan participant was "made whole" or had money to pay attorney's fees. *Page 3*

## DOL Targets MEWAs With New Powers of Interdiction and Seizure

The U.S. Department of Labor (DOL) on Dec. 5 proposed new enforcement and oversight rules targeting Multiple Employer Welfare Arrangements (MEWAs). Officers who ran sham MEWAs were using plan funds improperly, absconding with funds and disappearing to set up fraudulent entities in other states, DOL Assistant Secretary Phyllis Borzi said. Under the proposed rules: (1) MEWAs would register with DOL before starting business in a state; (2) they would file the Form M-1 with DOL, regardless of their size; (3) DOL could issue cease-and-desist orders against MEWAs without prior notice or hearings, if they commit fraud and abuse; and (4) DOL would gain fast-track power to seize assets from a MEWA when there is probable cause that the plan is financially unstable. This would enable DOL to preserve plan assets before they're totally dissipated, she said. *Page 5*

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Editorial: 202 872-4000

# Peer Into the Future ... Forecasting Health Benefits in 2012

By Adam V. Russo & Ron Peck



**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 Publishing Group's *Employer's Guide to Self-Insuring Health Benefits*.

**Ron Peck, Esq.** is an attorney with *The Phia Group, LLC*, and has been a member of *The Phia Group's* team since 2006. Ron is also currently of-counsel with *The Law Offices of Russo & Minchoff*. Ron has lectured at and participated in many industry gatherings and is frequently called upon to educate plan administrators and stop-loss insurers regarding changing laws and strategies.

Just when you thought the storm had passed and it was safe to emerge from your shelters ... just when you thought that all the health care reform requirements imposed on you and your health plans were finalized ... you thought wrong!

This time last year, we were under the impression that 2011 would bring with it a clear, concise set of parameters to guide plan administrators as they restructure their plans in accordance with the new law. Unfortunately, as the year comes to a close, we realize that 2011 brought with it more questions than answers. While it is impossible for us to review all of the 2011 issues and share everything we expect to see in 2012 in less than a thousand pages, we can certainly address some of the biggest issues we have seen develop over the year, and share with you our projections for the year to come. As always, as we learn new things over the next few months, we promise to share them with you.

The first important issue that needs to be addressed in this article is the epic Summary of Benefits and Coverage (SBC) adventure. The requirement that you draft a "mini-SPD" (as we like to call it) was supposed to go into effect in early 2012. Ladies and gentlemen, our own company is a self-funded plan, and we do not know how to draft an SBC. I guess that means we do not know how to draft a self-funded plan that is in compliance with the current rules. I doubt that fault lies with us, however, as these rules simply do not apply to the self-funded world! Yes, the guidelines were created with a fully insured policy in mind. Our phones keep ringing as self-funded client after self-funded client continues to reach out to us regarding these SBC mini-SPD documents.

Here is what we do know. In a nutshell, plans will be required to squeeze the most important portions of their plan into a (what we thought at the time) four-page "mini-SPD." In fact, we drafted an article for this fine publication last September titled, "The Four-Page Mini-SPD — Coming to a Plan Near You," in which we discussed the Patient Protection and Affordable Care Act's (PPACA) Section 2715, requiring plans to develop the aforementioned SBC. In that article we had a good chuckle as the policymakers enlarged the page maximum from four pages to eight pages, by allowing us to use the front and back of a single page, after they failed to create a template less than six pages in length. We knew then

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

CONTRIBUTING EDITOR: **ADAM RUSSO, ESQ.**  
THE PHIA GROUP LLC  
BRAINTREE, MASS.

DIRECTOR OF PUBLISHING: **LUIS HERNANDEZ**

ASSOCIATE PUBLISHER: **GWEN COFIELD**

EDITOR: **TODD LEEUWENBURGH**

DESKTOP PUBLISHING SPECIALIST: **SHAWNE HICKS**

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See *CE Column*, p. 14

# Appeals Court Carves Into Equitable Relief: Total Plan Reimbursement Was Unjust Enrichment

In a surprising decision, the 3rd U.S. Circuit Court of Appeals used the concept of “appropriate equitable relief” to restrict an employer-sponsored health plan’s recovery from a third-party settlement to less than what the plan paid out in health benefits.

Full reimbursement of expenses to the employer-sponsored health plan would be “inappropriate and inequitable relief,” the appeals court held, even though the plan had subrogation reimbursement provisions asserting recovery rights over *any monies* collected from a third party. The court reasoned that it would be inequitable because full recovery would constitute unjust enrichment for the plan because: (1) the plan participant’s recovery ended being less than what the plan paid after attorney’s fees were deducted; and (2) the plan never intervened in the third-party recovery. The case is *US Airways, Inc. v. McCutchen*, 2011 WL 5557411 (3rd Cir., Nov. 16, 2011).

The appeals court overturned a U.S. District Court for the Western District of Pennsylvania’s ruling (2010 WL 3420951) requiring the participant to pay the plan the whole amount.

The outcome diverges from most recent cases, which upheld plans’ claims on total proceeds, regardless of whether the plan participant was “made whole” or had money to pay attorney’s fees.

## The Facts

James McCutchen survived a serious automobile accident and underwent emergency surgery, which saved his life. He then spent several months in physical therapy and had a complete hip replacement. He retained an attorney who agreed to represent him for a contingent fee of 40 percent of any recovery. The US Airways health plan paid \$66,866 for his medical expenses.

Although McCutchen was severely injured and functionally disabled for life, he recovered only \$110,000 from third parties (\$10,000 from the person who caused the accident and \$100,000 from an uninsured motorist policy), with his attorney’s assistance. The plan did not intervene to enforce its subrogation rights.

After paying his attorney 40 percent, McCutchen had less money than the \$66,866 the plan spent. The attorney

placed \$41,500 of the settlement proceeds in a trust account to satisfy a future US Airways lien — assuming that the plan’s recovery would have to be reduced by 40 percent, commensurate with McCutchen’s legal fees. The record was unclear about where the rest of the settlement proceeds went.

When McCutchen refused to pay the plan back in full, US Airways sued McCutchen for “appropriate equitable relief” under ERISA (Section 502(a)(3)), demanding reimbursement of the entire \$66,866 (the \$41,500 fund plus \$25,366 from McCutchen personally) — without allowance for McCutchen’s legal costs.

## Plan Reimbursement Clause

US Airways’ summary plan description (SPD) reserved subrogation and reimbursement rights:

The purpose of the Plan is to provide coverage for qualified expenses that are not covered by a third party. If the Plan pays benefits for any claim you incur as the result of negligence, willful misconduct, or other actions of a third party, the Plan will be subrogated to all your rights of recovery. You will be required to reimburse the Plan for amounts paid for claims out of *any monies recovered* from a third party, including, but not limited to, your own insurance company as the result of judgment, settlement, or otherwise. In addition you will be required to assist the administrator of the Plan in enforcing these rights and may not negotiate any agreements with a third party that would undermine the subrogation rights of the Plan.

US Airways said this language allowed it recover the whole \$66,866 from McCutchen’s \$110,000 settlement.

See *Equitable Relief*, p. 4

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### Participant Seeks Limit on Recovery

McCutchen countered that it would be unfair and inequitable to reimburse US Airways in full: (1) when he was not fully compensated for his injuries, including pain and suffering; and (2) because the plan would be unjustly enriched if it recovered from him without any allowance for those costs.

Regarding the unjust enrichment argument, McCutchen said that because US Airways made no contribution to his attorney's fees and expenses, the plan would profit from his work pursuing the \$110,000 settlement.

Nevertheless, the district court ruled that McCutchen had to pay the plan the full \$66,866 (the \$41,500 held in trust plus \$25,366 from his own funds), relying on the plan provision as well as other 3rd Circuit opinions. McCutchen appealed.

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The outcome diverges from most recent cases that upheld plans' claims on total proceeds regardless of whether the plan participant was "made whole" or had money to pay attorney's fees.

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### Appeals Court Ruling

The appeals court broke with the district court, and instead decided that McCutchen could assert certain limitations, such as unjust enrichment, on US Airways' equitable claim.

Writing for the three-judge panel, Circuit Judge Julio Fuentes first noted that ERISA gives plan *beneficiaries* broader recovery rights than plan *fiduciaries*. Fiduciaries are limited to "appropriate equitable relief," provided under ERISA Section 502(a)(3); while beneficiaries are authorized to enforce plan terms and seek "benefits under the plan," under ERISA Section 502(a)(1)(B). The court would stress throughout the opinion that it was *appropriate* equitable relief, not *all* equitable relief that plans are entitled to when recovering from settlements.

Fuentes noted that the U.S. Supreme Court issued two major rulings on plan recoveries and equitable relief: *Knudson* and *Sereboff*.

- 1) In *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002), the High Court blocked a plan from tapping into a special needs trust, because that relief would have been inequitable. In *Knudson*, the Supreme Court said that "equitable relief" must mean something less than all relief."

- 2) In *Sereboff v. Mid Atlantic Medical Services, Inc.*, 547 U.S. 356 (2006), the Supreme Court moved away from a strict requirement that funds be "traceable" and ruled more liberally in favor of a plan's right to pursue equity through "liens by agreement." But it left open the question of the scope of the term "appropriate" in "appropriate equitable relief."

So the appeals court delved into the questions left open by *Sereboff*: How can Section 502(a)(3)'s requirement that equitable relief be "appropriate" restrict an ERISA plan's right to recovery (and whether the principle of unjust enrichment can limit US Airways' claim on McCutchen's settlement)?:

McCutchen argues that the phrase "appropriate equitable relief" means more than just the relief that US Airways seeks must be of an equitable type; courts must also exercise their discretion to limit that relief to what is "appropriate" under traditional equitable principles. In particular, he argues that the principle of unjust enrichment frames US Airways' claim. We agree.

In its rebuttal, US Airways cited three 3rd Circuit cases following the *Sereboff* decision in which the court declined to limit an ERISA plan administrator's right to reimbursement under the plan terms. The court said:

While we recognize that the District Court may have considered itself bound by these cases, each came before the Supreme Court's decisions in *Knudson* and *Sereboff*, which clarified the meaning of "appropriate equitable relief" in §502(a)(3), specified its central importance to fiduciaries' reimbursement suits under ERISA, and thereby undermined the reasoning and holding of our prior decisions. Our prior opinions in [those three cases] did not consider whether the phrase "appropriate equitable relief" in §502(a)(3) limits a fiduciary's right to relief. In fact, none of those cases even referenced §502(a)(3). These cases are therefore inapposite in light of the Supreme Court's intervening decisions.

US Airways also cited cases from other appeals courts, some of which were decided after *Sereboff*, which supported its position. The court disagreed, saying limiting the scope of equitable relief was nothing new.

Congress purposefully limited the relief available to fiduciaries under §502(a)(3) to "appropriate equitable relief." ... While our sister circuits pay homage to this language, they appear to reason that its requirement has been met so long as the suit can be properly characterized as an equitable action, without also asking whether the relief sought

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See *Equitable Relief*, p. 19

# To Protect Small Businesses, DOL Proposes Registration and Reporting Rules for MEWAs

The quest to escape the upward premium spiral has hurt some small employers. Some have been hurt by fly-by-night Multiple Employer Welfare Arrangements (MEWAs) that ended up being unable to pay claims, says the U.S. Department of Labor (DOL). In its quest to stop such MEWAs, DOL is proposing new enforcement and oversight rules (76 Fed Reg 76222).

DOL will target rogue MEWAs with these new enforcement and oversight rules, DOL Assistant Secretary Borzi stated in a conference call on Dec. 5.

- 1) *MEWAs must register with DOL before starting business in a state.* All MEWAs (and certain other entities that provide health benefits to the employees of two or more employers) will have to file the Form M-1 with DOL;
- 2) *DOL could issue cease and desist orders* without prior notice or hearings, preventing MEWAs from enrolling new enrollees if they present fraudulent or abusive behaviors (such as failing to pay claims); and
- 3) *DOL would gain fast-track power to seize assets* from a MEWA when there is probable cause that the plan is in a financially hazardous condition. This would enable DOL to preserve the plan assets before they're totally dissipated, she said.

The health reform law (the Patient Protection and Affordable Care Act – PPACA) added the tools to prevent insolvent or fraudulent MEWAs from operating, DOL said.

Reporting requirements for MEWAs have been in place since 1999.

But many MEWAs slipped through the cracks — and by the time they proved themselves to be improper, their owners and officers had absconded with funds, and often moved on to set up fraudulent entities in other states, Borzi said.

The enhanced reporting will allow DOL to hit the ground running when it gets a report on a MEWA's fraudulent activity from state insurance authorities, she said.

## Employers Will Vet MEWAs on New DOL Site

A DOL website containing information on MEWAs will appear around summer 2012, and employers will be able to learn about prospective MEWAs by looking them up there.

Information on who operates the MEWA and where MEWA funds are held will be included. If a MEWA is not listed on the DOL website, Borzi urged small employers to bypass that vendor and select a MEWA that has been registered with DOL.

A comment period on the proposed rule will remain open until March 5, 2012.

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**DOL could issue cease and desist orders without prior notice or hearings, preventing MEWAs from enrolling new enrollees if they are suspected of fraud and abuse, or if they fail to pay claims.**


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## The Heartbreak of MEWA Scams

Some employers used MEWAs as an option for quality coverage, but saw their premiums or contributions wasted and their employees harmed economically when MEWAs ended up not being above board, DOL said.

According to Borzi, such MEWAs become increasingly slower about paying small claims, and drag their feet on paying — or just don't pay — larger claims. Before long, they stop paying all claims. By the time complaints reach state authorities, the MEWA's officers have disappeared leaving beneficiaries with unpaid claims, often after having embezzled plan funds, she said.

### For More Information

To see a copy of the proposed rule, go to [http://www.ofr.gov/OFRUpload/OFRData/2011-30921\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-30921_PI.pdf); to see a fact sheet on it, go to <http://www.dol.gov/ebsa/pdf/fsproposedm1revisions.pdf>; and to see a current M-1 form, go to <http://www.dol.gov/ebsa/pdf/2010M1Package.pdf>. 

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# ERISA-like Features Do Not Give Self-Insured County Plan Right to Deferential Review, Court Rules

Most self-insured governmental plans adopt ERISA principles in governing trusts, and use ERISA-style plan documents and summary plan descriptions (SPDs). However, just because they look to ERISA for guidance when crafting programs, they would be mistaken to assume they have ERISA-style rights.

In *Daugherty v. Wayne County Bd.*, 2011 WL 5028365 (Ohio App. 9 Dist., Oct. 24, 2011), a self-insured county health plan argued that because it reserved itself discretionary authority in the SPD, that its disputed denials should be entitled to a more favorable review in court.

That ended up not being true, and its denial was overturned after a *de novo* review by a state appeals court.

Since the plan was a governmental plan not subject to ERISA, the court did not apply a deferential review to the plan decision, but rather applied its own *de novo* reading of the plan and SPD.

In the ruling, the Court of Appeals of Ohio (Wayne County) decided that a bone-anchored hearing aid (BAHA) is a “prosthetic device” covered by a county government’s employee health plan, affirming a similar lower state court ruling. The device was prosthetic because it took the place of an external ear and ear canal, thereby falling into plan language granting coverage for prosthetics, the appeals court held.

The court — substituting its own reading of the SPD for the plan’s — decided that it was not ambiguous whether a BAHA should be considered a “prosthetic device,” thereby rendering it covered (along with its surgical implantation) under the plan benefit for prosthetics.

The county plan argued, unsuccessfully, that the implant was a “hearing aid” that fell into the SPD’s catch-all exclusion for non-covered health services, even though it was not mentioned by name there.

The same facts, had the plan been a non-governmental ERISA plan, would have been reviewed under an arbitrary and capricious standard, and the denial probably would not have been overturned.

## Facts of the Case

Donna Daugherty, the spouse of a Wayne County (Ohio) employee, contested her husband’s employer health plan’s denial of payments for surgical implantation of a bone-anchored hearing device.

She sought preauthorization for the hearing implant. The claims administrator, United Healthcare, denied preapproval, but Daugherty went ahead with the procedure, then submitted a claim for \$11,585 in expenses for the implant. United denied \$7,700 of the claim. She appealed the decision to the County Board of Commissioners.

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Since the plan was a governmental plan not subject to ERISA, the court did not apply a deferential review, but rather applied its own *de novo* reading of the plan document and SPD.

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After the Board affirmed United’s denial, the Daughertys sued, seeking declaratory judgment that “the purchase costs and surgical implantation of the osseointegrated auditory prosthesis device” were covered under plan terms.

The trial court concluded that the SPD was ambiguous on whether the bone-anchored device was excluded as “non-covered,” or covered as a prosthesis. And construing the document liberally in favor of the plaintiffs, the trial court resolved the matter in Daugherty’s favor, awarding them coverage for the device.

The plan and United appealed the trial court’s reading of the plan/SPD’s language about prosthetic devices. They said the trial court: (1) incorrectly concluded that the BAHA was a prosthetic device and the SPD was ambiguous; and (2) erred by not deferring to the Board’s determination.

On appeal, they argued that: clear plan language indicated that the BAHA (a hearing aid) fell under the health plan’s blanket exclusion for non-medical services; and the lower court erred by not giving deferential review by the trial court.

## The Appeals Court Decides

The appeals court used a *de novo* standard of review to decide on whether the device was a covered prosthesis (*see next page*). Further, the appeals court also looked no further than the SPD to resolve the discrepancy — rather than the “official plan document” that the defendants

**See *Deferential Review*, p. 7**

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## Deferential Review (continued from p. 6)

said controlled — because that was the point of reference both sides used.

The appeals court said because there was no ambiguity about one thing: if the device was a “hearing aid” it would be excluded; but if it was a “prosthetic device” it would be a covered service.

However, the device *was* prosthetic, and because it was not specifically excluded in the SPD, it must be covered, the court held.

SPD language provided for coverage of prosthetic devices (including to replace ears), the court said.

[P]rosthetic devices are covered services. [They are defined as e]xternal prosthetic devices that replace a limb or an external body part, limited to [a]rtificial arms, legs, feet and hands [and] [a]rtificial eyes, ears and noses.

The BAHA device was a prosthetic device, based on product information and other evidence submitted by the Daughertys.

[T]he BAHA device is an “Osseointegrated Auditory Prosthesis,” which involves an external processor anchored to the skull bone behind the ear. The BAHA takes the place of the external ear and the ear canal and, according to the evidence the Daughertys submitted, is not a hearing aid. Inasmuch as the BAHA takes the place of the ear and ear canal, it is an external prosthetic device that replaces an ear.

### No Deferential Review

United and the Board’s decision would not enjoy deferential review, because this was a government plan not subject to ERISA.

The plan had argued that plan terms required deference be accorded to decisions made by the County Board, and that mandated that the courts use an arbitrary and capricious standard of review. That privilege, however, is reserved for discretionary decisions made by an ERISA fiduciary.

However, Wayne County’s health plan is a governmental plan not subject to ERISA. The plan and United never explained their position that “the same principles of deference should be applied” in a declaratory judgment action not involving an ERISA plan.

Therefore, enforcing its *de novo* review, the court affirmed the lower court and awarded benefits to Daugherty.

## Implications

ERISA has certain objectives. These include to: (1) protect the interests of plan participants; (2) facilitate plan administration; (3) promote efficiency and uniformity in plan administration; and (4) encourage employers to create such plans.

As demonstrated by this case, ERISA discretionary authority language provides ERISA plans ultimate and final rights to interpret plan terms and provisions. Their decisions are to be reviewed under an arbitrary and capricious standard of review.

It should be noted that certain states have become concerned about “discretionary language” in plans, and have attempted to restrict discretionary authority for plans not governed by ERISA.

A plan subject to ERISA and exempt from state laws can be beneficial as it relates to discretionary authority. In this case, however, the Wayne County plan tried to assert ERISA-plan rights, but failed because it was not in fact an ERISA plan.

### Concise Language

An important issue for plans is whether their plan language accurately reflects their true intentions. An SPD governs the plan and is a basic tool to inform participants of their rights and obligations under the plan.

In this instance, the issue was not that the plan was not permitted to have a certain exclusion, but more that the plan did not have concise language reflecting what it intended to cover and what it intended to exclude.

Plans should remember to say what they mean — and mean what they say — when it comes to their plan language. 🏠

### Lessons Learned From *Daugherty v. Wayne County Bd.*

**Discretionary Authority.** Consider the status of the plan when determining the influence a discretionary authority clause may have on the plan.

**Intentions.** Plan administrators should review the applicable plan language to ensure that what they intend to cover is covered, and what they intend to exclude is clearly excluded. 🏠

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# Administrator Flubs Stop-loss Claim; State-law Charges on Administrator Not Preempted

A claims administrator lost an attempt to dismiss negligence and breach of contract charges relating to its failure to process and pay a large claim before the final day of a stop-loss policy's run-out period.

The self-insured Hebrew Home health plan sued administrator CoreSource and stop-loss insurer Sun Life for negligence and breach of contract under state law, alleging that the administrator dragged its feet paying the claim and ended up missing a March 31 deadline that would have enabled the plan to collect \$180,000 in stop-loss reimbursement.

The U.S. District Court for Maryland rejected CoreSource's attempt to dismiss the case. The plan's complaint was not time barred because Hebrew Home was not subject to its own plan language limiting plan beneficiary lawsuits, and ERISA only partially preempted the state-law claims, it ruled.

Claims relating to the improper processing of benefit claims were preempted by ERISA, but alleged violations of service agreement clauses on submitting stop-loss claims were not preempted, the court said, because they did not relate closely enough to the plan. The case is *Hebrew Home of Greater Washington Inc. v. CareSource*, 2011 WL 5513229 (D. Md., Nov. 3, 2011).

The court, however, did dismiss breach of contract charges against Sun Life.

## The Facts

Under the Plan Supervisor Agreement (PSA), CoreSource agreed to help the Hebrew Home with plan administration. It reviewed beneficiary claims, determined plan eligibility and denied ineligible claims when necessary. It was also responsible for properly submitting stop-loss claims to Sun Life.

The Hebrew Home started stop-loss coverage with Sun Life on Jan. 1, 2003; it renewed its policy on Jan. 1, 2007, but it expired on Dec. 31, 2007. The policy included a three-month "run-out" period, meaning if the plan paid an eligible claim by March 31, 2008, Sun Life would have to reimburse it.

In 2007, a Hebrew Home employee incurred large medical costs to the plan. Hebrew Home sent the employee's claim to CoreSource for eligibility determination, processing and filing with Sun Life. However, CoreSource did not approve or process her claim until March 31, 2008, the final day of the run-out period. Unbeknownst to the Hebrew Home, the claim could not be paid on that

date due to insufficient funds; and the date was missed, a situation the Hebrew Home blamed on CoreSource.

Not surprisingly, Hebrew Home was unable to obtain reimbursement from Sun Life for the claim. On Aug. 20, 2008, Sun Life denied Hebrew Home's \$181,433 claim because the plan sponsor failed to fund and pay out the claim before the run-out period expired. The plan appealed twice, but Sun Life in May 2009 issued a final ruling that it wouldn't reverse its position.

Hebrew Home brought two counts against CoreSource and one count against Sun Life.

- Count I asserted breach of contract against CoreSource for failing to comply with PSA and ERISA plan rules on reviewing, processing and securing payment for the disputed claim.
- Count II asserted negligence against CoreSource for failing to approve, pay and ensure stop-loss funding for the disputed claim.
- Count III asserted a breach of contract claim against Sun Life for failing to reimburse Hebrew Home for the \$181,433 it paid out on the claim under the stop-loss policy.

CoreSource and Sun Life moved to dismiss. CoreSource said the plan's breach-of-contract and negligence claims were time-barred by the plan's two-year limit on lawsuits and preempted by ERISA. Sun Life said it was not liable for another party's breach of the stop-loss contract.

## Plan's Limits on Lawsuits Do Not Apply

CoreSource argued that Hebrew Home's claims were time barred by the plan's own language limiting beneficiary lawsuits.

The court would not allow that because the plan limits were designed for beneficiaries in disputes with the plan. The plan clause said a beneficiary seeking *benefits from the plan* has two years from the date its final appeal was rejected to sue the plan. Since Hebrew Home was not a plan beneficiary, but rather the plan sponsor itself, the court rejected the notion that this lawsuit was time barred.

## Partial ERISA Preemption

The court would render a split decision on ERISA preemption: Claims relating to the improper processing of benefit claims were preempted; but alleged violations of service agreement clauses on submitting stop-loss

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See *Failed S-L Claim*, p. 9

## **Failed S-L Claim** (continued from p. 8)

claims were not preempted. The court explored case law on the limits of preemption.

A failure to manage relations with an insurer can be remote enough from plan operations to avoid preemption. For example, in *Coyne v. Delany Co.*, 98 F.3d 1458 (4th Cir., 1996), an employer alleged violations of state negligence laws by insurance agents who failed to obtain replacement insurance. The court refused to preempt the negligence charge because ERISA is not meant to preempt “traditional state-based laws of general applicability” when they do not affect relations among traditional ERISA entities: employers, fiduciaries, plans and beneficiaries, the court said.

On the other hand, processing plan benefits is sufficiently related to the plan and charges involving that are preempted by ERISA, as indicated by the 4th Circuit ruling in *Tri-State Machine, Inc. v. Nationwide Life*, 33 F.3d 311 (4th Cir., 1994), the court said.

CoreSource’s liability for poor claims processing could not be resolved without reference to the plan, therefore ERISA would preempt on that claim.

In contrast, delivery of the stop-loss claim was governed by the PSA. Hebrew Home’s complaint about that issue was not preempted by ERISA because CoreSource’s duties relating to properly executing and securing stop-loss reimbursement were imposed by an agreement that was “separate and distinct” from the ERISA plan, the court said, referring to *Great-West Life v. Infosys & Networks Co.*, 523 F.3d 267 (4th Cir., 2008).

Further, the plan’s claims alleging PSA violations did not fall under one of the preemption categories set out by the U.S. Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). They did not: (1) mandate employee benefit structures or their administration; (2) bind employers or plan administrators to particular choices or preclude uniform administrative practices; or (3) provide alternative enforcement mechanisms to ERISA’s civil enforcement provisions. The court said much of the claim was about the PSA and not plan benefits.

Hebrew Home’s claims are not aimed at obtaining ERISA benefits. Rather, the claims seek damages proximately caused by CoreSource’s failure to fulfill its duties under the Plan Supervisor Agreement. The gravamen of these claims is that CoreSource failed to diligently seek reimbursement of Hebrew Home’s claim under the [PSA], and thus these claims are premised upon that agreement rather than the ERISA Plan.

CoreSource’s assertion that the conduct in question arose through its administration of an ERISA plan might prevail later in the process, the court said. When considering a motion to dismiss by defendants, however, courts accept the plaintiff’s allegations as true and see them in the light most favorable to the plaintiff. Since the court found that failure to secure stop-loss reimbursement was not sufficiently related to plan administration to be preempted, it refused to dismiss Counts I and II entirely.

Insofar as the claims related to a failure to submit stop-loss claims to Sun Life, those counts would stand; insofar as they related to processing plan benefits and paying routine claims on the health plan, they would be preempted, the court concluded.

### **S-L Insurer Walks Free**

The stop-loss insurer, however, was dismissed from the case, because its position was straightforward: Hebrew Home failed to comply with the stop-loss contract’s requirements of coverage.

There was no dispute that Hebrew Home failed to pay the employee’s claim before the end of the run-out period. Therefore, Hebrew Home had no breach of contract case against Sun Life for the denial, which the court deemed was proper.

The final day of a stop-loss run-out period has a real meaning, the court said, disregarding the plan’s attempt to argue that Sun Life was bound because Hebrew Home complied with the *spirit* of the agreement.

Hebrew Home claims that its obligation to make timely payments under the Reinsurance Policy constitutes not a condition precedent to Sun Life’s duties, but a covenant with which Hebrew Home substantially complied. This argument is unpersuasive. The clear language of the Insurance Policy supports the claim that the parties intended to enter into a contract, the terms of which required Sun Life to provide reimbursement only on claims paid out by Hebrew Home prior to the expiration of the run-out period.

### **Implications**

When discussing preemption, the court drew a line when it found ERISA preempted some of claims against CoreSource but did not preempt other claims.

#### ***Plan Supervisor Agreement (PSA) vs. Plan Language***

This assessment was due in part to the applicability of two varying documents. For example, the ERISA plan document contained specific language that related to how health care claims should be processed. In order to accurately process those claims, CoreSource needed to reference the plan document.

**See Failed S-L Claim, p. 10**

# DOL Clarifies MHPAEA's Effect on Pre-Authorization

The effect of the Mental Health Parity and Addiction Equity Act (MHPAEA) on prior authorization practices and other “nonquantitative treatment limitations” was clarified Nov. 17 in guidance from the U.S. Department of Labor (DOL).

The MHPAEA interim final rules issued in February 2010 imposed a detailed numerical formula for determining whether quantitative limits such as copayments and deductibles meet the act’s standards for parity. For nonquantitative limits, the rules were naturally more nebulous; factors used to apply these limits to mental health and “substance use disorder” benefits must be comparable to, and no more stringent than, those used for medical/surgical benefits, unless justified by “clinically appropriate standards of care.”

A group health plan may not require prior authorization for all mental health benefits while not requiring it

for any medical/surgical benefits, because prior authorization is a nonquantitative treatment limitation, according to one of the frequently asked questions (FAQs) DOL prepared jointly with the U.S. Departments of Health and Human Services and the Treasury.

And even if, for example, prior authorization is required for all inpatient benefits of either kind, a plan may not have a practice of routinely approving inpatient medical benefits for seven days, but mental health benefits for only one day. “The plan is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits,” DOL explained.

Requiring prior authorization for all outpatient mental health benefits but only a few types of outpatient medical/

See *MHPAEA FAQ*, p. 11

## **Failed S-L Claim** (continued from p. 9)

However, a separate document (the PSA) governed how the stop-loss insurer should be notified of major claims. To properly submit stop-loss claims to Sun Life, CoreSource needed to reference the PSA.

As this case illustrates, in handling issues between a plan and stop-loss insurer, it is important to identify the source from which the conflict arose. Here, the court found that the plan’s claims that related to plan administration (that is, based on plan language) qualified for ERISA preemption.

### *Funding of Claims*

Another noteworthy aspect of the case is the proper funding of claims for stop-loss reimbursement.

There is no argument that CoreSource was responsible for claims submission to Sun Life. However, it appears that part of the issue here related to the funding of the claim.

An important “missing” piece of this funding issue related to communication. It seems that the plan was unaware of the claim and the lack of funding for the claim.

This element of the case illustrates the significance of clear and timely communication when it comes to stop-loss reimbursement issues. The case may have ended differently if the plan had known of the funding issue and discussed it with Sun Life.

### *Timeliness*

Related to communication, is the timeliness issue. The stop-loss policy had language that specifically provided the terms for reimbursement of stop-loss claims. The language set forth clear timelines, and the claims were not paid within those timelines.

This case shows the court acceptance of a strict timely payment rule where the plan must pay within the confines of the stop-loss contract. 🏠

### **Lessons Learned From Hebrew Home of Greater Washington Inc. v. CareSource**

**Administrative Services Agreement.** Review the applicable services agreements in place between the plan and the third-party administrator (TPA) to ensure the duties and responsibilities outlined for each entity are accurate. Further, be sure both parties are aware of their obligations.

**Communication.** In addition to having a reserve available for the timely filing of claims, it is important for the plan and its TPA to have an open line of communication and understanding on how claims will be processed and expectations.

**Timely Payment.** As explained in this case, abiding by stop-loss deadlines is crucial for reimbursement. Be sure to assess the relevant stop-loss contract so everyone is aware of the timeframe for claim submission. 🏠

# State Parity Law Trumps ERISA Plan's Exclusion, So Case Against Plan Advances

As illustrated here, ERISA did not preempt the Washington Mental Health Parity Act.

Even though it correctly applied an insured ERISA plan's coverage restrictions on neurodevelopmental therapy for children over six years old, the administrator's refusal to pay a 10-year-old dependent's mental health treatment violated a state law that bound insurers and HMOs.

Accordingly, fiduciary breach, ERISA benefits and money damage claims against the administrator and plan could proceed, the U.S. District Court for the Western District of Washington held in *Z.D. v. Group Health Coop.*, 2011 WL 5299592 (W.D. Wash., Nov. 4, 2011).

## The Facts

Z.D. was a 10-year-old girl who was covered through her parents by the Technology Access Foundation Health Benefit Plan (the TAF plan), which in turn was insured and administered by Group Health Options, Inc., a Washington state insurer.

She was diagnosed with mental disorders recognized by the Diagnostic and Statistic Manual of Mental Disorders (the DSM-IV-TR), but the plan would not reimburse care she received to treat them.

The TAF plan language did not require the plan to cover Z.D.'s treatment. Instead, it stated:

**Neurodevelopmental Therapies for Children Age Six (6) and Under.** Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally

## MHPAEA FAQ (continued from p. 10)

surgical benefits also would be prohibited. "It is unlikely that the processes, strategies, evidentiary standards, and other factors" that the plan used to decide that only the few medical benefits warranted pre-authorization, would at the same time require it for all outpatient mental health and substance use disorder benefits, DOL indicated.

However, a plan may apply concurrent review to inpatient care where length of stay varies widely, even if in practice this affects mental health conditions more often, DOL noted, as long as "the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits." (The full text of the FAQs is available on DOL's website at <http://www.dol.gov/ebsa/faqs/faq-aca7.html>.)

disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member's condition would result without the services.

Group Health Options refused to reverse itself on administrative appeal, the plaintiffs contended.

## Beneficiary Seeks Coverage under State Law

Z.D. and her parents sued the administrator and the plan under Washington's Mental Health Parity Act and ERISA. They argued that the state mental health parity law (see box on p. 12) supplemented the plan, thereby requiring Group Health Options to cover the treatment.

They alleged that Group Health Options's reading of its policy resulted in "the exclusion and improper limitation of certain services to treat conditions listed in the DSM-IV-TR" and "have acted on grounds generally applicable to a broad group of individuals" situated similarly to Z.D.

They demanded: (1) coverage for Z.D.'s services; (2) a court injunction forcing Group Health Options never to issue another denial that violates Washington's Parity Law at RCW 48.46.291; and (3) any equitable relief available under ERISA Section 1132 (a)(3).

Group Health Options moved to dismiss the case, contending that:

- the family failed to exhaust the plan's internal appeals process;
- Group Health's denial was consistent with plan terms;
- Z.D.'s family had no basis for alleging Group Health acted in a fiduciary capacity or that the plan was harmed;
- Z.D.'s family was not entitled to equitable relief; and
- ERISA preempted any claim based on the Washington Mental Health Parity Act.

The court rejected Group Health Options's argument that Z.D. failed to exhaust administrative remedies. Exhaustion is an affirmative defense and not a pleading requirement (further, Z.D. claimed she had fruitlessly appealed to the plan), it said.

## State Law Governed

As for ERISA preemption, even though plan terms did not require coverage for neurodevelopment treatment of children over the age of six (and the denial was

See *Mental Health Parity*, p. 12

consistent with that), Washington law governed the plan. The following language, from the Group Health Medical Coverage Agreement required the plan and the HMO to:

comply with all applicable state and federal laws and regulations in performance of this Agreement. This Agreement is entered into and governed by the laws of the state of Washington, except as otherwise preempted by ERISA and other federal laws.

Washington law required Group Health to cover the mental health services at issue in this case, the court noted.

The court cited a U.S. Supreme Court decision in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), saying an ERISA plan is bound by state insurance regulations insofar as they apply to the plan's insurer. (**Note:** The court in *Holliday* presumed a higher level of state regulation for insured plans than for self-funded plans.)

#### *Not Negated by Another State Law*

Group Health Options countered that the state parity law at RCW 48.46.291 conflicted with Washington's Neurodevelopmental Therapy Mandate at

RCW 48.44.450, an earlier statute that required group health plans to cover neurodevelopmental therapies for beneficiaries ages six and under. The more limited earlier statute superseded the newer more general statute, the administrator argued.

The court rejected that, saying just because two state laws overlap does not mean that both cannot apply. If two overlapping statutes can be harmonized, and they're not in actual conflict with one another, a plan is obliged to comply with both to the extent possible, the court said, citing *Walker v. Wenatchee Valley Truck & Auto Outlet, Inc.*, 155 Wash. App. 199 (2010). In this case, however, the newer statute enhanced and built on the previous statute — rather than contradicting it or creating problems of interpretation. RCW 48.44.450 was a “floor” not a “ceiling,” the court said, and RCW 48.46.291 merely built on the coverage required in the former.

#### *Not Preempted by ERISA*

The court then ruled that ERISA did not preempt RCW 48.46.291, after holding that the state's mental health parity law governs insurance. Normally ERISA preempts state laws insofar as they govern ERISA employee benefit plans. However, the “savings clause” allows state laws to impact ERISA plans if such laws regulate insurance, (banking or securities).

A two-pronged test determines if a statute is spared preemption by the savings clause, according to the Supreme Court decision in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 342 (2003). First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

RCW 48.46.291 “readily satisfied” both prongs of *Miller's* saving clause test, the court said. First, the statute is directed at “health benefit plans” that are underwritten by an insurer. Second, a state law mandating mental health care services “obviously regulates the spreading of risk” and reflects “legislative judgment that the risk of mental-health care should be shared,” the court ruled.

#### **Fiduciary Duty**

Group Health Options argued against the breach of fiduciary duty claim, saying: (1) because the state law was not included in the plan, there was no discretion exercised in the denial; and (2) Z.D. alleged harm to beneficiaries but not harm to the plan (which would negate any relief except

### **Washington State's Mental Health Parity Law (at RCW 48.46.291)**

(2) *All health benefit plans offered by health maintenance organizations*

(a) that provide coverage for medical and surgical services shall provide: (a) For all group health benefit plans for groups other than small groups ... delivered, issued for delivery, or renewed on or after January 1, 2006, coverage for:

(i) *Mental health services.* The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

See *Mental Health Parity*, p. 13

## **Mental Health Parity** (continued from p. 12)

for “benefits due under the plan,” provided in ERISA’s recovery-of-benefits provisions at Section 1132(a)(1)(B)).

The court rejected the administrator’s first argument, saying that the plan *did* incorporate Washington law into the plan when it said state law must not be violated “in the performance of the plan agreement.” It then cited cases affirming that benefit determinations generally are considered to be a fiduciary act.

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**While there were two applicable laws relating to mental health involved. The laws did not conflict; they could both apply. When the newer law took effect, the plan should have been updated.**

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It rejected the second argument, holding that Z.D.’s claim was broader than a mere claim for “benefits due under the plan.” The family alleged that Group Health Options systematically failed to properly process claims and administer *all* plans it insures. The complaint sought to have Group Health “restore to the plan all losses resulting from its breach,” the court said. And the plaintiff sought an injunction stopping Group Health Options from enforcing terms in violation of the Washington state law, which was a broader claim in scope than “benefits due under a plan.”

### **Equitable Relief**

Group Health Options claimed that equitable and injunctive relief were unavailable because: (1) it was not acting in a fiduciary capacity; (2) “benefits due under the plan” were adequate to fix any injuries Z.D. suffered; and (3) money damages was not an available remedy under ERISA.

The court said the third argument was eliminated by the new U.S. Supreme Court ruling in *CIGNA Corp. v. Amara*, 131 S.Ct. 1866 (2011). In that ruling, the Supreme Court decided that monetary “compensation” (under Section 1132(a)(3) — for “relief typically available in equity”) could be used to rectify a trustee’s breach of duty, or to prevent a trustee’s unjust enrichment. Further, the court had already rejected the first two arguments. Accordingly, it rejected the administrator’s motion to dismiss.

## **Implications**

This case offers an important consideration for plans subject to state laws.

A minor, who was a dependent participant of an insured ERISA plan, sought treatment for mental disorders. The plan denied the claims, arguing that Washington’s Mental Health Parity Act was preempted.

In addition to the federal Mental Health Parity and Addiction Equity Act (MHPAEA), more than 40 states have parity laws. For the states with strong parity laws, MHPAEA is protective of state law. However, if a provision in state parity law offers less protection than the federal law, the federal law must prevail.

In this case, however, there were two applicable laws relating to mental health. The administrator argued that the earlier more limiting law was applicable (which the plan compiled with) and the more recent (and broader) law did not apply.

While there were two laws involved, the laws did not conflict; they could both apply. Thus, when the more recent law came into effect the plan should have updated the language to ensure compliance.

### **The 2010 Health Reform Law**

Another consideration for plans relates to the Patient Protection and Affordable Care Act.

Recently, FAQs were released that in part provided that certain nonquantitative limits on availability of mental health and substance use disorder benefits are prohibited under MHPAEA unless they also (and equally) apply for medical and surgical benefits (see story, p. 10).

For example, a group health plan is not permitted to require prior authorization from its utilization reviewer for use of mental health and substance use disorder benefits if it does not require prior authorization for use of medical or surgery benefits. 🏠

### **Lessons Learned From Z.D. v. Group Health Cooperative**

- 1) Continually update plan language in light of evolving laws and statutes.
- 2) Be mindful of how the health reform law and its constant revisions may impact your plan.
- 3) Review your plan language to ensure that it incorporates information from the recently released FAQs regarding mental health parity. 🏠

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# Gender Reassignment Surgery Officially Dubbed A Deductible Medical Expense

Expenses incurred for gender reassignment surgery and hormone therapy are now deductible medical expenses under Code Section 213.

The IRS announced in Action on Decision (AOD) 2011-03 that it has acquiesced to a 2010 Tax Court ruling that these expenses are deductible. The AOD appeared in the Nov. 21 Internal Revenue Bulletin. See: <http://www.irs.gov/pub/irs-aod/aod201103.pdf>.

The IRS announcement is a reversal of its earlier position on the matter, which was that expenses incurred for hormone therapy and sex reassignment surgery were not deductible because they did not treat a medically recognized disease or promote the proper function of the body. This replaces the agency's former stance, in Chief Counsel Advice (CCA) 200603025.

## Court Ruling the Catalyst

The *O'Donnabhain v. Commissioner* litigation prompted this reversal. In 2003, the IRS disallowed deductions that a taxpayer claimed for gender reassignment surgery and hormone therapy to treat gender identity disorder. A suit was filed in the Tax Court against the IRS over the disallowance. The taxpayer, Rhiannon O'Donnabhain, filed suit in the Tax Court to reverse the IRS' administrative determination and allow her deduction for the expenses of hormone therapy and gender reassignment surgery.

On Feb. 2, 2010, in *O'Donnabhain v. Commissioner*, 2010 WL 364206 (U.S. Tax Ct., Feb. 2, 2010), the Tax Court agreed with O'Donnabhain that her gender identity disorder is a disease under Section 213(d)(1)(A) and (9)(B). The court cited four bases for its conclusion:


- 1) the disorder is widely recognized in diagnostic and psychiatric reference texts;
- 2) the texts and all three experts testifying in the case consider the disorder a serious medical condition;
- 3) the mental health professionals who examined O'Donnabhain found that the disorder was a severe impairment; and
- 4) the appeals courts generally consider gender identity disorder a serious medical condition.

The Tax Court held that because hormone therapy and sex reassignment surgery treat the taxpayer's disease, they are medical care and the expenses for that medical care are deductible under Section 213. (See the April 2010 newsletter, as well as ¶713 and ¶801 in the *Guide*.)

## What This Means

The IRS said in the AOD that as a result of the *O'Donnabhain* decision, it will no longer take the position it had articulated in CCA 200603025 and will follow the Tax Court ruling.

This means that as far as the IRS is concerned, a taxpayer can deduct expenses incurred for gender reassignment surgery and hormone therapy. And expenses that are deductible under Section 213 can be covered by employer-provided health plans.

Employers might need to review their plans and: (1) decide whether to cover such treatment, or if not; (2) revise plan language; and (3) with the help of legal counsel, revisit exclusionary language that takes into account that the procedures are recognized as treating disease, may be medically necessary and are legitimate medical expenses. 

## CE Column (continued from p. 2)

that the requirement to draft an SBC would not be so easily implemented. Now, with 2012 on the horizon, the SBC is again a major area of discussion.

## SBC Template Requirement Put on Ice

As you might recall, the U.S. Department of Health and Human Services (HHS) was required to provide guidance and a template for compliance by March 23, 2011, with plan administrators required to provide these new SBCs to their participants beginning March 23, 2012. The aforementioned template was handed down a few months late on Aug. 18, 2011. As mentioned, the template failed to meet the requirements originally written into the law (a four-page limit) and we were advised that a front-and-back-of-the-page approach would be allowed. At that time, the floor was also opened for comment. Based on the number of comments received, and the variety of issues they address, the policy makers recently notified the public that the deadline of March 23, 2012 is hereby postponed indefinitely, and that they will also provide sufficient time to comply once the final regulations are issued and a new deadline is set.

If the template and final rules had been released in March 2012, plans were supposed to be given about a year to implement the program. Looking into our crystal ball, the template alone was five months late. Add five months to the original deadline, and that puts us in or

See *CE Column*, p. 15

about August 2012. That, of course, would be the new deadline if the template had been airtight and there were no other issues to address. That is not the case, however, and we have to believe it will take HHS at least another five to six months to straighten things out, before setting a final deadline. Thus, if the final rule is issued in early 2013, we wouldn't expect to see a deadline until late 2013, at the earliest. As such, while 2012 will be a year for watching the SBC develop, it won't be a year to actually develop an SBC yourself.

### **Plans Focused on Essential Benefits**

Another reform-based change we anticipate dealing with in 2012 includes changes to annual limits on essential health benefits (EHBs). Plans with a plan year starting on or after Sept. 23, 2011 but before Sept. 23, 2012 will see an annual limit on EHBs of \$1.25 million. As for plan years starting on or after Sept. 23, 2012 but before Jan. 1, 2014, the annual limit on essential health benefits will be \$2 million.

Although these are changes for 2012, the self-funded community needs to monitor several other current regulations when it comes to EHBs. This primarily relates to the definition of an EHB. While it is true that self-funded plans are not currently required to offer coverage for EHBs, they are prohibited from having annual and lifetime limits on any that they do offer. Moreover, they may be required to cover all EHBs in the future, via an expansion of the definition of "Minimum Essential Coverage" to include all EHBs.

### **Whither Accountable Care Organizations?**

Another hot topic being tossed around for 2012 deals with so-called "Accountable Care Organizations" or "ACOs," and Medicare. ACOs will allow providers to form organizations and voluntarily meet quality thresholds, help eliminate unnecessary tests and medical procedures, and encourage greater focus on preventive care. In exchange, they will receive a share in the cost savings they achieve for the Medicare program. Depending upon how well this experiment works, ACOs may spill into the private-insurance relationship as well.

Speaking of Medicare, the year 2012 will bring with it a lot of other developments, such as: (1) reduced rebates paid to Medicare Advantage plans; (2) bonus payments being issued to "high-quality" plans; (3) the creation of an "Independence at Home Demonstration" program to provide high-need Medicare beneficiaries with primary care services in their home; (4) fraud and prevention initiatives to establish procedures for screening, oversight and reporting for providers and suppliers

that participate in Medicare, Medicaid and CHIP; and (5) requiring additional entities to register under Medicare and increased penalties and new compliance and disclosure obligations for health providers.

There will also be new annual fees on the pharmaceutical manufacturing sector, enhanced collection and reporting data from federally conducted or supported health care and public health program surveys based on race, ethnicity, sex, primary language, disability status and for underserved rural and frontier populations.

In 2012, the reform law will: (1) reduce disparities by making improvements in coordination of care by providing funds for home visits for expectant mothers and newborns to reduce infant mortality; (2) promote cultural competency by requiring health plans to use language services and community outreach in underserved communities; and (3) end insurance discrimination by not allowing plans to charge individuals who have been sick and ensuring women pay the same premium as men.

### **New Fees on Self-funded Plans**

Another topic we have been following relates to the "Patient-Centered Outcomes Research Trust Fund Fees." This involves a fee that insurance plans and sponsors of self-funded plans must pay on a per-policyholder basis to fund the Patient-Centered Outcomes Research Trust Fund. The fund supports comparative clinical effectiveness research activities. For policy and plan years ending during fiscal year 2013, the fee will be equal to \$1 per individual covered under the policy or plan. For the remaining fiscal years, the fee increases to \$2 for each covered individual or enrollee.

What still needs to be decided in 2012 is how plans will calculate the average number of lives they include. A reasonable method for making this calculation needs to be determined and universally adopted. In addition, it is still unclear whether a plan should pay fees annually or quarterly and if reporting should occur on the same day for all plans regardless of the timing of their policy year.

In 2012, states will be required to establish a temporary reinsurance program. The intent of the program is to help stabilize premiums in states' individual markets during the first three years of operation of the notorious exchanges. Health insurers and third-party administrators (TPAs) of self-funded health plans will be required to make payments to the program for each of its years in operation. Many questions remain regarding the method of payment, whether the payments should be made to the federal government or through the states, and whether payments should be made monthly or annually.

See *CE Column*, p. 16

One of the more interesting questions relates to what role TPAs will play in this situation as well. While we have been told that TPAs will not be financially responsible for these fees, it is not set in statutory stone. We would hope that TPAs will be responsible for collecting the fee from the plans they work with; not payment of the fee itself.

A bigger question relates to the identification of self-funded plans. Our guess is that this is another role for TPAs, and is perhaps another area where the TPA can create a new revenue stream. We should expect to begin seeing some answers on this before summer 2012.

We would recommend that fees be collected on an annual basis, not on a per-month basis. Doing so on a per-month basis would be an extreme administrative burden and in many cases, very difficult to do accurately. Payment of the fee on an annual basis, using the average of the per-month totals, would ensure fewer administrative hardships and the ability for the plan to submit more accurate figures. TPAs should be allowed to act on the plan's behalf, but it should be recognized that they serve in purely an administrative role with no control over plan assets. Therefore, the TPA is not a fiduciary. We have already seen what problems this can bring.

### **Will the Enemies of Self-insuring Win?**

Moving on to yet another topic, the ERISA's regulatory exemption for self-funded plans is a persistent thorn in the side of state insurance regulators, and the fact that several stop-loss insurers have been focusing on the small-group market further drives the thorn deeper into their flesh. In this current economic environment, it can be expected that employers of all sizes faced with spiraling health care costs will continue to examine the self-funded option as a way to provide more cost-efficient health benefits to employees and their families. According to the Kaiser Family Foundation, the recent trend of small employers (3-199 workers) moving to self-insurance started in the early 1990s and accelerated slightly in the decade, rising from 13 percent in 1999 to 15 percent in 2009. The late 2000s saw a jump in self-funding, and we anticipate 2012 to be a banner year for this industry.

According to a Kaiser Family Foundation survey, approximately 60 percent of benefits are provided by self-funded group health plans. This percentage increased from 49 percent in the year 2000, according to the Kaiser Family Foundation and Health Research & Educational Trust's *Employer Health Benefits 2011 Annual Survey*, <http://ehbs.kff.org/pdf/2011/8225.pdf>.

HHS and the U.S. Department of Labor (DOL) published in their reports that 82.1 percent of large employer groups offer at least one self-funded health plan. See: *A Report to Congress on a Study of the Large Group Market* (March 31, 2011; website: <http://aspe.hhs.gov/health/reports/2011/LGHPstudy/index.shtml>).

### **Must Self-funding Suffer to Support Exchanges?**

This increase is fueled primarily by escalating costs and the search for a more cost-effective alternative to commercial health insurance. We have seen more and more brokers across the health insurance industry begin to look at self-funding. Good and bad things can be said about this. On a positive note, having more interest in self-funding means greater growth in our industry. Negatively, however, having brokers begin to place their clients in self-funded plans could lead to a misuse of self-funding, stop-loss and products that abuse the self-funded structure. All it takes is a few plans or participants to complain to their insurance commissioners about these "sham" self-funded products and you'll see arguments against self-funding grow. This is another forecast to watch out for in 2012.

Due to this vast amount of growth, one of the trends we have noticed in 2011, that we expect to see continuing into 2012, are attempts by those with a vested interest in health care exchanges seeking ways to attack the financial viability of self-funding. As employers come to realize that the cost of purchasing private insurance from fully funded insurers will continue to skyrocket, they will naturally consider alternatives (as previously discussed).

Those who support the exchange — a government-monitored exchange of private health policies, which meet (or beat) minimum standards (mandates) set by policymakers — realize that in order to have an exchange that works, and be able to offer generous coverage for premiums that are capped by law, the policies must enjoy a large risk pool comprised of healthy lives. Indeed, if only the sickest of the sick join the exchange, insurers will not be able to provide the mandated benefits while staying under the mandated cap on cost. There is thus a major concern among pro-exchange regulators that the growth of the small-employer self-funded marketplace will contribute to adverse selection in the group health care marketplace when the exchanges begin in 2014. Do not be surprised if these regulators continue to attempt to restrict self-funding by attacking stop-loss in various ways (such as by prohibiting its sale to smaller groups or by restricting terms, such as making attachment points higher). The key to success, they will

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See **CE Column**, p. 17

agree, comes in two parts: (1) require all Americans to purchase coverage [expanding the risk pool and ensuring healthy “low cost” lives join the pool]; and (2) eliminate other options available to healthy lives.

Thus, when HHS and DOL were independently instructed to release reports on self-funding, we anticipated a smear campaign meant to shrink support for self-funding as an option for health plan sponsorship. Instead, we ended up seeing a glowing review that enforced what we have been saying all along — self-funding gets the job done, often for less. (See the May 2011 *newsletter*.) One of the major issues we spotted, however, amidst the otherwise positive feedback related to stop-loss, is how smaller self-funded plans that would ordinarily not be able to afford the risk of self-funding (the threat of a catastrophic claim) are able to self-fund thanks to the presence of stop-loss protection for a low specific-deductible attachment point. The implication was that a plan with a low specific deductible is no different than a fully insured employer with a higher-than-average deductible.

### Is 2012 the Time to Shackle Stop-loss?

This issue came to a head in October 2011 when the National Association of Insurance Commissioners (NAIC) considered a recommendation that the NAIC amend its stop-loss model act to prohibit the sale of stop-loss insurance to small groups, or as an alternative, raise the minimum allowable specific attachment point to \$40,000. Self-funded plans that purchase stop-loss policies under what the NAIC classified as “low attachment points” were accused of actually being commercial health insurance products, and not self-funded plans. Since then we, in partnership with the Self-Insurance Institute of America (SIIA), have drafted white papers in response to this theory, explaining that stop-loss reimburses plans, not health care providers, and that unlike a fully insured employer, whose employee’s claims are paid by the insurer, a self-funded plan — regardless of its stop-loss deductible — is responsible for medical expenses.

It is only after the claims are paid that self-funded plans submit a claim for reimbursement and hopefully receive the funds. Whether their claim is accepted or denied, however, does not affect their obligation to pay their plan participant’s medical bill. Thus, even with a low attachment point, the key differentiator between a self-funded plan and fully insured policy is risk retention. Self-funded plans continue to be at risk for payment of claims. We anticipate that this dispute will gain momentum as we enter 2012.

It is clear that with the current action by the NAIC and state insurance commissioners, self-funded plans and TPAs will need to be careful with their stop-loss choices and insurers will need to be diligent with their offerings. Self-funded plans and TPAs need to educate their state insurance commissioners on the benefits of self-funding to ensure its viability as well.

### PPO Perspectives in 2012

A big issue that we addressed in 2011, and we are watching as 2012 approaches, relates to the role preferred provider organization (PPO) networks play in today’s benefits landscape, what benefits they truly provide to plans and alternatives that either exist or may develop over the next year. We have written many articles about the benefits and potential risks of PPO network arrangements. (See the December 2011 *newsletter*.) Two of the biggest issues we’ve seen, and expect to see more often in 2012, relate to the discount and payor status.

First, regarding the discount, as networks have expanded, exclusivity of in-network status has diminished. As the value of being an in-network provider has lost its value, the incentive for providers to offer real savings has lessened. This expansion of networks and reduction of the value of in-network status has resulted in discounts that do not measure up to the inflation we’ve seen on prices industry-wide. In other words, a 10-percent discount on a charge that is inflated by 700 percent is no great deal at all! Unfortunately, plans that enter into network agreements contractually obligate themselves to pay whatever the in-network provider charges, sacrificing their ability to audit the claims and dispute charges they believe to be excessive.

The second issue we expect to see relates to payor status. PPOs and providers are deeming TPAs to be payors, and thus responsible for payment of claims, when the plans said TPAs service fail to provide payment within the deadline set by the PPO contract. As a result, we are seeing — and anticipate seeing — providers performing audits, identifying late payments and pursuing TPAs for payment rather than the plan sponsors. As the benefits of PPO participation dwindle, and the risks faced when entering into a PPO arrangement increase, we believe we will see many more plans seeking to use PPO alternatives — such as pricing based on Medicare, a usual-and-customary or other pricing parameter.

This issue connects closely with a major lawsuit that may be heard by the Texas Supreme Court titled *GPA Holding, Inc. v. Baylor Health Care System*, No. 06-00120 (Dallas Cty., May 18, 2011). We recently filed a brief on behalf of SIIA in support of Group and Pension Admin-

See *CE Column*, p. 18

istrators Holding, Inc. (GPA), and in opposition to Baylor Health Care System (Baylor). We urged the court to reverse the judgment of the 5th District Court of Appeals (Dallas) as the financial integrity of all TPAs is placed in jeopardy by the prior ruling. This case presents the issue of whether a TPA, such as GPA, can be held financially responsible for expenses incurred by participants of self-funded plans. The lower court has obligated GPA to be a guarantor of payment. By doing so, it has eliminated the core element that differentiates a self-funded plan from an insurer. Consider the fact that 79 percent of employers use TPAs and about 55 percent of employees are members of plans using a TPA, Frederick D. Hunt, Jr., Society of Professional Benefits Administrators, writes in the article entitled *Everything You Wanted to Know About TPAs But Were Afraid to Ask*. See: <http://www.spmatpa.org/node/1600>.

### **Will TPAs Face More Fiduciary Circumstances?**

If the court does not reverse the appellate court decision, then a TPA will be held to be a fiduciary payor and thus deemed to be no different than an insurer — potentially eliminating self-funding and negatively impacting millions of self-funded plan participants nationwide. We argued that only a fiduciary may be deemed responsible for payment and have asked the court to reverse the lower courts' determination that deems GPA to be a guarantor of payment.

Based on this case and others like it that deem the TPA to be a payor and/or a fiduciary, one of the biggest decisions that TPAs and plans will have to make in 2012 is whether the fiduciary shift takes place. Who will take on the fiduciary responsibilities and what exactly falls within the “fiduciary realm?” Will TPAs begin to take on more of a fiduciary role since more and more courts are declaring that they are fiduciaries regardless of what the administrative services agreement states?

Finally, in what will be the biggest issue to watch in 2012, get ready for the primetime courtroom drama regarding the reform law's constitutionality.

As attorneys, we frequently review contracts on behalf of our clients. One constant is the “severability clause.” Most contracts include this clause, which in essence states that if any portion of the agreement is deemed to be illegal or unenforceable, the illegal provision is cut from the contract, and the remainder of the terms shall stay in effect.

An integral part of the reform law states that all U.S. citizens must carry health insurance. The challenge has

been made, however, that such a requirement is unconstitutional. Some argued further that if one part of the law is unconstitutional, the whole law is invalid. This argument was made because the aforementioned severability clause does not appear in the law. That shouldn't come as much of a surprise to anyone, since many lawmakers would likely not have voted in support of the law if it had lacked this provision. In other words, many legislators likely supported this law in its entirety, as an “all or nothing” document.

### **Could Health Reform Go Down in Flames?**

Multiple courts held that the provision is constitutional; including the *Thomas Moore Law Center v. Barack Obama* case back in October 2010, which was a 6th U.S. Circuit Court of Appeals decision. This was followed by the 4th Circuit decision in *Virginia v. Kathleen Sebelius* on Dec. 12, 2010, stating that states do not have the authority to challenge the law.

However, in the action brought by 26 states titled *Florida et al. v. U.S. Department of Health and Human Services*, the U.S. District Court for the Northern District of Florida in January 2011 declared the law unconstitutional, saying the individual mandate to purchase insurance exceeded Congress' authority to regulate interstate commerce. Further, the court held that because the clause was not severable, it had the effect of striking down the entire law. On Aug. 12, 2011, however, a divided three-judge panel of the 11th Circuit affirmed the lower court's decision ... but only in part. The court agreed that the mandate was unconstitutional, but held that it could be severed, leaving the rest of the reform law in place. Now, the case has been appealed to the U.S. Supreme Court, and the High Court has declared its intent to make the final decision. While we both agree that it will be a 5-4 decision, we just aren't sure which way the court will go.

The Supreme Court expects up to five-and-a-half hours of arguments to take place in March 2012. This is an exceptionally substantial amount of time being afforded by the Court, indicating that it understands this is an issue that is clearly important to the future of this country. The issues that will be the focus of the arguments include whether the mandate is based on the impermissible use of the Commerce Clause as well as whether the reform law can stand without the mandate. We cannot wait to write the article regarding this decision!

While 2011 had much to offer, 2012 looks like an endless roller coaster ride. We just hope that we do not get too sick by the end of it! 🏠

## Equitable Relief (continued from p. 4)

in the action is “appropriate” under traditional equitable principles and doctrines.

### ‘Equity Abhors a Windfall’

The court cited the recent U.S. Supreme Court decision (*Cigna Corp. v. Amara*, (131 S. Ct. 1866, May 16, 2011) (see the May 2011 *newsletter*) to say that although US Airways had not engaged in any misconduct, the execution of its contractual right of recovery was limited by the principle of unjust enrichment:

the importance of the written benefit plan is not inviolable, but is subject – based on equitable doctrines and principles — to modification, and indeed, even equitable reformation under §502(a)(3). ... While the basis for the reformation in *Cigna* was intentional misrepresentations by the employer and fiduciary, the broader and more relevant point is that when courts were sitting in equity in the days of the divided bench (or even when they apply equitable principles today) contractual language was not as sacrosanct as it is normally considered to be when applying breach of contract principles at common law. We do not suggest that US Airways conduct was fraudulent or dishonest in the way that *Cigna*’s was, but equitable principles can apply even where no one has committed a wrong.

In applying the traditional equitable principle of unjust enrichment, the court concluded that full reimbursement would not be “appropriate equitable relief,” consistent with ERISA Section 502(a)(3) because:

the amount of the judgment exceeds the net amount of McCutchen’s third party recovery, it leaves him with less than full payment for his emergency medical bills, thus undermining the entire purpose of the Plan. At the same time, it amounts to a windfall for US Airways, which did not exercise its subrogation rights or contribute to the cost of obtaining a third-party recovery. Equity abhors a windfall.

Accordingly, the appeals court vacated and remanded the district court’s judgment to determine what would be “appropriate equitable relief,” listing various factors for the district court to consider.

### Implications

This case leaves open potential issues for discussion on remand.

### Enforcement of Rights

In this case, the plan did not make attempts to enforce its rights and recoup funds until after the member settled

his claims. This leaves open what, if anything, would have changed if the plan had attempted to intervene in the case prior to settlement.

### Demand for Repayment

The plan also sought to recover more than what the member had retained from the settlement for himself. Not only did the plan file suit to recover the funds held in trust (\$41,500), but also the balance of its lien. As a result of this demand, the member would have had to pay \$25,366 above what was held in trust.

This presented more than a simple “common fund” issue as the plan was attempting to recover funds that represented more than the member’s net recovery after the member paid attorney’s fees and costs.

### Applicable Plan Language

In a similar situation, a plan may have benefited from stronger plan language. For example, a plan may have had a stronger argument if the language explicitly disclaimed the made-whole and common-fund doctrines.

However, within the 3rd Circuit, the court presumes these limitations do not apply unless the plan specifically states they will. As a result, the language should have been enough under the deferential standard of review.

### Appropriate Equitable Relief

In this case, the court stated that by the use of the word “appropriate,” Congress had intended to provide an injured plan participant with equitable limitations to the plan’s equitable rights. However, in discussing unjust enrichment, the door is opened to discuss the made-whole and common-fund doctrines. 🏠

## Lessons Learned From *US Airways, Inc. v. McCutchen*

**Plan Language.** Plan language, particularly in circuits with more demanding laws, is crucial to the success of a plan in seeking reimbursement on recovery cases.

**Negotiation.** The plan argued for a 100-percent recovery of claims paid. This may have been a situation where instead of incurring legal expenses, the plan and plan participant could have negotiated based on the specific facts of the circumstances.

**Precedent.** Watch for the final decision in this case, as well as decisions in other circuits where similar arguments may arise. 🏠

# Subject Index, Vol. 19

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