

NAIC Delays Vote on Model Law Raising Stop-loss Attachment Points

A proposal to raise specific attachment points in a stop-loss model act to a level was delayed after an Aug. 11 debate hosted by the National Association of Insurance Commissioners' ERISA working group. The working group cited the need to study the proposal further. Proponents of self-funding say tough stop-loss rules would restrict smaller firms' ability to self-insure health benefits. The Self-Insurance Institute of America said the proposal — which would triple specific stop-loss attachment points from \$20,000 to \$60,000 — is designed to discourage self-funding and create an environment that will funnel more workers working for small employers into the insurance exchanges created under the health reform law. **Page 3**

Employer Groups Call on 2nd Circuit To Preserve ERISA Plan Discretion

Second Circuit judges were urged to support the principle of deference to plan administrators' decisions over benefit plans in a July 26 *amicus* brief filed by the ERISA Industry Committee, American Benefits Council, U.S. Chamber of Commerce and Business Roundtable. If ERISA plans vest plan administrators with "discretion" to interpret plan provisions, courts must defer to that discretion and review such cases under an abuse of discretion standard. The industry groups said: (1) deference belongs with the plan administrator, who unlike federal judges, focuses only on health plans; and (2) deference ensures that multi-state plans get uniform administration across legal jurisdictions. Dissolving discretionary authority and deference could make plans have to adjust benefits determination processes on a court-by-court, jurisdiction-by-jurisdiction and judge-by-judge basis. Also, dissolution of discretion would ruin plans' ability to meet already strict prompt-pay expectations, they said. **Page 4**

ERISA Breach Justifies Damages Beyond 'Mere Premium Refunds'

Monetary damages for ERISA violations are becoming closer to reality for ERISA plans, with a federal appeals court applying recent U.S. Supreme Court precedent to hold that a plan beneficiary may be entitled to monetary compensation and estoppel — rather than just premium refunds — as a form of "appropriate equitable relief" under ERISA. In *McCravy v. Metropolitan Life*, a benefit plan accepted premium payments for an ineligible beneficiary — then tried to refund them after claims were filed. The newer outcome would not have been possible without the U.S. Supreme Court decision in *CIGNA v. Amara*, which broadened ERISA's definition of "appropriate equitable relief." **Page 6**

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Why Implementing Health Reform Will Fuel Skyrocketing Costs

By Adam V. Russo, Esq.



If the health reform mandates are not recalibrated, we will witness a cost explosion in the health system. To avoid that, the system must continue evolving, because health reform creates or leaves unresolved several key problems, which include: (1) insurers have to control the way they increase premiums, but providers don't have to control increases in what they charge; (2) reform's significant new taxes on devices and drugs will be passed on to insurers, and then consumers; and (3) the individual mandate has no "teeth," so people can avoid buying policies without legal repercussions. This means insurance pools will be sicker and costlier.

Introduction

As we all know by now, the U.S. Supreme Court health reform decision turned up a win for President Obama, based on the unexpected argument that the Constitution's taxation clause — not its Commerce Clause — authorized the individual mandate.

If the decision was based solely on the Commerce Clause, it would have been overturned. That was because the conservative tier of the Court — Justices Scalia, Kennedy, Thomas and Alito — joined with Chief Justice Roberts in rejecting the argument that the Constitution can make it an offense *not* to purchase an item or service.

The court however validated the individual mandate and thus the entire law, because Roberts and the liberal tier — Justices Kagan, Breyer, Ginsberg and Sotomayor — agreed the mandate fell into Congress' taxation authority.

Declawed Individual Mandate

Under that argument, those who fail to purchase will be taxed; those who fail to pay the tax might get in trouble (but not much, as we shall see). Because the individual mandate is a tax and not an order to buy, individuals who do not buy health insurance face fewer legal consequences. This has implications for reform's insurance risk pools and in turn, insurance premiums will be higher.

The taxing power does not give Congress the same degree of control over individual behavior as the commerce clause would have. If an individual does not maintain health insurance, all he or she has to do is make an additional payment to the IRS when paying taxes. While the individual mandate clearly aims to induce the purchase of health insurance, failing to do so is not unlawful. If someone chooses to pay the tax rather than obtain health insurance, he or she has fully complied with the law.

But here is where the problems start. What if you don't pay the tax? What happens to you then? Many income tax evaders go to prison. So why should health reform be any different?

Here's why. The health reform law bars the IRS from using several of its normal enforcement tools, such as criminal prosecutions and levies. The Supreme Court noted that if individuals reject the mandate and refuse to pay the tax, there will be no criminal penalties. Chief Justice Roberts reasoned that "there's no real compulsion here" since those who do not pay the penalty for not having insurance can't be sent to jail.

So how is the IRS supposed to collect the funds due to them? As far as health reform is concerned, Congress and the Court have declawed the IRS.

Employer's Guide to Self-Insuring Health Benefits

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See *CE Column*, p. 17

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A proposal to raise specific attachment points in a stop-loss model act to a level that proponents of self-funding say would restrict smaller firms' ability to self-insure health benefits was delayed after an Aug. 11 debate hosted by the National Association of Insurance Commissioners' ERISA working group. The working group cited the need to study the proposal further.

The Self-Insurance Institute of America believes the proposal — which would triple specific stop-loss attachment points from \$20,000 to \$60,000 — is designed to discourage self-funding, and create an environment that will funnel more workers working for small employers into the insurance exchanges created under the health reform law.

After the revisions to the model stop-loss act were proposed in early July, the NAIC received public comments decrying the proposal from SIIA, America's Health Insurance Plans, Blue Cross Blue Shield, Illinois Chamber of Commerce, Heartland Actuarial Consulting, CIGNA, HCC Life Insurance Co., the American Insurance Association and consumer representatives including Families USA, Consumers Union and the Service Employees International Union.

NAIC models are not laws, so they are not binding on plans or jurisdictions. However, states do base their own laws and regulations on NAIC models.

The Current Model

In its current form, the NAIC model says stop-loss insurance may have a specific attachment point of no less than \$20,000. For groups of more than 50, the annual aggregate attachment point may not be below 110 percent of expected claims. For groups of 50 or fewer people, the annual aggregate attachment point may not be less than the greater of: (1) \$4,000 times the number of group members; (2) 120 percent of expected claims; or (3) \$20,000. According to the NAIC, three states — Minnesota, New Hampshire and Vermont — have adopted the model act, and about 18 others have implemented elements of it.

Proposed Revisions

The proposed revisions to the model would triple the minimum specific attachment point to \$60,000. The minimum aggregate attachment point would: (1) nearly quadruple to \$15,000

times the number of group members; (2) increase 10 percentage points to 130 percent of expected claims; or (3) triple to \$60,000 (whichever is higher).


Note: California is also close to enacting a stop-loss regulation that imposes the \$60,000 specific attachment point on stop-loss insurers.

NAIC Procedure

At the Aug. 11 meeting, NAIC Chairwoman Christina Goe of Montana said the group was considering the revision to be a "guideline" that would pass on a majority vote, instead of a two-thirds vote required to "amend" the model. Then, states would have the option of adopting or not adopting this revised standard, Goe said. SIIA contends that no practical distinction would exist between a guideline amendment and an amended model act.

NAIC working group members tried to reassure the self-insured community by saying that the revision is not designed to prevent firms from self-insuring, and it is not intended to treat stop-loss as direct health insurance. Rather, they said, the proposed change was a response to medical inflation and changes in plan designs since 1995.

SIIA argues that NAIC's reasoning presupposed that the original limit of \$20,000 made sense, which it probably did not, given the fact that most states never put the original limit in place.

The working group concluded by saying it would revisit the matter further at its next meeting. A date for that meeting has not been set. The proposal has yet to work its way through NAIC's Regulatory Framework Task Force, its full Health Insurance and Managed Care Committee and the plenary NAIC membership. 

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Employer Groups Call on 2nd Circuit To Preserve ERISA Plans' Discretionary Powers

Courts must defer to plan administrators' decisions when the plan administrator reserves discretionary authority in the plan document, employee benefits and business groups told the 2nd U.S. Circuit Court of Appeals in a case that observers say is threatening employers' ability to manage their self-funded health plans.

Four groups — the ERISA Industry Committee, the American Benefits Council, the U.S. Chamber of Commerce and the Business Roundtable — filed an *amicus* brief July 26 to urge 2nd Circuit judges to support the principle of deference to plan administrators' decisions over benefit plans.

This is one of several recent court rulings that are eroding self-funded health plans' discretionary authority over their decisions, the groups say. This *amicus* brief is trying to call attention to the trend and how it would harm ERISA's fundamental goals of uniform nationwide plan administration and less litigation of benefits decisions.

The groups' brief asks the 2nd Circuit to consider the decision of the U.S. District Court for the Western District of New York in *Frommert v. Conkright*, 00-CV-6311 (W.D. N.Y., Nov. 17, 2011). This case has been litigated since 2002.

Plan Interpretation Disputed

The dispute in *Conkright* is whether Xerox Corp. excessively reduced employee retirement benefits for a group of employees who left, then rejoined, the company. A lump-sum benefits distribution was to be subtracted from future benefits when the workers rejoined the company. Employees were shortchanged, and the way the plan calculated the value of their offsets was not detailed in a plan document or summary plan description, they contended.

The plaintiffs (joined by the U.S. Department of Labor) argued that the plan's discretion can be overturned when it ignores participants' reasonable reading of ambiguous plan provisions.

The plaintiffs also argued that because, by law, no employee's pension benefits can be reduced by conditions that were not properly communicated in a summary plan description, Xerox's interpretation of the plan for returning former employees should be ignored because it failed to notify plaintiffs of the offset.

Initially, the U.S. District Court for the Western District of New York favored the Xerox plan administrator, ruling that it used a proper method and employees had adequate notice.

But the 2nd Circuit overturned that decision (*Conkright v. Frommert*, 535 F.3d 111 (2nd Cir., July 24, 2008)), concluding that the method constituted an improper cut-back of ERISA benefits. The U.S. Supreme Court took the case.

The 5-3 decision written by Chief Justice Roberts (*Conkright v. Frommert*, 2010 WL 1558979 (April 21, 2010)) overturned the appeals court decision because: (1) a single error was not enough to strip the plan administrator of discretionary authority; (2) there was no pattern of errors or evidence of bad faith that might change the standard of review; and (3) deference should be upheld where possible because frequent second-guessing of plan administrators would increase the frequency and difficulty of litigation. (See the June 2010 newsletter.)

The High Court remanded the case to the district court, which in December 2011 again ruled in Xerox's favor. The plaintiffs appealed to the 2nd Circuit again.

Employer Arguments for Deference

Here's a summary of points made in the employer groups' brief.

- **Deference to the plan administrator** “ensure[s] that administrative responsibility rests with those whose experience is daily and continual, not with judges whose exposure is episodic and occasional.” It also allows disputes to be resolved administratively, without costly prolonged litigation.
- **Dispelling plan discretion would be at odds with uniform administration**, and “would subject ERISA plans to potentially competing, *de novo* constructions in myriad district courts, destroying the uniformity on which ERISA plans depend. And they raise the specter of unexpected liabilities, creating uncertainty that can harm plan sponsors and beneficiaries alike.”
- **Expecting plans to consider participants' “reasonable expectations”** when making decisions would “stand discretion on its head.” The fact that different reasonable interpretations exist is separate from the question of who gets the final say, the brief stated.
- **Arguments that a conflict of interest should change the standard of review were baseless**, because there was no evidence that the conflict influenced the plan decision. The plaintiffs “nowhere identify how the alleged conflict here differs

See *Amicus Brief*, p. 5

from that at issue in every one of the thousands of ERISA plans in which the sponsor and administrator of the plan are governed by the same entity.”

- **Disregarding plan discretion would frustrate ERISA’s goals** of predictability and uniform administration and discourage employers from sponsoring ERISA plans.
- **The absence of detailed interpretations in an SPD** to resolve every possible ambiguity flies in the face of the SPD being a reasonable length and easy to read and navigate. An effort to subject the SPD notice to *de novo* review as a means to overturn a plan’s discretionary interpretation was an attempt to sidestep the Supreme Court’s April 2010 *Conkright* ruling affirming discretionary authority for plans.
- **The Supreme Court’s 2011 *Amara* ruling (see sidebar) did not support a court order to revise the plan document** as a means of equitable relief, because the plaintiffs in *Conkright* had not proven they were denied sufficient equitable relief under traditional means. Further, no evidence existed that Xerox engaged in fraud or disguising the plan’s true intent. And, theories of estoppel and unjust enrichment (on which the *Amara* ruling was based) were totally absent from the facts in the *Conkright* case.

For those reasons, the industry groups stated, the district court’s ruling must stand.

Implications

The trend started by *Amara* is troubling for many reasons.


First, health reform introduced mandatory usage of an independent review organization in difficult claims disputes. That eroded the permanency of plan administrator discretionary authority. Now, not only must plans and TPAs fear that IROs will overturn their decision — they may have to fear the courts as well.

Here’s a scenario we hope will not be commonplace. A displeased participant gets a *de novo* review at the IRO level. Even if the IRO upholds the plan’s decision, nothing stops the participant taking his or her complaint to a court of law, where a post-*Amara* court gives the case another *de novo* review. The court will not defer to the IRO’s or the plan’s decisions and the plan faces an activist judge not familiar with how health plans

work. The result overturns a plan and an IRO whose sole business is understanding health plans and benefits. That is why many benefits attorneys for plans hope an IRO’s decision will also get deference in court, but federal rules have not made that explicit yet.

Dissolving discretionary authority and deference could result in plans having to adjust benefits determination processes on a court-by-court, jurisdiction-by-jurisdiction and judge-by-judge basis. That’s hardly in line with ERISA’s goal of uniform, nationwide plan management.

Second, dissolution of discretion would ruin plans’ ability to meet already strict prompt-pay expectations, as plan administrators strive to check and double-check their decisions to ensure “air-tight” status. The result: providers complain, rescind discounts and participants are balance-billed. Another result: less prompt payment. The only remedy may be for plans to renegotiate the meaning of prompt pay with providers so it’s understood to mean 60 days and not 30 days.

Plans have too many incentives to take more time under the new regime: making sure claims are paid correctly, and scouring the landscape for any evidence that a court would use to overturn the decision. This trend will slow down claims payment even more! 

Supreme Court Decisions on Discretionary Authority

Most ERISA plans vest plan administrators with “discretion” to interpret plan provisions and decide whether to award benefits. Courts must defer to that discretion and review such cases under an abuse of discretion standard. That means that the plan’s decision stands unless the court is persuaded the decision was arbitrary or capricious.

An *amicus* brief written by employer groups discusses the applicability of these (and other) landmark decisions, each of which affect plan discretionary authority when making benefits determinations. (See story, page 4.)

The High Court’s ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 S. Ct. 101 (1989) established that administrators have authority to interpret the plan if that right is stated in the plan, and courts will defer to those interpretations.

In *Metropolitan Life v. Glenn*, 128 S. Ct. 2343 (2008), the Supreme Court ruled that when a conflict of interest exists, courts will consider the conflict as a factor when deciding whether there had been an abuse of discretion. Courts may overturn plan decisions to the extent that the conflict improperly influenced the plan’s determination.

In *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), the Court described how ERISA can be construed to allow participants to rewrite a plan provision and recoup money based on the reformed plan, in the wake of evidence that the plan misrepresented provisions in SPDs.

For more information about ERISA plans, see Tab 755 of the *Guide*. 

Plan May Face Money Damages for ERISA Violation, Not ‘Mere Premium Refunds’

Monetary damages for ERISA violations are becoming closer to reality for ERISA plans, with a federal appeals court applying recent U.S. Supreme Court precedent to hold that a plan beneficiary may be entitled to monetary compensation and estoppel — rather than just “mere premium refunds”— as a form of “appropriate equitable relief” under ERISA.

In *McCravy v. Metropolitan Life Ins. Co.*, 2012 WL 2589226 (4th Cir., July 5, 2012), a benefit plan accepted premium payments for an ineligible beneficiary — then tried to refund them when the mistake was discovered after claims were filed.

In earlier court proceedings, a refund was deemed the appropriate remedy. However, as the *McCravy* case progressed, the U.S. Supreme Court widened ERISA’s definition of “appropriate equitable relief” in *CIGNA v. Amara*, 2011 WL 1936077 (U.S., May 23, 2011). (See the July 2011 newsletter.)

The 4th U.S. Circuit Court of Appeals revisited *McCravy* in light of *Amara* and concluded that equitable relief theories of surcharge (make-whole) and estoppel can require the payment of benefits to an ineligible beneficiary.

McCravy involved a denied life and accidental death and disability claim, but it has implications for health plan administrators as well.

The Facts

Debbie McCravy enrolled her daughter Leslie as a dependent in her employer’s ADD plan, which was insured and administered by MetLife. Leslie was admitted to the plan when she was less than 19 years old. After Leslie was murdered at age 25 in 2007, Debbie filed a claim for benefits. MetLife denied McCravy’s claim, contending that Leslie did not qualify as an “eligible dependent child” because she was 25 at the time of her death.

MetLife limited coverage for “eligible dependent children” to: (1) unmarried children; (2) dependent for financial support; and (3) either (a) under age 19 or (b) under age 24 if enrolled full-time in school.

MetLife attempted to refund \$311, the amount in premiums MetLife had accepted to provide coverage for Leslie. Debbie McCravy rejected the refund.

McCravy then sued MetLife, arguing that waiver, estoppel, “make-whole” and other equitable theories entitled her to ERISA relief beyond the return of the \$311

she paid to insure Leslie. She also made state-law promissory estoppel and breach of contract claims.

McCravy contended that MetLife harmed her by representing that her daughter had coverage, which led her daughter not to purchase ADD coverage elsewhere, and the fact that the insurer accepted premium payments for six years without informing McCravy that Leslie was ineligible was a breach of fiduciary duty, she also contended.

The district court added that ERISA did not allow remedy apart from return of the premium, and conceded that the lack of further remedies leaves the door open for abusive plan windfalls.

District Court: Our Hands Are Tied

MetLife successfully moved to have the state-law claims preempted, and the district court ruled that she could not recover under ERISA for her breach-of-fiduciary-duty claim.

The district court denied Met Life’s motion to dismiss McCravy’s claims under Section 1132(a)(3) (for “relief typically available in equity”).

However, it added that ERISA did not allow remedy apart from return of the premiums, and conceded that the lack of such a remedy leaves the door open for abusive plan windfalls.

The law in this area is now ripe for abuse by plan providers, which are almost uniformly more sophisticated than the people to whom they provide coverage. With their damages limited to a refund of wrongfully withheld premiums, there seems to be little, if any, legal disincentive for plan providers not to misrepresent the extent of plan coverage to employees or to wrongfully accept and retain premiums for coverage which is, in actuality, not available to the employee in question under the written terms of the plan.

If the employee never discovers the discrepancy, the plan provider continues to receive windfall profits on the provision in question without bearing the financial risk of having to provide coverage.

See *Money Damages*, p. 7

Money Damages (continued from p. 6)

If the worst happens and the employee does file for the benefits for which he or she had been paying and seeks the coverage he or she believed was provided, the plan provider may then simply deny the employee's benefits claim, and have their legal liability limited to a refund of the premiums.

Amara Becomes a Game Changer

After the district court only awarded McCravy the improperly withheld premiums, she appealed to the 4th Circuit, which initially upheld the district court's final order to reimburse the premiums as the only available remedy. But that very same day (May 16, 2011), the Supreme Court announced its decision in *Amara*, and based on the *Amara* decision, the appeals court granted McCravy's motion for rehearing.

In *Amara*, the U.S. Supreme Court compelled a plan to revise a plan provision and pay beneficiaries based on the revised provision, in response to successful beneficiary arguments involving ERISA's civil enforcement provisions grounded in theories of surcharge and equitable estoppel.

Before *Amara*, participants were not entitled to monetary relief under ERISA's civil enforcement provisions. However, *Amara* held that relief under the following theories is now possible:

- **Estoppel** — A plan can be forced to pay beneficiaries amounts it would have had to if misrepresentations had been true.
- **Surcharge** — A plan can be forced to pay back losses to a beneficiary caused by the plan's errors or omissions, and to prevent it from being unjustly enriched by them. (**Note:** Surcharge is also known as "make-whole relief.")

The *Amara* court made it clear that both estoppel and surcharge had been squarely equitable forms of relief before the merger of courts of equity and courts of law, the circuit noted.

Accordingly, the 4th Circuit in *McCravy* found that because the remedy of surcharge is available as a form of appropriate equitable relief under Section 1132(a)(3), McCravy's remedy needn't be limited to a return of premiums.

MetLife may have to pay McCravy the amount of life insurance proceeds lost due to its ERISA violation, the 4th Circuit said.

Furthermore, because the remedy of estoppel is now considered to be "typically available in equity,"

McCravy could stop the plan from enforcing its dependent coverage limit for Leslie, after it represented that Leslie was covered and led her to expect benefits.

The 4th Circuit then vacated the district court's ruling and sent it back to that court, so it could fashion a remedy in the new broader understanding of equitable relief, but also with reference to the actual plan document in effect at the time. The earlier rulings used the summary plan document instead.

Employers should take note: Eligibility snafus are normally the result of employer failure to provide up-to-date information to their claims processor, rather than TPA errors and omissions.

Implications: Longer Wait Times

Employers should take note: Eligibility snafus are normally the result of employer failure to provide up-to-date information to their claims processor, rather than third-party administrator errors and omissions.

Yet, despite the error being the employer's, TPAs need to do a better job of educating employers on the need for up-to-date info, and the plan's responsibility to provide it. This starts with language in the administrative services agreement and extends to regular communications.

Regardless, as "equitable" penalties expand, TPAs will be shifting their attention from damage control post-mistake, to prospective confirmation that claims are payable and individuals are eligible. This, of course, is the natural response to an increase in penalties. In other words, mistakes cost more, so it's no longer okay to make them.

This will lengthen the time it takes to provide pre-certification and process claims. The more severe the implications for errors become, the harder it becomes to pay providers promptly. Networks and providers no doubt will react to the resultant delays, and what they do will be interesting to see.

This trend pressures plans to take a more alert approach to claims processing and eligibility confirmation. That's because courts are taking a more expansive (expensive for plans) view of remedies. For better or worse, the winds of change are now punishing those who fail to address issues, and those who don't cross their "t's" and dot their "i's" proactively. 🏠

TPA's Overpromise of Benefits Leads to State-law Claims When Plan Invokes Lifetime Limit

A plan's third-party administrator pre-certified medical services by telling a provider that "100 percent" of the contracted rate would be paid. However, as treatment continued the plan alleged that the patient's lifetime maximum was met. Subsequently, the plan cancelled the patient's coverage and failed to pay any medical claims.

The provider sued the plan and TPA for state-law misrepresentation and estoppel claims, which a federal judge held in *Tulsa Spec. Hosp. v. Boilermakers Nat'l H&W Fund*, 2012 WL 2887513 (N.D. Okla., July 13, 2012) were not preempted by ERISA because denying state-law claims based upon "the plan's insurer's misrepresentation" would not further the statute's purposes.

Tulsa Specialty Hospital had accused the Boilermakers National Health and Welfare Fund of falsely representing a plan participant as covered, then denying reimbursement, asserting that the patient had exhausted the plan's lifetime limit on benefits.

The court remanded the hospital's \$700,000 state-law misrepresentation and estoppel case to state court. In doing so, federal district judge Gregory Frizzell said ERISA was not invoked because no benefits assignment was involved, rejecting the plan's contention that the plan's anti-assignment language allowing it to pay providers directly converted the hospital into an ERISA beneficiary that can only sue in federal court.

TPA Authorizes Services

A Boilermaker plan beneficiary stayed in Kindred Hospital from April 28, 2010, to Nov. 8, 2010. Before admitting the patient, the hospital called the plan to authorize the service. An agent for CIGNA, the plan's TPA, preauthorized the service and stated that the hospital would be paid 100 percent of the contracted rate given that the deductible and out-of-pocket maximum had been met. Accordingly, the hospital admitted the patient. The hospital sent medical updates on the patient for the next two months, and a CIGNA agent repeatedly authorized continuing services.

On June 24, CIGNA once again authorized the patient stay, but requested a discharge plan for the patient by June 30. However, on June 29 CIGNA announced the patient was no longer authorized because he had exhausted his coverage effective June 14. Ultimately, the patient was not stabilized and the hospital could not discharge him until Nov. 8.

Kindred billed the plan \$723,000, and a second CIGNA agent said it had approved 194 days at the *per diem* rate and sent it to the plan for payment. She told the provider that correspondence about further failure to pay the claim should be addressed to the plan and not to CIGNA.

On June 24, CIGNA once again authorized the patient stay. However, on June 29, CIGNA announced the patient was no longer authorized because he exhausted his coverage as of June 14.

Plan Invokes Lifetime Limit

The hospital rebilled the services, requesting the payment CIGNA authorized. The fund in August 2011 finally asserted that the patient was terminated from the plan on July 21, 2010 and that his lifetime maximum had been exhausted when the plan received Kindred's claims. The court noted that the plan refused to provide documentary support for the claims. Kindred had no payment for any part of the patient's stay, which went from April 28, 2010, to Nov. 8, 2010.

Kindred sued the plan and CIGNA in state court alleging fraudulent misrepresentation, negligent misrepresentation, false information negligently supplied and promissory estoppel, and demanded more than \$700,000 in damages.

The plan removed the case to federal court. The hospital filed motions to remand the case to state court, and the court ruled for Kindred Hospital.

No Federal Question

The plan argued that all charges should be preempted by ERISA and that the hospital's only claim was under ERISA's enforcement provisions at Section 502(a), authorizing legal claims for benefits due under the plan for participants and beneficiaries.

The hospital denied that it was seeking ERISA benefits and argued it was neither a participant nor a beneficiary. The court again sided with the hospital.

See *Benefits Promised*, p. 9

Anti-assignment Is a Double-edged Sword

The plan tried to argue that the provider became a “beneficiary” (with standing to sue) under ERISA because it signed a form for direct payment from the plan. It said the executed form supported its preemption argument, and that Kindred was a beneficiary because the plan document gives it discretion to pay it directly. Ironically, this argument was based on the plan’s “No Alienation or Assignment of Benefits” policy.

That provision was strictly worded to limit rights to payment alone, which led the court to reject the argument.

The plan’s anti-assignment clause explicitly stated: (1) ERISA rights cannot be transferred under any circumstance; and (2) this is the case even when the plan pays providers directly.

The court concluded that the plan cited no legal authority for its argument that the limited language it cited converted providers into plan beneficiaries and there was no indication that benefits had been assigned.

Further, the provider did not base its state-law claims on an assignment of benefits, the court held.

The court then deliberated on whether the hospital’s common law claims should be preempted because they related to an ERISA plan. To decide this, the court looked to the 10th Circuit’s ruling in *Hospice of Metro Denver v. Group Health Ins. of Okla. Inc.*, 944 F2d 752 (10th Cir., 1991). There, the circuit court held that when courts decide on preemption the ultimate thing to consider is whether preemption can further the congressional intent behind ERISA:

[to] protect ... participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

In *Metro Denver*, as in this case, the judge concluded, ERISA preemption would not serve those purposes.

Denying a third-party provider a state law action based upon misrepresentations by the plan’s insurer in no way furthers ERISA’s purposes.

The court pointed to the distinction between a provider trying to recover a promised payment and plan participant trying to recover a benefit payment. It concluded that an application of Section 514 preemption would be stretching the meaning of “relates to an ERISA plan” too far.

Therefore, the court remanded the case, holding that Kindred’s suit was in fact a state-law case, and not preempted by ERISA.

Implications

Once again, we see that not all claims brought against an ERISA plan will have a valid preemption argument under ERISA.

Removal to State Court

Many ERISA plans fail in removing state-law claims to federal court when the underlying cause of action is clearly rooted in a state-law theory such as misrepresentation or estoppel. Although ERISA preemption is a powerful way to avoid many state laws and insurance regulations, plans should be aware that ERISA will not exempt them from all state-law claims.

Communication

The plan could have mitigated its damages if the plan had communicated more effectively with the TPA.

The problem started because the plan and its TPA were not on the same page. The TPA pre-certified medical services by telling a provider that “100 percent” of the contracted rate would be paid when in fact the plan was not able to fulfill the TPA’s promise.

If the plan and the TPA had taken the time to discuss the pre-certification, then perhaps the plan could have communicated to the TPA that it would be unlikely to cover the service at 100 percent and the resulting misrepresentation claim could have been avoided.

Self-funded plans, as fiduciaries, always should have the final say in determining when claims are payable under the terms of the plan document. As such, TPAs should take caution when making promises on the plan’s behalf, especially when those promises relate to a decision that only the plan can make. ⬆

Lessons Learned from *Tulsa Spec. Hosp. v. Boilermakers*

1. **Application of ERISA.** Plans should be cognizant of the potential impact ERISA’s application may have on a plan’s ability to remove a claim to federal court.
2. **Mitigation of Damages.** This case illustrates how imperative it is for the plan and its plan’s vendors to be on the same page and have clear and concise communication. ⬆

Nonreligious Firm Wins Enforcement Stay Of Reform's Contraceptive Mandate

A Colorado-based company that is not a religious organization got a temporary reprieve in complying with the Obama administration's mandate that health plans cover contraceptives without patient cost sharing, under a new ruling from the U.S. District Court in Colorado.

The requirement takes effect for non-grandfathered and non-religious employer health plans on Aug. 1.

Note: Compliance with the contraceptive coverage mandate is stayed until Aug. 1, 2013 for employers that fit into a slightly expanded enforcement safe harbor described in an Aug. 15 memo. See <http://cciio.cms.gov/resources/files/prev-services-guidance-08152012.pdf>.

Judge John Kane's grant on a motion for preliminary injunction is temporary, pending the judge's consideration of the case's merits; and even if it holds, it would be binding only on the plaintiff company. The injunction will last for three months and give both sides time to build their cases.

Background

On Aug. 1, 2011, the U.S. Department of Health and Human Services issued the contraceptive mandate as part of its rule to provide no-cost coverage for preventive care, which it defined to include contraception for women, starting with plan years that begin on or after Aug. 1, 2012. For more information, visit <http://www.hhs.gov/news/press/2011pres/08/20110801b.html>.

Religious groups objected. The Obama administration attempted a compromise in February 2012 by offering a year-long delay to religious employers, until August 2013. Other concessions were codified to help religious employers regarding the mandate.

Health Reform's Religious Employer Definition

In order to qualify for the "religious employer" exemption to the contraceptive mandate, an employer must meet the following criteria:

- 1) Its purpose is the inculcation of religious values.
- 2) It primarily employs persons who share the religious tenets of the organization.
- 3) It serves primarily persons who share the religious tenets of the organization.
- 4) It is a non-profit organization.

Hercules Industries Inc., a manufacturer/distributor of HVAC products, is neither a religious nor a non-profit employer (both of which are required if one is to avoid the mandate). Nor is the Hercules health plan capable of gaining an exemption through grandfathered status, the court noted.

Instead, the four siblings who run the company said they merely "seek to run Hercules in a manner that reflects their sincerely held religious beliefs." Contraceptives are not included in the Hercules Industries self-insured health plan, and its corporate mission statement is infused with religious goals. It challenged the contraceptive mandate as violating the Religious Freedom Restoration Act and the First Amendment, saying the mandate prevents it from exercising its religious beliefs. The company filed a motion for injunction to prevent the federal government from enforcing the mandate.

The Court Weighs In

The court did not accept the government's argument that the contraceptive mandate furthers an important health goal, and rejected the stance that noncompliance by one company posed a threat to the government's goal of furthering public health.

An injunction is meant to "to preserve the relative positions of the parties until a trial on the merits can be held," and is usually reserved for cases where the facts lean heavily in the plaintiff's favor, specifically when:

- 1) there is a likelihood of success on the merits;
- 2) a threat of irreparable harm exists that outweighs any harm to the non-moving party; and
- 3) the injunction would not harm the public.

But the court lowered this bar, allowing the case to be considered under an altered burden of proof, because the "questions [were] so serious, substantial, difficult and doubtful as to make the issue ripe for litigation and deserving of more deliberate investigation."

The court saw irreparable harm in implementing the new coverage mandates before the Nov. 1 start of the company's next plan year. This outweighed the government's harm in being unable to enforce the law, Kane said.

The court sidestepped government contentions that an injunction would harm the public goals of improving women's and children's health by equalizing the coverage of preventive services for women and men. It said

See *Nonreligious Firm*, p. 11

Small Employer Plans More Likely To Change Course in Response to Health Reform

In response to health reform, some employers may stop offering health coverage and opt instead to pay a fine, give workers a raise and send them to state-run health insurance exchanges. Compensating for that erosion of employer plans, the individual mandate (to get coverage or pay a penalty) will drive about 4 million workers into employer plans, according to research from various sources compiled by the U.S. Government Accountability Office.

Five statistical studies (microsimulations), 19 employer surveys and three mixed studies were included by GAO in its new overview of predictions about how employer plans will react to health reform.

The research was unanimous in saying that reform will: (1) have a more dramatic effect on small employers; and (2) prompt employers that continue providing coverage to adopt more expensive benefit designs, according to the GAO overview.

Four surveys found that smaller employers were more likely than other employers to stop offering health coverage in response to the health reform law.

Nine surveys also indicated that employers in general predict that their health plans will have to be modified, and will cost more, to include benefits required under health reform.

The list of factors impacting employer decisions to cover employees includes:

- the individual mandate;
- health insurance exchanges giving employees an option apart from the employer;
- insurance market reforms, which will make coverage “richer” and more expensive;
- subsidies for poorer individuals to get insurance on exchanges;
- penalties for large employers that do not offer coverage;
- tax credits for certain small businesses that provide coverage; and
- state Medicaid expansion.

See *Reform’s Effect*, p. 12

Nonreligious Firm (continued from p. 10)

that the exceptions for religious organizations and for grandfathered plans were already doing that. Kane also said preservation of religious rights “countered and even outweighed” the government’s public health goals.

On balance, the threatened harm to Plaintiffs, impingement of their right to freely exercise their religious beliefs, and the concomittant (*sic*) public interest in that right strongly (*sic*) favor the entry of injunctive relief.

Under the RFRA, the government may not “substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability.”

The government argued that Hercules Industries did not fall into the safe harbors to the mandate created earlier this year because it is neither a religious institution nor does it have a grandfathered health plan. In addition, it is an S-corporation that should be treated like a commercial entity, and not a person.

But the court rejected this and said those questions remained open:

Can a corporation exercise religion? Should a closely-held subchapter-s corporation owned and operated by a small

group of individuals professing adherence to uniform religious beliefs be treated differently than a publicly held corporation owned and operated by a group of stakeholders with diverse religious beliefs? Is it possible to “pierce the veil” and disregard the corporate form in this context?

The plaintiffs also suggested at least one viable alternative to forcing all plans to cover contraception, the court said. The government could provide cost-free contraception itself in a number of ways: creating a contraception insurance plan with free enrollment; directly compensating contraception and sterilization providers; giving tax credits or deductions for contraceptive purchases; or even imposing a mandate on contraception manufacturers to give its items away for free to uncovered individuals.

The court disregarded the government’s objection that solutions like these would create new obstacles to women.

These outstanding questions warranted further review, and that supported a three-month long injunction, during which both parties could build their cases. Reports indicate another dozen cases challenging the mandate, so similar rulings are a possibility. 🏠

Perhaps 4 Million Run to Exchanges

Studies based on formulas taking into account economic behavior and health data (microsimulations) varied in their predictions of the impacts starting in 2014, the year health exchanges go into effect.

The Centers for Medicare and Medicaid Services estimated almost no increase or decrease; the RAND Corp. and the Robert Wood Johnson Foundation each projected employer plans would cover 4 million new individuals (2.7 percent). The Congressional Budget Office projected a 2.5 percent net erosion of covered lives (about 4 million individuals) while the Lewin Group predicted a decrease of about half that much, GAO reported.

The numbers just cited reflect the combined effect of employer decisions to phase out health benefits and the individual mandate. If it weren't for the individual mandate, the four studies say, fewer Americans would be in employer plans than otherwise.

Individual Mandate Will Spur Enrollment

Longer-term microsimulation studies estimated that from about 2 million to 6 million fewer individuals would have employer-sponsored coverage in the absence of the individual mandate compared to having the mandate.

CBO and RAND said about four million fewer would have employer coverage, the Lewin Group estimated about two million and the Robert Wood Johnson Foundation estimated that six million Americans would remain or enroll in employer plans because of the individual mandate.

A study by the Employment Policies Institute predicted that the individual mandate would spur a 6-percent increase in the number of individuals with employer-sponsored coverage. Booz & Co. predicted a 4-percent net decrease in individuals covered by their employers.

Employers Predict Stronger Impacts

GAO felt it necessary to temper the statistical research with surveys asking employers what they will do,

and many of those showed clearer employer intent to drop coverage.

Sixteen of 19 employer surveys had at least some employers dropping coverage altogether, but 11 of 16 of those surveys had 10 percent or fewer employers dropping coverage in the near term. (The 11 survey sponsors were: the National Federation of Independent Business, Towers Watson, the International Foundation of Employee Benefit Plans, Benfield Research, Mercer, the HR Policy Association, the Midwest Business Group on Health, PricewaterhouseCoopers, Willis, Market Strategies International and McKinsey & Co.)

The remaining three employer surveys predicted companies would expand coverage or prompt employers to start offering health coverage.

The nine surveys that asked about benefit accounts indicated that from 17 percent to 73 percent of employers either planned to use account-based plans or saw them as a good idea.

Major Plan Design Changes Seen

Here are the plan-design responses the employers predicted they would use:

- **Greater employee cost sharing:** The nine surveys that examined benefit design changes indicated that 16 percent to 73 percent will consider increasing employee cost sharing, for example, through increased premiums, deductibles or copayments.
- **Account-based plans:** The nine surveys that asked about use of benefit accounts indicated that from 17 percent to 73 percent of employers either planned to use them or saw them as a good idea.
- **Self-insurance:** Two of the three surveys that examined becoming self-funded as a response to reform indicated that from 12 percent to 52 percent were considering doing so, and the third survey said 13 percent of employers reported increasing their consideration of such a move.

GAO also reported that some employers intended to drop coverage for retirees even if they continued to cover active employees in response to reform.

The proportion of employers offering health coverage has decreased over the last 10 years, from 68 percent in 2001 to 60 percent in 2011, GAO reported.

The report can be viewed at <http://www.gao.gov/products/GAO-12-768>. 

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Retailers and Hospitality Employers Face Steeper Reform Cost Increases

Health reform's requirement that employers insure work forces will hit the retail and hospitality industries harder than others, because they are staffed with more low-wage and part-time workers, consulting firm Mercer LLC reported on Aug. 8.

Forty-six percent of surveyed firms in the retail and hospitality sectors predicted health care cost increases of at least 3 percent for complying with health reform rules, according to Mercer's survey of 1,203 employers.

Reform-related increases are in addition to health cost inflation rising at double the rate of general inflation, Mercer stated.

Mercer also found expecting such increases: 40 percent of firms in the health care industry; 33 percent of firms in manufacturing; 32 percent of financial service firms; 31 percent of transportation firms; and 24 percent of firms in the government sector.

Sixty percent of respondents said they expected some form of cost increase due to reform, and of that, one-third (20 percent of the whole) forecasted increases of 5 percent or more.

One reason for more cost is the bypassed Medicaid expansion, which was the one part of the reform law that was stricken by the U.S. Supreme Court. More low-wage employees who would be covered under the higher Medicaid limits, will remain in employer plans because of that ruling.

Expanded Coverage Brings Changes

Behind these costs is the health reform requirement that employers offer coverage to all employees working 30 hours or more per week or face penalties.

Industries that have a high percentage of low-wage, part-time workers are more likely to restructure work forces so fewer workers make the 30-hour threshold. Industries that are in other sectors are more likely to create a new plan benefit for part-time, low-wage workers, or offer them existing full-time benefits, the report stated.


Forty-six percent of employers in retail and hospitality said they will need to change their health plans to comply with the requirement that coverage be extended to those working at least 30 hours a week. That's because such firms have large numbers of part-time and lower-paid workers. Health reform's employer mandate takes full effect in 2014.

Less than 25 percent of surveyed firms in manufacturing, financial services and transportation predicted having to change plans because of the 30-hour a week requirement.

Just 6 percent reported that they intended to immediately stop offering employees health benefits in response to the employer mandates.

Thirty-six percent said they had not begun or were behind in producing and distributing summaries of benefits and coverage, which must be handed out to plan participants in 2013.

About 75 percent of survey respondents said they had made sufficient progress: (1) implementing the \$2,500 cap on health FSA accounts; and (2) preparing the 2012 W-2 form to include amounts spent on health coverage.

For more information on meeting the employer mandate, complying with the SBC requirement and the W-2 mandate, see *The New Health Care Reform Law: What Employers Need to Know — A Q&A Guide*, by Thompson Publishing Group. 

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Slower Medicaid Expansion in Reform Ruling Doesn't Help Employer Plans

The only health reform provision that was repealed in the U.S. Supreme Court's decision — Medicaid expansion — will result in more individuals getting coverage through health insurance exchanges, and more individuals remaining uninsured, according to a July 24 report by the Congressional Budget Office.

Of the 6 million individuals who would have been covered by Medicaid if the law remained untouched, 4 million would remain uninsured, and 2 million would get coverage on the exchanges, according to CBO.

The federal reform law required state Medicaid programs to cover people with incomes up to 138 percent of the federal poverty level, rather than 100 percent of FPL. Otherwise, states would lose all federal matching funds. The High Court's repeal of the Medicaid expansion now gives states the latitude to choose whether to expand Medicaid as per the reform law. This necessitated a revision of the law's budgetary impact.

Billions Less on Medicaid

CBO in its report (see <http://www.cbo.gov/publication/43472>), which was updated for the recent Supreme Court decision, stated that the federal government would spend \$84 billion less over 10 years than it would have had the Supreme Court not struck down the law's Medicaid expansion in *NFIB v. Sebelius*.

The original federal budget estimate of net cost of reform's insurance coverage provisions was \$1.252 trillion from 2012 through 2022. Since the court's ruling, CBO estimates the provisions will cost \$1.168 trillion over that time span.

CBO predicted that federal outlays for:

- Medicaid and the Children's Health Insurance Program will decrease \$289 billion from \$941 billion to \$642 billion.
- Exchange subsidies will increase \$210 billion from \$808 billion to \$1.017 trillion.
- Small business subsidies will remain unchanged at \$23 billion.

CBO predicted that revenue sources from:

- Taxes and penalties (on employers) will **increase** \$4 billion from \$113 billion to \$117 billion.
- Penalties on individuals for remaining uninsured will **increase** \$1 billion from \$54 billion to \$55 billion.

- The excise tax on high-premium insurance plans will remain **unchanged** at \$111 billion.
- Other tax revenues (primarily) and outlays will remain **unchanged** at \$231 billion.

Medicaid Growth Restrained

Even without the coercion of the Medicaid expansion, CBO predicted that: one-third of the population will live in states that adopt 138 FPL voluntarily; one half will live in states that adopt something less than 138 FPL; and one-sixth will be in states that remain 100 percent of FPL.

How this will precisely affect the federal budget is unknown because it is too early to tell how many states will voluntarily expand Medicaid eligibility as per the law. (**Note:** Medicaid's costs are borne on average 43 percent by states and 57 percent by the federal government.)

More Remain Uninsured, Go to Exchanges

In states that don't expand up to the 138 FPL line, about one-third of the resulting Medicaid uninsureds will get coverage on the exchange, and about two thirds will remain uninsured, the report found. Thus, the Supreme Court decision will add 2 million enrollees to the exchanges and 4 million more to the ranks of the uninsured.

Health Reform Will Thin Out Employer Plans

More previously uninsured people will get insurance over the next 10 years, due to health reform, but reform will also thin the ranks of employer plans, the report predicts. Between 4 million and 6 million fewer people are estimated to have coverage through an employer, compared with coverage in the absence of the reform law. That number did not change significantly as a result of the Court's decision.

The Court's decision upholding the individual mandate did not change CBO's assessment of the mandate's effect on coverage.

Impact of Repealing Health Reform

Because the U.S. Supreme Court decision upheld the individual mandate, Republican opponents to the law in Congress have resumed efforts to pass legislation to repeal it. The House passed H.R. 6079, the Repeal of Obamacare Act, on July 11. **Note:** H.R. 6079 will go to

See *Slower Expansion*, p. 15

Slower Expansion (continued from p. 14)

the Senate for consideration, but getting it up for a vote in the Democratic-controlled chamber will be very difficult. Further, President Obama said he will veto the legislation if it passes.

Subsequently, House Speaker John Boehner, R-Ohio, asked CBO to review the budgetary impacts of repeal.

In response, the agency reported that repealing the health reform law would add \$110 billion to the deficit over 10 years, CBO wrote in a July 24 letter. Repeal would reduce *direct spending* by \$890 billion, but it would reduce *revenues* by \$1 trillion between 2013 and 2022, CBO estimated.

The Savings

Government coverage expansion efforts that add to spending would disappear. Subsidies to propel greater participation in the state-run health insurance exchanges would be eliminated. So would increased outlays for Medicaid and CHIP and tax credits for small employers to insure their groups. After factoring out some revenue raisers that partially pay for some of the expansion, CBO concluded that repealing these provisions would yield net budget savings of about \$1.17 trillion.


The Costs

While dismantling health reform would cut government spending, it also would remove a couple of new sources of revenue, and it would remove care delivery and payment reform measures that are projected to save money spent by the government on health services, CBO reported.

Tax Revenue

The “cost” (to a federal budget) comes in the form of a series of taxes on businesses and individuals that would be eliminated. These include penalty payments from employers and uninsured individuals, and revenues from excise taxes on “Cadillac plans.” The estimate included savings through Medicare and other federal health spending reform that would not happen if those reform provisions were repealed. **Budget cost:** About \$711 billion.

Taxes on Providers

The elimination of direct taxes on providers, such as increasing the Hospital Insurance payroll tax and extending it to net investment income for high-income taxpayers, and imposing fees or excise taxes on certain manufacturers and insurers would come at a cost to the federal budget of about \$570 billion. 

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HHS Will Quiz Benchmark Plans To Define Essential Health Benefits

How the U.S. Department of Health and Human Services will identify benchmark plans that would set the standard for essential health benefits under health reform was described in a final rule issued July 23.

This is important because policies sold on health insurance exchanges — for individuals and for small groups — must cover the EHB package.

Larger and self-funded employer plans are watching closely because (while observers say such plans already cover most EHB benefits) they'll be under market pressure to meet whatever is required to be offered on exchanges that they are not offering now.

The HHS rule: (1) addresses the collection of data from potential benchmark plans to define EHBs and (2) establishes a process for recognizing accrediting entities to certify qualified health plans for health insurance exchanges under health reform.

The final rules reflect 80 public comments received on the proposed rules, which came out June 5 with a 30-day comment period. The rules are viewed at http://www.ofr.gov/OFRUpload/OFRData/2012-17831_PI.pdf.

Non-qualitative Limits Excluded

The final rule slimmed down the definition of treatment limitations to: (1) include only quantitative limits (such as days of coverage and number of visits); and (2) exclude non-qualitative limits (such as prior authorization and step therapy requirements).

HHS will collect data from prospective benchmark plans on:

- quantitative treatment limits (number-of-visit limits on physical therapy, for example), including time limits;
- drug coverage; and
- plan enrollment data.

The agency rejected calls to collect data from benchmark plans on exclusions, medical necessity, habilitative services, cost-sharing (including premiums and copays), and other data fields. That was more than the agency needed to select benchmark plans.

The Payers That Will Write the Blueprint

The Essential Health Benefits Bulletin of last Dec. 16 determined that the benefits models would be based on the leading health insurance products in each state. See <http://cciio.cms.gov/resources/files/Files2/12162011/>

[essential_health_benefits_bulletin.pdf](#). Four categories of plans will be eligible to be benchmark plans, and HHS will be collecting data from them:

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national federal employee health plan options by enrollment; or
- the largest insured commercial non-Medicaid HMO plan operating in the state.

On July 7, HHS issued a list of the plans eligible to become benchmark plans, which therefore HHS may be surveying. The "data window" for insurers to submit data will remain open until Sept. 4. The list can be viewed at: <http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.

Accreditation of Insurers

HHS said it had already appointed the National Committee for Quality Assurance and URAC (formerly known as the Utilization Review Accreditation Commission) to accredit qualified health plans, because they met performance measures and had a track record of accrediting health plans, the rule states. They will perform this duty on an interim basis, until more accrediting agencies, which could include state agencies, are approved.

Plans that cover the EHB package must cover the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive/wellness services and chronic disease management; and pediatric services, including oral and vision care.

HHS' stated goals for the EHB package are that they:

- reflect typical employer health benefit plans;
- reflect balance among the categories;
- account for diverse health needs across many populations;
- ensure there are no incentives to discriminate against elderly or disabled people;

See *Benchmark Plans*, p. 17

CE Column (continued from p. 2)

If noncompliance with the mandate is not subject to criminal or civil penalties under the Tax Code and interest does not accrue for failure to pay the penalty, why would anyone in their right mind pay the tax?

Therefore, it seems that nothing will happen to health reform “no-coverage tax evaders,” and the tax becomes almost more like a donation than a real tax.

Uncompensated Care Remains

We think it is important to focus on the part of Roberts’ opinion that relates to self-insured plans:

... because state and federal laws nonetheless require hospitals to provide a certain degree of care to individuals without regard to their ability to pay. Consider EMTALA — the Emergency Medical Treatment and Active Labor Act. Under EMTALA hospitals have to give out uncompensated care. They pass on the cost to insurers through higher rates, and insurers, in turn, pass on the cost to policy holders in the form of higher premiums.

This process works for fully funded insurers that charge premiums, but what about self-funded employers? Who do they pass the costs onto — employees? The notion that we can spread the expense of medical costs, and thus allow providers to “balance their books,” by simply raising premiums and adding more premium-payers to the risk pool, leaves out self-funded plans.


Requiring healthy lives to buy insurance and pay premiums will not help self-funded plans spread the rising cost of health care, spurred in part by health reform.

People Will Get Insured After Getting Sick

The Supreme Court’s decision leaves intact all the new coverage mandates and new programs that existed the day before the decision (excepting of course the forced expansion of state Medicaid programs). Unfortunately for those of us who pay the bills, most of them pump up costs in a major way.

Benchmark Plans (continued from p. 16)

- ensure compliance with mental health parity laws;
- provide states a role in defining EHB; and
- balance comprehensiveness and affordability.

The final goal for HHS is to publish final rules describing which benefits will be essential under the health reform law. More guidance also will be targeted at accrediting agencies. 

Approximately 2.5 million new young adults up to age 26 are now covered on their parents’ policies. The ban on lifetime limits removes a brake on very long, expensive hospital stays. Reform introduced a ban on denying care because of pre-existing conditions. These facts — in tandem with the unlikelihood that those who violate the individual mandate will pay the tax — could precipitate an upward cost spiral.

Example. A 27-year-old healthy employee decides not to take part in your employer-based coverage because he feels he doesn’t need it and it’s too expensive. With that extra \$300 a month he can purchase a new car. He doesn’t join the exchange for the same reason. While the cost is cheaper per month, he hasn’t gone to the doctor in more than a year and still feels it’s a waste of money. So under the current rules he owes a tax but since he is told that nothing can happen to him if he doesn’t pay — not even accumulated interest — he decides not to pay. He stays like this for the next six months when suddenly he feels gravely ill one morning, rushes to the hospital emergency room and is told he has a serious disorder that needs immediate treatment.

Since he now cannot be denied coverage (due to the pre-existing condition rule), he buys coverage on the exchange. After one year of treatment, he has paid \$2,000 in premiums, but the insurers have paid out more than \$200,000 for his medical care.

This will occur again and again across the country because young, healthy people will have no reason or incentive to join or pay into the exchanges. Unless healthy lives join, the exchanges will collapse.

Insured Plans Must Improve Effectiveness

One of the least talked about but rather important reform provisions is the required reporting of proportion of premium dollars spent on clinical services, quality and other costs and providing rebates to consumers. When the law went into effect, insurance companies paid out about 74 cents of every dollar to medical benefits. The new rules require that amount to rise to 80 to 85 cents on a dollar. This seems to be beneficial to the self-funded world, since the large insurers will not have the funds available to spend so easily on advertising. (Guess we will be seeing much fewer commercials and stadium sponsorships.)

Also, plans must provide preventive health benefits without imposing copays or other out-of-pocket charges. About 54 million Americans now have expanded coverage of at least one preventive service since the law went into effect, according to an analysis by the Kaiser Family

See **CE Column**, p. 18

Foundation. In addition, 32.5 million seniors took advantage of these preventive services. We're wondering if the definition of preventive care will expand. Aromatherapy anyone?

Consider my home state of Massachusetts: When our own version of health reform was enacted, everyone had to have coverage (our own mandate), and insurers issuing policies via the exchange (aka, the Connector) had to cover certain essential health benefits. The list of mandated benefits was frugal, and the insurers were able to abide by the rules and keep the costs down. Each year, however, lobbyists convinced regulators to add additional services to the list of essential health benefits. Soon, the insurers couldn't afford to provide the mandated benefits while keeping premiums below the lawful maximum.

The federal requirement that insurance companies justify "unreasonably" large premium increases will be a huge issue, as we have seen in Massachusetts first hand. Once our exchange was created, insurers had to justify the rate increases year after year. When the state refused their increases, the insurers sued the state based on the fact that they were losing money due to the increased cost of care and aforementioned broad scope of mandated benefits. Until that time, the public and state's attitude was that the insurers were bad guys. It was only after transparency occurred and the public and state officials saw that provider costs were spiraling out of control that our state finally began to focus on the cost of care and not just access to health insurance.

This is poised to happen at a federal level if folks allow history to repeat itself.

Note: The Bay State on July 6 enacted a law (see <http://www.malegislature.gov/Bills/187/senate/s02400>) to effectuate cost control at the provider level. The law holds the annual increase in total health care spending to the rate of growth of the state's Gross State Product. It requires state-controlled health plans to use global and other alternative payments, and not fee-for-service. It requires the price of procedures and services to be published on a website; and it appoints a new commission where provider prices can be challenged if they far exceed the norm. We will be watching this development closely.

The federal health reform law, just like the Massachusetts law, establishes standards for insurers to use in providing information on benefits and coverage and will eventually create a new federal body that will block insurers from raising rates. To make that work, though, the regulators also will eventually stop providers from raising costs, to help insurers hold up their end of the bargain.

Health Insurance Exchanges

Reform-mandated insurance exchanges are moving ahead, even though some states want no part of them. Exchanges will provide access to insurance for those who don't have coverage through employment. The CBO estimates that 23 million Americans will gain coverage through the state exchanges by 2019. The government will provide tax credits for individuals and families making less than 400 percent of the federal poverty level, which is currently \$92,000 for a family of four.

Some states, including Texas, will not set up an exchange. but if it does as much, the federal government will create one for the state in 2014, and the resulting system may not be the best plan for Texans.

Taxes, Taxes and More Taxes

We are sure that most of you must be asking the same question: How are we going to be paying for this stuff? Well, there are many new taxes coming!

There will be a new excise tax on high-premium health plans, or as the media likes to call them, Cadillac plans. These plans are equal to 40 percent of premiums paid on plans costing more than \$27,500 annually for a family, starting in 2018. Medicare payroll taxes will increase for couples with income of more than \$250,000 a year. And an unearned income tax, such as capital gains, is subject to additional 3.8-percent tax.

One of the "cooler" taxes to be assessed will be a tax for customers of indoor tanning salons — they will pay a 10-percent tax. Good to know that all the people who like artificial tanning will be helping the country pay for health reform.

What scares the heck out of us is the tax on insurance companies, drug companies and device makers, starting in 2014. This will increase costs by tens of billions of dollars, which will turn up in hospital bills since medical devices use occurs in hospitals. These costs will be passed on to insurers, then to consumers.

Taking Advantage of the Disadvantages

Health reform is here to stay. Self-funded plans need to realize that the advantages that our industry has over everyone else are plentiful. We can tailor our plans to the needs of our employees; we have access to claims data to identify the risks to our plans and we can then develop wellness programs that can help minimize these risks. Unlike the government bureaucracies and insurers, we can maneuver like a speedboat, amending when needed to address specific challenges. Being exempt from many of reform's disadvantages and our unique ability to implement innovative processes make it a great time to advance self-funding's interests. 🏠

Subject Index, Vol. 19

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