

# ERISA

in the

# Post-PPACA

# Cross-Hairs



**T**he Employee Retirement Income Security Act ("ERISA") has been a solid foundation for employee benefit plans since it was enacted in 1974. This federal law was passed by Congress intending to set forth minimum standards for pension plans in private industry and protect the interests of employee health benefit plan participants and their beneficiaries, as well as create a comprehensive scheme of federal enforcement to ensure uniformity in the administration of benefit plans offered by multi-state employers.

Written by Christopher Aguiar, Esq. and Ron E. Peck, Esq.  
THE PHIA GROUP, LLC

For many in the health benefits industry, we view ERISA as our own little hero; but the truth is this monster applies to more than just private, self-funded health plans. ERISA applies to almost all health plans – both self-funded and fully insured (save for a few specifically enumerated exceptions), as well as pension plans.

Those of us that deal heavily with private, self-funded health plans can be excused for referring to such programs as “ERISA plans,” even though (truth be told) almost all plans are “ERISA plans.” In reality, however, it’s not the applicability of ERISA that matters, but rather – the true power of a private, self-funded plan is the fact that state insurance law does not apply, thanks to ERISA’s preemptive powers; arising in part from the deemer and savings clauses.

ERISA is like a great castle wall... and all health plans (self-funded and fully insured) are hiding behind it. Outside the fortress, the conquering forces of state regulation are hammering at the walls. They have successfully knocked the wall over where the fully funded insurance carriers were hiding. As a result, although ERISA applies to such insurance, so too does state law. Where private, self-funded health plans hide, however, the ERISA wall has successfully repelled state law... at least, for the time being.

For years, State regulators have dreamed of a day that ERISA’s ability to prevent the application of their State laws to private, self-funded plans would come to an end. One need not look any further than the state of New York to see repeated attempts at re-drafting laws whose specific purpose is to chip away at the ERISA and plans rights, including their ability to avoid the cumbersome meddling of state legislators. Look just a little bit further and you’ll see states all over the map from Connecticut to California looking for more covert, albeit equally offensive ways of minimizing the impact of ERISA on their regulatory powers and scope of influence.

For those of us that see the value in a uniform, nationally administered self-funded program, state based regulation is a nightmare. For a moment, however, let’s give the state regulators and legislators the benefit of the doubt and assume that they believe – to their very core – that the laws they pass and impose on fully funded insurance carriers strengthen their state and the people they represent. The fact that private self-funded plans can provide coverage in their State, while avoiding the socially beneficial, rational and flat out equitable rules they created, is outrageous.

This anti-ERISA/anti-preemption attitude is not new. It has been, for instance, quite pervasive in the health benefits arena specific to the subrogation and reimbursement rights of benefit plans. Until recently, the banner was carried by a vocal minority. It has, however, recently seen an influx of new supporters. Where once, anti-ERISA sentiment was strictly the hobby of State legislators; private entities and Federal lawmakers are now siding with the anti-ERISA crowd. Why? Because private, self-funded health plans are, in the words of Timothy S. Jost, Professor of Law at the Washington and Lee University School of Law, co-author of books and articles regarding health care regulation and relied upon by numerous law makers and insurance commissioners, “The greatest threat facing exchanges,” due to “adverse selection.”

What is adverse selection? This is the phenomenon that occurs when an opportunity to shift bad-risk appears without an equal shift of good-risk as well. The development of the individual-policy exchanges (resulting from the passage of The Patient Protection and Affordable Care Act [“PPACA”]), created a method

for high-risk (sick, costly, pre-existing condition, etc.) participants to secure health insurance. To counter this costly migration of high-cost lives to the exchanges, it was believed, that many low-risk/low-cost lives would join the exchanges as well. Many employers, who – heretofore had provided coverage for high-cost populations – chose to terminate their costly insurance programs and send their high-risk, costly lives to the exchange. Employers who, meanwhile, employ healthy employees, held onto their low-risk/low-cost lives, in the form of self-funded health plans. By hoarding the low-cost lives and burdening the exchanges with the high-cost lives, the exchanges – one of the pillars upon which PPACA is built – cannot stand.

Those who are invested in PPACA’s success, therefore see private self-funding as an enemy; and as the saying goes, the enemy of my enemy is my friend. Bolstering a desire to end self-funding and adverse selection, an alliance has formed between PPACA supporters and state insurance powers; against ERISA and the private self-funded plans it protects.

Take, for example, the aforementioned state of New York, but more specifically the 2nd Circuit and the Federal appellate jurisdiction in which it resides. It was less than two years past that the Supreme Court of the United States, for the fourth time since 2002, reaffirmed ERISA’s preemptive power establishing that not only did ERISA plans have the ability to preempt application of state regulation under its “express preemption” clause, but cases involving ERISA plans that “relate to” employee benefits were subject to federal court jurisdiction by way of ERISA’s “complete preemption” provision. Strip all the legal lingo away and you have a very basic concept; when a claim is brought to a court by

any party and that claim has anything to do with provision of benefits under an ERISA health benefit plan, that claim has virtual automatic entry to the federal courts at the option of either party; or so it seemed to be the case until the 2nd Circuit's recent decision in *Wurtz v. Rawlings*, 761 F.3d 232 (2014).

In *Wurtz*, the federal court diverted from what was established authority (that a claim against an ERISA plan to vitiate a plan's subrogation rights "related to" employee benefits and therefore could be heard in federal court) and, instead, ruled that a claim against subrogation rights does not relate to employee benefits. It therefore fails the threshold question needed to gain entry into a federal court. How, you might ask, can a claim to maximize benefits under a health plan via subrogation not "relate to" employee benefits? As inconceivable as it seems, the Federal court found a way to turn against an overwhelming amount of authority and create a scenario where self-funded benefit plans, absent some other method of entry into federal court, may be forced to stay and have their preemption arguments heard in state court, at the mercy of state judges who have historically demonstrated an aversion to ERISA's preemption scheme. Plans ill prepared for this possibility will find themselves in unfriendly territory, arguing against application of laws and theories to which Congress never intended them to be subject.

At least in the subrogation context, the idea of Federal courts taking liberties with ERISA preemption is certainly not new. One need only look at traction in the Supreme Court since the late 1990's. Some Federal jurisdictions, like the 9th Circuit, have shown an almost maniacal obsession with contorting the rights of ERISA

plans wherever possible. In almost every situation, the High Court has come down and righted the ship. Perhaps the High Court will do the same in the 2nd Circuit as industry advocates, including both the Self Insurance Institute of America ("SIIA") and the National Association of Subrogation Professionals ("NASP") have recently filed an amicus brief in support of a Writ of Certiorari to the Supreme Court to hear this 2nd Circuit case and overturn the decision (once again) allowing benefit plans to administer plans in the 2nd circuit as they would in any other circuit, without fear of application of divergent state law.

While ERISA attacks are pervasive in the subrogation realm, make no mistake, they are prevalent in other areas as well. SIIA has been engaged in a dispute regarding a Michigan tax imposed on self funded plans since 2011. The battle continues into the upcoming year as SIIA is filing an appeal to the Supreme Court of the United States asking the Court to overturn a 6th Circuit U. S. Court of Appeals decision that ERISA does not bar a provision forcing self-insured benefit plans to pay a tax imposed by Michigan; intended to aid in the funding of its Medicaid program. At the core of the dispute is a familiar issue; to what extent does this tax "relate to" employee benefits? Proponents of the tax assert that the tax has no impact or bearing on how a benefit plan pays or administers claims. Of course, those proponents ignore the multi-state issues implicated where benefit plans either have employees in multiple states, or pay claims to providers in multiple states. The tax imposed by Michigan is imposed only with regard to Michigan residents obtaining care in the state of Michigan. Benefit plans will necessarily be required to administer

claims differently where this tax is applied than when it isn't – so, where is the disconnect?

Despite the efforts discussed above, we see a troubling trend as it relates to the rights of ERISA plans, developing at a fundamental level. The Department of Labor ("the DOL") is the Federal agency charged with enforcing the rules governing the conduct of plan managers, investment of plan assets, reporting and disclosure of plan information, enforcement of the fiduciary provisions of the law and worker's benefit rights. As evidenced through the development of PPACA, it is not unprecedented for federal agencies (charged with administration of a statute with the breadth of ERISA) to have substantial rule making authority that is considered to have the force of law. With this agency rulemaking power in mind, the amount of anti-ERISA decisions seems to have experienced an uptick since PPACA became the law of the land. Coincidence, or collusion?

In October 2014, the DOL entered into the sphere of ERISA plans in the form of an "FAQ". Essentially, the DOL issued notice that benefit plans utilizing a reference based pricing approach to benefit payments would need to craft the plan carefully, with specifically enumerated standards to be followed, to avoid balances billed to the patient being credited against that participant's maximum out of pocket deductible. Why is this important? Since PPACA banned benefit plans' ability from establishing lifetime maximums, all amounts billed to patients above the annual maximum out of pocket, effectively becomes the responsibility of the benefit plan. Imagine for a moment the impact this may have on the fiduciary obligations of a plan who has established maximum payable amounts at some multiple of Medicare



LISTEN - UNDERSTAND - LEVERAGE - SOLVE

A CONTRACT IS A LEGAL DOCUMENT.



# A TRUE PARTNERSHIP IS SO MUCH MORE.

Our experience, innovation and track record are only meaningful if we are able to help our clients. We will listen carefully to your goals and challenges and leverage our deep and varied resources to deliver a customized solution that meets your needs.

Find out what you can expect from a true partner at [partnerre.com/health](http://partnerre.com/health).

Underwritten by PartnerRe America Insurance Company  
Executive Office: 199 Fremont St., San Francisco, CA 94105  
Form HAD1214 12/2014

PartnerRe



WE HAVE THE

# EXPERTISE

AND A COLLABORATIVE CULTURE TO HELP YOU SUCCEED.

Just having group benefits expertise is not enough. At AmWINS, we have taken specialization one step further by creating a practice that enables our team of specialists to collaborate with one another quickly, helping you give the best options to your self-funded clients. That's the competitive advantage you get with AmWINS Group Benefits.

**AmWINS**<sup>®</sup>  
Group Benefits

SPECIALIZING IN GIVING YOU MORE.

**NEBCO**

 **WebTPA**

**Stop Loss**  
Insurance Services

 **BEACON**  
RISK STRATEGIES

**AmWINS Rx**



allowable. Will plans now be subject to lawsuits alleging a breach of fiduciary duty because they are possibly required by law to pay more than they originally established as payable under the terms of the plan? What about a plan that employs a reference based payment structure and then obtains stop loss insurance underwritten on the basis of those maximum allowable rates? How can the DOL effectuate its administrative obligations over ERISA while seemingly establishing law that may force a benefit plan to pay amounts directly in contravention with the terms of the plan necessarily forcing them to be in breach of their fiduciary duties under ERISA?

Just a few weeks later, the DOL threw its hat into the fray as it relates to the recent surge in stop loss regulation. In this area, which has been quickly developing and likely will continue to be among the hottest

topics of the 2015 legislative season, the DOL opined via a Technical Release on November 6 that, indeed, stop loss insurance attachment levels can be regulated by the state without fear of the application of ERISA preemption. This is, undoubtedly a huge win for those states that have for years tried (and failed) to take down the barriers to legislation of self-insured plans provided by ERISA. By making stop-loss less accessible to employers, self-funded opportunities die on the vine.

When evaluating the preceding examples, one could argue that the DOL is simply doing its job. Perhaps, it too, is being placed in an untenable position, that of being heavily involved in the administration of two of the largest statutes ever written, which just so happen to contradict each other in their effects. In a vacuum, one might argue that the DOL is simply looking at two separate laws, assessing them, interpreting them, issuing regulation pertinent to them and passing the buck; that it is virtually impossible to comply with both without breaching fiduciary duties, breaking the law, or incurring penalties. When the DOL's actions and positions are viewed in their totality, however, the intent seems much more nefarious.

Look back to about mid 2013 and you may recall the DOL's role in the case of *Liberty Mutual Insurance Company v. Susan L. Dorgan in her capacity as the Commissioner of the Vermont Department of Regulation*. Vermont passed a healthcare database statute that Liberty Mutual claimed was preempted by ERISA as it applied to ERISA plans. The statute required health insurers, care providers, facilities and government agencies to "file reports, data, schedules, statistics, or other information as determined by the commissioner" and defined the term "health insurer" broadly such that it included any administrator of a self-insured group health plan, including Third Party Administrators. Liberty Mutual sued the



# THE PHIA GROUP

## EMPOWERING PLANS

**CONSULTING SERVICES**

**PLAN DRAFTING SERVICES**

**SUBROGATION & RECOVERY SERVICES**

**Learn With Us**

- Recognized Industry Leadership**
- Gap Free Review**
- Claim Evaluation and Analysis**
- Reference-Based Pricing Program Support and Balance Billing Solutions**

**Plan With Us**

- Phia Document Management ("PDM")**
- Phia Certified SPD**
- Plan Documents - Reviewed, Revised, Amended**
- Multiple Plan Formats**

**Save With Us**

- The Legal Advantage**
- The Phia System™**
- Unmatched Results**
- Overpayment Recovery**

**The Phia Group Hosts Frequent Educational Webinars  
To Learn More and Register – Visit [www.phiagroup.com](http://www.phiagroup.com)**

The Phia Group, LLC | 163 Bay State Drive Braintree, MA 02184 | Phone: 781-535-5600 | Email: [info@phiagroup.com](mailto:info@phiagroup.com)

state because, it argued, requiring this reporting created administrative burdens imposed by the state and therefore triggered ERISA preemption. The DOL, which has historically defended ERISA's broad preemptive capabilities, filed an amicus brief in support of the State of Vermont. Industry analysts opined that this action was indicative of a shift in the DOL's approach and causally related to the administration's need to bolster the success of PPACA by negatively impacting the success of the private healthcare marketplace.

On a more anecdotal level, one of the authors of this very article recently left the world of academia. While attending graduate level classes (and in light of a decade of experience in the self-funded health plan space), I spent some time taking courses focusing on ERISA and visiting seminars regarding health

reform; featuring speakers from none other than the DOL. On more than one occasion, DOL representatives focused their discussion on the "evils" of ERISA plans – perhaps informed discourse was expecting too much. The message was clear; "self-funded plans are unfair, unfunded and lack financial viability!" When taken to task, these representatives ignored the counterpoint, in some instances even ignoring citations to reports on self-funded plans done by the DOL itself, as mandated by PPACA. Indeed, the anti-ERISA prognosticators are even taking their biased propaganda to the hallowed halls of academia. The hope? Shape minds and create droves of advocates for toppling private self-funding, thereby bolstering the exchanges with low risk/low cost lives. Allow no analysis, no discourse, no acknowledgement of the successes of the industry; it isn't conducive to

their efforts; in fact, the very truth that self-funding is the best way to maximize benefits and minimize costs for a group is the very reason they need the private self-funded market to crumble.

So, whether it be experts like the Commonwealth Fund and Timothy Jost, the NAIC, state regulators looking for creative ways to impose burdens on ERISA plans, the Federal Courts, or the perhaps most troubling of all, the DOL, it has become painfully apparent that as it relates to ERISA, "Big Brother" is not on our side. The fact that ERISA plans and especially self-funded plans have seemingly found a way to provide comprehensive, cost effective benefits (a model the country seems to be embracing as the ratio of self-funded benefit plans grows annually) is bad news for those who are invested in PPACA and the exchanges, which are financially dependent upon the low-cost lives



What's behind every great venture? Typically, considerable risk. And right behind that, there's us. HCC Life brings you over 35 years of medical stop loss experience, industry-leading financial ratings and experts who know what to do with it all. Intelligence beats the odds every time. We call it **Mind over risk.**



**HCC**

**HCC Life Insurance Company**

[hcc.com/life](http://hcc.com/life)

For more information, visit us online at [hcc.com/life](http://hcc.com/life).

A subsidiary of HCC Insurance Holdings, Inc.

msl2205 - 09/14

currently self-funded. Their goal seems clear, force PPACA to be successful – at any cost! Our goal, then, must also be clear; educate and advocate! Self-funded health plans currently make up over 60% of the private insurance market. There is a power in numbers that we must take advantage of. Those with interests in the continuity of ERISA must take it upon themselves to spread the word regarding the importance of ERISA; its ability to do what the public sector has failed to do – that is, provide access and coverage to plan participants. If we allow “Big Brother” to control the rhetoric, their message and intention seems clear. Adverse Selection is the main threat to the exchanges and PPACA, even if it is a byproduct of intelligent people shying away from a faulty option. If “they” have their way, ERISA, federal preemption and private self-funding will be eradicated. The question is, what will you do about it? ■

*Christopher Aguiar has been a member of The Phia Group team since 2005 and spent the first few years honing his subrogation and third party recovery and negotiation skills while learning the incredibly complex field of subrogation and benefit plan recovery law. As an attorney with The Phia Group, Christopher has become a valuable member of the Legal Department responsible for the oversight and education of staff on the ever developing arena of subrogation law as well as the strategic development and implementation of the organization recovery program. Christopher also consults with self-funded benefit plans regarding plan drafting, plan language analysis, reference based pricing, claims appeal assistance, balance billing defense, overpayment recovery, as well as stop loss and PPO disputes. He was selected to present at the 2012 Annual Conference for the National Association of Subrogation Professionals in Las Vegas, Nevada. Christopher obtained his law degree from Suffolk University Law School in Downtown Boston, MA.*

*Ron Peck, Sr. Vice President and General Counsel, has been a member of The Phia Group's team since 2006. As an attorney with The Phia Group, Ron has been an innovative force in the drafting of improved benefit plan provisions, handled complex subrogation and third party recovery disputes and spearheaded efforts to combat the steadily increasing costs of healthcare. In addition to his duties as counsel for The Phia Group, Ron leads the company's consulting, marketing and legal departments.*

*Ron is also frequently called upon to educate plan administrators and stop-loss carriers regarding changing laws and strategies. Ron's theories regarding benefit plan administration and healthcare have been published in many industry periodicals and have received much acclaim. Prior to joining The Phia Group, Ron was a member of a major pharmaceutical company's in-house legal team, a general practitioner's law office and served as a judicial clerk. Ron is also currently of-counsel with The Law Offices of Russo & Minchoff.*

*Ron obtained his Juris Doctorate from Rutgers University School of Law and earned his Bachelor of Science degree in Policy Analysis and Management from Cornell University. Ron is also a Certified Subrogation Recovery Professional (“CSR”).*



## **Do you aspire to be a published author?**

Do you have any stories or opinions on the self-insurance and alternative risk transfer industry that you would like to share with your peers?

We would like to invite you to share your insight and submit an article to *The Self-Insurer*! SIIA's official magazine is distributed in a digital and print format to reach over 10,000 readers around the world. *The Self-Insurer* has been delivering information to the self-insurance/alternative risk transfer community since 1984 to self-funded employers, TPAs, MGUs, reinsurers, stop-loss carriers, PBMs and other service providers.

**Articles or guideline inquiries can be submitted to Editor Gretchen Grote at [ggrote@sipconline.net](mailto:ggrote@sipconline.net).**

***The Self-Insurer* also has advertising opportunities available.** Please contact Shane Byars at [sbyars@sipconline.net](mailto:sbyars@sipconline.net) for advertising information.