McGraw Wentworth

REFORM Update

Issue Eighteen October 2010

October 18, 2010

The government continues to release guidelines to help employers and health plans comply with many complicated aspects of health care reform. The recent guidance includes:

- New questions and answers posted on the Department of Labor's Web site at http://www.dol.gov/ebsa/faqs/faq-aca.html.
- Department of Labor's Technical Release 2010-20 listing the latest rules on appealing internal claim denials and provides a non-enforcement position on certain aspects of appeals until July 1, 2011.
- IRS Notice 2010-63 clarifying part of the confusion over applying Section 105(h) non-discrimination requirements to fully insured plans and requesting your comments.

This *Reform Update* reviews the newly released information.

New Q & A's

The Department of Labor's Web site answers many new questions on a host of practical issues. A summary of these questions includes:

- A question on the DOL's approach to implementing all the near-term aspects of health care reform. The DOL hopes to act as a consultant, working with employers, insurance carriers, states, providers and others affected to help them comply with the complicated health care reform requirements. As with most new guidance, the DOL will enforce the health care reform act, but it will allow organizations leeway to correct problems whenever possible.
- A question from insurance carriers on how to monitor grandfathered plans when they are frequently not aware of an employer's contribution strategy. Plans can lose grandfathered status if the employer shifts more than 5 percentage points of the contribution rate to the employees. Until the regulations become final (the current regulations are interim), DOL will not treat an insured group health plan as losing grandfathered status immediately based on an employer's change to the contribution schedule, providing the employer and insurance carrier take the following steps:
  1) When renewing the plan, the employer must inform the insurance carrier of the contribution rate for that plan year. In addition, the employer must disclose the contribution rate as of March 23, 2010.
  2) The insurance carrier's policies, certificates or contracts must prominently and effectively state that the employer (or plan sponsor) must notify the carrier of any contribution rate changes during the plan year.

Multi-employer plans must also follow these steps to receive the same relief if the contribution rate changes.

- A question on adult dependents. Does the requirement to cover children up to age 26 apply to all dependents? For example, if the plan allows an employee to cover a grandchild or a niece, can the plan insist these individuals meet certain dependency requirements before it will cover them? The answer was yes, but only when they are not considered the employee's children.

Most of the other questions deal with the issues discussed in the next two sections. It appears the government will continue to answer questions on its Web site.

DOL Technical Release 2010-20

Health plans and health insurance carriers have expressed concern about making the necessary changes to meet the new appeal and review requirements in time to meet the deadline (first day of first plan year following September 23, 2010, with a delayed effective date for grandfathered plans). To alleviate those concerns, this Technical Release allows a grace period until July 1, 2011, for certain requirements related to claims review and appeals. The grace period means the government will not take action against a plan that is working in good faith to adopt certain requirements but does not yet have them in place. The DOL also created temporary safe harbors until the federal review process is complete.

This latest Technical Release (2010-20) clarifies exactly which new internal claims appeals provisions will have a grace period. For more details on the changes, please read our Reform Updates, Issues 13 and 15 at http://mcgrawwentworth.com/resources_reformupdate.html.

Just to review, the following are the key changes that health care reform made to the internal claim review process:

1) Added rescission of coverage to the definition of a denied claim.
2) Reduced the amount of time a plan has to determine whether it will grant an urgent care claim. Currently, plans have 72 hours. The new rules shorten that time to 24 hours.
3) Clarified the terms for a full and fair review of claims and appeals. Plans must provide new or additional claim-related evidence considered, relied upon or generated free of charge. In addition, if the plan uses a new or an additional rationale for denying the claim during the appeals stage, the claimant must have a reasonable opportunity to respond.
4) Spelled out conflicts of interest among people involved in making benefit decisions. For example, a plan cannot deliberately select a claim adjudicator or a medical professional knowing that person will probably deny the claim.
5) Required claim notices to be provided in a culturally and linguistically appropriate manner.
6) Required claim notices to include certain specific additional content.

7) Spelled out consequences when a plan or carrier does not abide by the interim final regulations. In that case, the claimant is considered to have exhausted the internal claims and appeals process and can then ask for an external review or seek other remedies available under ERISA or state law.

The grace period until July 1, 2011 applies only to these changes:

- # 2 (timeframe for making urgent care determinations)
- # 5 (culturally and linguistically appropriate claim notices)
- # 6 (broader content in the notification process)
- # 7 (external review or other remedy if the plan does not follow new requirements)

However, in order for the grace period to apply, the plan must demonstrate they are making efforts to adopt these new requirements. Most of these changes will be addressed by your health plan vendor. It is in your best interest to periodically request a status update on adopting the new requirements.

IRS Notice 2010-63

IRS Notice 2010-63 somewhat clarifies Section 105(h) non-discrimination requirements for fully-insured plans. First, this health care reform requirement applies to group health plans on the first day of the first plan year after September 23, 2010; however, the effective date can be delayed for grandfathered plans.

According to Section 105(h), a health plan cannot favor highly compensated employees when it comes to eligibility or benefits. On the other hand, if different employees have different benefit plans the plan is not necessarily discriminatory. Specific tests must be performed to determine whether your plan design favors highly compensated employees. The details of the testing process can be found in our 2006 Benefit Advisor, Issue 9 at http://mcgrawwentworth.com/Benefit_Advisor/2006/BA_Issue_9.pdf.

This notice clarifies the Section 105(h) penalties for operating a discriminatory plan. Before health care reform, the penalty applied only to highly compensated individuals covered by self-funded medical plans. If a plan was found to be discriminatory, the health benefits for highly compensated individuals lost tax-favored status. Health care reform seemed to add a $100 a day penalty for each plan participant. IRS Notice 2010-63 clarifies the penalties going forward.

The penalties depend on the plan's funding:

Fully Insured Plans – An insured group health plan that does not meet Section 105(h) requirements must pay taxes, remedies and penalties that generally apply to plans failing to comply with Chapter 100 of the Internal Revenue Code. Following are the potential penalties:

- An excise tax of $100 a day for each person discriminated against.
- A civil action for appropriate equitable relief.

Self-Funded Plans – Health care reform does not change the penalty for self-funded plans. Highly compensated individuals lose health benefit tax advantages if the self-funded plan does not meet the Section 105(h) non-discrimination requirements.

In addition to clarifying the penalties for not complying with Section 105(h), the government is asking for your comments on any additional guidance you need.

McGraw Wentworth will continue to issue *Reform Updates* to address new information and guidance on health reform.