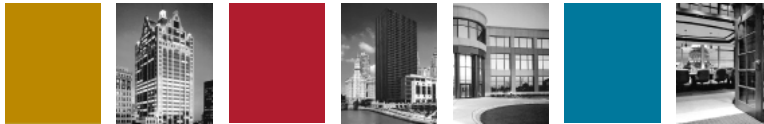


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2010 Administrative Requirements Overview

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Topics for Today

- Grandfathered plans
- Administrative changes

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What is a “Grandfathered” Plan?

- PPACA requires group health plans to make several changes to coverage. However, some of these changes do not apply where the plan has “grandfathered” status
- A “grandfathered plan” is a plan that was in effect as of the date of PPACA’s enactment—March 23, 2010
 - So, a “brand new” plan created after then is not grandfathered
 - Suppose Start-Up Co. is established May 1, 2010 and immediately creates a health plan for its employees. The plan is not grandfathered
- Regulations clarify that each “benefit package” considered separately:
 - Suppose plan offers HMO, PPO and POS options. If HMO loses its grandfathered status, PPO and POS options will still retain theirs
 - How does a sponsor demonstrate what “benefit packages” it has? May need to document this determination (later slide)

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Collectively-Bargained Plans

- Special rule for insured collectively bargained plans: such plans retain grandfathered status, regardless of changes made (like switching carriers or decreasing benefits), until the last collective bargaining agreement in effect as of March 23, 2010 terminates
 - Thereafter, the collectively bargained plan is subject to the grandfathering rules just like any other plan
 - What if CBA is extended prior to its normal termination date?
- Self-funded collectively bargained plans are treated like non-collectively bargained plans

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What Rules Apply to both GF and Non-GF Plans?

2010 - 2011

- No annual limit or lifetime limits on benefits
- No rescissions (except if fraud or misrepresentation)
- Coverage for adult children up to age 26 (GF can ask coverage question)
- No pre-existing condition exclusion for enrollees under 19 years old

March 2012

- Summary of Benefits using HHS uniform definitions

2014

- No preexisting condition exclusions for any enrollees
- Waiting periods limited to 90 days

Other

- Employer Mandates
- Cadillac Plan Tax
- FSA / HSA / HRA Changes

What Rules do GF Plans Avoid?

2010 - 2011

- No cost sharing for preventive care or immunization
- Code sec. 105(h) applies to fully-insured plans
- Allow individuals to choose pediatrician / primary care provider
- Allow females to choose ob/gyn without referral
- Internal appeals and external review process
- Allow emergency services without preauthorization and treat as in-network
- Disclose certain plan info (may be fully-insured only)

2014

- Various insurer requirements
- Cost sharing/deductible limits for certain plans
- No discrimination against individuals in clinical trial
- No discrimination on health care providers acting within scope of license
- No health status discrimination (with caveat); wellness reward to 30%

Will we Lose our Grandfathered Plan Status if we...?

- Have a complete turnover in plan participants (i.e., everyone who was in plan on 3/23/2010 is no longer participating)?
 - No, that is ok
- Fail to include in our “plan materials” a statement that the plan is grandfathered?
 - Yes, that will cause a loss
 - “Plan materials” seems to include SPD and any other doc “describing” plan benefits
 - Is it immediately effective?
 - Model language in regulations but can lead to some confusion
- Enter into new insurance policy?
 - Yes, that will cause a loss (exception for collectively bargained plans)
- Add new employees (whether “newly hired” or “newly enrolled”)?
 - No, that is ok; unclear if any limits to term “newly enrolled”

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Will We Lose our Grandfathered Status if we ...?

- Engage in an “abusive” corporate transaction (e.g., transfer employees from high-cost to low-cost option)?
 - Yes, that will cause a loss
- Eliminate benefits for particular condition (or benefits to diagnose or treat particular condition)?
 - Yes, that will cause a loss
- Increase a percentage cost-sharing requirement (e.g., 20% coinsurance increased to 25%)?
 - Yes, that will cause a loss
- Increase a fixed-amount cost-sharing requirement other than a copayment (e.g., increase a \$500 deductible or \$2,500 out-of-pocket maximum)?
 - Perhaps. No loss if cost of change equals or is less than medical inflation + 15 percentage points

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Will We Lose our Grandfathered Status if we ...?

- Increase a fixed-amount copayment (e.g., office visit copayment increases from \$30 to \$40)?
 - Perhaps. No loss if cost of change equals or is less than greater of: (1) \$5 (increased by medical inflation); or (2) medical inflation + 15 percentage points
- Decrease the employer contribution by more than 5 percentage points (e.g., employer used to contribute 60% of family coverage, now contributes 50%)?
 - Yes, that will cause a loss
- Add a new annual limit (e.g., plan did not have annual limit on 3/23/2010 but adds one)?
 - Yes, that will cause a loss
- Decrease the dollar value of an annual limit (assuming plan imposed one on 3/23/2010)?
 - Yes, that will cause a loss

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Grandfathered Plan Strategies



- Each benefit package or option considered separately
 - If want to maintain GF status, document each benefit package
- “Laminate” your 3/23/2010 plan—will need a document to prove what plan terms were
- Is it worth it to try and maintain GF status? What costs are avoided? How much extra work is it to try and stay within GF safe harbor?
 - Calculate expected cost of each change if lose GF status (and whether employer or employee pays cost)

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Administrative Changes

- New appeal procedures (GF plans are excepted)
- Applying Code Section 105(h) (nondiscrimination rules) to fully-insured plans (GF plans are excepted)
- Transparency disclosure rules for fully-insured plans (GF plans are excepted)
- No wellness plan inquiries on lawful firearms or ammunition (GF plans are excepted)
- Summary of benefits (4 pages) (no GF exception; all plans must comply)
- Form W-2 reporting rules (no GF exception; all plans must comply)
- “Dumping” individuals into state high risk pool (no GF exception; all plans must comply)
- No retaliation / no discrimination
- CLASS Act

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New Appeal Procedures (2010 – 2011)



- Creates several new rights for claimants, including
 - Right to review “file,” which may be broader than the current ERISA right to request “relevant information”
 - Right to present testimony as part of appeal
 - Right to continue receiving coverage during appeal process
- Under regulations, DOL standard remains in place, but is broadened in seven ways:
 - Expanded definition of “Adverse Benefit Determination”
 - Notification of urgent care claim determination shortened
 - Additional evidence disclosure requirements
 - New impartiality requirements
 - New notice requirements
 - Continued coverage requirement
 - Strict compliance and risks for failing to do so
- External review (new concept for many self-funded plans)

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“Adverse Benefit Determination” / Urgent Care

- Now includes any rescission of coverage
 - Even if no adverse effect on any particular benefit at time of rescission
- Notification of urgent care claim determination shortened to 24 hours
 - Previous standard was 72 hours but “electronic communication” enables “faster decision-making today than in the year 2000” (when prior regulations released)
 - Standard not based on business days
 - Some delay possible if claimant fails to provide sufficient information to decide on claim
- Can be difficult to satisfy – e.g., urgent care claim received Friday at 4:30 p.m., must answer by Saturday at 4:30 p.m.
 - What if answer requires consultation with a specialist, who is not available in those 24 hours?
- For both, discuss with TPAs (and possibly carriers)

Additional Evidence Disclosure Rules

- Non-ERISA plans (e.g., self-funded, governmental plans) now must effectively follow ERISA rules and the new rules
 - In rare circumstances, health plan will also provide disability benefits; unclear if ERISA disability rules also incorporated by reference
- Plan or issuer must provide claimant with any new or additional evidence which the plan or issuer considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale, for an adverse benefit determination
- Information must be provided as soon as possible and sufficiently in advance of the date that the issuer or plan has to issue its decision
 - Designed to “give the claimant a reasonable opportunity to respond” prior to date final decision is to be issued
- Plan cannot charge for providing this information
- Information must be provided regardless of whether claimant requested it
- Discuss with TPA (and possibly insurer)

New Impartiality Rules

- Plan or issuer must adjudicate claims and appeals in a manner to ensure independence and impartiality of the persons involved in the decision
 - Presumably applies also to employers, although regulations only state “plan” or “issuer”
- Decisions regarding hiring, compensation, termination, promotion, or similar matters regarding an individual must not be made based upon the likelihood that the individual will support the denial of benefits.
- Example: CFO on Appeals Committee. If the CFO's bonus is tied to the plan sponsor's net profit, the CFO has an interest in keeping the net profit as high as possible. For a self-funded plan, the CFO may have an interest in denying high medical plan claims if they would reduce net profit
 - Unclear how far to take the argument; e.g., if have stop-loss, ok? What if high claims would increase stop-loss premiums in future years?

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New Notice Requirements

- Notice of an adverse benefit determination must describe:
 - Date of service
 - Health care provider
 - Claim amount (if applicable)
 - Diagnosis, treatment, and denial codes (and the corresponding meaning of these codes)
 - Description of the plan's or issuer's standards used to deny the claim (e.g., if the claim was denied as not medically necessary, the denial notice must include a description of the medical necessity standard)
 - If a final internal adverse benefit determination, a discussion of the decision

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New Notice Requirements

- Notice (adverse or approval) must:
 - Describe available internal appeals and external review processes, including information regarding how to initiate an appeal
 - Describe the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist enrollees with the internal claims and appeals and external review processes
 - Application to self-funded, ERISA-covered plan unclear
 - Model notices to be released – likely wait for these notices and customize as needed

New Notice Requirements

- Continued coverage requirement
 - Pending outcome of an internal appeal, the plan or issuer must continue to provide coverage to the claimant
- Strict compliance
 - If a plans or issuers fails to “strictly” adhere to the requirements, the claimant will be deemed to have exhausted the internal claims and appeals process
 - Means the claimant may initiate an external review or pursue any available remedies under applicable law
 - Substantial compliance or de minimus errors irrelevant
 - If claimant brings lawsuit under ERISA Section 502(a), claim or appeal “deemed denied on review without the exercise of discretion by an appropriate fiduciary”
 - Does this cause loss of loss of deferential standard in judicial proceedings, regardless of whether “Firestone” language exists? If so, will courts agree with DOL interpretation?

External Review

- PPACA requires plans to provide participants an external review of claims
 - Participant has the ability to seek an independent third-party's decision regarding whether the claim should have been covered
 - Appears third-party's decision is binding upon the claims and the plan or issuer, unless other remedies are available under state or federal law
 - Seems to mean that following the internal review, the participant has the choice of the external review or judicial review

External Review

- Two types of external review: state and federal
 - Regulations indicate the federal external review will be detailed at a later time
 - Federal law will defer to state external review when it:
 - Exists (state has implemented a review procedure)
 - Applies (the plan can be subject to the state law; e.g., insured plans, non-ERISA plans, some MEWAs)
 - Meets the NAIC's Uniform Model Act's standards
 - HHS will determine whether the state's external review process meets the requirements

State External Review

- Notable terms on state external review:
 - No minimum limit on the amount of the claim to be eligible for external review (e.g., plan cannot impose a minimum claim amount of \$500 for an external review to occur)
 - Claimant must have a period of at least four months following the receipt of an adverse benefit determination in which to request an external review
 - Cost of external review is paid by the issuer (and presumably the plan)
 - State selects the reviewing organization
 - Claimant can submit additional information (not clear that the plan or issuer is permitted to respond)

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State External Review

- Transition period for state external review
 - States are to bring their external review processes up to the NAIC standard by July 1, 2011
 - Prior to July 1, 2011, compliance with the external review process in place at that time will be deemed sufficient for purposes of providing an external review process
 - On and after July 1, 2011, if the state external review process is still noncompliant, the plan must use the federal process

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Federal External Review

- Applies to any adverse benefit determination other than determination of eligibility for health plan
 - E.g., plan only covers employees working 30 hours or more per month; dispute on how to calculate “30 hours” not subject to external review
- Future guidance will use standards “similar” to NAIC Uniform Model Act on external review
- Will describe:
 - How claimant initiates external review
 - Procedure for preliminary review to see if process applies
 - Random assignment of external reviews to approved entities
 - Expedited reviews for urgent medical situations
 - For experiment or investigational treatments, “additional consumer protections” to ensure “adequate” scientific and clinical experience taken into account

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Federal External Review

- Review binding on plan or issuer, as well as claimant, “except to the extent other remedies are available under State or Federal law”
 - Presumably participant or beneficiary could sue (at least for ERISA-covered plans), perhaps effectively appealing the denial
 - Could a plan sue? Is it a one-sided appeal process (only in favor of participants and beneficiaries)?
- Will be “additional notice requirements” for plans to describe these Federal external reviews

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Form and Manner of Notices

- Plan and issuer must provide claims / appeal notices in a “culturally and linguistically appropriate manner”
 - If less than 100 participants, provide notice upon request in a non-English language in which lesser of 500 or more participants, or 10% or more of all participants, are literate only in same non-English language
 - If so, must:
 - Include a statement in English version, prominently displayed in non-English language, offering provision of such notices in non-English language
 - Once request made by claimant, provide all subsequent notices to claimant in non-English language
 - Apply to claimant’s entire family?
 - If provide customer assistance process (e.g., hotline), provide assistance in non-English language

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Transparency Disclosure Rules (2010 – 2011)

Design

Admin

Comm

- Fully-insured group health plans will have to disclose certain information to “secretary” and insurance commissioner
 - Plus, must make it available to “public”
- Scope of data unclear – no guidance yet
- Could include claims data, data on enrollment, numbers of claims denied
- Self-funded plans seem exempt
- Wait for guidance

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105(h) for Fully-Insured Plans (2010 – 2011)



- Fully insured health plans will generally be required to satisfy Code § 105(h) nondiscrimination rules
 - Requirements include complex eligibility and benefits tests previously applicable only to self-insured plans
 - Violation of rule seems to be \$100/day excise tax, not taxation for highly compensated, but somewhat unclear
- Carefully examine executive-only policies and any other plan differences (eligibility, waiting periods, benefits)
 - If lose GF status, identify plan design differences and have test run periodically (perhaps more than once per year)
 - If discriminatory, modify plan or prepare to pay penalties

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Summary of Benefits



- Literally effective first plan year on or after 9/23/2010 but special distribution deadline is 24 months after 3/23/2010 (model to be provided by government by 3/2011)
- Significant penalties (up to \$1,000 for each willful failure)
- Four-page summary of benefits must be provided by plan administrator (self-insured plan) or insurer (insured plan) in paper or electronic form
 - To all applicants, policyholders, and enrollees both at the time of initial enrollment and at annual enrollment
 - Applies in addition to ERISA required SPD
- Appearance and language requirements include
 - Presentation in “culturally and linguistically appropriate manner”
- Material modification not reflected in most recent summary is not effective without 60-day advance SMM

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Summary of Benefits

- Required content includes (in four pages!)—
 - uniform definitions of standard insurance and medical terms
 - coverage, including cost sharing for “essential health benefits”
 - coverage exceptions, reductions, and limitations
 - cost-sharing provisions (like deductible, coinsurance, and co-pay)
 - renewability and continuation of coverage provisions
 - examples illustrating common benefit scenarios
 - whether “minimum essential coverage” is provided and statement plan ensures that its share of the total allowed costs of benefits under plan is not less than 60% of such costs
 - statement that coverage document should be consulted
 - phone number for questions and website for insurance policy or SPD

Lawful Firearms and Ammunition (2010 - 2012)

- Certain wellness and “health promotion activities” created pursuant to “quality of care” rules under PPACA cannot require disclosure or collection of information relating to:
 - (1) presence or storage of lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or
 - (2) the lawful use, possession, or storage of a firearm or ammunition by an individual
- Effective date unclear – would seem to be 2010 – 2011, but another cross reference refers to no later than March 2012
- Also unclear if this applies to all wellness programs or only those created pursuant to PPACA “quality of care” provisions
- “Health promotion activities” not well-defined
- Consider: (1) waiting for guidance; (2) asking wellness vendor if they ask the question (e.g., in a health risk assessment)

Form W-2 Reporting Rules (2011)



- Effective in 2011, usually for W-2 distributed January 2012 (revised Form W-2 to be issued)
- Employers must report the “aggregate cost” of “applicable employer sponsored coverage” on employee Form W-2
 - Includes private sector and governmental employers
 - Applicable employer sponsored coverage includes insured or self-insured major medical benefits
 - Accident or disability insurance, long-term care or specified disease coverage, and hospital indemnity or other fixed indemnity insurance are excluded
 - Aggregate cost is determined using rules similar to COBRA
 - Dental or vision coverage offered “under a separate policy, certificate, or contract of insurance” is apparently excluded

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“Dumping” Individuals Into State High Risk Pool (2010)



- Effective in 2010 (90 days after 3/23/10), lasts until 2014
- Applies to individual (over 19) with preexisting condition but no creditable coverage for 6 months
- No Incentives to Join Pool: Insurer, employer, or plan that encourages individuals to disenroll and join pool must reimburse expenses paid
 - Encouragement may include provision of money or other consideration plus other criteria to be identified in regulations
- If violated, employer’s plan becomes liable for person’s medical expenses
- Will this apply to “cash in lieu of benefits”?

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No Retaliation / No Discrimination

- Employer cannot discharge or discriminate against an employee for objecting to, or refusing to participate in, a violation of certain PPACA provisions
- A “health program or activity” receiving federal financial assistance cannot discriminate in violation of certain federal laws
 - Terms not yet defined – e.g., will “financial assistance” include early retiree reinsurance program assistance? Will “program or activity” apply to employer-sponsored health plan?



CLASS Act (2011)

- Federal long term care insurance program
- Employees required to pay premium to participate
- Employer can forward on premiums but is not obligated to do so

Questions?

- Thank you for attending

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