

Benefits Alert

April 2010

COBRA Subsidy Extended And Expanded, Again

The Temporary Extension Act of 2010 (P.L. 111-144) again extends the cut-off date for eligibility for the 65% COBRA subsidy to employees involuntarily terminated by March 31, 2010, from February 28, 2010. In addition, certain employees whose hours were cut before being terminated now qualify for the subsidy. *Take note:* An additional extension of the COBRA subsidy is in the Congressional pipeline.

REDUCTION IN HOURS PRECEDING TERMINATION

Employees who experienced a reduction in hours that resulted in a loss of health care coverage on or after September 1, 2008, and who are involuntarily terminated between March 2, 2010, and March 31, 2010, and eligible

to elect COBRA, now qualify for the 65% COBRA subsidy. Employees need not have elected COBRA benefits, or they could have elected COBRA benefits but let that coverage drop when their hours were reduced in order to be eligible for subsidized benefits.

Plan administrators are required to provide these employees with notification within 60 days of termination. Employees have a 60-day election period, beginning on the date notice of the special election period is provided, to elect subsidized COBRA benefits. *Twist:* The length of the COBRA coverage period begins running from the date their hours were reduced, not the date they were terminated. These employees, therefore, are eligible for subsidized benefits

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until either the end of their 18-month COBRA coverage period, or the end of the 15-month subsidized COBRA coverage period, whichever comes first.

The Department of Labor (DOL) will issue model notices, which will be available on its website, www.dol.gov.

MISCELLANEOUS PROVISIONS

While the IRS has said in the past that it's willing to defer to employers' determinations that employees were involuntarily terminated, the Temporary Extension Act takes this one step



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Model CHIP Notice Is Released

The 2009 Children's Health Insurance Program (CHIP) Reauthorization Act requires employers to provide employees with written notice of the availability of health premium assistance under Medicaid or CHIP. The Department of Labor (DOL) has released a model notice you can use to fulfill this notification duty.

ONE STATE IS ALL IT TAKES

The employer CHIP notice is intended to notify employees of potential opportunities currently available for subsidized coverage in the states in which they reside. This notice must be provided annually, but doesn't have to be provided separately from other health plan disclosures, such as open enrollment packets or summary plan descriptions.

CHIP notices are required when a state provides medical assistance under Medicaid or CHIP, and must be provided to employees regardless of whether they're enrolled in the group health plan. Currently 40 states have such programs. The states that *don't* are: Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maryland, Michigan, Mississippi, Ohio, South Dakota, and Tennessee. However, just because you're located in one of these states doesn't mean you're off the notification hook. According to the DOL, if a group health plan provides benefits in one of the 40 covered states, you must provide the CHIP notice to all employees in the CHIP state, regardless of your location or principal place of business.

Example: Mega is an em-

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COBRA Subsidy Extended And... (cont.)

further and codifies the IRS's intentions. Under the new law, employers' decisions regarding involuntary terminations *must* be respected, if those decisions are based on a reasonable interpretation of the American Recovery and Reinvestment Act (ARRA) and related guidance, and employers maintain supporting documentation of their determinations, including an attestation of employees' involuntary termination. *Note:* Employers are already required to keep attestations of employees' involuntary terminations as part

of their ARRA substantiation.

In addition, a new penalty applies to plan sponsors that fail to respect the DOL's determination that an employee is eligible for subsidized benefits. The DOL or the employee may sue the plan sponsor to enforce the determination and for other appropriate relief. Sponsors that fail to extend subsidized coverage to employees may be liable for a penalty of \$110 per day per violation. The penalty clock begins to tick 10 days after the date the plan sponsor receives the DOL's determination. ❖

ployer in the District of Columbia and sponsors a group health plan. Mega's employees live in D.C., Virginia, West Virginia, Delaware, and Pennsylvania. Since at least one state offers Medicaid or CHIP premium assistance, it must provide each employee with a CHIP notice. Mega could provide notice only to employees residing in Virginia, West Virginia, and Pennsylvania, since those are the states that offer premium assistance. On the other hand, it could provide notice to all its employees, regardless of where they live.

The model notice is a national notice, and the DOL stressed that covered states could supplement the information contained in the notice with information on their websites. The DOL also warned that the notice, which must be provided to employees annually, will more than likely undergo annual revisions to reflect changes at the state level. Finally, the DOL said that employers that don't face multi-state complexities may choose to modify the model notice to provide more comprehensive state information.

TIMING OF NOTICES

Employees must receive their CHIP notices by the later of the first day of the first plan year beginning after February 4, 2010, or May 1, 2010. Therefore, notice must be provided by May 1, 2010, for plan years beginning between February 4, 2010, and April 30, 2010. For employers whose next plan year begins on or after May 1, 2010, notice must be provided by the first day of the next plan year. ❖

Interim Final Regs Implement Mental Health/Substance Abuse Parity Law

Mental health parity has been on the books since 1996. The law was substantially expanded in 2008 to require group health plans to cover substance abuse disorders, and to mandate that plans place mental health/substance abuse benefits on a more even par with medical/surgical benefits. Small employers — those with not more than 50 employees on business days during the preceding calendar year — are excluded from these provisions. The law became effective for plan years beginning October 3, 2009. Interim final regulations, which become effective for plan years beginning July 1, 2010, fill in many details of the law.

EVEN STEVEN

These regs are intended to ameliorate prior practices, which allowed group health plans to set different co-payments and stricter limits on mental health benefits than they did for medical/surgical benefits. The regs use several strategies to accomplish this. For example, to prevent health insurers from splitting off mental health/substance abuse benefits into a separate benefits package, the regs specify that they apply to health insurance coverage for mental health/substance abuse benefits *in connection with* a group health plan that offers medical/surgical benefits.

Further, the regs establish a

general parity requirement. Under general parity, plans can't apply *any* financial requirement (e.g., deductibles, co-insurance, out-of-pocket expenses, annual limits, and lifetime limits) or treatment limitation (e.g., limits on the frequency of treatment, the number of visits, days of coverage, or other limits on the scope or duration of treatment) to mental health/substance abuse benefits in any *classification* and *coverage unit* that is more restrictive than the *predominant financial requirement* or treatment limitation that applies to *substantially all* medical/surgical benefits in the same classification. The regs provide formulas for determining the *predominant financial* and *substantially all* requirements. Coverage units are self-only and family coverage. There are only six classifications:

- inpatient, in-network;
- inpatient, out-of-network;
- outpatient, in-network;
- outpatient, out-of-network;
- emergency care; and
- prescription drugs.

Moreover, general parity applies separately to each type of financial requirement or treatment limitation. So self-only (or family coverage) for inpatient, in-network co-pays or treatment limitations for medical/surgical benefits must be compared to self-only (or family coverage) for inpatient, in-network co-pays or treatment limitations for

mental health/substance abuse benefits, and so on. To put more teeth into the ban on treatment limitations, plans that provide any mental health/substance abuse benefits must provide benefits in each classification for which any medical/surgical benefits are provided.

Non-quantitative measures are measures that are non-numerical. Parity applies to these non-quantitative measurements:

- medical management standards, which limit or exclude benefits based on medical necessity or medical appropriateness, or on whether the treatment is experimental or investigative;
- formulary design for prescription drugs;
- standards for admitting providers into a network;
- a plan's methods for determining usual, customary, and reasonable charges, refusals to pay for higher-cost therapies until it's shown that a lower-cost therapy isn't effective; and
- exclusions based on failing to complete a course of treatment.

To take parity a step further, all employer-provided

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Sorry, Wrong Number

Non-filers of Form 5500 or Form 5500-EZ who received certain CP 403 or 406 notices from the IRS should note that the fax number contained in the notices, 801-620-6117, is incorrect. The correct fax numbers are 801-620-7116 or 801-620-6900. ❖

Benefits Alert

Interim Final Regs Implement Mental Health/Substance... (cont.)

medical benefits constitute one group health plan. *Upshot:* Plans can't apply cumulative financial requirements (e.g., annual deductibles) or cumulative quantitative treatment limits (e.g., days of coverage or number of visits) to mental health/substance abuse benefits separately from medical/surgical benefits. For example, if one package covers medical/surgical benefits and another covers mental health/substance abuse benefits, parity applies to the combined packages, which is considered one plan. There is one annual deductible, and limits on mental health/substance abuse benefits can't be more restrictive than other treatment limits. Similarly, if three medical/surgical packages are offered, mental health/substance abuse benefits must be combined with each medical/surgical package, and then assessed for parity on a combined basis.

The regs don't define plan terms. To ensure that plans don't misclassify a benefit in order to avoid parity, the regs state that plan terms defining whether benefits are mental

health/substance abuse benefits must be consistent with generally recognized independent standards of current medical practice. The regs also don't define such terms as inpatient, outpatient, or emergency care. But plans must apply those terms consistently for medical/surgical benefits and mental health/substance abuse benefits. For example, plans that treat a hospital stay of more than 12 hours as inpatient care for medical/surgical benefits, must treat a hospital stay of more than 12 hours as inpatient care for mental health/substance abuse benefits.

NOTICE REQUIREMENTS

The amended law includes two new disclosure provisions for group health plans. First, plan administrators must, upon an employee's or beneficiary's request, make available the criteria for medical necessity determinations related to mental health/substance abuse benefits. Second, plan administrators must, upon an employee's or beneficiary's request, make available the reasons the plan denied reimbursement or pay-

ment for services related to mental health or substance abuse benefits. The regs clarify that these disclosures must comport with ERISA's general disclosure rules — primarily that the disclosure is provided automatically and free of charge.

INCREASED COST EXEMPTION

Under a cost exemption, if parity results in an increase of the actual total cost of coverage for medical/surgical benefits and mental health/substance abuse benefits for the plan year of more than 1% (2% for the first plan year), parity won't apply to the group health plan during the following year. Thus, the cost exemption may only be claimed for alternating plan years. If a plan seeks to use this exemption, the determination of whether the exemption applies must be made after the plan has complied with the parity rules for the first six months of the plan year involved. Plans must use a qualified actuary to make this determination. Plans that qualify for the exemption must notify the federal and state governments, plan participants, and beneficiaries. ❖