Foster & Foster, Inc.

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BENEFITS BULLETIN

Regulatory Updates & Claims Issues

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DISABILITY CLAIM AND APPEAL PROCEDURES

The U.S. Department of Labor's new regulations for disability claims are effective for disability claims filed on or after April 1, 2018. Although targeted at long-term disability (LTD) plans, the new rules apply to any claims where benefits are conditioned on the showing of disability, regardless of how the plan characterizes the benefit. Thus, they apply to short-term disability (STD) benefits also.

A plan's procedures for disability claim denials and appeals should substantially mirror non-disability claims. However, there are some differences for disability claims which are outlined below:

- Initial denials and denials of appeals should contain a "complete discussion" of why the claim was denied, and include the standards applied in reaching that decision. If the plan disagreed with a health care or vocational professional, or with the Social Security Administration, the denial must explain why.

  For example, if a plan standardly allows a maximum of six weeks of disability benefits after a normal delivery, the denial notice for any lost time in excess of six weeks could say "It is this Plan's policy to allow up to six weeks of disability after a normal delivery."

- Plans may not deny benefits on appeal based on new or additional evidence or rationales that were not included when the initial denial was made, unless the claimant is given notice and a fair opportunity to respond.

  The commentary accompanying the regulations say that claimants must be given any and all information received (or generated) by the plan during the 45-day period after the initial denial is issued. This corresponds to the 45 days plans have to determine the disposition of a disability claim.

The new rules do not apply if a plan relies only on the Social Security Administration's disability award to determine if a participant is disabled.

Action Required - SPDs and Plan Documents will need to be updated to reflect the new requirements. In addition, disability claim denials

and appeals must be written in a culturally and linguistically appropriate manner.

USING MEDICARE RATES TO DETERMINE ALLOWABLE CHARGES

Large plans are increasingly capping their non-network professional reimbursements at a percentage of Medicare's allowable amount, instead of limiting charges to reasonable and customary (R&C) amounts.

The percentage over Medicare used to determine the allowable amount varies by plan, but it is most commonly between 110% and 140%.

Here are some of the reasons for abandoning R&C:

- Allowable fee determinations based on Medicare rates are typically lower than R&C fees.
- Some out-of-network providers charge excessive amounts. And, as the only or predominant billers for certain types of service in a geographic area, they can drive up the R&C data.
- It is easier for providers to challenge R&C amounts than Medicare rates. R&C data is not always strictly accurate, and can vary depending on how it's calculated.
- Providers may not like the way Medicare determines its payment rates, but they are very familiar with it. Since 77% of health care payers calculate their allowable charges using those rates, providers are expecting most of their reimbursements to be based on a percentage of the Medicare allowable.
- Although plan offices have to pay a licensed provider for the entire set of Medicare allowable charges, it is still possible to determine the allowable amount for a particular service using the CMS online look-up tool. https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx. Plans that have a low out-of-network claims volume can use this tool for free without purchasing the full data set.

2018 OUT-OF-POCKET MAXIMUMS (NON-GRANDFATHERED PLANS)

For 2018, the maximums that non-grandfathered plans can require in patient cost-sharing (out-of-pocket limits) for medical/Rx coverage (combined) are $7,350 for single coverage and $14,700 for family coverage.

The maximum out-of-pocket limit for high deductible health plans (HDHPs) in 2018 are $6,650 for single coverage and $13,330 for family coverage. The minimum deductibles under HDHPs are $1,350/single and $2,700/family. The maximum health savings account (HSA) contributions are $3,450/single and $6,900/family.

MEDICAL MARIJUANA

Despite the trend to legalize marijuana, and the number of states that allow its use for medical purposes (29 states plus D.C.), the federal government still classifies marijuana as a Schedule 1 drug. Schedule 1 drugs and products have a high risk of abuse and are subject to the harshest range of criminal penalties—a designation marijuana shares with heroin, ecstasy and LSD.

Past congressional proposals to reclassify marijuana as a Schedule 3 drug have failed, largely due to objections made by the U.S. Drug Enforcement Administration (DEA) and the U.S. Federal Food and Drug Administration (FDA). These agencies have concluded that marijuana has no federally approved medical use.

Large insurers exclude marijuana, as do Medicare, TriCare and the Federal Employees Health Plans. Insurers say that there is not enough evidence that marijuana is safe and more effective than other treatments.

Why This Matters - Medical marijuana can cost users up to $1,000 per month for their supplies. As the number of users increases, there may be pressure on health plans to help pay for it. Right now claims for marijuana can be denied as experimental or not FDA-approved (depending on plan language). But lobbying groups and marijuana suppliers may soon be using and/or promoting online appeal templates to challenge marijuana's experimental status on the basis that so many states permit its use.

To protect against potential appeals, we believe that plans should include a specific exclusion in their Summary Plan Descriptions (SPDs).

GENETIC TESTS AT PHARMACIES

Private laboratories are beginning to partner with pharmacies in marketing over-the-counter DNA testing kits. The lab results from a self-obtained DNA test are claimed to help consumers determine the efficacy of certain proposed drugs or treatments. The patient is billed by

the lab, and the lab reimburses the pharmacy for collecting the saliva sample. (The test results may include additional components, such as whether or not the person is at risk for certain genetic diseases.)

Genetic tests to determine a drug's effectiveness or toxicity based on the patient's DNA are called pharmacogenetics. The field of pharmacogenetics looks for DNA markers that can reliably predict the efficacy of several cancer-fighting drugs, anti-coagulants and psychiatric medications. There are over 100 drugs approved by the Food and Drug Administration (FDA) that include genomic information in their prescribing information.

Pharmacogenetics may eventually play a key role in the treatment of some diseases, but for now that role is limited. The medical necessity and utility of only a small number of genomic tests has been established, and only in certain circumstances. There is still a lack of scientific evidence for the clinical utility of most tests, especially considering the small role genetics play in many complex diseases, and the availability of other screening methods.

Coverage Consideration - Only tests that are ordered by a physician and that meet the plan's coverage guidelines should be covered at this time. Tests obtained from over-the-counter test kits should continue to be excluded, even if some or all of the laboratory charges would have been covered if ordered by a physician.

CADILLAC TAX DELAYED UNTIL 2022

The Affordable Care Act's excise tax on high-value plans has a new effective date of January 1, 2022. It was originally scheduled to apply starting in 2018 but was previously delayed until 2020.

Foster & Foster will continue to monitor legislative action on the Cadillac Tax and its potential implications for our clients.

ACA TAX ON HEALTH INSURERS SUSPENDED

The Health Insurance Tax (HIT), a hefty Affordable Care Act tax on health insurers, has been suspended for 2019. This fee went into effect in 2014, was suspended for 2017, but went back into effect for 2018. Suspending the tax for 2019 will save insurers and their customers, including Medicare Advantage and EGWP plans, billions of dollars. The effect of the HIT varies by insurer and plan, but it will cost Medicare Advantage and MA plans an estimated $255 per person in 2018.

MEDICARE HIGH-INCOME EARNERS

Plans that move their Medicare-eligible retirees to insured Medicare Advantage or Employer Group Waiver Plans (EGWPs) may find that some of their retirees will be billed an extra Part D premium by the Centers for Medicare and Medicaid Services (CMS). This is because Medicare charges higher monthly Part B and Part D premiums for high-income earners under a program called the "income-related monthly adjustment amount" (IRMAA). The amount of the extra premium is tied to the cost of the Medicare program and is tiered based on income. About 6% of Medicare beneficiaries paid the higher premiums in 2015. Recent legislative changes changed the income brackets and the result was that more people will pay the higher amounts.

If a person is in a high-income bracket, he or she will pay the higher Part B premium whether or not the plan provides retiree medical coverage. However, they will only be billed for the Part D premium surcharge if they are enrolled in a Part D plan. EGWPs and Medicare Advantage plans that include prescription drug coverage are Part D plans.

Medicare uses the modified adjusted gross income reported on the person's 1099 form from two years prior to determine whether to bill for the IRMAA surcharge. The following chart lists the surcharges based on income and filing status.

2018 PART D HIGH INCOME (IRMAA) SURCHARGE (BASED ON 2016 INCOME)

Single	Married & filed jointly	Married & filed separately	Monthly Medicare surcharge
$85,000 or less	$170,000 or less	$85,000 or less	n/a
$85,000 up to $107,000	$170,000 up to $214,000	n/a	$13.00
$107,000 up to $133,500	$214,000 up to $267,000	n/a	$33.60
$133,500 up to $160,000	$267,000 up to $320,000	n/a	$54.20
> $160,000	> $320,000	> $85,000	$74.80

The amounts above are just for Part D. Part B IRMAA surcharges are much higher. For more information see www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-

sheets/2017-Fact-Sheet-items/2017-11-17.html.

Why This Matters - Plan administrators should be aware of these charges so that they can answer questions posed by affected retirees. Retirees can be told that the surcharges are billed and collected by CMS. The plan itself does not charge high-income earners more for its drug coverage, nor does it receive the extra money from CMS.

** REMINDER **
2018 PCORI FEES

Depending on their plan year (see chart), plans will need to make either their fifth or sixth PCORI fee payment this July 31.

JULY 31, 2018 PCORI FEES		
PY start	PY end	7/31/18 Rate
2/1/16	1/31/17	$2.26
3/1/16	2/28/17	$2.26
4/1/16	3/31/17	$2.26
5//1/16	4/30/17	$2.26
6/1/16	5/31/17	$2.26
7/1/16	6/30/17	$2.26
8/1/16	7/31/17	$2.26
9/1/16	8/31/17	$2.26
10/1/16	9/30/17	$2.26
11/1/16	10/31/17	$2.39
12/1/16	11/30/17	$2.39
1/1/17	12/31/17	$2.39

PCORI fees apply to plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. Plans with January 1 plan years will pay the fees for a total of seven years; their final payments will be due next year.