

Health Care Reform

Supplemental Guidance Issued on Several Topics

to Clarify PPACA Compliance

Bulletin

September 23, 2010

Separate pieces of new guidance arrived this week from the three federal agencies charged with enforcing the Patient Protection and Affordable Care Act (PPACA): the Departments of Treasury, Health and Human Services (HHS) and Labor (“the Departments”).

The releases explain portions of the law or supplement prior interim final regulations and represent an effort to assist employers and insurers working in good faith to understand and comply with PPACA provisions that have immediate effective dates. This approach includes transition provisions, grace periods, safe harbors and other interpretations to aid in compliance.

The new guidance includes:

- New Questions & Answers (<http://www.dol.gov/ebsa/faqs/faq-aca.html>)
- DOL Technical Release 2010-02 on Interim Procedures for Claims and Appeals (<http://www.dol.gov/ebsa/newsroom/tr10-02.html>)
- Revised Model Notice of Adverse Benefit Determination (<http://www.dol.gov/ebsa/IABDModelNotice2.doc>)
- IRS Notice 2010-63 on Discrimination in Favor of Highly Compensated Individuals in Insured Group Health Plans (<http://www.irs.gov/pub/irs-drop/n-10-63.pdf>)

Highlights of the guidance are summarized below.

New Questions & Answers on the DOL Website

Grandfathered Plans — Until they issue final regulations, the Departments will not treat an insured group health plan as having lost grandfathered status simply because of a change in the employer contribution rate if the employer plan sponsor and the insurer (“issuer”) do the following:

- Upon renewal, an issuer requires a plan sponsor to disclose its contribution rate to the issuer for

the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it).

- The issuer’s policies, certificates, or contracts of insurance prominently and effectively disclose that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year.

For policies renewed prior to January 1, 2011, issuers should take these steps no later than January 1, 2011. If these steps are taken, an otherwise grandfathered insured group health plan will continue to be considered grandfathered. This relief does not apply if the issuer knows that there has been at least a five-percentage-point reduction in employer subsidy or if the plan no longer qualifies for grandfathered status for other reasons. Nothing in the PPACA prevents a policy, certificate, or contract of insurance from requiring a plan sponsor to notify an issuer in advance (e.g., 30 or 60 days) of a change in the contribution rate.

Multiemployer plans may follow similar steps to those described above where they do not know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. Similarly, where multiemployer plans have either a fixed-dollar employee contribution or no employee contribution, a contributing employer’s contribution rate may change (e.g., after making up a funding deficit in the prior year or to reflect a surplus). In such cases, if there is no increase in the employee contribution and any changes in the coverage would not otherwise cause the plan to cease to be grandfathered, a change in a contributing employer’s contribution rate will not, in and of itself, cause a grandfathered health plan to lose that status.

The Departments say they will soon address the conditions under which a grandfathered group health plan may change carriers without losing grandfathered status.

Claims, Internal Appeals and External Review —

Grandfathered plans need not comply with the new claim appeal and external review requirements. Non-grandfathered insured plans may be eligible for transitional relief, allowing such plans to use existing state external processes in one of the states in which they operate in order to comply with the new federal requirements. This transitional relief applies whether or not the plan was in existence on March 23, 2010, or is a new plan.

Non-grandfathered self-insured plans may also obtain certain transitional relief under DOL Technical Release 2010-01, which offers an enforcement safe harbor if such plans either:

- Follow the procedures described there (which are based on the NAIC Uniform Health Carrier External Review Model Act)
- Voluntarily comply with a state external review program

Even when a plan does not satisfy all of the safe-harbor standards, the Departments will consider facts and circumstances to determine compliance, including, for example, when a self-insured plan fails to contract with at least three independent review organizations (IROs) but can show other steps were taken to ensure that its external review process is independent and without bias. Moreover, when a self-insured plan contracts with a third-party administrator that, in turn, contracts with an IRO, a plan can satisfy the standards as if it had contracted directly with the IRO.

The Departments also confirmed that the interim final claim and appeal regulation only shortened the time for making initial determinations with respect to urgent care claims, but did not change the time frame for making internal appeals decisions. Consequently, the Departments have revised the model notice (<http://www.dol.gov/ebsa/IABDModelNotice2.doc>).

As detailed elsewhere in this bulletin, on September 20, 2010, the Department of Labor issued Technical Release 2010-02 (<http://www.dol.gov/ebsa/newsroom/tr10-02.html>), providing an enforcement grace period until July 1, 2011, for non-grandfathered plans that will have difficulty making systems changes in time to comply with some of the new standards

for claims and internal appeals. The grace period applies only for certain new content required under interim final claims and appeals regulations, such as coding information on notices of adverse benefit determination and notices of final adverse benefit determination.

Coverage of Children — A plan or issuer may limit group health plan coverage for children until the child turns 26 by limiting coverage to only those “children” who are described in Internal Revenue Code Section 152(f)(1) (i.e., only sons, daughters, stepchildren, adopted children including children placed for adoption, and foster children). For individuals not described in IRC Section 152(f)(1) (e.g., grandchild or niece) a plan can impose additional conditions on eligibility for health coverage (e.g., that the individual be a dependent for income tax purposes).

Out-of-Network Emergency Services — The PPACA requires a group health plan providing emergency service benefits in an emergency department of a hospital to cover such services without regard to whether a provider is in-network and generally without any copayment or coinsurance greater than if services were provided in-network.

However, the PPACA does not require plans or issuers to cover amounts that out-of-network providers may balance bill. Minimum payment standards apply under the interim final regulation, however, to ensure that a plan does not pay an unreasonably low amount to an out-of-network emergency service provider that could then balance bill the patient.

The Departments have clarified that if a state law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums provided in the interim final regulations. Likewise, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy such payment minimums. In either case, patients must be provided with adequate and prominent notice of their lack of financial responsibility for such amounts to prevent them from inadvertently paying them. Even if state law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than what would apply if the services were provided in-network.

DOL Technical Release 2010-02 on Interim Procedures for Claims and Appeals

Grandfathered plans are not required to comply with the new claim appeal and external review requirements. In Technical Release 2010-01 (August 23, 2010), the DOL provided interim procedures for non-grandfathered self-insured plans to comply with the new Federal *external* review process. In Technical Release 2010-02 (September 20, 2010), the DOL has announced an enforcement grace period — until July 1, 2011 — for compliance with certain new *internal* claims and appeals requirements for non-grandfathered plans.

This means that group health plans (whether subject to ERISA or not) and *health insurance issuers* in the group market must have an internal claims and appeals process that incorporates the ERISA internal claims procedure (29 CFR 2560.503-1) along with any updates to that procedure adopted by the DOL. The extension of these rules to issuers is new.

The Departments' interim final regulations provide the following *additional* standards for *internal* claims and appeals processes (beyond the existing ERISA claims procedure):

1. Rescissions are eligible for internal claims and appeals whether or not the rescission has an adverse effect on any particular benefit at the time.
2. Despite the provision in the DOL claims procedure regulation requiring claimant notification on urgent care claims not later than 72 hours after the receipt of the claim, a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) on a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.
3. Plans and issuers are required to provide a claimant (free of charge) with new or additional evidence considered, relied upon or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for an internal appeal denial, and a reasonable opportunity for the claimant to respond to the new evidence or rationale.
4. Decisions regarding hiring, compensation, termination, promotion or similar matters with respect to an individual such as a claims adjudicator or medical expert must not be based upon the likelihood that the individual will support the denial of benefits.

5. Notices must be provided in a culturally and linguistically appropriate manner, as required by the PPACA and as provided in the interim final regulations (*Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the PPACA*, July 23, 2010).
6. Notices to claimants must provide additional content. Specifically:
 - Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
 - The plan or issuer must ensure that the reason(s) for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, and a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
 - The plan or issuer must provide a description of available internal appeals and external review processes, including how to initiate an appeal.
 - The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.
7. If a plan or issuer fails to *strictly adhere* to all the requirements of the interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or state law.

According to the Departments, some plans and issuers indicate that they did not anticipate all of the additional standards and more time is needed to change plan or policy procedures and to modify computer systems in order to comply. Consequently, DOL Technical Release 2010-02 provides an enforcement grace period until July 1, 2011, for certain standards described above to give plans and issuers more time to comply.

Specifically, for the following standards as numbered above:

2. regarding the 24-hour time frame for making urgent care claims decisions,
5. regarding providing notices in a culturally and linguistically appropriate manner,
6. requiring broader content and specificity in notices, and
7. regarding substantial compliance,

the Departments will not take enforcement action against a group health plan, during the grace period, that is working in good faith to implement such additional standards but does not yet have them in place. This also means that no excise tax liability should be reported on IRS Form 8928 with respect to a failure to meet these particular standards. HHS is encouraging states to allow similar grace periods with respect to issuers, and HHS will not cite a state for failing to substantially enforce the PPACA provisions in these situations.

IRS Notice 2010-63 on Discrimination in Favor of Highly Compensated Individuals in Insured Group Health Plans

The IRS has requested public comment on what additional regulatory guidance would be helpful to employers and insurers regarding the application of the nondiscrimination requirements of Internal Revenue Code Section 105(h)(2) to insured plans under the PPACA. The request was issued in IRS Notice 2010-63 (September 20, 2010). These nondiscrimination requirements currently apply to self-insured medical reimbursement plans and will apply to insured group health plans that are not grandfathered for plan years beginning on or after September 23, 2010. Comments must be submitted to the IRS by November 4, 2010.

Non-grandfathered insured group health plans now will be subject to the nondiscrimination requirements that apply to self-insured medical reimbursement plans under IRC Section 105(h)(2). A self-insured medical reimbursement plan satisfies the requirements of IRC Section 105(h)(2) only if the plan does not discriminate in favor of highly compensated individuals regarding eligibility to participate and benefits provided under the plan.

The arcane nondiscrimination rules for self-insured plans, which were written by Congress in 1978 and have been seldom enforced or interpreted by the IRS

since 1981, will now be applied to non-grandfathered insured group health plans. As a result, all of the ambiguities associated with these rules for self-insured plans will become relevant for insured plans as well.

In addition, a different and more onerous set of penalties will apply to an insured group health plan that fails the nondiscrimination rules than apply when self-insured plans fail. If a self-insured plan fails the IRC Section 105(h) requirements, highly compensated individuals are taxed on some or all of the benefits they actually receive, but employers are not penalized. Now, if an insured group health plan fails to comply with IRC Section 105(h), the plan is subject to a civil action to stop the noncompliant practice and the plan or plan sponsor is subject to an excise tax or a civil money penalty.

Specifically, a non-grandfathered insured group health plan that fails to comply with the nondiscrimination requirements of IRC Section 105(h) is generally subject to an excise tax of \$100 per day multiplied by the number of individuals discriminated against (typically, the number of non-highly compensated employees), along with a potential civil action under ERISA to halt the noncompliant practice or to award appropriate equitable relief. Governmental employer plan sponsors will be subject to civil money penalties of \$100 per day per individual discriminated against if an insured non-grandfathered plan fails the rules.

Conclusion

Final regulations on the various interim final regulations issued this summer under the PPACA are expected to be published beginning next year. Meanwhile, employers struggling to comply with numerous PPACA mandates that are effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011, for calendar year plans) will likely welcome the limited relief provided under this latest round of guidance.

About Towers Watson

Towers Watson is a leading global professional services company that helps organizations improve performance through effective people, risk and financial management. With 14,000 associates around the world, we offer solutions in the areas of employee benefits, talent management, rewards, and risk and capital management.