GROOM LAW GROUP

September 22, 2010

MEMORANDUM

Re: Enforcement Grace Period for Key Aspects of New Claims and Appeals Rules and Additional Rules on Grandfathering, Age 26 Dependent Coverage, Highly Compensated Employees, and other PPACA Requirements

On September 20, 2010, the Departments of Labor ("DOL"), Health and Human Services ("HHS"), and Treasury (collectively, the "Agencies") released interim guidance establishing an enforcement grace period for key aspects of the new claims and appeal procedure rules under the Patient Protection and Affordable Care Act ("PPACA"). The interim guidance, titled DOL Technical Release 2010-2, is available at www.dol.gov/ebsa, and provides that the enforcement grace period will run until July 1, 2011. During this grace period, the Agencies will not take enforcement action against plans and health insurance issuers that are "working in good faith" to implement specific aspects of the new claims and appeals rules.

Additionally, on September 20, 2010, the Agencies issued responses to a number of "Frequently Asked Questions" ("FAQs") concerning regulations that have been issued pursuant to PPACA, including questions relating to maintaining grandfather status, the new claims and appeals rule, coverage of dependent children to age 26, and out-of-network emergency services. The FAQs are available at www.dol.gov/ebsa, and on HHS's website, at http://www.hhs.gov/ociio/regulations/implementation_faq.html

Also, on September 20, 2010, the IRS issued Notice 2010-63, requesting comments on the application of Code § 105(h) nondiscrimination rules to insured group health plans and providing information regarding penalties. The Notice is available at http://www.irs.gov/pub/irs-drop/n-10-63.pdf

I. Background

On July 23, 2010, the Agencies published an Interim Final Rule (the "IFR") that implemented requirements imposed by PPACA with respect to benefit claims and appeals of denied claims. *See* 75 Fed. Reg. 43,330 (July 23, 2010). The IFR applies to group health plans, insurance issuers offering group health insurance coverage, and insurance issuers offering individual policies, but does not apply to grandfathered plans. The IFR requires that plans and insurers comply with the existing DOL claims and appeals regulation (codified at 29 C.F.R. § 2590.503-1), and it sets forth a number of new requirements relating to claims and appeals with which plans and insurers must comply. The requirements of the IFR apply for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). A detailed discussion of the IFR's requirements is available in our memorandum to clients dated July 28, 2010, which is available at http://www.groom.com/resources-521.html.

A. The IFR's New Requirements for Adverse Benefit Determinations and Notices of a Plan's Decision on Appeal

The IFR modified the existing DOL claims and appeals regulation in several respects and imposed a number of new requirements on plans and insurers. Specifically, the IFR imposed the following additional standards for internal claims and appeals processes:

1. The scope of an "adverse benefit determination" subject to the claims and appeals rules is expanded to include a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);

2. The timeframe for deciding urgent care claims is reduced from a maximum of 72 hours, to 24 hours after receipt of the claim;

3. Plan and insurers are required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or insurer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale;

4. Plans and insurers cannot base decisions regarding the hiring, compensation, termination, or promotion of individuals such as a claims adjudicator or medical expert upon the likelihood that the individual will support the plan's denial of benefits;

5. Notices regarding claims and appeals must be provided in a "culturally and linguistically appropriate" manner, meaning that such notices have to be provided in an applicable non-English language if numerical thresholds set forth in the IFR are satisfied;

6. Notices to claimants regarding the denial of a claim or appeal 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 and treatment codes and their corresponding meanings;

    - The plan or insurer must ensure that the reason for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or insurer'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 insurer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- The plan or insurer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman; and

7. If a plan or insurer fails to strictly adhere to all the requirements of the IFR and even if there is a de minimis violation of the new rules, the claimant is deemed to have exhausted the plan or insurer's internal claims and appeals process, regardless of whether the plan or insurer has substantially complied with the IFR, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

B. <u>The Enforcement Grace Period</u>

In Technical Release 2010-2, the Agencies state that, since publication of the IFR, plans and insurers have advised the Agencies that they would need additional time to modify computer systems and plan procedures to incorporate all of the new requirements of the IFR. To provide this additional time, the Technical Release establishes an *enforcement grace period until July 1, 2011* with respect to some – *but not all* – of the additional standards set forth in the IFR.

Specifically, Technical Release 2010-2 provides that the enforcement grace period will apply with respect to the following new standards established by the IFR:

- Standard No. 2, above, regarding the timeframe for deciding urgent care claims;

- Standard No. 5, above, regarding providing notices in a culturally and linguistically appropriate manner;

- Standard No. 6, above, requiring broader content and specificity in notices – including the disclosure of diagnosis and treatment codes and their corresponding meanings; and

- Standard No. 7, above, regarding a claimant's deemed exhaustion of the plan's internal claims and appeals process where a plan has not "strictly adhered" to the requirements under the IFR.

The Technical Release provides that this non-enforcement grace period is only available with respect to these specific aspects of the IFR, meaning that plans and insurers must comply with all other aspects of the IFR and the DOL's existing claims and appeals regulation. Moreover, this grace period only applies to plans and insurers that are "working in good faith to implement" the standards detailed above.

If a plan is working in good faith to implement the above standards, neither DOL nor the IRS will take enforcement action against a group health plan during the grace period (and a plan will not have to report any excise tax liability on IRS Form 8928 with respect to a failure to satisfy any of the above standards). In addition, HHS will not take enforcement action during the grace period against a self-funded non-federal governmental health plan that is working in good faith to implement the above standards, and HHS will encourage States to provide a similar grace period for insurers.

II. New FAQs on PPACA Regulations

The Agencies also released FAQs regarding various PPACA regulations, which should be of assistance to plans and insurers working to implement the new requirements. The FAQs address the Agencies' enforcement position as well as issues relating to grandfather status, new external review requirements, coverage of dependents, and out-of-network emergency care. The key FAQs are discussed below:

A. Overall Enforcement Position

The FAQs begin by discussing the Agencies' overall approach to implementation and enforcement of the new rules. FAQ-1 says compliance assistance is a "high priority" for the Agencies and that they will continue to emphasize "assisting (rather than imposing penalties on)" plans and issuers who are working diligently and in good faith to understand and come into compliance with the new law. The FAQ says that the Agencies' approach will include transition provisions, grace periods, safe harbors, and other policies to minimize disruption to existing plans and practices.

B. Grandfathering

1. Decrease in Employer Contributions

The Agencies issued several FAQs relating to loss of grandfather status based upon a decrease in employer contributions of more than 5 percent. (The grandfather regulation generally provides that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate toward the cost of any tier of coverage by more than 5 percentage points below the contribution rate on March 23, 2010).

a. Insured Plans

In response to the grandfather regulation, insurers advised the Agencies that they do not always have the information needed to know whether (or when) an employer changes its rate of contribution toward the cost of group health plan coverage. In response, the Agencies issued FAQ-2, which provides that, until the issuance of final regulations, the Agencies will not treat a grandfathered insured group health plan as having immediately lost grandfather status based on a change in the employer contribution rate if:

- Upon renewal of the insurance coverage, the insurer requires the plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 if the insurer does not already have it (so that the insurer can make its own comparison); and

- The insurer's policies, certificates, or contracts of insurance disclose – in a prominent and effective manner – that plan sponsors are required to notify the insurer if the contribution rate changes at any point during the plan year.

For policies renewed prior to January 1, 2011, the FAQ states that insurers should take the above steps no later than January 1, 2011. The FAQ says that, if these steps are taken, an insured group health plan that is grandfathered will continue to be considered a grandfathered health plan.

The FAQ goes on to state that the insured plan will lose grandfathered status based upon a decrease in the employer's contribution rate as of the earlier of: (1) the first date on which the insurer knows that there has been at least a 5-percentage-point reduction; or (2) the first date on which the plan no longer qualifies for grandfathered status for other reasons, without regard to the 5-percentage-point reduction.

Another FAQ related to the grandfather rules addresses how a change in insurance carriers may impact grandfather status. FAQ-6 says that the Agencies "anticipate that they will shortly address the circumstances under which grandfathered group health plans may change [insurance] carriers without relinquishing their status as grandfathered health plans." This guidance is potentially significant in that it suggests that there may be at least some circumstances where a change in policies or carriers may not, in and of themselves, impact grandfather status.

The Agencies also included FAQ-5) that says they "might issue" further guidance on selected issues as they review comments and that final regulations on the various IFRs are expected to be published beginning next year (2011).

b. Multiemployer Plans

In a separate FAQ, the Agencies note that, similar to insurers, multiemployer plans do not always know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. Accordingly, the Agencies state that if multiemployer plans and contributing employers follow steps similar to those outlined above with respect to insured plans, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the employer's contribution rate has changed. (FAQ-3)

Additionally, in FAQ-4, the Agencies note that some multiemployer plans have either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage. In such cases, a change in a contributing employer's contribution rate will not, in and of itself, cause a plan that is otherwise grandfathered to lose such status,

provided that there is no increase in the employee contribution toward coverage and any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered.

C. Claims and Appeal Rules

The Agencies issued several FAQs relating to the new claims and appeals rules, most of which relate to the new enforcement safe-harbor for the Federal external review process. A detailed discussion of the safe-harbor for the federal external review process is available in our memorandum dated August 25, 2010, which is available at http://www.groom.com/resources-531.html

Among other things, these FAQs provide that:

- For plans that do not strictly comply with all the standards set forth in the enforcement safe-harbor for the Federal external review process, compliance will be determined on a case-by-case basis. Thus, a plan that does not satisfy all of the standards of the technical release's safe harbor may, in some circumstances, nonetheless be considered to be in compliance with PPACA's external review requirement (FAQ-8);

- Plans are not required to contract with Independent Review Organizations ("IROs") directly. Instead, a plan's third party administrator may contract with IROs on behalf of a plan (FAQ-9); and

- Plans may contract with out-of-state IROs (FAQ-10).

Additionally, FAQ-11 provides a significant clarification regarding the timeframe in which plans and insurers must decide appeals involving urgent care. Specifically, FAQ-11 provides that under the claims and appeals IFR, plans are only required to decide *claims* involving urgent care within a maximum of 24-hours; *appeals* that involve urgent care continue to be subject to the 72-hour maximum set forth in the DOL's existing claims and appeals regulation. The FAQ specifically notes that "the [Agencies'] model notice of adverse benefit determination issued on August 23, 2010, was unclear as to which times have been shortened," and states that a revised notice was issued on September 20, 2010, which is available at www.dol.gov/ebsa.

D. Dependent Coverage of Children

In FAQ-14, the Agencies state that plans *may* impose conditions for covering children not described in Internal Revenue Code section 152(f)(1) – for example, grandchildren and nieces/nephews – as dependents, such as requiring that they be dependents for income tax purposes. This is helpful guidance, although it may have come too late in the year for some plans to take advantage of it for the 2011 plan year. Dependent coverage requirements under PPACA are set forth in the interim final regulations entitled, "Group Health Plans and Health Insurance Issuers Relating to

Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act." 75 Fed. Reg. 27122 (May 13, 2010). Those regulations interpret the provisions of PHSA § 2714, which requires a plan that provides coverage for dependent children to continue to make such coverage available for an adult child until the child turns 26 years of age. A detailed discussion of the dependent coverage requirements is available in our memorandum to clients dated May 13, 2010, which is available at http://www.groom.com/resources.html. The regulations do not provide a definition of "child" for purposes of this rule. However, the regulations do provide that a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Treas. Reg. sec. 54.9815-2714T(b) (emphasis provided). See also, Preamble, 75 Fed. Reg. 27122, 27124.

Because it has historically been very common for plans to include criteria such as residency, support, and claiming a child on a federal tax return as eligibility requirements for dependents, many plan sponsors have been forced to change their plan's definition of dependent to eliminate all non-relationship criteria. Plan sponsors have particularly struggled with how to comply with PPACA and at the same time limit coverage for certain categories of children, like grandchildren, that the plan sponsor wants to cover, but only to the extent that the employee is providing primary support. Further complicating this issue is the fact that, for federal tax purposes, to the extent that an employer defines dependent in a manner that is broader than the § 152(f)(1) definition (e.g., a child for whom the employee is a legal guardian but not a foster parent), the employer may be required to impute the fair market value of such coverage into an employee's income, unless the child otherwise meets the definition of qualifying child or qualifying relative. See IRS Notice 2010-38.

These issues are largely resolved by the issuance of FAQ-14, which restores the ability of a plan sponsor to limit the circumstances under which coverage is provided to a dependent who is not a son, daughter, stepson, stepdaughter, adopted child or foster child. Accordingly, for any individual outside of these categories, plans can continue to impose additional eligibility criteria, such as claiming a child on a federal tax return. Unfortunately, because this guidance has come so late in the year, many plans may have already completed plan document and summary plan description revisions and open enrollment materials for the 2011 plan year. Therefore, implementing this change may require amending plan documents, revising open enrollment materials, and/or issuing summaries of material modification.

E. Out-Of-Network Emergency Services

With respect to coverage of out-of-network emergency services, the Agencies clarify the minimum payment standards set forth in the "patient protections" regulation (see 75 Fed. Reg. 37188 (June 29, 2010)). In FAQ-15, the Agencies state if a State law prohibits balance billing, plans and insurers are not required to satisfy the payment minimums set forth in the regulation concerning out-of-network emergency providers. Similarly, if a plan or insurer is contractually responsible for any amounts balance billed

by an out-of-network emergency services provider, the plan or insurer is not required to satisfy the payment minimums set forth in the regulation.

The FAQ notes, however, that in both situations, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to any balance billed amounts, to prevent inadvertent payment by the patient. Nonetheless, even if State law prohibits balance billing, or if the plan or insurer is contractually responsible for amounts balance billed, the plan or insurer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.

III. Highly Compensated Employees

In FAQ-16, the Agencies note that the IRS issued Notice 2010-63 ("Notice") on September 20, 2010, addressing PPACA's prohibition (new PHSA § 2716) against discrimination in favor of highly compensated individuals in insured group health plans. The Notice states that the Department of the Treasury and the IRS are considering issuing guidance on the extension of the 105(h) requirements to insured group health plans. This suggests that Treasury/IRS may not intend to revise/clarify the rules under Code § 105(h) generally, which is unfortunate, as existing guidance on the application of the eligibility and benefits tests under Code § 105(h) is, in many respects, unclear.[1] Although the Notice is primarily designed to solicit comments and announce the November 4, 2010 deadline for submitting such comments, the IRS does make several clarifying points concerning the application of PHSA § 2716 and related penalties.

Specifically, the Notice makes clear that the consequences of violating 105(h) that apply to discriminatory self-insured health plans (i.e., highly compensated individuals include all or a portion of the benefits received in income), do not apply to insured plans that are subject to Code § 105(h) pursuant to PHSA § 2716. Rather, the following penalties apply in the case of a violation of PHSA § 2716:

- The Code: There is a $100 per day per individual excise tax in Code § 4980D that applies to violations of the chapter 100 group health plan requirements (capped at 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for the group health plan or $500,000, whichever is less). The Notice makes clear that this tax applies with respect to individuals who are *discriminated against* for each day the plan does not comply with the requirement (i.e., individuals who

[1] Final regulations that were published in 1981 (Treas. Reg. § 1.105-11) leave many questions unanswered. As a result, it is often necessary to look to lesser forms of guidance (e.g., private letter rulings, informal IRS internal advice memorandums, and informal statements made by IRS officials) for clarification on basic issues and also to look to regulations that apply for nondiscrimination testing of qualified retirement plans. Obtaining certainty in this area is further complicated by the fact that the IRS will not issue private letter rulings on issues involving Code § 105(h). See Rev. Proc. 2010-3, § 3.01(10).

are not eligible for coverage under a plan). The excise tax is imposed on the employer or, in the case of a multiemployer plan, on the plan, and does not apply to small employers with between 2 and 50 employees. Employers have an affirmative obligation to report this tax liability on Form 8928.

- ERISA: There is an ability to bring a civil action to enjoin a noncompliant act or practice or for appropriate equitable relief under part 7 of ERISA. Thus, DOL may enforce this provision against a group health plan. In addition, participants, beneficiaries, and fiduciaries may sue to enforce this provision.

- PHSA: There are civil money penalties of $100 per day per individual *discriminated against* for each day the plan does not comply with the requirement (capped at 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for the group health plan or $500,000, whichever is less). This penalty appears to be limited in this context to non-federal governmental group health plans.

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Authors: Chris L. Keller, Mark C. Nielsen, Christy A. Tinnes, Brigen L. Winters

If you have any questions, please contact your regular Groom contact or any of the attorneys listed below:

Jon W. Breyfogle	jbreyfogle@groom.com	(202) 861-6641
Jenifer A. Cromwell	jcromwell@groom.com	(202) 861-6329
Elizabeth T. Dold	edold@groom.com	(202) 861-5406
Thomas F. Fitzgerald	tfitzgerald@groom.com	(202) 861-6617
Lonie A. Hassel	lhassel@groom.com	(202) 861-6634
Cheryl Risley Hughes	chughes@groom.com	(202) 861-0167
Christine L. Keller	ckeller@groom.com	(202) 861-9371
Tamara S. Killion	tkillion@groom.com	(202) 861-6328
Mark C. Nielsen	mnielsen@groom.com	(202) 861-5429
Allison B. Rogers	arogers@groom.com	(202) 861-0162
William F. Sweetnam, Jr.	bsweetnam@groom.com	(202) 861-5427
Christy A. Tinnes	ctinnes@groom.com	(202) 861-6603
Brigen L. Winters	bwinters@groom.com	(202) 861-6618