

Questions regarding Affordable Care Act Implementation

Compliance

Q1: Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits for consumers that are beginning to take effect or that will become effective very soon. What is the Departments' basic approach to implementation?

The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.

Grandfathered Health Plans

Q2: After the interim final regulations on grandfathered health plans were issued, some issuers commented that they do not always have the information needed to know whether (or when) an employer plan sponsor changes its rate of contribution towards the cost of group health plan coverage. (Generally, the interim final regulations provide that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate based on cost of coverage towards the cost of coverage by more than 5 percentage points below the contribution rate on March 23, 2010.)

For purposes of determining whether an insured group health plan is a grandfathered health plan, what steps should issuers and employer plan sponsors take to communicate regarding changes to the plan sponsor's contribution rate?

The Departments have determined that, until the issuance of final regulations, they will not treat an insured group health plan that is a grandfathered plan as having ceased to be a grandfathered health plan immediately based on a change in the employer contribution rate if the employer plan sponsor and issuer take the following steps:

- Upon renewal, an issuer requires a 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 issuer does not already have it); and
- The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner 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 insured group health plan that is a grandfathered health plan will continue to be considered a grandfathered health plan.

The relief in this Q&A2 will no longer apply as of the earlier of the first date on which the issuer knows that there has been at least a 5-percentage-point reduction or the first date on which the plan no longer qualifies for grandfathered status without regard to the 5-percentage-point reduction.

Moreover, nothing in the Affordable Care Act or the interim final regulations 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 in advance) of a change in the contribution rate.

Q3: Similarly, multiemployer plans do not always know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. What steps should multiemployer plans take to communicate with contributing employers regarding employer contributions towards coverage?

If multiemployer plans and contributing employers follow steps similar to those outlined in Q&A2, above, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the contribution rate has changed.

Q4: Also with respect to multiemployer plan coverage, some multiemployer plans have stated that it is common for such plans to have either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage. In such cases, is it relevant if a contributing employer's contribution rate changes (for example, after making up a funding deficit in the prior year or to reflect a surplus), provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution

towards the cost of coverage?

In this circumstance, if there is no increase in the employee contribution towards coverage and any changes in the coverage terms 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 plan that is otherwise a grandfathered health plan to cease to be a grandfathered health plan.

Q5: Are the Departments receiving other comments and questions regarding the grandfather regulations? Is more guidance expected?

The Departments invited comments on their interim final grandfather regulations, as well as on the appeals regulations and other provisions whose applicability is affected by status as a grandfathered health plan. The Departments have issued some sub-regulatory guidance on the appeals regulations and will continue to review and evaluate comments on these and other regulations, and might issue further sub-regulatory guidance on selected issues as comments are evaluated. Final regulations on the various interim final regulations recently issued under the Affordable Care Act are expected to be published beginning next year.

Q6: Will the Departments change the current rules so that a grandfathered group health plan that changes carriers does not relinquish its status as a grandfathered health plan?

The Departments anticipate that they will shortly address the circumstances under which grandfathered group health plans may change carriers without relinquishing their status as grandfathered health plans.

Claims, Internal Appeals, and External Review

Q7: My plan already provided an external review process before the Affordable Care Act was enacted. Can my already-existing external review process be deemed to comply with Public Health Service Act (PHS Act) section 2719(b)?

If your plan existed prior to enactment of the Affordable Care Act, you should first check to see if your plan is a grandfathered health plan. If it is, the new external review provisions of PHS Act section 2719(b) do not apply to your plan.

If your plan is not a grandfathered health plan and it is insured, the Departments have provided transitional relief under which plans can use existing State external processes, in one of the States in which they operate, to comply with the new Federal requirements. This transitional relief applies regardless of whether the plan already existed on March 23, 2010 or is a new plan .

If your plan is not a grandfathered health plan and it is self-insured, relief is also provided. On August 23, 2010, the Department of Labor issued Technical Release 2010-01, which sets forth an enforcement safe harbor. If the plan complies with one of the methods set forth in the release, the Department of Labor and the IRS will not take any enforcement action with respect to PHS Act section 2719(b) during the transition period. [See also Q&A8](#), below.

Q8: What if a self-insured plan's external review process does not satisfy the safe harbor in the DOL technical release?

The technical release provides a safe harbor from enforcement by the Departments. For plans that do not strictly comply with all the standards set forth in the technical release, compliance will be determined on a case-by-case basis under a facts and circumstances analysis. 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 PHS Act section 2719(b).

For example, one of the standards set forth in the technical release requires self-insured plans to contract with at least three independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan's failure to contract with at least three IROs does not mean that the plan has automatically violated PHS Act section 2719(b). Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.

Q9: Similarly, what if a self-insured plan does not contract directly with any independent review organization (IRO), but contracts with a third-party administrator (TPA) that, in turn, contracts with an IRO?

The technical release does not require a plan to contract directly with any IRO. Where a self-insured plan contracts with a TPA that, in turn, contracts with an IRO, the standards of the technical release can be satisfied in the same manner as if the plan had contracted directly. Of course, such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review. Moreover, fiduciaries of plans that are subject to ERISA have a duty to monitor the service providers to the plan.

Q10: What if there is no IRO in my plan's State?

The IRO is not required to be in the same State as the plan. Plans may contract with an IRO even if it is located in another State.

Q11: The Departments' regulations make changes to shorten the times for making initial determinations with respect to urgent care claims, but did not make any changes to the times for making internal appeals

decisions. The Departments' model notice of adverse benefit determination issued on August 23, 2010, was unclear as to which times have been shortened. What is the rule?

Only the times for making the initial benefit determination were changed. The Departments have revised the model notice to eliminate confusion. The revised notice includes a header that reads, "Revised as of September 20, 2010"

Q12: I anticipate that my plan will no longer be a grandfathered plan and will have a hard time making systems changes in time to comply with some of the new standards for claims and internal appeals. Is there any relief?

Yes, on September 20, 2010 the Department of Labor issued Technical Release 2010-02 at <http://www.dol.gov/ebsa/newsroom/tr10-02.html> providing an enforcement grace period until July 1, 2011 to give plans and issuers necessary time to make certain procedural and computer system changes to comply with the new requirements.

Q13: The September 20, 2010 technical release, among other things, gives plans and issuers additional time (as an enforcement grace period until July 1, 2011) before they have to provide new content (such as coding information) on notices of adverse benefit determination and notices of final adverse benefit determination. Does this mean that notices are not required during the grace period?

No. The Technical Release 2010-02 provides that the standards of the Department of Labor's claims procedure regulation issued on November 21, 2000 (29 CFR 2560.503-1) apply. A grace period is given only for the new content required under paragraph (b)(2)(ii)(E) of the Departments' July 23, 2010 interim final claims and appeals regulations. In addition, under existing regulations, claimants may obtain coding and other information relevant to the claimant's claim for benefits free of charge upon request. See 29 CFR 2560.503-1(h)(2)(iii).

Dependent Coverage of Children

Q14: Will a group health plan or issuer fail to satisfy section 2714 of the Public Health Service Act (PHS Act) and its implementing interim final regulations merely because it conditions health coverage on support, residency, or other dependency factors for individuals under age 26 who are not described in section 152(f)(1) of the Internal Revenue Code (Code)? (That section of the Code defines children to include only sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children.)

No. A plan or issuer does not fail to satisfy the requirements of PHS Act section 2714 or its implementing regulations because the plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

Out-Of-Network Emergency Services

Q15: Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. At the same time, the statute does not require plans or issuers to cover amounts that out-of-network providers may "balance bill". Accordingly, the interim final regulations under section 2719A set forth minimum payment standards in paragraph (b)(3) to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient.

Are the minimum payment standards in paragraph (b)(3) of the regulations intended to apply in circumstances where State law prohibits balance billing? (Similarly, what if a plan or issuer is contractually obligated to bear the cost of any amounts balance billed, so that the patient is held harmless from those costs?)

No. As stated in the preamble to the interim final regulations under section 2719A, the minimum payment standards set forth in paragraph (b)(3) of the regulations were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. If a State law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations. Similarly, 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 the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, 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 the copayment or coinsurance requirement that would apply if the services were provided in network.

Highly Compensated Employees

Q16: Are the Departments planning to issue any guidance regarding the provisions of Public Health Service Act (PHS Act) section 2716 (which prohibits discrimination in favor of highly compensated individuals in insured group health plans)?

Yes, on September 20, 2010 the Internal Revenue Service released [Notice 2010-63](#), to be published in Internal Revenue Bulletin 2010-41, October 12, 2010. This bulletin provides background information on the statutory provisions of PHS Act section 2716 that has been reviewed and approved by the three Departments. In addition, it invites comments to be considered in the development of future guidance.