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HEALTH LAW ALERT
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Agencies Publish Affordable Care Act FAQs, Guidance
Topics Include: Claims & Appeals, Grandfathered Status, Non-ERISA Plan Exemptions

The Office of Consumer Information and Insurance Oversight (OCIIO), the Employee Benefits Security Administration (EBSA) and the Internal Revenue Service (IRS) (together, the Agencies) issued frequently asked questions (FAQs) and other guidance this week on a variety of topics concerning implementation of the Affordable Care Act. The guidance includes:

- FAQs published by the OCIIO on a variety of topics (click here);
- The EBSA's Technical Release No. 2010-02 concerning internal processes for claims and appeals (click here);
- A memorandum from OCIIO addressing HIPAA opt-out provisions for which sponsors of self-funded, nonfederal governmental plans are eligible (click here); and
- An IRS notice relating to highly compensated employees (click here).

The guidance explains that the Agencies' "approach to implementation [of the Affordable Care Act] 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."

The OCIIO FAQs indicate that the Agencies plan to publish final rules "beginning next year" to replace the interim final rules published earlier this year. In addition, the FAQs promise that the Agencies will "shortly" issue guidance explaining how grandfathered group health plans "may change [insurance] carriers without relinquishing their status as grandfathered health plans." Under the current Rule, insured group plans cannot change insurers without losing grandfathered status. This guidance is therefore likely to provide groups with greater flexibility in changing insurers.

Internal Claims and Appeals

Grace Period for Provisions of Internal Claims and Appeals Process Implementation. In EBSA's Technical Release, the Agencies recognize that "more time is needed [for group health plans

and health insurance issuers] to change . . . procedures and to modify computer systems in order to come into compliance" with several requirements of the "Internal Claims and Appeals and External Review Processes" Rules the Agencies published in July. Accordingly, the Technical Release explains that the Agencies will provide a grace period through July 1, 2011 for the following provisions of those Rules:

- The requirement that a health plan notify a claimant of an urgent-care benefit determination (whether adverse or not) within 24 hours;[1] 45 C.F.R. § 147.136(b)(2)(ii)(B);

- The requirement that notices of benefit determinations be provided in a culturally and linguistically appropriate manner; 45 C.F.R. § 147.136(b)(2)(ii)(E);

- The requirements for additional content to be contained in notices of benefit determination, including diagnosis code and meaning of the diagnosis code, denial code and meaning of the denial code, a description of available appeals processes (internal and external), and contact information for a health insurance consumer assistance office or ombudsman (as established under the Affordable Care Act); 45 C.F.R. §§ 147.136(b)(2)(ii)(E)(*1*)-(*4*); and

- Deemed exhaustion of the health plan's internal claims and appeals process (which permits the claimant to initiate remedies available under ERISA or State law) if the health plan "fails to strictly adhere to all the requirements" of the Rule; 45 C.F.R. § 147.136(b)(2)(ii)(F).

During the grace period, the Agencies will take no enforcement actions against a group health plan or health insurance issuer that is "working in good faith to implement [these] standards but [that] does not yet have them in place."[2]

Revised Model Notice. The OCIIO FAQs instruct that the Agencies revised their model notice of adverse benefit determination to "eliminate confusion" concerning required timelines for making internal appeals decisions.

Grandfathered Health Plans

Health insurers that provide coverage to group health plans often are not aware of the amount employers (or other plan sponsors) contribute to the premium for enrollees' health coverage. This amount—the employer contribution rate—is one factor in determining whether an employer's insured group health plan qualifies for status as a

[1] The Department of Labor's 72 hour standard will remain in effect during the grace period. *See* 29 C.F.R. § 2560.503-1(f)(2)(i).

[2] OCIIO will encourage "States to provide similar grace periods with respect to health insurance issuers."

grandfathered health plan. A grandfathered health plan may avoid compliance with some of the Affordable Care Act's requirements. Thus, without information about the employer's contribution rate, a health insurance issuer cannot definitively categorize an employer's group health plan as a grandfathered health plan.

To address this issue, an OCIIO FAQ explains that an insurer should require each employer that sponsors a grandfathered health plan to provide a representation of:

- The employer's contribution rate as of March 23, 2010; and
- The employer's contribution rate upon renewal each year thereafter, as long as the employer intends to maintain grandfathered health plan status.

In addition, the insurer should "disclose in a prominent and effective manner" in its policies, certificates or contracts of insurance that the employer "is required to notify the [insurer] if the contribution rate changes at any point during the plan year." The Agencies will view an insured group health plan as a grandfathered plan as long as (a) the insurer complies with these requirements, (b) the employer provides the requisite representations, and (c) the insurer is not aware that the employer has reduced its contribution rate by 5% or more (or otherwise has ceased to be a grandfathered health plan).

To benefit from this safe harbor, the Agencies require insurers to obtain representations and make appropriate disclosures no later than January 1, 2011. The FAQs suggest that a multiemployer plan that is not aware of employers' contribution rates may "follow similar steps" in order to comply.

ACTION ITEM: *Insurers with insured group grandfathered health plan business should (1) implement a procedure to obtain the representations described above from each affected group and (2) insert the notices described above in its policies, certificates, or contracts of insurance.*[3] *An insurer should also consider including a provision in group policies that requires plan sponsors to notify the insurer prior to any reduction in contribution rate.*

Self-Funded, Nonfederal Governmental (Non-ERISA) Health Plans

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) self-funded, nonfederal governmental health plans (*e.g.*, health plans sponsored by school districts, municipalities, and States) were permitted to opt-out of a number of provisions that private-sector ERISA plans (as well as insured nonfederal governmental plans) were required to comply with. OCIIO guidance explains that the Affordable Care Act terminated the right of these government plans to opt-out of some of these requirements. Specifically, self-funded, nonfederal governmental plans will no longer be allowed to opt-out of and must therefore comply with:

[3] The Guidance says "policies, certificates **or** contracts of insurance," not "**and** contracts of insurance." Accordingly, an insurer may provide notice in any one of these documents, rather than all three.

- Limitations on preexisting condition exclusions;
- Requirements for special enrollment periods; and
- Prohibitions against discriminating against individual participants and beneficiaries based on health status.

Out-of-Network Emergency Services

Under the "Patient Protections" Rule published in June, a health plan is required to pay an out-of-network provider of emergency care a "reasonable amount" to ensure the provider does not "balance bill" the enrollee for an excessive amount. The "reasonable amount" is deemed to be the greatest of (a) the median in-network provider-negotiated rate, (b) 100% of the usual and customary fee (or other method the plan generally uses to calculate out-of-network fees), and (c) the amount Medicare would pay (see Health Law Alert at 4). An OCIIO FAQ explains that a health plan is not required to pay this "reasonable amount" in States that prohibit balance billing by emergency care providers, because the enrollee is already adequately protected by State law.

Highly Compensated Employees

The IRS notice provides clarification on penalties for insured plans' failure to comply with IRS provisions prohibiting discrimination in favor of highly compensated employees. The guidance does not, however, provide an explanation of how insurers should comply with those nondiscrimination provisions.

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