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Grace Period for Some Internal Appeal Changes; Clarification On Grandfathered Plan

Various aspects of the Affordable Care Act (ACA) are to become effective as of the first plan or policy year on or after September 23, 2010, and there has been recent guidance addressing a number of the implementation issues employers and insurers face. Some of the most critical issues are summarized below.

Enforcement Grace Period for Certain Aspects of the New Claim and Appeal Procedures

The Interim Final Rules issued in July 2010 set forth a number of new requirements to the existing Department of Labor (DOL) claim and appeal procedures with which both non-grandfathered insured and self-funded group health plans must comply. To review the new requirements for internal appeal procedures, recall that the Interim Final Regulations provided the following additional standards for internal claims and appeal procedures:

1. The definition of an "adverse benefit determination" includes a rescission of coverage, regardless if there is a specific claim at issue.
2. The time period for making initial urgent care determinations is reduced from 72 to 24 hours (though the time for deciding appeals remains 72 hours).
3. Plans and insurance issuers are required to provide the claimant free of charge with new or additional evidence considered, as well as any new or additional rationale for a denial on appeal, and sufficient time to respond. The Interim Final Regulations do not provide guidance as to how much time will be deemed "sufficient."
4. Addressing a potential conflict of interest, decisions regarding hiring, compensation, termination, promotion or similar matters of those who administer claims cannot be based on the likelihood that the individual will support the denial of benefits. This applies to whatever entity (*i.e.*, an insurer, a third-party administrator (TPA), the plan sponsor, *etc.*) adjudicates the Plan's claims.
5. Plan notices must be provided in a culturally and linguistically appropriate manner.
6. Notices must provide additional, detailed content regarding information relating to claim determinations and denials, clear descriptions of both internal and external appeal procedures and the availability of health insurance consumer assistance or an insurance ombudsman.

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7. Failure to adhere to all these requirements of the Interim Final Regulations will allow the claimant to be deemed to have exhausted his/her administrative remedies and go directly to court under either ERISA or state law.

Grace Period --In Technical Release 2010-02, the DOL announced that there would be an enforcement grace period until July 1, 2011 with respect to the standards set forth above in items 2, 5, 6 and 7. The DOL, the Treasury Department (IRS) and the Department of Health and Human Services (DHHS) (collectively, the "Departments") will not take any enforcement action during this grace period against a group health plan, and the DHHS will not take any enforcement action against a self-funded nonfederal governmental health plan, that is working in good faith to comply with these requirements, but has not been able to fully comply. DHHS is encouraging states to provide similar grace periods with respect to health insurers, and DHHS will not cite states for failing to enforce these requirements during the grace period.

Clarification on Certain Requirements for Grandfathered Plans

The Departments amended the Interim Final Regulations to modify one of the circumstances that can lead to the loss of grandfathered status. Under the Interim Final Regulations issued on June 17, 2010, if a plan sponsor of a group health plan that insured benefits changed insurance companies, that modification of the plan's benefit arrangement would cause the plan to lose grandfathered status while a self-funded plan sponsor's decision to change third party administrators would not cause the plan to lose grandfathered status. In an amendment to these Interim Final Regulations issued November 17, 2010, the Departments determined that this rule had a disparate impact on insured group health plans versus those that are self-funded. Accordingly, this loss of grandfathered status rule was modified as follows:

- A change in insurers occurring on or after November 15, 2010, the date this amendment was made available for public inspection, will not cause an insured group health plan to lose its grandfathered status. If the change in insurance coverage became effective after March 23, 2010, but before November 15, that change in coverage will still cause the plan to lose its grandfathered status.
- The date of the new coverage will be determined on the date the coverage becomes effective, not on the date of the new contract.
- If the change in insurers results in any of the coverage changes that would otherwise cause a loss in grandfathered status, the plan will still lose its grandfathered status. These changes are: eliminating coverage for a specific condition or diagnosis, certain percentage increase in cost sharing, increase in fixed deductibles or out of pocket maximums, certain percentage increases in fixed copayments, or imposition of, or reduction in annual dollar limits. In short, a

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change in insurers will not cause a loss of grandfathered status, unless the change causes one of these impermissible changes in coverage.

- To maintain its status as a grandfathered plan, the plan must provide the new health insurer with documentation of plan terms, including benefits and cost sharing, employer contributions, and annual limits, of the prior coverage sufficient for the new insurer to determine whether the new policy will in fact lead to any of the changes noted above.

The Departments also recently issued a series of frequently asked questions (FAQs) that are aimed at clarifying certain aspects of administering grandfathered plans. Among the key items addressed were:

- If upon renewal, the insurer requires the employer to make a representation about its contribution rate for the renewal year and its contribution rate on March 23, 2010, and the insurer's policies, certificates, *etc.* 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, the Departments will not take any enforcement action; provided, however, the insurer does not in fact know that there has been at least a 5% reduction in the plan sponsor's contribution rate or that the plan has lost grandfathered status for any other reason.
- There are only six changes that can cause a plan to lose grandfathered status: (1) elimination of all or substantially all benefits to diagnose or treat a particular condition, (2) increase in the percentage cost-sharing requirement (*i.e.*, raising an individual's coinsurance), (3) increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15%, (4) increase in a copayment by an amount that exceeds medical inflation plus 15% (or, if greater, \$54 plus medical inflation), (5) decrease in an employer's contribution rate towards the cost of coverage by more than 5%, and (6) imposition of annual limits on the dollar value of all benefits below specific amounts.
- Grandfathered plan analysis applies on both a benefit package-by-benefit package basis, and a tier-by-tier basis. Thus, a PPO arrangement can lose grandfathered status, while the HMO option retains it. If a plan has a multi-tiered structure (*e.g.*, self, self plus one, self plus two, self plus three or more) changes to each tier will be compared to the rates for a corresponding tier on March 23, 2010. Adding new tiers of coverage that do not correspond to previously existing tiers, however, will not cause a plan to lose grandfathered status. Each change in cost sharing is tested separately.

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- The requirement to disclose information regarding the grandfathered status of a plan can be provided whenever a summary of the benefits under a plan is provided to participants and beneficiaries. This can be in a Summary Plan Description (SPD), a Summary of Material Modifications (SMM), open enrollment materials, or other materials. It need not be done in a special distribution, but could be if such is needed to get the information to all participants and beneficiaries in a timely fashion.

Action Steps

Employers should consult with their insurers or TPAs to assess how and when these additional internal claims procedure requirements are being implemented. Those who intend to have their group health plans (or specific benefit programs within their plans) retain grandfathered status now have some additional flexibility regarding insured coverages, but should still pay attention to those steps that can cause the plan to lose its grandfathered status.

If you have any questions about this new guidance and how it applies to your medical and cafeteria plan arrangements, or if you have questions about other aspects of ACA compliance or any other employee benefit issues, please contact any of the Honigman attorneys listed in this Alert.

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