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Department of Labor Issues Q&As Regarding Selected Provisions of the Affordable Care Act

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On September 21st, the U.S. Department of Labor (the "Department") issued a series of questions and answers (Q&As) clarifying a handful of issues arising under the Affordable Care Act.[1] Topics covered include grandfathered plans, internal and external claims procedures, dependent coverage, out-of-network emergency services, and what constitutes a "highly compensated employee" for purposes of the Act's insurance non-discrimination rules. In the first of these Q&As, the Department endeavored to establish that the Departments of Treasury, Labor, and Health and Human Services are taking a collaborative approach to enforcement, asserting that the agencies 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."

In the Q&As that follow, the Department endeavors to follow this approach by providing clear, administrable rules that answer some important and vexing questions. The table set out below summarizes selected Q&As and explains their effect on the applicable provisions of the Act.

Provision	Q&A Clarification
(1) *Grandfather rules [Q&A 2]* The grandfather plan interim final regulations provide, among other things, that a group health plan will cease to be grandfathered if the employer decreases its contribution rate towards the cost of coverage by more than five percentage points below the contribution rate on March 23, 2010. However, it is not clear what happens when carriers do not 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.	The Department prescribes the following steps for purposes of determining whether an insured group health plan is a grandfathered health plan: • Upon renewal, the carrier 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; and • The carrier's policies, certificates, or contracts 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. This relief is not available as of the earlier of (i) the first date on which the issuer knows that there has been at least a five-percentage-point reduction or (ii) the first date on which the plan no longer qualifies for grandfathered status without regard to the five-percentage-point reduction. Moreover, carriers may require a plan sponsor to notify the carrier in advance (*e.g.*, 30 or 60 days) of a change in the contribution rate.
(2) *Grandfather rules* [*Q&A 6*] Under the grandfather interim final rule, a change in carriers under an insured group health plan results in the loss of grandfather status. [*Q&A 6*]	The Department anticipates that they will shortly address the circumstances under which grandfathered group health plans may change carriers without relinquishing grandfathered status.
(3) *Grandfather rules* [*Q&As 7 & 8*] Interim final rules (and related guidance items) set out detailed external review requirements for non-grandfathered plans. Many states already require external review. But the extent to which existing external review processes may be deemed to comply with the new requirements is not clear.	The Q&A notes that the Department has provided transitional relief under which plans can use existing state external processes to comply with the new federal requirements. Relief is also available in the form of an enforcement safe harbor. Moreover, for self-funded plans that do not strictly comply with all the required standards, compliance will be determined on a case-by-case basis under a facts and circumstances analysis.
(4) *External claims procedures [Q&A 8]* Under the current rules, self-funded plans are required to contract with no fewer than three separate independent review organizations (IROs).	According to the Department, a self-insured group health plan's failure to contract with at least three IROs does not mean that the plan has automatically violated the external review requirement. Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.
(5) *External claims procedures [Q&A 9]* Under the current guidelines, self-funded plans must have an independent review process with at least three IROs that are hired randomly or in rotation. But it was not clear whether the self-insured plan's third-party administrator (TPA) can contract with the IRO on the plan's behalf.	The Department clarified that self-funded plans need not contract directly with the IRO. Rather, the plan is allowed to contract with a TPA that, in turn, contracts with the IRO.

(6) *Notices of adverse benefit determinations [Q&A 13]* A September 20, 2010 Department of Labor technical release gives plans and issuers additional time before they have to provide new content on notices of adverse benefit determination and notices of final adverse benefit determination. Apparently, some commentators interpreted this to mean that notices are not required during the grace period.	The Department clarifies that the grace period is given only for the new content.
(7) *Dependent coverage [Q&A 14]* The requirement that coverage be extended to "adult children" up to age 26 has caused some confusion. Specifically, to what extent may plans condition health coverage on support, residency, or other dependency factors for individuals under age 26 who are not "dependents" for tax purposes (*i.e.*, sons, daughters, stepchildren, adopted children—including children placed for adoption—and foster children)?	The Department made clear that a plan may limit health coverage for children until the child turns 26 to only those children who are dependents for tax purposes.
(8) *Out-of-network emergency services [Q&A 15]* For plan years commencing after September 23, 2010, a group health plan or health insurance coverage must generally provide 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. The statute does not require plans or issuers to cover amounts that out-of-network providers may "balance bill," within limits intended 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. The question is whether the minimum payment standards are intended to apply in circumstances where state law prohibits balance billing or in the face of a contractual provision of similar effect.	The Department's position is that the minimum payment standards were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. Therefore, if a state law prohibits balance billing, plans and issuers are *not* required to satisfy the payment minimums set forth in the regulations. (This makes perfect sense, since, if enrollees are not responsible for the balance, it really does not matter how much that balance is.) 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. 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.

Endnotes

1 The Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 Pub. L. 111-152 (Mar. 30, 2010) (collectively, the "Act").

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