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WELFARE BENEFITS AND ERISA LITIGATION LAW ALERT

OBAMA ADMINISTRATION ISSUES KEY FINAL INTERIM REGULATIONS REGARDING PATIENT PROTECTION AND AFFORDABLE CARE ACT

The following is a summary of key final interim regulations that the Obama Administration has issued regarding the implementation of the Patient Protection and Affordable Care Act (the "PPACA" or "Act") enacted on March 23, 2010. As discussed in the prior Welfare Benefits and ERISA Litigation Law Alert, this law includes many provisions affecting the administration, design, and cost of group health plans, and establishes mandates for employers to provide health coverage.

A) Right to internal and external review of decisions by health plans

Under the new regulations, new health plans beginning on or after September 23, 2010, must have an internal appeals process that may be used by plan participants and beneficiaries when a health plan denies a claim for a covered service or rescinds coverage. As part of the internal review process, participants and beneficiaries must be provided with detailed information about the grounds for the denial of claims or coverage. Moreover, they must be notified about their right to appeal, and provided with instructions on how to pursue the appeals process. The regulations mandate a full and fair review of the denial as well as an expedited appeals process in urgent cases.

Furthermore, if a patient's internal appeal is denied, patients in new plans will have the right to appeal to an external independent reviewer. These external procedures must meet high standards for full and fair review that must comply with those established by the National Association of Insurance Commissioners (NAIC). These new regulatory internal and external review procedures do not apply to "grandfathered" health plans, as defined in the Act and under the new regulations summarized below.

B) New rule on protecting “grandfathered” status

Under the PPACA, group health plans who were in effect on the date of the statute’s enactment are exempt (i.e. “grandfathered”) from the applicability of many of the Act’s provisions. The “grandfathering” covers both employees and their families who were enrolled in the health plan as of the date of the statute’s enactment, as well as new employees and their families who enroll subsequently.

The new rule, which is already in effect, allows plans that existed on March 23, 2010, to innovate and contain costs by allowing insurers and employers to make routine changes without losing “grandfathered” status. Generally, “grandfathered” plans have the flexibility to make changes so long as they don’t substantially reduce people’s benefits or increase their cost-sharing. For instance, “grandfathered” plans are be able to:

- raise premiums to reasonably keep pace with health care costs;
- make some changes in the benefits that they offer; and
- continue to enroll new employees and family members.

“Grandfathered” plans also must provide written notice to participants and beneficiaries of their “grandfathered” status. Moreover, these plans must maintain records documenting the terms of the plan in effect as of March 23, 2010.

Additionally, plans will lose their “grandfathered” status if they choose to significantly cut benefits or increase out-of-pocket spending for those covered under the plan. The following are examples of actions that may lead to the loss of a plan’s “grandfathered” status:

- switching health insurance carriers or obtaining a new heath plan other than the renewal of a policy or plan that existed prior to March 23, 2010, even if the benefits under the new plan are equal to the ones under the previous plan;
- changing the plan to eliminate or substantially reduce benefits to diagnose or treat a particular condition;
- increasing any percentage of co-insurance;
- increasing a fixed amount of cost-sharing requirement over certain limits;
- increasing a fixed amount of co-pay over certain amounts;
- decreasing the employer contribution rate towards the cost of coverage over certain limits in any tier of coverage; and
- decreasing or imposing new annual limits on the dollar value of existing benefits.

C) Extension of dependent coverage for adult children under the age of 26

The Departments of Health and Human Services, Labor, and Treasury have issued regulations implementing the Affordable Care Act by expanding dependent coverage for adult children up to age 26. These new rules become effective on September 23, 2010. Dependent coverage for those under 26 applies even if the adult child no longer lives with his or her parents, is not a dependent on a parent's tax return, and/or is no longer a student. Furthermore, this extended provision of coverage applies to both married and unmarried children under 26, although their own spouses and children do not qualify for coverage.

For plan or policy years beginning on or after September 23, 2010, the new regulations mandate that plans and issuers must give eligible adult children an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. The new policy does not otherwise change the enrollment period or start of the plan or policy year. In addition, the new rules apply only to health insurance plans that offer dependent coverage in the first place.

If you have any question regarding this matter, you may contact any of the attorneys listed below, members of our Welfare Benefits and ERISA Litigation Practice Team.

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