Proskauer

DOL Begins Enforcing the ACA through Plan Audits

April 17, 2012

Recent written audit requests to health and welfare plans from the U.S. Department of Labor (DOL) have included inquiries related to various mandates under the Affordable Care Act (the ACA or the Act). This is a significant development in the ongoing implementation of the ACA's various coverage and related mandates, in that it marks the first appearance of ACA-related topics in DOL auditing practices. While the recent U.S. Supreme Court oral arguments caused speculation as to the future of the ACA, unless and until the ACA is ruled unconstitutional by the Supreme Court, the Act is enforceable and will be enforced by the DOL. Thus, employer-provided group health plans must continue to comply and otherwise implement the ACA's various coverage and related mandates. Likewise, plan sponsors must comply with any ACA-related DOL audit requests, and be prepared to produce documents to prove that their plan complies with the ACA's various mandates.

Areas Addressed in Audits:

The DOL audit requests relating to the ACA can be divided into three types: (1) requests as to plans claiming grandfathered status; (2) requests as to plans not claiming grandfathered status; and (3) requests as to all health plans regardless of grandfathered status. For each type of request, the DOL has asked to examine the types of documents listed below.

1. For grandfathered plans (*i.e.*, that are claiming or have claimed grandfathered status under Section 1251 of the ACA):

a. disclosure statements regarding grandfathered status included in material distributed to participants and beneficiaries describing the benefits provided under the plan; and

b. records documenting the terms of the plan on March 23, 2010, along with any ancillary documents required to verify the status of the grandfathered plan.

The DOL audit questions listed above appear to be aimed at substantiating that the plan in question complies with two requirements under the final interim regulations on grandfathered health plans under the ACA issued by the Departments of Labor, Health and Human Services, and Treasury on June 14, 2010; namely that plans must: (1) provide a specific notice that the plan believes it is a grandfathered health plan in any materials that describe the plan's benefits to participants or beneficiaries; and (2) maintain, and make available upon a government agency's request, records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010, as necessary to verify, explain, or clarify the plan's grandfathered status. See our June 21, 2010 client alert that summarizes these regulations.

2. Requests applicable to non grandfathered plans:

a. the plan's choice provider disclosure notice, along with a list of participants who received that notice;

b. documents relating to the plan's emergencies services benefits;

c. documents relating to the preventative services for each plan year on or after September 23, 2010;

d. the plan's internal claims and appeals procedures;

e. notices relating to adverse benefit determinations, the plan's final internal adverse determination notice, and the plan's final external review determination notice; and

f. contracts or agreements with independent review organizations or third-party administrators providing external review.

The DOL audit requests listed above appear to be aimed at substantiating that the plan in question complies with certain coverage mandates that apply only to nongrandfathered health plans, including covering certain preventive care services without cost sharing, as well as that any emergency hospital services must be provided without requiring prior authorization or higher cost sharing amounts, even for out-of-network services. See our June 28, 2010 client alert that addresses these mandates. In addition to these mandates, nongrandfathered health plans must adopt new internal and external claims procedures pursuant to guidance issued under the ACA. This guidance provides a safe harbor for compliance with the Act's requirement to offer a binding external review process under the plan. For this purpose, the nongrandfathered health plan must contract with three independent review organizations to handle external claims appeals. See our July 30, 2010 client alert that addresses the new claims and appeals rules.

3. Requests applicable to all plans:

a. for plans with dependent care coverage, a sample of the notice describing enrollment opportunities relating to coverage of children up to age 26;

b. a list of any participants who had coverage rescinded and the reason for such rescission;

c. if the plan imposes or has imposed a lifetime limit since September 23, 2010, documents relating to that limit for each plan year; and

d. if the plan has imposed an annual limit since September 23, 2010, documents relating to that limit.

These requests appear to be aimed at eliciting information necessary for the DOL to determine a group health plan's compliance with four primary mandates applicable to all group health plans, regardless of the plan's grandfathered status. First, the Act requires group health plans and insurance issuers that provide dependent child coverage to make that coverage available for children until they attain age 26. See our May 11, 2010 client alert that addresses this mandate. In addition, the Act does not permit the rescission of coverage absent fraud or material misrepresentation on behalf of the individual claiming coverage under the group health plan. For this purpose, a rescission is simply the retroactive termination of coverage for any reason other than non-payment of premiums. Finally, the ACA does not permit group health plans to impose lifetime or annual limits on benefits deemed to be "essential," a term that needs further definition by the oversight agencies. See our June 28, 2010 client alert that addresses the rules governing rescissions as well as lifetime and annual limits.

Best Compliance Practices:

Generally, plan sponsors and administrators must be able to demonstrate that their plans comply with the ACA, which requires documentary evidence – from plans, record keepers, and/or service providers. Written records of the steps taken to comply with the ACA since September 23, 2010, including detailed records of participation information and communications with participants about enrollment periods and coverage, should be retained in a readily accessible fashion. For example, plans should keep and be able to produce notices of coverage for children up to 26 years of age, and evidence of distribution. Likewise,any plan amendments or written policies that were adopted to implement the ACA mandates discussed above should be ready for production.

Upon receiving such an audit request, you should contact counsel immediately, as the issues are complex, and swift action is often necessary to protect the various rights and interests of the numerous entities involved in administering health and welfare plans. Please feel free to contact your Proskauer lawyer or any member of our Health Care Reform Task Force with questions on this alert or any aspect of health care reform.