Health care reform remains alive and well as DOL enforces ACA through plan audits

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With the Supreme Court's ruling on health care reform pending, the fate of the Affordable Care Act remains largely uncertain. In the meantime, however, the law is still in force. The Department of Labor has begun requesting, through recent audit requests on health and welfare plans, that employers prove their plans currently comply with the Act. Is your plan ready?

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.
3. Requests as to all health plans regardless of grandfathered status.

For each type of request, the DOL has asked to examine documents establishing the plan sponsor's compliance with the Act.

Requests applicable to grandfathered plans

Some of the DOL's attention is focused on whether a plan is properly accorded grandfathered status under Section 1251 of the ACA. DOL inquiries can include:

- Disclosure statements regarding grandfathered status included in material distributed to participants and beneficiaries describing the benefits provided under the plan.
- Records documenting the terms of the plan on March 23, 2010, the ACA's enactment date, 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.

Under those regulations, plans must: provide a specific notice, in any materials that describe the plan's benefits to participants or beneficiaries, that the plan believes it is a grandfathered health plan; and 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.

Requests applicable to all plans

- For plans with dependent care coverage, a sample of the notice describing enrollment opportunities relating to coverage of children up to age 26.
- A list of any participants who had coverage rescinded and the reason for such rescission.
- If the plan imposes or has imposed a lifetime limit since Sept. 23, 2010, documents relating to that limit for each plan year.
- If the plan has imposed an annual limit since Sept. 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 several primary mandates applicable to all group health plans, regardless of the plan’s grandfathered status.

First, the Act requires that group health plans and insurance issuers that provide dependent child coverage make that coverage available for children until they attain age 26.

Second, 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 nonpayment of premiums.

Finally, the ACA does not permit group health plans to impose lifetime dollar limits on benefits deemed to be "essential," a term that needs further definition by the oversight agencies, nor does the Act permit annual dollar limits to be placed on these benefits.

In light of the uncertainty as to the Supreme Court’s ruling, employers should consider their alternatives and keep their options open. While it is premature to act based on a perceived notion of how the court may rule, sponsors should nonetheless be considering contingency plans so as to position themselves to respond accordingly.

Here are a few examples of issues that may arise if the court strikes the Act in its entirety (or at least the provisions of the Act that relate directly to the individual mandate, employer mandate, coverage mandates, and the establishment of the state-sponsored health insurance exchanges).

- **Coverage mandates.** Some plans are drafted such that the ACA’s coverage mandates are automatically eliminated from the plan if the ACA is struck down by the Supreme Court. For example, the ban on lifetime and annual dollar limits with respect to essential health benefits would automatically be eliminated from the plan, and the pre-ACA annual and lifetime limits reinstated. Sponsors of such plans need to consider the possible negative consequences of such an action, including, for example, the employee morale issues that inevitably arise whenever there is a real or perceived benefit cutback, as well as the claims and litigation that often follow. Likewise, the sponsor of a plan that does not include an "automatic repeal" provision, but that nevertheless is considering amending its plan to effectuate such a repeal, needs to consider now the implementation of such a strategy.

- **Retiree medical exit strategy.** An employer that is looking to exit sponsorship of its retiree medical plan, and to use the ACA-mandated state-sponsored health insurance exchanges as a "soft landing" for retirees whose plan coverage is thereby terminated, needs to consider a world absent those exchanges. If the entire Act is ruled unconstitutional, the health insurance exchanges would no longer be required. Under such a scenario, it is anticipated that many states would likely not offer an exchange. Thus, a strategy for eliminating retiree medical coverage based on the assumption that exchanges will be available would have to be reconsidered.

- **Workforce realignment.** Beginning in 2014, the Act imposes an employer mandate, which is a penalty on employers who fail to provide affordable health care coverage to full-time employees. For this purpose, the ACA defines a full-time employee as an individual who works more than 30 hours per week. Some employers may be planning to realign their work forces to employ more employees who work less than 30 hours per week (or to otherwise reduce the hours of its current part-time workforce to no more than 30 hours per week) to avoid penalty. Any such workforce realignment inherently carries with it risks of litigation under the Employee Retirement Income Security Act and the various federal antidiscrimination statutes (e.g., the Age Discrimination in Employment Act and Title VII of the Civil Rights Act). Therefore, if the employer mandate is invalidated, employers will wish to reconsider this strategy.

**Best practices to Prepare for DOL ACA-related audits**

Generally, plan sponsors and administrators should be prepared to demonstrate that their plans comply with every aspect of the ACA, which generally requires documentary evidence from plans, recordkeepers and/or service providers.
Based on the substance of the recent DOL audit requests, plans will likely be expected to prove they comply with multiple ACA-related requirements, such as:

- Grandfathered status
- Notice to participants of grandfathered status
- Coverage for dependents to age 26 since Sept. 23, 2010, and notice of special enrollment periods for the same
- Elimination of lifetime and annual limits on essential health benefits;
- Participation and rescission of coverage
- Internal and external claims procedures
- Other coverage mandates, such as those concerning preventive care services and emergency hospital services.

Inadequate responses to these requests could lead to additional inquiries from the DOL, such as requests for additional documents, interviews, information, site visits, investigations and even DOL enforcement actions, and lawsuits by individual participants and beneficiaries. Various penalties could be imposed by the DOL and/or the IRS for failure to implement certain ACA-related coverage mandates. For example, the Act levies a penalty of up to $100 a day per affected individual for the failure to provide coverage to adult children who are under the age of 26.

Given these risks, plan sponsors should prepare now to be able to prove their plans' compliance with the ACA. In particular, there are several specific steps that plan sponsors, administrators, fiduciaries, and service providers can take to ensure that compliance can be proven and that such audits go as smoothly as possible:

- Document steps taken to comply with the ACA's requirements
- Retain all records of plan design, administration, and maintenance, including contracts with third-party service providers such as IMOs
- Have agreements with entities such as service providers or record keepers to obtain records that are needed to prove compliance
- Have any plan amendments or written policies that were adopted to implement the ACA mandates ready to produce
- Upon receiving such an audit request, 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.

In short, while employers must wait to learn the future of health care reform, they should not wait to prepare for the potential consequences of the Supreme Court's ruling, or to respond to DOL audits in the interim.

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