MY BENEFIT ADVISOR

Renewal Considerations

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Potential Liability Exposures Due to COVID-19-Related Extensions

Employees have an extended timeframe to, in part, elect COBRA, make COBRA payments, add dependents, and appeal denials of benefits. As the timeframe may extend beyond the current plan year, in some cases with coverage going into effect retroactively for many months, there are concerns about what gaps in insurance coverage there could be. This may particularly be an issue with stop loss insurance.

Employers must disregard the Outbreak Period, March 1, 2020 until 60 days after the announced end of the National Emergency, for each of the following topics below. At this point, an end to the National Emergency has not been announced, and it should be noted that the announced end date of the National Emergency may not be the same date as the end of the Public Health Emergency period announced by HHS (currently October 23, 2020). For purposes of the below examples, February 28, 2021 is used as the end of the Outbreak Period, but it may end earlier than this date, in which case the following examples are subject to the change.

COBRA: applies to all health plans of employers with 20 or more employees.

- The 60-day election period for a qualified beneficiary to elect COBRA continuation of coverage.
- The date for making monthly COBRA premium payments.
- The date for individuals to notify the plan of a qualifying event or disability determination.

Potential Issues

- An employee fails to make a COBRA premium payment for the month of July 2020 by the end of July (missing the July 1 deadline and grace period under traditional rules). Under new rules, as long as s/he makes the payment by March 30, 2021, his or her July 2020 coverage must be reinstated.
- COBRA is an employer law, not a carrier law. If a participant is seeking coverage retroactively this far in the past, there could likely be a large claim. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Special Enrollment Rights: applies to major medical plans.

- The date for a participant to request a special enrollment right for group health plan coverage which is otherwise 30 days from the loss of other coverage or acquisition of a dependent (60 days for loss of Medicaid or SCHIP or for a gain of premium assistance).

Potential Issues

- An employee has a baby on April 15, 2020. She could request enrollment to the medical plan in March 2021 for an April 15, 2020 effective date. Her employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.

- Carriers of insured plans are directly subject to the HIPAA Special Enrollment Rule. However, stop loss carriers are not. Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Claims for Benefits: applies to all ERISA-covered plans.

- The date within which individuals may file a benefit claim as described under the plan's terms.

Potential Issues

- An employee did not make a timely claim under traditional rules for a medical service provided in June 2020. S/he could make a claim in April 2021 for reimbursement of the June 2020 expense. The employer has a self-funded plan and switches stop loss carriers effective January 1, 2021.

- Carriers of insured plans and some third-party administrators ("TPAs") are claims fiduciaries. Who will adjudicate the claim? Will carriers, including stop loss carriers, cover these claims? If so, will the prior carrier or current carrier pay?

Appeals of Denied Claims: applies to all ERISA-covered plans.

- The date within which claimants may file an appeal for an adverse benefit determination. For health and disability claims, a claimant has 180 days, for all other claims 60 days.

Potential Issues

- An employee's claim for benefits is denied in April 2020. S/he misses the opportunity to appeal, resulting in a lack of exhausting administrative remedies and, thus, the inability to pursue the matter further under traditional rules. Employee appeals in April 2021.

- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

External Review: applies to all non-grandfathered major medical plans.

- The date the claimant may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination.

- The date within which a claimant may file information to perfect a request for external review.

Potential Issues

- An employee's claim for benefits is denied in April 2020. Employee misses the opportunity to request for an external review. Employee appeals in January 2021.

- Carriers of insured plans and some TPAs are claims fiduciaries. Who will adjudicate the claim? If the employee prevails on appeal, will the stop loss carrier cover these claims? If so, does the prior carrier or current carrier pay?

Below you will find a breakdown of how these rules apply to each line of coverage.

MEDICAL CARRIERS (FULLY INSURED)

All issues may apply:

- COBRA
- Claims for Benefits*
- Appeals of Denied Claims*
- External Review (only non-grandfathered major medical plans)*

Carriers are directly subject to the HIPAA Special Enrollment Rule.

MEDICAL STOP LOSS CARRIERS/ SELF-FUNDED MEDICAL PLANS

- COBRA
- Special Enrollment Rights
- Claims for Benefits
- Appeals of Denied Claims
- External Review (only non-grandfathered major medical plans).

If the TPA has been appointed a claims fiduciary, which one will adjudicate claims should there be a change in carrier? Review stop loss coverage to determine coverage protections.

DISABILITY (ADVICE TO PAY)

- Claims for Benefits
- Appeals of Denied Claims

Not as worrisome, as the employer pays the claims regardless.

LIFE INSURANCE, DISABILITY (INSURED)

- Claim for Benefits*
- Appeals of Denied Claims*

DENTAL, VISION (INSURED)

- COBRA
- Claims for Benefits*
- Appeals of Denied Claims*

Not as worrisome due to limited liability.

DENTAL, VISION (SELF-FUNDED)

- COBRA
- Claims for Benefits
- Appeals of Denied Claims

Not as worrisome due to limited liability.

* Carriers are claims fiduciaries, but which one will adjudicate claims, should there be a change in carrier? Informal responses from the major medical carriers suggest that, in a fully insured arrangement, the medical carrier at the date of service is responsible for the claims, assuming the extended emergency period timeline is met, premiums were paid, affected claims were for a covered service, and plan requirements are otherwise met.

Employer Action

Employers should consider the following:

For a currently insured medical plan going self-funded (or vice versa):

- Current carrier should adjudicate and pay claims, but best practice would be to so confirm.

For a currently self-funded medical plan remaining self-funded and with the same stop loss carrier and/or TPA at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules.

For a currently self-funded medical plan remaining self-funded but switching stop loss carriers and/or TPAs at renewal:

- Review stop loss policy terms to determine if there is sufficient coverage (including prior policy runout and run-in provisions of new coverage);
- Best practice to amend SPD to reflect these rules;
- Establish which administrator (current or new) will adjudicate the claims.