



Healthcare re-FORUM

Healthcare Re-Forum : 2010 Issue No. 26

Additional Guidance Issued for Mandates Taking Effect September 23, 2010 (Part II)

The Departments of Health and Human Services, Labor and the Treasury (the Departments) released additional Frequently Asked Questions (FAQs) on October 8, 2010, addressing issues pertaining to the implementation of the Patient Protection and Affordable Care Act (PPACA). This most recent guidance continues the Departments' clarification of various PPACA provisions and interim final regulations (IFRs).



Maintaining Grandfathered Status

As specified in the Departments' FAQs, plans that are continuing to provide the same coverage that was in place as of March 23, 2010, will only lose their grandfathered status if they make one or more of the following changes:

1. Substantially eliminate benefits to diagnose or treat a particular condition
2. Raise coinsurance requirements
3. Increase a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points
4. Increase copayments by an amount that exceeds medical inflation plus 15 percentage points (or \$5 plus medical inflation if greater)
5. Decrease the employer's contribution rate by more than 5 percentage points
6. Impose annual limits on the dollar value of essential benefits below allowable amounts

A plan's grandfathered status applies on a benefit package-by-benefit package basis. If a plan offers a PPO, a POS and an HMO, and makes changes that cause only one of these benefit options to lose its grandfathered status, the remaining unchanged options are still grandfathered plans.

In addition, rules in the IFR about grandfathering state that employer contributions apply on a tier-by-tier basis. If a group health plan modifies the tiers of coverage it had in effect on March 23, 2010 (i.e., from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two and self-plus-three-or-more), the employer contribution for any new tier would be evaluated for compliance by comparing it to the corresponding tier that was in effect on March 23, 2010. The employer contribution for self-plus-one, self-plus-two and self-plus-three-or-more would need to be within 5 percent of the family coverage that was in effect on March 23, 2010. If a grandfathered plan had a self-only coverage tier and added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose its grandfathered status.

Grandfathered plans that exceed allowable copayments in one category of services (i.e., specialty care) while keeping it the same in another (i.e., primary care) would lose grandfathered status.

Group health plans may continue to offer premium discounts or additional benefits as an incentive for wellness. The use of cost-sharing surcharges as penalties in wellness programs should be closely evaluated to ensure compliance with the rules for maintaining grandfathered status. Plans also need to closely monitor ERISA and applicable state and federal laws when offering wellness incentives to make sure they are in compliance with any applicable non-discrimination rules.

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Dental and Vision Benefits

Dental or vision benefits structured as exempt benefits under the Health Insurance Portability and Accountability Act (HIPAA) are not subject to PPACA reforms. Dental and vision benefits are considered to be exempt under HIPAA if they are offered under a separate policy, certificate or contract of insurance, or are not integral parts of the group health plan. Dental and vision benefits are not considered to be an integral part of the plan if a participant has the right to elect not to receive the coverage, or they must pay an additional premium if they elect to receive the coverage.

Rescissions

The Departments' FAQs clarify that, in some instances, retroactive termination of coverage is permitted for administrative reasons. The Departments' FAQs ask, "What about retroactive terminations of coverage in the normal course of business?"

1. Rules about rescission included in the IFR clarify that a plan error (such as mistakenly covering a part-time employee) may be cancelled prospectively once identified, but not retroactively rescinded unless there was evidence of fraud or intentional misrepresentation by the employee.
2. If a plan covers only active employees, and a terminated employee does not pay premiums for COBRA coverage but has a continuation of coverage due to a delay in administrative recordkeeping, the retroactive elimination of coverage back to the date of employment termination is not considered a rescission.
3. If a plan does not cover ex-spouses and COBRA continuation premiums (if required) are not paid by the employee or ex-spouse, and the plan is not notified of a divorce, the plan's termination of coverage retroactive to the divorce is not considered to be a rescission of coverage.

Preventive Health Services

Some of the recommendations and guidelines of the United States Preventive Services Task Force (USPTF) and other relevant federal committees do not provide definitive guidelines that specify the scope, setting or frequency of the preventive items or services to be covered. The Departments' FAQs state that the plan or issuer, in the absence of definition, can use reasonable medical management techniques to determine the frequency, method, treatment or setting for providing a recommended preventive health service.

Clarification Relating to Policy Year and Effective Date of the Affordable Care Act for Individual Health Insurance Policies

Rules in the IFR about coverage of dependent children up to age 26 have led to varying interpretations by states and issuers regarding when a policy year begins for individual policies. The confusion has arisen from the practice of carriers in the individual market designating a policy year of January 1 through December 31 for an individual policy, while the coverage actually begins on October 1. The Departments have sought to clarify this issue in the FAQs by stating that implementation of PPACA begins with the first new period of coverage on or after September 23, 2010, whether this new coverage period is a full or shortened period of coverage. For PPACA, in the example above, the policy year begins with the first new coverage (i.e., October 1, 2010), not when the next 12-month policy year begins.

For more information related to the Departments' FAQs about implementation of the PPACA, please visit <http://www.dol.gov/ebsa/faqs/faq-aca2.html>.

Future Topics:

- How Does Collective Bargaining Impact Grandfathered Status
- Another Look at High Risk Pools