Health Care Reform ADVISORY
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U.S. Department of Labor Issues Two Additional Sets of Frequently Asked Questions under the Affordable Care Act

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Following an initial set of Frequently Asked Questions (FAQs) issued on September 20, 2010, the Department of Labor's Employee Benefits Security Administration has released two additional sets of questions and answers dealing with selected issues arising under the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (together, the "Act"). While the Department of Labor issued these FAQs, they are the joint effort of the Departments of Health and Human Services, Labor, and the Treasury (collectively, the "Agencies"). We described the highlights of the September 20th FAQs in a recently issued client alert. This advisory summarizes the FAQs issued on October 8, 2010 and October 13, 2010.

The October 8th FAQs

Grandfathered health plans

The Agencies reiterate that, under the grandfather regulations, any one or more of six changes (measured from March 23, 2010) to a health plan or health insurance coverage will cause the plan or coverage to lose grandfather status. The six changes are:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition
- Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%)
- Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points
- Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation)
- Decrease in an employer's contribution rate towards the cost of coverage by more than five percentage points
- Imposition of annual limits on the dollar value of all benefits below specified amounts

Separately, and in response to some apparent confusion in the matter, the Agencies provided the following additional clarifications:

- A plan with multiple benefit package options (i.e., a PPO, a POS arrangement, and an HMO) could decide to forgo grandfather status for one option (e.g., the HMO) without doing so for the others (i.e., the PPO and POS).
- Where an employer restructures its tiers of coverage, compliance is tested tier by tier. Thus,

for example, if a group health plan modifies the tiers of coverage it had on March 23, 2010 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 tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. But if the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers, the addition of new tiers would not cause the plan to lose grandfather status.

- Where an employer raises the copayment level for a category of services (e.g., outpatient or primary care) by an amount that would result in the loss of grandfather status, but retains the copayment level for other categories of services (such as inpatient care or specialty care), the plan will forfeit grandfather status.
- Changes to premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries under wellness programs may result in a loss of grandfather status. (Presumably, this means that a decrease in the premium discount to 10% from 20% would constitute a decrease in an employer's contribution rate of more than five percentage points.)

Dental and vision benefits

Dental or vision benefits that are structured as excepted benefits are not subject to the Act's insurance market reforms. Under the Health Insurance Portability and Accountability Act (HIPAA), dental (and vision) benefits generally constitute excepted benefits if they are (1) offered under a separate policy, certificate, or contract of insurance, or (2) not an integral part of the plan. For dental or vision benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a separate right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

Rescissions

The Act imposes broad prohibitions on coverage rescissions, i.e., "cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage." There is an exception for fraudulent or intentional misrepresentations. Questions have arisen about the scope of the rule and its exceptions (e.g., are misrepresentations limited to those involving medical history?) and retroactive terminations of coverage in the "normal course of business."

The Agencies confirmed that the statutory prohibition relating to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. For example, errors might include mistakingly covering a part-time employee. In this latter instance, coverage may be cancelled *prospectively* once identified, but not retroactively, absent fraud or intentional misrepresentation. While this is not the result employers might have hoped for, the Agencies identified two common situations which would not result in a rescission. In the first, an employer's human resources department reconciles lists of COBRA-eligible individuals with their plan or issuer via data feed once per month. Where an employee elects coverage but fails to pay the premium, the Agencies do not consider the retroactive elimination of coverage back to the date of termination of employment to be a rescission. Under the second, where a plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Agencies do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage.

Preventive health services

The Act generally requires plans and carriers to cover preventative health services based on current government guidelines. Where a recommendation or guideline for a recommended preventative health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or carrier can use reasonable medical management techniques (which generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or similar practices) to establish any coverage limitations under the plan.

Clarification relating to policy year (individual market)

The Agencies note—and take issue with—the practice of some states and carriers to apply the rules governing dependent coverage of children to age 26 on the basis of a policy year instead of the date of issue, thereby extending the time at which these rules apply. The Agencies made clear that compliance with the Act's requirements for policies in the individual market sold on or after September 23, 2010 must go into effect on the date that coverage begins, irrespective of what period the carrier designates as the policy year. Where carriers have relied in good faith on guidance or instructions from a state insurance regulator to the contrary, however, they will be afforded an unspecified "reasonable period of time" to come into compliance.

The October 13th FAQs

The Agencies reiterate that HIPAA statutory exemptions going back to 1997 for group health plans with "less than two participants who are current employees" (such as plans in which only retirees participate) apply to the Act's group market reforms. But in making this point, they highlighted a question on which guidance has not been issued, i.e., whether a plan that provides long-term disability benefits and covers both active employees and retirees is exempt under HIPAA. The Agencies will solicit comments from employers and other stakeholders on this issue, and they plan to issue guidance in 2011. Until then, these plans will be treated as exempt from the Act's group market reforms. In the meantime, plans may adopt any or all of the Act's insurance market reform requirements without prejudice.

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