

# FAQS ABOUT THE AFFORDABLE CARE ACT IMPLEMENTATION – PART II

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October 8, 2010

Set out below are a number of Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act. They have been prepared jointly by the Departments of Health and Human Services, Labor and the Treasury. Like the FAQs the Departments issued on September 20, 2010, these FAQs answer questions from stakeholders with a view to helping people understand the new law and benefit from it, as intended.

The ongoing guidance the Departments are providing reflects our approach to implementation, which emphasizes assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the Affordable Care Act, as well as our commitment to work with families and individuals to make it as easy as possible for them to obtain the protections and benefits of the new law.

The Departments anticipate issuing further responses to questions and other guidance under the Affordable Care Act in the future. We hope these publications will be helpful by providing additional clarity and assistance.

## **GRANDFATHERED HEALTH PLANS**

**Q1: Our company sponsors a group health plan for our employees that has been in effect since March 23, 2010. We and the issuer of the policy under the plan are considering whether we could make various changes to the plan without losing grandfathered status. If we avoid making any of the six specific changes described in paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, are there other changes to our existing plan/policy that we need to be concerned could cause it to relinquish grandfathered status?<sup>1</sup>**

**A1:** No. Paragraph (g)(1) of the Departments' interim final grandfather regulations provides that any of six changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status. Briefly stated, these six changes are:

- 1) Elimination of all or substantially all benefits to diagnose or treat a particular condition.
- 2) Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20 percent to 25 percent).
- 3) Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.
- 4) Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, \$5 plus medical inflation).

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<sup>1</sup> These FAQs do not address the change in issuer question that the Departments stated is under consideration in Q&A 6 of the FAQs issued on September 20, 2010.

- 5) Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points.
- 6) Imposition of annual limits on the dollar value of all benefits below specified amounts.

For a plan that is continuing the same policy, these six changes are the **only** changes that would cause a cessation of grandfather status under the interim final regulations. (As noted, the Departments are separately considering under what circumstances otherwise grandfathered plans may change issuers without relinquishing their status as grandfathered health plans.)

**Q2: My plan offers three benefit package options – a PPO, a POS arrangement, and an HMO. If the HMO relinquishes grandfather status, does that mean that the PPO and POS arrangement must also relinquish grandfather status?**

**A2:** No. The grandfather analysis applies on a benefit-package-by-benefit-package basis. In this situation, it is permissible to treat the PPO, POS arrangement, and HMO as separate benefit packages. Accordingly, if any benefit package ceases grandfather status, it does not affect the grandfather status of the other benefit packages.

**Q3: How do the Departments' interim final grandfather rules regarding changes in employer contributions apply where an employer restructures its tiers of coverage?**

**A3:** The interim final grandfather regulations provide that the standards of paragraph (g)(1)(v) for employer contributions (listed above as item (5) in Q&A-1) apply on a tier-by-tier basis. As a result, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, 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. In this example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent).

If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). Therefore, for example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.

**Q4: If an employer plan sponsor raises the copayment level for a category of services (such as outpatient or primary care) by an amount that exceeds the standards set forth in paragraph (g)(1) of the interim final regulations, but retains the copayment level for other categories of services (such as inpatient care or specialty care), will that cause the plan to relinquish grandfather status?**

**A4:** Yes. Each change in cost sharing is separately tested against the paragraph (g)(1) standards of the Departments' interim final grandfather regulations.

**Q5: How do the Departments' interim final grandfather regulations affect wellness programs sponsored by group health plans?**

**A5:** Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries, by rewarding high quality providers, and by incorporating evidence-based treatments into benefit plans.<sup>2</sup> However, penalties (such as cost-sharing surcharges) may implicate the paragraph (g)(1) standards listed above in Q&A 1 and should be examined carefully. In addition, plans should take steps to ensure compliance with applicable nondiscrimination rules (such as the HIPAA<sup>3</sup> nondiscrimination rules for group health plans and group health insurance coverage with respect to an individual based on a health status related factor) and any other applicable Federal or State law.

## **DENTAL AND VISION BENEFITS**

**Q6: What if my dental (or vision) benefits are structured as excepted benefits under HIPAA? Does that exemption exempt my dental (or vision) plan from the Affordable Care Act's market reforms?**

**A6:** Yes. If benefits constitute excepted benefits under HIPAA, the requirements of the Affordable Care Act's market reforms do not apply. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they:

- Are offered under a separate policy, certificate, or contract of insurance; or
- Are 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 right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision) benefits would constitute excepted benefits, and the market reform provisions would not apply to that coverage.

## **RESCISSIONS**

**Q7: The Affordable Care Act (through Public Health Service Act section 2712) generally provides that plans and issuers must not rescind coverage unless there is fraud or an individual makes an intentional misrepresentation of material fact. A rescission is defined as it is commonly understood under the law – a cancellation or**

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<sup>2</sup> The Departments intend to take additional steps in the future to promote wellness. Specifically, the Departments' interim final regulations for preventive care invited comments related to the development of guidelines and value-based insurance designs that foster higher-value choices on the part of consumers, while ensuring access to critical, evidence-based preventive services. Moreover, the Affordable Care Act (through Public Health Service Act section 2705) will give plans and issuers additional flexibility to reward participants and beneficiaries in group health plans for meeting standards related to a health factor.

<sup>3</sup> HIPAA is the Health Insurance Portability and Accountability Act of 1996.

**discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage.**

**Is the exception to the statutory ban on rescission limited to fraudulent or intentional misrepresentations about prior medical history? What about retroactive terminations of coverage in the “normal course of business”?**

**A7:** The statutory prohibition related to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. An example in the Departments’ interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee.

On the other hand, some plans and issuers have commented that some employers’ human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission.

Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan’s termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.)

## **PREVENTIVE HEALTH SERVICES**

**Q8: Some of the recommendations and guidelines of the United States Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) and the Health Resources and Services Administration (HRSA) do not definitively state the scope, setting, or frequency of the items or services to be covered. What should my plan do if an individual requests, for example, daily counseling for diet?**

**A8:** The interim final regulations regarding preventive health services provide that if a recommendation or guideline for a recommended preventive health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer 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 determine any coverage limitations under the plan. Thus, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and these established techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service.

## **CLARIFICATION RELATING TO POLICY YEAR AND EFFECTIVE DATE OF THE AFFORDABLE CARE ACT FOR INDIVIDUAL HEALTH INSURANCE POLICIES**

**Q9:** Some States and issuers have interpreted the definition of a policy year in the interim final regulation on dependent coverage of children to age 264 to mean that if an issuer establishes a policy year for the insured under an individual policy on a basis other than the effective date of coverage (such as a calendar year beginning January 1, 2012), then the provisions of the Affordable Care Act do not apply to those policies before the start of the policy year. Can compliance with the Affordable Care Act requirements for policies in the individual market sold on or after September 23, 2010 be effective on a date other than the date that coverage begins?

**A9:** No. We understand that carriers in the health insurance individual market may designate a fixed policy year, but continue to issue policies throughout the year. For example, a carrier may designate a policy year of January 1 through December 31 for an individual policy under which coverage begins on October 1.

However, the statute and regulations contemplate implementation of the Affordable Care Act requirements at the beginning of the first new period of coverage that begins on or after September 23, 2010, whether this new coverage period is a full or shortened period of coverage. If a policy begins to cover an individual effective on a date that is on or after September 23, 2010, the initial policy year for that individual, for purposes of determining the effective date of the Affordable Care Act requirements, begins on the first date on which the coverage is effective. This initial period of coverage might be an abbreviated policy year. For example, it may run from October 1, 2010 through December 31, 2010, with a new calendar-based policy year beginning on January 1, 2011 (assuming the individual renews the policy), or from December 1, 2010 through June 30, 2011, with a new policy year beginning each July 1 (again, assuming the policy is renewed). It would be a “policy year” for purposes of the Affordable Care Act effective date if it is a new period of coverage, regardless of when (or whether) the first subsequent 12 month policy year begins.

If issuers, however, have relied in good faith on guidance or instructions from a state insurance regulator indicating that the provisions of the Affordable Care Act are not applicable until the beginning of the first full policy year of the individual coverage, then carriers will be afforded a reasonable period of time after the issuance of this guidance to come into compliance with the law. Nonetheless, subsequent to the issuance of this guidance, issuers may not rely in good faith on any contrary guidance or instruction issued by a state insurance regulator.

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<sup>4</sup> See 75 FR 27122, published May 13, 2010.