

Departments Release New Health Care Reform FAQs

The Departments of Labor, Health and Human Services and the Internal Revenue Service (collectively, the Departments) issued two new sets of frequently asked questions (FAQs) that provide some much needed clarification on the market reforms contained in the Patient Protection and Affordable Care Act (PPACA).

Following are some of the highlights.

GRANDFATHERED STATUS

- For existing plans and policies, the six specified changes¹ contained in the regulations are the only changes that would cause a cessation of grandfathered status under the existing regulations. (Part II Q/A-1)
- In addition to the six specified changes, entering into a new policy, certificate or contract of insurance after March 23, 2010 will result in a loss of grandfathered status. The Departments are considering whether there are certain instances that would allow a grandfathered plan to change insurance carriers without losing grandfathered status. At this point, no such determination has been made. (Part II Q/A-1)
- A decrease in the employer contribution rate by more than 5% points will result in a loss of grandfathered status. Plans must determine this on a tier-by-tier basis. The guidance clarifies that if the tiers of coverage are modified from what was in place on March 23, 2010 (e.g. move from a two-tier structure to a four-tier structure), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. (Part II Q/A-3)
 - **Example:** On March 23, 2010, a plan had two tiers of coverage, single and family. The employer contribution was 50% for family coverage. After March 23, 2010, the plan moves to a four-tier structure (single, single-plus-one, single-plus-two, single-plus-three-or-more). In order to retain grandfathered status, the contribution rate for any tier (other than single only coverage) must be within 5% points of 50% (i.e. at least a 45% employer contribution rate).
- If a plan is looking to implement a wellness program that rewards (or penalizes) individuals based on a health factor, the plan must comply with the HIPAA wellness program rules.² If such incentives (or penalties) are in effect after March 23, 2010, and impact premiums, copays, deductibles, or other plan limits, careful analysis is required to determine whether such plan design changes will result in a loss of grandfathered status. (Part II Q/A-5)

¹ 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% to 25%).
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).
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.

Also, entering into a new policy, certificate or contract of insurance after March 23, 2010 will currently result in a loss of grandfathered status. This scenario assumes the policy, certificate or contract of insurance that existed on March 23, 2010 remains in place.

² A wellness program that rewards certain behaviors as they relate to health factors must comply with five requirements under the HIPAA wellness program rules. Briefly, these rules are:

1. The reward cannot exceed 20% of the cost of coverage under the plan;
2. The program must be reasonably designed to promote health and prevent disease;
3. Individuals must have the opportunity to qualify for the reward at least once a year;
4. The reward must be available to all similarly situated individuals and a reasonable alternative must be provided to individuals who cannot satisfy the standard due to medical reasons; and
5. The plan must disclose the availability of the reasonable alternative in plan materials.

DENTAL AND VISION BENEFITS

- The guidance reiterates that if dental or vision benefits are structured as excepted benefits³ under HIPAA, the requirements of the PPACA's market reforms will not apply. (Part II Q/A-6)

RESCISSIONS

- Generally, a group health plan is prohibited from rescinding coverage unless there is fraud or an individual makes an intentional misrepresentation of material fact. A *rescission* is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure by the individual to timely pay premiums. The guidance provides some examples of issues that may come up in the "normal course of business". (Part II Q/A-7)
 - **Example:** 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.
 - **Example:** 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.
 - **Example:** 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.)

EXEMPTION FOR GROUP HEALTH PLANS THAT COVER LESS THAN TWO CURRENT EMPLOYEES

- The guidance clarifies that a group health plan that covers "less than two participants who are current employees" is exempt from the group market reform requirements of the PPACA. This may include a plan in which only retirees participate. (Part III Q/A-1)

For a copy of the FAQs, visit:

- Part II: <http://www.dol.gov/ebsa/faqs/faq-aca2.html>
- Part III: <http://www.dol.gov/ebsa/faqs/faq-aca3.html>

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³ *Excepted benefits* are limited-scope dental or vision benefits (1) provided under a separate policy, certificate, or contract of insurance or (2) otherwise not an integral part of the group health plan. Benefits are not considered to be an integral part of a plan, whether the benefits are provided through the same plan or a separate plan, if the following two conditions are met: (1) the participant has the right to elect not to receive the coverage; and (2) if the participant elects to receive the coverage, the participant must pay an additional premium or contribution for it.

- *Limited-scope dental benefits* are defined as "benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth)."
- *Limited-scope vision benefits* are defined as "benefits substantially all of which are for treatment of the eye."