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FAQS ON HEALTH CARE REFORM FROM FEDERAL AGENCIES

The federal agencies (Department of Health & Human Services, Department of Labor, and Treasury Department) have jointly issued guidance in the form of Frequently Asked Questions (FAQs) regarding health care reform implementation. The agencies issue FAQs to answer questions that arise after regulations have been issued.

The first set of FAQs discusses grandfather rules; adult dependents; claims, appeals and external review; and additional compliance issues. The second set addresses grandfather rules; dental and vision benefits; rescissions; and preventive health services. The third set addresses group health plan exemptions for plans with two or fewer employees (retiree-only plans). It is anticipated that there will be frequent additions to these health reform FAQs. The Department of Labor has updated its website to add links to the FAQs and other information on health reform.

Among other things, the FAQs clarify the following:

-- *Implementation approach*. The agencies' approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans working diligently and in good faith to understand and come into compliance with the new law. Employer groups have recommended that the agencies adopt a good faith standard for compliance with many of the health reform regulations and continue to urge additional time and flexibility for employer health plan sponsors throughout the implementation process.

-- *Stand alone dental and vision.* The health reform rules (e.g., adult child coverage to age 26) do not apply to excepted benefits under the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, dental and vision benefits generally constitute “excepted benefits” if they require separate elections and are not an integral part of the plan in that participants have a right not to elect coverage and must pay an additional premium if they do.

-- *Retiree-only plans.* Plans that apply only to retirees and other former employees are exempt from the health reform rules. Therefore, the health reform rules (e.g., adult child coverage to age 26, 100% coverage of preventive services, prohibition on lifetime dollar limits on essential health benefits, etc.) do not apply to "retiree only" group health plans. It is unclear whether a plan that covers retirees as well as individuals on long-term disability (LTD) would fit within this exemption (the agencies will issue a request for public comment on this matter). In the meantime, a plan that covers both retirees and individuals on LTD will be considered exempt from the requirements, and if the agencies ultimately decide that such plans will not be exempt, this decision will be applied prospectively, so as not to penalize plans that have relied on the interim guidance. Guidance is expected on this issue in 2011.

-- *Dependent coverage.* Plans may limit coverage for children up to age 26 to only those children described in section 152(f)(1) of the Internal Revenue Code (this section defines children to include sons, daughters, stepchildren, adopted children (including children placed for adoption) and foster children). For an individual who is not described in 152(f)(1), including grandchildren, nieces, and nephews, plans may impose additional conditions for eligibility for health coverage, such as a condition that the individual be a dependent for tax purposes. Thus, a plan may limit health coverage for children until the child turns 26 to sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children, while imposing additional conditions on eligibility, such as a condition that the individual be a dependent for income tax purposes–for individuals not described in 152(f)(1), such as a grandchild or niece.

-- *Rescissions.* A group health plan can not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. But some terminations of coverage in the normal course of business are not considered to be rescissions, such as retroactively eliminating coverage back to the date of termination of employment because of delays in reconciling plan eligibility (e.g., HR departments often reconcile eligibility monthly rather than in real time), or terminating coverage retroactive to a divorce where a plan does not cover ex-spouses, 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. Plans may also correct errors, such as mistakenly covering a part-time employee, by canceling coverage prospectively, but not by retroactively rescinding coverage unless there was some fraud or intentional misrepresentation by the employee.

-- *Preventive services.* Non-grandfathered plans must cover, without cost-sharing, government-recommended preventive services. 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, a plan can use reasonable medical management techniques to determine any coverage limitations under the plan. Plans do not have to cover all requests beyond what they cover using reasonable medical management tools.

-- *Out-of-network emergency services.* Minimum payment standards apply to ensure that a plan does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply bill the balance to the patient (these minimum payment standards are not intended to apply in circumstances where state law prohibits balance billing). Similarly, if a plan is contractually responsible for any amounts balance billed by an

out-of-network emergency services provider, the plan does not have to satisfy the payment minimums. However, in either case, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts. In addition, even if state law prohibits balance billing, or if the plan is contractually responsible for amounts balance billed, the plan may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.

-- *Benefit-by-benefit approach.* The grandfather analysis applies on a benefit-package-by-benefit-package basis. Thus, for example, if a plan offers three benefit options—a PPO, a POS arrangement, and an HMO—as separate benefit packages, and the HMO relinquishes grandfather status, that does not affect the grandfather status of the other benefit packages.

-- *Insured plans.* For a plan that is continuing the same policy, the six situations in which a group health plan ceases to be a grandfathered health plan are the only changes that would cause a loss of grandfather status. The agencies are still considering the circumstances under which insured plans will be allowed to change carriers without losing grandfather status. Note that the interim final regulations provide that if an employer enters into a "new policy, certificate, or contract of insurance" after March 23, 2010, then the new policy, certificate, or contract is not a grandfathered health plan, so until further guidance is issued, employers should proceed with caution.

-- *Tiers of coverage.* The grandfather standards related to employer contributions apply on a tier-by-tier basis, thus allowing a group health plan to modify or add tiers of coverage without losing grandfathered status. Accordingly, with respect to the tier-by-tier assessment of changes in employer contribution under the grandfather rule, if a plan modifies the tiers of coverage it had on March 23, 2010 (e.g., 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. So, for example, if the employer contribution rate for family coverage was 50% 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% (i.e., at least 45%). But if 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 previously covered, the new tiers would not have to be tested under the grandfather rules. 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, whatever it is, would not cause the plan to lose grandfather status.

-- *Co-payment levels.* Plans must test each change in co-payment levels separately. If any of the changes is greater than medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation), it is sufficient by itself to trigger the loss of grandfathered plan status. For example, if plans change co-payment levels for only one category of service (e.g., outpatient services or primary care), but keep co-payment levels for other categories of services (e.g., inpatient care or specialty care), the change in outpatient co-payment levels may trigger loss of grandfathered status if they are high enough, even if all other co-payment levels remain the same.

-- *Wellness incentives.* Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors through a wellness program, but penalties (such as cost-sharing surcharges) may implicate the six changes that defeat grandfather status and also may violate other nondiscrimination rules, so these provisions should be examined carefully. In determining whether plan changes trigger loss of grandfathered status, plans must count wellness incentives like premium and cost-sharing discounts or surcharges when testing for changes in employer contribution rates and plan participant cost-sharing levels. This suggests, for example, that a plan that charges a higher co-payment amount to smokers could lose grandfather status if that higher amount exceeds medical inflation plus 15 percent (the limit on co-payment increases contained in the grandfather rules). It follows that plans would need to structure their wellness programs to offer cost-sharing "rewards" i.e., give participants a discount off a "standard" cost-sharing amount for engaging in desired behaviors, rather than imposing a "penalty," i.e., a surcharge on the "standard" cost-sharing amount. Alternatively, plans could structure wellness programs so that rewards or penalties are associated with premiums rather than cost-sharing, since the grandfather rules do not impose limits on the ability to raise premiums.

-- *Claims, internal appeals, and external review.* Plans that do not strictly comply with all the claims processing, internal appeals, and external review standards set forth in the guidance may in some circumstances still be considered to be in compliance with health reform. Compliance will be determined on a case-by-case basis under a facts and circumstances analysis. For example, a self-insured group health plan's failure to contract with at least three independent review organizations (IROs) does not mean that the plan has automatically violated the rule. Instead, a plan may demonstrate compliance via other steps taken to ensure that its external review process is independent and without bias. Plans are also not required to contract directly with any IRO. Instead, the requirements are met where a self-insured plan contracts with a third-party administrator that, in turn, contracts with an IRO. However, such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review. Also the IRO is not required to be in the same state as the plan. Rather, plans may contract with an IRO in another state.

Conner Strong will continue to keep you informed as additional agency guidance is issued. For a complete list of Legislative Updates issued by Conner Strong, visit our online Resource Center. Should you have any questions, please contact your Conner Strong representative toll-free at 1-877-861-3220.