Thomas D. Bixby
Law Office LLC
Legal Advice for Health Plans

HEALTH LAW ALERT
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More Affordable Care Act FAQs and Guidance Issued
Grandfathered Plans, Individual, and "Child-Only" Policies Addressed

The Departments of Health and Human Services, Labor, and Treasury (together, the Agencies) have issued more frequently asked questions (FAQs) and other guidance in the past week on several topics concerning implementation of the Affordable Care Act. Several FAQs address the status of grandfathered health plans. In addition, Health and Human Services Secretary Sebelius explained in a letter to the National Association of Insurance Commissioners (NAIC) that insurers may use a variety of strategies with "child-only" policies to prevent adverse selection risks arising from the Affordable Care Act's prohibition on pre-existing condition exclusions for children under the age of 19. The FAQs published by the Agencies also:

- Address application of the Affordable Care Act insurance reform provisions to:
    - Individual policies effective after September 23, 2010;
    - Dental and vision coverage;
    - Very small group health plans (zero or one current employees), and
    - Plans covering only retirees (or individuals on long-term disability).
- Provide clarifications of the Agencies' position on rescissions and preventive health services.

The Department of Health and Human Services' website has all of the FAQs (including the FAQs[1] published on September 20) in a single location. *See*, http://www.hhs.gov/ociio/regulations/implementation_faq.html#first. The Department of Labor posted some of the new FAQs to its website at http://www.dol.gov/ebsa/faqs/faq-aca2.html (FAQs published last week) and the remaining new FAQs at http://www.dol.gov/ebsa/faqs/faq-aca3.html (FAQs published this week). The Secretary's letter to the NAIC (and a Department of Health and Human Services Press Release on the subject is available at http://www.hhs.gov/news/press/2010pres/10/20101013a.html.

[1] Click here for my Health Law Alert on the September 20 guidance (or go to tbixbylaw.com and click on the "Resources" page); see the second bullet under "Health Law Alerts."

Child-Only Policies

Secretary Sebelius's letter to the NAIC acknowledged "concerns about adverse selection" arising from the prohibition on use of pre-existing conditions in underwriting child-only policies. But, she said the Agencies had "clarified that a range of practices related to 'child-only' policies are not prohibited by the Affordable Care Act," including permitting health insurance issuers to:

- Determine, with respect to the individual market, the number and length of open enrollment periods for children under 19 (as well as those for families and adults), consistent with state law;
- Adjust rates based on health status as permitted by state law (until 2014);
- Impose a surcharge for dropping coverage and subsequently reapplying for coverage (if permitted by state law);
- Implement rules, consistent with state law, to help prevent employers from encouraging workers to enroll children in child-only policies instead of employer-sponsored insurance; and
- Sell "child-only" policies that are self-sustaining and separate from closed "child-only" books of business if permitted by state law.

Grandfathered Health Plans

Nearly half of the Agencies' new FAQs address the (apparently) vexing issue of maintaining grandfathered health plan status. The FAQs instruct that health plans will not lose their status as grandfathered plans, unless they make one of the six changes specified in the Rule (*see* 45 C.F.R. § 147.140(g)(1)). No other changes will affect a plan's grandfathered status.[2] The FAQs also clarify that grandfathered status is determined for each benefit package. That means an employer with three benefit packages does not lose grandfathered status for all three benefit packages because of changes to one of the benefit packages. Thus, an example provided in the FAQ explains that an employer with three options—PPO, POS, and HMO—may maintain grandfathered status for the PPO and POS benefit packages even if significant changes to the HMO benefit package cause the HMO benefit package to lose status as a grandfathered health plan.

The FAQs indicate that the Grandfathered Health Plan Rules do not affect wellness program *incentives*, but wellness program *penalties* "may implicate" the provisions that terminate a plan's grandfathered status and "should be examined carefully." The FAQs also

[2] An insured health plan may also lose its status as a grandfathered plan by changing health insurance issuers. *See* 45 C.F.R. § 147.140(a)(1)(ii). The Agencies' new FAQs reiterate that, notwithstanding this provision of the Grandfathered Health Plan Rule, they will issue guidance on the circumstances under which "otherwise grandfathered plans may change issuers without relinquishing their status as grandfathered health plans."

address how the Grandfathered Health Plan Rules apply to different "tiers" of coverage—*e.g.*, employee-only, employee-and-spouse, or family.

Application of Rules to Various Types of Health Plans

Individual Coverage. The Agencies addressed some controversy over the effective date of Affordable Care Act insurance reform provisions with respect to individual policies that have effective dates beginning on or after September 23, 2010. Some health insurance issuers treat all individual policies as a single block of business with a policy year beginning on, for example, January 1. Although group plans with a plan year beginning on January 1 would not need to comply with the Affordable Care Act insurance reform provisions until January 1, the Agencies clarify that individual policies with effective dates after September 23 must comply with Affordable Care Act provisions as soon as the policies go into effect.

This guidance came as a surprise to many insurers because (at least in part) some state insurance regulators have issued "guidance or instructions . . . 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." Because of this confusion, health insurance issuers that "relied in good faith" on State regulators' guidance "will be afforded a reasonable period of time after the issuance of this guidance to come into compliance with the law."

Dental and Vision. The FAQs indicate that dental and vision benefits are "excepted benefits," which are not subject to the Affordable Care Act's insurance reform provisions, as long as the "plan provides its dental (or vision) benefits pursuant to a separate election by [a subscriber] and the plan charges [some amount, which may be nominal, for] the coverage." Hence, unless a subscriber can opt out of dental (or vision) coverage, the coverage is subject to the Affordable Care Act requirements.

Very Small Plans and Retiree-only (or Disability-only) Plans. Plans with "less than two" current employees have been exempt from HIPAA requirements since 1997 and retain that exemption under the Affordable Care Act's insurance reforms. That means very small groups—with one employee—are not subject to the Affordable Care Act requirements. Moreover, groups made up solely of retirees or individuals on long-term disability are not subject to the Affordable Care Act provisions—at least for now—because such groups have less than two "current employees." The Agencies intend to issue a "request for information"—seek public input—on application of the Affordable Care Act requirements to retiree-only and long-term-disability-only plans "very soon." But, the Agencies make clear that, "[t]o the extent future guidance on this issue is more restrictive with respect to the availability of the exemption than [these FAQs], the [future] guidance will be prospective, applying to plan years that begin some time after its issuance."

Rescissions

The FAQs addressed common practices insurers engage in with respect to group plans, such as retroactively terminating coverage for an individual after the group failed to

provide timely notification of, for example, a former employee's termination or a former spouse's divorce which makes the former employee or spouse ineligible for coverage. The Agencies explain that these terminations, though retroactive, do not qualify as rescissions that are prohibited by the Affordable Care Act because they are "due to a delay in administrative recordkeeping." Presumably, the fact that the administrative delay is beyond the insurer's control is an important factor in the Agencies' determination that the retroactive termination is permissible.

Preventive Health Services

Finally, the FAQs reiterate that a plan is allowed to impose reasonable limits on the preventive services it covers. Although some of the preventive care recommendations and guidelines that the Affordable Care Act requires health plans to cover with no out-of-pocket costs "do not definitively state the scope, setting, or frequency of items or services to be covered," a health plan is not required to cover unlimited preventive care items and services. The FAQs point out that the Affordable Care Act Rule permits health plans to "use reasonable medical management techniques to determine the frequency, method, treatment, or setting" for the required covered items and services. *See* 45 C.F.R. § 147.130(a)(4).

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For more information, please contact Tom Bixby at (608) 661-4310 or TBixby@tbixbylaw.com