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Additional Guidance Released on the Market Reform Provisions of the Health Care Reform Law

The agencies responsible for implementing the health care reform law have released additional guidance on the law's market reform provisions. Two sets of Frequently Asked Questions (FAQs) provide important clarifications on grandfathered health plans, stand-alone dental and vision plans, wellness incentives, preventive care guidelines, and exemptions from the market reform requirements.

Background

In recent weeks, the Departments of Health and Human Services, Labor and Treasury (the agencies responsible for implementing health care reform) have begun issuing "sub-regulatory" guidance (i.e., guidance that is not in the form of regulations). Some of this guidance has taken the form of Frequently Asked Questions (FAQs), intended to address issues that may have been raised by, or not clearly addressed in, the various interim final regulations. FAQs Part I was posted on the DOL website on September 20, 2010. (See our September 22, 2010 *For Your Information*.) FAQs Part II and Part III were posted on October 8, 2010 and October 13, 2010, respectively.

Grandfathered Plans

On June 17, 2010, the agencies issued interim final regulations on grandfathered health plans and the types of changes that would cause plans to lose grandfather status under the Patient Protection and Affordable Care Act (PPACA). (See our June 23, 2010 *For Your Information*.)

The FAQs provide additional information on several aspects related to grandfathered plans. Importantly, the FAQs confirm that ***only*** the following six types of changes to a plan or policy in effect on March 23, 2010 will cause a plan to lose grandfather status –

- elimination of all or substantially all benefits to diagnose or treat a particular condition
- increase in an individual's percentage of a cost-sharing requirement (e.g., coinsurance)
- 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 toward the cost of coverage by more than 5 percentage points
- imposition of annual limits on the dollar value of benefits below the amounts outlined in the interim final regulations issued on June 28, 2010, namely $750,000, $1,250,000 and $2,000,000 for each plan year beginning on or after September 23, 2010, 2011 and 2012, respectively. (See our July 2, 2010 *For Your Information*.)

BUCK COMMENT. *Based on this clarification, it appears that changes to a drug formulary or network will not jeopardize grandfather status. The FAQs note that the agencies are currently considering circumstances under which an insured plan may change issuers without losing grandfather status, which will be welcome guidance to plan sponsors with insured plans.*

Changes in Cost-Sharing. The FAQs reiterate that each change in cost-sharing is tested separately and that an increase in employee cost-sharing in even one category of services (e.g., such as a change in an office visit copayment) will result in a loss of grandfather status if the increase exceeds the applicable standard.

Plans with Multiple Benefit Options. The FAQs confirm that the grandfather analysis applies on a benefit-package-by-benefit-package basis. If a plan offers different benefit package options, such as a PPO, HMO and POS, the options would be tested separately. Thus, the loss of grandfather status by the HMO would not affect the continued grandfather status of the PPO or POS.

Changes in Tiers of Coverage. As noted above, grandfather status will be lost if the employer's contribution rate toward the cost of coverage is decreased by more than 5 percentage points. The FAQs clarify that if a plan eliminates or modifies any of the tiers of coverage it had on March 23, 2010 (e.g., changes from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, etc.), the employer contribution rate for any new tier would be tested by comparing it to the contribution rate for the corresponding tier in effect on March 23, 2010. For example, if the employer contribution rate for the family tier on March 23, 2010 was 50%, the employer contribution rate for any new tier of coverage other than self-only could not be less than 45%.

BUCK COMMENT. *Some plan sponsors are considering changing the tier structure of their plans in response to the required extension of dependent coverage to children up to age 26. The requirements noted here may limit their ability to make this change and still maintain grandfather status.*

The FAQs also clarify that a plan can add new coverage tiers for classes of individuals not previously covered under the plan without losing grandfather status, as long as it does not eliminate or modify a tier of coverage in existence on March 23, 2010.

BUCK COMMENT. *This would permit a plan that newly adds coverage of domestic partners to add a new tier of coverage that provides for a lower employer contribution.*

Wellness Programs. The FAQs state that plans may continue to provide incentives for wellness programs but warn that penalties under a wellness program, such as cost-sharing surcharges, "may implicate" the standards set out above and should be examined carefully. In addition, the FAQs advise plans to take steps to ensure they do not run afoul of HIPAA nondiscrimination rules regarding penalties based on health status.

BUCK COMMENT. *"Value-based" plan designs that waive or vary copayments for certain health conditions and contribution surcharges such as smoker/non-smoker rates are becoming more prevalent as plan sponsors try to manage their wellness programs. The guidance provides positive news that such programs are still permitted. However, sponsors will have to carefully consider each component of their plan designs to be sure that modifying a component does not cause the plan to lose its grandfathered status inadvertently – e.g., making a change in the smoker surcharge that results in a 5 percentage point reduction in the employer contribution rate.*

Exemption from the Market Reform Provisions

The preamble to the "grandfather" regulations stated that HIPAA-excepted benefits (such as stand-alone dental and vision plans), very small plans and certain retiree-only health plans are exempt from PPACA market reform provisions. The FAQs confirm that certain plans are exempt from PPACA market reform provisions and provide additional clarification. Dental or vision benefits will not be subject to market reform requirements if they are offered under a separate policy or contract of insurance, or if they are (1) elected separately and (2) the plan charges even a nominal contribution toward the cost of coverage. Because the HIPAA statutory exemption for plans that cover "less than two participants who are current employees" is still effective, retiree-only plans are also exempt from the market reform provisions.

The FAQs also state that until future guidance is issued, a plan that covers only retirees and long-term disability benefit recipients will be treated as exempt from both HIPAA and the market reforms. To the extent future guidance is more restrictive with respect to the exemption, it will apply prospectively.

Preventive Care

Under PPACA, non-grandfathered plans are required to cover with no cost-sharing requirements certain preventive care services recommended by, or pursuant to guidelines issued by, agencies such as the United States Preventive Services Task Force. (See our July 20, 2010 *For Your Information*.) Interim final regulations issued on July 19, 2010 provided that a plan could use reasonable medical management techniques to limit or exclude benefits if the recommendation or guideline did not specify the frequency, method, treatment or setting for the provision of the service. The FAQs confirm that to the extent not specified in a recommendation or guideline, a plan may rely on "the relevant evidence base" and established techniques to determine these measures.

BUCK COMMENT. *Plan sponsors should work with their third party administrators to make sure their medical management techniques and procedures are based on reasonable evidence-based criteria.*

Rescissions

The interim final regulations issued on June 28, 2010 provide that, for purposes of PPACA, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay a premium. PPACA generally prohibits a plan from retroactively rescinding coverage except in instances of fraud or intentional misrepresentation of material fact. This is the case even when the termination of coverage has nothing to do with an individual's medical history, such as when a plan mistakenly covers part-time employees who rely on the coverage for some time. The regulations state that the coverage may only be canceled prospectively.

The FAQs provide two examples involving non-payment of premiums where coverage may be canceled retroactively. If a plan covers only active employees but only reconciles lists of eligible participants once a month and discovers that a terminated employee is still covered but has not paid premiums post-termination, the plan may retroactively terminate coverage as of the employee's termination date. Similarly, if a plan that does not cover ex-spouses is not notified of a divorce and neither the employee nor the former spouse paid the full COBRA premium for coverage, the plan may terminate the former spouse's coverage retroactive to the date of divorce.

BUCK COMMENT. *Although both examples permit retroactive termination of coverage for non-payment of required premiums or contributions, the plan may be required to offer coverage back to the date of the termination of coverage under COBRA.*

Conclusion

It is likely that more sub-regulatory guidance will be issued as the DOL, Treasury and HHS attempt to provide information on a more rapid basis. This is particularly helpful as the implementation date for calendar year plans is approaching quickly. Buck's consultants are available to assist you in assessing the impact of this guidance on your plans.