FAQ "Stack"

Agency FAQs on PPACA implementation

OVER the last several months, the Departments of Labor, Treasury, and Health and Human Services (the Agencies) have issued a series of FAQs regarding implementation of PPACA. This month, we summarize some of the key issues addressed in the FAQs.

Grandfathering Issues: The Interim Final Rules on grandfathered status generally provide that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate toward the cost of any tier of coverage by more than five percentage points below the contribution rate on March 23, 2010. Insurers commented to the Agencies that they do not always have the information needed to know whether (or when) an employer changes its contribution rate.

In the FAQs, the Agencies provide that, until the issuance of final regulations, the Agencies will not treat a grandfathered insured group health plan as losing grandfathered status based on a change in the employer contribution rate if (1) upon renewal of the insurance coverage, the insurer requires the plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010, if the insurer does not already have it (so that the insurer can make its own comparison); and (2) the insurer's policies, certificates, or contracts of insurance disclose—in a prominent and effective manner—that plan sponsors are required to notify the insurer if the contribution rate changes at any point during the plan year.

For policies renewed prior to January 1, 2011, the FAQ states that insurers should take the above steps no later than January 1, 2011. The FAQ also states that the insured plan will lose grandfathered status based upon a decrease in the employer's contribution rate as of the earlier of (1) the first date on which the insurer knows that there has been at least a five-percentage-point reduction; or (2) the first date on which the plan no longer qualifies for grandfathered status for other reasons, without regard to the five-percentage-point reduction.

Dependent Coverage of Children: Another FAQ provides generally that plans may impose conditions for continued coverage of children not described in Internal Revenue Code section 152(f)(1)—for example, grandchildren and nieces/nephews. The Interim Final regulation on the depen-

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 Illustration by You Jung Byun

dent child coverage requirement provides that a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant, but does not provide a definition of "child" for this purpose.

The FAQ provides generally that a plan sponsor may limit the circumstances under which coverage is provided to a dependent who is not a son, daughter, stepson, stepdaughter, adopted child, or foster child. Accordingly, for any individual outside of these categories, plans can continue to impose additional eligibility criteria, such as claiming a child on a federal tax return.

Grandfathered Plans: An FAQ confirms that the six changes resulting in the loss of grandfathered status listed in the Interim Final Regulations on grandfathered status are the only such changes that result in loss of grandfathered status. Another FAQ provides generally that, in the case of a plan with three options—a PPO, POS arrangement, and HMO—it is permissible to treat the three options as separate benefit packages for grandfathering purposes.

A third FAQ finds that a category of benefits (e.g., primary care benefits) *cannot* be treated as its own option in order to try to prevent a change in cost sharing within that one category from affecting the grandfathered status of the other categories. A fourth FAQ explains how the restriction on employer contribution rate changes applies where an employer restructures its tiers of coverage (e.g., family coverage replaced by self plus one, self plus two, etc.).

Rescissions: PPACA provides that a group health plan or health insurance issuer offering coverage may not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage.

A FAQ provides helpful guidance allowing a plan to terminate coverage retroactive to the date of employment termination where the plan has a monthly review process under which it detects and makes corrections. This suggests that it may be possible to use a monthly review and correction process like the one in the FAQ in other circumstances, and appears to put a gloss on the example in the Interim Final Rule.

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