

FAQs About the Affordable Care Act Implementation Part IV

Set out below are three Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act. They have been prepared jointly by the Departments of Health and Human Services, Labor and the Treasury (the Departments). Like the FAQs the Department issued on [September 20, 2010](#), [October 8, 2010](#), and [October 12, 2010](#), these FAQs answer questions from stakeholders with a view to helping people understand the new law and benefit from it, as intended.

The Departments anticipate issuing further responses to questions and other guidance under the Affordable Care Act in the future. We hope these publications will be helpful by providing additional clarity and assistance.

Q1: The Departments' interim final grandfather regulations provide that, to maintain status as a grandfathered health plan, a group health plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan. Must a grandfathered health plan provide the disclosure statement every time it sends out a communication, such as an EOB (explanation of benefits), to a participant or beneficiary? If not, how does a grandfathered health plan comply with this disclosure requirement?

A grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. While it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.

Q2: If an individual health insurance policy that was in place on March 23, 2010 included a feature that allowed a policy holder to elect an option under which he or she would pay a reduced premium in exchange for higher cost sharing, could such an election be made after March 23 without affecting the policy's grandfather status even if the increase in cost sharing for the individual would exceed the limits under the grandfather rule on increases in cost sharing?

Yes. The cost-sharing level that would apply under this option would be grandfathered as part of the policy in place on March 23, 2010 even if it did not apply for the particular individual at that time. As long as the policy holder had that option available on March 23 under the policy, he or she could exercise the option after March 23 without affecting grandfather status, even if the result would be that the particular individual's cost-sharing would increase as a result of electing this option by an amount in excess of the grandfather rule limits.

Q3: An employer has maintained a plan since before enactment of the Affordable Care Act that reimburses expenses for special treatment and therapy of eligible employees' children with physical, mental, or developmental disabilities. The treatment or therapy is not covered by the employer's primary medical plan or plans. Reimbursable expenses may include expenses for special treatment or therapy from licensed clinics or practitioners, day or residential special care facilities, special education facilities for learning-disabled children, or camps offering medically oriented programs that are part of a child's continued treatment, or for special devices. The plan is operated separately from the employer's primary medical plans; employees who are otherwise eligible may participate in the plan without participating in those primary medical plans. The plan limits the total benefits for any eligible child to a specified lifetime dollar limit.

Would it be a reasonable good faith interpretation of the Affordable Care Act and the regulations thereunder for the plan sponsor to take the position that the plan does not violate the prohibition, under section 2711 of the Public Health Service Act (PHS Act) and the related interim final regulations, on imposing a lifetime dollar limit on “essential health benefits,” as defined in section 1302(b) of the Affordable Care Act (the lifetime limit prohibition)?

Yes. In accordance with the preamble to the Departments’ interim final regulations implementing PHS Act section 2711, for plan years beginning before the issuance of final regulations defining “essential health benefits,” for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.” (Of course, the regulations may differ in their definition of “essential health benefits” from reasonable interpretations used before the regulations are issued.) Accordingly, in the case of plans described above, for such plan years: (i) the Departments will treat as a reasonable good faith interpretation of section 2711 of the PHS Act and the regulations thereunder the position that the imposition of the per-child lifetime dollar limit on benefits provided under such plans does not violate the lifetime limit prohibition, and (ii) the imposition by such plans of such a limit will not result in an enforcement action by the Departments against such plans under PHS Act section 2711.