United Actuarial Services, Inc.
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BENEFIT NEWS BRIEFS

Additional FAQs on Affordable Care Act and MHPAEA

The Departments of Health and Human Services, Labor and the Treasury (the Departments) jointly issued *FAQs* (*FAQ* Part V) about implementation of the *Affordable Care Act* and the *Mental Health Parity and Addiction Equity Act* (*MHPAEA*). The *FAQs* are available at *http://www.dol.gov/ebsa/faqs/faq-aca5.html.* A specially prepared copy with a Table of Contents for ease of use is available by *"clicking here."*

The new guidance consists of seven *FAQs* about the *Affordable Care Act* and eight *FAQs* about the *MHPAEA.*

Two of the *Affordable Care Act FAQs* address issues of general relevance concerning the requirement to issue a notice of material modifications 60-days before the effective date of such modifications and age 26 coverage rules. We set out these two FAQs below:

Q4: When are group health plans and health insurance issuers required to comply with the notice requirement in PHS Act Section 2715 (d)(4), which generally requires a 60-day prior notice for material modifications to the plan or coverage?

PHS Act Section 2715 as added by the Affordable Care Act generally provides, among other things, that not later than 12 months after the date of enactment of the Affordable Care Act, the Departments must develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage and, not later than 24 months after the date of enactment, plans and issuers must begin to provide the summary pursuant to the standards.

PHS Act Section 2715(d)(4) generally provides that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of Section 102 of the Employee Retirement Income Security Act (ERISA)) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice

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of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

Accordingly, it is the view of the Departments that group health plans and health insurance issuers are **not** required to comply with the 60-day prior notice requirement for material modifications in PHS Act Section 2715 (d)(4) until plans and issuers are required to provide the summary of benefits and coverage explanation pursuant to the standards issued by the Departments. The Departments have not yet issued the standards. (emphasis added)

Q5: My group health plan normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19. Is this permissible?

Yes. The Departments' regulations implementing PHS Act Section 2714 provide that the terms of a group health plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). While this generally prohibits distinctions based upon age in dependent coverage of children, it does **not** prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this case, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the Departments will not consider the arrangement described in this question (including waiver, for individuals under age 19, of the generally applicable copayment) to violate PHS Act Section 2714 or its implementing regulations. (emphasis added)

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