McGraw Wentworth

REFORM Update

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This *Reform Update* clarifies the following recent federal guidance on several aspects of health care reform:

- Actuarial value and cost-sharing reduction bulletin.
- Frequently asked questions about the Summary of Benefits and Coverage.
- Formalized guidance on the expanded coverage for women's preventive care services.

Because of the changes required in 2014, we expect the government to release guidance regularly this year.

Actuarial Value and Cost-Sharing Reduction Bulletin

This bulletin reviews the proposed rules for assessing the actuarial value of individual and small group health plans offered within or outside the public Exchange. It also discusses a method for handling cost-sharing reductions in the Exchange. The government has requested stakeholder comments before it develops a final approach.

To recap, health care reform requires insured plans in the Exchange to offer distinct levels of coverage, often referred to as the "metal tiers." Each tier will have an associated actuarial value:

Platinum Plan	90 % Value
Gold Plan	80% Value
Silver Plan	70% Value
Bronze Plan	60% Value

The actuarial value of a health plan will be based on its coverage of essential health benefits. More information on essential health benefits can be found in our *Reform Update* at http://www.mcwent.com/Reform_Update/2012/Reform_Update_37.pdf.

The Academy of Actuaries describes two possible methods for calculating the actuarial value of a health plan. The recommended approach uses a standard data set in the individual and small group market. CMS (Centers for Medicare and Medicaid Services) would develop the data set based on claims for a standard population, weighted for expected market enrollment. The claims data would reflect average unit prices and utilization patterns. CMS would create a tool that allows plans to calculate the actuarial value by entering specific plan design features, such as deductibles and copayments.

A standard database will allow consumers to review actuarial values in order to compare plans more accurately. Two plans with all of the same cost-sharing features will have the same actuarial value when a standard database is used. Plans that are more successful in managing utilization and total cost will have lower premium costs in their metal tier.

CMS intends to develop a national standard database. In order to account for geographic differences in health care costs, it will apply three different pricing tiers. In addition, any state may develop its own state-specific standard database. Each state may also use demographic and other adjustors along with sound actuarial principles to modify the national standard database.

The bulletin discusses developing the actuarial value calculator. The government will require the insurer to input only a handful of cost-sharing features, such as deductible, coinsurance, out-of-pocket maximums, prescription drug copays and possibly other copays. It recognizes that members use in-network providers for most services; therefore the value will be measured only on in-network plan provisions. Actuarial value will be measured based on essential health benefits. Each state will determine its own essential health benefit benchmark plan. The tool is intended to represent the entire range of potential benchmark benefits available.

In order to account for differences in actuarial estimates, the government will allow a reasonable "de minimis" variation in the actuarial values used to determine a plan's level of coverage. The proposed "de minimis" variation is plus or minus two percentage points. For example, a silver plan could have an actuarial value ranging from 68 percent to 72 percent.

The bulletin also explains the special circumstances that occur when consumer-driven health plans are paired with a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA). If the actuarial value was simply calculated on the high deductible plan in these arrangements, then the value would likely be understated because many employers contribute to these accounts. For plans with HSAs, the employer contribution to the HSA will be used to determine the actuarial value. For plans with HRAs, the annual amount allotted toward the HRA will be used to determine actuarial value. In general, these accounts allow balances to roll over from year to year. Thus, the actuarial value will account only for new contributions during the year, and not any funds available as a result of a rollover.

Finally, the bulletin proposes an approach to the cost-sharing reductions available in some circumstances in the Exchange. The health plans offered through the Exchange will have actuarial values associated with their metal tier. Health care reform requires that the value of specific plans be increased for certain low-income individuals with household incomes of 250 percent or less of the federal poverty level (FPL). These cost-sharing reductions will be based on the silver level of benefits. They will affect individuals as follows:

Household Income	Silver Plan Value	Cost-Sharing Reduction Value
133% - 150% of FPL	70% Value	94%
151% - 200% of FPL	70% Value	87%
201% - 250% of FPL	70% Value	73%

The bulletin proposes that insurers offering silver plans will need to construct three additional silver plan options to meet the actuarial values accounting for cost-sharing reductions. It proposes achieving these values by reducing out-of-pocket maximums, if possible. The carrier will project the cost of providing the higher-level benefit plan based on membership. The government will provide funding to cover expected costs monthly and will reconcile the advanced payments to the actual cost-sharing reductions annually.

Frequently Asked Questions About Summary of Benefits and Coverage

The Department of Treasury, the Department of Health and Human Services and the Department of Labor (the Departments) recently answered frequently asked questions (FAQs) regarding the summary of benefits and coverage (SBC). Final guidance on the SBCs was issued in February. You can find details on that guidance in our *Reform Update* at http://www.mcwent.com/Reform_Update/2012/Reform_Update_39.pdf.

The answers reaffirm some of the information in the final regulations. They also clarify key issues, including:

- **Compliance Approach:** During the first year, the Departments will not penalize plans that are working in good faith to comply with the rules. Instead, they will focus on reviewing the steps stakeholders have taken to comply with the SBC requirement. Their approach will be prescriptive, not penalty focused.
- **Single SBC:** Plans may produce only one SBC for each plan option. To that end, plans can include information that may differ depending on coverage election. One SBC, for example, can reflect single and family deductibles and single and family out-of-pocket maximums. However, the examples should use self-only coverage. The examples should specify self-only coverage is assumed.
- **Carve-Outs:** The intention is to include information regarding benefit carve-outs in the SBC. Employers may carve out prescription drug coverage or, in some cases, mental health and substance abuse coverage. The Departments anticipate that employers will enter into agreements with service providers to provide the information required in the SBC. The Departments will also limit enforcement of these arrangements, as long as the employer takes steps to obtain correct information to complete the SBC.
- **COBRA Beneficiaries:** COBRA beneficiaries must receive SBCs. A qualifying event does not trigger the requirement to provide an SBC. However, open enrollment rights do apply to COBRA beneficiaries. At open enrollment, plans will be required to provide an SBC for the plan in which the COBRA beneficiary is enrolled.
- **Electronic Posting:** Employers may post SBCs on the internet for eligible individuals that are not enrolled if:
    - The format is readily accessible.
    - A paper copy of the SBC is available free upon request.
    - The plan provides a postcard or e-card (a card sent by e-mail) that states the location of the SBC and the importance of the document.

Sample language was provided for the postcard:

> **Availability of Summary Health Information**
> As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
>
> Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.
>
> The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).

- **Culturally and Linguistically Appropriate:** The county of residence determines whether the SBC needs to state it is available in another language. In counties where 10 percent or more of the population is literate in the same non-English language, the SBC must state in the non-English language that it is available in that language upon request.

  Sample statement language in Spanish, Chinese, Tagalog and Navajo can be found in the model notice for adverse benefit determinations at http://www.dol.gov/ebsa/IABDModelNotice2.doc.

  In addition, the government will post county-by-county data at http://www.cciio.cms.gov/resources/factsheets/clas-data.html.

  Written translations of the entire SBC in Spanish, Chinese, Tagalog and Navajo will be available at http://www.cciio.cms.gov/programs/consumer/summaryandglossary/index.html.

- **SPD References:** The SBC cannot substitute a reference to the SPD (Summary Plan Description) to fulfill any content requirements. The SBC can, however, refer to the SPD in the footer as a place to find more information. In completing a requirement, the plan can even explain where to find the issue in the SPD. However, the SBC itself must include the required content.

- **Headers and Footers:** The SBC template has headers and footers included on all pages. However, they are not required, so the plan can choose to include the header only on the first page or include the footer on the first and last pages only. The OMB number used in the sample template should not be included on any SBC a plan creates.

- **Coverage Period:** The header of the SBC includes a coverage period. This data element is intended to reflect the coverage period for the group health plan overall. If the plan year is a calendar year, then the coverage period is considered the calendar year.

- **Miscellaneous Formatting Issues:**
  - Although plans can make minor adjustments to row and column sizes, they cannot delete a row or column.
  - Plans may continue plan information from one page to the next.
  - Plans can use generic terms to identify coverage options, such as "standard option" or "high option." These terms should correlate with your plan option names.
  - The insurance carrier and plan names can be used interchangeably.
  - Plans can add bar codes or control numbers to the SBC for quality control purposes.
  - The SBC may state a plan is grandfathered; however, such a statement is not required.

At this point, the Departments do not intend to make any global changes to the SBC template. However, they may choose to refine the SBCs if they identify potential issues.

A copy of the SBC in Word format can be found at http://cciio.cms.gov/resources/other/index.html#sbcug. Select the standard format option.

Formalized Guidance on the Coverage Expansion for Women's Preventive Care Services

The Departments of Treasury, Labor, and Health and Human Services just released an Advanced Notice of Proposed Rulemaking, clarifying the requirement to expand coverage for contraceptives. The details addressing the expansion of women's preventive care services can be found in our *Reform Update* at http://www.mcwent.com/Reform_Update/2012/Reform_Update_40.pdf. This latest notice formalized the recent guidance and offered more ideas on providing religious accommodations for contraceptive coverage.

In particular, the Departments reiterated that churches are not required to cover contraceptive services. The Departments are seeking comments on how to define a religious employer to qualify for the coverage exemption. The current narrow definition may be expanded as part of the final regulations.

To accommodate certain organizations, the Departments also clarified the temporary enforcement safe harbor that allows a delay in contraceptive coverage. The safe harbor is available to group health plans sponsored by a non-profit employer that, on or after February 10, 2012, do not provide some or all of the required contraceptive coverage because of religious beliefs. As of now the safe harbor remains in effect until the first day of the first plan year beginning on or after August 1, 2013. The Departments need more time to establish an approach for contraceptive coverage for religious affiliated organizations.

The Departments are committed to developing final regulations that meet two goals:

- Accommodating non-exempt, non-profit organizations with religious objections to covering contraceptive services.

- Ensuring that participants covered under such plans can still receive contraceptive coverage with no cost-sharing.

This notice outlines a number of ideas for meeting these goals:

- If an organization qualifies for the religious accommodation and the plan is insured, the rulemaking proposes that:
    - The organization must notify the insurer that it qualifies for the accommodation. This notice will state that the organization will not act as the designated plan administrator or claims administrator for contraceptive benefits.
    - The insurer will provide coverage, without contraceptives, to these organizations.
    - The insurer will need to create a separate plan to provide contraceptive coverage directly to the participants of these organizations without cost-sharing. This plan would be viewed as "excepted benefits" under HIPAA.
    - The insurer must notify participants directly of the coverage available for contraceptives.
    - There will be no premium charge for the separate contraceptive coverage.
    - The insurer cannot require any cost-sharing from plan participants for contraceptive coverage.
    - Insurers will pay for this coverage with the estimated savings from not having to pay for services participants would have incurred if contraceptives had not been covered.
- If an organization qualifies for the religious accommodation and the plan is self-funded, the Departments intend to reach the same goal as with insured plans. This notice provides a number of options that can be considered:
    - The notice recommends that the plan's TPA (third party administrator) cover plan participants' contraceptives.
    - The TPA would be designated as the plan administrator solely for contraceptive benefits. The TPA would be responsible under ERISA for the contraceptive services coverage only.
    - The TPA would be required to inform plan participants of this benefit.
    - The religious organization would be required to inform the TPA upfront that it qualifies for the religious accommodation. The TPA would not have to enter into a contract for services with the organization if it did not want to accept responsibility for providing contraceptive coverage.
    - The notice suggested several options for covering the cost:
        - The TPA could apply revenue that is not due to plan sponsors, such as drug rebates, service fees, disease management program fees or other sources.
        - The TPA could receive funds from a private non-profit organization.

  - The TPA could receive a rebate under the health care reform reinsurance program. Although this program was not created to reimburse contraceptive expenses for participants in religious organizations' plans, it appears that the Departments may direct the use of reinsurance funds for this purpose.
  - The Departments may decide to identify an insurer that will provide contraceptive services to TPAs with clients that qualify for a religious accommodation. They would contract with at least two multi-state carriers. The costs would be offset by discounting user fees that the insurer would need to pay to operate in the Exchange.
  - Public funding of the contraceptive coverage for self-funded religious employers is also being considered.

- The guidance also clarifies student health insurance options. Student health plans are eligible for the temporary enforcement safe harbor. The Departments indicated they will take an approach similar to the one taken in the group health plan market.

The final regulations will include a process to certify that a religious organization meets the requirements for an accommodation. This self-certification process will be used to notify insurance carriers and TPAs that the plan is eligible for the contraceptive exclusion. Also, the notice would inform carriers and TPAs that they must provide direct coverage to these plans' participants.

Under the proposed rule, religious organizations that qualify for the temporary enforcement safe harbor must notify participants that they will not cover contraceptives under the plan. This notice is seen as a temporary requirement for the delayed effective date. The Departments do not intend for this requirement to be an ongoing responsibility beyond the first year.

Plans can use reasonable medical management techniques to determine the specific items and services where cost-sharing is waived. For example, a plan may cover generic contraceptives with no cost-share, but require cost-sharing for brand name contraceptives. However, if a medical reason to use the brand name exists, then the cost-sharing must be waived in that specific instance for the brand-name contraceptive.

The federal rules requiring contraceptive coverage with no cost-sharing establish a coverage floor. Twenty-eight states require contraceptive coverage in their insured plans. In these states, the federal rules serve as the floor. The state-required coverage cannot be more restrictive than the federal rules. On the other hand, if a state's consumer protections are more generous than the federal requirements, the state can enforce the more generous requirements.

The Departments are seeking direct comments on all the ideas proposed for meeting their two goals:

- Accommodating non-exempt, non-profit organizations with religious objections to covering contraceptives services.
- Ensuring that participants covered under such plans receive contraceptive coverage with no cost-sharing.

In addition, they asked for direct feedback on the following:

- The number of religious organizations and insurers that the contraceptive coverage rules will affect.
- The estimated administrative cost for providing separate contraceptive coverage, including details on the nature of the cost.
- The average cost and savings to health plans, health plan participants and the public for providing contraceptive coverage.

In addition to requesting written feedback, the Departments intend to hold listening sessions to seek ideas about contraceptive coverage requirements.

Remember, these exclusions and accommodations will apply only to religious organizations. Non-religious employers should proceed with expanding coverage for well-women services on their non-grandfathered plans, as of the first day of the first plan year beginning on or after August 1, 2012.