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REFORM Update

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The government recently released two sets of Frequently Asked Questions (FAQs). One set answers questions on Summaries of Benefits and Coverage (SBCs). The other answers a number of questions on other issues, such as annual dollar limits, provider issues and clinical trials.

FAQs - Summaries of Benefits and Coverage (SBCs)

The basic requirements of SBCs are discussed in our *Reform Update* at http://www.mcgrawwentworth.com/Reform_Update/2012/Reform_Update_39.pdf.

An SBC is a four-page, double-sided document summarizing the benefits available under a health plan. The structure and content of SBCs are highly regulated. Plans need to send SBCs to participants as of the first annual enrollment period beginning on or after September 23, 2012. Employers must give newly eligible employees SBCs with their benefit information as of the first day of the first plan year occurring on or after September 23, 2012.

The government issued new templates for employers. These templates are available at http://cciio.cms.gov or http://www.dol.gov/ebsa/healthreform. Employers should use them to explain coverage beginning on or after January 1, 2014 and before January 1, 2015. The FAQs refer to this time period as the second year of applicability.

The only change to the SBC template and sample SBC is the addition of elements required for 2014. A question on page 4 asks whether the coverage provided is considered minimum essential coverage. Minimum essential coverage is an employer-sponsored group health plan that is not considered an excepted benefit plan under HIPAA. The new template also includes a question about whether the plan meets the minimum value standard, which means it must have at least a 60 percent value.

It may be difficult for some employers to adapt the new template for the second year of applicability. The government will not take action against an employer if they use the old template as long as they address the new content. Employers using an old template could include a cover letter with the SBC stating the following:

> **Does this Coverage Provide Minimum Essential Coverage?**
> The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/does not] provide minimum essential coverage.**
>
> **Does this Coverage Meet the Minimum Value Standard?**
> In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value

standard." **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

The government previously indicated that it would change the 2014 SBC to eliminate annual maximums on essential health benefits. However, it did not change the template. The FAQs indicate that the SBC should keep the question "Is there an overall annual limit on what the plan pays." The SBC answer column should say "no." For the second year of applicability, plans may, at their discretion, remove the row with the question regarding annual dollar maximums.

The SBC template will continue to show two coverage examples, one for a normal maternity and the other for managing Type 2 diabetes. The government will not add any new coverage examples for 2014.

The government's approach to enforcing the SBC requirements will continue to be consultative rather than punitive. It will work with employers, insurance carriers and states to help them comply with SBC guidelines.

Insurance carriers do not need to issue SBCs for products they no longer offer.

The FAQs confirm that an anti-duplication requirement still applies. For an insured employer-sponsored health plan, the employer and the insurance carrier must provide the SBC. However, if one party provides it, that would meet the requirement for the other party. The FAQs confirm the anti-duplication requirements also apply to student health insurance coverage.

These FAQs are good news for employers. Changes required for SBCs in 2014 will be minimal. In addition, the government will continue to allow good faith compliance to apply to SBCs.

FAQs – Various Issues

The Departments of Labor, Health and Human Services, and the Treasury jointly published these FAQs, on a variety of compliance issues.

Annual Limit Waivers

Starting in 2010, health insurers and group health plans could ask to waive the annual dollar limit for group health plans. One question inquires whether a plan can change a policy year or plan year to extend the length of the waiver. The answer is no. The government has kept track of the end date of the waivers, which is typically based on the plan year or policy year. For example, if a waiver approval letter states that a waiver is granted for a plan or policy year beginning on April 1, 2013, then the waiver will expire on March 31, 2014. An employer or plan granted a waiver can, however, choose to end the waiver at any time before it expires.

Provider Nondiscrimination Rules

The health care reform act states that a group health insurance carrier or group health plan shall not discriminate against health care providers acting within the scope of their licenses by not allowing them to participate in the plan. The carrier is ***not obligated*** to contract with any provider willing to abide by the terms and conditions for participation the carrier establishes. Carriers or health plans can also vary reimbursement rates based on quality and performance measures.

The FAQs indicate that the Departments do not anticipate issuing any new guidance on this self-implementing provision. It affects non-grandfathered health plans as of the first day of the first plan year beginning on or after January 1, 2014. Until more guidance is issued, health plans must make a good faith effort to interpret the law reasonably. To the extent that an item or service is covered under a health plan and subject to any reasonable medical management techniques, an insurer will not deny coverage based on a provider's license or certification. The provider must, of course, be operating within the scope of the license.

The Departments will work with employers and health plans to help them comply with this provision.

Clinical Trials

Another requirement of health care reform is to cover plan members that participate in specified clinical trials. If a group health plan covers a qualified individual, then such a plan:

1. May not deny participation in an approved clinical trial of a cancer treatment or other life-threatening disease or condition.
2. May not deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial.
3. May not discriminate against patients simply because they participated in the trial.

Qualified individuals are generally those patients eligible to participate in an approved clinical trial according to the trial protocol. In addition, they must meet one of the following two requirements:

1. The referring health care professional is a participating provider who has concluded that participating in the trial would be appropriate.
2. Patients or beneficiaries provide medical and scientific information establishing that participating in the trial would be appropriate.

The Departments do not plan to issue regulations on clinical trials in the near future. They believe the statute is self-implementing. They expect health plans to comply in good faith with their understanding of clinical trial coverage.

Both sets of FAQs will help employers meet specific health care reform requirements in 2014. We can expect to see more FAQs this year as stakeholders begin to comply with the requirements.