Affordable Care Act Implementation Alert

The Affordable Care Act and your self-funded health plan

Independence Administrators

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FREQUENTLY ASKED QUESTIONS ABOUT THE AFFORDABLE CARE ACT IMPLEMENTATION

At Independence Administrators, we know how important it is for you to understand how the health care reform law is changing the future of health care benefits. By providing current information on the interpretation and implementation of the law, we are helping to provide you with the support to help become – and remain – compliant with all its applicable provisions.

The Department of Labor (DOL) periodically issues ***Frequently Asked Questions (FAQs)*** related to various provisions of the Affordable Care Act (ACA). The FAQs are designed to help consumers, plan sponsors, health insurers, and other stakeholders understand the law, become compliant, and benefit from its provisions.

This ACA Implementation Alert highlights the four most recent FAQs – Parts XII through XV – which were released February 2013 through April 2013. We have provided a general overview of their contents and links to the detailed FAQs for your reference.

FAQs: Part XII

Issued February 20, 2013

Part XII of the Frequently Asked Questions addresses the topic of cost-sharing limitations for both large and small employers as stated in the Affordable Care Act. It also answers several specific questions about preventive services coverage.

WHAT SHOULD I KNOW ABOUT LIMITATIONS ON COST-SHARING?

The ACA has two cost-sharing limitations on non-grandfathered group health plans (including self-funded) for plan years that begin in 2014. The first limitation sets an annual out-of-pocket maximum – including deductibles, copays, and coinsurance – for a qualified health plan. The second sets deductible limits on small group (100 employees or fewer) for fully insured plans. The FAQs on this topic address who must comply with deductible limitations and the annual limitation on out-of-pocket maximums, transition relief, and the basis for adjustments in future years.

WHAT SHOULD I KNOW ABOUT COVERAGE OF PREVENTIVE SERVICES?

The interim final regulations require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for a variety of preventive health services, without the imposition of cost-sharing requirements. In general, preventive services include routine immunizations, recommended health screenings, and evidence-based items or services.

There is **no cost-sharing** for:

- visiting an out-of-network provider if there is no in-network provider for a specific preventive service;
- United States Preventive Services Task Force (USPSTF) recommendations:
  - aspirin and other over-the-counter recommended preventive items and services when prescribed by a health care provider;
  - polyp removal during a routine colonoscopy;
  - genetic counseling and BRCA testing (breast cancer susceptibility), if appropriate and recommended;
  - certain preventive services if a provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population.
- vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP);

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- women's preventive services:
  - multiple preventive services may be administered in a single visit, if appropriate;
  - additional "well-woman" visits that may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors;
  - screening and counseling for interpersonal and domestic violence;
  - high-risk Human Papillomavirus (HPV) DNA testing for women with normal cytology results who are 30 years of age or older to occur no more frequently than every three years;
  - annual HIV counseling and screening (including HIV testing) for all sexually active women;
  - approved contraceptive methods (and any related implantation, removal, and medical management) including prescribed over-the-counter methods for women;
  - pre- and postnatal breastfeeding support, counseling, equipment, and supplies, which may include purchase or rental.

FAQs: Part XIII

Issued March 8, 2013

WHAT SHOULD I KNOW ABOUT EXPATRIATE HEALTH PLANS?

Part XIII of the Frequently Asked Questions pertains specifically to the unique challenges that Expatriate Health Plans face in regard to compliance with certain provisions of the Affordable Care Act. In particular, challenges in reconciling and coordinating the multiple regulatory regimes that apply to expatriate health plans might make it impossible or impracticable to comply with all the relevant rules – at least in the near term. The FAQ on this topic provides more detail on which requirements must be satisfied, transitional relief, and which ones are still under review.

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FAQs: Part XIV
Issued April 23, 2013 (corrected)

Summary of Benefits and Coverage

Part XIV of the Frequently Asked Questions addresses issues related to the ACA's requirement that health insurance issuers and group health plans provide participants with a Summary of Benefits and Coverage (SBC). The template and sample completed SBC were first made available in February 2012, but did not include language regarding whether a plan or coverage provides minimum essential coverage (MEC) or meets minimum value (MV) requirements. In April 2013, the DOL issued a new ***SBC template*** and ***sample completed SBC*** that include this information. In addition to changes to the SBC, this FAQ also discusses the specific safe harbor provisions that will be extended as well as an anti-duplication provision for student health insurance coverage.

WHAT SHOULD I KNOW ABOUT THE SBC UPDATES?

The updated SBC applies to the "second year of applicability" – plan years beginning on or after January 1, 2014, and before January 1, 2015.

The FAQs in Part XIV answer specific questions related to:

- templates for the SBC and uniform glossary after the first year of applicability;
- inclusion of information on MEC and MV for SBCs already in process;
- addressing the elimination of annual limits on essential health benefits;
- relief from adding additional coverage examples;
- safe harbors and enforcement relief extension for providing a SBC and a uniform glossary for the first year of applicability;
- extension of safe harbors with respect to insurance products that are no longer offered;
- anti-duplication rule applicability for student health insurance coverage.

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FAQs: Part XV

Issued April 29, 2013

Part XV of the Frequently Asked Questions provides guidance on several different topics: annual limit waiver expiration date, provider non-discrimination, clinical trials, and transparency reporting.

WHAT SHOULD I KNOW ABOUT THE ANNUAL LIMIT WAIVER EXPIRATION DATE BASED ON A CHANGE TO A PLAN OR POLICY YEAR?

The FAQ provides guidance on whether a group health plan or health insurance issuer – that was granted a waiver from the annual limits requirements – can extend the expiration date of the waiver if the plan year changes prior to the waiver expiration date. The response explains why changing the plan year does not change the waiver expiration date.

WHAT SHOULD I KNOW ABOUT PROVIDER NON-DISCRIMINATION?

The Affordable Care Act imposed provider non-discrimination requirements that are applicable to non-grandfathered group health plans and health insurance issuers for plan years beginning on or after January 1, 2014. The ACA states that group health plans and health insurance issuers may not discriminate against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. However, it does not require that they contract with a provider willing to abide by the terms and conditions for participation, nor does it prevent them from establishing varying reimbursement rates based on quality or performance measures. The regulation was written as self-implementing, so there are no plans to issue additional regulations regarding provider non-discrimination rules prior to its effective date.

WHAT SHOULD I KNOW ABOUT COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS?

The ACA published regulations regarding coverage of individuals participating in approved clinical trials for the treatment of cancer or other life-threatening diseases or conditions. According to the guidelines, group health plans and health insurance issuers may not deny the individual participation in the clinical trial, or coverage of routine patient costs in connection with participation. Nor may they discriminate against the patient for his or her participation in it. The requirements are applicable to non-grandfathered group health plans and health insurance issuers for plan years beginning on or after January 1, 2014. The regulation was written as self-implementing, so there are no plans to issue additional regulations regarding participation in clinical trials prior to its effective date.

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WHAT SHOULD I KNOW ABOUT TRANSPARENCY REPORTING?

According to the ACA regulations regarding transparency reporting, health insurance issuers seeking certification of a health plan as a qualified health plan must make accurate and timely disclosures of certain information to the appropriate Health Insurance Marketplace (also known as the Exchange), the Secretary of Health and Human Services, the state insurance commissioner, and to the public. The FAQ also provides guidance around when plans and issuers need to comply with the transparency reporting requirements.

HOW CAN INDEPENDENCE ADMINISTRATORS HELP?

To learn more about how Independence Administrators can support you in complying with the requirements of the Affordable Care Act, or if you have questions about your plan, please contact your Independence Administrators account representative.

Independence Administrators does not provide legal or tax advice. The final determination of whether the Plan Sponsor meets the requirements of the Affordable Care Act must be made by the Plan Sponsor in consultation with the employer's own legal counsel or tax advisor.

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