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Health Care Reform Management Alert Series

Tri-Agency FAQs Address Annual Limit Waivers, Provider Selection, Clinical Trials and Transparency Notices

Issue 64

This is the sixty-fourth issue in our series of alerts for employers on selected topics on health care reform. (Click here to access our general Summary of Health Care Reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

Recent tri-agency FAQs address a number of upcoming requirements under the Affordable Care Act, as described below.

Annual Limit Waivers - Expiration Date

What did we already know?

The Affordable Care Act prohibits plans from placing annual or lifetime dollar limits on essential health benefits. But, to help ease into 2014 when the new "marketplaces" become available, HHS implemented a waiver program allowing certain plans to continue imposing annual dollar limits on these benefits. The waiver program was primarily aimed toward so-called "mini-med" plans that have an overall annual limit on all benefits (e.g., the plan does not pay a single dollar after the participant receives $10,000 in benefits for the year). The rationale behind the waivers: A mini-med plan is better than no plan, at least before 2014 when the marketplaces become available. Waivers issued under the program generally expire at the end of the plan year ending on or after December 31, 2013. So, off-calendar year plans might not be required to comply with the dollar limit prohibition until mid-2014.

[✓] Applies to grandfathered plans

[✓] Applies to new health plans

What does the new guidance say?

HHS granted waivers based on the plan year in effect when the plan sponsor applied for the waiver. So, even if a plan sponsor changes insurers or plan years, the compliance deadline will not change. For example, if a plan sponsor applied for a waiver based on a plan year ending April 30, but later changes to a plan year ending on November 30, the waiver will still end on April 30, 2014, and the plan must comply (i.e., remove all annual dollar limits on essential health benefits) beginning May 1, 2014.

Coverage for Routine Costs Relating to Clinical Trials

[ ] Applies to grandfathered plans

[✓] Applies to new health plans

What did we already know?

For plan years beginning on or after January 1, 2014, nongrandfathered plans (both self-funded and fully-insured) must cover routine patient costs relating to certain approved clinical trials for the treatment of cancer or another life-threatening condition. To be clear, plans are not required to cover the cost of the clinical trial itself (e.g., the device or service), just the routine related patient

costs (e.g., hospital stay, etc.).

What does the new guidance say?

The agencies confirmed that this provision is effective for plan years beginning on or after January 1, 2014, but indicated that the agencies will not issue guidance before that date. Instead, plans should move forward using a good faith, reasonable interpretation of the law.

No Discrimination In Provider Selection

What did we already know?

For plan years beginning on or after January 1, 2014, nongrandfathered plans may not discriminate against health providers that are acting within the scope of their licenses or certification under state law. However, this provision does not require plans to contract with providers who are unwilling to abide by the terms of the plan or accept network reimbursement rates. Further, plans may establish varying reimbursement rates based on quality or performance measures.

[ ] Applies to grandfathered plans

[✓] Applies to new health plans

What does the new guidance say?

The agencies confirmed that this provision is effective for plan years beginning on or after January 1, 2014, but indicated that the agencies will not issue guidance before that date. Instead, plans should move forward using a good faith, reasonable interpretation of the law.

Transparency Disclosure

What did we already know?

Nongrandfathered plans must disclose to HHS and make available to the public certain information including (but not limited to):

- Claims payments practices
- Data on enrollment/disenrollment
- Data on the number of claims denied
- Information on cost-sharing and out-of-network coverage

[ ] Applies to grandfathered plans

[✓] Applies to new health plans

What does the new guidance say?

The guidance clarified that this requirement (originally effective in 2014) will be delayed at least one year, until 2015. The requirement will only become effective after the agencies issue further guidance.

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