

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XV)

April 29, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cciio.cms.gov/resources/factsheets/index.html>), these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended.

Annual Limit Waiver Expiration Date based on a Change to a Plan or Policy Year

Q1: If a group health plan or health insurance issuer that was granted a waiver from the annual limits requirements under Public Health Service Act (PHS Act) section 2711 changes its plan year (or, in the individual market, policy year) prior to the waiver expiration date, can that change modify the expiration date of the waiver?

No. Changing the plan year (or, in the individual market, policy year) does not change the waiver expiration date. Annual limit waivers under PHS Act section 2711¹ were approved by HHS for the plan or policy year in effect when the plan or issuer applied for the waiver. The same holds true for waiver extensions. They extended the waiver based on the date of the plan or policy year in effect when the initial application was submitted. As a result, waiver recipients that change their plan or policy years will not extend the expiration date of their waivers.

For example, if a waiver approval letter states that a waiver is granted for an April 1, 2013 plan or policy year, the waiver will expire on March 31, 2014, regardless of whether the plan or issuer later amends its plan or policy year. That said, waiver recipients may terminate the waiver at any time prior to its approved expiration date, for example, on December 31, 2013 rather than on March 31, 2014.

¹ The annual limit waiver program was established in the June 28, 2010 interim final regulations (IFR) (codified at 26 CFR 54.9815-2711T; 29 CFR 2590.715-2711; and 45 CFR 147.126) that implemented PHS Act section 2711, as amended by the Affordable Care Act. PHS Act section 2711 generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage (other than with respect to non-grandfathered individual health plans) from imposing lifetime or annual limits on the dollar value of essential health benefits, but allows “restricted annual limits” with respect to essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for plan years (in the individual market, policy years) beginning before January 1, 2014. The IFR provided that these restricted annual limits may be waived by the Secretary of HHS if compliance with the IFR would result in a significant decrease in access to benefits or a significant increase in premiums. Subregulatory guidance issued by HHS set forth the process for obtaining such a waiver. For a listing of relevant guidance, see <http://cciio.cms.gov/resources/regulations/index.html#alw>.

Additionally, HHS requested that each plan or issuer provide its effective dates of coverage as part of its annual limit waiver application, in part so that HHS would have a record of the waiver's expiration date. As noted in the Technical Instructions,² waiver recipients must retain all records pertaining to their waiver applications to permit HHS to conduct audits of waiver applications. If there is a discrepancy between the plan or policy year in an original application and a subsequent annual update, HHS may review the waiver to determine whether the group health plan or health insurance issuer is in compliance with HHS's policy on annual limit waivers.

Provider Non-Discrimination

PHS Act section 2706(a),³ as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." PHS Act section 2706(a) does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." Similar language is included in section 1852(b)(2) of the Social Security Act⁴ and implementing HHS regulations.⁵

Q2: Will the Departments be issuing regulations addressing PHS Act section 2706(a) prior to its effective date?

² See Technical Instructions, page 3, [http://ccio.cms.gov/resources/files/annual%20 limit waivers technical instructions update 081911.pdf](http://ccio.cms.gov/resources/files/annual%20limit%20waivers%20technical%20instructions%20update%20081911.pdf). (June 17, 2011).

³ PHS Act section 2706(a) also is incorporated into section 715(a)(1) of the Employee Retiree Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (the Code). Accordingly, the Departments have concurrent jurisdiction over the implementation of PHS Act section 2706(a).

⁴ Section 1852(b)(2) of the Social Security Act provides that "A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan."

⁵ 42 CFR 422.205 provides, in part, that a "[Medicare Advantage] organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision." Section 422.205 further provides that it "does not preclude any of the following [actions] by the MA organization: (1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis); (2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty; [and] (3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities."

No. The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.

Coverage for Individuals Participating in Approved Clinical Trials

In general, PHS Act section 2709(a),⁶ as added by the Affordable Care Act, states that if a group health plan or health insurance issuer in the group and individual health insurance market provides coverage to a qualified individual (as defined under PHS Act section 2709(b)), then such plan or issuer: (1) may not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial.

⁶ PHS Act section 2709 also is incorporated into section 715(a)(1) of ERISA and section 9815(a)(1) of the Code. Accordingly, the Departments have concurrent jurisdiction over the implementation of PHS Act section 2709.

A qualified individual under PHS Act section 2709(b) is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Q3: Will the Departments be issuing regulations addressing PHS Act section 2709 prior to its effective date?

No. The statutory language of PHS Act section 2709 is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2709 is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

Until any further guidance is issued, group health plans and health insurance issuers are expected to implement the requirements of PHS Act section 2709 using a good faith, reasonable interpretation of the law. The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the law and will work with families and individuals to help them understand the coverage for clinical trials provision and benefit from it as intended.

For questions about the coverage for clinical trials provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.

Transparency Reporting

Under section 1311(e)(3) of the Affordable Care Act, as implemented by regulations at 45 CFR 155.1040(a) and 156.220, health insurance issuers seeking certification of a health plan as a qualified health plan (QHP) must make accurate and timely disclosures of certain information to the appropriate Health Insurance Marketplace (also known as Exchange), the Secretary of HHS, and the state insurance commissioner, and make it available to the public. Section 2715A of the PHS Act,⁷ as added by the Affordable Care Act, extends the transparency reporting provisions under section 1311(e)(3) to non-grandfathered group health plans and health insurance issuers offering group or individual coverage, except that a plan or coverage not offered through an

⁷ PHS Act section 2715A also is incorporated into section 715(a)(1) of ERISA and section 9815(a)(1) of the Code. Accordingly, the Departments have concurrent jurisdiction over the implementation of PHS Act section 2715A.

Exchange shall only be required to submit such information to the Secretary of HHS and state insurance commissioner, and make the information public.

Q4: When do plans and issuers have to comply with the transparency in coverage reporting requirements under section 1311(e)(3) of the Affordable Care Act and section 2715A of the PHS Act?

Section 1311(e)(3) of the Affordable Care Act, as implemented at 45 CFR 155.1040(a) and 156.220, requires QHP issuers to submit specified information to the Marketplace and other entities in a timely and accurate manner. However, because QHP issuers will not have some of the data necessary for reporting under this requirement until during or after the first year of operation of their QHPs (e.g., QHP enrollment and disenrollment), HHS is clarifying that, in order to comply with section 1311(e)(3) as implemented at 45 CFR 155.1040(a) and 156.220, QHP issuers will begin submitting information only after QHPs have been certified as QHPs for one benefit year.⁸

Similarly, because section 2715A of the PHS Act simply extends the transparency provisions set forth in section 1311(e)(3) of the Affordable Care Act to group health plans and health insurance issuers offering group and individual health insurance coverage, the Departments clarify that the reporting requirements under section 2715A of the PHS Act will become applicable to group health plans and health insurance issuers offering group and individual health insurance coverage no sooner than when the reporting requirements under section 1311(e)(3) of the Affordable Care Act become applicable. As previously stated, the Departments will coordinate regulatory guidance on the transparency in coverage standards for coverage offered inside and outside of the Marketplaces.⁹

⁸ Benefit year is defined as a calendar year for which a health plan provides coverage for health benefits. 45 CFR 155.20.

⁹ See Preamble to the Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310, 18417 (March 27, 2012).