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CLIENT BULLETIN

Upcoming 2011 Compliance Dates For Group Healthcare Plans

This *Client Bulletin* will review select 2011 compliance dates for multiemployer group healthcare plans. The dates are a mix of new compliance dates under the *Patient Protection and Affordable Care Act (PPACA)* and reminders of other established dates such as *Part D* reporting as well as for the *Mental Health Parity and Addiction Equity Act of 2008* (*MHPAEA*).

Selected 2011 Healthcare Plan Compliance Dates

TOPIC	COMPLIANCE DATE(S)
Patient Protection and Affordable Care Act (PPACA) ***NEW!!!***	1st day of 1st Plan Year beginning on or after September 23, 2010
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (***Check your CBA if on delayed rule***)	Later of Plan Years beginning on or after January 1, 2010 or expiration date of CBA in effect on or before October 3, 2008.
Medicare D Creditable Coverage Disclosure to CMS	Within 60 days after beginning of Plan Year (March 1, 2011 for CY Plans)
Medicare D Creditable Coverage Notices to Medicare Beneficiaries	Generally on or before November 15th each year.
Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCD ***(Coming Soon!)***	*HIPAA* 5010 code sets by January 1, 2012 and ICD-10 code set by October 1, 2013.

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Patient Protection and Affordable Care Act (PPACA)

This portion of this *Client Bulletin* focuses on health care reform compliance dates under the PPACA, generally called the *Affordable Care Act* (or ACA) for grandfathered and non-grandfathered self-insured group health plans. Requirements applicable to insured groups or individual market health plans are not included in this discussion.

A grandfathered health plan is one which was in existence on March 23, 2010 and which has maintained grandfathered status. A non-grandfathered health plan is a grandfathered plan that lost its grandfathered status or a new plan in existence after March 23, 2010. A chart showing reforms applicable to each type of plan is available by "*clicking here*." A summary entitled *Grandfathered Plan Status - How to Keep It or Lose It* is available by "*clicking here*."

Important Websites to Bookmark

Published guidance and other information about the *Affordable Care Act* is available at: *http://www.hhs.gov/ociio/regulations/index.html* and also at the DOL website at: *http://www.dol.gov/ebsa/healthreform/.*

The *section below* lists effective dates of reforms applicable to ***both*** **grandfathered and non-grandfathered group health plans**. Grandfathered and non-grandfathered Plans must comply with the following reforms by the **first day of the first Plan Year beginning on or after September 23, 2010**, unless otherwise noted. For calendar year plans, that is January 1, 2011. The chart below lists compliance dates based on Plan Year. Note plans with Plan Years beginning on October, November or December 1st needed to be compliant in 2010.

Plan Year Beginning	Compliance Date
October 1	October 1, 2010
November 1	November 1, 2010
December 1	December 1, 2010
January 1	January 1, 2011
February 1	February 1, 2011
March 1	March 1, 2011
April 1	April 1, 2011
May 1	May 1, 2011
June 1	June 1, 2011
July 1	July 1, 2011
August 1	August 1, 2011
September 1	September 1, 2011

The following are reforms applicable to both grandfathered and non-grandfathered plans by the first day of the first Plan Year beginning on or after September 23, 2010. They are broken down into changes affecting both grandfathered and non-grandfathered plans.

Grandfathered and Non-grandfathered Plans

- No *lifetime* limits on coverage;
- Prohibition on "unreasonable" *annual* limits on essential benefits (3-year phase-in allowed under regulations);
- No *rescissions* of coverage unless for fraud (a rescission is a retroactive cancellation of coverage – prospective cancelations are not rescissions);
- Extension of dependent coverage to age 26 (plans may exclude coverage if the dependent has coverage available through their own employer); *HOWEVER, non-grandfathered plans must offer age 26 coverage even if the dependent has other employer-sponsored coverage available;*
- No *pre-existing conditions exclusions* for children under 19; and
- Development and utilization of uniform explanation of coverage documents and standardized definitions. (These standards are to be developed by March 23, 2011 and group health plans will be required to use such documents and information for participants and others by **March 23, 2012**. *See Benefit News Briefs 2011-01 for update)*

The section below lists reforms applicable only to non-grandfathered plans. These reforms are generally applicable to such plans on the **first day of the first Plan Year beginning on or after September 23, 2010**. For calendar year plans, that is January 1, 2011. These reforms are in addition to the requirements applicable to both grandfathered and non-grandfathered plans discussed above. The Plan Year beginning and Compliance Date Chart would also apply to non-grandfathered plans for these reforms.

Non-grandfathered Plans Only

- Coverage of recommended *preventative services* with no cost sharing (*Benefit News Briefs 2010-57*);
- Patient protections such as *guaranteed access* to OB-GYNs and pediatricians (model notice at *Benefit News Briefs 2010-53*);
- *Appeals process* for appeals of coverage determinations and claims (includes internal appeals and external review, see *Benefit News Briefs 2010-59, 2010-63* and *2010-68 (grace period for certain external review rules until July 1, 2011*); and
- Coverage of *emergency services* without prior authorization and at the same cost sharing as in-network.

All of these changes have been discussed in detail in various Research Department publications, several are noted above.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

The new law is generally effective the later of Plan Years beginning on or after January 1, 2010 or the expiration date of the collective bargaining agreement (CBA) in effect on or before October 3, 2008, without regard to any extensions thereof. By now many plans are subject to the law, but there may still be plans not yet subject due to the delayed date of collectively bargained plans. ***Now is a good time to review your plan's effective date if it qualified for a delayed date due to the CBA rule.***

Regulations were issued on February 2, 2010, as well as later follow-up guidance. See *Special Bulletin* 2010-09 (regulations) and *Special Bulletin* 2010-52 (FAQ) and *Benefit News Briefs* 2011-01 (more FAQs).

The *MHPAEA* concurrently amends several laws including *ERISA* and the *Code* by amending the prior *Mental Health Parity Act (MHPA)* and is briefly summarized below.

The prior *MHPA* provided for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with the limits on medical/surgical benefits. The *MHPA* did not require parity for substance abuse or chemical dependency. The *Wellstone/Domenici Act* changed this and now requires parity for "mental health" benefits and also for "substance use disorder" benefits.

The *MHPAEA Act* does NOT require group health plans (GHP) to offer *mental health* or *substance abuse* benefits. However, if a GHP does provide both medical and surgical benefits along with mental health and/or substance use disorder benefits, the plan must impose the same *lifetime* and *annual limits* to the mental health and substance use disorder benefits as currently provided under the plan for medical and surgical benefits, as well as comply with the other rules set out below.

The deductibles, copayments, coinsurance and out-of-pocket expenses of *mental health* or *substance use disorder benefits* must be no more restrictive than the deductibles, copayments, coinsurance and out-of-pocket expenses applied to *substantially all medical* and *surgical benefits* covered by the plan. No separate cost sharing requirements applicable only to mental health or substance use disorder benefits are allowed.

In addition, the "*treatment limitations*" applicable to the plan's mental health or substance use disorder benefits must be no more restrictive than the *predominant treatment limitations* applied to *substantially all* medical and surgical benefits covered by the plan. Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment. No separate treatment limitations applicable only to mental health or substance use disorder benefits are allowed.

The law contains a cost exemption similar to the increased cost exemption under the *MHPA* and provides for a one-year exemption from the *MHPAEA* if costs to a plan increase 2% the first year or 1% any subsequent year due to the law. Detailed criteria for calculating the plan's increased costs are included in the law.

Two other significant changes are: (1) requiring disclosure of the criteria for "medical necessity" determinations on mental health or substance use disorder benefits and (2) requiring plans that provide coverage for medical or surgical benefits by out-of-network providers to provide coverage for mental health or substance use disorder benefits by out-of-network providers.

Medicare D Creditable Coverage Disclosure to CMS

Healthcare plans that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage."

This disclosure to CMS is required whether the entity's coverage is primary or secondary to Medicare. **The Disclosure to CMS Form is due no later than 60 days following the beginning of the healthcare plan's Plan Year** (renewal year, contract year, filing year, etc.). That would be **March 1, 2011** for calendar year plans, etc.

If a healthcare plan does not offer prescription drug benefits to any Medicare Part D eligible individuals on the beginning date of their Plan Year (renewal year, contract year, etc.), the plan is not required to complete the disclosure to CMS form for that plan year.

Entities **must** use the online Creditable Coverage Disclosure Form to disclose its creditable coverage status to CMS. The Form and helpful information can be found at Disclosure to CMS Guidance and Instructions at:
https://www.cms.hhs.gov/CreditableCoverage/40_CCDislcosure.asp#TopOfPage.

The website has the Disclosure to CMS Form, Creditable Coverage Disclosure to CMS Guidance and Creditable Coverage Disclosure to CMS Form Instructions and Screen Shots and other helpful links and information.

Medicare D Creditable Coverage Notices to Medicare Beneficiaries

By November 15th of each year, health plans that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the entity's coverage is "creditable prescription drug coverage" (Disclosure Notice). A Disclosure Notice is required whether the entity's coverage is primary or secondary to Medicare. Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage.

The Centers for Medicare and Medicaid Services (CMS) has posted Guidance and Creditable Coverage Notices are for use after January 1, 2009, which are available at: *http://www.cms.gov/CreditableCoverage/.*

The Disclosure Notice must be provided to all Part D eligible individuals who are covered under, or who apply for, the entity's prescription drug coverage. Neither the statute nor the regulations create any exemption based on whether prescription drug coverage is primary or secondary coverage to Medicare Part D.

Thus, for example, the Disclosure Notice requirement applies with respect to Medicare beneficiaries covered by the Plan who are:

- active employees,
- disabled,
- on COBRA,
- retired, and
- covered as spouses or dependents (including those spouses or dependents that may be disabled or on COBRA) under active employee coverage or retiree coverage.

Generally, an individual is a Part D eligible individual if the individual is "entitled" to Medicare Part A and/or enrolled in Part B.

An individual becomes "entitled to" Medicare Part A when the person actually has Part A coverage, and not simply when the person is first eligible. A person has Part A coverage without being subject to monthly Part A premiums if the person has attained age 65 and has monthly social security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability. An individual who is eligible for social security benefits but has not applied for such benefits becomes entitled to Medicare Part A only upon the filing of an application for Part A benefits.

Technically, the notice requirement under 42 CFR Section 423.56(f) specifies Disclosure Notices must be made to Part D eligible individuals, at a minimum, at the following times:

1. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) – beginning November 15th through December 31st of each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D, as described under Section 423.38(a);
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. Upon request by the individual.

If the Disclosure Notice is provided to all plan participants annually, prior to November 15th of each year, *CMS will consider items 1 and 2 to be met.* This guidance clarifies that "*prior to*" means that the individual must have been provided the Disclosure Notice within the past twelve months.

Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS

The compliance dates for new *HIPAA* transaction and code set requirements are coming soon. See *Research Memo 2008-41* for details. Covered entities, including all group health plans, using electronic transactions must implement new versions of the *HIPAA* standard transactions by January 1, 2012, and use the ICD-10 code set by October 1, 2013.

The National Center for Health Statistics (NCHS) has recently completed a crosswalk that maps ICD-9-CM Volumes 1 and 2 to ICD-10-CM. CMS also developed a crosswalk that maps ICD-9-CM Volume 3 to ICD-10-PCS. These crosswalks are revised each fall and are available at: *http://www.cms.hhs.gov/ICD10.*

The following charts compare ICD-9 and ICD-10 Diagnosis and Procedure codes:

Comparison of ICD-9-CM versus ICD-10-CM and ICD-10-PCS Comparison

ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
3-5 characters in length	3-7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric	Digit 1 is alpha; Digits 2 and 3 are numeric; Digits 4-7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality
Difficult to analyze data due to non-specific codes	Specificity improves coding accuracy and richness of data for analysis
Codes are non-specific and do not adequately define diagnoses needed for medical research	Detail improves the accuracy of data used for medical research
Does not support interoperability because it is not used by other countries	Supports interoperability and the exchange of health data between other countries and the U.S.

Comparison of ICD-9-CM versus ICD-10-CM and ICD-10-PCS Comparison

ICD-9-CM Procedure Codes	ICD-10-PCS Procedure Codes
3-4 numbers in length	7 alpha-numeric characters in length
Approximately 3,000 codes	Approximately 87,000 available codes
Based upon outdated technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality
Generic terms for body parts	Detailed descriptions for body parts
Lacks description of methodology and approach for procedures	Provides detailed descriptions of methodology and approach for procedures
Limits DRG assignment	Allows DRG definitions to better recognize new technologies and devices
Lacks precision to adequately define procedures	Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information

More information about the ICD-10 codes can be found at: *http://www.cms.hhs.gov/ICD10/01_Overview.asp*.

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