United Actuarial Services, Inc.
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CLIENT BULLETIN

Upcoming 2012 Compliance Dates For Group Healthcare Plans

This *Client Bulletin* will review select 2012 compliance dates for multiemployer group healthcare plans, including a mix of new compliance dates under the *Affordable Care Act (ACA)* and reminders some *Part D* reporting dates.

The United States Supreme Court is set to hear oral arguments on the constitutionality of the *ACA* in March of this year and a decision is expected to be announced in June. That decision may impact compliance with the *ACA*. Until then, plans must move ahead as the *ACA* is still the law of the land. We will report on the Court's decision once issued.

Selected 2012 Healthcare Plan Compliance Dates

TOPIC	COMPLIANCE DATE(S)
Affordable Care Act (ACA) **Grandfathered and Non-Grandfathered Plans**	
• ***Lifetime/Annual Limits**** ➢ $1,250,000 ➢ $2,000,000 *(unless the plan has a "waiver")	Plan Years beginning on or after: ➢ 9/23/11, but before 9/23/12 ➢ 9/23/12, but before 1/1/14
• ***Submission Of Error-Free Claims Lists For Plans Participating In ERRP Subsidy***	March 30, 2012
• ***Summary of Benefits and Coverage (SBC)***	March 23, 2012 date delayed!
• ***Comparative Clinical Effectiveness Research Fees***	Plan years ending after 9/30/12 Program ends 2019
• ***"Waiver of Annual Limits" Submission***	December 31, 2012

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Selected 2012 Healthcare Plan Compliance Dates	
TOPIC	**COMPLIANCE DATE(S)**
Affordable Care Act (ACA) **Non-Grandfathered Plans**	
• ***Internal Claims and Appeals*** ➢ Identifying Requirements ➢ Reasons for Denial ➢ Description of Processes	Plan years beginning on or after July 1, 2011
• ***Internal Claims and Appeals*** ➢ "Culturally and Linguistically Appropriate" Notices ➢ Diagnosis & Treatment Codes ➢ Deemed Exhaustion or Remedies ➢ Urgent Care Deadlines	Plan Years beginning on or after January 1, 2012
• ***External Review Obligations*** ➢ self-funded plans contract with two IROs for external review to qualify for safe harbor. ➢ self-funded plans contract with three IROs for external review to qualify for safe harbor.	➢ January 1, 2012 ➢ July 1, 2012
Medicare D Creditable Coverage	
• ***Disclosure to CMS***	60 days after start of Plan Year (March 1, 2012 for CY Plans)
• ***Notices to Medicare Beneficiaries***	Generally on or before October 15 each year.

Patient Protection and Affordable Care Act (ACA)

This portion focuses on health care reform compliance dates under the *ACA* for Grandfathered and Non-Grandfathered self-insured group health plans, including multiemployer 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 *ACA* is available at:

HHS - *http://cciio.cms.gov/*

DOL- *http://www.dol.gov/ebsa/healthreform/*

IRS - *http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6*

Reforms for Both Grandfathered and Non-Grandfathered Plans

There are three compliance items under the *ACA* for 2012. These are: (1) Lifetime/Annual Limits; (2) Summary of Benefits and Coverage (SBC); and (3) Comparative Clinical Effectiveness Research Fees.

Lifetime/Annual Limits

The *ACA* prohibited health plans from having a lifetime limit on the dollar amount of benefits for any individual, but allow an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the amounts in the following schedule:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.
- For plan years beginning on or after January 1, 2014, no annual limits.

However, if the plan has a "waiver" from annual limits the above rules do not apply.

For plans without waivers, some plans are amending their annual limits each year to reflect the annual limits allowed for that plan year while other plans were amended to include the whole transition period. Plans that did not amend for the whole transition period will want to make sure that their annual limit is amended for the remaining transition years.

Submission Of Error-Free Claims Lists To ERRP

In September of 2011, the ERRP announced a new, fully-automated review system giving detailed feedback on Claims Lists, new flexibility in the permitted layouts for Claims Lists, and an **extended deadline** for submitting detailed Claims Lists for prior reimbursements from December 31, 2011 to **March 30, 2012**.

Given this expedited feedback, all Claim Lists submitted on or after October 3 must be error-free in order for the plan sponsor to be able to submit a reimbursement request, and then be approved for payment. If a Claim List is determined to be invalid as a result of the automated review and cancelled from the system, the sponsor may resubmit a corrected Claim List. For a Claim List to be deemed error-free, it must pass the automated review. See *Benefit News Briefs 2011-59*.

Plan Sponsors must not include any claim lines with an "incurred date" after December 31, 2011 in their Claim Lists. If health benefit items or services with later incurred dates are submitted, the entire Claim List will be deemed invalid and the Claim List Response File will return errors for those claim lines which have incurred dates after December 31, 2011. See *Benefit News Briefs 2011-82*.

Summary of Benefits and Coverage (SBC)

Originally set for a March 23, 2012 compliance date, the 4-page SBC requirement has been delayed ***until*** *final regulations are issued.* ***HHS stated the final regulations will have a delayed implementation date.*** See *Benefit News Briefs 2011-79*.

While this news took some pressure off of plan sponsors, the SBC deadline will eventually come. Plans may still wish to do the initial review of the plan document, SPD and draft SBC template in preparation of the final regulations. We will report on the final regulations once issued.

Comparative Clinical Effectiveness Research Fees

This fee applies each plan year ending after September 30, 2012. Therefore, the first plan year to which the fee on an applicable self-insured health plan applies would be a plan year that ends on or after October 1, 2012. The fee does not apply to plan years ending after September 30, 2019. Accordingly, if the plan year were the calendar year, the fee would apply to calendar plan years 2012 through 2018. See *Benefit News Briefs 2011-40*.

> The fee is equal to $2 multiplied by the average number of lives covered under the plan ($1 in the case of plan years ending before October 1, 2013).
>
> The fee must be paid by the plan sponsor, which is the board of trustees in a multiemployer plan.

The IRS has solicited comments on how to administer collection of the fee, but no mechanism is yet in place to collect the fees. Plan sponsors should be aware the day will come to pay the fee. See *Benefit News Briefs 2011-40*.

"Waiver of Annual Limits" Submission

The *ACA* allows health plans temporary waivers to the *ACA*'s phase out of annual dollar limits if compliance with the new annual benefit minimums would result in a

significant decrease in access to benefits or a significant increase in premiums. These waivers are temporary and after 2014 no waivers of the annual dollar limit provision are allowed. See *Benefits News Briefs 2010-88* and *Special Bulletin 2010-90* for background information on the waivers and also: *http://www.healthcare.gov/news/factsheets/annuallimit06172011a.html*.

Unless a waiver is obtained, the minimum coverage annual limit is $1,250,000 for plan years starting after September 23, 2011, $2,000,000 for plan years starting after September 23, 2012 and no annual dollar limits are permitted with respect to plan years beginning on or after January 1, 2014, even for plans with waivers.

Guidance on how to apply for or renew a plan's annual waiver and the steps needed to maintain the waiver is available by "*clicking here*" or at: *http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf*.

Pursuant to this guidance, applicants who received a new waiver or waiver extension prior to September 22, 2011 must re-submit the information described in the guidance each year ***by the end of each calendar year*** (Annual Limit Update). Specifically, the first Annual Limit Update must be submitted by **December 31, 2012.** The second Annual Limit Update must be submitted by December 31, 2013.

According to the guidance, each plan waiver recipient – whether via a Waiver Extension or a new waiver application – will be required to distribute an updated annual notice to eligible participants (Annual Notice). A Model Annual Notice is available by "*clicking here*." See *Benefit News Briefs 2011-77*.

Reforms for Non-Grandfathered Plans Only

The section lists reforms applicable only to Non-Grandfathered plans. These reforms generally should have been implemented by Non-Grandfathered plans by now, but if a Grandfathered plan becomes Non-Grandfathered or a new plan is started, it must comply with the rules applicable to Non-Grandfathered plans.

A plan or coverage will cease to be a Grandfathered plan when an amendment to plan terms which trips one of the six "loss of grandfather status" triggers becomes effective – regardless of when the amendment is adopted, even if the change is effective mid-plan year. The following six triggers causing loss of Grandfathered status are found at the *ERISA* Regulation at 29 CFR 2590.715-1251(g)(1):

- Elimination of benefits.
- Increase in percentage cost-sharing requirement.
- Increase in a fixed-amount cost-sharing requirement other than a copayment.
- Increase in a fixed-amount copayment (if greater than the "trend" rate allowed).

- Decrease in contribution rate by employers and employee organizations.
- Changes in annual limits.

See *http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs6.html (*Q&A's 4 & 5).

The reforms applicable only to Non-Grandfathered plans are:

- 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*, *2010-68* and *2011-50).*
- Coverage of *emergency services* without prior authorization and at the same cost sharing as in-network.

Technical Release 2011-02 changed the interim enforcement safe harbor regarding external review for self-insured plans subject to *ERISA* and/or the Internal Revenue Code to contracting with at least two accredited IROs and rotating assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

Specifically, to be eligible for a safe harbor from enforcement from the DOL and the IRS, self-insured plans will be required to contract with at least **two IROs** by January 1, 2012 and with at least **three IROs** by July 1, 2012 and to rotate assignments among them.

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, 2012** for calendar year plans.

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.gov/CreditableCoverage/45_CCDisclosureForm.asp.*

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 October 15 of each year (formerly November 15), 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 April 1, 2011, which are available at: *http://www.cms.gov/CreditableCoverage/.*

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