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CLIENT BULLETIN

Upcoming 2013-2014 Compliance Dates For Group Healthcare Plans

This *Client Bulletin* will review select 2013-2014 compliance dates for multiemployer group healthcare plans under the *Affordable Care Act (ACA).* We are discussing 2014 changes as steps will need to be taken by Funds during 2013 in preparation for compliance by 2014. We are focusing on changes applicable to multiemployer group health plans.

We will not be providing much discussion on aspects of the *ACA* that affect employers or much discussion of the health care exchanges. For discussion of prior *ACA* compliance matters see *Client Bulletins 2011-03* and *2012-06*.

Selected 2013-2014 Healthcare Plan Compliance Dates

Affordable Care Act (ACA)

Grandfathered and Non-Grandfathered Plans

TOPIC	COMPLIANCE DATE(S)
• ***Lifetime/Annual Limits**** ***Unlimited***	Plan years beginning on or after January 1, 2014
• ***Summary of Benefits and Coverage (SBC)***	1st Plan year beginning on or after September 23, 2012 (but see discussion on "evergreen" plans)
• ***60-Day Advance Notice of Material Changes to SBC Required***	1st Plan year beginning on or after September 23, 2012
• ***Comparative Clinical Effectiveness Research Fees***	Plan years ending after 9/30/12 Program ends 2019

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Selected 2013-2014 Healthcare Plan Compliance Dates	
Affordable Care Act (ACA) **Grandfathered and Non-Grandfathered Plans**	
TOPIC	**COMPLIANCE DATE(S)**
• ***Reinsurance Fee***	Data submission no later than November 15 of 2014 Plan Year
• ***"Waiver of Annual Limits" Submission & Notices to Participants***	Annual Update by December 31, 2013
• ***No Preexisting Condition Exclusions for Adults (Children previously addressed)***	Plan years beginning January 1, 2014
• ***Coverage Of Up To Age 26 Dependents Even If They Are Eligible To Enroll In Other Employer Sponsored Health Care***	Plan years beginning January 1, 2014
• ***90-Day Limit On "Waiting Periods"***	Plan years beginning January 1, 2014
• ***Increased Wellness Plan Incentive Maximums Raised***	Plan years beginning January 1, 2014

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 several compliance items under the *ACA* for 2013-2014. These are: (1) lifetime/annual limits; (2) summary of benefits and coverage (SBC); (3) 60-day advance notice of material modifications affecting the SBC; (4) comparative clinical effectiveness research fees; (5) reinsurance fees; (6) "waiver" filings; (7) no preexisting condition exclusions; (8) coverage of dependents up to age 26 even if they are eligible to enroll in other employer sponsored health care; (9) 90-day limit on "waiting periods"; and (10) increased maximums on wellness plan incentives.

Lifetime/Annual Limits

The *ACA* prohibited health plans from having a lifetime limit on the dollar amount of benefits for any individual, but allowed 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.

However, if the plan obtained an annual limits "waiver", the above rules do not apply for the applicable plan year. 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.

For plan years beginning on or after January 1, 2014, no *annual or lifetime limits are allowed*.

Plans will want to make sure they are amended as needed to reflect the "*no annual limit/no lifetime limit*" rule beginning in the 2014 Plan Year. The rule will apply to calendar year on plans January 1, 2014.

Summary of Benefits and Coverage (SBC)

The *ACA* requires creation of an 8-page Summary of Benefits and Coverage (SBC). The original compliance date of March 23, 2012 was delayed ***until*** *final regulations were issued.* Final regulations were issued in 2012 and the new compliance date is discussed below. *See Client Bulletins 2012-08, 2012-26 and 2012-53 and Benefit News Briefs 2011-79 and 2012-14.*

The *ACA* requires distribution of an SBC by a group health plan to participants and beneficiaries on the following dates:

- **Initial Distribution** – 30 days before 1st Plan Year beginning on or after September 23, 2012 [A special rule apparently applies to "automatic renewal" plans that use an "evergreen election." As discussed in detail below, the rule would consider an initial distribution of 30 days before the 2nd Plan Year beginning on or after September 23, 2012 as good-faith compliance];
- **Special Enrollment** – within 90 days of enrollment;
- **Renewals** – *If the plan requires renewal* to maintain coverage and if renewal is automatic, then no later than 30 days prior to the 1st day of the new Plan Year;
- **On Request** – No later than seven business days following receipt of the participant's or beneficiary's request; and
- **Material Modification** – No later than 60 days prior to the effective date of any material modification of the **content** of the SBC. This is discussed in further detail below.

The SBC regulations are found at 29 CFR 2590.715-2715. More information on SBCs can be found at the DOL page at: *Summary of Benefits and Coverage and Uniform Glossary.*

60 Days Notice Prior To Material Modifications of the SBC

Generally, notice of any amendment constituting a material modification in any of the terms of the Plan that would affect the content of the SBC must be given not later than 60 days prior to the date on which the modification will become effective. *See ERISA* Regulation Section 2590.715–2715(b).

This requirement does not affect the requirement to send a Summary of Material Modification (SMM) under *ERISA* Regulation Section 2520.104b–3. An SMM is required for any material modification to the plan or any change in the information required to be included in an SPD, such as a change in Trustees. See *Research Memo 2007-15* for more information.

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* and *Client Bulletins 2012-21 and 2012-66.*

> The Comprehensive Clinical Effectiveness Research Fee (effectiveness 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 regulations adopt usage of IRS Form 720 for payment of the fee. Form 720 may be filed electronically. See *www.irs.gov/efile* for more information on e-filing the Form 720. *Note: As of the date of this publication, the current Form 720 has not been amended to include this new fee.*

Although electronic filing of the Form 720 is not required, the IRS *encourages filers to file the Form 720 electronically*. A responsible party wishing to file the Form 720 electronically must submit it through an approved transmitter software developer.

To electronically file the Form 720, the filer will incur the cost of the required service fee for online submission.

Self-insured calendar year plans ending December 31, 2012 must file their Form 720 by July 31, 2013. Plans with plan years ending in 2013 must file their Form by July 31, 2014. See the regulation on filing dates for insured and self-insured plans by "*clicking here*."

The "effectiveness fee" under the *Patient-Centered Outcomes Research Trust Fund* (PCORTF) *Rule* can be paid out of plan assets. See *Client Bulletin 2013-07*, FAQ 8 for more information.

Reinsurance Fees

The reinsurance fee was discussed in detail in *Client Bulletin 2012-65*. Generally, for an insured plan, the health insurance issuer pays the fee. For a self-insured plan, the plan is liable for the reinsurance fee, not the plan sponsor. This means the plan itself can pay the expense from plan assets. See Regulation *Preamble* at 77 FR 73118, 77198, footnote 56.

The *Preamble* estimates the reinsurance fee cost to be **$5.25 per person per month ($63/year)** in benefit year 2014 and less in succeeding years.

The regulations state that a contributing entity must submit an annual enrollment to HHS no later than November 15 of benefit year 2014, 2015 and 2016, as applicable. The annual enrollment count should be the average number of covered lives of reinsurance contribution enrollees for each benefit year.

Then, within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count.

The contributing entity must remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

There are three methods that a self-insured group health plan may use to determine the average number of covered lives for purposes of the annual enrollment count used to calculate the reinsurance fee. The three methods are the (1) *Actual Count Method or Snapshot Count Method;* (2) *Snapshot Factor Method* and (3) *Form 5500 Method. See Client Bulletin 2012-65* for details.

"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. No annual dollar limits are permitted with respect to plan years beginning on or after January 1, 2014, even for plans with waivers. See *Benefits News Briefs 2010-88* and *Special Bulletin 2010-90* for more information.

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

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). The Annual Limit Update for 2013 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*.

No Preexisting Condition Exclusions

Previously, the law only prohibited preexisting condition exclusions on dependents under age 19. Effective for plan years beginning on or after January 1, 2014, a group health plan, or a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on any covered life. See *ERISA* Regulation Section 2590.715–2704.

Coverage Of Up To Age 26 Dependents Even If They Are Eligible To Enroll In Other Employer Sponsored Health Care

Previously, for plan years beginning prior to January 1, 2014, a group health plan that qualified as a *grandfathered* health plan and that has dependent coverage of children could exclude an adult child who has not attained age 26 from coverage if the adult child was eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent.

Effective for plan years beginning on or after January 1, 2014, a group health plan, or a health insurance issuer offering group health insurance coverage, such adult children may NOT be excluded from coverage under as a dependent on their parent's plan even if the adult child is eligible to enroll in eligible employer-sponsored health plan other than a group health plan of a parent. See *ERISA* Regulation Section 2590.715-2714.

90-Day Limit On "Waiting Periods"

By way of background, the *ACA* provides that, for plan years beginning on or after January 1, 2014, a group health plan shall not apply any waiting period that exceeds 90 days. A "*waiting period*" is defined as "*the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the plan*."

It is important to note that *this section* of the *ACA* itself does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees, but merely prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage becomes effective. Other sections of the ACA address the employer coverage mandate.

This guidance will remain in effect at least through the end of 2014. Regulations or other guidance on these issues applicable for periods after 2014 will provide adequate time to comply with any additional or modified requirements.

Unfortunately, application of these rules in the multiemployer context is not directly discussed. Hopefully, future guidance will specifically address multiemployer health plans. For detail on the 90-day waiting period rules see *Benefit News Briefs 2013-01.*

Increased Wellness Plan Incentives Maximums Raised

These proposed wellness regulations are similar in many ways to the pre-*ACA* 2006 final wellness regulations and continue to divide wellness programs into the following two categories:

- "*Participatory wellness Programs,*" which include the majority of wellness programs, and
- "*Health-contingent wellness programs*."

These proposed rules would be effective for plan years beginning on or after January 1, 2014 for both *grandfathered and non-grandfathered plans*

"*Participatory wellness programs*" generally are available without regard to an individual's health status. These include, for example:

- A program that reimburses all or part of the cost for membership in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly no-cost health education seminar.
- A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment.

"*Health-contingent wellness programs*" generally require individuals to meet a specific standard related to their health to obtain a reward. Examples of health-contingent wellness programs include the following types of programs:

- Programs that provide a reward to those who do not use, or decrease their use of, tobacco.
- Programs that provide a reward to those who achieve a specified cholesterol level or weight as well as to those who fail to meet that biometric target but take certain additional required actions.

The proposed regulations require *health-contingent wellness programs* to follow certain rules, including:

- frequency of opportunity to qualify (annually),
- size of reward (30%, up to maximum of 50% of cost of coverage of tobacco cessation programs),
- uniform availability and reasonable alternative standards,
- reasonable design, and
- notice of other means of qualifying for the reward.

For more details see *Client Bulletin 2012-64.*

Reforms for Non-Grandfathered Plans Only

This section lists reforms applicable only to Non-Grandfathered plans. These reforms generally should have already been implemented by all 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 the 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 that cause 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 at* Q&As 4 & 5 for more information.

The reforms applicable only to Non-Grandfathered plans are:

- Coverage of recommended *preventative services* with no cost sharing (*Benefit News Briefs 2010-57; 2011-49; 2012-33; 2012-43 and 2013-12)*.
- 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 and Technical Release 2011-02*).
- Coverage of *emergency services* without prior authorization and at the same cost sharing as in-network. See *ERISA* Regulation Section 2590.715–2719A(b)

Trustees and their professional advisors have their work cut out for them in making plan amendments and distributing notices in order to make a timely transition to the 2014 Plan Year rules that are coming into effect.

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