ACA Compliance

centrix BENEFIT ADMINISTRATORS

Administrative Simplification

Important Notice: On Oct. 4, 2017, the U.S. Department of Health and Human Services (HHS) published a withdrawal notice in the Federal Register for the proposed rule titled "Administrative Simplification: Certificate of Compliance for Health Plans." Please note that health benefit plans must still comply with HIPAA-mandated standards and operating rules for electronic transactions. Also, HHS retains the authority to review plans for compliance. But withdrawal of the proposed rule means that plans will not have to certify their compliance as outlined in the proposed rule.
Previously, on Oct. 31, 2014, HHS had announced a delay in enforcing Health Plan Identifier requirements until further notice.

The U.S. Department of Health and Human Services (HHS) published a proposed rule requiring all health plans to submit information and documentation demonstrating compliance with standards and operating rules for certain electronic transactions.
Key organizations:

- CAQH: Council for Affordable Quality Health Care
- CORE: CAQH's Committee on Operating Rules on Information Exchange

Proposed rule requirements:

- Controlling health plans*, including self-funded plans, have to get either a CAQH/CORE "seal" or a "HIPAA" credential showing that they meet HIPAA electronic standard transactions; and
- Controlling health plans, including self-funded plans, have to send proof that they received this certification.

Proposed certification deadlines
According to the proposed rule, a controlling health plan that obtains an HPID**:

- before Jan. 1, 2015, must meet the submission requirements for the first certification of compliance on or before Dec. 31, 2015.
- on or after Jan. 1, 2015, and on or before Dec. 31, 2016, must meet the submission requirements for the first certification of compliance within 365 calendar days of obtaining an HPID.
- after Dec. 31, 2016, is not required to meet the requirements proposed in this rule for the first certification of compliance.

**Controlling health plans control their own business activities, actions or policies, or are controlled by an entity that is not a health plan.*
***On Oct. 31, 2014, HHS announced a delay in enforcing HPID requirements until further notice.*

Auto-Enrollment

The Affordable Care Act's requirement to automatically enroll new full-time employees in one of their employer's health benefits plans has been repealed.
On Nov. 2, 2015, the Bipartisan Budget Act of 2015 was enacted, which, among other things, repealed the auto-enrollment provision contained in Section 18A of the Fair Labor Standards Act (FLSA).
In general, the provision had required FLSA-covered employers with more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefits plans.

Benefit Mandates

The ACA requires that the following provisions are implemented for self-funded health plans.

- 90-day waiting period[1]
- No pre-existing exclusions
- Removal of annual and lifetime dollar limits
- Coverage for dependents to age 26[2]
- No pre-existing condition exclusions for persons younger than 19
- Increased parity for out-of-network emergency services[3]
- 100 percent coverage for certain in-network preventive services[3] (See the Preventive Services section for more information.)
- Additional claim and appeal rights[3]

The 90-day waiting period and elimination of pre-existing exclusions were mandated for plan years on or after Jan. 1, 2014, All other provisions were mandated for plan years on or after Sept. 23, 2010.

1Plans may not impose a waiting period of more than 90 days. For the 2014 plan year, employers may impose an "orientation period" not to exceed one calendar month less one calendar day.
2To avoid possible penalties, businesses subject to the employer mandate must provide health coverage to a dependent adult child through the end of the month in which he or she attains age 26. If coverage extends beyond the 26th birthday, the value of the coverage can continue to be excluded from the employee's income for the full tax year (generally a calendar year) in which the adult dependent child turns 26.
3The provision does not apply to grandfathered plans.

Certificates of Credible Coverage

The Affordable Care Act (ACA) does not require the issuance of certificates of credible coverage. Previously, HIPAA required these certificates to be issued as proof of previous health coverage. The ACA repealed the requirement, effective Dec. 31, 2014. However, a former employee may require proof of coverage under a client's health plan so that the individual can enroll in a new health plan under special enrollment rights. In this situation, Centrix Benefits Administrators may be able to provide a certificate of prior coverage after Dec. 31, 2014, at a client's request. Clients should discuss this issue with their Client Manager.

Clinical Trials

The Affordable Care Act (ACA) requires all self-funded nongrandfathered health plans to provide benefit coverage to "qualified individuals" for routine patient costs incurred during an "approved clinical trial." With this provision, items and services provided as part of an approved clinical trial must be covered by an employer-sponsored health plan consistent with typical coverage for a member not participating in a clinical trial. This requirement does not apply to grandfathered plans.
The coverage does not apply to the actual device, equipment or drug that is typically given to participating patients free of charge by the medical device or pharmaceutical company sponsoring the trial.
Ths mandate became effective for plan years on or after Jan. 1, 2014.

Cost Sharing

The Affordable Care Act establishes annual limits on in-network out-of-pocket maximums on Essential Health Benefits (EHBs) for nongrandfathered plans. (This cost-sharing provision does not apply to grandfathered plans.) The annual out-of-pocket maximum applies to the plan on the first day of the first plan year. The in-network annual out-of-pocket maximum may be divided across multiple categories of benefits, provided the aggregate of all separate out-of-pocket maximums applicable to all in-network EHBs under the plan do not exceed the annual out-of-pocket maximums for that plan year.

Remember!

Self-funded group health plans are not required to cover Essential Health Benefits. But, if they do, they cannot impose lifetime or annual dollar limits on those benefits.

Final Rule - Annual Cost Share Limit for 2022 Plan Year

Maximum Annual Limitation on Cost Sharing for Plan Year 2022
The final rule adopts a 2022 maximum annual limitation on cost sharing of $8,700 for self-only coverage and $17,400 for other than self-only coverage. This is an approximately 1.8 percent increase above the 2021 parameters of $8,550 for self-only coverage and $17,100 for other than self-only coverage.
2021
A non-grandfathered group health plan's in-network out-of-pocket maximum for EHBs for the 2021 plan year cannot exceed $8,550 for self-only coverage and $17,100 for other than self-only coverage, an increase of approximately 4.9% from 2020. The in-network out-of-pocket maximum applies to all individuals, regardless of whether an individual has a self-only plan or other-than-single coverage.
2020
A non-grandfathered group health plan's in-network out-of-pocket maximum for EHBs for the 2020 plan year cannot exceed $8,150 for self-only coverage and $16,300 for other than self-only coverage, an increase of slightly more than 3 percent from 2019. The in-network out-of-pocket maximum applies to all individuals, regardless of whether an individual has a self-only plan or other-than-single coverage.
2019
A group health plan's in-network out-of-pocket maximum for EHBs for the 2019 plan year cannot exceed $7,900 for self-only coverage and $15,800 for other-than-single coverage, an increase of 7 percent from 2018. The in-network out-of-pocket maximum applies to all individuals, regardless of whether an individual has a self-only plan or other-than-single coverage (including a high deductible health plan).

Electronic Funds Transfers & Remittance Advice Transactions

The U.S. Department of Health and Human Services (HHS) released standards for electronic funds transfers and electronic remittance advice transactions for health plans' electronic payments to healthcare providers.

The Interim Final Rule, released in 2012, does not require healthcare providers to accept payments electronically. However, effective Jan. 1, 2014, if a provider wants to receive payment electronically, a health plan must oblige and conduct the transaction in compliance with standards identified in the Interim Final Rule.

Proposed Regulations on Form 5500

Federal agencies are proposing changes to improve the Form 5500 Annual Return/Report, the primary source of information about the operations, funding and investments of private-sector, employment-based pension and welfare benefit plans in the U.S. The form is filed by private-sector employee benefit plans.

The proposed rules would apply to all ERISA-covered health plans, regardless of:

- *size*
- *grandfathered status*
- *whether an excepted benefit under the Affordable Care Act, and*
- *whether funded with a trust, unfunded or a combination unfunded/insured. (An unfunded plan is a self-funded health plan that pays benefits as needed solely from the general assets of the employer sponsoring the plan.)*

However, fully insured group health plans with fewer than 100 participants at the beginning of the plan year would be required to only answer a limited number of questions on the Form 5500 and the proposed new Schedule J. Currently, most private employer-sponsored group health plans with fewer than 100 participants that are fully insured, unfunded or a combination of the two, do not file the Form 5500 Annual Return/Report under the current Department of Labor exemptions.

Federal agencies released the proposed regulations on July 11, 2016. If adopted, the changes generally would apply for plan years beginning on or after Jan. 1, 2019. Written comments to the proposed regulations are due to the U.S. Department of Labor by October 4, 2016.

Proposed Schedule J: Compliance Section

The compliance section of the proposed Schedule J asks:

- whether all plan assets were held in trust, held by an insurance company qualified to do business in a state, or as insurance contracts or policies issued by an insurance company.
- whether the plan's Summary Plan Description and Summaries of Any Material Modifications, and Summary of Benefits and Coverage are in compliance with the applicable requirements; and
- whether coverage provided by the plan complies with federal laws and the federal labor department's regulations.

Non-federal governmental plans are not required to file annual reports pursuant to ERISA 103 or 104. Accordingly, any reporting required of such plans and issuers will be addressed separately by the Department of Health and Human Services in future rules or guidance.

Proposed Schedule J

The proposed Schedule J would collect information on the characteristics of the plan that is providing group health benefits, including:

- approximate number of participants and beneficiaries covered under the plan at the end of the plan year, and the number of persons offered and receiving coverage through COBRA;
- whether the plan offers coverage for employees, spouses, children and/or retirees; and
- the type of group health benefits offered under the plan (for example, medical/surgical; pharmacy or prescription drug; mental health/substance use disorder treatment; wellness program; preventive care; and vision, dental or other type of benefits).

Plans that provide group health benefits are asked to:

- Report whether one or more of the plan's benefit package options are claiming grandfathered status under the Affordable Care Act (ACA),
- Report whether the plan is a high deductible health plan, is a health flexible spending account (FSA) or includes a health FSA as a component, or is a health reimbursement arrangement
- Report whether the plan received rebates, refunds, or reimbursements from a service provider

Rebates, refunds or reimbursements refer to items such as a medical loss ratio rebate under the ACA and offset rebates from favorable claims experience. If these were received, filers would be required to report the type of service provider, the amount received and how the rebates were used (for example, returned to participants, premium holiday or payment of benefits).

- Identify any service providers to the plan not already reported on Schedule A (Insurance Information) or Schedule C (Service Provider Information) by providing the name, address, telephone number, employer identification number, and, if applicable, the National Insurance Producer Registry number.
- Provide the National Producer Number established by the National Association of Insurance Commissioners.

Service providers with a National Producer Number include third party administrator/claims processors, including issuers subject to an "administrative services only (ASO)" contract; mental health benefits managers; wellness program managers; substance use disorder benefits manager; pharmacy benefit managers or drug providers; and independent review organizations.

- Report the total premium payment made for any stop loss coverage, as well as information on the attachment points of coverage, individual claim limits and/or the aggregate claim limit contained in the policy.

For group health plans that are not required to complete a Schedule H (generally, fully insured, unfunded plans, or combination insured/unfunded plans), the proposed regulations would require that information regarding employer and participant contributions be reported on the Schedule J, including employer contributions received, participant contributions received, employer contributions receivable, participant contributions receivable, other contributions received or receivable (including non-cash contributions) and the total of all contributions. Filers would also be required to report whether there was a failure to timely transmit participant contributions to the plan.

Proposed Schedule J (cont'd)

In addition, plans that provide group health benefits are asked to report:

- Claims payment data

This data would include information on:

1. How many post-service benefit claims were submitted during the plan year, and how many of those claims were:
   - approved during the plan year
   - denied during the plan year
   - pending at the end of the plan year
   - benefit claim denials appealed during the plan year
   - appealed claims upheld as denials and how many were payable after appeal.
2. How many post-service benefit claim denials were appealed during the plan year, and how many of those appeals were:
   - Upheld during the plan year as denials
   - Overturned and approvedduring the plan year after appeal
3. How many pre-service benefit claims appealed during the plan year were:
   - Upheld the denials during the plan year
   - Approved during the plan year after appeal
   - Whether the plan was unable to pay claims within one month of being approved for payment at any time during the plan year and, if so, the number of unpaid claims, the total amount not paid, and the number of claims not paid within three months or longer.
   - The total dollar amount of claims paid during the plan year. If the plan provides benefits through an insurance policy, filers would be required to identify any delinquent payments to the insurance carrier within the time required by the carrier, and identify whether any delinquencies resulted in a lapse in coverage.

The federal labor department is considering, in addition to the information requested in the new Schedule J, whether to require plans to report more information on denied claims, such as the dollar amount of claims that were denied during the plan year, the denial code, and/or whether the claims were for mental health and substance use disorder benefits or for medical/surgical benefits.

Penalties

The penalty for failure or refusal to file a Form 5500 is a maximum of $2,063 per day, up from a maximum of $1,100 per day. The penalty became effective after August 1, 2016.