MILLENNIUM BENEFITS CONSULTING

MILLENNIUM UPDATE

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In This Issue

We know that summer is a busy time, whether managing your workload around vacation time or marketing your plans and preparing for Open Enrollment. That is why we've developed these "Benefit HOT SPOTS" addressing timely benefit information you can scan and make sure you are up to speed with compliance and carrier news.

As always, at MBC we're available to dig deeper and discuss the impact to your benefit plans, so contact us with your questions and for more information.

Benefit HOT SPOT #1: Medicare D Determination and Communication Now In October

Under health care reform, the Medicare D annual election period will occur earlier this year. The new annual enrollment time frame will be October 15 through December 7. The change applies beginning with plan year 2012 (i.e. beginning with the 2011 election period this fall).

How Does this Impact Employers?

- The determination for "creditable or non-creditable" coverage applies to the upcoming plan year.
- Any changes to the pharmacy plan will need to be made earlier in the year (August - September), so that pharmacy plans can be reviewed earlier, and the carriers can make the determinations earlier.
- Determination letters will need to be sent no later than October.
- Generally, employers send letters with open enrollment; however, this year it may need to be a separate mailer. *We recommend sending to all employees.*

MBC has contacted all the carriers to ensure that they are aware of this earlier timeline and have the tools in place to make the determinations prior to October 15. We will request determinations in order to meet this new deadline.

Benefit HOT SPOT #2: New Internal and External Claim Review Rules

New rules have been released that impact internal claim procedures and external reviews for **non-grandfathered health plans and insurers**. Most of these rules take effect July 22, 2012.

Here are a few of the provisions worth noting:

- To decide urgent-care claims, plans will now only have take up to 72 hours - rather

than 24 hours - to decide urgent-care claims, provided certain conditions are met.

- Diagnosis and treatment codes need not be included in claim denial notices, but participants may still request this information.
- Self-insured ERISA plans which determined to use a federal safe harbor for external review must contract with at least two independent review organizations by Jan. 1, 2012.

We will be contacting the carriers to follow-up on the regulations that impact them and will keep you posted on their response. If you have any questions regarding these regulations, don't hesitate to contact us at 678-805-3500.

Benefit HOT SPOT #3: Coverage for Dependents to Age 26 - Favorable Tax Status?

One of the most recent clarifications to the Patient Protection and Affordable Care Act (PPACA) is regarding the tax status as it relates to the coverage for Dependents to Age 26.

As you know, under the PPACA, a group health plan that offers dependent coverage for children must make that coverage available to dependents up to age 26. Essentially, adult children are covered regardless of the following:

- Marital status
- Place of residence (as it relates to the participant)
- Employment status
- Financial dependence

For many employees, this is a welcome change and peace of mind that their children will have health insurance. So, what's the catch?

Taxes! One of the changes PPACA implemented was to provide favorable tax treatment for these dependents (through the end of the taxable year in which the dependent turns 26).

However, there is one BIG exception:

A few states (Georgia included) currently do not conform to the federal income tax law for this specific provision. For those states, employers may have to calculate and report "imputed income." The good news is that in most of these states, there is pending legislation which we will be monitoring. We will keep you posted on developments.

Benefit HOT SPOT #4: Aetna Chiropractic Network - Changes in the Network and Medical Review

If you are an Aetna customer, please read the following.

Effective July 1, Aetna has contracted with American Specialty Health (ASH) to provide the chiropractic network. This change will broaden the network and change the process for medical review.

Here's how it impacts the employees:

- For plans that cover chiropractic services, a medical review generally takes place after 25 visits. With the change to ASH, this medical review will begin after 5 visits.
- As the rollout occurs, there are 5 states that will have chiropractors added to the network (533 additional for Georgia). On the flip side, there are some chiropractors that do not belong to the ASH network. ASH is actively working to recruit these providers.

For Employers, the good news is that if you currently offer chiropractic coverage, there will be discounts with additional providers and a more immediate review for medical necessity. Both of these changes will aid in the goal of providing lower costs and making sure the services paid under your plan are indeed medically necessary.

Next Steps: We will continue to monitor these changes with Aetna. We are happy to help with communicating these adjustments to your employees, so feel free to give us a call to discuss further.

Benefit HOT SPOT #5: CIGNA Claim Filing - New Guidelines

If you are a CIGNA customer, please read the following.
These changes impact all employer groups with CIGNA and will be implemented through a 2-step roll out process. The first phase begins August 1, 2011. Phase 2 starts at the beginning of 2012.

August 1, 2011: In-Network Claim Changes
Starting August 1, 2011, participating providers must submit medical and behavioral health claims within 90 days of the date of service. If a claim is not submitted within the new time frame, CIGNA will not reimburse the provider. However, CIGNA members are not liable for payment if their in-network provider misses the claim-submission window.

January 1, 2012: Out-of-Network Claim Changes
Effective January 1, 2012, CIGNA will change the timeframe for submitting out-of-network claims to 180 days. Please note that this does impact CIGNA members who use out-of-network providers. Watch for additional details coming in the September-October time frame.

Best Regards,

Keith Tallmadge and The Team
at Millennium Benefits Consulting