Legislative Highlights
February 2013

BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois is pleased to offer you the latest legislative updates. Below you will find the key highlights as we know them today.

The federal government has released thousands of pages of proposed rules, final rules, FAQs and guidance related to the Affordable Care Act (ACA) in the past two months. We are communicating the information as quickly as possible to keep you informed. While we work to provide more details in future Legislative Highlights, please continue to forward any ACA-related questions to your account representative.

IRS Releases Final Regulation on Premium Tax Credit; HHS, IRS Release Proposed Rules on Individual Mandate Exemptions, Minimum Essential Coverage

The Internal Revenue Service (IRS) on Jan. 30 released a final rule on the premium tax credit provision of the Affordable Care Act, clarifying an issue from the more comprehensive final rule that it published in May 2012. According to the regulation, an eligible employer-sponsored plan is considered affordable for "related individuals" if the portion of the annual premium the employee must pay for self-only coverage (the required contribution percentage) does not exceed 9.5 percent of the employee's household income.

In addition, the U.S. Department of Health and Human Services (HHS) and the IRS on Jan. 30 each released proposed rules that explain the Affordable Care Act's individual mandate and lay out the eligibility rules for receiving exemptions, as well as the process by which individuals can receive certificates of exemption.

The proposed rule also cites five exemptions that exchanges may grant to individuals, as well as the process for receiving an exemption. These situations include incarceration, religious conscience, membership in a health care sharing ministry, membership in an Indian tribe and hardship.

HHS also clarified in the new rules that short gaps in coverage won't trigger the coverage requirement, which means that temporarily employed individuals won't be fined for losing their health coverage between jobs.

The proposed rules also expand the definition of minimum essential coverage, which now includes the following:

- Employer-sponsored coverage (including COBRA coverage and retiree coverage)
- Coverage purchased in the individual market
- Medicare Part A coverage
- Medicaid coverage
- Children's Health Insurance Program coverage
- Certain types of Veterans health coverage
- TRICARE

For more information, the departments released a joint fact sheet on the proposed rule.

Comments on HHS' proposed rule are due 45 days after publication in the Federal Register. The Treasury's proposed rule on the individual mandate will be open for a 90-day comment period from the date of publication in the Federal Register. The Treasury has also scheduled a public hearing for May 29.

We are currently reviewing the final and proposed rules and will send you information on key aspects as they are available.

Federal Government Delays Exchange Notification Requirement for Employers; Issues Guidance on HRAs

On Jan. 24, 2013, the U.S. Departments of Labor, Health and Human Services (HHS) and Treasury released a FAQ providing guidance on a number of Affordable Care Act (ACA) provisions.

Of particular note, the Labor Department has delayed the deadline for employers to send notices to their employees about the availability of Health Insurance Exchanges.

Originally, the deadline was March 1, 2013. The new deadline will be in late summer or early fall, in order to coincide more closely with the exchange open enrollment date of Oct. 1, 2013. The FAQ states that additional guidance will be issued on this topic in the future.

In addition, the FAQ addresses several questions related to Health Reimbursement Arrangements (HRA). Specifically, the departments distinguished between HRAs that are combined with employer-sponsored group coverage ("integrated"), and those that are "stand-alone" HRAs. Stand-alone HRAs appear to violate ACA's prohibition on annual dollar limits, while integrated HRAs may be permissible, provided the underlying employer-sponsored group coverage complies with ACA's prohibition on those limits. The FAQ went on to provide examples of both integrated and stand-alone HRAs.

The departments indicated that they planned to issue additional guidance on HRAs.

HHS Releases HIPAA/HITECH Omnibus Final Rule

On Jan. 17, 2013, the U.S. Department of Health & Human Services (HHS) released its 563-page final rule on the Health Insurance Portability and Accountability Act (HIPAA). The final rule is based on statutory amendments under the Health Information Technology for Economic and Clinical Health (HITECH) Act. The final rule modifies HIPAA Privacy, Security, Breach Notification and Enforcement Rules and implements protections under the Genetic Information Nondiscrimination Act of 2008.

The changes in the final rule include, but are not limited, to the following:

- Makes business associates of covered entities directly liable for compliance with certain of the HIPAA Privacy and Security Rules requirements.
- Strengthens the limitations on the use and disclosure of protected health information for marketing and fundraising purposes, and prohibits the sale of protected health information without individual authorization.
- Expands individuals' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full.
- Requires modifications to, and redistribution of, a covered entity's notice of privacy practices.
- Prohibits most health plans from using or disclosing genetic information for underwriting purposes.
- Adopts changes to the HIPAA Enforcement Rule to incorporate the increased and tiered civil money penalty structure.
- Replaces the "significant risk of harm" standard for determining breach notification with a "low probability" standard. A risk assessment is still allowed.

The rule was scheduled to be published in the Federal Register on Jan. 25, 2013, and is effective on March 26, 2013. Covered entities and business associates are provided a 180-day compliance period and must comply by Sept. 23, 2013.

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HHS Releases Additional Guidance to States on Health Insurance Exchanges

On Jan. 3, 2013, The U.S. Department of Health and Human Services (HHS) released additional guidance on the partnership model of a federally facilitated exchange, also known as the state partnership exchange.

In a state partnership exchange, the state has the opportunity to assume what are known as "plan management" functions, and/or certain "consumer assistance" functions. The guidance provides states with additional information as to roles and responsibilities they can, and HHS will, have in these state partnership exchanges.

States have until Feb. 15, 2013, to tell HHS whether they want to participate in state partnership exchange.

Generally, the guidance indicates that HHS plans to have states, in state partnership exchanges, take on significant roles in carrying out plan management and consumer assistance functions in order to prepare those states to eventually transition from a partnership model federally facilitated exchange to a state-based exchange.

However, the guidance also makes clear that even in a state partnership exchange, HHS will remain responsible for its overall operation and will provide oversight to the states to ensure they carry out their exchange-related roles and responsibilities. In a state partnership exchange, HHS will carry out all minimum exchange functions not performed by states, such as enrollment and establishment and maintenance of the exchange website and call center.

The state of Illinois has submitted its blueprint for a state partnership exchange and is awaiting HHS' approval. On Jan. 3, 2013, HHS conditionally approved New Mexico's blueprint for its state-based exchange. The Texas and Oklahoma governors have said they will not operate state-based exchanges or participate in a partnership exchange. If a state does not submit its application that is not a partnership model by the deadline, then HHS will establish a federally facilitated exchange in that state.

Update Regarding the PCORI Final Rule

The IRS released its final rule on the Patient-Centered Outcomes Research Institute (PCORI) Fee on Dec. 6, 2012. The final rule reflects few changes from the proposed rule. Below are highlights of the final rule:

- The IRS did not adopt recommendations to include standards intended to prevent double counting individuals with coverage under a group health plan through two separate insurance policies (ex: affiliated insurers providing separate policies for in-network and for out-of-network services).
- The rule includes provisions allowing the sponsor of an applicable self-insured health plan that provides coverage through both fully-insured and self-funded options to participants and beneficiaries to exclude individuals covered solely by the insured option when reporting the number of covered lives that will be subject to the PCORI fee.
- The rule clarifies that the fee does not apply to employee assistance, disease management or wellness programs as long as they do not provide significant benefits in the nature of medical care or treatment.
- The rule makes clear that the fee is applicable to retiree coverage and to coverage provided pursuant to COBRA or similar state or federal continuation coverage requirements.
- The final rule includes special rules to determine the number of covered lives during the first and last years the fee is in effect.
- The final rule (consistent with the proposed rule) does not provide for third-party reporting or payment of the PCORI fee.

In accordance with the PCORI final rule, Blue Cross and Blue Shield of Illinois (BCBSIL) will not assume any reporting or fee-related responsibility for its self-funded business. We recommend groups seek the advice and counsel of qualified tax and legal professionals. For fully insured business, BCBSIL will report and remit the fee.

If you have any further questions, do not hesitate to contact your BCBSIL representative or call our ACA Fees Hotline at 888-775-6892, Monday to Friday 8:30 a.m. to 5 p.m. CT and 7:30 a.m. to 4 p.m. MT.

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'Fiscal Cliff' Bill Makes Changes to ACA, Patches Medicare Physician Reimbursement

The American Taxpayer Relief Act (the legislative response to the "fiscal cliff"), which the House and Senate passed on New Year's Day and President Barack Obama signed on Jan. 2, 2013, includes some changes to the Affordable Care Act (ACA) and Medicare physician reimbursements.

The bill permanently repeals the Community Living Assistance Services and Supports (CLASS) Act, a provision of the federal long-term care insurance program in ACA.

The bill also eliminates additional funding for Consumer Operated and Oriented Plans (CO-OPs), which were established under ACA to operate as nonprofit, member-driven health insurance issuers. The U.S. Department of Health and Human Services (HHS) had already distributed approximately $1.9 billion (of the $3.8 billion in authorized funding for the program) to the 24 plans that have already been created. The bill eliminates all unobligated CO-OP funds, but sets aside 10 percent of the unobligated funds to help with administrative costs for these 24 plans.

In addition, the bill delayed a 26.5 percent cut to Medicare physician reimbursements for another year, at a cost of $25.2 billion. The temporary "doc fix" is being paid for by a series of cuts to hospitals.