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BlueCross BlueShield of Illinois

Implementation of ACA Women's Preventive Services Now Incudes Coverage for Electronic Breast Pumps

Effective April 15, 2013, Blue Cross and Blue Shield of Illinois (BCBSIL) is expanding its implementation of preventive services under the Affordable Care Act (ACA) to include coverage for electric and hospital grade breast pumps. This coverage applies to non-grandfathered plans and policies, and expands the breastfeeding support options available to members without cost-sharing.

PUMP TYPE	COVERAGE LEVEL	QUALIFYING SOURCE	LIMIT/RESTRICTION
Manual Breast Pump E0602	100% - no cost-share	In-Network, Out of Network, Retail	N/A
Electric Breast Pump E0603	100% - no cost-share	In-Network Provider or contracted Durable Medical Equipment (DME) supplier only	Two per calendar year
Hospital Grade Breast Pump E0604	100% - no cost-share Rental Only (see limit/restriction)	In-Network or contracted DME supplier*	Coverage is the rental cost up to the purchase price ($125-$150) * standard process for DME rental equipment applies - monthly rental costs should not cumulatively exceed purchase price. Hospital grade pump available for rental only at this time.
Breast Pump Supplies A4281-A4286 are covered at 100% without cost-sharing.			

NOTE: Grandfathered groups that have previously included coverage for pumps will not be impacted by this change.

Please contact your BCBS representative if you have questions regarding this information.

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Essential Health Benefits Cost-Sharing Fast Facts

The flurry of information about the essential health benefits' (EHBs) deductible cap, out-of-pocket limits, and safe harbor for carve outs has many people scratching their heads. If you're one of them, here are some fast facts and resources to help you keep up with it all.

Large, self-insured and grandfathered health plans don't have to cover EHBs in 2014. However, if they cover EHBs...

- These plans must meet certain EHB cost-sharing requirements.
- All plans must eliminate annual dollar limits on EHBs for their 2014 plan year.
- All plans must have already eliminated lifetime dollar limits.
- Non-grandfathered plans must cap member out-of-pocket expenses for EHBs (in-network). There are exceptions under a safe harbor.
- Grandfathered plans are not required to cap out-of-pocket expenses for EHBs.

Non-grandfathered fully insured small group health plans and non-grandfathered individual plans must cover EHBs in 2014.* And ...

- These plans must meet certain EHB cost-sharing requirements.
- Most of these plans must eliminate annual dollar limits on EHBs for their 2014 plan year.
- All plans must have already eliminated lifetime dollar limits.
- These plans must cap member out-of-pocket expenses for EHBs (in-network).
- Non-grandfathered insured small group plans must cap deductibles for EHBs in 2014 at $2,000 for individual coverage and $4,000 for family coverage. The deductible cap can be exceeded if reasonably necessary to ensure the benefit plan hits a "metallic level" (actuarial value threshold).

All plan types can use these resources to help navigate the essential health benefits cost-sharing landscape.

- The EHB Cost-Sharing Requirements Recap provides a snapshot of these requirements based on a plan's grandfathered status.
- FAQs about EHB out-of-pocket limits provide details about how the safe harbor works and other important questions.

* May be subject to your health plan's anniversary date or plan year. This information does not constitute legal advice and it may be subject to change. Please consult your benefit booklet for the specific terms and conditions of your coverage.

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EHB Cost-Sharing Requirements Recap

REQUIREMENTS	DETAILS	WHO MUST COMPLY
No lifetime dollar limits[1] on EHBs	• Now and in the future • Includes in-network and out-of-network covered expenses	• Grandfathered • Non-grandfathered • All group and individual plans
No annual dollar limits[1] on EHBs	• Now and in the future • Must cover EHBs without annual dollar limits • Begins on group plan 2014 renewal date • Includes in-network and out-of-network covered expenses • Restricted annual dollar limits allowed through plan year 12/31/2013	• Grandfathered • Non-grandfathered • All group and most individual plans
Restricted annual dollar limits[1] on EHBs	• Must provide at least $2M in coverage for EHBs • Includes in-network and out-of-network covered expenses • BCBS has already removed annual dollar limits for group plans except for ASO/self-funded groups who have opted to set restricted annual dollar limits	• Grandfathered • Non-grandfathered • All group and most individual plans
Must cap member out-of-pocket expenses for EHBs	• Begins on group plan 2014 renewal date • $6,400 individual/$12,800 family is the current CMS estimated limit for 2014 • There are exceptions under a safe harbor • Includes EHB expenses from in-network providers	• Non-grandfathered • All group sizes and individual plans
Deductible cap for EHBs	• Begins on group plan 2014 renewal date • $2,000 individual/$4,000 family • Includes EHB expenses from in-network providers	• Non-grandfathered fully insured small group only for 2014

[1]Groups can set visit and frequency limits on some EHBs

Frequently Asked Questions (FAQs) EHB Out-of-Pocket Limits

Q. What benefits are considered essential health benefits (EHBs)?

EHBs include services and items across these 10 essential health benefit categories.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Habilitative and rehabilitative services and devices
8. Laboratory services
9. Preventive and wellness services, and chronic disease management
10. Pediatric services

Insured small group plans and individual plans that are non-grandfathered must cover EHBs in 2014. This applies whether these plans are sold in or outside of the exchange (also known as the Health Insurance Marketplace). The minimum package of items and services that must be covered in each of these health benefit categories is generally defined by each state's EHB benchmark plan.

Q. Which plans must cap out-of-pocket expense for EHBs in 2014?

Non-grandfathered plans that cover essential health benefits (EHBs) must cap member out-of-pocket expenses for EHBs (in-network) for plan years beginning on or after Jan. 1, 2014.

Q. How will large, self-insured and grandfathered plans define EHBs for the purpose of meeting cost-sharing requirements?

Until now, self-funded plans and carriers like BCBS were allowed to use "good faith" definitions to comply with the ban on dollar limits for EHBs. However, the government has indicated an "authorized definition" of EHBs will be needed to comply with the cost-sharing requirements in the future. At this point, it's unclear whether the "good faith" definition will stand as an HHS "authorized" definition for 2014 plan years. We are actively working to clarify details on this point.

Q. Would the state EHB benchmark plans serve as an "authorized definition" for large, self-insured and grandfathered plans?

The state EHB benchmark plans define the items and services that must be covered as essential health benefits for non-grandfathered individual and non-grandfathered, fully-insured plans in 2014. However, it is not clear whether these benchmark plans will work as an "authorized definition" for large, self-insured and grandfathered plans in 2014.

Q. What types of member expenses must be applied toward the out-of-pocket maximum?

The following types of member expenses must apply to the out-of-pocket maximum:

- ✓ Deductibles for EHBs (in-network)
- ✓ Coinsurance for EHBs (in-network)
- ✓ Copayments for EHB (in-network)
- ✓ Other EHB expenditure required by, or on behalf, of an enrollee (in-network)

Q. What types of member expenses would <u>not</u> be part of the out-of-pocket maximum?

- Cost-sharing (i.e., deductibles, coinsurance and copayments) for out-of-network benefits (for network plans)
- Balance billing for out-of-network providers
- Premiums
- Expenditures required by, or on behalf, of an enrollee for non-covered services

Frequently Asked Questions (FAQs) EHB Out-of-Pocket Limits *(Continued)*

Q. How does the out-of-pocket maximum work when essential health benefits are carved out to (administered by) more than one service provider?

Each service provider can independently calculate and maintain separate out-of-pocket maximums -- as long as the total does not exceed ACA's annual out-of-pocket cap on member expenses for essential health benefits for 2014 (CMS estimate for 2014 is $6,400 individual and $12,800 family). However, medical/surgical and mental health/substance abuse disorder benefits must be calculated and maintained together to meet federal mental health parity requirements.

EXAMPLE- Out-of-Pocket Caps for EHBs Administered by Multiple Service Providers - NO SAFE HARBOR

Service provider/ Benefits administered	INDIVIDUAL out-of-pocket limit	FAMILY out-of-pocket limit
Service Provider A /Medical Includes mental health and substance abuse	$4,100	$8,200
Service Provider B/ Pediatric Dental	$700	$1,400
Service Provider C / Pharmacy	$1,600	$3,200
TOTAL*	$6,400	$12,800

* Cannot exceed ACA's out-of-pocket cap for essential health benefits.
There are exceptions under a safe harbor.

Q. What are the details of the safe harbor related to EHB out-of-pocket limits?

The safe harbor for the 2014 plan year allows each service provider to calculate and maintain separate out-of-pocket maximums (OOPM) - as long as the OOPM for each service provider does not exceed the CMS estimated out-of-pocket limits of $6,400 individual and $12,800 family. Medical/surgical and mental health/ substance abuse disorder benefits must be calculated and maintained together to meet federal mental health parity requirements.

EXAMPLE- Out-of-Pocket Caps for EHBs Administered by Multiple Service Providers with the SAFE HARBOR IN 2014

Service provider/ Benefits administered	INDIVIDUAL out-of-pocket limit	FAMILY out-of-pocket limit
Service Provider A /Medical Includes mental health and substance abuse	$6,400	$12,800
Service Provider C / Pharmacy	$6,400	$12,800
TOTAL	$12,800	$25,600

Q. How does the safe harbor from the EHB out-of-pocket requirement work?

Each individual service provider that administers EHB benefits can maintain its own out-of-pocket (OOP) cap up to the CMS estimated limits of $6,400 individual /$12,800 family for the 2014 plan year.

If a group health plan uses multiple service providers to administer its essential health benefits, it is eligible for the safe harbor under the following conditions:

- The plan's "major medical coverage" cannot exceed ACA's OOP cap.
- Member out-of-pockets for essential health benefits beyond major medical cannot exceed ACA's OOP cap. For example a group with prescription drug coverage must limit the member's out-of-pocket expenses for these benefits to the ACA cap.
- Member out-of-pockets for medical/surgical and mental health/substance use disorder benefits must still cross-accumulate up to single OOP as required under federal mental health parity law.

Q. There are also deductible limits. Do all plans have to cap deductibles on EHBs?

Not at this time. It appears that the deductible cap only applies to non-grandfathered fully insured small group plans in 2014. However, this is subject to future rulemaking from the federal government.

This information does not constitute legal advice and it may be subject to change. Please consult your benefit booklet for the specific terms and conditions of your coverage.

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Federal Government Releases Updated FAQs on Summary of Benefits and Coverage

The U.S. Departments of Health and Human Services (HHS), Labor and Treasury on April 23 issued a series of Frequently Asked Questions that are intended to answer questions states may have about Affordable Care Act-related subjects, including the Summary of Benefits and Coverage (SBC).

The FAQs provide guidance on the preparation of SBCs for use during the "second year of applicability," –defined as documents provided in connection with group health plan and group and individual health insurance coverage beginning on or after Jan. 1, 2014, and before Jan. 1, 2015.

Topics the FAQs addresses include:

- Template (authorized for second year of applicability).
- Sample completed SBC (authorized for second year of applicability).
- No additional changes to the SBC during the second year of applicability are anticipated.
- Safe Harbor period has been extended until September 23, 2014, that meets three conditions:
  - the insured product is no longer being actively marketed;
  - the health insurance issuer stopped actively marketing the product prior to Sept. 23, 2012; and
  - the health insurance issuer has never provided an SBC with respect to the insured product.
- SBCs must include a statement about whether the plan or coverage provides minimum essential coverage (i.e., if the coverage meets the individual shared responsibility provisions of the Affordable Care Act) and if the coverage meets minimum value requirements.
- If a plan or insurer is unable to modify the SBC to include information on minimum essential coverage or minimum value, it may provide such disclosures on a separate cover letter or similar statement.
- The template and model SBC have been updated to reflect that the plan or insurer does not impose annual limits on the dollar value of essential health benefits for plan and policy years beginning on or after Jan. 1, 2014. As an alternative, the departments will allow plans and insurers to delete the row on the "Important Questions" chart regarding whether there is an overall annual limit on what the plan pays.

For any questions you may have regarding SBCs, please contact your Account Executive.

HHS Finalizes Rule on Medicaid Expansion

The U.S. Department of Health and Human Services (HHS) on March 29 released a final rule on the Affordable Care Act (ACA) Medicaid expansion to people with incomes of up to 133 percent of the federal poverty level.

Effective Jan. 1, 2014, the federal government will pay 100 percent of the cost of newly eligible adult Medicaid beneficiaries through 2016, in states that expand Medicaid eligibility. From 2017 until 2020, it will move toward a permanent 90 percent matching rate.

The final rule also describes the method states will use to claim the matching rate.

Illinois has stated it will be expanding Medicaid.

The final rule is effective 60 days after publication in the Federal Register. HHS also asked for comments on parts of the final rule. Those comments are due 60 days after the rule's publication in the Federal Register.

Additionally, HHS also released a brief Q&A on Medicaid and premium assistance describing alternative approaches to covering the Medicaid population through qualified health plans in the Exchange, also known as a health insurance marketplace.

BlueCross BlueShield of Illinois

Proposed Rule Delays Part of SHOP Exchange

You may have recently read media stories reporting that SHOP – Small Business Health Options Program – has been delayed until 2015. We wanted to provide information to update you on what is happening with SHOP in 2014.

In a proposed rule published on March 11, the U.S. Department of Health & Human Services (HHS) would delay a part of the SHOP exchange until 2015. SHOP is an exchange created by the Affordable Care Act (ACA) for small businesses and their employees. However, the proposed rule does not delay the entire program.

Through the SHOP exchange (also known as a marketplace), small employers (1-100, or 1-50 until 2016 if a state allows it) will be able to buy health coverage for their employees. Small businesses may also be eligible for the Small Business Tax Credit that is only available on the SHOP exchange. HHS regulations interpreting ACA originally provided employers three options for providing health insurance to their employees via SHOP:

- Employer choice: Employer may select one or more specific plans on behalf of employees or self
- Hybrid choice: Employer can select metallic level and then an employee can select any plan (from any carrier) within that level
- Employee choice: Employee can select any plan being offered on the exchange, if it meets SHOP requirements

The proposed rule would delay these options until 2015 for federally facilitated SHOP exchanges, including state partnership exchanges. Instead, in these exchanges, only the employer choice purchasing model is available. This means the employers select one plan for employees in 2014. The proposed rule would also delay the premium aggregation function of the SHOP exchange, which allows a SHOP to collect payments from multiple sources and submit them to the carrier, rather than having small businesses pay the insurer directly.

Under the proposed rule, state-based SHOP exchanges would still be able to offer either employee choice or employer choice in 2014. It would also allow those SHOPs to defer premium aggregation until 2015.
The comment period on the proposed rule closed on April 1. The final rule is under development. We will provide updates as the government releases additional information.

Source:
http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04952.pdf