Legislative Highlights
June 2013

BlueCross BlueShield of Illinois

Department of Labor Releases Model Exchange Notice for Employers

The U.S. Department of Labor on May 8 released **guidance** regarding the employer notification about new coverage options through the health insurance exchange (also known as the health insurance marketplace). The guidance includes model notices for employers that **provide a health plan** and for those that **don't**, and a new deadline for distributing the notice to current and new employees.

The Department of Labor originally delayed the deadline to distribute the notice in January. Employers are required to provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, the department will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice not later than Oct. 1, 2013.

The notice is required to be provided automatically, free of charge. It can be provided in writing either by first-class mail, or electronically if the department's electronic disclosure safe harbor requirements are met.

The guidance also provides an updated model election **notice** for group health plans for purposes of the continuation coverage provisions under COBRA, to include additional information regarding health coverage alternatives offered through the exchange.

We are currently reviewing the guidance and will provide more information as it becomes available.

New Update

Essential Health Benefits Cost-Sharing Fast Facts

We initially ran a version of this article with CMS estimated 2014 out-of-pocket (OOP) limits for in-network EHBs. This new version has been updated with the final 2014 OOP limits for in-network member EHB expenses released by the IRS in early May.

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.

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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 the health plan's anniversary date or plan year.

This information does not constitute legal or tax advice and it may be subject to change. Please consult your summary plan description (SPD)/benefit booklet for the specific terms and conditions of your coverage.

Update Regarding Electronic Breast Pump Coverage

As previously communicated, effective April 15, 2013, BCBSIL expanded 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.

This communication outlines the updated information regarding the limits and restrictions.

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 benefit period Coverage is the cost up to the purchase price ($125-$150)
Hospital Grade Breast Pump E0604	100% - no cost-share Rental Only (see limit/restriction)	In-Network or contracted DME supplier	Hospital grade pump only available for monthly DME rental. Coverage is up to the purchase price of $1,000 or 12 months whichever comes first. Upon end of coverage, unit must be returned to DME provider.
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.

IRS Releases Proposed Regulations on Minimum Value

On May 1, the Internal Revenue Service released proposed **regulations** on the minimum value of eligible employer-sponsored plans and other regulations regarding the federal premium tax credit.

Starting in 2014, whether a plan provides minimum value will be relevant in determining an employee's eligibility for the premium tax credit and any potential penalty owed by the employer under the Employer Shared Responsibility provisions.

The proposed regulations affect individuals who enroll in qualified health plans through health insurance exchanges (also known as health insurance marketplaces) and claim the premium tax credit, and exchanges that make qualified health plans available to individuals and employers. The proposed regulations also provide guidance on determining whether health care coverage under an eligible employer-sponsored plan provides minimum value and affects employers that offer health coverage and their employees.

Comments about the proposed regulation are due within 60 days of its May 3 publication in the *Federal Register*.

We are currently reviewing the proposed regulations and will provide more information as it becomes available.

CMS Releases Final Version of Exchange Application

On April 30, the Centers for Medicare and Medicaid Services (CMS) released a final version of the enrollment **application** individuals will use to apply for health coverage on the health insurance exchanges (also known as health insurance marketplaces).

Consumers can apply online, by phone or paper when open enrollment begins Oct. 1, 2013. On the health insurance exchange consumers will be able to use the form to apply and see all of their options for enrollment, including plans in the exchange, Medicaid, the Children's Health Insurance Program (CHIP) and potential premium tax credits.

Federal Government Releases FAQs on Annual Limit Waivers, Non-Discrimination and Clinical Trials

On April 29, the U.S. Departments of Labor, Health and Human Services (HHS) and Treasury released **FAQs** providing guidance on a number of Affordable Care Act (ACA) provisions.

Expiration Date for Annual Dollar Limit Waivers

Question one applies to health plans or issuers that have received a waiver or waiver extension to allow them to set restricted annual dollar limits on essential health benefits (EHBs). The guidance notes that the effective dates of coverage listed in a plan's or issuer's original waiver application determine the expiration date for the waiver on annual dollar limits.

In other words, if a health plan changes its plan or policy year, this will not change the waiver expiration date. For example, if a group health plan was granted a waiver based on a June 1, 2013 plan/policy year, the waiver expires on May 31, 2014 – even if the plan or issuer changes its plan/policy year. A group may terminate its annual dollar limits waiver any time before its approved expiration date. For example, a group with a May 31, 2014 expiration date can choose to terminate its waiver on Dec. 31, 2013.

The FAQ indicates that HHS can review a group's waiver to determine whether the plan or issuer is in compliance with HHS's policy on annual limit waivers. For more information about annual limits and waivers visit **http://cciio.cms.gov/programs/marketreforms/annuallimit/**.

Provider Non-Discrimination

With regard to the provider non-discrimination provision, the departments do not expect to issue regulations in the near future. Health care providers will not be prevented from participation in an insurer's provider network if willing to abide by the terms and conditions for participation and are acting within the limits of their medical license or certification. Plans and issuers should use a good faith, reasonable interpretation to implement the law. The provision is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years beginning on or after Jan. 1, 2014.

Clinical Trials

The departments also noted they do not anticipate issuing further guidance regarding coverage for individuals participating in approved clinical trials in the near future. If a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. This provision of health care reform applies to non-grandfathered group health plans and health insurance issuers offering individual or group coverage for policy or plan years beginning on or after Jan. 1, 2014. Until further guidance is issued, the departments expect health insurance issuers to implement the requirements of the law "using a good faith, reasonable interpretation of the law."

We will keep you updated if further guidance is issued on these provisions.

New SBC Tool Coming Soon

Under the **Affordable Care Act**, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). Producers and group administrators have been using the SBC PIVOT Tool to retrieve, download and distribute SBCs for standard plans to participants and beneficiaries.Effective June 17 for producers and June 24 for group administrators, the new SBC Tool link will be available on Blue Access for Producers℠ (BAP) and Blue Access for Employers℠ (BAE). This new tool allows users the continued access to the standard group SBCs. Enhancements include the ability to:

- Customize "Coverage for"
- Customize "Coverage Period"
- Access Spanish SBC(s)Look for more information coming prior to the release dates.
  Please send any questions regarding SBCs to your account or sales executive.

Affordable Care Act Frequently Asked Questions:

We regularly receive a number of questions regarding Affordable Care Act (ACA) regulations and the impact ACA will have on both employers and members. In an effort to continue offering timely information to accounts, we are sharing Frequently Asked Questions about ACA. If you have additional inquiries about the law, please reach out to your account representative.

Contraceptive Coverage

Eligible benefit plans include coverage under ACA for contraceptives to be covered without cost-sharing for plan/policy years beginning on or after Aug. 1, 2012, for non-grandfathered plans. If you have a question about an ACA provision, contact your account executive.

Q. Why aren't we covering all contraceptives?

A: The ACA provision does not mandate that all drugs and devices be covered. The rules governing coverage of preventive services allow plans to use reasonable medical management to help define the nature of the covered service.

We have identified one or more products within each of the 11 FDA-approved methods of contraception that will be covered without cost-sharing. However, we are not covering all drugs and devices without cost-sharing. **View our Comprehensive Contraceptives List.**

Q. Why are some covered contraceptives a brand name and others are generic?

A: Under the ACA provision, plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost sharing for branded drugs, if a generic version is available and just as effective and safe. In the event a member wants to determine the cost of drugs and devices that are not covered without cost-sharing, the Prime Therapeutics website has an interactive tool for calculating the cost of items per plan.

Summary of Benefits and Coverage

Q. How can a member get an SBC in a language other than English?

A: A member may request an SBC in a non-English language by calling one of the customer service numbers in the Language Access Services section of the SBC. SBCs are available in English, Spanish, Chinese, Tagalog and Navaho, and there is no fee for providing SBCs in these languages.

Preventive Services

Q. Does it matter whether or not the preventive care service is delivered by a health care provider in the Blue Cross and Blue Shield of Illinois network?

A: Yes. Members must receive preventive care services from health care providers in their employer's benefit plan network in order for the service to be covered without cost-sharing (with no co-pay, co-insurance or deductible). If employees or family members use a doctor that is not in their health benefit plan's network, they may be required to pay for all or part of the cost of the service.

The Individual mandate

We have received a number of questions about the individual mandate in the ACA. Beginning Jan. 1, 2014, most U.S. citizens and legal residents will be required to have a minimum level of health care coverage. As always, if you have a general question about an ACA provision, contact your account representative.

Q. Does an individual have to be covered for at least nine months out of the calendar year to avoid a tax penalty under the individual mandate?

A: The U.S. Department of Health and Human Services (HHS) released a proposed rule in January that clarified that short gaps in coverage won't trigger the coverage requirement, which means that temporarily unemployed individuals won't be fined for losing their health coverage between jobs.

For more information, HHS and the Internal Revenue Service released a joint fact sheet on the proposed rule.