Legislative Highlights

August 2013

BlueCross BlueShield of Illinois

Administration to Delay Employer Shared Responsibility Penalty

The Obama administration, in a blog post on July 2, announced that it will delay for a year the Affordable Care Act (ACA) mandatory employer and insurer reporting requirements and the Employer Shared Responsibility payments. The administration says it expects to release formal guidance on this delay.

We will review the formal guidance when it is released and continue to work with our clients to understand what is required by ACA and what options are available to them.

FAQs on SHOP Exchanges Now Available

The Affordable Care Act (ACA) requires most U.S. citizens and legal residents to have health insurance on Jan. 1, 2014. Under ACA, individuals and small businesses will have the option to purchase health insurance through health insurance exchanges (also known as the health insurance marketplaces).

We have created FAQs that go into more detail about the Small Business Health Options Program (SHOP) exchanges. The FAQ can be found **here**.

Among some of the questions the FAQ answers:

- What types of plans can be sold in the exchange?
- Can small groups with grandfathered plans keep their existing coverage?
- Are employers required to use the exchange to purchase insurance?
- Are there additional reasons a small group employer would use the SHOP exchange?
- What will the role of the broker be with respect to exchanges?

HHS Releases Final Rule on Standards for Navigators and Non-Navigators on Exchanges

The U.S. Department of Health and Human Services (HHS) on July 12 released a **final rule** that addresses various requirements applicable to Navigators and non-Navigator assistance personnel in federally facilitated exchanges, including state-partnership exchanges. It also applies to non-Navigator assistance personnel in state exchanges funded through federal exchange establishment grants.

The final rule:

- Finalizes the requirement that exchanges must have a certified application counselor program
- Creates conflict-of-interest, training and certification and meaningful access standards
- Clarifies that any licensing, certification or other standards prescribed by a state or exchange must not prevent application of the provisions of Title I of the Affordable Care Act
- Adds entities with relationships to issuers of stop-loss insurance to the list of entities that are ineligible to become Navigators
- Clarifies that the same ineligibility criteria that apply to Navigators apply to certain non-Navigator assistance personnel

Exchanges are also directed to designate organizations, which will then certify their staff members and volunteers to be application counselors who will assist consumers.

HHS released a **fact sheet** that describes the differences between the various consumer assistance roles.

The rule was published in the *Federal Register* on July 17.

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

IRS Releases Proposed Rule on Premium Tax Credit Reporting Requirements for Exchanges

On July 2, the Internal Revenue Service published a **proposed rule** on reporting requirements for the health insurance exchanges (also known as health insurance marketplaces) under the Affordable Care Act (ACA).

The proposed rule:

- Requires exchanges to report to the IRS information concerning individuals enrolled in qualified health plans, including the monthly amount of advance tax credit payments, if any.
- Requires exchanges to report to the IRS the specified information for each qualified health plan electronically to the IRS on an annual basis and to facilitate efficient tax administration on a monthly basis, and specify the information that must be reported in each category.
- Directs exchanges to furnish to individuals enrolled in a qualified health plan through the exchange a written statement that includes the information the exchange must report to the IRS annually.

We anticipate that public comments on the proposed rule will be due on Sept. 3.

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

Federal Government Releases Final Rule on ACA Contraceptives Coverage that Addresses Religious Exemption

On June 28, the federal government released a **final rule** that addresses a provision in the Affordable Care Act relating to coverage or payment of contraceptive services without cost sharing. The final rule clarifies the contraceptive services requirements for religious institutions and nonprofit religious organizations that object to contraceptive coverage on moral grounds. We are currently reviewing the final rule and will send you information on key aspects as they become available.

Seven Frequently Asked Questions about Clinical Trials Coverage in 2014

The Clinical Trials provision of the Affordable Care Act (ACA) goes into effect for plan years beginning on or after Jan. 1, 2014. It requires that if a "qualified individual" is in an "approved clinical trial" then the Plan may not:

1. Deny the individual participation in the clinical trial;
2. Deny the coverage of **routine patient costs** for items and services furnished in connection with the trial; or
3. Discriminate against the individual on the basis of the individual's participation in such trial.

This only applies to non-grandfathered plans.

We have had a number of questions requesting details about the provision, and we want to provide additional information about the mandate by sharing some of the more frequently asked questions.

Q What is a "qualified individual" according to ACA?

A A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" based on either of the following:

- The individual's health care provider has concluded that participation is appropriate, or
- The participant provides medical and scientific information establishing that his or her participation is appropriate according to the trial protocol with respect to treatment of cancer or other life-threatening condition.

Q What is an "approved clinical trial" according to ACA?

A An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other **life-threatening condition** or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA) or drug trials exempt from having an investigational new drug application). **A life-threatening condition** is any disease from which the likelihood of death is probable, unless the course of the disease is interrupted.

Q What are routine patient costs associated with clinical trials?

A ACA describes routine patient costs in clinical trials that health insurers must cover as "all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. " This includes items such as hospital visits, imaging or laboratory tests, and medications.

Q What is not included in the clinical trials provision?

A According to ACA, the clinical trial provision does not include:

- "The investigational treatment, device, or service itself," which is typically covered by the trial's sponsor, such as the National Cancer Institute (NCI) or a pharmaceutical company.
- "Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient."
- "A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis."

Q What is the expected cost impact resulting from the implementation of the clinical trials provision of ACA?

A The expected financial impact and cost implications estimated for clinical trials are minimal since many of the routine costs referred to in the law are services that are generally covered today.

Q What is Blue Cross and Blue Shield of Illinois' (BCBSIL) Medical Policy in regards to clinical trials for 2014?

A BCBSIL has developed policies to address the mandated coverage of clinical trials. Click **here** for our recently updated Medical Policy regarding clinical trials.

Q Is additional federal guidance expected?

A According to an FAQ released by the federal government, we do not anticipate additional guidance regarding clinical trials in the near future. While we await guidance, we will continue to operate using a good faith interpretation of the law, and we will release more information as it becomes available.

BlueCross BlueShield of Illinois

Affordable Care Act: Summary of Benefits and Coverage New SBC Tool Now Available For Small Group 2-150 AE's, Brokers, Producers & Employer Newsletters

The new Summary of Benefits and Coverage (SBC) tool is now available for small group 2-150) Brokers, Producers and Group Administrators. The new SBC Tool link is 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 the "Coverage for" section;
- Customize the "Coverage Period" section; and
- Access the Spanish SBC.

The new SBC Tool replaced the current SBC PIVOT tool beginning on Aug. 1, 2013.

The following resources are available:

- **View a demo** of the new SBC Tool.
- **View a Training Presentation**
- **Review the buckslip**

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.

MINIMUM ESSENTIAL COVERAGE

Q What happens to individuals who fail to meet the requirement to have health insurance in 2014?

A Beginning Jan. 1, 2014, most U.S. citizens and legal residents will be required to have health insurance that meets minimum essential coverage or pay a tax penalty. In 2014, the penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1% of income, whichever is greater. However, there are some exemptions to the "minimum essential coverage" requirement.

Exemptions to the "minimum coverage requirement" include those who:

1. Cannot afford coverage
2. Meet religious objection requirements
3. Have income below the minimum threshold for filing a tax return. (For example, in 2012, the threshold to file a tax return was $9,750 for an individual, $12,500 for a head of household, or $19,500 for married filing jointly.)
4. Are members of a health care sharing ministry
5. Are members of an Indian tribe
6. Have suffered hardship which includes:
   a. individuals who are projected to have no offer of affordable coverage;
   b. individuals who are not required to file an income tax return but who technically fall outside the filing threshold statutory exemption; and
   c. individuals who would be eligible for Medicaid but for a state's choice not to expand Medicaid eligibility. The hardship exemption will be available on a case-by-case basis for individuals who face other unexpected personal or financial circumstances that prevent them from obtaining coverage.

7. Are in prison or jail
8. Have coverage gaps of less than three months in a year
9. Are undocumented immigrants

SHOP EXCHANGES

Q We heard reports that the federally facilitated SHOP exchanges won't be operational in 2014. Is that true?

A No. The U.S. Department of Health & Human Services released a final rule on May 31 that delayed a portion of the Small Business Health Options Program (SHOP) exchange until 2015. However, the final rule does not delay the entire program.

SHOP is a health insurance exchange (also known as a health insurance marketplace) created by the Affordable Care Act for small businesses and their employees. Under the final rule, employee choice will be delayed in the federally facilitated exchange and will be made optional for state-based exchanges in 2014; employers may select one plan for employees in 2014 in federally facilitated exchanges. State-based SHOP exchanges will still be able to offer either employee choice or employer choice in 2014.

INDIVIDUAL EXCHANGE

Q When is open enrollment on the individual exchange?

A The health insurance exchange, also known as the health insurance marketplace, is scheduled to open on Oct. 1, 2013. Because the program is new, individuals will have until March 31, 2014, to buy a plan for 2014. After the first year, open enrollment will run from Oct. 15 to Dec. 7 each year. The exchange will provide special enrollment periods for people who have life changes or other situations.

INDIVIDUAL HEALTH INSURANCE EXCHANGE

Q What's the difference between a premium tax credit and a cost-sharing subsidy?

A A premium tax credit is a monthly amount that lowers your (or your family's) eligible payment for insurance coverage. The assistance may help taxpayers with income between 100 and 400 percent of the Federal Poverty Level. It's a refundable credit, which means that it even helps people who don't file an income tax return. The credit may also be paid in advance to a taxpayer's insurance company to help cover the cost of premiums. Cost-sharing subsidies limit the maximum out-of-pocket costs a health plan may charge. For eligible people, cost-sharing amounts — such as deductibles, coinsurance or copayments — would be reduced.

WOMEN'S PREVENTIVE SERVICES

Q I know that BCBSIL expanded its coverage of electric and hospital grade breast pumps in addition to manual breast pumps a few months ago. Where can members purchase or rent the pumps?

A As of Apr. 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 in addition to manual breast pumps.

- Manual breast pumps can be purchased at local retail locations.
- An electric breast pump can only be purchased from an in-network provider or contracted Durable Medical Equipment (DME) supplier.
- Hospital grade breast pumps are available for rental only from a contracted DME supplier.