Legislative Highlights

November 2013

BlueCross BlueShield of Illinois

Obama Administration Issues Guidance on Individual Mandate Deadline

The Obama administration issued guidance this week that allows individuals until March 31, 2014, to enroll in coverage through the Health Insurance Marketplace without having to pay the individual shared responsibility tax penalty.

Under the Affordable Care Act, beginning Jan. 1, 2014, most U.S. citizens and legal residents are required to have health care coverage or may face a tax penalty.

However, before this recent guidance, a situation might have arisen where some individuals who enrolled during the open enrollment period would have been subject to the individual shared responsibility tax penalty. Under the new guidance, the government will consider anyone who enrolls via the Marketplace by March 31, 2014, as having met the individual mandate requirement for 2014.

Open Enrollment and Special Enrollment Periods on the Health Insurance Marketplace

The opening of the **Health Insurance Marketplace** provides access to purchase individual products for people who may not have previously had access to health insurance.

While many people will continue to keep employer-sponsored coverage, some may have lost their coverage, or simply want to explore their options on the Marketplace.

Open enrollment for individual coverage for eligible U.S. citizens and legal residents on the Marketplace extends from Oct. 1, 2013, to March 31, 2014.

Once open enrollment ends, there are still certain circumstances when someone may be able to apply for coverage on the Marketplace outside of the Marketplace open enrollment dates. Here are some FAQs about open enrollment, special enrollment periods and COBRA:

Q When does coverage on the Marketplace take effect?

A Since open enrollment for 2014 will last longer than usual — from Oct. 1, 2013, to March 31, 2014 — the effective date of an individual's health insurance coverage will depend on when he signs up for a plan:

- Enrolls on or before Dec. 15, 2013 – coverage will be effective on Jan. 1, 2014.
- Enrolls between the first and 15th of any subsequent month – coverage will be effective on the first day of the following month. For example, an individual enrolls Jan. 5, 2014; coverage will start on Feb. 1, 2014.
- Enrolls between the 16th and the last day of any month between Dec. 1, 2013, and March 31, 2014 – coverage will be effective on the first day of the second following month. For example, an individual enrolls on Feb. 22, 2014; coverage will start on April 1, 2014.

After this ***initial*** open enrollment, the open enrollment period will begin on Oct. 15 and end on Dec. 7 of each year and coverage will be effective Jan. 1 of the following year.

Q What if a person's situation changes and he needs health care coverage? Can he go to the Marketplace outside of the open enrollment period?

A If a person loses his job or has another qualifying life event, he may qualify for a special enrollment period on the Marketplace. A person will qualify if:

- He loses minimum essential coverage.
- He gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption.
- He becomes a citizen, national or lawfully present individual.
- He is eligible to enroll but didn't because of a mistake, misrepresentation or inaction of an officer, employee or agent of the Marketplace.
- The plan he enrolled in substantially violated a material provision of its contract with the individual.
- He becomes newly eligible for premium tax credits or cost-sharing assistance.
- He becomes ineligible for premium tax credits or cost-sharing assistance.
- He makes a permanent move and has access to new health plans.
- He is a member of an American Indian tribe. (American Indians can enroll in a plan or change plans one time each month.)
- He demonstrates to the Marketplace that he has other extenuating circumstances that qualify him for special enrollment.

When any of these situations happen, he will have 60 days to go to the Marketplace to enroll in a health insurance plan or change plans.

If he buys insurance directly from Blue Cross and Blue Shield of Illinois, he can update his information online in Blue Access for Members℠ or by calling the number on the back of his member ID card. If he loses his coverage during the year, he can also qualify for a special enrollment period on the Health Insurance Marketplace (subject to certain exceptions, including loss of coverage for failure to pay premiums on a timely basis).

Q If a person is covered as an individual in the Marketplace, can he decide to drop his Marketplace coverage at any time and come back on the employer-sponsored group plan?

A The qualifying events for an individual to be eligible for the group coverage plan are the same qualifying events as listed above. There must be an open enrollment or a qualifying event in order for the employee to come back on the group health plan.

Q If a person has employer-provided coverage, can he seek coverage on the Marketplace?

A Yes, a person with employer-provided coverage may seek coverage on the Marketplace. However, if the person is eligible for employer-sponsored coverage that is affordable and meets minimum value, he may not be eligible for the premium tax credit and cost-sharing assistance on the Marketplace. He should also review his employer's eligibility rules before making a decision about the coverage option that is right for him.

Q What if an employee is not on the group plan and is not eligible until open enrollment of May 1, 2014? Can he obtain coverage on the group plan effective for Jan. 1, 2014, or does he have to wait for open enrollment? If he has to wait until open enrollment, will he face a penalty?

A Affordable Care Act regulations state that an individual is not liable for a penalty for lack of carrying minimum essential coverage until they have had an opportunity to enroll in the employer's health plan if they will be eligible during the annual open enrollment. For example, in this case, because the employee is eligible for his group plan, but open enrollment does not begin until May 1, 2014, he will not face a penalty for not having minimum essential coverage. However, he will not be able to enroll in his employer's coverage until May 1, 2014.

Q How will the Affordable Care Act affect COBRA eligibility?

A The Affordable Care Act did not eliminate COBRA or change the COBRA eligibility rules.

Q If a person loses his job, can he retroactively get coverage on the Marketplace? For instance, if he loses his job and his coverage ends on Feb. 1, can he buy an individual plan on the Marketplace on March 1 and be covered retroactive to Feb. 1?

A No. If a person purchases coverage on the Marketplace on March 1, it would begin on April 1.

Q If a person loses his job on Feb. 1, can he go on COBRA until he can purchase a plan on the Marketplace and it becomes effective? For instance, if he loses his employer coverage as of Feb. 1, can he purchase an individual plan on the Marketplace that goes into effect on March 1, but accept and pay for COBRA for February?

A Yes. In this scenario, a COBRA-eligible employee can carry COBRA coverage until his new Marketplace Qualified Health Plan is effective on March 1.

Q Can someone drop COBRA coverage to get Marketplace coverage at any time?

A No. A person can only drop COBRA coverage to switch to Marketplace coverage during the open enrollment period. Outside of the open enrollment period, a person can seek Marketplace coverage once his COBRA coverage expires.

Updated 90-day Waiting Period FAQ Now Available for Employer Groups

A newly updated and expanded FAQ for the 90-day waiting period provision is now available (see below).

This FAQ has been updated with new regulatory information that was included in the FAQ released by the federal government in March. The FAQ also includes additional details of Blue Cross and Blue Shield of Illinois' (BCBSIL) business decisions and implementation plans for group accounts impacted by the 90-day waiting period requirements.

Updated 90-Day Waiting Period FAQ

This provision of the Affordable Care Act applies to all fully insured and self-insured group health plans — both grandfathered and non-grandfathered. It does not apply to plans in the individual market.

The federal government issued a proposed rule on the 90-day waiting period in March 2013. The government issued an FAQ in September 2013 that clarifies the following, among other things:

- Plans and issuers can rely on the agencies' guidance from the March 2013 proposed rules at least through 2014.
- To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to Jan. 1, 2015.

The following examples and FAQs show how we are administering the 90-day waiting period and answers some frequently asked questions. Our cross-functional workgroup will review and address any operational issues that may arise. Please note that our current interpretation of the requirements and our business approach could change based on final rules when they are issued.

EXAMPLES:

An employee is hired Sept. 15, 2013, and the group's effective date is Jan. 1, 2014. Since the individual's waiting period has exceeded 90 days at the start of their plan year, coverage must be made available as of Jan. 1, 2014.

An employee is hired March 1, 2014, and the employer has a June 1, 2014, plan year. That employee's coverage must be available as of the start of the plan year on June 1, 2014, so the waiting period does not exceed 90 days.

Frequently Ask Questions (FAQs)

Q Can benefits start on the 91st day or the first of the month following 90 days?

A The 91st day or the first of the month following 90 days of the date of hire will no longer be options that we administer.

Q Are there any plans that are excluded from the 90-day waiting period?

A The provision applies to both grandfathered and non-grandfathered group health plans, and fully insured and self-insured business. It also applies to government accounts. It does not apply to plans in the individual market.

Q Does this need to be applied on Jan. 1, 2014?

A It needs to be applied on the first plan year on or after Jan. 1, 2014.

Q What if an employee elects coverage late? Do they still have to be insured within 90 days?

A Under the proposed rule, coverage needs to be made available to employees and their dependents within 90 days, but there is no penalty to the employer or plan sponsor if an employee or dependent is late in electing coverage, which causes the 90-day period to be exceeded.

Q How does the proposed rule work for employees who are already in a waiting period prior to Jan. 1, 2014?

A For employees who are already in a waiting period prior to Jan. 1, 2014, the days served prior to the plan year will count towards the 90-day waiting period limitation.

Q Does the new 90-day waiting period limitation have a significant impact on our existing business?

A Most large group and ASO groups have a 30-day waiting period. We anticipate that this will mostly impact small group accounts.

Q What operational changes will BCBSIL have to make to meet the new requirements?

A We have formed an implementation workgroup that is continuing to develop strategies, update documentation, implement procedures, and communicate new information.

Q How will BCBSIL communicate the changes to groups?

A We have developed a communications plan that details our outreach to producers and employers about the provision. All impacted accounts will be notified in October, November and December of actions required in order to comply with the waiting period requirements. Communications are being created for different market segments, for plans with an effective date of Jan. 1, 2014, and after.

New 2014 Summary of Benefits and Coverage Available as of Oct. 1, 2013, for Groups 2-150

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). SBCs for plans beginning on or after Jan. 1, 2014, are now available in the SBC Tool.

If you need a 2013 or 2014 template, you will be able to access either version via the plan year drop-down menu on the SBC Tool.

The Spanish SBCs will be available this month.

The updated **training demo** of the new SBC Tool is available for viewing. We have provided a **PDF copy of the training** for your convenience. For quick reference, you can also **view this buckslip**.

Please send any questions you may have regarding SBCs to your account representative.

Reminder: Summary of Benefits and Coverage Replaces Highlight Sheets for 2-150 Groups

Under the **Affordable Care Act** (ACA), all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan. The SBC is intended to provide clear, consistent, easy-to-understand descriptions that may make it easier for people to understand their health insurance coverage and for consumers to shop for and compare insurance plans.

The SBC is completed using a government-designed template, so the SBC is consistent across all health insurance plans. The SBC includes:

- What is covered by the plan
- What is not covered by the plan
- Cost-sharing provisions and exclusions
- Coverage examples
- A website and phone number for customer service and obtaining more information

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in the insurance policy.

Due to the ACA requirement, as of Oct. 1, 2013, Blue Cross and Blue Shield of Illinois (BCBSIL) has replaced the current highlight sheets with SBCs for all 2-150 groups. BCBSIL will no longer manage or oversee the creation and administration of highlight sheets. As previously communicated, you will be able to retrieve an SBC using the new SBC Tool to customize the "Coverage Period" and "Coverage For" sections.

For further instructions on SBC customization, please refer to the updated **training demo**. We have provided a **PDF copy of the training** for your convenience. For quick reference, you can also **view this buckslip**.

Summary of Benefits and Coverage — SBC Updated on the SBC Tool (1-150 Groups)

You may have recently retrieved a Summary of Benefits and Coverage (SBC) from the SBC Tool that describes an overview of what your plan covers and your level of cost-sharing for those services. Update(s) have been processed and are now available on the SBC Tool to retrieve.

Review the below listing for more details on the update(s) and always review the SBC for accuracy before distributing to members.

We appreciate your patience as we continue to improve our processes.

Updated Plans

Plan	Update
All NGEN Plans	Various updates
All non-HSA NSRG Plans	Out-of-Pocket Maximum updated to exclude "Prescription Copays"

New Clinical Trials Flier Available

The clinical trials provision of the Affordable Care Act goes into effect for non-grandfathered plans 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 health insurance plan may not:

- Deny the individual participation in the clinical trial.
- Deny the coverage of routine patient costs for items and services furnished in connection with the trial.
- Discriminate against the individual on the basis of the individual's participation in such trial.

In an effort to provide you and your group clients with more information, we have created this **flier**, detailing some popular questions and answers regarding clinical trials. You can download, print and share the flier. As always, feel free to contact your account representative with any clinical trials questions you or your clients may have.

Your Group's Bill and ACA Fees in 2014 (Fully Insured Groups)

Throughout the year, Blue Cross and Blue Shield of Illinois (BCBSIL) has provided information on the Affordable Care Act (ACA) fees that go into effect beginning January 2014. In addition to any applicable federal and state taxes, fees will include:

- Annual Fee on Health Insurers ("Health Insurers Fee")
- Transitional Reinsurance Program Contribution Fee ("Reinsurance Fee")

Fully Insured Plans

In January 2014, your group's bill will display a separate line notice of a total for ACA fees. Because each ACA fee is calculated differently, the exact dollar amount of these fees is shown collectively on the bill of the group market segment affected.

Here's an example of the 2014 group bill with the ACA fees notice.

You can also see the ACA fees information in the group bill online at **Blue Access for Employers**[SM].

Final ACA Fee Percentages

The Annual Fee on Health Insurers (Health Insurer Fee) and the Transitional Reinsurance Program Contribution Fee (Reinsurance Fee) have been finalized for BCBSIL fully insured groups as a percentage of billed premiums in 2014. Refer to the chart below, which identifies the final percentages by market segment.

State	Small Group (2-50)	Non-Regulated Small Group (51-150)	Large Group (151+)
IL	3.1	3.25	3.25

Resource Information

If you want more details about ACA fees, please contact your BCBSIL representative.

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.

Appeals and External Review

Q **Under ACA, what are the requirements for providing notices about the appeals process in foreign languages?**

A There are certain requirements for adverse benefit determinations associated with non-grandfathered plans and policies. Plans or insurers must provide a notice, upon request, in an applicable non-English language as identified by the Department of Health and Human Services (e.g., Spanish, Tagalog, Navajo or Chinese) if 10 percent or more of the population of a member's county of residence is literate in the same non-English language.

In the English version of notices, plans and insurers must also include a statement in any applicable non-English language that tells members how to access the plan's or insurer's language services. Blue Cross and Blue Shield of Illinois made the business decision to accommodate all requests in the four languages (Spanish, Tagalog, Navajo or Chinese), regardless of county of residence or grandfathered status. Since we do not track requests, it is only a one-time request. Members must make a new request for each notice that they need translated.

Grandfathering

Q **Will grandfathering end? Can a group remain grandfathered in 2014 at renewal if it continues to meet the ACA grandfather requirements?**

A To date, there has not been any guidance or language from the federal government to suggest that grandfathering will end. As long as the group continues to comply with existing grandfathering rules, it can remain grandfathered. To learn more about changes that can trigger a loss in grandfathered health plan status, refer to this Grandfathered Plan Fact Sheet.

BlueCross BlueShield of Illinois

Clinical Trials

The clinical trials provision of 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.
3. Discriminate against the individual on the basis of the individual's participation in such trial.

This only applies to non-grandfathered plans.

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). Examples include 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.

Minimum Essential Coverage

Q How much is the penalty if a person does not get coverage in 2014?

A Beginning in 2014, most people who choose to go without coverage will pay a tax penalty, unless they are part of an exempt group or qualify for an exception.

The shared responsibility penalty is the lesser of:

1. The sum of the monthly penalty amounts for each individual in the shared responsibility family; or
2. The sum of the monthly national average Bronze plan premiums for the shared responsibility family.

In 2014, the penalty is $95 per adult and $47.50 per child (with the penalty for a family capping at $285), or 1 percent of income, whichever is greater. However, neither of these penalties may exceed the cost of the national average of the lowest Bronze metallic plan on the exchange. These penalties will increase each year.

Note that some people are exempt from the Individual Shared Responsibility tax penalty because of financial hardship, religious beliefs, incarceration, or if they have special coverage as established by another law, such as American Indians.