Legislative Highlights

October 2013

BlueCross BlueShield of Illinois

Fact Sheet on Health Insurance Marketplace Now Available

We have created a new **fact sheet** about the Health Insurance Marketplace which gives readers a quick snapshot about coverage options, financial assistance and features of the health plans available on the Marketplace.

The fact sheet includes answers to the following questions:

- How does the Health Insurance Marketplace work?
- What if a person can't afford health insurance?
- What coverage options will be available on the Marketplace?
- What are the major features of the Qualified Health Plans available in the Marketplace?

FAQs on Employer Marketplace Notice

Employers subject to the Fair Labor Standards Act (FLSA) are required to distribute the notice about the Health Insurance Marketplace of Illinois to employees. Below are some frequently asked questions and answers about the notice, including one update and one new question about what information employers need to provide on the notice.

What is the Marketplace notification?

Employers who are subject to the FLSA have to send a notice to employees about new coverage options through the Marketplace.

To which employers does this apply?

According to the **Department of Labor** (DOL), the FLSA applies to employers that employ one or more employees who are engaged in, or produce goods for, interstate commerce. For most employers, a test of not less than $500,000 in annual dollar volume of business applies.

The FLSA also specifically covers the following entities: hospitals; institutions primarily engaged in the care of the sick, the aged, mentally ill, or disabled who reside on the premises; schools for children who are mentally or physically disabled or gifted; preschools, elementary and secondary schools, and institutions of higher education; and federal, state and local government agencies.

This **link** from the DOL may provide some additional assistance about who is subject to the FLSA. However, the employer needs to make the determination on whether it is subject to the FLSA.

What information do employers need to provide?

Section 18B of the FLSA, as added by Section 1512 of the Affordable Care Act (ACA) **states** the notice to inform employees of coverage options must include the following:

1. Informing the employee of the existence of the Marketplace including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;

2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and
3. If the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

All of that information can be found on the first page of the model employer Marketplace notice that the Department of Labor (DOL) has provided:

- **Model Notice for Employers who Provide a Health Plan**
- **Model Notice for Employers without a Health Plan**

Employers who would like to fill out the information on pages two and three of the form may do so. However, the information that ACA requires is found on the first page of the model notice.

What is the deadline for distributing the notice?

Employers are required to provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, an employer has to provide the notice 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 by Oct. 1, 2013.

By what method does the employer have to distribute the notice?

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.

Is there a model notice that employers can use?

Yes. The federal government has released model notices for employers that provide a health plan and for those that don't.

- **Model Notice for Employers that Provide a Health Plan**
- **Model Notice for Employer Without a Health Plan**

Employers can use these notices until the federal government releases final notices. The forms are also available in Spanish **here** (provide a health plan) and **here** (don't provide a health plan). Additional details are on the DOL **website**.

The federal government may be updating the notice in the future. However, employers are allowed to use the currently available versions.

HHS Releases Final Rule on Health Insurance Marketplace

On Aug. 28, 2013, the U.S. Department of Health and Human Services released a **final rule** that covers several aspects of the Affordable Care Act's Health Insurance Marketplace.

The 300-page final rule outlines Marketplace standards with respect to eligibility appeals, agents and brokers, privacy and security, issuer direct enrollment and the handling of consumer cases. It also finalizes standards regarding a state's operation of the Marketplace and Small Business Health Options Program.

The rule will be effective 30 days after its publication in the *Federal Register,* which was scheduled for Aug. 30, 2013. We are currently reviewing the final rule and will provide more information as it becomes available.

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BCBSIL 2014 Approach: EHB "Authorized" Definition to Address Dollar Limits and Out of Pocket Maximum (OOPM)

Why is this important for fully insured and self-funded large groups (51+)?

Large groups regardless of funding type and grandfathered small group plans are not required by the Affordable Care Act (ACA) to cover essential health benefits (EHBs) in 2014. However, for any EHBs covered beginning with the 2014 plan year, insurers and self-funded plan sponsors must use an "authorized" definition when designing their benefit plans to meet the following ACA requirements for these plan types:

- No annual or lifetime dollar limits on any EHBs that happen to be covered; and
- Non-grandfathered plans must set limits on member cost-sharing for any in-network EHBs (and out-of-network emergency services) they cover. The out-of-pocket maximum cannot exceed $6,350 for individual coverage and $12,700 for family coverage in the 2014 plan year.

Previously, insurers and self-funded plan sponsors could use a "good faith" definition to determine which benefits are considered EHBs for the purpose of removing lifetime and annual dollar limits on EHBs.

Starting with the 2014 plan year, insurers and self-funded plan sponsors must use an "authorized" definition to determine which benefits are EHBs. This means using a definition authorized by the Secretary of the United States Department of Health and Human Services (HHS). For now, HHS has indicated that a state EHB benchmark plan, as supplemented (if necessary) by HHS to include coverage of all 10 EHB categories, is considered an "authorized" definition. Future guidance is expected from the federal government on this topic.

What is the BCBSIL standard approach to an EHB "authorized" definition for 2014?

Our standard approach to an "authorized" definition for EHBs will be to follow the **benchmark plan**[1] for the state in which the coverage has been issued.

Important notes for large accounts:

- Only custom accounts (both self-insured and fully insured) can select which EHBs will be covered for their 2014 plan year.
- Custom accounts can request an alternative "authorized" definition through their BCBSIL account representative.
- Any dollar limits on EHBs that may be covered by standard (pre-packaged) plans (51+) will be removed or converted to visit or item limits. To identify EHBs, we will follow the EHB benchmark plan in the state in which the coverage has been issued.
- Contact your BCBSIL account representative with additional questions about our standard approach to EHB and OOPM requirements.

[1]The link provided for the state benchmark plans go the **cms.gov** website. The benchmark plans published on this site may not include comprehensive details for each state.

This information does not constitute legal or tax advice and it may be subject to change.

The information provided here is only intended to be a brief summary of the laws that have been enacted and is not intended to be an exhaustive description of the laws or a legal opinion of such laws.

IRS Releases Two Proposed Rules on Employer Shared Responsibility Provisions

On Sept. 5, the Internal Revenue Service (IRS) released two proposed rules on the reporting requirements of the Employer Shared Responsibility provisions of the Affordable Care Act.

The proposed rules involve reporting requirements in Sections **6055** and **6056** of the Internal Revenue Code, which the Obama administration delayed until 2015. Both proposed rules seek comments about streamlining the information that employers, insurers and other entities must provide to the IRS.

Comments for the two proposed rules are due 60 days after publication in the *Federal Register*. We are currently reviewing the proposed rules and will provide more information as it becomes available.

IRS Releases Rules on Individual Shared Responsibility, Small Business Tax Credit

The Internal Revenue Service (IRS) recently released two rules related to the Affordable Care Act (ACA).

The **final rule** implements the Individual Shared Responsibility requirements, including what is considered Minimum Essential Coverage (MEC) and what is required to maintain MEC. The U.S. Department of Health and Human Services released a related **final rule** on MEC on July 1.

The IRS released a **proposed rule** on ACA's Small Business Health Tax Credit. Among the highlights of the proposed rule:

- Small employers must purchase coverage through the Small Business Health Options Program to be eligible.
- Transition relief is available for eligible small employers with plan years beginning on a date other than the first day of its taxable year.
- An employer cannot have more than 25 full-time employees and must pay at least 50 percent of the premium, and the average annual wages have to be less than $50,000 per full-time employee.
- The maximum tax credit increases to 50 percent of the premium costs (and up to 35 percent for tax-exempt organizations).
- Proposes rules for who counts toward the 25 full-time employees and for determining annual wages.
- Provides details on calculating the tax credit, which begins to phase out if the number of employees exceeds 10 or when the average annual wages exceed $25,000.
- The tax credit is available to small employers for two consecutive taxable years.

Public comments on the proposed rule will be due 90 days after publication in the *Federal Register*.

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

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

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, will be available in the SBC Tool system on Oct. 1, 2013, on the new SBC template format.

The Departments of Health and Human Services, Labor and Treasury issued a series of **Frequently Asked Questions** on April 23, 2013, that included the SBC update. The updates to the SBC template will include the following:

- Annual Limit Row has been removed
- Minimum Essential Coverage (MEC) language added
- Minimum Value (MV) Standard language added

If you need a 2013 template, you will still be able to access it via the plan year drop-down menu in the SBC Tool.

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

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

Employer Shared Responsibility

Q. What is happening with Employer Shared Responsibility?

A. In early July, the Obama administration **announced** that it will delay until 2015 the ACA mandatory employer and insurer reporting requirements and the Employer Shared Responsibility payments. The Internal Revenue Service plans to issue regulations on the reporting requirements later this year. We will review those proposed regulations when they are released and continue to work with our clients to understand what is required by ACA and what options are available to them.

Clinical Trials Coverage

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:

- 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

This applies only to non-grandfathered plans.

Q: What is a qualified individual for clinical trials 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.
- 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.

Summary of Benefits and Coverage (SBC)

Q. What is the process for creating an SBC for fully insured or ASO groups for a Jan. 1, 2014, effective date and beyond?

A. By law, the insurer and the employer each have the independent responsibility of creating and distributing the SBC for fully insured health plans. The law makes it the employer's responsibility to create and distribute the SBC for self-insured plans. The health insurer has no legal obligation to do so.

Here is the process for each type of group:

FULLY INSURED GROUPS

Our approach to fully insured groups:

- We will create the SBC for all fully insured plans and ensure that information is accurate.
- We will only create the SBC for medical benefits that we administer. The employer is responsible for gathering information for benefits that we do not administer.
  - **For standard fully insured plans,** the group administrator will access the SBC using our SBC Tool and will distribute it to members. A link with access instructions to our SBC site has been distributed to all group administrators. Group administrators will have the ability to log on to the site to access their plan's SBC.
  - **For custom fully insured plans,** the Account Executive (AE) will request BCBSIL's services to create the SBC per the Benefit Program Application (BPA). The AE and/or the plan administrator will validate and approve the information in the SBC. The AE will provide the completed SBC electronically to the group administrator, who will distribute it to members per the Benefit Program Application (BPA).
- We will provide translation services and provide the SBC in foreign languages in accordance with the regulation. The employer must request the SBC in a foreign language. We will not automatically provide SBCs in foreign languages.

SELF-INSURED GROUPS

The law makes it the employer's responsibility to create and distribute the SBC for self-insured plans. BCBSIL has no legal obligation to do so.

Our approach to self-insured groups:

- We will create the SBC for self-insured groups that request our services per the BPA.
- The AE and/or the plan administrator will validate and approve the information in the SBC.
- The AE will provide the completed SBC electronically to the group administrator, who will distribute it to members per the BPA. If an ASO client requests BCBSIL to print and mail the SBC to subscribers, a fee will be assessed as noted on the BPA.
- We will provide translation services and provide the SBC in foreign languages in accordance with the regulation. The employer must request the SBC in a foreign language. A fee will be assessed. We will not automatically provide SBCs in foreign languages.