Legislative Highlights
April 2014

BlueCross BlueShield of Illinois

Federal Government Releases Proposed, Final Rules on Marketplace, Reporting Requirements

The U.S. Department of Health and Human Services (HHS) recently released several proposed and final rules related to Get Covered Illinois, the Official Health Marketplace of Illinois and the Basic Health Program under the Affordable Care Act (ACA). Also, the Internal Revenue Service (IRS) released final rules on reporting requirements related to minimum essential coverage and employer-sponsored coverage.

HHS released a **proposed rule** on the Marketplace and insurance market standards for 2015 and beyond. The proposed rule:

- Sets forth standards related to product discontinuation and renewal, quality reporting, non-discrimination standards, minimum certification standards and responsibilities of Qualified Health Plan issuers operating in the individual exchanges and the Small Business Health Options Program (SHOP).
- Adjusts parameters of ACA risk mitigation programs (risk adjustment, risk corridors and reinsurance, or 3Rs) to account for market uncertainty stemming from the administration's November 2013 transitional policy as well as sets forth additional standards related to the 3Rs.
- Updates various other aspects of ACA initiatives, including:
  - standards for consumer assistance programs;
  - the opt-out provisions for self-funded, non-federal governmental plans and the individual market provisions under the Health Insurance Portability and Accountability Act of 1996; and
  - recognition of certain types of foreign group health coverage as minimum essential coverage.

The IRS released two final rules regarding how information on minimum essential coverage and employer-sponsored coverage should be reported to the government.

The **final rule** on Section 6055, which will assist the IRS in tracking minimum essential coverage to help enforce the individual mandate:

- Provides two avenues for penalty relief.
- Says the IRS will use Taxpayer Identification Numbers (TINs) to track whether individuals have coverage. A date of birth may be used in place of the TIN under certain conditions.
- Applies to health insurance issuers, certain employers and government agencies that provide minimum essential coverage to their employees.

The **final rule** on Section 6056:

- Applies to employers with 50 or more full-time employees.
- Requires applicable employers to report information about health care coverage they offer to their full-time employees.
- Allows self-insured employers to have a single, consolidated form to report to the IRS and employees under both sections 6055 and 6056.
- Contains standards on ACA's requirements on employer-furnished statements so that employees can determine, on an annual basis, whether they may claim a federal premium tax credit.

The 2015 Notice of Benefits and Payment Parameters final rule sets forth rules on payment parameters and oversight provisions, cost-sharing parameters and cost-sharing reductions and user fees for federally facilitated Marketplaces. It also provides standards for a variety of provisions, including privacy and security of personally identifiable information, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans and SHOP.

CMS also released a **final rule** on the Basic Health Program (BHP). The final rule sets forth a framework for BHP eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states and federal oversight.

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

Updated Fliers and FAQs

We've updated a number of fliers and FAQs to keep you informed and help you stay current on the latest ACA-related information.

Health Care Reform Overview Charts:

- Individual and Small Group (1-50) Plans
- Large Group (51+) Plans

Open and Special Enrollment FAQs

SHOP FAQs

Pre-existing Condition Exclusions FAQs

2015 Cost-sharing Limits

The U.S. Department of Health and Human Services' Notice of Benefit and Payment Parameters for 2015 **final rule** set the following cost-sharing parameters for 2015.

- **Out-of-pocket Maximum:** The maximum annual limit on cost sharing will be **$6,600** for self-only coverage and **$13,200** for family coverage. As a reminder, if a plan is non-grandfathered, out-of-pocket member expenses for in-network essential health benefits (EHBs) cannot exceed these out-of-pocket limits.
- **Deductible Limit for Small Groups (1-50):** The maximum annual limit on small group deductibles will be **$2,050** for self-only coverage and **$4,100** for family coverage. As a reminder, non-grandfathered small group plans must cap deductibles for in-network EHBs at these amounts.
- **Pediatric Dental Coverage:** Stand-alone pediatric dental plans covering pediatric dental EHBs will have cost-sharing limits of **$350** for coverage of one child and **$700** for coverage of two or more children.

Federal Government Again Extends Pre-Existing Condition Insurance Plan Coverage

On March 14, the Centers for Medicare & Medicaid Services (CMS) **announced** that it will again extend transitional coverage to those currently enrolled in the **Pre-Existing Condition Insurance Plan** (PCIP). Under the new arrangement, coverage in the PCIP, which is the temporary federal high-risk pool program, can be extended until April 30, 2014.

The **Affordable Care Act** created the PCIP to make health coverage available to eligible individuals with pre-existing conditions until 2014, when the pre-existing condition exclusions provision became effective for people of all ages and coverage became available through Get Covered Illinois, the Official Health Marketplace of Illinois.

The PCIP in Illinois will offer extended coverage through April 30, 2014.

In February 2013, CMS announced that it was suspending enrollment of new applicants in the PCIP. State-based PCIPs suspended their enrollment as well.

Clarification of "Your Cost" and the "Limitations & Exceptions" Columns on the SBC

We have recently received questions surrounding the wording in the Summary of Benefits and Coverage (SBC). Plans and issuers must complete the responses in the "Your Cost" and the "Limitations & Exceptions" columns with specific wording:

- A coinsurance percentage must be in the "Your Cost" columns (in network/out of network), if applicable.
- If there is no coinsurance, there are two statements that are allowed:
  - "No charge" if the employee pays nothing
  - "Not covered" if the service is not a covered benefit

The amounts listed are applicable after any overall deductible and per-occurrence deductibles. The wording on Page 1 of the SBC under the "Why this Matters" column states the member must pay up to the deductible amount before the plan begins to pay for the covered services.

The SBC is a government-issued template with only minor wording modifications allowed. Therefore, we are unable to change the wording in the "Your Cost" and the "Limitations & Exceptions" columns to "No Charge after the Deductible."

Review the SBC template.

Custom Summary of Benefits and Coverage (SBC) Request Tool Enhancements Coming Soon for Groups 151+

The SBC Team will roll out enhancements to the **Custom SBC Request Tool** in late April 2014.

These user-requested enhancements are designed to make the use of the Custom SBC Request Tool simpler. Some of the enhancements include:

- 'Type of Request' tab
  - Update to 'Submission types' to support easier identification of various submissions
  - Update to required fields including ability to enter data-specific information
  - Ability to add additional information related to translation requests, including specific benefit agreement details
- Additional categories to simplify searches
- Enhanced features to support the print and mail process
  - Updated requestor capabilities
  - Additional email notifications
  - Additional status categories

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SBC Updated on the SBC Tool for Illinois Groups 1-50

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. Updates have been processed and are now available on the SBC Tool to retrieve.

Review the below listing for more details on the updates 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 2014 NGEN plans (1-50)	In the deductibles section, "Doesn't apply to certain preventive care & copays" was replaced with "Doesn't apply to preventive care & certain copays."
PS314BCSIILO	Removed "Prescription drugs do not apply to the deductible" from the Rx section.