Legislative Highlights

September 2013

BlueCross BlueShield of Illinois

Nine FAQs about the 90-Day Waiting Period

For plan years beginning on or after Jan. 1, 2014, a group health plan or health insurance issuer offering group health insurance coverage cannot apply any waiting period that exceeds 90 days to individuals seeking to enroll in the health plan. A waiting period is the period that must pass before coverage for an employee (or dependent) who is otherwise eligible to enroll under the terms of the plan can become effective.

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. We have formed a cross-functional workgroup to review and address any operational issues necessary for compliance, but our current interpretation of the rule and our business approach could change based on final rules.

Q: Many of our current plans have a 90-day waiting period and offer eligibility on the 91st day. Is this still allowed?

A: Our current interpretation of the proposed rule is that the 91st day or the first of the month following 90-day eligibility will no longer be compliant.

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

A: The provision applies to:

- Grandfathered and non-grandfathered group health plans
- Fully insured plans (large and small)
- All self-insured plans
- ERISA-governed group health plans (both fully insured and self-insured)
- Non-federal government plans (both fully insured and self-insured)
- Church plans (both fully insured and self-insured)
- It does not apply to plans in the individual market.

Q: Does this need to be applied on Jan. 1, 2014, or at renewal?

A: At renewal. The 90-day waiting period applies to plan years beginning on or after Jan. 1, 2014. If the plan year is Jan. 1, 2014, it would apply on Jan. 1, 2014. If the plan year is June 1, 2014, it applies on June 1, 2014.

Example: An employee is hired March 1, 2014, and the employer has a six-month waiting period with a June 1, 2014, plan year. That employee's coverage must be available as of the plan renewal on June 1, 2014, because, under the proposed rule, continuing the waiting period would result in a waiting period that exceeds 90 days.

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 otherwise eligible employees and their dependents within 90 days of the employee's hire date, 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: Is the 90-day waiting period measured in calendar days?

A: Yes. The 90-day waiting period is measured from the first day of eligibility, and coverage must be made available no later than the 90th day, even if that day falls in the middle of the month or on a weekend.

Example: An employee is hired March 3, 2014. If the employee's coverage begins on June 1, 2014, the waiting period would be 91 days. Therefore, coverage would need to be made available as of Saturday, May 31, 2014.

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 when the proposed rule goes into effect on the employer's plan renewal Jan. 1, 2014, or after, the days served prior to the renewal date will count toward the 90-day waiting period.

Example: An employee who has elected coverage is hired Sept. 15, 2013, and is in a 90-day waiting period. If the individual's waiting period has exceeded 90 days upon plan renewal on Jan. 1, 2014, coverage must be made available as of that day.

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

A: We anticipate that this will mostly impact small group accounts.

Q: What operational changes will Blue Cross and Blue Shield of Illinois (BCBSIL) have to make to comply with the new standards?

A: We have formed an implementation workgroup to review and address any operational issues. We will develop a transition strategy, effective communication, review the need for any new processes or changes to existing processes, and update any related paperwork, as necessary.

Q: How will BCBSIL communicate the changes to accounts?

A: We are in the process of identifying all affected groups and are developing a communications plan as needed to address the waiting period with producers and employers.

Affordable Care Act Out-of-pocket Maximum Safe Harbor

You may have read media stories recently reporting that the Affordable Care Act out-of-pocket maximum (OOPM) requirements have been delayed. We want to clear up any confusion.

The stories are actually referring to the OOPM safe harbor for group health plans and group health insurance issuers for the 2014 plan year, which the federal government announced back in February. Although the issue is now getting media coverage, nothing has changed since February. The safe harbor applies to non-grandfathered group health plans when benefits under the plan are administered by more than one service provider.

Status of HIPAA Omnibus Rule Implementation for ASO Customers

Blue Cross and Blue Shield of Illinois (BCBSIL) is in the process of implementing the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule that the federal government finalized on Jan. 17, 2013. The following is an update on how the Omnibus Rule impacts our ASO customers.

Business Associate Agreements/Addendums

- **Existing ASO customers on a standard BCBSIL template:** We reviewed our current Business Associate Agreements/Addendums (BAAs) and have concluded that the content of the BAA complies with the spirit of the Omnibus Rule. Therefore, we will not actively amend existing BAAs. However, if an employer group's legal counsel believes that changes need to be made to the current BAA due to the Omnibus Rule, please forward these changes to your account representative.
- **Existing ASO customers on a customized non-standard BCBSIL template:** We will not actively amend these BAAs. However, if an employer group's legal counsel believes that changes are required in order to comply with the Omnibus Rule, please forward these changes to your account representative.
- **New ASO customers:** The current BCBSIL template BAAs will be available through your account representative when they are finalized.

Individuals' Right to Access Their Protected Health Information

BCBSIL has amended its policies and procedures to allow individuals who request a copy of their Protected Health Information (PHI) to receive it in an electronic format.

Standard for Data Breaches

For groups who have delegated Health Information Technology for Economic and Clinical Health (HITECH) Act breach notification services to BCBSIL, we will be using the new objective, four-factor risk assessment test to comply with the requirements under the Omnibus Rule.

Finalized 2014 Affordable Care Act (ACA) Fees for Fully Insured Large Groups Now Available

The Annual Fee on Health Insurers ("Health Insurer Fee") and the Transitional Reinsurance Program Contribution Fee ("Reinsurance Fee") have been finalized for Blue Cross and Blue Shield of Illinois (BCBSIL) fully insured large groups (151+) at 3.25 percent of billed premiums for 2014. This is a decrease from the previously estimated 4 percent.

This fee percentage began appearing in renewals and proposals for large groups on Monday, Aug. 5, 2013. If you have already released or negotiated a 2014 renewal, you will be contacted by your account representative to adjust the fee information.

ACA fees will appear on bills beginning in January 2014. A fee disclaimer will be included in bills and will provide the exact amount allocated to applicable federal and state taxes, including the new ACA fees. Medical premiums will be adjusted to include xthe Health Insurer Fees and Reinsurance Fees, beginning with the bill for January 2014 coverage.

As a reminder, for small groups (2-50), the ACA fees estimate remain at 4 percent of billed premiums in 2014, but this number will be recalculated based on final rate approval by the Illinois Department of Insurance.

About ACA Fees

Beginning in 2014, ACA requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government. This is commonly referred to as the Annual Fee on Health Insurers, or Health Insurer Fee. For the calendar year, the amount of this fee is determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding calendar year. This fee applies to fully insured group and individual market segments.

In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run from 2014 through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded health group plans. This will apply to all group (including self-funded/ASO) and individual market segments.

BlueCross BlueShield of Illinois

Additional Information Regarding Employer Marketplace Notice

The Oct. 1 deadline for employers to distribute the notice about the Health Insurance Marketplace of Illinois to employees is approaching. Below are some frequently asked questions and answers about the notice.

Q: What is the Marketplace notification?

A: Employers who are subject to the Fair Labor Standards Act (FLSA) have to send a notice to employees about new coverage options through the Marketplace.

Q: To which employers does this apply?

A: According to the **Department of Labor**, 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.

Q: What is the deadline for distributing the notice?

A: 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.

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

A: 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.

Q: Is there a model notice that employers can use?

A: 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 Employers 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 Department of Labor **website**.

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

Q: Will Blue Cross and Blue Shield of Illinois be preparing and/or distributing the notice for groups?

A: We currently do not plan to prepare or distribute these notices on behalf of employers.

We are still evaluating the most cohesive method to assist employers with completing certain fields in the model notice. When we reach a final business decision and approach, we will provide additional communication and guidance.

As always, if your customers have questions about an ACA provision, you can reach out to your account representative.

Summary of Benefits and Coverage Replacing Highlight Sheets

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 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 and 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.

Blue Cross and Blue Shield of Illinois (BCBSIL) will be replacing the current highlight sheets with SBCs as of Sept. 30, 2013, for all groups 2-150. 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 instructions on SBC customization, please refer to the training materials **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.

Colonoscopy Preventive Services

Q: What colonoscopy procedures does Blue Cross and Blue Shield of Illinois (BCBSIL) consider to be preventive under the Affordable Care Act (ACA)?

A: For non-grandfathered plans, BCBSIL covers a service associated with a colonoscopy for the purpose of screening for colorectal cancer as ACA preventive with no member cost-sharing. If a procedure is submitted by the provider as a colorectal cancer screening, we will cover the service as preventive based on the intent of the test and not on the findings. If a problem is found during the screening and a procedure is performed to address the problem (such as polyp removal), the claim will still be paid as preventive with no cost sharing, as long as it has been submitted by the provider with a preventive services code.

Q: What services are considered part of the screening colonoscopy?

A: The following services are considered part of the colonoscopy screening:

- Colonoscopy screening procedure
- Pathology services
- Anesthesiology (if necessary)
- Outpatient facility fee

A service that is directly related to a colonoscopy to screen for colorectal cancer will be covered as a preventive service for non-grandfathered plans as required by ACA.

Waiting Period

Q: With the changes to the waiting period not being able to be longer than 90 days, do you know if groups can use the wording of "three months" instead of "90 days" in benefits and other account-related materials?

A: The language for the 90-day waiting period is specific to "90 days." Based on the proposed rule, our understanding is that "three months" ***cannot*** be used because that may exceed 90 days. However, final rules have not been issued yet by the federal government.

Appeals and External Review

Q: If the appeal goes to the external review and gets overturned, does that automatically go to Blue Cross and Blue Shield of Illinois to process the adjustment of that claim?

A: Yes. If the Independent Review Organization (IRO) overturns the denial, our Service Delivery and Operations Division will process the adjustment within a reasonable timeframe.

Q: What is the time frame for a member to appeal an adverse benefit determination?

A: For an internal appeal, the member has 180 days from the date the member receives the denial to file an internal appeal. For an external appeal, the member has four months from the date when the member receives the internal appeal denial or the final adverse benefit determination (ABD).

This information is a high-level summary and for general informational purposes only.
The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.