Sept. 2, 2014

2015 ACA/Regulatory Renewal Checklist

For Small Groups (1-50)

BlueCross BlueShield of Illinois

This checklist gives you a quick look at the changes that affect non-grandfathered and grandfathered plans related to the Affordable Care Act (ACA) and other key regulations. It also will help you understand ACA-related changes if a health plan is losing grandfathered status. Please note the following:

- Some of the provisions included below went into effect prior to 2015.
- This information is subject to change. This document was published on Sept. 2, 2014, and changes may have occurred since its publication date.
- This information is not intended to be comprehensive. It does not encompass all ACA requirements and regulations for the 2015 plan year.
- Blue Cross and Blue Shield of Illinois (BCBSIL) clients are advised to consult qualified legal counsel and/or tax professionals to ensure compliance.
- This checklist only applies to small groups with a new ACA metallic benefit plan.

What's Important for 2015

Provision	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Actuarial Value (Metallic Levels) –** Actuarial value (AV) measures the average portion of expected health care expenses that will be paid for by the insurer. Non-grandfathered health insurance plans in the individual and small group market must meet AV or "metallic level" coverage requirements for essential health benefits (EHBs). Health care reform establishes metallic levels so that people can compare plans that offer different levels of EHB coverage. The metallic levels are Platinum (90% AV), Gold (80% AV), Silver (70% AV) and Bronze (60% AV), where the percentages reflect the portion of expenses paid by the insurer.	No	Yes
☐ **Essential Health Benefits (EHBs) –** Certain health benefits that are deemed "essential" must be covered. The minimum package of items and services that must be covered by these plans is generally defined by each state's EHB benchmark plan. Grandfathered plans don't have to cover EHBs, but if they do, they can't set any annual or lifetime dollar limits on those EHBs.	No	Yes
☐ **Health Plan Identifier (HPID) –** The HPID, along with the national provider identifier implemented in 2004, is a standard identifier that was required by the original Health Insurance Portability and Accountability Act of 1996 (HIPAA). BCBSIL has not yet enumerated but will acquire an HPID to meet the Nov. 5, 2014, date as required by CMS.	Yes	Yes
☐ **Health Insurer Fee –** The premium in a group's bill will be adjusted to reflect the effects of the Health Insurer Fees, which will be inclusive of any additional federal and state taxes applicable to these fees. For fully insured groups, BCBSIL is responsible for reporting and paying these fees to the federal government or other appropriate entity based on the number of covered lives of its member base. This provision requires covered entities providing health insurance (health insurers) to pay an annual fee to the federal government. These fees are designed to support programs that will stabilize premiums and provide subsidies to qualified individuals to help them purchase coverage. The Health Insurer Fee does apply to stand-alone vision and dental plans.	Yes	Yes

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Key Provisions *CONTINUED*

	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Mental Health Parity –** Generally, the Mental Health Parity and Addiction Equity Act (MHPAEA) prohibits certain individual and group health plans from applying financial requirements (e.g., copays) or treatment limits (e.g., number of annual visits) on mental health or substance use disorder services that are more restrictive than those applied to the health plan's medical and surgical benefits. They also prohibit certain individual and group health plans from imposing non-quantitative treatment limitations (NQTLs) (e.g., medical management techniques, network reimbursement and entrance requirements, etc.) on mental health and substance use disorders that are more stringently applied than those applied to the health plan's medical and surgical benefits. We have reviewed our insured products to ensure they comply with parity.	No	Yes
☐ **Out-of-pocket Maximums for EHBs –** For the 2014 plan year, a one-year safe harbor allowed groups to have a separate OOPM (not to exceed $6,350 for individual coverage/$12,700 for family coverage) for each separate service provider (e.g., medical could have an OOPM of $6,350 and pharmacy could have a separate OOPM of $6,350). However, the safe harbor expires in the 2015 plan year. For plan years beginning on or after Jan. 1, 2015, member cost sharing for in-network EHBs, across all service providers, cannot exceed the OOPM set by ACA. The OOPM cannot exceed $6,600 for individual coverage and $13,200 for family coverage in the 2015 plan year. Generally, member cost sharing that is considered part of the OOPM includes: • Deductibles for in-network EHBs • Coinsurance for in-network EHBs • Copayments for in-network EHBs • Any other expenditure required by, or on behalf of, an enrollee for in-network EHBs including out-of-network emergency services and member liability on reference-based pricing (RBP) claims	No	Yes
☐ **PCORI –** The Patient-Centered Outcomes Research Institute (PCORI) fee funds patient-centered outcomes (also referred to as comparative clinical effectiveness) research. It is subject to certain adjustments, including the percentage increases in the projected per capita amount of the National Health Expenditures. The fee is multiplied by the average number of lives covered under the plan or policy for plan years ending on or after Oct. 1, 2014, and before Oct. 1, 2015. For fully insured groups, BCBSIL is responsible for reporting and paying these fees to the federal government or other appropriate entity based on the number of covered lives of its member base.	Yes	Yes
☐ **Pediatric Dental and Vision –** ACA requires that each employee and dependent (enrolled in an applicable medical plan) must have pediatric dental EHB coverage even if that employee or dependent is not eligible for these services. However, employees or dependents who are not eligible for these services will not pay a premium for the coverage. The law requires pediatric dental coverage as an EHB for non-grandfathered fully insured small group and non-grandfathered individual plans with plan/policy years beginning on or after Jan. 1, 2014.	No	Yes

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Key Provisions *CONTINUED*

	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Preventive Services –** ACA requires non-grandfathered health plans and policies to provide coverage for "preventive care services" without cost sharing (such as coinsurance, deductible or copayment), when the member uses a network provider. Services may include screenings, immunizations and other types of care, as recommended by the federal government and the U.S. Preventive Services Task Force (USPSTF). Effective May 1, 2014, we expanded preventive services coverage to include the following: • Breastfeeding supplies (electric and hospital grade breast pumps) are covered when obtained through an out-of-network provider, where coverage was previously excluded. Coverage may not be at 100 percent with no cost share. Some limitations and restrictions may apply based on the group coverage for preventive services. Retail purchases of electric breast pumps are not considered out of network. • Over-the-counter aspirin, vitamin D, folic acid, iron and fluoride covered with no cost share with a prescription from a provider. This does not apply to groups who have carved out their pharmacy coverage to a Pharmacy Benefit Manager. • BCBSIL provides coverage for the BRCA test based on the outcome of medical review, which is used to determine appropriateness. Claims submitted for BRCA tests that have a preventive diagnosis will be paid with no member cost share if approved during medical review. Claims that do not contain a preventive diagnosis are processed at the non-ACA benefit level, as defined in the group's contract, also assuming medical review approval.	No	Yes
☐ **Reinsurance Fee –** The premium in a group's bill will be adjusted to reflect the effects of the Reinsurance Fee, which will be inclusive of any additional applicable federal and state taxes. The Reinsurance Fee was designed to pay for a temporary transitional reinsurance program that will run from 2014 through 2016 and will be funded by reinsurance contributions (reinsurance fees) from health insurance issuers and self-funded group health plans. The Reinsurance Fee does not apply to stand-alone vision or dental plans.	Yes	Yes

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Key Provisions *CONTINUED*

	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Summary of Benefits and Coverage (SBC) –** ACA requires all health insurers and group health plans to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is completed using a government designed template, so the SBC will be consistent across all health insurance plans and will include: • 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 For fully insured/premium groups that request our services for the SBCs with coverage beginning on or after Jan. 1, 2014, BCBSIL will complete the minimum essential coverage (MEC) and minimum value sections of the SBC. Generally, the SBC must be provided: • Upon application • Upon request, as soon as practical, but no later than seven business days following such request • By the first day of coverage, only if there are any changes made to the SBC that was provided upon application • In the case of a special enrollee, the SBC must be provided no later than when a Summary Plan Description (SPD) is required to be provided, which is 90 calendar days from the date of enrollment	Yes	Yes
☐ **Waiting Periods –** Limit waiting periods for employees eligible for group coverage to no longer than 90 calendar days. The effective date of coverage cannot exceed 91 calendar days from the date of hire (unless an employee or dependent is late in electing coverage).	Yes	Yes
☐ **Wellness Incentives –** ACA changes the maximum reward that can be provided under HIPAA's health factor–based wellness program from 20 to 30 percent. The reward under such a program can be up to 30 percent of the cost of employee coverage. Additionally, the secretaries of Health and Human Services, Labor and Treasury can expand the reward up to 50 percent of cost of coverage if deemed appropriate.	Yes	Yes

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Employer Responsibilites

Provision	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **6055/6056 Reporting –** Beginning with the 2015 plan year, Section 6055 requires health insurers and sponsors of self-insured plans to report MEC coverage to the Internal Revenue Service (IRS) yearly. Insurers and self-insured plans must also report to their MEC recipients, so the individuals can report that coverage when filing their federal income taxes. The reporting to both individuals and the IRS for 2015 is due in early 2016. BCBSIL will provide Section 6055 (MEC) reporting to the IRS for insured groups. Section 6056 reporting requires *applicable large employers* to report to the IRS information about the health coverage they provide to their employees. Generally, an applicable large employer has 50 or more full-time or full-time equivalent employees. Employers also have to provide statements to employees regarding their health coverage, primarily so employees can determine if they are eligible for a premium tax credit for health insurance through Get Covered Illinois, the Official Health Marketplace of Illinois. The Section 6056 reporting to both employees and the IRS for 2015 is due in early 2016. BCBSIL will not be able to provide support to applicable large employers for Section 6056 (Employer Shared Responsibility reporting) to the IRS or the employer's employees.	Yes	Yes
☐ **Employer Shared Responsibility (ESR) –** Generally, under ESR, applicable large employers (generally, 50 or more full-time or full-time equivalent employees) face a potential penalty if they don't provide MEC to full-time employees that has both minimum value (company is paying at least 60 percent of covered health care expenses for a typical population) and is affordable (full-time employees cannot pay more than 9.5 percent of their income for the lowest-cost, self-only coverage). Employers with fewer than 50 full-time employees are not subject to ACA's ESR provisions. In February 2014, the IRS released a final rule on the ESR provisions. For 2015, employers with between 50 and 99 full-time employees are exempt from the ESR penalty if the employer provides an appropriate certification and meets certain conditions. In 2015, employers subject to the mandate must offer coverage to 70 percent of their full-time employees or risk penalties for failure to offer coverage to all full-time employees and dependents. To avoid a penalty in 2016, employers subject to ACA's ESR provisions must offer coverage to 95 percent of their full-time employees and dependents. This rule applies whether the failure to offer coverage is intentional or unintentional. However, this rule does not shield the employer from the penalty for offering inadequate coverage if any of the full-time employees, including those who are not offered coverage at all, receive a premium tax credit or cost-sharing assistance for purchasing coverage through the Marketplace.	Yes	Yes
☐ **Marketplace Notice –** As of Oct. 1, 2013, employers have to provide employees with written notice of the Marketplace. For 2014 and beyond, an employer has to provide the notice to new employees within 14 days of an employee's start date. 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 of Labor's electronic disclosure safe harbor requirements are met. • Model Notice for Employers who Provide a Health Plan • Model Notice for Employers who Provide a Health Plan (Spanish) • Model Notice for Employers without a Health Plan • Model Notice for Employers without a Health Plan (Spanish)	Yes	Yes

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Plans Losing Grandfathered Status

In addition to the provisions listed above that are required for non-grandfathered plans, plans losing grandfathered status must also implement changes that went into effect prior to 2015. For more information on grandfathered health plans and what changes or events may cause a plan to lose grandfathered health plan status, go to **bcbsil.com/PDF/aca_grandfathered_plans_il.pdf**.

If the plan is losing grandfathered status, notify your account representative of the group's intent to waive grandfathered status.

☐ **Appeals and Reviews –** Amend process for appeals by implementing appeals and external review requirements.
☐ **Clinical Trials –** Requires that if a "qualified individual" is in an "approved clinical trial," 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; and (3) discriminate against the individual on the basis of the individual's participation in such trial.
☐ **Community Rating –** Health insurance issuers can only use the following rating factors: geographic area, family demographics, age and tobacco use.
☐ **Direct Access –** Allow direct access to OB/GYNs for female enrollees without pre-authorization or referral.
☐ **Emergency Services –** Cover emergency room (ER) services without pre-authorization, even for out-of-network providers, and apply prudent layperson definition of an emergency medical condition. If services are rendered out of network, ACA cost-sharing requirements apply. This is for the initial ER services in the emergency room, including the emergency room physicians fee – and does not include ambulance or facility/professional fees for follow-up medical treatment.
☐ **Non-discrimination Regarding Health Care Providers –** Health care providers can participate in an insurer's provider network as long as they follow the terms and conditions for participation and act within the limits of their medical license or certification.
☐ **Physician Choice –** Allow members to choose any participating primary care physician or pediatrician.
☐ **Pre-existing Condition Exclusions –** Eliminate pre-existing condition limitations for enrollees of all ages.
☐ **Preventive Services –** Remove cost-sharing requirements on certain recommended preventive services.

The information in this handout is subject to change based on subsequent federal and state laws, regulations and guidance. 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.