Producer Bulletin

Capital BLUE

2015 PPACA Large Group Benefit Impacts

Producer Communication #677
Issued August 5, 2014
UPDATED June 30, 2015

Message

Beginning January 1, 2015, PPACA requirements for in-network (INN) out-of-pocket (OOP) limits, as well as how the limits are reached, will impact benefit designs for large groups (100+) as they renew. Pharmacy (Rx) INN member expense must now be accounted for in the overall INN OOP limit. As a result of these requirements, new plan ID's will be generated to accommodate the benefit changes and the new ID's will be in an 8 digit format.

Groups must now also communicate specific details to Capital concerning benefits they have elsewhere that must be accounted for in the overall OOP maximum.

Details

OOP Limit

For large groups (100+), at their next renewal beginning on or after January 1, 2015, all non-grandfathered groups (fully insured and ASO) must comply with regulations that limit member liability for in-network (INN) services. Specifically under this requirement, the following provisions must be met for 2015:

1. The OOP limit for INN services must not exceed $6,600 for an individual and $13,200 for a family
2. The OOP limit must include all member cost share (deductible, coinsurance, and copay) for medical and Rx services
3. The Rx may accumulate toward a combined (medical/Rx) INN OOP limit or limits for both medical and Rx may be set separately, provided that when combined they do not exceed the allowable limit (e.g., a separate $4000 Individual INN medical OOP and $2,600 Individual INN Rx OOP does not exceed $6,600).
    a. Out of network (OON) OOP limits are not held to these requirements or calculation methods
4. Combined OOP (INN and OON) must meet the PPACA requirement limiting OOP responsibility to $6,600 for an individual and $13,200 for a family
5. Employer funding does not increase the OOP benefit limit. For example, it is not permissible to have a $10,000 INN OOP individual limit and fund $9,500 through an HRA.

CBC's small group and mid-market plans have complied with this requirement as of January 2014.

The majority of Capital's existing large group customers do not currently accumulate Rx expense toward the INN OOP max. The inclusion of the Rx OOP expense in the INN OOP max will result in benefit design changes for most of our large groups.

Groups that carve out mental health (MH) and substance abuse (SA) must also include any member cost share dollars into the medical OOP max. Federal MH/SA parity legislation does not permit a separate OOP max for MH/SA services.

The OOP limit regulations do not apply to senior only products.

OOP Max Credit

When benefit changes cause accumulators to reset during a benefit period, credit must be given for any INN OOP amount met by the member prior to the change. This ensures that the OOP liability during the benefit period does not exceed the allowable PPACA amount. The benefit limit is determined by the PPACA requirement in place on the first day of the benefit accumulation period (January 1 for calendar year groups or 1st day of the month at beginning of the plan year for plan year groups).

Renewal Process

Small (2-50) and Mid-Market (51-99) groups

All small and mid-market group benefit offerings for 2015 are already compliant with the new regulations.

Large groups (100+)

Groups with Rx through CBC:

Groups that purchase their Rx benefits through CBC will have their INN Rx expenses cross accumulate with their medical INN OOP expenses toward a single OOP limit. Renewal documents will reflect the group's current OOP limit with Rx included. Account Executives and Producers may wish to consult with their groups to determine if the existing OOP limits should be raised in order to make the inclusion of the Rx OOP more rate neutral. If a new OOP limit is not quoted, the renewal will be based on the current OOP limit with the Rx OOP cross accumulating. A large group may request separate limits be placed on medical and Rx (not to exceed the PPACA maximum). Producers should contact the Account Executive with these group requests.

Groups with Rx Elsewhere (i.e., ESI, Caremark Direct):

Groups that do not have their Rx through CBC will be assumed to be establishing separate limits for their medical and Rx OOP unless cross accumulation has been requested via the Account Executive. For groups who choose to have CBC cross accumulate their medical and Rx OOP, a request will need to be submitted via the Account Executive with an approximate 60 day lead time. A Certification of Prescription Drug Coverage form (*Attachment A*) must be completed and submitted to the Account Executive with the request. There will also be a $1 PCPM administrative fee applied to carve out groups who choose to have CBC cross accumulate their Rx OOP with their medical OOP. If a group chooses to have CBC cross accumulate their carved out Rx expense they must provide underwriting with benefit design details as well as claims history to ensure accurate rates can be calculated. Details are contained on the attestation form.

Calendar Year Benefit Groups on Plan Year Renewals. (Non-January Renewals)

Based on clarification received in March 2015, in order to be compliant with PPACA INN OOP max requirements, the benefit period accumulation requirement that was in place on the first day of the benefit period must be followed. Previously, we had taken the approach that benefits had to be compliant based on a group's renewal date. This clarification impacts calendar year groups that renew on a plan year basis (other than January).

Groups that begin their benefit period on January 1, 2015 must meet the 2015 benefit accumulation requirements regardless of the fact that their renewal does not take place until later in the year. For 2015, this means that the OOP limit must include or account for the Rx member OOP. As previously stated,

groups may accumulate to a single INN OOP max or have separate Rx and medical INN OOP's that when combined do not exceed the 2015 limit of $6,600 individual and $13,200 family.

Adjustments will be made to the benefit accumulators for those groups that have plan year renewals with calendar year benefit periods to ensure compliance with the PPACA requirements. This will be accomplished in the following manner:

Group has Rx with CBC

Effective July 1, 2015, groups who have their Rx benefits with CBC will have their medical OOP accumulators modified to accumulate medical and Rx to a combined PPACA OOP, which will be set at the PPACA OOP maximum. To bring groups into compliance, all medical OOP expenses from January 1, 2015 and Rx expenses from July 1, 2015 will accumulate to the INN OOP max for 2015. Rx changes will be effective July 1, 2015 and OOP cost share will be accumulated from this date forward. To account for member OOP Rx amounts met from January 1, 2015 through June 30, 2015 reports will be run and those OOP amounts will be added to their 2015 OOP to ensure members do not exceed the 2015 PPACA OOP limits. If necessary, member refunds will be provided.

Groups who carve out Rx

Groups who carve out their Rx will be contacted and must select a separate amount to apply to each medical and Rx OOP that when combined are PPACA compliant. Once these groups have received communication, CBC will make the OOP max changes effective January 1, 2015. If necessary, member refunds will be provided.

New Business Quotes

Quotes for effective dates of January 1, 2015 and beyond must be compliant with the new regulations for Rx accumulation toward OOP limits. Producers should review all quote requests prior to submission to ensure they are compliant with the PPACA OOP limit requirements. Underwriting will reject quotes where the INN OOP limits exceed $6,600 individual and $13,200 family.

Benefit Carve Out (i.e., Mental Health,)

Groups that carve out benefits and wish for CBC to cross accumulate the member's cost share in the OOP maximum must contact their Account Executive to request and ensure compliance with PPACA regulations is maintained.

Plan ID changes

As a result of the benefit changes required for the 2015 PPACA requirements, Plan IDs will be expanding from 7 to 8-digits for all commercial medical and prescription drug plans to distinguish between groups.

The following changes will be applied to Plan IDs effective January 2015:

1. Plan IDs will be going to an 8-digit format (example PPOEJ001).
2. Plan IDs will be coded to indicate the type of medical and OOP Rx accumulation. The 5th digit of the Plan ID will be coded to indicate one of the following:
   - 0 = No Cross Accumulation
   - J = Cross Accumulation with CBC (Integrated CBC Medical/Rx OOP)
   - K = Cross Accumulation with CBC and Other Carrier (Medical or Rx with Other Carrier and Integrated Medical/Rx OOP)
   - Z = No Cross Accumulation with CBC and Other Carrier (Medical or Rx with Other Carrier and OOP amounts accumulate separately)

- X = Private Exchange (My Coverage Selector)

3. Plan ID sequences on medical and Rx will be coded to match which will indicate the medical and Rx options that are selected together.
4. Medical and Rx Plan IDs will be rated together (i.e., one rate for each medical and Rx combination). For example, PPOEJ001 must be selected with RXREJ001, PPOEJ003 must be selected with RXREJ003, but PPOEJ001 may not be selected with RXREJ003.

The Plan IDs as outlined above is consistent with how small and mid-market groups are handled today.

Account Administration Electronic Enrollment Specialists have planned procedures to work with each impacted eGEMS/eFile group through this transition.

Attachments

- **Attachment A** – Certification of Prescription Drug Coverage Form

Questions

Contact your Preferred Agency with any questions. Thank you.

Producer Bulletin

Capital BLUE

Employer Paying Premium for Individual Policy Coverage

Producer Communication #714
Issued June 26, 2015

Message

Capital BlueCross cannot knowingly accept payments that violate the various statutes which prohibit a group/employer from paying the premium for an individual policy for active employees.

Details

Employers cannot generally pay the cost of individual health insurance premiums for their active employees. The group may face serious consequences if found to be in violation under several laws including, but not limited to, ERISA (**Employee Retirement Income Security Act),** MSP (Medicare Secondary Payer), ADA (Americans with Disabilities Act), and ACA (Affordable Care Act).

If Cash processing receives payment from an employer that indicates the payment is for an individual account of an active employee, the payment will be rejected and returned.

Payment of Individual health insurance premiums for retirees is permitted.

Questions

Contact your Preferred Agency with any questions. Thank you.

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Formulary and Utilization Management Program Updates: July 1, 2015

Producer Communication #715
Issued June 26, 2015

Message

The Capital BlueCross Pharmacy & Therapeutics (P&T) Committee, consisting of practicing physicians, pharmacists and other health care experts, reviews medications in all therapeutic categories according to safety, efficacy and overall value. Formulary development is a dynamic process. The P&T Committee regularly reviews new and existing medications to ensure the Formulary remains responsive to the needs of our members and providers.

Details

Decisions from recent P&T Committee meetings (November 2014 and February 2015) resulted in updates made to the open/closed and selectively closed formulary (*Attachment A)*
Updates include:

- Newly Marketed Drugs
- Products Changing Tier Status
- Pharmacy Utilization Management Programs

July 1, 2015 changes of note:

- Nasal steroids will require prior authorization
- Victrelis will be moving from brand preferred to brand non-preferred

Formulary updates are communicated via BenefitFOCUS, Simply-Well, and the Provider Administrative Bulletin. Quarterly Formulary Update-Decision Summaries by Quarter for the open/closed formulary and the selectively closed formulary can also be found on the pharmacy page of our website, www.CapBlueCross.com

Attachments

- **Attachment A –** Open/Closed and Selectively Closed Formulary Updates

Questions

Contact your Preferred Agency with any questions. Thank you.

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The following formulary updates may affect Commercial members who have prescription drug coverage through Capital BlueCross:

Newly Marketed Drugs KEY: (PAR) = Prior Authorization Required; (ST) = Step Therapy Required; (QLL) = Quantity Level Limits Apply **lowercase bold print** = generic; UPPERCASE PRINT = BRAND				
Brand Name	**Commercial (Open/Closed)***	**Commercial Selectively Closed****	**Indication**	**Preferred Alternatives**
AKYNZEO (EPA, QLL)	4	NC	Chemotherapy induced nausea and vomiting	**granisetron** or **ondansetron**
BELSOMRA (PAR, QLL)	4	NC	Insomnia	**zopiderm** or **eszopiclone**
CERDELGA# (PAR)	3	2	Type 1 Gaucher Disease	N/A
CONTRAVE (PAR)	4	NC	Obesity	**phentermine (PAR)**
ESBRIET# (PAR)	3	2	Idiopathic Pulmonary Fibrosis	N/A
HARVONI# (PAR)	4	NC	Genotype 1 Chronic Hepatitis C Infection	N/A
IMPAVIDO	3	2	Leishmaniasis	N/A
JARDIANCE	4	NC	Type 2 Diabetes	JANUVIA, TRADJENTA
JUBLIA (PAR)	4	NC	Fungal infection of the toenail	**ciclopirox, terbinafine**
KERYDIN (PAR)	4	NC	Fungal infection of the toenail	**ciclopirox, terbinafine**
NORTHERA# (PAR)	4	NC	Neurogenic orthostatic hypotension	**midodrine**
OFEV# (PAR)	3	2	Idiopathic Pulmonary Fibrosis	N/A
STRIVERDI RESPIMAT	4	NC	Chronic Obstructive Pulmonary Disease	FORADIL, SEREVENT
TRULICITY (EPA)	4	NC	Diabetes Mellitus	BYETTA or VICTOZA
VIEKIRA PAK# (PAR)	4	NC	Hepatitis C	HARVONI# (PAR) or SOVALDI# (PAR)
ZYDELIG# (PAR)	3	2	Relapsed chronic lymphocytic leukemia (CLL), relapsed follicular B-cell non-Hodgkin lymphoma (FL), relapsed small lymphocytic lymphoma (SLL)	N/A

***Open/Closed Formulary - Tier 1 = generic preferred, Tier 2 = generic non-preferred, Tier 3 = brand preferred/formulary, Tier 4 = brand non-preferred/non-formulary

****Selectively Closed Formulary - Tier 1 = generic, Tier 2 = brand preferred/formulary, Tier 3 = brand non-preferred/non-formulary, NC = Not Covered

#Indicates specialty medication

Capital BlueCross Formulary Update

KEY: (PAR) = Prior Authorization Required; (ST) = Step Therapy Required; (QLL) = Quantity Level Limits Apply
lowercase bold print = generic; UPPERCASE PRINT = BRAND

Products Changing Tier Status - Effective July 1, 2015

Brand Name	Commercial (Open/Closed)* Current Tier	Commercial (Open/Closed)* New Tier	Selectively Closed** Current Tier	Selectively Closed** New Tier	Preferred Alternatives
HARVONI# (PAR)	4	3	NC	2	N/A
REVATIO suspension# (PAR)	4	3	3	2	N/A
VICTOZA	4	3	3	2	N/A
VICTRELIS#▼ (PAR) (**boceprevir**)	3	4	2	3	N/A
ZORVOLEX	4	3	3	2	N/A

*****Open/Closed Formulary - Tier 1 = generic preferred, Tier 2 = generic non-preferred, Tier 3 = brand preferred/formulary, Tier 4 = brand non-preferred/non-formulary*
******Selectively Closed Formulary **-** Tier 1 = generic, Tier 2 = brand preferred/formulary, Tier 3 = brand non-preferred/non-formulary, NC = Not Covered*
#Indicates Specialty Medication
▼New users only, current users will be grandfathered

Pharmacy Utilization Management Program Updates

KEY: (PAR) = Prior Authorization Required; (ST) = /Step Therapy Required; (QLL) = Quantity Level Limits Apply
lowercase bold print = generic; UPPERCASE PRINT = BRAND

Drug Additions to the Prior Authorization Program

Effective Immediately (unless otherwise indicated)

Drug Class/Drug	Purpose/Guidelines/Limits
BELSOMRA (PAR, QLL)@	Subject to diagnosis of insomnia
CERDELGA# (PAR)	Subject to diagnosis of Gaucher disease type 1 and CYP 2D6 status.
CONTRAVE (PAR)@	Subject to use for obesity.
ESBRIET# (PAR)	Subject to diagnosis of Idiopathic Pulmonary Fibrosis
HARVONI# (PAR)	Subject to diagnosis of Hepatitis C genotype 1 and liver status.
JUBLIA (PAR)@	Subject to diagnosis of toenail fungal infection and failure or intolerance to oral agents (i.e. **terbinafine**, **itraconazole**)
KERYDIN (PAR)@	Subject to diagnosis of toenail fungal infection and failure or intolerance to oral agents (i.e. **terbinafine**, **itraconazole**)
Nasal Steroids† (Beconase AQ, Dymista@, Nasonex, Omnaris, Zetonna@, Qnasl, Rhinocort Aqua@, and Veramyst@) (PAR)	Subject to trial and failure of both budesonide and flunisolide nasal spray or under 6 years of age or have a diagnosis of nasal polyps

Pharmacy Utilization Management Program Updates

KEY: (PAR) = Prior Authorization Required; (ST) = /Step Therapy Required; (QLL) = Quantity Level Limits Apply
lowercase bold print = generic; UPPERCASE PRINT = BRAND

Drug Additions to the Prior Authorization Program

Effective Immediately (unless otherwise indicated)

Drug Class/Drug	Purpose/Guidelines/Limits
NORTHERA[#] (PAR)[@]	Subject to diagnosis of adults with neurogenic orthostatic hypotension due to primary autonomic failure, dopamine beta hydroxylase deficiency, or nondiabetic autonomic neuropathy
OFEV[#] (PAR)	Subject to diagnosis of Idiopathic Pulmonary Fibrosis
VIEKIRA PAK[#@] (PAR)	Subject to diagnosis of Hepatitis C genotype 1 and liver status and trial and failure of HARVONI[#] (PAR)
ZYDELIG[#] (PAR)	Subject to diagnosis of relapsed chronic lymphocytic leukemia (CLL) for whom rituximab alone would be considered appropriate therapy due to other co-morbidities. Subject to diagnosis of relapsed follicular B-cell non-Hodgkin lymphoma (FL) for who have received at least two prior systemic therapies. Subject to diagnosis of relapsed small lymphocytic lymphoma (SLL) for who have received at least two prior systemic therapies.

[#]Indicates Specialty Medication
[@]Indicates not covered on Selectively Closed Formulary
[†] Effective July 1, 2015; Impacted members will be notified prior to change

Enhanced Prior Authorization (EPA) Program

Effective Immediately

Drug Class/Drug	Guidelines
AKYNZEO (EPA, QLL)[@]	Subject to trial and failure of **granisetron** or **ondansetron**
TRULICITY (EPA)[@]	Subject to trial and failure of an oral antidiabetic agent or insulin

[@]Indicates not covered on Selectively Closed Formulary

Drug Quantity Management Program (QLL)

Effective Immediately

Drug Class/Drug	Quantity Limit
AKYNZEO (EPA, QLL)[@]	1 capsule/15 days
BELSOMRA (PAR, QLL)[@]	30 tablets/30 days

[@]Indicates not covered on Selectively Closed Formulary