2011 Group Renewal Bulletin

Blue Cross and Blue Shield of Minnesota
Fully insured groups

Enclosed is your 2011 Group Renewal Bulletin which outlines benefit clarifications, process modifications and other recommended health plan changes that may affect your members. As we embark on a new era of health care reform, it's important to know that this bulletin includes the first wave of changes required by new federal health care reform legislation – including both the Patient Protection and Affordability Act signed in March and the second reconciliation bill that followed.

As health care reform continues, you can count on Blue Cross Blue Shield of Minnesota to be your trusted guide in navigating the changing health care landscape, providing you the information and guidance you need to effectively manage your health care benefits.

The attached document provides a summary of changes that will be implemented with your health plan renewal, on or after September 23, 2010.

- Blue Distinction Centers® for spine surgery and for knee and hip replacement
- Creditable coverage disclosure for pharmacy benefits
- Emergency Care
- Medical equipment, prosthetics and supplies
- Notification requirements
- Skilled nursing facility language update
- Legislative update: Federal health care reform, Mental Health Parity, and State of Minnesota legislative mandates

Action required
Please share this information with your plan members as part of your annual health plan renewal process. The changes will also be reflected in the 2011 Certificate of Coverage issued to each employee under the plan. For the most current and detailed medical policy descriptions, members may also be directed online to bluecrossmn.com.

If you have questions about the information provided, please contact your agent or Blue Cross account manager.

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Blue Distinction Centers for Spine Surgery and for Knee and Hip Replacement

Blue Cross and Blue Shield of Minnesota, the Blue Cross and Blue Shield Association* and other Blue plans have identified nationwide high-quality providers for high-risk and high-cost specialty care. The new Blue Distinction Centers for Spine Surgery℠ and Blue Distinction Centers for Knee and Hip Replacement℠, join the existing nationwide network of specialty centers for bariatric surgery, cardiac care, complex and rare cancers and transplants. These Blue Distinction specialty care facilities have been selected after a rigorous evaluation of clinical data that provided insight into the facility's structures, processes and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care criteria, as established by expert physician panels, surgeons, behaviorists and nutritionists (*an association of independent Blue Cross and Blue Shield plans).

Blue Distinction Centers provide your employees and their families with a credible means of identifying hospitals that meet their individual health care needs for select procedures and conditions. Early research indicates that Blue Distinction Centers demonstrate better, more consistent overall outcomes. Quality care means fewer errors, complications or the need to be readmitted, which can result in higher satisfaction. And when your employees use proven quality providers, everyone benefits.

Effective, July 1, 2010, for all renewing fully insured groups, customer service representatives will encourage all members to use the new Blue Distinction Centers. *

In addition, a benefit option is available to fully insured groups effective January 1, 2011. Benefit plan designs may be modified to encourage Blue Distinction Centers usage for these services. If elected, members must use a Blue Distinction provider to obtain the highest level of benefits. The Blue Distinction benefit design is as follows:

- Highest level for Blue Distinction Centers
- Reduced benefit for non Blue Distinction participating providers
- No coverage for nonparticipating providers

***Note:** The benefit differential option and soft steerage for Blue Distinction Centers are NOT available for groups on the Accord, Value, BluePlus or other alternative networks.

Please contact your Blue Cross account manager if you have questions.

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Creditable coverage disclosure for pharmacy benefits

There are two disclosures relating to creditable coverage: 1) disclosure to Medicare-eligible members; and 2) disclosure to Centers for Medicare and Medicaid Services (CMS).

Member notification of creditable coverage status is due each year on November 14, upon member request, upon plan design change, or upon termination of coverage. Member notification is the employer's responsibility.

Employers must also disclose creditable coverage status to CMS, which includes information relating to the prior disclosure to members. The CMS disclosure must be provided within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS.

Detailed instructions and requirements regarding member notification and CMS disclosure can be found at:
cms.hhs.gov/creditablecoverage

Your Blue Cross account manager can provide information regarding the creditable or noncreditable status of your plan.

If an employer does not offer prescription drug benefits to any Medicare-eligible individuals, the employer is not required to fulfill the member disclosure nor the disclosure to CMS in that plan year.

Emergency Care

Fully insured groups who previously elected copayments on outpatient facility fees will now process as follows:

- Outpatient hospital/facility charges will be paid at 100% after copayment.
- Outpatient professional charges will be paid at 100% and are NOT subject to copayment or a deductible.

This change is effective for groups renewing on or after January 1, 2011.

Health plans with coverage for emergency services subject to the deductible and overall coinsurance will not be impacted by this change.

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Medical equipment, prosthetics and supplies

The following changes are being made to the durable medical equipment and supplies (DME) benefit for groups on an Aware PPO or CMM product.

Beginning with fully insured groups renewing as of July 1, 2010, the DME benefit will now process according to the benefit plan's overall deductible and coinsurance. There should be minimal impact to your employees as the DME network of participating providers is robust and offers statewide access. Groups who renew after July 1, 2010, will have the change made upon their renewal date.

Notification requirements

Effective January 1, 2011, for all renewing fully-insured groups, notification requirements have been revised. The language has changed from "Recommended" to "Required" for an approved prior authorization, preadmission notification, preadmission certification, and/or emergency admission notification.

This revision aligns contract language with Blue Cross' review of inpatient services and health care industry standards. Blue Cross reviews services to verify that they are medically necessary and that the treatment provided is the proper level of care.

Skilled nursing facility language update

The fully insured certificate of coverage (COC) description for skilled nursing facility (SNF) have been updated. The following language has been removed, as access to skilled nursing facilities locally and nationally is no longer an issue.

"If you are unable to obtain a bed in an in-network skilled nursing facility within a 50-mile radius of your home due to full capacity, you may be eligible to receive services at an out-of-network skilled nursing facility at the in-network level of coverage."

Legislative Update: Federal Health Care Reform

How health care rules may apply

There are multiple rules that take effect upon renewal on or after September 23, 2010. Some of the rules apply to all groups, while others apply differently based on whether the plan was in effect prior to the enactment of Federal Health Care Reform on March 23, 2010.

Rules applicable to all group health plans

All group health plans must implement a number of the rules. This is true regardless if their plan(s) was in existence prior to the enactment of the law, their funding type (self or fully-insured), and/or if their plan is subject to a collectively bargained agreement. There are no exceptions or special provisions in the enactment. All group health plans must include:

- No lifetime limits on coverage for essential benefits for all plans. Plus an enrollment period for those who have met the plan's LTM and are still otherwise eligible for enrollment. Note: Interim Final Rules on "essential benefits" are still pending.
- No rescissions of coverage except for fraud or intentional misrepresentation
- Extension of parents' coverage to young adults under 26 years old regardless of residence, student status, marital status, financial dependency, or employment status (grandfathered plans may exclude children who have other employment-based coverage until 2014). Plus an enrollment period for those eligible to enroll who lost coverage or were ineligible but are now under age 26.
- No coverage exclusions for enrollees (under age 19) with pre-existing conditions
- No annual limits may be applied to essential benefits.

Rules applicable based on grandfathered status

Some groups are eligible to claim what is known as ***grandfathered*** status and delay applying certain rules to their plan(s). Grandfathered health coverage is coverage provided by a group health plan prior to March 23, 2010, the date of Health Care Reform enactment. As outlined above, these groups are required to implement certain rules and are subject to additional reporting requirements.

Conversely, group health plans that were not in existence prior to March 23, 2010 are defined as ***non-grandfathered*** health coverage and are subject to an additional set of rules. Plans that would have been eligible to claim grandfathered status may have also forfeited their eligibility by making significant changes upon renewal that reduced benefits or increased costs to consumers may then also be considered "non-grandfathered".

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Preventive Care

Health Care Reform requires ***non-grandfathered*** plans to cover preventive care services at no cost to the member. The Law also requires that plans cover preventive services as they have been defined by:

- United States Preventive Services Task Force (USPSTF)
- Advisory Committee of Immunization Practices (ACIP), under the Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA) Guidelines for Preventive Care and Screenings for Infants, Children and Adolescents

For groups that have followed our recommended preventive care benefits, services covered will not significantly change with Health Care Reform as the majority of the recommendations are already included. New preventive care services have been added. Examples of these are:

- Screening, counseling and behavioral interventions for obesity in adults
- Screening for major depressive disorders in adolescents
- Counseling for tobacco use

To comply with Health Care Reform and to ensure the preventive care benefit is easy to understand, Blue Cross has consolidated preventive care, prenatal and well-child services into one ***Preventive Care Package.*** *Detailed information on what is included in our Preventive Care Package is available for review at www.employers.bluecrossmn.com*

Please review any potential cost impact with your account manager.

Action Required

Upon group plan renewal, Blue Cross will amend your plan(s) to add the Health Care Reform rules as specified above to all fully and self insured employer plans to ensure compliance with the health care law. These changes will take effect upon the first renewal on or after September 23, 2010.

All plans must notify Blue Cross of their grandfathered status for the upcoming renewal. To make certain we accurately administer your plan and keep accurate records, we ask that you **complete the enclosed *Administrator Evaluation Form* and return it to your Blue Cross account manager.**

Please note that if an employer elects to forego their plans' grandfathered status they must implement the additional benefit mandates as required by Health Care Reform. Also, grandfathered plans may choose to implement additional benefit mandates early without losing their grandfathered status. Please contact your Blue Cross account manager if you have questions.

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Short term Reforms 2010 (effective for groups renewing on or after September 23, 2010)

Rule	Applies to grandfathered plans	Applies to non-grandfathered plans
No lifetime limits on coverage for essential benefits for all plans. Note: Interim Final Rules that define "essential benefits" are still pending.	√	√
Extension of parents' coverage to young adults under 26 years old (grandfathered plans may exclude children who have other employment-based coverage until 2014) *Note: Blue Cross implemented Dependent Age 26 for fully insured group plans effective June 1, 2010 to avoid a gap in coverage for young adults.*	√	√
No rescissions of coverage except for fraud or intentional misrepresentation	√	√
No coverage exclusions for children (under age 19) with pre-existing conditions	√	√
No annual limits	√	√
Additional Benefits*: • Guaranteed access to pediatricians and OB-GYN's • Emergency Services must be provided without prior authorization requirements and non-participating providers must be covered at the same benefit and cost sharing level as services provided for participating providers		√
Preventive services, must be provided as defined by Health Care Reform, without cost sharing.		√
Additional reporting and disclosure requirements	√	
Internal/External appeals requirements		√
*Prior to PPACA, the majority of health plans/issuers provided these patient protections		

Health Care Reform Frequently Asked Questions	
How are essential benefits defined?	Interim Final Rules that provide more details on "essential benefits" are still pending. At a high level, Health Care Reform legislation defines essential benefits as: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services "including behavioral health treatments" • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care
What is a grandfathered group?	*General Rules on Grandfathered Status* • Grandfathered health coverage is coverage provided by a group health plan as of March 23, 2010, the date of Health Care Reform enactment • Any plan not in existence prior to March 23, 2010 is considered a non-grandfathered plan. • The grandfathering rules are applied separately to each benefit plan made available under a group health plan (e.g., the rules would apply separately to each plan that you offer. For example, if you offer a $500 deductible and a $1500 deductible plan, the rules apply separately to each). • A grandfathered health plan may cover family members of an employee who was enrolled in a group health plan on March 23, 2010 and whose family members enroll in the member's plan after March 23, 2010.
Do the grandfather rules apply to collectively bargained plans?	• Coverage under an insured collectively bargained plan is grandfathered at least until the last Collectively Bargained (CBA) relating to the coverage that was in effect on March 23, 2010 terminates. • Insured CBA plans must comply with the reform rules that are applicable to grandfathered plans on the first day of the first plan year on or after 9/23/2010. • Insured CBA plans may adopt health care reform rules without being treated as terminating the

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	CBA. • Changing insurance carriers is not treated as terminating the CBA. • After the last CBA relating to coverage in effect on March 23, 2010 terminates, general grandfather rules apply. • There is no special grandfathering rule for self-insured collectively bargained plans. A self insured plan maintained pursuant to one or more collective bargaining agreements is subject to the grandfathering requirements.
What health care reform rules apply to grandfathered health plan coverage?	All grandfathered group health plans (fully-insured, self-insured, and collectively bargained plans) must provide the following benefits for plan years starting on or after September 23, 2010: • No lifetime limits on coverage for essential benefits for all plans. Note: Interim Final Rules that define "essential benefits" are still pending. • No rescissions of coverage except for fraud or intentional misrepresentation • Extension of parents' coverage to young adults under 26 years old regardless of residence, student status, marital status, financial dependency, or employment status (grandfathered plans may exclude children who have other employment-based coverage until 2014) • No coverage exclusions for children (under age 19) with pre-existing conditions, and • No annual dollar limits may be applied to essential benefits.
Are there any additional requirements for grandfathered groups?	Yes, in addition, grandfathered plans are subject to disclosure requirements to retain grandfathered status. In order to maintain grandfathered health plan coverage status, group health plans must do the following: Disclose grandfathered status in member communications: • Any plan materials provided to a member describing the benefits provided under a plan must include a statement that the plan believes it is grandfathered health plan coverage as defined in Health Care Reform. • The plan must also provide contact information for questions and complaints in any such materials. Model language is available in the regulations. Maintain documents evidencing grandfathered status The group health plan must maintain records documenting the plan or policy terms in effect on March 23,

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	2010, and any other documents necessary to verify, explain, or clarify its status as grandfathered health plan coverage. Records must be maintained during the period the group claims grandfathered status plus six years.
What types of changes will result in a loss of grandfathered health plan coverage status?	There are many types of changes that can result in the loss of grandfathered health plan status. Following are some examples: • Entering into a new policy, certificate, or contract of insurance with the plan's issuer (except plans under a collective bargaining agreement that was in effect on 3/23/10). • Changing health insurance issuers. However, if a plan has three benefit options, and the plan only changes the issuer of one of the options, only the coverage under the option that has a new issuer is no longer grandfathered health plan coverage. • A change to eliminate all, or substantially all, benefits to diagnose or treat a particular condition. • Any increase in a percentage (coinsurance) cost sharing requirement. • A decrease by more than 5% in the employer's contribution towards the cost of any tier of coverage for any class of benefits. • A decrease in, or addition of, a new annual limit on the dollar value of benefits.
What types of changes do NOT result in the loss of grandfathered status?	• Addition of family members • Addition of new employees • Modification to conform to federal/state requirements • Premium adjustments • TPA changes • Cessation of coverage of one or more enrollees • Voluntary compliance with Health Care Reform • Early compliance with Health Care Reform
What health care reform rules apply to non-grandfathered health plan coverage?	Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. All non-grandfathered group health plans (fully-insured and self-insured) must also provide certain benefits for plan years starting on or after September 23, 2010. These benefits include: • No lifetime limits on coverage for essential benefits for all plans

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	• No rescissions of coverage except for fraud or intentional misrepresentation • Extension of parents' coverage to young adults under 26 years old • No coverage exclusions for children (under age 19) with pre-existing conditions, and • No annual dollar limits may be applied to essential benefits • Patient protection: guaranteed access to pediatricians and OB-GYNs • Emergency services must be provided without prior authorization requirements and non-participating providers must be covered at the same benefit and cost sharing level as services provided for participating providers • Coverage for preventive services, as defined by Health Care Reform, without cost sharing
How will preventive care services, as defined by Health Care Reform, be different that what our group already receives from Blue Cross?	Preventive care is important to overall health and the key to long-term good health. As a market leader in health and wellness, Blue Cross and Blue Shield of Minnesota has always offered a comprehensive preventive care benefits. The impact of this health care reform rule will have minimal impact upon fully and self insured benefit plan offerings that already align with Blue Cross offerings. To comply with Health Care Reform new preventive care services have been added. Examples of these are: • Screening, counseling and behavioral interventions for obesity in adults • Screening for major depressive disorders in adolescents • Counseling for tobacco use *Detailed information on what is included in the Blue Cross Preventive Care Package is available for review at www.employers.bluecrossmn.com* Grandfathered plans are exempt from the requirement.
What are the additional benefits?	The law requires certain patient protections for group health plans (grandfathered plans are exempt). Guaranteed access: • Plans that require or provide for the designation of a participating primary care provider (PCP) must guarantee access to PCP, pediatricians, and OB-GYNs. This means that enrollees have the right to (1) choose a PCP or a pediatrician when a plan or issuer requires designation of a PCP; or (2) obtain obstetrical or gynecological care without prior authorization. Blue Plus plans have provided this access for many years.

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	Emergency services: • Requires plans to cover emergency services without prior authorization or regardless of whether the provider participates in the plan's network. • Requires equivalent cost-sharing for network and non-network providers, and prohibits any limitations more restrictive than those imposed on services provided by network providers. • Uses a "prudent layperson" definition of emergency medical condition. Blue Plus and Blue Cross have provided these benefits for many years.
Are retiree-only plans impacted by health care reform?	Stand-alone retiree-only plans are not subject to the Health Care Reform law.
How will Health Care Reform impact personal spending accounts?	Health Savings Accounts (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) changes effective January 1, 2011 for new groups and renewing groups with non-grandfathered plans. Account-based plans were largely untouched by the legislation and remain a good way for employers that have a consumer driven health plan, to promote consumerism and employee tax savings. Following are several Health Care Reform rules that apply to consumer-driven health plans: • The penalty for using HSA money for non-allowed items increases from 10% to 20% (applies to distributions after December 31, 2010). • The increase in the penalty to 20% also applies to Archer MSAs • FSA, HSA and HRA (Archer MSA, VEBA) accounts can no longer be used for over-the-counter (OTC) drugs and medicines without a physician's prescription or a letter of medical necessity signed by a doctor for that specific OTC item (effective for claims incurred on or after January 2011 for all groups regardless of when their plan year starts). **Definition of "tax dependent" changed** There was also a change in the definition of "tax dependent" for purposes of tax-free health coverage • Effective March 30, 2010, Health Care Reform expanded the definition of "dependent" for purposes of tax-free health coverage to include a "child" who will not yet turn age 27 during the year, regardless of whether the child otherwise qualifies as a tax dependent. A "child" for this purpose is defined as in Internal Revenue Code (IRC) Section 152(f)(1), and includes children,

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	stepchildren, adopted children and eligible foster children. This rule will have an immediate impact on plans such as FSAs or HRAs that condition eligibility of a child qualifying as a tax dependent for health coverage purposes (i.e., under IRC Section 105(b)). The exclusion under IRC Section 105 applies only for reimbursements for medical care for dependents who are not age 27 or older at any time during the employee's taxable year (which you may assume is a calendar year). Employers may rely on the employee's representation as to the child's birth date. NOTE: Health Care Reform changed the definition of "dependent" for purpose of tax-free health coverage only; it did not change the definition of "tax dependent" for purposes of the individual income tax rules.
Informational Only	
Salary non-discrimination	Effective September 23, 2010, insured group health plans (other than grandfathered plans) are prohibited from discriminating in favor of highly compensated individuals in terms of eligibility and benefits.
Appeals and external review	**Appeals** • The appeals process must include an internal claims appeal process; provide notice to enrollees, *in a culturally and linguistically appropriate manner*, information about the availability of an internal and external appeals process and the existence of any state or federal ombudsman to assist with appeals; include an opportunity to review their file, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. **Culturally and linguistically appropriate standard** • Adverse benefit determinations and subsequent appeal-related notifications must be provided in a specific language when certain thresholds are met. • **Plan that covers fewer than 100 participants (employees)** at the beginning of a plan year: The plan complies if the plan provides notices *upon request* in a non-English language in which *25 percent or more* of all plan participants are literate only in the same non-English language • **Plan that covers 100 or more participants (employees)** at the beginning of a plan year: The plan complies if the plan provides notices upon request in a non-English language in which the *lesser of 500 or more participants, or 10 percent or more* of all plan participants, are literate only in the same non-English language.

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	• Employers are responsible to inform Blue Cross if it meets the above thresholds of employee participants who are literate in only a non-English language AND identify the language. Blue Cross is not responsible for any penalties related to employer's failure to notify Blue Cross. **External appeals** • All plans subject to state regulation must comply with state external review requirements that, at minimum, include the protections in the NAIC's External Review Model Act; or • For states without an external review process that meets these requirements and for self-funded plans, implement an external review process that meets minimum standards established by the Department of Labor.

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Update to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the Act)

On February 2, 2010, the Internal Revenue Service and the U.S. Departments of Labor and Health and Human Services issued interim final regulations (IFR) that expand the criteria to determine if health plans meet mental health and substance use disorder parity standards. The IFR applies to health plans offered by employers with 51 or more employees and takes effect generally with plan years that begin on or after July 1, 2010. (Alternate effective dates may apply for health plans subject to collectively bargained agreements.)

Blue Cross and Blue Shield of Minnesota ("Blue Cross") has done extensive parity assessments on the benefit plans we administer. Additionally, Blue Cross contracted with an independent actuarial evaluation, and they largely confirmed our results. Like many other health plan companies, our analysis shows that IFR compliance will require a number of employer health plans to make benefit plan design changes.

Fully insured groups with more than 51 members:
As the insurer Blue Cross is responsible for your IFR compliance. We have assessed your benefit plan and if your group is in compliance then you will not see any changes with your renewal and no further action is required.

If you are offering benefit plans that are **not** at parity, we will work with you (and your agent as appropriate) to identify what changes can be made. Recommended benefit plan designs that are in compliance will be provided by your account manager during the renewal process.

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State of Minnesota Legislative Mandates

Oral Oncology Parity

Effective August 1, 2010 the Minnesota State Legislative requires that fully insured health plans provide oral chemotherapy to members at a cost sharing that is at parity with cost sharing for intravenous and injected chemotherapy.

Private Duty Nursing

Effective July 1, 2010 the Minnesota State Legislature requires fully-insured health plans to provide private duty nursing to certain individuals who are also covered under Medical Assistance (MA).

Coordination of Benefits (COB) Primacy Rules

Blue Cross and Blue Shield of Minnesota administers coordination of benefits (COB) primacy rules based on the National Association of Insurance Commissioner's (NAIC) guidelines. Minnesota's previous regulations allowed an individual non-group health plan to always be the secondary payer if the other insurance was a group health plan. Minnesota recently amended the law to coincide with the current NAIC model in which a non-group health plan is now regarded in the same way as a group health plan for primacy purposes. This allows group health plans the possibility to benefit from coordination of benefits savings as the group health plan will no longer automatically be made to pay as the primary plan. Effective immediately, Blue Cross is administering the new COB rules for all groups. We anticipate that only a minimal number of our members will be directly affected by this change.

Provider Collection of Deductibles and Coinsurance

Effective 08/01/2010 a new state law allows providers to collect a patient's anticipated deductible and coinsurance amount prior to the claims submission. This applies to Minnesota providers and their patients, regardless of where the patient resides and regardless of the participation status of the provider.

Providers may not withhold a service for a member based on a patient's failure to pay a deductible or coinsurance at or prior to the time of service. Overpayments by patients to providers must be returned to the patient by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider.