

2012 Group Renewal Bulletin

Blue Cross and Blue Shield of Minnesota
Fully insured groups



Enclosed is your 2012 Group Renewal Bulletin which outlines benefit clarifications, process modifications and other plan changes that may affect your members. You may receive a second bulletin later this year that outlines any pertinent legislative actions, if they impact your health plan. This document provides a summary of changes that will be implemented upon your 2012 health plan renewal.

The following provides a summary of changes or informational items that will be implemented with your health plan renewal, on or after January 1, 2012.

- Chiropractic services
- Prenatal and well child
- Nonparticipating provider pricing
- Creditable coverage disclosure for pharmacy benefits
- Massachusetts creditable coverage service option
- Master Group Contract update
- Prescription drugs

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 2012 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**.

Grandfathered plans must complete and return the Premium Contribution Reporting Tool and the Plan Election Form details are described below.

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

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Grandfathered plans

Fully insured grandfathered plans must complete the Premium Contribution Reporting Tool and submit it along with a signed Plan Election Form each plan year. Documents must be received within 10 business days of your next plan year or your plan will be considered non-grandfathered and all applicable health care reform provisions will be applied to your plan. An electronic copy of the forms can be found on our employer portal at: employers.bluecrossmn.com

The forms can be located under Forms and Guides. Please complete the forms and email them to your Blue Cross account manager.

Note: Signatures may be typed since we are accepting these forms electronically.

Chiropractic services

Chiropractic office visits can no longer accumulate to the annual service limits for out-of-network providers. Services for therapies and manipulations will continue to accumulate to the service limit.

Prenatal and well child

Health care reform requires that prenatal and well child are covered at 100% of billed charge for out-of-network providers.

Nonparticipating provider pricing

To provide greater transparency when members utilize nonparticipating providers, the allowed amount will be determined based upon Medicare's allowed amount.

This change does not impact the nonparticipating pricing for emergency services for fully or self-insured non-grandfathered plans. Allowed amounts for emergency services, provided at an emergency department of a hospital, and by nonparticipating providers are based on billed charge.

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 October 15, upon member request, upon plan design change, or upon termination of coverage. Member notification is the employer's responsibility.

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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.

Massachusetts creditable coverage service option

Massachusetts (MA) law requires that residents age 18 and older have health insurance. To avoid monetary penalties, adults must have health insurance that meets minimum creditable coverage requirements. Several employer and employee notification and filing obligations accompany this creditable coverage requirement. To assist you in these efforts, Blue Cross and Blue Shield of Minnesota offers the following service.

Optional Blue Cross notification and filing service For employees

For accounts purchasing this service, Blue Cross will identify all employees and dependents with a Massachusetts address and who have or had active health plan coverage any time during the calendar year. A 1099-HC form will be prepared and mailed to each of these employees as defined by the MA Department of Revenue (MA DOR). The 1099-HC form will meet MA DOR reporting requirements and will be used by employees to complete their individual tax form. Blue Cross will pull data as of December 31 of each year.

One 1099-HC form will be generated for each covered family (employee and all dependents). We will not send a form to members with retiree coverage that supplements Medicare coverage. Retirees who reside in Massachusetts can report to the MA DOR that they have Medicare.

For employers

Blue Cross will also prepare and send a report to the MA DOR that complies with the employer's 1099-HC filing requirements. We will provide you with a report that can be used for auditing and compliance with MA DOR requirements. Blue Cross will also prepare and submit to the MA DOR quarterly electronic reports of any corrections completed after the filing deadline. The MA Health Care Reform Filing Service meets Massachusetts filing requirements for avoiding employer/employee state filing penalties.

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Fees

The fee for this service is \$40 for each 1099-HC form issued to a Massachusetts resident. There is a minimum fee of \$120 and a maximum fee of \$7,500.

Action requested

If you would like Blue Cross to provide the notification and filing service, you are asked to complete the online forms located at employers.bluecrossmn.com under Forms & Guides. By completing and signing these forms, you will be authorizing Blue Cross to provide the MA Health Care Reform Filing Service for your group and that you agree to pay the associated fees. **Your preference will be binding unless you notify us of a change by completing a new authorization form.** You will need to submit these forms to your Blue Cross representative **no later than October 31, 2011.**

Master Group Contract update

Language has been added to the master group contract under Article XIX-Health Care Reform, section 5. Rebates. This change is related to rebates that would be required if Blue Cross or Blue Plus does not meet thresholds for Medical Loss Ratio, or MLR.

MLR is a financial measurement comparing the percentage of premium dollars spent on health care services and improving the quality of care, versus how much is spent on administrative expenses. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%, where 20 cents of each premium dollar pays administrative expenses. Blue Cross and Blue Plus will be reporting MLRs for individual, small group and large group market segments each year. If we do not meet the MLR thresholds set by the Affordable Care Act for any of those market segments, rebates must be given to all groups and/or members who were effective in that market segment during the year.

It is our responsibility to keep our administrative costs low and rate our products so that your premium dollars are primarily going to claims costs. We expect to meet the MLR thresholds, since historically we've spent 90 cents of every health care dollar collected on members' health care costs. If we are unable to meet the thresholds for our small or large group market segments, we'll need your help to distribute rebates to you and your members appropriately. The contract language change outlines your responsibilities in the event a rebate must be paid.

If a rebate must be paid, we will provide additional education, processes and tools to assist you to rebate your members. The first potential rebate would be based on the financial results from 2011, with a deadline of August 1, 2012 for completing payment.

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Prescription drug terminology change

Blue Cross is changing terminology of prescription drugs from formulary/nonformulary to preferred/nonpreferred. This is a terminology change; the benefits will remain the same.