

Blue Cross 2010 Renewal Bulletin (summary of mandated changes)

Step therapy

Effective January 1, 2010, a step therapy program will be a standard part of the pharmacy offering for all Carleton College Blue Cross plans.

A step therapy program is a “step” approach to providing drug coverage. It is designed to encourage the use of cost-effective prescription drugs when appropriate. This means that members may first need to try an alternative, typically a generic drug, before Blue Cross and Blue Shield of Minnesota will cover certain medications prescribed by their physician.

Step therapy programs are developed using Food and Drug Administration (FDA) guidelines, clinical evidence and research. They ensure that our members are taking appropriate and cost-effective medications.

Blue Cross’ standard step therapy program will apply edits to the following therapeutic categories:

- Antidepressants (anti-depressants will be grandfathered in if there is consistency with one prescription drug and usage requirements)
- Cholesterol lowering
- Diabetic monitors and strips
- Proton pump inhibitors

Notification will be sent to members who will be impacted by this change. If members are currently taking a drug that Blue Cross includes in their step therapy program, they will be asked to contact their physician. Members’ physicians can discuss with the member what medication options are best for them. Their physician will be able to determine whether to write a new prescription or to submit a written request for them to continue their current medication.

Preventive Care Services

Blue Cross annually reviews the preventive care benefit to ensure it continues to align with the most current nationally recognized evidence-based health care guidelines which provides the highest quality and cost effective health care for your group. These guidelines are developed by professional associations and experts in the field of preventive care (e.g., Centers for Disease Control and Prevention (CDC), National Committee for Quality Assurance (NCQA), Institute for Clinical Systems Improvement (ICSI), Advisory Committee on Immunization Practices (ACIP), and others).

Preventive care services update:

The following lab tests will no longer be covered at the highest level of preventive care services.

- Hemoglobin – CBC
- Urinalysis
- Thyroid screening

These lab tests will now process at the illness/medical level of benefit. The coverage of these lab tests has been updated as there are no national or local evidence-based standards that identify them as a preventive service.

Preventive care services language update:

1. Preventive care services are now defined in the Certificate of Coverage (fully insured) with the following language:

Benefits for services identified as preventive care are determined based on recommendations and criteria established by professional associations and experts in the field of preventive care. For all other eligible services, please refer to “Hospital Inpatient,” “Hospital Outpatient” and “Physician Services.”

2. The term physical exam is changing to *preventive medical evaluation*. This term is deemed industry standard.

3. The term “Immunizations” is changing to *standard immunizations*. Standard immunizations are defined in the Notes section as: Eligible standard immunizations (e.g., diphtheria or tetanus) are covered under the preventive care benefit based on recommendations and criteria established by professional associations and experts in the field of preventive care. For non-standard immunizations, please refer to “Physician Services,” as they are covered at the illness/medical level of benefit.

4. The language for the cholesterol/lipid profile is changing to *lipid profile, including total and HDL cholesterol*

These administrative updates are effective January 1, 2010, upon renewal for all fully insured groups and any self-insured groups. All eligible services are subject to member’s benefit design, including cost sharing, e.g., deductibles, coinsurance, copays, etc. Benefits can be verified in your Certificate of Coverage (fully-insured).

Medicare Secondary Payer Reporting Requirements

A federal law called the Medicare, Medicaid, and SCHIP Extension Act of 2007 was passed. Section 111 of the law requires carriers to participate in a Medicare Secondary Payer (MSP) data exchange with the Centers for Medicare & Medicaid Services (CMS). This data is being requested by CMS in order to identify Medicare beneficiaries whose group health plan or other coverage is primary to Medicare. The law identifies group health plan carriers as being the Responsible Reporting Entities (RRE) required to gather the necessary data elements. Blue Cross and Blue Shield of Minnesota and Blue Plus, as RREs, must gather the required data and submit files to CMS on a quarterly basis. Starting January 1, 2009, we are required to gather the following information from employers:

- Social Security numbers (SSNs) for existing actively working employees aged **55 and older** (i.e., those who had coverage with Blue Cross before January 1, 2009)
- SSNs for actively working employees and their dependents aged **55 and older** whose coverage first became effective January 1, 2009 and later
- Employee count (both full-time and part-time employees – whether or not covered under the group health plan)
- Tax identification number (TIN) or employer identification number (EIN) for all groups, regardless of coverage effective date

Prior to *January 1, 2011*, we must start collecting SSNs for actively working employees and their dependents aged **45 and older**, in addition to employee count and TIN/EIN, for reporting on or after January 1, 2011.