

2011 Group Renewal Bulletin

Blue Cross and Blue Shield of Minnesota
Fully insured groups



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) <i>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.</i>	√	√
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*: <ul style="list-style-type: none"> 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		

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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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	<p>CBA.</p> <ul style="list-style-type: none"> • 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.
<p>What health care reform rules apply to grandfathered health plan coverage?</p>	<p>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:</p> <ul style="list-style-type: none"> • 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.
<p>Are there any additional requirements for grandfathered groups?</p>	<p>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:</p> <p><u>Disclose grandfathered status in member communications:</u></p> <ul style="list-style-type: none"> • 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. <p><u>Maintain documents evidencing grandfathered status</u> The group health plan must maintain records documenting the plan or policy terms in effect on March 23,</p>

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	<p>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.</p>
<p>What types of changes will result in a loss of grandfathered health plan coverage status?</p>	<p>There are many types of changes that can result in the loss of grandfathered health plan status. Following are some examples:</p> <ul style="list-style-type: none"> • 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.
<p>What types of changes do NOT result in the loss of grandfathered status?</p>	<ul style="list-style-type: none"> • 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
<p>What health care reform rules apply to non-grandfathered health plan coverage?</p>	<p>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:</p> <ul style="list-style-type: none"> • No lifetime limits on coverage for essential benefits for all plans

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	<ul style="list-style-type: none"> • 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
<p>How will preventive care services, as defined by Health Care Reform, be different that what our group already receives from Blue Cross?</p>	<p>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:</p> <ul style="list-style-type: none"> • Screening, counseling and behavioral interventions for obesity in adults • Screening for major depressive disorders in adolescents • Counseling for tobacco use <p><i>Detailed information on what is included in the Blue Cross Preventive Care Package is available for review at www.employers.bluecrossmn.com</i></p> <p>Grandfathered plans are exempt from the requirement.</p>
<p>What are the additional benefits?</p>	<p>The law requires certain patient protections for group health plans (grandfathered plans are exempt). Guaranteed access:</p> <ul style="list-style-type: none"> • 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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	<p>Emergency services:</p> <ul style="list-style-type: none"> • 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. <p>Blue Plus and Blue Cross have provided these benefits for many years.</p>
<p>Are retiree-only plans impacted by health care reform?</p>	<p>Stand-alone retiree-only plans are not subject to the Health Care Reform law.</p>
<p>How will Health Care Reform impact personal spending accounts?</p>	<p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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). <p>Definition of "tax dependent" changed</p> <p>There was also a change in the definition of "tax dependent" for purposes of tax-free health coverage</p> <ul style="list-style-type: none"> • 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.