



Implementation Guidelines

For individual market members

**Near-term benefit changes required in the
Patient Protection and Affordable Care Act**



The information in this document is valid as of August 31, 2010.

Introduction

The Patient Protection and Affordable Care Act (PPACA) requires several benefit changes be made beginning with plan years starting on or after Sept. 23, 2010. BCBSM, BCN and Blue Care of Michigan, Inc. refer to these changes as “near-term benefit requirements.” For purposes of this alert, BCN and Blue Care of Michigan, Inc. are collectively referred to as “BCN.”

Changes relating to PPACA near term provisions will be implemented for BCBSM and BCN individual market plans on Jan. 1, 2011 to ensure compliance and as little disruption to our members as possible. Jan. 1 is the beginning of the plan year for BCBSM and BCN individual market plans.

Since PPACA became law on March 23, 2010, the Department of Health and Human Services (HHS) has released regulations for various provisions. At this time, BCBSM and BCN are implementing benefit changes impacted by the following provisions:

- Extending dependent coverage up to age 26
- Removal of lifetime dollar limits
- Removal of pre-existing condition exclusions for children up to age 19 (Note: the pre-existing conditions waiting period for children up to age 19 will be waived for new enrollment in BCBSM and BCN individual market plans as of Sept. 23, 2010. In addition, any remaining days of the waiting period for children who have not exhausted their 180-days will be waived.)

- Adding or expanding preventive care and immunizations. Evidence-based preventive services which have been identified by the United States Preventive Services Task Force and the Health Resources and Services Administration, as well as immunizations set by Centers for Disease Control will be covered by all individual market plans, open and closed to new enrollment. There will be no cost sharing or annual maximum for services that are recommended. These requirements only apply to services provided by in-network providers.
- Prohibiting rescissions with limited exceptions
- Clarifying emergency services

BCBSM and BCN were compliant with the following provisions prior to the passage of PPACA, therefore no action is required:

- OB/Gynecologist for Women’s Access
- Pediatrician for Child’s PCP

HHS has yet to issue clarifying regulations for “essential benefits” related to annual dollar limits. When these regulations become available, BCBSM and BCN will move forward with benefit changes related to these provisions.

The information in this document is based on BCBSM’s review of the national health care reform legislation. It is not intended to impart legal advice. Interpretations of the reform legislation may vary. This overview is intended for informational and educational purposes only and does not replace a more rigorous review of the law’s applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice. Analysis is ongoing and additional guidance is also anticipated from the Department of Health and Human Services. Additionally, some reform regulations may differ for particular members enrolled in certain programs such as the Federal Employee Program, and those members are encouraged to consult with their benefit administrators for specific details. All of the benefit and rating changes outlined in this document are subject to OFIR approval.

Grandfathering

BCBSM and BCN individual market plans are considered new and will not be grandfathered. All plans open and closed to new enrollment will be compliant with reform provisions as of January 1, 2011.

Rating Impacts

The benefit rating impacts of these PPACA near-term provisions, including pre-existing conditions waiting periods for children up to 19 and the extension of dependent coverage up to 26, will be applied on Jan. 1, 2011, creating premium changes on that date. Individual market subscribers will receive letters prior to this rate increase.

Please note that BCBSM and BCN are still assessing the impacts with regard to immunizations and preventive coverage with no cost-sharing. Any potential rate impacts will be separate from those noted above.

Rate Disclaimer

A disclaimer statement similar to the following will be added to the MyBlue website, rate sheets, member bills, rate calculators and other communications, as applicable:

To comply with new requirements in the Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, insurers are required to make changes to individual market plans. This may result in an adjustment to the subscriber's rates. To learn more about the PPACA, please visit bcbsm.com/healthreform.

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Dependent Coverage:

Overview

- PPACA requires that health plans offer dependent coverage for child dependents up to age 26. BCBSM and BCN define child dependents as those related to the subscriber by birth, marriage, legal adoption or guardianship.
- Eligibility will no longer be limited by financial dependency, marital status or enrollment in school. The dependent must provide proof of Michigan residency. The dependent is eligible even if he or she has access to employer-sponsored insurance.
- BCBSM will allow coverage of dependents through the end of the calendar year of their 26th birthday, which will be reflected in the certificates and riders for current and newly developed products.
- Subscribers will no longer be able to choose the Family Continuation Rider (FC) for dependent(s).

Special Enrollment Period

Individuals who are now eligible for dependent coverage under PPACA can request enrollment in a health plan during the special enrollment period. The special enrollment period only applies to individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage ended before they turned age 26.

The special enrollment period will be held Nov. 1, 2010 through Nov. 30, 2010 to enroll the qualified PPACA dependents in health plans effective Jan. 1, 2011.

To enroll an eligible dependent:

During the Special Enrollment Period only:

- Dependents may only be added to a parent's policy by the subscriber. Only an eligible dependent who is related to the subscriber by birth, marriage, legal adoption or guardianship may be added to a parent's policy. The eligible dependent must be a Michigan resident.

- The subscriber must contact Customer Service to add an eligible dependent during this period, with a coverage effective date of Jan. 1, 2011.
- The eligible dependent must be under 26 years of age as of Jan. 1, 2011. If the dependent will be 26 on or before Jan. 1, 2011, the dependent is not eligible to enroll.
- A subscriber can add eligible dependents to an open or closed individual market or group conversion contract, even if the dependent was not previously enrolled.
- The pre-existing conditions waiting period will be waived for the re-enrolled dependent:
 - Always if dependent is younger than 19 years of age (18 years + 364 days)
 - Always for enrollment in a group conversion plan
 - Always if the 19+ dependent exhausted his or her pre-existing conditions waiting period when previously enrolled on the subscriber's contract.
- If the individual market product has a 90-day benefit waiting period, this waiting period will restart even if the eligible dependent previously met the benefit waiting period.
- If the individual market product includes a dental rider (Flexible Blue DentalSM or Flexible Blue Dental PlusSM), the dependent will be allowed to enroll in this dental plan only. No other dental products are eligible for enrollment during the Special Enrollment Period.
- The current policy regarding changing plans remains in place, i.e., subscribers may change plans only at anniversary date or upon a rate increase.

After the Special Enrollment Period has expired, current enrollment policies should be followed.

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Ancillary Guidelines

Although PPACA provisions do not impact dental or vision plans, BCBSM has chosen to extend dependent coverage to age 26 for selected individual market dental and vision benefits as follows:

- Dependent coverage for dental and vision benefits will be extended to dependents up to age 26 for all current and new enrollment in:
 - Individual Care Blue PlusSM with preventive dental and vision
 - Flexible Blue Dental PlusSM (optional dental benefits for Individual Care Blue Plus and Flexible Blue IISM).
- Dependent coverage will NOT be extended to age 26 for:
 - Personal Blue DentalSM
 - Personal Blue Dental PlusSM
 - Flexible Blue DentalSM (closed to new enrollment)
 - Personal DentalSM (closed to new enrollment)
 - Family Continuation riders for these products will NOT be eliminated.

Cost Impacts

Under the interim final regulations, the FC rider will no longer be compliant as a different rate is charged depending on the age of the covered dependent. As a result, FC riders currently used for all individual market medical plans will be eliminated as of Jan. 1, 2011.

Contract rate tiers for singles, two-person and families will be adjusted as necessary and all FC dependents will be reclassified as regular dependents. Subscribers will be charged based on their new contract tier. Depending on the makeup of the subscriber's dependents, changes in the bill will vary. FC charges will no longer apply, but some single contracts will move to two-person and some two-person contracts will move to families.

Rates may not differ based on dependent age. A 20-year-old dependent may not be charged more than a 2-year-old dependent. If a 20-year-old is a subscriber, the 20-year-old will not receive the dependent rate. The 20-year-old subscriber will be charged the subscriber rate for a 20-year-old.

Removal of Lifetime Dollar Limits:

Overview

PPACA prohibits health plans from imposing lifetime dollar limits on "essential benefits." BCN was compliant with this provision prior to the passage of PPACA, so no action is required for BCN health plans. However, some BCBSM individual market plans do apply lifetime dollar limits. Lifetime dollar limits will be removed on medical and prescription benefits such as overall lifetime dollar limit and specified organ transplants. Rating impacts related to this change are minimal.

Special Enrollment Period

A member whose coverage ended because of reaching a lifetime dollar limit under their plan who is otherwise eligible for coverage is now eligible to re-enroll in a BCBSM individual market plan.

This special enrollment period will be held Nov. 1, 2010 through Nov. 30, 2010 for health plans effective Jan. 1, 2011.

To enroll a member who previously reached their lifetime dollar limit:

During the Special Enrollment Period only:

- Coverage effective date is Jan. 1, 2011
- The subscriber must contact Customer Service to enroll themselves or an eligible dependent who is related to the subscriber by birth, marriage, legal adoption or guardianship. The individual must be a Michigan resident.
- A subscriber, or the subscriber's eligible dependent, will be allowed to re-enroll in any product, open or closed, individual market or group conversion contract.
- However, to enroll in a closed individual or group conversion product, the subscriber or the subscriber's eligible dependent must have met the lifetime dollar limit while enrolled in the closed product.

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- If the individual market product has a 90-day benefit waiting period, this waiting period will restart even if the subscriber or dependent previously met the waiting period.
- If the individual market product includes a dental rider (Flexible Blue Dental or Flexible Blue Dental Plus), the subscriber or dependent will be allowed to enroll in this dental plan only. No other dental products are eligible for enrollment during the Special Enrollment Period.
- The current policy regarding changing plans remains in place, i.e, subscribers may change plans only at anniversary date or upon a rate increase.

After the Special Enrollment Period has expired, current enrollment policies should be followed.

Pre-existing condition exclusions for children up to age 19

PPACA prohibits health plans from limiting or excluding benefits, including the denial of coverage, related to a condition that was present before the date of enrollment for coverage for enrollees under the age of 19.

On Sept. 23, 2010, the 180-day pre-existing condition waiting period for children under 19 will no longer apply to new enrollment in Option A, Option C and MyBlue plans. In addition, any remaining days of the waiting period will be waived for children under age 19 who have not exhausted their 180-day pre-existing condition waiting period. Claims that were denied for the pre-existing condition waiting period prior to Sept. 23, 2010 are not affected. This regulation does not affect the 90-day benefit waiting period.

BCN will no longer be able to medically underwrite its individual products (OneBlueSM and BCMI Personal PlusSM) for enrollees under the age of 19. These members can no longer be denied coverage due to a pre-existing condition.

Rating impacts due to these changes will be minimal.

Emergency Services

PPACA prohibits preauthorization requirements or restrictions for emergency services. If a plan covers emergency services in the emergency department of a hospital, the services must be covered without requiring copayments or coinsurances for non-network services that are greater than what applies to network services (if the plan provides benefits through a network). Therefore, BCBSM's reimbursement rate for non-participating facilities will be updated.

BCN individual market plans were compliant with this regulation prior to the passage of PPACA.

There will be no rating impacts.

Prohibit Rescissions with limited exceptions

PPACA prohibits rescissions (e.g., retroactive termination), except in the case of fraud or intentional misrepresentation of a material fact. In cases where rescission is allowed, PPACA requires a 30-day prior written notice before rescission. Cancellations due to non-payment or other reasonable causes are permitted, but a 30-day notice to the member is required.

BCBSM and BCN individual plans do not require any benefit changes.

BCBSM and BCN are still reviewing the impact of this legislation on the retroactive membership changes.

There will be no rating impacts.

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Immunization and Preventive care with no cost sharing

PPACA states that evidence-based preventive services which have been identified by the United States Preventive Services Task Force and the Health Resources and Services Administration, as well as immunizations set by Centers for Disease Control will be covered by all individual market plans, open and closed to new enrollment. There will be no cost sharing or annual maximum for services that are recommended. These requirements only apply to services provided by in-network providers.

Going forward, all plans will include preventive care services, such as:

Health maintenance exam, EKG, cholesterol screening and other select lab procedures
Gynecological exam
Pap smear screening – laboratory and pathology services
Well-baby and child care visits
Fecal occult blood screening
Flexible sigmoidoscopy exam
Prostate specific antigen (PSA) screening
Routine mammogram and related reading
Routine Colonoscopy
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act

OB/Gynecologist for women's access

PPACA states that plans may not require authorization or referral for obstetrical or gynecological care by in-network health care professionals specializing in obstetrics or gynecology. For those obstetric and gynecological services that require both primary care physician referral and plan prior authorization, the federal statute requires the specialist referral to replace the PCP referral, but the plan retains the right to impose prior authorization requirements.

BCBSM and BCN individual plans were compliant with this regulation prior to the passage of PPACA.

There will be no rating impacts.

Pediatrician for child's PCP

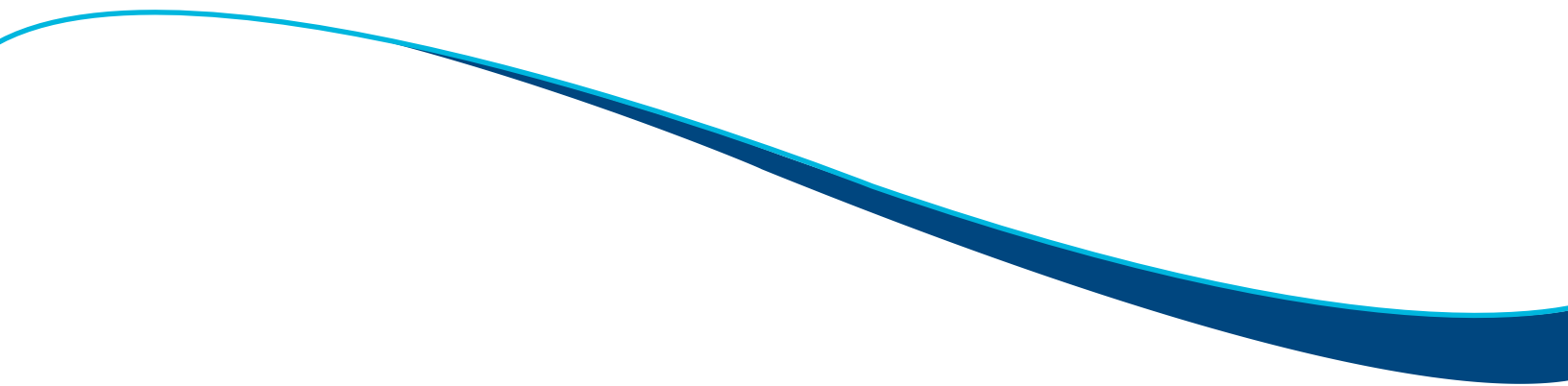
PPACA states that plans that require members to choose a primary care provider must allow members to choose any participating primary care physician, or pediatrician in the case of a child, from any available participating primary care provider or pediatrician available to accept the individual.

BCBSM and BCN individual plans were compliant with this regulation prior to the passage PPACA.

There will be no rating impacts.

Questions? Agents should contact the Agent Hotline at 800-788-7334. Individual members should contact Customer Service at 888-288-2738.

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