



Implementation Guidelines

For group customers

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 and BCN refer to these changes as “near-term benefit requirements.”

Changes relating to PPACA near-term provisions will be implemented for most groups on Jan. 1, 2011 to ensure compliance and as little disruption to our group customers as possible. Groups with documented plan years that fall between Sept. 23, 2010 and Dec. 31, 2010 will see product changes on their plan year within that timeframe.

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

- Extending dependent coverage up to age 26
- Immunization and preventive coverage with no cost-sharing
- Removal of lifetime dollar limits
- Removal of pre-existing condition exclusions for children up to age 19
- Prohibiting rescissions with limited exceptions
- Clarifying emergency services

Explain to groups that we are making near-term benefit changes on Jan. 1, 2011 to ensure timely implementation and compliance.

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” relating to annual dollar limits, with the exception of preventive services. When these regulations become available, BCBSM and BCN will move forward with benefit changes related to those provisions.

Changes required to conform to the above regulations are being made to all certificates, riders, enrollment forms, Benefits at a Glance, Special Modification of Benefits and ASC Plan Modifications as required. Membership and claims system changes will be made on the dates noted under the cost impacts section through an automated process.

Discuss the PPACA changes with your groups and provide them with the group takeaway document.

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Plan Year Interpretation:

There are several sequential criteria to determine plan year. BCBSM and BCN have found most groups' plan years run Jan. 1 through Dec. 31, as this is when plan deductibles and benefit cycles reset. Plan year is not synonymous with "renewal date" or "enrollment date," although there are circumstances where those dates could be the same.

BCBSM and BCN identification of a group's plan year:

- The date that is designated as the plan year in the plan document of a group health plan, except if the plan document does not designate a plan year or if there is no plan document, the plan year is:
 - The deductible or benefit year used under the plan;
 - If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;
 - If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or
 - In any other case, the plan year is the calendar year

Implementation Timeline: Existing Business

Renewal Date	Plan Year Date	Effective Date of Benefit Changes	Rate Impact Date* (area-rated & ERS)	Billing Impact Date* (due to membership reclassification)	Implementation Plans
Sept. 23, 2010 – Sept. 22, 2011	Sept. 23, 2010 - Dec. 31, 2010 (must provide Plan Document)	Plan Year Date	2011 renewal date	Plan Year Date	A special rider, Special Modification of Benefits or ASC plan modification will be applied through a Group Wide Change
Sept. 23, 2010 – Sept. 22, 2011	Jan. 1, 2011	Jan. 1., 2011	2011 renewal date	Jan. 1, 2011	Near Term Benefits implemented through an automated effort effective Jan. 1, 2011, no manual group wide changes are required
Sept. 23, 2010 – Sept. 22, 2011	Jan. 2 - Sept 22, 2011	Jan. 1, 2011	2011 renewal date	Jan. 1, 2011	Near Term Benefits implemented through an automated effort effective Jan. 1, 2011, no manual group wide changes are required

*Additional detail is provided in this document.

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Implementation Timeline: New Business

Group Effective Date	Plan Year	Effective Date of Near Term Benefits	Rate Impact Date* (area-rated & ERS)	Billing Impact Date* (due to membership reclassification)	Implementation Plans
Sept. 23, 2010 – Dec. 31, 2010	Plan year not documented	Jan. 1, 2011	2011 renewal date	Jan. 1., 2011	Near Term Benefits implemented through an automated effort effective Jan. 1, 2011, no manual group wide changes are required
Sept. 23, 2010 – Dec. 31, 2010	Sept. 23, 2010 - Dec. 31, 2010 (must provide Plan Document)	2010 Plan Year Date	2011 renewal date	2010 Plan Year Date	Near Term Benefits implemented on plan year date
Jan 1, 2011 – Sept. 22, 2011	Jan. 1, 2011 – Sept. 22, 2011	New Business Effective Date (Jan. 1, 2011 and later)	New Business Effective Date	New Business Effective Date	Near Term Benefits systematically applied

*Additional detail is provided in this document.

Plan Year:

“Plan year” is not synonymous with “renewal date” or “enrollment date,” although there are circumstances where those dates could be the same. Typically a plan year is when the deductible resets, which is Jan. 1 for the majority of our groups.

-  Most groups' benefit changes will be implemented on Jan. 1, 2011
 - BCN groups with a plan year rider will be have benefit changes implemented on the date that their plan year begins.
-  No Group Wide Change is needed for the near-term benefit changes required in PPACA. They will automatically be implemented on Jan. 1, 2011 for all groups.

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Grandfathering

Grandfathered group plans are exempt from complying with the following PPACA near term requirements:

- Emergency services
- Immunization and preventive care with no cost-sharing
- OB/Gynecologist for women's access
- Pediatrician as a child's primary care physician
- Covering newly eligible dependents that currently have their own employer-sponsored coverage

In most cases, BCBSM and BCN are implementing these PPACA near-term requirements for both grandfathered and non-grandfathered groups since it is anticipated that there will be no or minimal cost impacts.

To be considered a grandfathered plan, groups must meet several administrative requirements and may not significantly change benefits or employee and employer contribution levels from those in existence on March 23, 2010. These rules will make it difficult for groups to control their overall costs, and it's unlikely that they will choose to maintain grandfathered status until 2014 when most of the potential value associated

with grandfathering would be realized. In fact, a recent Hewitt Associates [survey](#) found that 90 percent of U.S. companies anticipate losing grandfathered status by 2014.

To ensure that the implementation process is as streamlined and efficient as possible, BCBSM and BCN will treat fully insured group plans and individual market plans as new plans, including all area/industry and ERS-rated business. We also strongly encourage self-insured groups to choose to be treated as a new plan, even if they're eligible to be treated as a grandfathered plan.

If self-insured groups choose to remain grandfathered, a certification letter is required stipulating that it's actively tracking grandfathered status and holding the appropriate information in the case of an audit.

Groups with collectively bargained agreements do not have a delayed effective date for the near-term reform provisions. Near-term requirements will be implemented for all groups effective Jan. 1, 2011. **This will not negatively impact groups who choose to exercise their grandfathering eligibility related to future PPACA regulations, as complying with these reform provisions is considered one of the allowable plan changes which does not jeopardize grandfather status.**

Ensure groups understand the need to comply with the near-term benefit changes required under PPACA, even if grandfathered.

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Cost Impacts

- The near-term benefit changes are anticipated to have a minimal impact on rates for underwritten groups or costs for self-insured groups.
- **Due to the anticipated minimal impact on rates and the goal to ensure compliance and minimize disruption for our customers, any rate adjustments required for underwritten groups will be applied at a group's next annual renewal date on or after Jan. 1, 2011. Additionally, any adjustments required to ASC stop loss fees and/or attachment points will also be applied at a group's renewal on or after Jan. 1, 2011. Self-insured groups will be responsible for claims paid based on the required adjustments to coverage.**
- For those groups with a plan year prior to Jan. 1, 2011, a special rider, Special Modification of Benefits or ASC plan modification, will be developed allowing these groups to comply on their required date. Rates for underwritten groups will not be impacted until their next renewal following Jan. 1, 2011.

Note: More information on cost impacts related to dependent coverage changes is included in the dependent coverage section of this document.

Please note that disclaimer language has been added to all Rate Sheets that were released after July 9, 2010. For RateEase, disclaimers will start with the fourth-quarter release on July 7, 2010 and for eQuoting/SMART, they will start with the July 13, 2010 fourth-quarter release. There are two sets of disclaimers, listed below, specifying the audience.

Disclaimer for ALL Rate Sheets/Quoting Systems/ERS Renewal Packages:

To comply with new requirements in the Patient Protection and Affordable Care Act (PPACA) (also referred to as health care reform), groups may be required to make changes to their health insurance coverage. If necessary, this may result in an adjustment to the rates. To learn more about the PPACA, please visit our webpage, bcbsm.com/healthreform. You should also consult with your legal counsel for any legal advice on how you may comply with the law and regulations and the applicability to your plan.

Self-Insured Renewal Packages (Local & Multi-State):

To comply with new requirements of the Patient Protection and Affordable Care Act (PPACA) (also referred to as health care reform), many group health plans may be required to modify their health care plan and coverage. In the attached renewal, claim projections and illustrative rates have not been adjusted to reflect these changes. To learn more about PPACA, please visit our webpage, bcbsm.com/healthreform. You should also consult with your legal counsel for any legal advice on how you may comply with the law and regulations and the applicability to your plan.

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Dependent Coverage: Overview

- PPACA requires that groups offer dependent coverage for children up to age 26. BCBSM defines child dependents as those related to the employee by birth, marriage, legal adoption or legal guardianship. This requirement will be extended to all lines of business on Jan 1, 2011.
- Dependent eligibility will no longer be limited by financial dependency, marital status or enrollment in school.
- BCBSM and BCN will adjust their policies to allow coverage of dependents through the end of the calendar year of their 26th birthday.
- As previously communicated in a [Reform Alert](#), BCBSM and BCN agreed to suspend the annual removal of 25-year-old dependents. As of Jan. 1, 2011*, we will begin allowing the addition of dependents between the age of 19 and 26 in accordance with PPACA.
- Rates charged for dependents can no longer vary by the age of the covered dependent.
- Groups will no longer be able to choose dependent coverage riders for their employees. While the Dependent Continuation (DC) rider is no longer available, the DC rating **methodology** complies with PPACA and will be used for rating all dependent coverage moving forward, even for plans that previously had a Family Continuation (FC) rider. There is more information about this under the Dependent Coverage: Cost Impacts section of this document.
- For background, the dependent coverage riders previously sold are defined below:
 - **Dependent Continuation Rider (DC):**
The DC rider applies rates based on the number of members on each contract. There are three rate levels: one-person contracts, two-person contracts and family contracts. Groups with the DC rider pay the same premium for families of three as they do for families of seven, regardless of the age of the dependents.
 - **Family Continuation Rider (FC):**
With the FC rider, groups cover adult dependents by paying an additional premium for each 19- to 25-year-old eligible adult dependent. Therefore, a family of seven could pay a different rate than a family of three depending on the age of the dependents. This rating methodology does not comply with PPACA.

*For groups with documented plan years that fall between Sept. 23, 2010 and Jan. 1, 2011, the changes will occur with a group's plan year date.

Dependent Coverage: Ancillary Guidelines

- Groups that offer medical and any ancillary product (Rx, dental, vision) will have their dependent coverage eligibility extended to age 26 for all lines of business. Rating will be consistent with medical coverage.
- Groups that only offer Stand Alone DentalSM or vision without BCBSM or BCN medical coverage and have a FC rider will retain coverage for eligible dependents up to age 25. Groups that currently offer a DC rider will be extended to age 26.

Advise groups with medical and ancillary benefits that dependent coverage will be extended to age 26 for all lines of coverage with the exception of groups with Stand Alone Dental or stand alone vision that currently use FC.

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Dependent Coverage: Cost Impacts

BCBSM and BCN currently use two group rating methodologies for dependent coverage, FC and DC, when adding adult dependent coverage.

Under the interim final regulations, the FC rider will no longer be compliant because FC charges a different rate depending on the age of the covered dependent. As a result, DC rating methodology will be built in for all groups starting Jan. 1, 2011.

For groups with plan years beginning on or after Jan. 1, 2011*, contract tier rates for one-person, two-person and families will not be changed, but all FC dependents will be reclassified as regular dependents similar to the way dependents are enrolled for DC riders. Customers will be charged based on their new contract distribution changing their bill. Depending on the makeup of the dependents, changes in the bill will vary. FC charges will no longer apply, but some one-person contracts will move to two-person, and some two-person contracts will move to families.

Groups with the DC rider will not see a change to their monthly bill. Groups who offer adult dependent coverage with the FC rider will notice a change in membership classification. At the group's next renewal, on or after Jan. 1, 2011, groups will see an estimated cost increase of less than 1.25 percent on average. This cost increase includes the estimated impact of enrolling additional dependents. Smaller groups will generally see a wider range of changes based on the composition of the group's enrollment.

*For groups with documented plan years that fall between Sept. 23, 2010 and Jan. 1, 2011, the changes will occur with a group's plan year date.

The chart below summarizes the changes that will be made:

IF:	THEN:
Group has FC	All FC dependents will be changed to regular dependents on Jan. 1, 2011 Group's bill will reflect membership reclassification once FC dependents are changed to regular dependents
Group has DC	No change to membership classification No change to group's bill
Group does not have FC or DC	Group's bill will reflect membership additions of adult dependents

The conversion of FC dependents to regular dependents will result in contracts moving between membership classes as follows:

Before Enrollment Change	After Enrollment Change
One-Person + 1 FC	Double
One-Person + 2 or more FCs	Family
Two-Person + 1 or more FCs	Family
Family + 1 or more FCs	Family

If a group is making a Group Wide Change prior to Jan. 1, 2011, do not sell the FC rider, only the DC rider. Note: Groups under 50 will not have the option to add the DC rider prior to Jan. 1, 2011. DC rating methodology will be built in for all groups starting Jan. 1, 2011.

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Dependent Coverage: *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. If a group currently holds their open enrollment during the fourth quarter, then the group can use their normal open enrollment period, as long as it is 30 days in duration.

BCBSM and BCN provided detailed information about the special enrollment period the week of August 16, 2010. You can find the information by searching the *YourMarketplace* or *BluesMarketplace* archives.. This communication also includes further enrollment instructions for those groups with plan years between Sept. 23, 2010, and Dec. 31, 2010.

Removal of Lifetime Dollar Limits: *Overview*

PPACA prohibits health plans from imposing lifetime dollar limits on “essential benefits.” BCN certificates and riders do not include lifetime dollar limits and will not be impacted. However, some BCBSM groups and one BCN Service Company group with a self-funded HMO product do apply lifetime dollar maximums. On Jan. 1, 2011* lifetime dollar limits will be removed on medical and prescription benefits, such as overall lifetime dollar limits, human organ transplants, specified organ transplant, etc. For underwritten groups, the rating impacts are 0.3 percent and 0.1 percent for limits of \$1 million and \$5 million, respectively.

Removal of Lifetime Dollar Limits: *Special Enrollment Period*

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

This special enrollment period will be held from Nov. 1, 2010 through Nov. 30, 2010. If a group currently holds their open enrollment during the fourth quarter, then the group can use their normal open enrollment period, as long as it is 30 days in duration.

BCBSM and BCN provided detailed information about the special enrollment period the week of August 16, 2010. You can find the information by searching the *YourMarketplace* or *BluesMarketplace* archives. This communication also includes further enrollment instructions for groups with plan years between Sept. 23, 2010, and Dec. 31, 2010.

Do not sell optional Lifetime Dollar Limit benefits to groups making a Group Wide Change.



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Immunization and preventive care with no cost sharing

PPACA states that private health plans must fully cover 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. Cost sharing may apply to preventive services that are listed as optional or removed from the recommended lists. The benefits include evidence-based preventive services, such as routine screenings and immunizations. These requirements only apply to services provided by in-network providers.

On Jan. 1, 2011, BCBSM and BCN are making changes to preventive benefits to comply with PPACA, including the removal of annual dollar limits from BCBSM group plans.

In most cases, the cost impacts will be minimal. Groups that currently do not offer preventive benefits will have greater impacts. BCBSM and BCN groups are projected to see an increase of 1 percent or less for those groups who have the "standard" preventive benefits. However, BCBSM groups with no or limited preventive care will likely experience cost increases between 3 to 5 percent.

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

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 an existing health condition on the date of enrollment for enrollees under the age of 19.

On Jan. 1, 2011, BCN will no longer medically underwrite dependents up to age 19 on a One Subscriber Group contract. BCBSM will remove pre-existing condition waiting periods for children up to age 19 from those groups that previously had them. This will result in a less than .2 percent cost increase for those impacted groups.

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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, on Jan. 1, 2011*, BCBSM's reimbursement rate for non-participating facilities will be updated.

BCN was compliant with this regulation prior to the passage of PPACA.

This change will not impact rates for underwritten groups.

Prohibit Rescissions with limited exceptions

PPACA prohibits rescissions (e.g., retroactive termination), except in the case of fraud or intentional misrepresentation of 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 do not require any benefit changes.

BCBSM and BCN are still reviewing the impact of this legislation on the retroactive membership changes. We will not make any policy changes until final regulations are provided by the U.S. Department of Health and Human Services.

This regulation may impact a group's ability to request retroactive membership changes.

This change will not impact rates for underwritten groups.

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 group plans were compliant with this regulation prior to the passage of PPACA.

This change will not impact rates for underwritten groups.

Pediatrician as a child's primary care physician

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 group plans were compliant with this regulation prior to the passage of PPACA.

This change will not impact rates for underwritten groups or costs to self-insured groups

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