

Frequently Asked Questions for group customers

Patient Protection and Affordable Care Act: Near-term benefit requirements

Please see the group [implementation guidelines](#) for specific BCBSM and BCN group implementation plans.

Implementation timeline and plan year

How does Blue Cross Blue Shield of Michigan and Blue Care Network define a group's "plan year?"

There are several sequential criteria to determine plan year.

A group's plan year is identified as "plan year" in their plan document. If a group does not have a plan document or the plan document does not designate a "plan year," then PPACA indicates plan year is when deductibles or other benefit limits reset.

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.

Is "plan year" the same as "renewal date?"

"Plan year" is not synonymous with "renewal date" or "enrollment date," although there are circumstances where those dates could be the same.

How will BCN handle HRA groups' plan year since BCN HRA deductibles adjust on a plan year, not calendar year?

BCN HRA groups will be handled in accordance with their plan years which may be different than their calendar year.

What if I have a group that has a documented plan year between Jan. 2, 2011, and Sept. 22, 2011? When will the changes be implemented?

BCBSM and BCN will implement the near term benefit changes for most groups on Jan 1, 2011. BCN groups with a plan year rider will see the changes implemented on their plan year date.

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Grandfathering

What is considered a grandfathered plan?

A grandfathered plan is a group health plan in which individuals are enrolled on or prior to March 23, 2010. Additionally, 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 may make it difficult for groups to control their overall costs and may make it unlikely that groups will choose to maintain grandfathered status until 2014 when most of the potential value associated with grandfathering would be lost.

What are some of the requirements groups must maintain in order to keep grandfathering status?

PPACA limits groups from making changes to their benefits as of March 23, 2010, in order to maintain grandfather status. To maintain grandfather status, groups cannot change:

- copays by more than \$5 plus the cost of medical inflation or by 15 percent plus medical inflation;
- deductible values by 15 percent plus medical inflation; and
- employer and employee contribution levels.

What is BCBSM and BCN's grandfathering approach?

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. Self-insured groups are strongly encouraged to choose to be treated as a new plan, even if eligible to be treated as a grandfathered plan.

Billing and Rating

What is the difference between the billing impact and the rating impact?

Billing impact is the date when the membership reclassifications will be effective and could potentially result in the assignment of a new contract type (i.e., two people versus 1 person with a Family Continuation (FC) rider, or a family versus two people plus 1 FC) which will change Jan. 1, 2011, for the majority of our groups. Although the tier rates quoted to a group will not change, the composition of adult dependents may result in some contracts being billed a different contract tier rate.

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Rating impact is the date the actual rates will incorporate adjustments to account for the additional PPACA benefits such as covering preventive services with no cost sharing, which will not be effective until the group's next renewal on or after Jan. 1, 2011.

If a group has a January renewal, when will the new Dependent Continuation (DC) rating methodology charges be reflected on their bill— will it be January 1 or later?

The new membership configurations reflecting DC rating methodology versus FC rating methodology will be effective Jan. 1, 2011.

For BCBSM groups, because the changes will not be completed prior to the generation of their January bill, the January bills will not yet reflect the change. That is, the January bills will be based on current benefits and membership configurations (e.g., FC or DC). When the February invoice is generated it will include a retroactive adjustment to incorporate the changes for January.

For BCN groups, appropriate changes in rating methodologies will appear in their January bill.

For groups that have already received their 2011 rate sheets and don't incorporate changes under PPACA, will new rate sheets be distributed reflecting the appropriate rate prior to Jan. 1., 2011?

BCBSM will send out updated rate sheets to those groups to reflect rates resulting from PPACA changes.

BCN will not be reissuing rate sheets to groups if PPACA changes were not included in their original rates.

Dependent Coverage

Eligibility & Coverage

When will a dependent that turns 26 be terminated from the contract?

BCBSM and BCN will allow the dependent to stay on the contract until the end of the calendar year of their 26th birthday. However, self-funded groups have the option of taking the dependent off the contract on their 26th birthday or thereafter. They will work with BCBSM and BCN on this process.

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What is the membership reclassification?

All current Family Continuation (FC) dependents will be reclassified to regular dependents on Jan. 1, 2011, which could cause a shift in the membership classification by pushing some one-person contracts plus FC to move to two-person, and some two-person contracts plus FC move to family coverage. The FC dependents will then be rated using the dependent continuation (DC) rating methodology as of Jan 1, 2011.

Will BCBSM and BCN change how they are rating the DC rider?

No, the DC rating methodology, which is currently used for the DC rider, will be used for all dependents going forward. On Jan. 1, 2011, this methodology will systematically be applied and the DC rider will no longer exist. Note: This only applies to medical coverage, not stand alone dental (i.e., no BCN or BCBSM medical offering)

What if the eligible dependent is offered coverage through their own employer?

For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan may exclude an adult child, who has not attained age 26, from coverage only if the adult child is eligible to enroll in an employer sponsored health plan other than a group health plan of a parent. However, even if eligible to grandfather, the cost impact may be minimal since other dependents up to age 26 must still be offered coverage, and the group may also need to perform audits in order to truly understand if the dependent has other employer-sponsored coverage.

Special Enrollment Period

When and how long is the special enrollment period?

BCBSM and BCN are conducting the special enrollment period from Nov. 1 through Nov. 30, 2010 for the newly eligible dependents. Groups that currently hold a 4th quarter open enrollment period can utilize the open enrollment period to enroll newly eligible dependents but must make sure the enrollment period is at least 30 days long.

If a fourth quarter 30 day open enrollment period is already scheduled, what is the effective date for the newly eligible dependents? Will it still be January 1 or is it their normal fourth quarter open enrollment effective date? (For example, if their fourth quarter open enrollment effective date is Nov. 1, and they hold their open enrollment from Oct. 1 through Oct. 31, will the 25-year-old be added effective Nov. 1 or wait until Jan. 1?)

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If an annual fourth quarter open enrollment is scheduled, the newly eligible dependents will still not be in effect until Jan. 1, 2011 since that is the plan year date for most of our groups in which they will be implemented on.

May a subscriber choose to switch the entire contract to another benefit plan offered by its employer if a newly eligible dependent is being added during the special enrollment period?

Yes, the contract holder must be allowed to move to any other available plan offered by their employer.

May an employee who did not elect coverage during the previous open enrollment period, but wishes to enroll a newly eligible dependent, also elect coverage for himself and other eligible dependents during the special enrollment period?

Yes, during the special enrollment period new subscribers can enroll if they are including newly eligible dependents.

Riders

Will the FC and DC rider structure stay the same?

Groups will no longer be able to choose dependent coverage riders for their employees as of Jan. 1, 2011. 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.

If a group's renewal is Jan.1, 2011, will the group be charged the higher DC family rate at this time?

Yes, groups will see a rate increase as a result of PPACA-required benefit changes. The new rate will be effective on the group's 2011 renewal date.

Vision, Dental, and Hearing Coverage

How are stand-alone vision and dental plans affected?

BCBSM and BCN will not be changing stand-alone vision or dental plans (i.e., no BCN or BCBSM medical offering) unless the group has the DC rider. In that case, BCBSM and BCN will extend eligibility to allow the addition of a dependent up to age 26 who meets all other requirements for special enrollment. If the group has the FC rider, the group may keep it, but BCBSM and BCN will not be extending eligibility to dependents that are age 26. If the group wants to add 26-

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year-olds to stand-alone vision and dental plans, the group will need to switch to the DC rider which will ONLY be available for stand alone dental starting on Jan. 1, 2011.

Immunization and Preventive Care with no cost-sharing

Is BCBSM removing the annual dollar maximum on preventive care benefits?

Yes, to comply with PPACA, BCBSM will be removing all annual dollar limits on preventive care and immunization benefits effective Jan. 1, 2011.

Will there still be member cost sharing for preventive services such as annual gynecological exams?

No, PPACA requires that private health plans cover evidence-based preventive services and immunizations with no cost-sharing. This will result in no co-payments, coinsurance or deductibles being applied to preventive or immunization services.

If a group currently does not offer any preventive services in its plan will it be required to move to a new plan in order to comply with PPACA?

No, we will add the mandated preventive care and immunizations to existing plans so that groups will become compliant with the law.

Emergency Services

Will a non-participating professional provider be able to balance bill for the difference between the BCBSM and BCN approved amount and the charge for the service, or will this be eliminated under the new rules?

Non-participating providers may still balance bill the difference between the approved amount and the charge for the service.

Lifetime dollar limits

Are all lifetime dollar limits being removed Jan 1, 2011?

Yes, 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.

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Does the elimination of lifetime dollar maximums apply to stop-loss carriers (re-insurance carriers)?

No, the mandate applies to lifetime dollar limits that are placed on essential benefits. The intent of the law is to ensure members have access to coverage for essential benefits. Self-insured groups purchase stop-loss coverage to limit their risk for catastrophic claims or unusually high payout, and it does not adversely affect or limit a group member's access to coverage of essential benefits. So stop-loss does not fall under the PPACA mandate provisions.

Annual dollar limits

Are BCBSM and BCN removing annual dollar limits at this time?

The U.S. Department of Health and Human Services 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.

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