health reform

Frequently Asked Questions: Benefit Changes

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Preventive Care at no Additional Charge FAQ's

What is the Preventive Care mandate?
The Affordable Care Act (ACA) expanded the preventive health services be provided at no cost-sharing (no copayment or coinsurance) on all health plans. Blue Shield implemented this mandate for groups renewing on or after September 23, 2012, and January 1, 2011 for Individual and Family Plans.

What are the preventive services are now included under this mandate?
Preventive services that must be covered at no additional charge now include:

- Preventive care for children up to age 16
- All generally accepted cancer screening, including breast, cervical, and prostate
- Preventive services and immunizations for children and adults

What does this mean for my Blue Shield coverage?
Under this mandate, you will not be charged a deductible, copayment or coinsurance for preventive services. Most of these services were already covered by Blue Shield of California and Blue Shield Life. For those that were previously covered as medical benefits, they will now be covered as preventive services and members will no longer pay a copayment.

If my plan is grandfathered, will I have to pay for preventive services?
Preventive services may continue to have member cost-sharing for grandfathered plans.

Preventive Services for Women FAQ

What is the Preventive Services for Women mandate?
Beginning August 1, 2012 additional preventive heath services for women have been added to the preventive services that must be offered at no charge under the Affordable Care Act (ACA). These services will be provided without a co-payment, co-insurance or a deductible.

What are the services for women that are now covered at no additional cost?
Preventive services for women include:

- Well-woman visits: This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services and additional visits if women and their providers determine they are necessary.

- Gestational diabetes screening: This screening is for women 24 to 28 weeks pregnant and other pregnant women at high risk of developing gestational diabetes.

- HPV DNA testing: Women who are 30 or older will have access to high-risk HPV DNA testing every three years, regardless of pap smear results.

- STI counseling, and HIV screening and counseling: Sexually-active women will have access to annual counseling on HIV and sexually transmitted infections (STIs).

- Contraception and contraceptive counseling: Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. For contraceptives covered in the pharmacy benefit, all generics are covered with no copay. Select brand name contraceptives may require a copay if a generic is available, which may be waived for medical necessity.

- Breastfeeding support, supplies, and counseling: Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.

- Domestic violence screening: Screening and counseling for interpersonal and domestic violence should be provided for all women.

Which health plans are affected by this provision?
All non-grandfathered health plans will need to include these services without cost sharing for plan years beginning on or after August 1, 2012.

Are there any cases where a member would still have to pay cost sharing?
There are certain exceptions where cost-share would still need to be paid:

- If preventive services are performed by out-of-network providers, the carrier may impose cost-sharing.
- Select brand name contraceptives may still have cost-sharing imposed if a generic is available.
- Male sterilization procedures may still have cost-sharing imposed.
- Cost-sharing can also be imposed on:
    - The office visit if a patient receives a recommended preventive service that is billed separately from the office visit.
    - The office visit if a patient receives a recommended preventive service that is not billed separately from the office visit, but the primary purpose of the visit was not to receive the preventive service.
    - Any treatment for a condition diagnosed by a recommended preventive service.

Member Appeals FAQ

What is the Member Appeals mandate?
The member appeals mandate of the Affordable Care Act (ACA) requires that carriers change their internal appeals procedures so that members can continue to receive coverage, pending the outcome of the appeals process. This mandate went into effect on September 23rd 2010 for all Blue Shield health plans.

How will this affect me if I appeal a Blue Shield coverage decision?
Under this mandate, if you appeal a Blue Shield coverage decision, there will be no interruption in coverage while the appeal is in progress. You will be covered until the appeals process is complete.

Rescissions FAQ

What is the Rescissions mandate?
The Rescissions mandate of the Affordable Care Act (ACA) states that once an enrollee is covered under a plan, a carrier may only rescind coverage in cases in which the individual "performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage." This mandate went into effect on September 23rd 2010 for Blue Shield Individual and Family plans.

Does this mandate affect the Blue Shield coverage I have through my employer?
No. Blue Shield does not rescind coverage of members covered through their employer.

How does this mandate affect my Blue Shield Individual and Family coverage?
Under this mandate, Blue Shield can only rescind (cancel) your Individual and Family coverage if you commit deliberate fraud, or for non-payment of your premiums.

Lifetime Dollar Limits FAQ

What is the Lifetime Dollar Limit mandate?
Under the Affordable Care Act (ACA), there are no longer lifetime dollar limits on "essential health benefits" for IFP plans and for all group plans. This mandate became effective upon renewal on or after September 23, 2010 for group plans, and on January 1, 2011 for Individual and Family Plans

What does this mean for my health coverage with Blue Shield?
Prior to this mandate, health insures such as Blue Shield could set a limit on the dollar amount for which a patient could be covered for medical expenses for as long as they had coverage through the carrier. This limit has been removed for services defined under the ACA as "essential health benefits".

What are "essential benefits"?
Although not specifically defined by the Department of Health and Human Services (HHS), the general list of essential health benefits includes:

- Emergency services
- Maternity and newborn care
- Mental health, substance abuse disorder services, and behavioral health treatment
- Prescription drugs
- Preventive, wellness, and chronic disease management
- Pediatric services, including dental and vision care

When will lifetime dollar limits be removed from all benefits?
In 2014, lifetime dollar limits on all benefits will be removed.

Annual Dollar Limits FAQ

What is the Annual Dollar Limit mandate?
Under the Affordable Care Act (ACA), there are no longer annual dollar limits on "essential health benefits" for IFP plans and for all group plans. This mandate became effective upon renewal on or after September 23, 2010 for group plans, and on January 1, 2011 for Individual and Family Plans

What does this mean for my health coverage with Blue Shield?
Prior to this mandate, health insures such as Blue Shield could set a limit on the dollar amount for which a patient could be covered for medical expenses during the 12 months of the coverage year. This limit has been removed for services defined under the ACA as "essential health benefits".

What are "essential benefits"?
Although not specifically defined by the Department of Health and Human Services (HHS), the general list of essential health benefits includes:

- Emergency services

- Maternity and newborn care
- Mental health, substance abuse disorder services, and behavioral health treatment
- Prescription drugs
- Preventive, wellness, and chronic disease management
- Pediatric services, including dental and vision care

When will annual dollar limits be removed from all benefits?
In 2014, annual dollar limits on all benefits will be removed.