health reform

Frequently Asked Questions: How Health Reform Law Protects Patients

In this section:

“Grandfathered” Health Plans

What is a "grandfathered" health plan?
In legal terms, “grandfathered” means that an existing situation can be exempted from a new rule. Grandfathered health plans are older plans that are currently do not have to comply with new health reform rules. Many plans that were effective on or before March 23, 2010—when the Affordable Care Act (ACA) was signed into law—are considered grandfathered health plans. Most of these plans will need to comply with the law starting in 2014.

Which Blue Shield plans are eligible for grandfathered status?
Blue Shield is only grandfathering Individual and Family plans.

Isn’t Blue Shield required to offer grandfathering on all their health plans?
The ACA give health carriers like Blue Shield the option of deciding which plans they grandfather.

Is my plan automatically grandfathered? Or do I have to take to make it grandfathered?
If you enrolled in or renewed an Individual or Family Plan before March 23, 2010, your health plan was grandfathered automatically

What specific requirements or mandates apply to grandfathered plans?
The listing below shows which mandates apply to which audience.

- Extension of dependent coverage up to age 26
- Removal of lifetime dollar coverage limits on essential benefits
- No member cost-sharing for preventive benefits
- No pre-existing condition exclusions for enrollees under 19

I have a grandfathered plan. Will it always be grandfathered?

Your plan will remain grandfathered as long as Blue Shield continues to offer grandfathered status on the plan, and the plan continues to meet all grandfathered plan criteria. This means that certain changes cannot be made to the plan. See below for what those changes are.

What changes could cause my Individual plan to lose its grandfathered status?
The following changes could cause your plan to lose its grandfathered status:

- Changing benefits
- Dropping a dental or vision plan that was part of your medical plan

What changes do NOT cause my Individual plan to lose its grandfathered status?
The following changes may not cause your client's plan to lose grandfathered status:

- Changing carriers while maintaining the same benefits
- Changes made to comply with federal or state legal requirements
- Adding family members to existing coverage

Frequently Asked Questions for Patient Protections

What is the Patient Protections mandate?
The Affordable Care Act (ACA) requires that insurers provide certain protection for members obtaining care, including:

- A patient's right to select any participating physician as their primary care provider. This applies to primary pediatric care providers as well
- No referral needed for OB/GYN services
- Improved access to out-of-network emergency care
- No higher copays/coinsurance for out-of-network emergency services
- No prior authorizations for emergency services

What did Blue Shield do to implement this mandate?
Blue Shield was compliant with these provisions prior to the ACA as they were already required by California law. Therefore no additional implementation was necessary

Frequently Asked Questions for Medical Loss Ratio

What is the Medical Loss Ratio mandate?
Under the Affordable Care Act (ACA), health insurers are required to spend a minimum percentage of premium revenue on medical expenses. The percentage of premium spent on medical expenses is called the Medical Loss Ratio (MLR).

What are the health reform requirements for Medical Loss Ratio?
For individuals and small group health plans – health insurers must spend no less than 80% of member premiums on medical expenses. For large employer groups (more than 50 employees), insurers must spend no less than 85% of premium revenue on medical expenses.

When did MLR go into effect?
MLR went into effect on January 1, 2011. The MLR calculations for that year were reported on June 1, 2012.

Will MLR be required every year?
Yes, the ACA required that health insurers perform MLR calculations every year beginning 2011.

Which health plans are subject to MLR?
The MLR reporting and rebate requirements apply to all comprehensive health coverage - whether purchased through an employer or individually (IFP) - underwritten by Blue Shield—including grandfathered plans.

Does MLR apply to self-funded (ASO) employer groups?
The MLR requirements of health reform do not apply to self-funded (ASO or ASC) business.

Does MLR apply to Medicare Supplemental (Med Supp) plans?
The MLR requirements of health reform do not apply to Medicare Supplemental plans.

What if Blue Shield does not meet the MLR thresholds?
If health insurers do not meet the required MLR for a calendar year, they will be required to pay rebates to employers and individuals by August 1st of the year following the calendar year to comply with a federally mandated deadline.

What are MLR calculations and rebate determinations based upon?
MLR calculations and rebate determinations are based on market segment. All plans are grouped by market (individual market, small (50 or fewer employees) employer group market, and large (more than 50 employees) employer group market), and rebates are paid to all plans in the market if the minimum loss ratio is not met.

Are Individual and Family Guarantee Issue (GI) plans included in the rebate distribution?
Yes.

How is MLR calculated?
The basic calculation for determining MLR is to divide the medical expenses of the plan by the earned premiums. This will determine the percentage of revenue spent on claims costs.

$$\text{MLR} = \frac{\text{medical expenses}}{\text{earned premiums}} = \text{\% of revenue spent on claims}$$

- Medical expenses are payments for clinical services (incurred claims) and expenditures for activities to improve healthcare quality.

- Earned premiums is revenue generated from plan premiums, minus state and federal taxes, licensing fees, and regulatory fees.

How are MLR rebates determined?
If a plan expends more than the allowed amount on administrative expenses as compared to medical claims, a rebate will be required. All rebates must be distributed by August 1st, 2012.

- Large employer group (51 or more employees)
  If less than 85% is spent on medical expenses, the difference must be returned to the employer group.

- Small employer group (2 – 50 employees) and Individual subscribers
  If less than 80% is spent on medical expenses, the difference must be returned to the employer group. If rebates are due to IFP subscribers, the subscriber will receive a rebate check.

  REBATE EXAMPLE: If the MLR for a large group segment (51 or more employees receiving a W2 from the employer) is 75%, then10% of the premium (the difference of 85% MLR threshold minus the actual MLR of 75%) must be paid back to the employer group by August 1st, 2012 .

What do members need to do to qualify for a rebate from Blue Shield or to claim a rebate that is owed?
Blue Shield calculates the MLR for each of our market segments based on requirements provided by the Department of Health and Human Services. If a member in a certain market segment is owed a rebate, they do not need to take any action to claim it. They will be notified by Blue Shield per the HHS requirements and a rebate check will be mailed to them.

Is the rebate amount based on how much premium the subscriber paid?
Yes.

Is a rebate considered income or profit for tax purposes?
Under certain circumstances, the rebates may be taxable to individual policyholders. Please consult a tax professional.

How does Blue Shield's 2% pledge relate to MLR?
Blue Shield's pledge to limit profits to 2% and return the excess profits to consumers is not related to MLR. MLR is a federal health reform mandate, while the 2% pledge is an internal program initiated by Blue Shield.

Frequently asked questions Summary of Benefits & Coverage

The final Summary of Benefits & Coverage (SBC) rule issued in February 2012 as part of the Affordable Care Act (ACA) requires all health insurers and self-insured group health plans to provide individuals with uniform coverage documentation. The purpose is to give consumers an easier way to understand the coverage they already have and/or help them make "apples-to-apples" comparisons of available options when purchasing new coverage. The SBC rule went into effect on September 23, 2012.

Which health plans are impacted by the SBC rule?

The SBC rule applies to employees and dependents of group and individual health plans. It applies to all fully insured and self-insured plans, regardless of grandfathered status. The SBC rule does NOT apply to stand-alone dental and vision plans, or to Medicare Advantage or Medicare Supplemental plans.

Who will provide the SBC documents for all required health plans?

Beginning September 23, 2012, health insurers and employers are jointly required to provide SBC documents for insured accounts and self-insured group health plans to all individuals newly enrolling for coverage, experiencing a special enrollment event, renewing their coverage, and 'upon request' by other enrollees.

SBC documents include:

- *Summary of Benefits and Coverage (SBC)* – four page (double-sided) benefit summary describing plan benefits, cost sharing and limitations.

- *Coverage Examples (CE)* - included with the SBC, illustrating customer costs based on a specific plan's benefits for common medical scenarios.

- *Notice of Modification (NM)* – a notice that is required to be sent to enrollees whenever there is a material modification to the benefit.

- *Standard Glossary* – a standard Health and Human Services (HHS) document with definitions for common medical and insurance terms. HHS provided the glossary to all health carriers

When will the SBC rule go into effect?

Effective dates are as follows:

- **Group – to Participants enrolling or reenrolling at open enrollment:** Effective for any coverage for which the first day of open enrollment takes place on/after 9/23/01.
- **Group – to Participants enrolling other than through open enrollment (including newly eligible and special enrollees):** Effective starting on the first day of the plan year beginning on/after 9/23/12.
- **Group – to Insured plan sponsors:** Effective immediately on 9/23/12 upon application, when changes occur, at renewal and upon request.
- **Individual:** Immediately on 9/23/12.

What additional events will require the distribution of an SBC?

The SBC forms will be distributed to employers, employees and enrollees at designated points in the enrollment process:

- Upon application
- By first day of coverage (if there are changes)
- Upon renewal
- During special enrollments
- Upon request
- Upon material modification (during plan year, as defined under ERISA)

What is a "Material Modification" and how will it be communicated?

A material modification is any change that an average participant would consider an important enhancement or reduction in benefits. If a material change is made to a plan during the plan year that is not reflected in the most recent SBC, a notice must be provided at least 60 days before the effective date of change.

In what delivery format can the SBC documents be delivered (paper or electronic)?

The SBC rule allows for delivery in paper format. Plans may also provide copies electronically, but only if certain requirements are met. The requirements are different in the group and the individual markets and depend upon whether the SBC Form is delivered to an employer/group, to a prospective enrollee or to a subscriber.