

NewsfromBlue

IMPORTANT UPDATES FOR BENEFIT ADMINISTRATORS

March 2009

Health Care Reform

To help repair the economic conditions, in mid-January the American Recovery and Reinvestment Act (Stimulus Bill) was introduced with a \$787 billion recovery. The bill allocated \$59 billion specific to health care, including:

- Subsidies to health care coverage for the unemployed; providing coverage through Medicaid
- Assistance to state Medicaid programs
- Health information technology systems
- Prevention and wellness

On February 17th, President Obama signed the final version of the Stimulus Bill. As we are able to review the final bill, we will keep you posted of the implications for employers and health plans.

Blue Cross and Blue Shield of Florida believes that the severity of the affordability and uninsured issues require a case for transformational change in today's health care environment. Our vision of reform includes five critical elements:

- Prevention and wellness
- Evolution in health care delivery
- Universal coverage
- Consistent and equitable funding for safety net programs
- Personal responsibility

As we move forward, we pledge to continue the dialogue, develop solutions that align with this vision, and work with various stakeholders to develop integrated approaches to health care affordability and access. Our mission is to advance the health and well-being of Florida's citizens and moves us to work toward a system where appropriate health care is available to all.

NetworkBlue Update

[Click here](#) to view a listing of providers that have recently joined NetworkBlueSM.

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CHIP Legislation

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) was passed into law February 4, 2009. This is a very large bill that was finalized quickly, and has many changes to it since 1997 when it was called the State Children's Health Insurance Program (SCHIP). CHIP is a matching program, with the Federal government and the State of Florida both contributing funds.

At this time we have teams studying this bill to determine potential impacts, but can provide you the following high-level summary of the largest changes:

- It extends CHIP authorization to September 30, 2013.
- States must adopt at least 5 of the 8 enrollment and retention provisions, one of which is the elimination of an asset or resource test. The child's parent or guardian can declare assets by simply signing a document. These are effective April 1, 2009.
- States are allowed to provide CHIP coverage of pregnancy related assistance to low-income women who are pregnant, subject to certain conditions.
- Medicaid and CHIP coverage of legal aliens who have resided in the country for less than 5 years.
- Dental care is required to be included in CHIP coverage effective October 1, 2009.
- Mental health parity requirement is established for CHIP plans that provide mental health or substance use disorder benefits. They cannot be more restrictive than the other medical services.

"This vital legislation provides health security for millions of children in working families and builds momentum for comprehensive health care reform. Expanding coverage for kids is a big first step toward ensuring that all Americans have affordable, quality health care."

— Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP).

We encourage you to read further details. Here is a link to the [Henry J. Kaiser Family Foundation's summary](#), and the [ModernHealthcare.com](#) website to get you started. We will keep you informed.

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Autism Coverage Legislation Implementation



Senate Bill 2654 was signed into law in 2008, and included a provision requiring large group insurance and HMO plans to include coverage for Autism Spectrum Disorders beginning April 1, 2009. This coverage will be included for new large groups (51+) with effective dates on or after April 1, 2009.

For existing large groups, the coverage is effective on renewals that occur on or after April 1, 2009.

This Autism Spectrum Disorder coverage includes a \$36,000 annual benefit maximum and a \$200,000 lifetime benefit maximum. These services can be covered for children who were diagnosed as having a developmental disability at age 8 or younger and are either:

- Under 18 years old; or
- Over 18 years old, and still in high school

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Florida Health Care Plan Acquisition

In our continued effort to provide members with expanded access to an array of high quality, affordable health care choices, we're pleased with our recent acquisition of Florida Health Care Plan, Inc. (FHCP) from Halifax Hospital Medical Center (HHMC). Serving Volusia and Flagler counties, FHCP will operate as a community-based, locally managed, HMO subsidiary of Blue Cross and Blue Shield of Florida (BCBSF).

FHCP is a successful, high quality, mixed staff-model health care plan with 53,000 members consisting of large and small employer group plans, Medicare Advantage Part D Plans and the Cover Florida Plan, 300 physicians, including 60 employed physicians, 12 health care facilities and eight pharmacies in the two counties.

We will keep you informed of details, as they are available.

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Benefit Accumulator Now Offers Flexibility

Today, benefit accumulators—including deductibles, out-of-pocket maximums and any benefit maximums—reset to \$0 (with the exception of lifetime maximums) on January 1 of each calendar year. In order to support current customer needs and match existing competitor capabilities, we now have the ability to administer benefit accumulators based on a non-calendar year benefit period (a flexible period of time in which benefits accumulate for a group).

Large groups (51+) with BlueOptions® and/or BlueChoice® plans can now select the non-calendar year (i.e. 6/1/09–5/31/10) option to align their accumulation period (aka benefit period), with their contract or plan year. All other products (i.e., BlueCare®, BlueMedicareSM, etc.) will continue to have benefit accumulators only administered on a calendar year basis and not have the non-calendar year option.

BlueOptions and BlueSelect® for small groups will become eligible for the non-calendar year benefits period option beginning August 1 with October 1 effective dates.

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COBRA Tools for Federal and State Processes

Two new tools are available to assist with the COBRA process.

Need help with the Federal COBRA process or State COBRA regulations and process? Review our [Federal COBRA tool](#) and our [State COBRA tool](#) that will assist you with your understanding of the enrollment processes involved.

The recent American Recovery and Reinvestment Act (Stimulus Bill) includes a subsidy for COBRA. The enrollment processes on these two tools will not be affected. We will provide you with more information on the COBRA subsidy and how we will work to comply with it very soon.

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A Failsafe Product—FamilyBlue

To help uninsured families, we developed the FamilyBlueSM medical discount card. FamilyBlue may be just the right solution to provide those that are uninsured with discounts on health care, pharmacy, vision, dental, hearing, alternative care, diabetic supplies, vitamins and supplements.

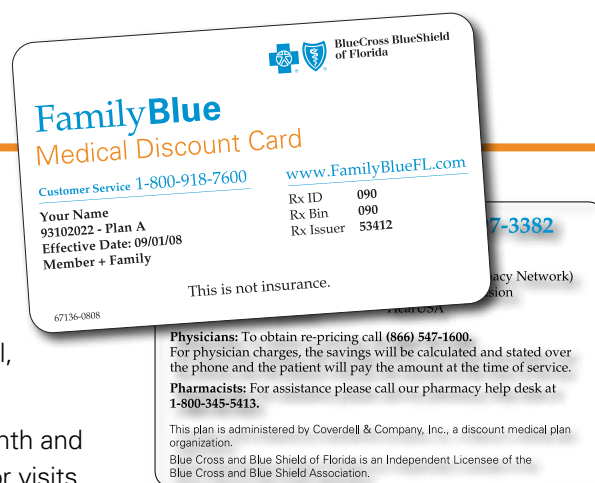
Members can choose from two plans: Plan A - \$19.95 per family per month and Plan B - \$14.95 per family per month. Both plans offer discounts on doctor visits, medical services and prescription drugs. For the extra \$5 a month with Plan A, members receive discounts on dental, vision, hearing care, diabetic supplies and vitamins.

FamilyBlue offers:

- Coverage for up to six family members for one low monthly premium
- Between 5% to 40% percent on everyday medical services
- Patient advocacy services, such as negotiating services for medical bills exceeding \$1,500
- No restrictions or limitations on pre-existing conditions, immigration status or dependent eligibility
- Guaranteed acceptance
- Spanish language capabilities at every touch point for Hispanic consumers

Blue has something for everyone.

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Network Strength is a Key Asset

Today more than ever, maintaining a high-quality and effective network of physicians and other medical professionals is an integral part to our success. Our competitive advantage includes the breadth and depth of our networks to meet member needs. Because of the size and strength of our networks, members receive the vast majority of their services from physicians in-network. In fact, in-network utilization across the lines of business has consistently remained in the 94 to 95 percent range.

“With the broad access and deepest discounts, coupled with innovative care management programs, we not only help manage medical costs, we counsel and coordinate with both provider and members so that patients receive wellness services and the care they need”

*— Dr. Barry Schwartz, vice president
of network management for
Blue Cross and Blue Shield of Florida*

Another advantage to the size of our networks is that deep discounts are in place to help employers more effectively manage medical costs. Based on the most recent claims information evaluated by independent consultant, Milliman & Associates, Blue Cross and Blue Shield of Florida (BCBSF) continues to enjoy the deepest discounts on a statewide basis over any other health care company.

For hospital-based physicians, 97 percent of anesthesiologists, radiologists and ER physicians participate in a BCBSF network. For hospital-based pathologists, 94 percent participate in the BlueChoice[®] network and 89 percent participate in the NetworkBlueSM (BlueOptions[®]) network. Many hospitals contract out for selected services with providers, so it is important that our members check and choose in-network providers to secure their payment level responsibility and avoid balance billing.

To check the participation status providers, members can visit www.bcbsfl.com. They just go to the Member section, then select “Find a Doctor and More” on the left side under Quick Links which takes them to our online provider directory. There they can find participating physicians and hospitals.

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Don't Forget —Let Quest Remind You

Quest Diagnostics now has a free email reminder program to help members remember their appointments, lab work, events and important health information. Encourage members to sign up today at QuestDiagnostics.com/patient.



Here's how it works:

- Step 1:** Sign up by choosing the reminder(s) that matter most
- Step 2:** Receive an e-mail reminder to talk to your doctor about these tests or exams
- Step 3:** Get an order from your doctor
- Step 4:** Schedule your test

Members can choose the language, categories, when and how often to be reminded. Reminders can be scheduled to correspond with testing for follow-up office visits for things such as diabetes, heart disease, women's health, men's health and more.

When it's time for a test, patients can easily schedule an appointment for lab testing at a Quest Diagnostics Patient Service Center from a link in the email reminder. Each reminder also includes links to monthly health awareness topics such as skin cancer, food allergies, ovarian cancer, and chronic kidney disease.

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CDHP: You Should Know...

Recently, we implemented single sign on capabilities with ACS|Mellon account for Health Savings Accounts (HSA). Now members can access their HSA accounts directly through MyBlueServiceSM without having to sign on again with the Mellon website. And don't forget that members may also access their FSA and HRA information on MyBlueService.

Also, Mellon Bank has changed the interest rate paid to all clients from .50% to .25%. This change is primarily due to the current economic climate and downward adjustments to federal interest rates. We expect that all banks have or will follow this trend as the market continues to move.

NOTE: BCBSF offers only the high-deductible health plan to be used in conjunction with the Health Savings Account (HSA). For more information on the tax advantages and implications of an HSA, contact your legal or tax advisor.

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Generic Drug Substitution Benefit Clarification

In the January issue of *NewsfromBlue*, we introduced the required generic substitution benefit (effective April 1), encouraging members to choose lower cost generic drugs in place of high cost brand medications. To help clarify how this affects the member's health and/or the pharmacy deductible and out-of-pocket maximum, please keep these key points in mind:

- If the member chooses to fill a prescription with a brand name drug when there is a generic available, they will pay more than they would for the generic drug.
- Depending on the type of drug, this could represent a significant cost difference. As a result, members may think they've satisfied their deductible and/or out-of-pocket responsibility sooner than what is correct.
 - **Non-HSA Plan with Rx Deductible:** If a member chooses to fill a brand medication when a generic equivalent is available, ONLY the cost of the generic equivalent will apply towards the member's deductible.

- **HSA Plan with Integrated Rx:** For members who are enrolled in a HSA compatible plan with Integrated Rx, the cost difference between the generic and brand will not apply towards the member's deductible or out-of-pocket maximum. If a member chooses to fill a brand medication when a generic equivalent is available, ONLY the cost of the generic equivalent will apply towards the member's deductible and/or out of pocket maximum.

- Mandatory generic substitution does not apply if the prescriber requests the brand drug. In order for the member to fill the brand name prescription without paying the cost difference, the prescribing physician must indicate "Medically Necessary" on the prescription.

This will be a standard benefit for all existing fully insured groups upon their renewal, starting with groups that renew on April 1, 2009. Administrative Services Only (ASO) groups who would like to add this benefit upon renewal may do so. This will be a standard benefit for all new groups (ASO and fully insured) that enroll with us on or after April 1, 2009. Fully insured groups (500+) and ASO groups (any size) can opt out of the standard benefit if they prefer.

More than 94% of our members already use generic equivalents and the impact of this new pharmacy benefit will be reflected in the new rates upon the groups' renewal.

Please review these [Frequently Asked Questions](#) for more information.

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FCL Corner

Oral Health and the Total Health Connection

BCBSF and Florida Combined Life (FCL) are engaged in a joint effort to promote the benefits of good oral health to customers enrolled in both our health and dental plans.

The connection between oral health and overall health is clear – from heart disease and cholesterol levels, to diabetes and prenatal health, dental care has an impact on total health and well-being. For example, periodontal (gum) disease has been associated with a higher overall rate of heart disease, and healthy gums are connected to lower cholesterol levels. Also, treatment of periodontal disease has been shown to improve the control of blood sugar levels in diabetics. Finally, pregnant women with periodontal disease may be more likely to deliver preterm, low-birth weight babies, but the right dental treatment may minimize their risk.

The Total Health project will use a variety of tools to educate, inform and encourage compliance with

recognized standards of good oral health, particularly targeted to customers in three condition categories: Diabetes, Coronary Artery Disease and Maternity. The project is expected to officially kick-off in March and continue throughout 2009 and beyond.

Look for more information and updates on this exciting project in upcoming editions of *NewsfromBlue*.

The Impact of Social Security Workload on Disability Insurance

See the [attached article](#) outlining the impact of the Social Security Administration's drop in staffing, as well as budget constraints, on disability insurance. As a result, it is more important than ever for employers to offer long-term disability insurance, such as our BlueRestoreSM disability products, to help their employees remain financially stable should a disability occur.

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