

Member Communication for 2016 Group Renewal Bulletin

Blue Cross and Blue Shield of Minnesota
Service Cooperatives



Each year there are a number of health plan changes that may affect members. Typically these include benefit clarifications, process modifications and other plan changes. This document provides a summary of changes that will be implemented upon your 2016 health plan renewal.

The following provides a summary of changes or informational items that will be implemented with your health plan renewal, on or after January 1, 2016.

- Mandatory Generics
- Out-of-pocket maximum requirements
- Step Therapy
- Value Based Programs (VBPs)
- Healthy Start/Maternity Management
- BlueCore Platform Member Migration – Health and Wellness Impact

Mandatory Generic Drug Feature

The mandatory generic feature is being added. Mandatory generic substitution means that the member pays the lowest cost for using a generic drug in place of the brand-name equivalent medication. If the member chooses to get a brand-name drug when an equivalent generic drug is available, they will have to pay the difference in cost between the brand-name and the generic drug and any coinsurance and/or deductible that applies. When they reach their out-of-pocket maximum, they would still pay the difference in cost between the brand-name and the generic drug, even though they are no longer responsible for coinsurance and/or deductible.

Out-of-pocket maximum requirements

In the final Notice of Benefit and Payment Parameters for 2016, the Department of Health and Human Services (HHS), clarified that the self-only maximum annual limitation on cost sharing (OOP maximum) applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only (i.e. family coverage).

An OOP max is an annually determined cap on the amount of cost-sharing a member must pay out-of-pocket for covered health care costs, including:

- Deductibles
- Copays
- Coinsurance

This does not include the premium amount for the plan

The out-of-pocket (OOP) maximum for the plan can be no greater than the self-only or other than self-only cap established for that year for the relevant coverage type. Cost-sharing accumulates to the OOP max based on:

- Covered Benefits (Essential Health Benefits (EHBs), EHB and other designated benefits or all benefits)

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- Network (in-network only or more generous network tiers); and
- Plan design

For plan years beginning on or after January 1, 2016, the max OOP limits are:

- \$6,850 for single coverage (in-network only)
- \$13,700 for family coverage (in-network only)

Minimum Value Plan will remain \$6,350/\$12,700 embedded HSA for 2016.

Large group plans are not required to provide EHBs, BUT to the extent covered benefits are EHBs:

- No lifetime or annual dollar limits can apply to covered benefits that are EHBs but visit limits may apply.
- EHBs delivered by an in-network provider must accumulate to the OOP max. Non-EHB services may accumulate to the OOP max.

2016 HSA limits:

The Internal Revenue Service (IRS) 2016 contribution limits for health savings accounts (HSAs), out-of-pocket maximums, and minimum deductible levels for high-deductible health plans are as follows:

2016 Minimum Deductibles for HSA Compliant HDHPs

- Individual \$1,300 (unchanged from 2015 limit)
- Family \$2,600 (unchanged from 2015 limit)

2016 Maximum Out-of-Pockets for HSA Compliant HDHPs

- Individual \$ 6,550 (2015 limit is \$6,450)
- Family \$13,100 (2015 limit is \$12,900)

2016 Maximum Annual Contribution Levels

- Individual \$3,350 (unchanged from 2015 limit)
- Family \$6,750 (2015 limit is \$6,650)
- "Catch up" amount for 55+ account holders is \$1,000 (unchanged)

Groups with 4th quarter carryover:

If an HSA-compliant HDHP design includes the benefit of 4th quarter carryover, the minimum annual deductible must be increased by 25 percent to accommodate the extended deductible period. This means that in 2016, plans with 4th quarter carryover must have a deductible of at least \$1,625 for individual coverage and \$3,250 for family coverage.

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HSA-compliant HDHP with an embedded deductible:

It is permissible to have an individual member (embedded) deductible on family policies as long as the individual deductible is not less than the minimum family deductible amount established by HSA law (\$2,600 in 2016).

Groups with 4th quarter carryover and an embedded deductible:

If a groups wants both an individual “embedded” deductible and 4th quarter deductible carryover, the minimum individual deductible required is a \$3,250 (\$2,600 based on the embedded deductible rule, plus an additional 25 percent based on the 4th quarter deductible carryover rule).

Step Therapy

Step therapy will be a standard part of the pharmacy offering. A step therapy program is a “step” approach to providing drug coverage. It is designed to encourage the use of cost-effective prescription drugs when appropriate. This means the member may first need to try an alternative, typically a generic drug, before Blue Cross will cover certain medications prescribed by the physician.

Step therapy programs are developed using Food and Drug Administration (FDA) guidelines, clinical evidence and research. They ensure that members are taking appropriate and cost-effective medications.

Value Based Programs (VBPs)

The Blue Cross and Blue Shield of Minnesota local provider network value based program, previously called Performance Based Provider Reimbursement (PBPR), will now be called Value Based Program Reimbursement (VBPR).

Value Based Program Reimbursement is now integrated across all the national Blue Cross plans. These integrated solutions provide employees access to locally developed, value-based care programs, delivered on a national scale. FBPR providers have access to more information on their attributed patients and can more easily identify gaps in care, develop comprehensive care plans and prevent unnecessary care and avoidable adverse events. VPBRs align healthcare payments with improved member health outcomes to deliver maximum value to employers and their employees, resulting in lower cost trends over time through better coordinated care and performance-based payment using nationally consistent criteria.

Health and Wellness Changes, Updates

Healthy Start/Maternity Management

Effective January 1, 2016, the Healthy Start Program will be discontinued as it exists today. A new Maternity Management Program will be available for all members at that time.

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What is the Maternity Management Program?

The Maternity Management Program offers an expectant mother the tools and support needed throughout her pregnancy to help her make better informed decisions about her healthcare, in conjunction with her provider.

Who is eligible?

The program is included for any member carrying a current Blue Cross identification card.

How do members enroll?

Members who Blue Cross identifies as high risk will be active outreach performed by a nurse with specific training in obstetrics. All other lower risk members must contact Blue Cross to opt-in to the program. Members can call toll free number to enroll Monday through Friday, 8:00 a.m. – 4:30 p.m. Central Standard Time. After hours members may leave a message and will receive a return call from a health coach.

What do members get when they enroll?

By enrolling in the Maternity Management Program, the expectant mother will receive:

- Access to a health coach, Registered Nurse (RN) with expertise in obstetrics and perinatal
- Comprehensive pregnancy and baby health education tools.

BlueCore Platform Member Migration - Health and Wellness Impact

All Blue Cross Blue Shield of Minnesota members will be migrating to a new claims and eligibility platform over the next three years. Once this migration occurs, members will have access to new health and wellness tools.

Minnesota Service Cooperative group will migrate to this new BlueCore claims platform upon renewal in 2017. Group migrating to BlueCore will be required to re-register for online employer and member portals.

The new health and wellness tools will generally provide the current capabilities members have access to today, such as online health coaching, health risk assessment, educational tools and resources. In addition, members will gain access to several new capabilities, including:

- Mobile Apps
- Personal Health Record (PHR)
 - Health Summary Reports
 - Sharing of PHR Data with Providers
 - Health Record Portability / Universal Access

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- Device Connection Center
- Message Board Exchanges

In addition to the changes to the health and wellness resources, upon migration, groups who have purchased health and wellness incentives will move to a new platform. This transition will provide a better integrated member experience by utilizing one integrated platform and data source.