2014 Changes for Small Employers

Blue Cross Blue Shield of Rhode Island

General Changes

Under the Patient Protection and Affordable Care Act (ACA) and Rhode Island regulations, health insurance carriers in the small group market are required to offer medical plans which include Essential Health Benefits (EHBs). These include a pediatric dental benefit unless the employer has purchased a Qualified Dental Plan, which complies with certain EHB requirements and has been approved by HealthSource RI or another state's health insurance marketplace (also called an exchange).

Here are some changes you and your employees may see due to these requirements:

- If you previously offered both a medical and dental plan, your employees received only one ID card. Now your employees may receive two separate ID cards, one for your medical plan (which will now include coverage for some pediatric dental services) and one for your standalone dental plan.
- Your billing statements will reflect the employee twice: under a medical-only class and a dental-only class.
- If your coverage previously included Blue Cross' Essential dental plan, your bill will now reflect a separate dental-only class, as this plan is now considered a standalone dental plan.
- If employees have two ID numbers, you will need to submit their enrollment updates under each subscriber ID as applicable (e.g., address changes, adding/terminating a medical or dental policy, adding/terminating dependents). This is for manual submissions and submissions using the Electronic Enrollment Web application.

If you use our Electronic Enrollment Web application:

- We have updated all plans and products to comply with the 2014 healthcare reform requirements.
- You will now see the 2014 equivalent of their current plan and products. You will notice this in the **class description** field.
- If you are planning on selecting a new plan/product for 2014, the Electronic Enrollment tool will be updated to reflect their new selection when it is received and processed by BCBSRI.
- Even though you will see the 2014 description of the plan or product offering, any employees added prior to January 1, 2014 will be enrolled into your 2013 plan.

Billing Statements

You will notice some changes to your billing statements. These were made to accommodate changes related to how medical plans are rated. We will continue to work on improving the display of the information that is provided to you on your monthly billing statements.

Section 2 Summary:

- For medical plans the monthly rates will be displayed as 0.00 because each employee and dependent will be rated based on their age (counting up to three children under age 21). We cannot continue to display a composite rate by contract tier [Individual, Family, Subscriber & Spouse, or Subscriber & Child(ren)].

Section 3 Detail of subscribers for current billing period:

- For medical plans, you will now see either "Family Age Rated" or "Ind. Age Rated" instead of "Individual" or "Family." This just means that the rate is based on their age and is no longer based on the contract type.
- You may also see employees listed with two separate identification numbers if they are enrolled in both a medical plan and a dental plan.

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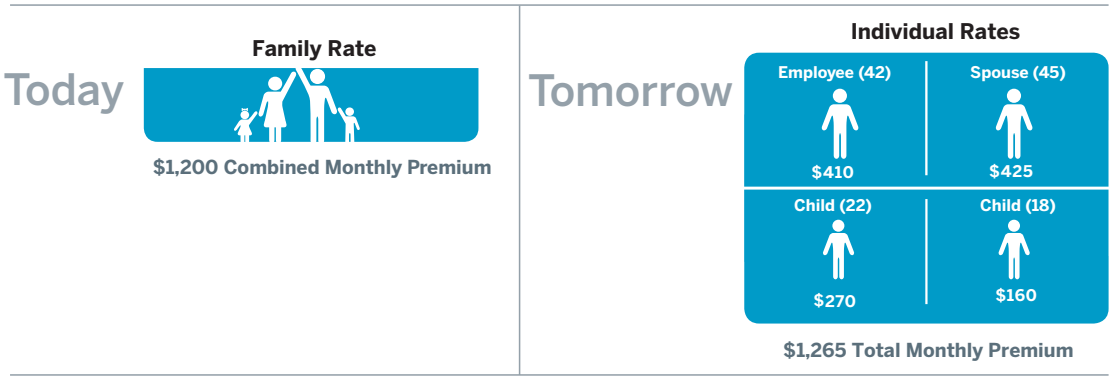
- You will notice that rates vary for each of your employees. As a reminder, rates are now based on the age of each employee and their dependents as of the effective (or renewal) date. For family plans, the rate is calculated by adding up the rate for each family member, counting all dependents including children. For children under age 21, only the three oldest children are counted towards the family premium, please refer to Fig. 1.

Fig. 1



90-Day Waiting Period

The ACA limits waiting periods (sometimes referred to as a probationary period) to no more than 90 days. The Department of Health and Human Services (HHS), the Internal Revenue Service (IRS), and the Department of Labor (DOL) (collectively, the "Departments") have issued proposed regulations advising on how this mandate should be implemented.

What is a waiting period?

The waiting period is the period of time that must pass before coverage for an individual employee or their dependent(s)—who is/are otherwise eligible to enroll—will become effective.

When does this go into effect?

For plan years beginning on or after January 1, 2014, group health plans and health insurance issuers may not delay enrollment of an otherwise eligible individual in health coverage for more than 90 days.

What do you need to do?

When you renew your coverage in 2014, you will need to change the waiting period for eligible employees to ensure that it does not exceed 90 days. If you currently have a waiting period which is longer than 90 calendar days, you need to change it beginning with the first plan year that begins on or after January 1, 2014. BCBSRI assumes that your plan year is the same as your renewal date unless you tell us otherwise.

What is BCBSRI doing?

BCBSRI will continue to monitor this regulation and keep you posted on any changes once the regulations are finalized. BCBSRI will also make changes to our systems to ensure that the waiting period does not exceed 90 calendar days. We will begin to count days versus months moving forward. Our standard waiting period policy will continue to be that coverage will be effective on the first of the month following the date of hire.

However, employers will be able to establish their waiting period so long as it does not exceed 90 calendar days.

For small employers (50 or fewer employees), we will allow the following waiting periods:

- Our standard, which is first of the month following date of hire.
- First of the month following the first 30 days of employment.
- First of the month following the first 60 days of employment.

More Information

To learn more, please visit
BCBSRI.com/healthcare reform/faqs.

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

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