BlueCross BlueShield of Texas

2015

Countdown to Coverage

The Producer Guide to Open Enrollment

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association.

November 13, 2014

Countdown to Coverage

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Table of Contents

Timeline....................3

Policy Updates....................4

- Allowable Changes to Grandfathered Plans....................4
- Special Enrollment Reasons for Changes/Applications after February 15....................4

Discontinue/Renewals....................5

- Individual Discontinuation Overview....................5
- Non-grandfathered/Grandmothered/Transitional Plans....................5
- Grandfathered Plans....................8
- Affordable Care Act/Metallic Plans....................9
- Non-renewable plans due to moving from service area....................14
- BCBSTX.com/StayBlue or BCBSTX.com/KeepMeBlue....................14

Producer Administration....................15

- FFM Producer Registration Overview....................15
- Product Training Module Now Available in ComplianceWire....................16
- Updates on Producer of Record Transfers and Agent Assignment Confirmations....................17
- Why the Retail Shopping Cart is a Good Idea for Your Clients....................17
- Resubmit Applications Using 2015 Paperwork....................18

Subscriber Support....................19

- 2014 Plan Quotes and Applications Saved in the Retail Shopping Cart Removed on Nov. 14....................19
- Application Tracker Helps Welcome Individual Applicants....................20
- CMS Releases Plan to Keep Marketplace Enrollees Covered....................20
- Cancelling and Choosing New Plans....................21
- Convenient payment options available for your clients....................21
- Billing Related to HMO/PPO Changes....................22
- Expanding Customer Service for Open Enrollment!....................23
- The Importance of Capturing Social Security Numbers for *all* Enrollees....................24
- Select Individual Plans to Lose HSA-Compatible Status in 2015....................24
- Verifying networks when considering a plan....................25
- What to know about catastrophic plans....................25
- Remember clients with short-term plans during open enrollment....................26

Timeline

Date	Action
October/November	Discontinuation/Renewal materials drop in-home to members
November 15	Open Enrollment begins
December 15	Last day to enroll (for individuals without a Special Enrollment Period) for a Jan. 1, 2015 effective date
December 31	Last day to enroll (for individuals with a Special Enrollment Period) for a Jan. 1, 2015 effective date*
January 1	Final day to submit first payment for new policies, purchased either on or off the Marketplace with a January 1 effective date
February 15	Open Enrollment ends (for individuals without a Special Enrollment Period)
March 1	Open Enrollment ends (for individuals with a Special Enrollment Period)*

**Refers to discontinuation members who qualify for a Special Enrollment Period due to loss of minimum essential coverage*

Policy Updates

Allowable Changes to Grandfathered Plans

Individual grandfathered members were provided with the option to remain in their current plan or move to a new plan effective in 2015. If a member elects to remain in his or her current policy, the policy's deductible cannot be altered.

However, rollovers to the exact same policy and deductible may be permitted for dependents covered under these grandfathered plans based on the following situations:

- Divorce
- Death of the primary insured/policyholder
- The primary insured/policyholder turns 65 and is eligible for coverage through Medicare
- The dependent turns 26 and is no longer eligible for coverage as dependent

Special Enrollment Reasons for Changes/Applications after February 15

To enroll in Health Insurance Marketplace plan or an off-Marketplace plan, after February 15, applicants will need to meet the qualifications of the Special Enrollment Period. A special enrollment period is triggered by a qualifying event such as marriage, divorce or a move. If members qualify for one of the special events, they may have the opportunity to purchase a new policy directly from us through the normal process, or through the Marketplace. Your clients can go directly to the Marketplace website and report a change in circumstances.

Some of the reasons for Special Enrollment include:

- Loss of minimum essential coverage, such as the loss of a job or through a divorce.
- Change in family size due to factors such as marriage, birth, adoption, divorce, or death.
- Change to citizenship or immigration status.
- Release from incarceration.
- Current plan substantially violated a material provision of its contract.
- Newly eligible or ineligible for premium tax credits or cost-sharing assistance.
- Newly pregnant or disabled (may result in eligibility for Medicaid and loss of premium tax credit eligibility).
- Permanent move to a new county or ZIP code and have access to new health plans.
- Member of an American Indian tribe (American Indians can enroll in a plan or change plans one time each month).
- Demonstrated other extenuating circumstances that qualify for special enrollment.

When any of these events happen, an individual may have 60 days before and after the event occurs to either enroll in a health insurance plan or change plans. For those who missed open enrollment and don’t qualify for special enrollment, temporary coverage is another option for coverage until the next open enrollment period begins.

Discontinue/Renewals

Individual Discontinuation Overview

Blue Cross and Blue Shield of Texas (BCBSTX) will **discontinue:**

Non-grandfathered/grandmothered/transitional individual plans on December 31, 2014.

Due to loss of minimum essential coverage, affected members now qualify for a special enrollment period and may select a new plan by December 31, 2014, to remain covered on January 1, 2015. Open enrollment ends on February 15, 2015, but members with special enrollment eligibility will be allowed to enroll in a plan through March 1, 2015, (members must select "loss of minimum essential coverage" on applications as the reason for the special enrollment).

Individuals enrolled in a grandfathered or Affordable Care Act (ACA) plan purchased on or off the Health Insurance Marketplace will be allowed to renew their current coverage or choose a new ACA/metallic plan.

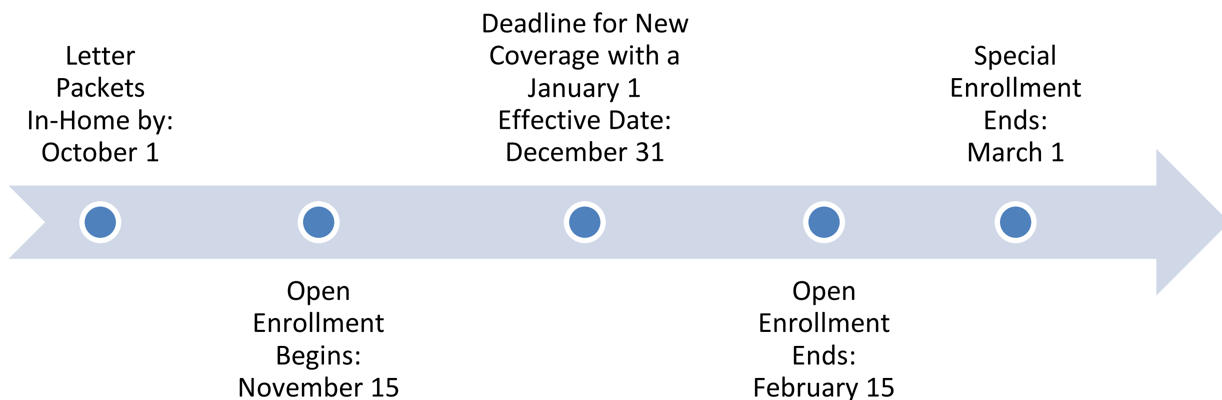
Non-grandfathered/Grandmothered/Transitional Plans

Overview

Plans purchased after May 23, 2010, and before October 1, 2013, will not be allowed to renew their current coverage. These members must choose a new ACA/metallic plan to ensure they are covered in 2015.

Non-grandfathered/grandmothered/transitional plan members now qualify for a special enrollment period and may choose a new ACA/metallic plan by December 31, 2014 to be covered under a new plan on January 1, 2015. Under the special enrollment period, these members will be allowed to enroll in a plan through March 1, 2015. Members must select "loss of minimum essential coverage" on applications as the reason for the special enrollment.

Discontinuation Timeline



Sample Communications

- Cover Letter
- Centers for Medicare and Medicaid Services' Notice
- Frequently Asked Questions

Discontinuation Questions

1. **Why is my client's plan being canceled? I thought he/she could keep his/her plan?**
   Starting on January 1 of this year, the Affordable Care Act began requiring health insurance plans to accept members without pre-existing conditions, offer guaranteed issue plans (which basically means that if you apply for coverage, you can get coverage) and also creates new essential health benefits. Your client's current plan doesn't offer these benefits and will end on December 31. To stay covered under a new plan starting on January 1, he/she will need to choose a new plan by December 31.

2. **Why would my client want to move to a new plan? What's different?**
   These new plans follow Affordable Care Act guidelines which include accepting members with pre-existing conditions and offering guaranteed issue plans – which basically means that if your client applies for coverage, he/she will get coverage – these new plans also cover some essential health benefits. Your client's current plan doesn't have these features.

3. **How much will a new plan cost?**
   Information on new plans and rates won't be available until November 15 – the first day of the Affordable Care Act's open enrollment. Premiums are different for everyone and depend on what plan best meets your client's needs and budget. There are also other things that can influence premiums like the new benefits under the Affordable Care Act or if your client qualifies for an advanced premium tax credit or other financial assistance.

4. **How can my client make a decision now? There isn't enough information.**
   Information on 2015 plans and rates isn't available until November 15, the first day of the Affordable Care Act's open enrollment period. At that time your client can begin reviewing what his/her options are – if his/her doctors and hospital are in network and whether or not he/she qualifies for financial assistance to help cover health insurance costs. To make sure your client is covered on January 1, he/she needs to choose a new plan by December 31. When he/she chooses a new plan, make sure to select the "loss of minimum coverage" option on his/her application.

5. **My client has health problems, can he/she still get a new plan?**
   Yes, under Affordable Care Act guidelines members are accepted regardless of any pre-existing conditions.

6. **My client can't afford a new health insurance plan.**
   The Affordable Care Act may help lower health insurance costs, based on household size and income. Visit our website starting on November 15, the first day of the Affordable Car Act's open enrollment period, and follow the steps to see if your client qualifies for help to lower his/her costs.

7. **I don't want my client to lose his/her doctor and/or hospital.**
   Making sure that your client's doctor and hospital is in-network is important. When you begin looking at options, make sure that your client's doctors and hospital are in the plan's new network and that any prescriptions are covered through the new plan. Remember that he/she can begin looking at his/her new plan options starting on November 15 – the first day of the Affordable Care Act's open enrollment period.

8. **My client doesn't support the Affordable Care Act and doesn't want a new plan.**
   The decision for choosing a new plan is up to your client. If your client does not want to choose a new plan, he/she doesn't have to – but please remember that under the Affordable Care Act, he/she may have to pay a penalty if he/she doesn't have health insurance coverage in 2015.

9. **How long does my client have to make a choice?**
   The Affordable Care Act's open enrollment period begins on November 15 and goes through February 15 of next year. If your client wants to be covered under a new plan starting on January 1, he/she needs to choose a new plan by December 31. When a new plan is selected, make sure to mark "loss of minimum essential coverage" as his/her reason for enrolling in a new plan. If he/she chooses a plan after December 31, he/she will have a time when he/she is not covered under any plan.

10. **What kind of cost-sharing assistance is available?**
    Most health insurance plans have out-of-pocket costs that an individual may owe when they receive medical treatment. Your client may pay part of the cost for a doctor visit or a medical procedure or test. Cost-sharing assistance helps lower these out-of-pocket costs. If your client qualifies for a premium tax credit and his/her income is below a certain amount, he/she is also eligible for cost-sharing assistance.

11. **Will my client be able to get adult dental coverage with a new plan?**
    Yes. After your client has chosen your new health plan, he/she will see an option to add adult dental coverage.

12. **My client lives in this state, but he/she has a dependent(s) that doesn't. What should he/she do about those that don't live in-state?**
    If your client has dependents under this plan, who live in another state, they will need to choose a new Blue Cross and Blue Shield plan for the state they live in.

    If dependents live outside the state while attending college, they are covered and can remain on the plan.

13. **What are my client's options if a dependent is turning <26 or 65>?**

    If a client's dependent is turning 26, this member must enroll under a new, separate plan. They can no longer be covered under your plan as a dependent.

    If a member is turning 65, Medicare coverage options are available online through easeintomedicaretx.com

    If your client or a dependent is already 65 or older and does not qualify for Medicare, there may be other options available to enroll in a new non-Medicare plan or explore coverage alternatives.

Grandfathered Plans

Overview

Plans purchased before May 23, 2010, will be allowed to remain in their current coverage or choose a new Affordable Care Act (ACA)/metallic plan.

Mental Health Parity Benefit and Deductible Changes
The required notice from the Centers for Medicare and Medicaid Services (CMS) includes a list of benefit changes applicable to the member's plan starting on Jan. 1, 2015. For members enrolled in a grandfathered plan that previously covered mental health and/or chemical dependency benefits, please note the following change to these benefits:

- With respect to any mental health or chemical dependency services, which are covered benefits under the plan, any day, dollar or visit maximums will be removed;
    - benefits will be paid the same as any other illness;
    - member cost sharing for these benefits will be included in the out-of-pocket maximums.

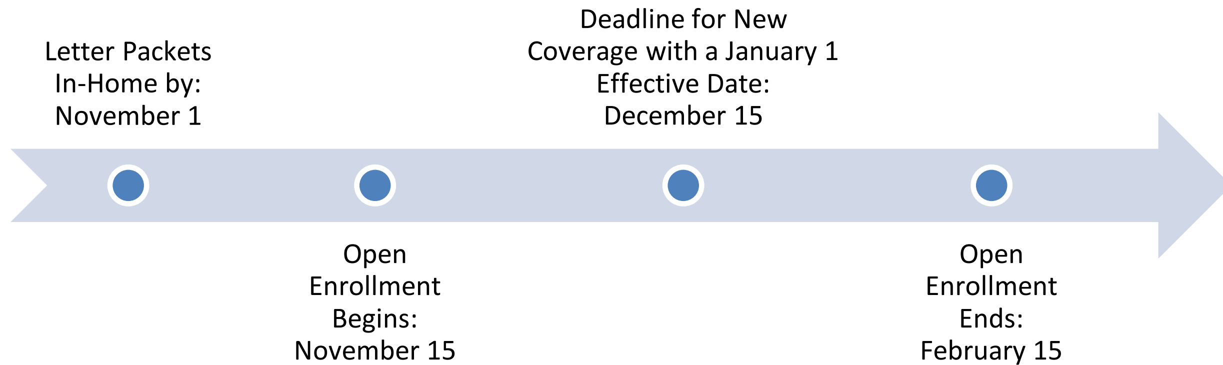
- Coverage for mental health or chemical dependency services in residential treatment facilities will be included.

For certain grandfathered plans, there will also be a change to deductibles so that plans remain compatible with Health Savings Accounts:

- Individual plan deductibles with less than $1,300 will now have a new deductible of $1,300 in 2015.
- Family plan deductibles with less than $2,600, will now have a new family deductible of $2,600 for 2015.

Not all grandfathered policies are impacted by these changes. Please click here for impacted policies by group number.

Renewal Timeline



Sample Communications

- Cover Letter
- Centers for Medicare and Medicaid Services' Notice
- Frequently Asked Questions

Renewal Questions

See the following section, "Affordable Care Act/Metallic Plans," for answers to renewal questions.

Rate Information

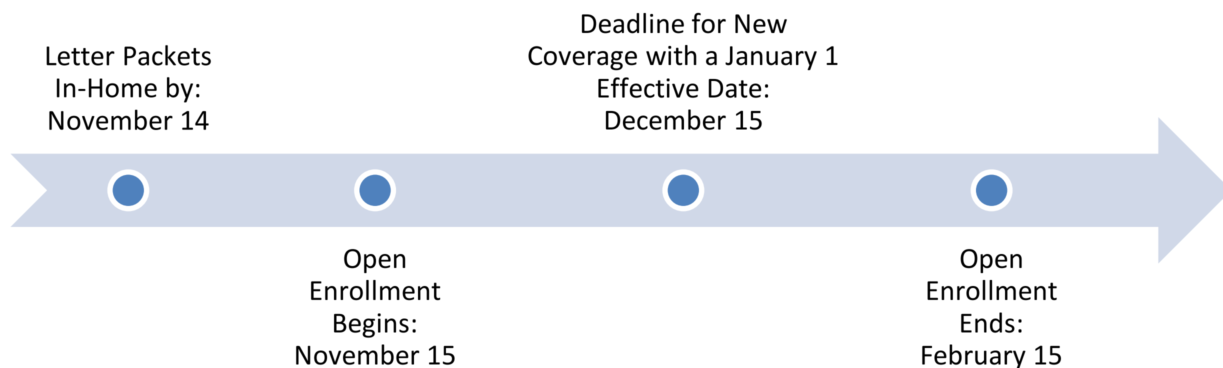
See the following section, "Affordable Care Act/Metallic Plans," for answers to rate questions.

Affordable Care Act/Metallic Plans

Overview

Plans purchased either on or off the Health Insurance Marketplace will be allowed to renew their existing coverage or decide to choose a new plan.

Renewal Timeline



Sample Communications

Off-Marketplace Materials	On-Marketplace Materials WITH Advanced Premium Tax Credit	On-Marketplace Materials WITHOUT Advanced Premium Tax Credit
Cover Letter	Cover Letter	Cover Letter
Centers for Medicare and Medicaid Services' Notice	Centers for Medicare and Medicaid Services' Notice	Centers for Medicare and Medicaid Services' Notice
Frequently Asked Questions	Frequently Asked Questions	Frequently Asked Questions

Renewal Questions

1. **How can my clients keep their current plans?**
   If your clients want to keep their current plans (and their plans are not being discontinued) he/she doesn't need to do anything. Their plans are scheduled to renew on January 1. They should continue to use their current plan and make premium payments as normal.

2. **If my client keeps his/her current plan, will he/she receive a new ID card(s)?**
   No, his/her current ID cards should continue to be used. He/she won't need a new card if he/she is keeping their current plan.

3. **How does my client order a replacement ID card?**
   Your client can order a replacement ID card online through Blue Access for Members℠ at bcbstx.com/member.

4. **My client wants to choose a new plan – what does he/she need to do?**
   We have a lot of plan options for your client to choose from. He/she can choose a new plan during the Affordable Care Act's open enrollment period; it begins on November 15 and goes through February 15. Simply log on to bcbstx.com/keepmeblue to see his/her options. If he/she wants a new plan to start on January 1, he/she needs to select a new plan by December 15.

5. **If my client chooses a new plan, how can I make sure that his/her doctors and hospital are included in the network?**
   Making sure the right doctors and hospital are in-network is very important, that's why we created a helpful Provider Finder tool that can be used to make sure your client's doctors and hospital are in network for the new plan he/she wants. The Provider Finder tool is easy to use, simply log in to bcbstx.com/keepmeblue and click on "Check to see if your doctor is in the network button," this will take you to it.

6. **If my client chooses a new plan, will his/her prescriptions be covered?**
   It's important to make sure that the new plan covers the prescriptions your client uses – you can go online to bcbstx.com/member/prescription-drug-plan-information to review our list of prescription drugs covered under the new plan and what they will cost.

7. **If my client chooses a new plan, when will it start?**
   It all depends on when your client enrolls in a new plan. If he/she enrolls in a plan between the first and fifteenth of the month, the new plan will begin on the first day of the next month. For example, if he/she enrolls in a new plan on December 10, the new plan will begin on January 1.

   If your client enrolls in a new plan after the fifteenth of the month, the plan will begin on the first day of the second month after he/she enrolled. For example, if he/she enrolls in a new plan on December 17, the new plan won't begin until February 1.

   It is important to remember that open enrollment begins on November 15 and ends on February 15, 2015. If your client wants to choose a new plan and wants it to begin on January 1, he/she must enroll in that plan by December 15. Otherwise, his/her plan may begin or February 1 or later.

8. **What happens to my client's current plan, if he/she decides to choose something new?**
   If your client chooses a new plan, his/her current plan will be canceled when the new plan begins. Remember, he/she can choose a new plan only during the open enrollment period of November 15 through February 15.

9. **What happens if my client doesn't choose a new plan during open enrollment?**
   If your client doesn't choose a new plan during the open enrollment period of November 15 through February 15, he/she will stay in his/her current plan.

10. **How can my client save money on his/her health insurance?**
    Your client may be able to get a premium tax credit if he/she chooses a new plan through the Marketplace. To see if your client qualifies for a premium tax credit, visit bcbstx.com/keepmeblue and click on the "Get Your Official Tax Credit" button. This button will take you to the Health Insurance Exchange where an account can be created to see if he/she qualifies for a tax credit, which could help lower monthly premiums.

11. **If my client received a premium tax credit this year, does he/she need to do anything to make sure he/she gets a tax credit next year?**
    Yes, to make sure your client gets an updated premium tax credit for next year, he/she will need to log in to bcbstx.com/keepmeblue and click on the "Get Your Official Tax Credit" button. This will take him/her to the Marketplace. He/she may be asked to create a new user name and password. From there, he/she will follow steps to update the premium tax credit information. Remember that premium tax credits are only available through a Marketplace plan.

12. **The government notice says my client didn't receive any money for the 2014 premium tax credit – could he/she receive money?**
    Your client may qualify for a premium tax credit which could help lower monthly premium costs – to find out if he/she qualifies – log in to bcbstx.com/keepmeblue and click on the "Get Your Official Tax Credit" button. This will take him/her to the Marketplace. He/she may be asked to create a new user name and password. From there, follow steps to update the premium tax credit information. Remember that your client can only get a premium tax credit if he/she chooses a Marketplace plan.

13. **If my client chooses a new plan, can he/she get adult dental coverage too?**
    Yes, if your client chooses a new health plan, he/she will have the option to add adult dental coverage.

14. **What happens if my client chooses a new plan?**
    If your client chooses a new plan, he/she will get new ID cards and information on his/her plan, how he/she will be billed, and how to pay premiums.

15. **My client has a plan through the Marketplace – what happens if he/she wants to choose a new plan that isn't on the Marketplace?**
    If your client has a 2014 Marketplace plan through us or through healthcare.gov – and he/she wants to choose a new plan outside of the Marketplace for next year – he/she will need to log in to healthcare.gov to cancel his/her current plan. Plans must be canceled at least 14 days before the cancellation is to begin. For example, if your client wants his/her coverage to end on December 31, a request to cancel must be submitted by December 14, at the latest.

    Your client can then log in to bcbstx.com/keepmeblue to choose a new plan. Remember, if he/she wants a new plan to start on January 1, he/she must enroll in that plan by December 15.

16. **My client has a plan through the Marketplace – what happens if he/she wants to choose a new plan through the Marketplace?**
    To choose a new Marketplace plan, your client can then use the healthcare.gov site or log in to bcbstx.com/keepmeblue where we also have Marketplace plans. Remember, if your client wants a new plan to start on January 1, he/she must enroll in that plan by December 15.

17. **My client wants to choose a new plan – but he/she has a pre-existing condition**.
    Under the Affordable Care Act, your client can choose a new plan regardless of pre-existing conditions. If he/she applies for coverage, he/she won't be turned down and we will not put any riders limiting his/her coverage. But remember that in most cases, your client can only choose a new plan during the open enrollment period, which begins on November 15 and ends on February 15. If he/she wants a new plan to begin on January 1 – he/she must make a decision by December 15.

18. **My client wants to choose a new plan, but he/she wants to make sure that the new plan has some of the benefits of his/her current plan. What does he/she need to do?**
    It is important to compare plans and make sure that the new plan your client wants includes the benefits needed. Starting on November 15, the first day of open enrollment, he/she can log on to bcbstx.com/keepmeblue to shop and compare plans. Remember that in most cases your client can only choose a new plan during the open enrollment period – which begins on November 15 and ends on February 15.

Rate Information

Rate information will be included in all member renewal materials. For questions, regarding rates, please refer to the following Frequently Asked Questions:

1. **Is the rate in my client's letter what he/she will pay in 2015?**
   The following answer applies only to grandfathered plan members:
   The rate shown is for your client's medical plan only. If he/she has made any changes to his/her plan – such as adding a dependent or receiving an adjustment due to age or moving – the rate shown may not include those changes. We'll send another notice before his/her new rate begins – it will include medical and dental rates, if he/she has a dental plan through us.

   The following answer applies only to ACA/metallic plan members:
   The rate shown in your client's letter is the final rate he/she will pay in 2015. This rate is only for his/her medical plan – if he/she also has a dental plan through us, he/she get another letter with information on the dental rate. But, if he/she has made recent changes to his/her medical plan, such as adding a dependent or receiving an adjustment due to age or moving, the rate may be different.

2. **Why did rates increase?**
   There are many factors that affect rates including advances in medical technology, prescription drugs and ways to treat injuries and illnesses. Your clients' premiums are being adjusted to reflect these increased costs. If your client feels like he/she can't afford the new rate, there may be ways to save money, including a premium tax credit that lowers their monthly premium. This credit is only available with plans purchased through the Marketplace. To find out if your clients qualify for the credit, visit the Retail Shopping Cart and click on the "Get Your Official Tax Credit" button. This button will take you to the Marketplace where your client can create an account and see if he/she qualifies for a tax credit.

3. **Does the State/Federal government know about this increase?**
   Yes, the state/federal government knows about our rate increase, we provided the State Department of Insurance and the Centers for Medicare and Medicaid Services the 2015 rates before they could be considered final.

4. **What can affect the rate my clients pay?**
   Your clients' rates may be affected by changes like age, moving or adding or losing a dependent.

5. **My client received a letter about his/her new rate – but it says that the new rate won't begin for a long time – why is he/she being told about this now?**
   Under the Affordable Care Act rules, your client can only change plans during the open enrollment period, which begins on November 15 and ends on February 15. Your client's rate adjustment may happen outside of this time period – so we're providing this new rate early - to make sure that he/she has time to change his/her plan, if he/she wants to. Once the open enrollment period ends, he/she may not have a chance to change to a new plan until the next open enrollment period, which happens late next year.

6. **How can my clients save money?**
   The open enrollment period begins on November 15. At that time you can help your clients look at all the other plan options that may more economical, and you can also see if your clients qualify for premium tax credits or cost-sharing assistance. The premium tax credit is only available with plans purchased through the Marketplace. To find out if your clients qualify for the credit, visit the Retail Shopping Cart and click on the "Get Your Official Tax Credit" button. This button will take you to the Marketplace where you can help create an account for your client to see if he/she qualifies for a tax credit.

Non-renewable plans due to moving from service area

When a member moves out of the service area for their health plan, they will receive a notice from BCBSTX letting them know their move has caused them to be in a non-renewable plan and thus they will need to select a new plan sold in their area.

This is considered a qualifying event, triggering a special enrollment period (SEP). They will have 60 days to select a new plan. This could cause some confusion if their SEP falls during Open Enrollment. Here are some details they need to know:

- They will not be able to shop for a new plan until the market opens on Nov. 15, 2014. This is because we will not be selling any 2014 plans through the remainder of the year, but we cannot begin selling 2015 plans until Nov. 15.
- They will have until Dec. 31, 2014, instead of Dec. 15, 2014, to select a new plan for coverage beginning Jan. 1, 2015.
- They will have 60 days from their qualifying event or Nov. 15, whichever is later, even if that takes them past the Feb. 15, 2015, end of open enrollment.
- If they move out of state, they will be notified that their plan is being discontinued and they will need to work with the Blue Cross and Blue Shield Plan in their state to obtain new coverage.

BCBSTX.com/StayBlue or BCBSTX.com/KeepMeBlue

Keeps Your AOR Status and Helps Clients with Options

To assist your clients in identifying new plan options for 2015, you are encouraged to use the bcbstx.com/stayblue or bcbstx.com/keepmeblue landing pages, as instructed within your client's renewal communications. Starting on Nov. 15, 2014, your clients will be able to log in to the Retail Shopping Cart using the identified landing pages to review their coverage options. It is important to note that **if your client uses either landing page, your agent of record status will remain unchanged.**

Producer Administration

FFM Producer Registration Overview

Producers and subproducers helping individuals enroll in Qualified Health Plans (QHPs) on the Federally Facilitated Marketplace (FFM) must register annually with the Centers for Medicare & Medicaid Services (CMS), a process that includes completing and passing the Individual Marketplace Curriculum. See all the information you need to know about FFM registration!

CMS Resources for Completing the FFM Registration Process
For the latest federal requirements for helping consumers enroll in Marketplace plans, see these links:

- Agent and Broker FFM Registration: A Walk through the Registration Steps
- Registering to Participate in the FFM for the 2015 Plan Year
- Resources for Agents and Brokers in the Health Insurance Marketplaces
- Frequently Asked Questions Regarding Agents and Brokers, May 30, 2014

Top 10 Things You Need Before Updating Your FFM Information in ComplianceWire
Have you completed the 2015 CMS Agent/Broker Marketplace registration process? If so, be sure to submit your updated information, including your completion certificate, to us via ComplianceWire. What do you need before getting started? See the Checklist.

Online Process for Submitting CMS Marketplace Certificates
If you've completed the CMS Agent/Broker Marketplace registration process, submit required information via one easy online form. Read one of our guides or watch an instructional video.

- See the six-page Quick Start or check out the more detailed 15-page How-To Guide.
- Watch a 15-minutes video.

Online Resources: 2015 Marketplace Training Site
We have an online 2015 Marketplace Training site for you with resources on using ComplianceWire, selling Marketplace plans, following CMS registration guidance and more. See the resource site today!

Complete FFM Registration or Risk Sales and Retention Opportunities
Read about the deadlines and producer requirements around completing the FFM registration and how these will affect your compensation, even for policies initially sold in 2014.

Agency Alert: Subproducer Data Essential to Marketplace Compensation
It's important for agencies to understand the role of subproducers so that agencies can be compensated for Marketplace policies. See our Agency Alert for more details on completing subproducer requirements.

Individual Product Training Module Now Available in ComplianceWire
ComplianceWire now has an Individual Marketplace Product Training module available. Find out how to access the training or see the next article for more details.

ComplianceWire Technical Support
For ComplianceWire Technical Support such as logging in and password resets, contact our Help Desk at 888-706-0583, Monday through Friday, 7 a.m. to 10 p.m. CT and Saturday 7 a.m. to 3:30 p.m. CT.

Product Training Module Now Available in ComplianceWire

We are using ComplianceWire, an online learning management system, so our producers can submit annual Individual Marketplace Curriculum Certificates of Completion and other Federally Facilitated Marketplace (FFM) information. ComplianceWire now has an Individual Marketplace Product Training module available. The training covers Benefits and Plans, Plan Structures, Network information, Retail Shopping Cart tips and a Challenge section to test your knowledge. The training also allows you to access a Major Medical Products presentation with an overview of products available in the individual market for the 2015 plan year.

The training is available to all of our producers registered with a National Producer Number (NPN). Don't know your NPN? Go to the National Insurance Producer Registry NPN Lookup.

Follow the quick start steps below to access the product training or see our step-by-step instructions.

Log In to ComplianceWire

1. Go to https://www.compliancewire.com/partners/hcscproducers.
2. Next to "User Id," enter your **NPN**. Your NPN must be 10 digits. Add leading zeros if your NPN is not 10 digits. For example, if your NPN is 1234567, enter 0001234567. Your User Id for ComplianceWire will always be your NPN.
3. Enter the same 10-digit **NPN** for the "Password" field. You should change your password after your initial ComplianceWire login. If you've used ComplianceWire in the past and already changed your password, be sure to use your new password.
4. Next to "Company Code," enter **HCSCProducers** as one word. This field is not case sensitive.
5. If you agree to the Terms of Use, click the **I Accept** button.

Access the Training

1. After you log in, select the **Knowledge Center** tab.
2. Click on the To-Do List in the left menu and find the **Title** column.
3. Search for the **"2015 Under 65 Training Disclaimer"** and select it. Read the disclaimer.
4. If you understand and acknowledge the disclaimer, enter your ComplianceWire User Id and Password and electronically sign the disclaimer form.
5. Click on the **To-Do List** in the left menu again and find the **Title** column.
6. Search for the "HCSC Individual Marketplace (Under 65) Training" and select it.
7. Read the training and complete the challenge questions at the end. You can return to ComplianceWire and the training module at any time.

Training Resources

We have a new 2015 Marketplace Training resource site that includes information on using ComplianceWire, selling Marketplace plans, following CMS registration guidance and more. Save it in your bookmarks or favorites and check back frequently for updates.

Technical Support

For ComplianceWire Technical Support, such as logins and password resets, contact the Help Desk at 888-706-0583, Monday through Friday, 7 a.m. to 10 p.m. CT and Saturday 7 a.m. to 3:30 p.m. CT. For all training-related questions or concerns via email, contact qhp_training@bcbsok.com.

Updates on Producer of Record Transfers and Agent Assignment Confirmations

Producer of Record Transfers: Hold Begins Nov. 15

Producer of Record Transfer Forms for retail policies will not be accepted from Nov. 15 through 30 days after the end of the Open Enrollment Period (OEP).

On the Blue Access for Producers[SM] website, the Producer/Agent of Record Transfer Form for the individual market will be unavailable during this time.

Any Producer of Record Transfer Forms submitted after Nov. 14 will not be processed. The hold on transfers allows our Producer Administration teams to focus on the Agent Assignment Confirmation process for Marketplace polices.

We will notify you when the process is restored, approximately 30 days after the end of the OEP.

Agent Assignment Confirmations: Opens in December

Beginning in January 2014 and through mid-May, we established an Agent Assignment Confirmation process for those producers concerned that their producer information was not captured during the Marketplace enrollment process.

Our Producer Administration teams will offer this service again beginning in December and throughout the OEP. However, this process is not enabled at this time and the AgentAssign@hcsc.net email address has been decommissioned.

Watch for an update in December on the opening of the Agent Assignment Confirmation process!

Why the Retail Shopping Cart is a Good Idea for Your Clients

For customers who know they want Blue Cross and Blue Shield coverage, using the Retail Shopping Cart is the best path for shopping and submitting an application. Did you know:

- If you are a certified agent and use your ExpressLink or the “Find an Agent” button within the Retail Shopping Cart, your agent information will be passed to our downstream systems to receive credit for the sale.

- Your clients can save, compare and see if they qualify for a premium tax credit using the shopping cart tool.

- Applicants can apply their official premium tax credit when enrolling through the Retail Shopping Cart (remember, premium tax credits are only available through Marketplace plans). Once the applicant completes their eligibility application on the Marketplace, their tax credit and any cost sharing will be applied to their quote within Retail Shopping Cart. At check out, they will be able to pay their reduced premium amount.

- The initial payment can be submitted with the applicant's application through the Retail Shopping Cart. Submitting a payment with an application is the easiest way to ensure the application is processed quickly and there is no delay in the coverage being activated on the effective date.

Resubmit Applications Using 2015 Paperwork

If your clients recently submitted applications for coverage starting on January 1, 2015, and used 2014 paperwork, they will need to resubmit their application starting on November 15, 2014, (the first day of the open enrollment period) using new 2015 paperwork.

The submitted 2014 applications will be canceled. If a premium payment was also submitted, a refund will be issued.

Please advise your clients to throw away any old enrollment materials.

Special Enrollment Applications

If your client submitted an application for a special enrollment, the earliest effective date for this special enrollment is now January 1, 2015. Therefore, any special enrollment applications should also be resubmitted using 2015 paperwork (which will be available starting November 15, 2014, the first day of the open enrollment period).

Important Dates to Remember

To ensure that your clients are covered under a new plan on January 1, 2015, clients must select and enroll in a plan by December 15, 2014. If an application is received after this time, the new plan may not begin until February 1, 2015, or later.

Subscriber Support

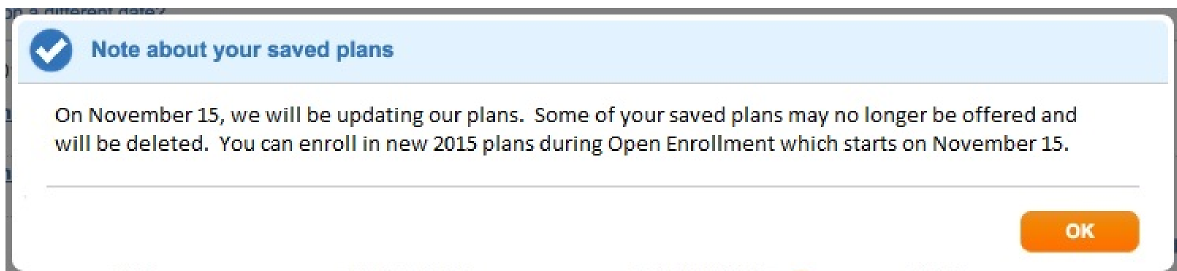
2014 Plan Quotes and Applications Saved in the Retail Shopping Cart Removed on Nov. 14

Beginning Nov. 15, the first day of the Open Enrollment Period (OEP), Retail Shopping Cart account users can shop for and save 2015 OEP health plan quotes and health insurance applications.

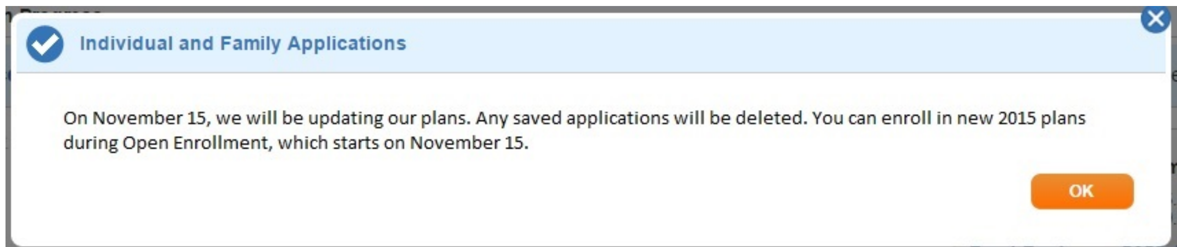
However, plan quotes and in-progress applications created and saved for 2014 Special Enrollment Periods (SEPs) will be removed from user accounts on Nov. 14. Plan quotes and applications for the 2014 OEP were removed from accounts months ago.

User Notices

From Nov. 2 through Nov. 14, users logging in to their Retail Shopping Cart accounts who select the "Individual & Family Saved Plans" tab will see the following message:



If they select the "Individual & Family Applications" tab, they will see this message:



Saving 2014 and 2015 SEP Applications

Users will not be able to save new SEP applications from Nov. 15 through early December. Users can still apply for SEP policies during this period but they must complete and submit the applications; saving in-progress SEP applications during this period will be disabled. Producers will be notified in early December when the SEP application saving function is restored.

Application Tracker Helps Welcome Individual Applicants

In preparation for 2015 open enrollment, we have updated our email and web-based application tracker that allows applicants to track their application through each step of the process from when they apply to when their coverage becomes active.

Only applicants that provide an email address will be able to use the tracker. Because of this, it is important that producers use the client's email addresses when submitting an application.

When an application is received, the following steps occur:

- An automated email is generated that sends the person an application case number and a tracking number that are required to use on the web-based tool. The link to the tracker is also provided.
- The online application tracker shows applicants when their application is received, when it is processed and they are enrolled, when ID cards are sent, and when their first payment is applied and they can start using their benefits.
- The tracker has been enhanced to deliver more information about the selected coverage and provide links to helpful resources members can use to understand their benefits.
- Applicants receive an email when their enrollment is completed, telling them what the next steps will be and directing them to their new Blue Access for Members℠ online account.

The tool is used for all on- and off-Marketplace products, including dental plans. The data behind the tool is updated every two hours, so the information in the application tracker is kept current.

A producer version of the tracker is not currently available, and producers will not be receiving a copy of the emails for their clients at this time. Producer integration is part of a later phase of development and is targeted to be available within the next year.

CMS Releases Plan to Keep Marketplace Enrollees Covered

On Wednesday, Oct. 15, the Centers for Medicare & Medicaid Services (CMS) published their plans to help current Marketplace enrollees keep their coverage for 2015. This means your Marketplace clients will be receiving various materials from CMS, as well as from us.

Marketplace Enrollee Communications from CMS

CMS noted that their campaign, beginning this week, will include outreach directly through mail, email and phone calls. In a new brochure, CMS encourages current enrollees to review their current plans, update their applications, compare their current plans with other plans, choose plans that fit their needs and complete 2015 enrollment.

In addition to releasing the new brochure, CMS shared examples of their Marketplace Model Open Enrollment and Annual Redetermination Notices. These notices are in both English and Spanish.

- Enrolled, but not getting a tax credit or help with costs
- Eligible, but not enrolled
- Updated tax information shows income too high to continue help with costs
- Tax Information shows income changes that could result in owing on tax return
- Marketplace authorized to check tax information with no change in income
- Marketplace not authorized to check tax information

Cancelling and Choosing New Plans

If your client wishes to cancel their current plan and select a new plan for 2015, please note the following:

If your client wants to cancel a Marketplace plan and move to an off-Marketplace plan, a request to cancel coverage should be submitted through healthcare.gov. Plans must be canceled at least 14 days before the cancellation is requested to begin. (For example, if your client wants his/her coverage to end on December 31, a request to cancel must be submitted by December 14, at the latest.)

After the Marketplace plan is canceled, your client can then log on to bcbstx.com/keepmeblue to select a new plan. Your Agent of Record status will remain unchanged.

> Remember, if your client wants a new plan to start on January 1, enrollment must happen by December 15.

If your client wants to cancel a Marketplace plan and move to a new on-Marketplace plan, he/she may use the healthcare.gov site or log in to bcbstx.com/keepmeblue to select a new Marketplace plan.

> Remember, if your client wants a new plan to start on January 1, enrollment must happen by December 15.

Convenient payment options available for your clients

A new enrollee's first premium payment activates their coverage. They can start using their benefits within days of making their payment, sometimes the next day. Then they will continue to have coverage as long as they pay their premium each month to keep the coverage active.

All individual and family policies are now on monthly payment schedules. Subscribers will receive a bill each month. We offer many choices to make it easy to pay.

- They can pay by mail using a personal check, cashier's check or money order with the payment coupon.
- One time payments can be made using the OrbiPay* payment line toll-free at 877-433-3755 or through the OrbiPay secure website found at bcbstx.com/member/payment-options.
- Recurring electronic funds transfer (EFT) can be set up by calling Customer Service toll free at 888-697-0683. Note that if they pay their first payment when they enroll, and then set up recurring payments, they could end up being double drafted. If they pay with enrollment, they should wait until they receive their next month's bill to set up recurring payments.
- Payments in cash can be made at any of the MoneyGram® locations in the U.S., including most Walmart, ACE Cash Express and CVS stores. MoneyGram locations in Walmart and Albertsons stores also take debit card payments.
- One-time payments can be made over the phone by calling the BillMatrix* Automated Payment Center at 866-654-8569 and entering the necessary information when prompted. Callers will need their 9-digit Member ID number to complete the payment. Members can also log in to their Blue Access for Members account and look for the Billing and Payments section. If they click the Pay with Credit Card button they will be redirected to a secure website for submitting payment by card.

** Orbipay is the secure payment processing system offered by Alacriti Payments, LLC. BCBSTX has contracted with Alacriti to process ACH/electronic check payments. BillMatrix is the secure payment processing system offered by Fiserv. BCBSTX has contracted with Fiserv to process payments with debit, credit and pre-paid debit cards.*

Billing Related to HMO/PPO Changes

If a member elects to move from a PPO plan to an HMO plan – or vice versa – and has an outstanding balance on their current plan, please note the potential impacts to their bill:

Member's Current Plan	If the Member Moves to a New PPO Plan	If the Member Moves to a New HMO Plan
PPO	If a member moves to a new PPO plan for 2015, we will send a new bill that includes the new plan – once the member's enrollment change has been processed. The member should continue to pay the bill as usual. However, it's important to know that **if the member has an outstanding premium balance for his/her current/old plan, any payment sent for the new plan will be used to pay the current/old plan's outstanding debt**. This means that the member may risk the new plan being un-paid and canceled and the member could be responsible for any costs related to health care services recently used. There may also be tax implications for going without health insurance – even if it is only for a few months during the year. The member's bill will provide information as to whether the member owes money on their current/old plan.	If a member moves to a new HMO plan for 2015, we will send a new bill that includes the new plan information. **For the member's new plan to go in to effect, we must receive the first month's premium payment before the new plan begins.** If we do not receive this payment, we may not be able to pay claims on any health care services the member receives through the new plan. **If the member's current/old plan has an unpaid balance, he/she could risk cancellation of the current/old plan.** This means that he/she could be responsible for any costs related to health care services recently used. There may also be tax implications for going without health insurance – even if it is only for a few months during the year.

Member's Current Plan	If the Member Moves to a New PPO Plan	If the Member Moves to a New HMO Plan
HMO	If a member moves to a new HMO plan for 2015, we will send a new bill that includes the new plan – once the member's enrollment change has been processed. The member should continue to pay the bill as usual. However, it's important to know that **if the member has an outstanding premium balance for his/her current/old plan, any payment sent for the new plan will be used to pay the current/old plan's outstanding debt**. This means that the member may risk the new plan being un-paid and canceled and the member could be responsible for any costs related to health care services recently used. There may also be tax implications for going without health insurance – even if it is only for a few months during the year. The member's bill will provide information as to whether the member owes money on their current/old plan.	If a member moves to a new HMO plan for 2015, we will send a new bill that includes the new plan information. **For the member's new plan to go in to effect, we must receive the first month's premium payment before the new plan begins.** If we do not receive this payment, we may not be able to pay claims on any health care services the member receives through the new plan. **If the member's current/old plan has an unpaid balance, he/she could risk cancellation of the current/old plan.** This means that he/she could be responsible for any costs related to health care services recently used. There may also be tax implications for going without health insurance – even if it is only for a few months during the year.

Expanding Customer Service for Open Enrollment!

In preparation for expected high call volumes and customer questions, we have:

- Added more Customer Service Advocates, including bilingual staff
- Spent 200,000+ hours training for the enrollment process
- Expanded our individual member call center hours to 24/7 starting December 1
- Implemented new courtesy call back process to minimize customer hold times during heavy call volume periods

In addition, we have turned on the *eQuestions* tool through the Retail Producer Portal for open enrollment sales quoting questions. This allows you to email your questions to a secure email box. You will usually receive a response within 48 hours.

The Importance of Capturing Social Security Numbers for *all* Enrollees

You know that providing accurate information for all enrollees on an application is important. A Social Security Number is a key piece of information for each enrollee on an application that impacts their ability to get financial assistance through the Marketplace. It is also important for our reporting to CMS. We will be reaching out to members who do not have Social Security Numbers on record as applications come in, so capturing them at the time of enrollment will improve the overall customer experience for your clients.

If you have clients who do not have a Social Security Number, please provide their Tax Identification Number instead.

Select Individual Plans to Lose HSA-Compatible Status in 2015

Renewal packets for 2015 Affordable Care Act/metallic plans will be provided to individual members prior to Open Enrollment, which begins on Nov. 15, 2014. Two health plans will lose their high-deductible health plan (HDHP) designation upon the 2015 renewal.

State	Plan Name (HCSC Product & Cost Sharing Name)	Exchange Status (On/Off/Both)	Network Name	HSA Compatible	Marketing Plan ID
TX	Blue Choice Bronze PPO 005	Off	Blue Choice	No	BPS430BCAITXO
TX	Blue Choice Bronze PPO 005	On	Blue Choice	No	BPS429BCAITXP

Members will receive a renewal packet with this change in the government-required notice. The letter will state:

- This product will not be compatible with a HSA in 2015. If you would like to choose a new HSA qualified plan, please refer to the contact information within this letter.

HSA funds can continue to be used to finance all expenses eligible under IRS Section 213(d). However, members who no longer have an eligible HDHP cannot make contributions to their HSA account. Members may experience tax implications if they choose to renew their current plan. By choosing another HDHP option with us, members may continue to use their HSA account. For additional details regarding HSA contribution limits and uses, the member should contact their tax advisor.

Please ensure members enrolled within these affected plans are aware of the compatibility issue and choose a new coverage option if they wish to remain in an HSA-compatible plan.

Verifying networks when considering a plan

Just in time for this year's open enrollment period, the Know Your Network SM educational campaign materials are now available for producers to download on Blue Access for ProducersSM.

These materials are part of a widespread educational campaign that began earlier this year. They offer a way for producers to educate your clients and prospective clients about network basics and the importance of staying in network. Producers can log in to **Blue Access for Producers** SM and select Marketing and Sales, then the Individual tab, and click the **Know Your Network Campaign Materials** link to find the following fliers and video:

- What to Consider when Shopping HMO Plans and PPO Plans - explains network basics about plans and provides important talking points.
- Is an HMO Right For You? - explains how an HMO plan functions and offers advice for selecting plans.
- Get the Most Out of Your HMO Health Plan – explains how to find key information on the ID card and how to use the Provider Network.
- Get the Most Out of Your PPO Health Plan – provides cost-savings tips for getting the most out of a PPO health plan and understanding provider networks.
- Know Your NetworkSM video - addresses out-of-network utilization and the benefits and importance of staying in network to avoid unexpected costs and high bills.

They are available in English and Spanish.

What to know about catastrophic plans

Catastrophic health insurance plans are only for people who are under 30 years old **or** who qualify for a "hardship exemption." A hardship exemption means that they cannot afford any of the plans available. If they qualify for the hardship exemption but still want some amount of insurance, a catastrophic plan may be their only option.

How to apply for a hardship exemption

1. Go to healthcare.gov/exemptions
2. Scroll down to "How to apply for exemptions."
3. Select "form to apply for exemption based on coverage being affordable."
4. Print, complete and sign the form. Include any documents needed as proof.
5. Mail the exemption form and any documents needed to:

   Health Insurance Marketplace – Exemption Processing
   465 Industrial Blvd.
   London, KY 40750

What Happens Next?

The Marketplace will review the form and send a letter letting them know if they qualified for an exemption. If they qualify, they will get an exemption certificate number (ECN). This is an important number – it proves hardship status and allows them to sign up for a catastrophic plan. Once they have that ECN number, you can resubmit their application for catastrophic coverage by calling us at 888-731-0406.

Remember clients with short-term plans during open enrollment

Short-term health insurance provides temporary coverage for 1–11 months. Short-term plans can provide immediate basic health care coverage, but they do not meet the Affordable Care Act's minimum essential coverage requirements. As a result, depending on your short-term plan clients' circumstances, they may be subject to pay a tax penalty. Losing coverage under a temporary plan does not qualify for a special enrollment period, so your clients will need to consider applying during open enrollment.

You can run a list of your clients with short-term plans through the Retail Producer Portal.