Health Care Reform (the Exchange)  
Answers to Frequently Asked Questions

As a health care provider, you need to know how the health care reform law will affect you and your patients. The Answers to Frequently Asked Questions below were developed to assist with questions regarding health care reform and the Exchange (Marketplace).

How do I know if I am a participating provider in your products on the Exchange?

Florida Blue’s Exchange (Marketplace) plans are based on existing product portfolios and use existing provider network arrangements such as BlueOptions® (NetworkBlue), BlueCare® (Health Options, Inc.) and BlueSelect. Your participation in our Exchange products depends on whether you are a participating provider in a network that supports our products.

How do I participate if I am not participating in one of the networks listed above?

If you are not participating in any of our networks, then you must be a registered provider with Florida Blue in order to be considered a participating provider. If you are currently a registered provider with Florida Blue and wish to be considered for participation in another network(s), complete the appropriate Provider Request to Participate form below:

• Individual Practitioner Request to Participate
• Ancillary Provider Request to Participate

What is the coverage effective date for members enrolled on the Exchange?

For members who enroll on the Exchange from Nov. 15, 2014 – Dec 15, 2015, the coverage effective date is Jan. 1, 2015.

Exchange open enrollment continues from Dec. 15, 2014 – Feb. 15, 2015. Applications received prior to the 15th day of the month are effective the first day of the following month. For example, if an application is received on Jan. 10, 2015, the coverage effective date is Feb. 1, 2015. For applications received between the 16th day of the month and the last day of the month, coverage starts the first day of the second following month. For example, if an application is received on Jan. 16, 2015, the coverage effective date starts on March 1, 2015.

Can a member enroll on the Marketplace after Feb. 15, 2015?

Yes. The deadline to enroll is February 15, 2015. If a member does not enroll by then, the only way to obtain 2015 health coverage is to qualify for a 2015 Special Enrollment Period. A member can qualify for a Special Enrollment Period due to marriage, having a baby, adopting a child, or placing a child in
foster care and losing other health coverage. These life changes may affect the coverage or savings for which a member is eligible. Members should report life changes to the Exchange as soon possible.

How will our office recognize an Exchange member?

Look for the following alpha prefixes on ID cards for Exchange members:

- VMB = Individual HMO
- VMA = Individual PPO
- XJQ = Small Group HMO
- XJX = Small Group
- VME/VMD = Individual HMO and PPO (off the Exchange)

How do I verify member benefits?

You may verify eligibility and benefits for Florida Blue members on the Exchange as you do today for any other Florida Blue member. Providers and/or their designees (billing services, clearinghouses, etc.) should use clinical, financial and administrative electronic self-service capabilities including those accessed through Availity. These capabilities include but are not limited to:

- Submitting administrative inquiries electronically through Availity using Authorizations and Referrals Review and Inquiry, Eligibility and Benefits, CareCalc, the Claim Reconciliation Tool and Claims Status.

- When using certain Availity transactions (Authorizations and Referrals Review and Inquiry, Eligibility and Benefits Inquiry), providers should use the automated transaction capability and obtain a transaction ID through Availity. Providers will not receive eligibility and benefits information from Florida Blue without a transaction ID. This transaction ID will also provide fast-path priority service if you should need to call the Florida Blue Provider Contact Center for assistance. You may call the Provider Contact Center at (800) 727-2227.

What if a member does not have an ID card, or I can't find eligibility and benefits information in Availity?

If you cannot find member information in Availity, call the Provider Contact Center at (800) 727-2227 for enrollment status or have the member call the number on the back of their ID card. As a reminder, if a member does not have an ID card and does not know their member ID number, you can check eligibility and benefits in Availity by using the member’s name and date of birth.

Will providers who already use electronic transactions have to do anything differently?

No. Providers should continue to follow the same processes in place today.

Who are the “covered entities” mentioned in the legislation?

Covered entities under HIPAA are health care clearinghouses, health care providers who conduct electronic health care transactions and health plans.
Does the Affordable Care Act (ACA) require coverage for preventive care?

The ACA requires non-grandfathered plans to provide coverage for certain preventive care services. This coverage must be provided without cost sharing impacts for members (e.g., coinsurance, deductible or copayments) for services provided in-network.

Non-grandfathered group health plans (insured and self-funded) and non-grandfathered individual policies issued or renewed on or after Sept. 23, 2010 must cover preventive services without cost share impacts for members (e.g., coinsurance, deductible or copayments.) Women's preventive health services are generally applicable to non-grandfathered plans with effective or renewal dates on or after Aug. 1, 2012.

What services are considered preventive care?

The ACA defines preventive care services as follows:

- Items or services recommended with an A or B rating by the U.S. Preventive Services Task Force.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration.
- Preventive care and screenings for women supported by the Health Resources and Services Administration per Aug. 1, 2011 guidelines include:
  - Well-woman visits
  - Screening for gestational diabetes
  - Human papillomavirus DNA testing
  - Counseling for sexually transmitted infections
  - Counseling and screening for a human immune-deficiency virus
  - Contraceptive methods and counseling
  - Breastfeeding support, supplies and counseling
  - Screening and counseling for interpersonal and domestic violence

Do the ACA requirements apply to both in-network and out-of-network services?

No. Health plans are not required to provide coverage for recommended preventive services delivered by out-of-network providers. Member cost-share amounts may apply to recommended preventive services delivered by an out-of-network provider.

Do the requirements apply to other preventive services that are included as a benefit under the plan?

No. A plan is not required by the ACA or its regulations to provide coverage or waive member cost-sharing requirements for any item or service that is not on the list of recommended preventive services.
Are there other exemption options for the contraceptive coverage requirement for those employers who do not qualify for a religious employer exemption?

Yes. Employers and or schools that that meet certain criteria may be eligible for a temporary enforcement safe harbor for plan years beginning prior to Jan. 1, 2014. After Jan. 1, 2014, certain groups will be exempt from providing contraceptive coverage under their group health plan if they meet the definition of an eligible organization under the rule.

To qualify for the safe harbor, the entity must meet the following criteria:

- The organization is organized and operates as a non-profit entity.
- From Feb.10, 2012 onward, all or the same subset of contraceptive coverage was not provided at any point by the group health plan established or maintained by the organization, consistent with applicable state law, because of the religious beliefs of the organization.
- The plan provides a mandated notice to participants indicating that contraceptive coverage will not be provided for the first plan year beginning on or after Aug.1, 2012.
- The organization self-certifies that it satisfies these criteria and documents its self-certification.

To qualify as an eligible organization, the entity must meet the following criteria:

- The organization opposes providing coverage for some or all of any contraceptive services on account of religious objections.
- The organization is organized and operates as a nonprofit entity.
- The organization holds itself out as a religious organization.
- The organization self-certifies that it satisfies these criteria and documents its self-certification.

Can a plan require members to obtain a referral or prior authorization before seeking care from a participating ob/gyn provider?

No. A health plan may not require an authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat the authorization as the authorization of a primary care provider. However, a plan may require prior authorization before providing benefits for certain services, such as a uterine fibroid embolization procedure.

Will pre-existing condition exclusions change?

Yes. The law prohibits pre-existing condition exclusions in certain cases. Pre-existing condition exclusions are prohibited for children under 19 for plan years beginning on or after Sept. 23, 2010. Starting in 2014, this prohibition will extend to adults. Both of these provisions apply to group grandfathered plans. However, the requirements do not apply to individual grandfathered plans.

The regulation prohibits both limitation or exclusion of benefits and denial of coverage based on a pre-existing condition, and, therefore, in effect creates guaranteed issue for enrollees under age 19 for plan years beginning Sept. 23, 2010.

What do product “metal levels” mean to me as a provider?
Beginning in 2014, non-grandfathered health plans in the individual and small group Exchange markets must meet certain coverage requirements and are categorized into “metal” levels: bronze, silver, gold and platinum.

These metal levels will allow consumers to compare plans with similar levels of coverage and consider factors such as premium amounts and provider participation to make informed decisions on which health plan best fits their needs.

- Checking member benefits through Availity is how you will determine what copayment and/or deductible should be requested from a member at the time of service.

**Will providers be reimbursed differently for members with Marketplace (Exchange) plans vs. non-Marketplace plans?**

No. Reimbursement rates for covered services will be as set forth in the participating provider agreement for the applicable network regardless of whether the member has a Marketplace (Exchange) or non-Marketplace health plan.

**Are there any changes to member grace periods?**

Members receiving advanced premium tax credits (subsidies) qualify for a three month grace period that begins when a member fails to pay the full premium and ends when a member pays all the outstanding premiums.

For Marketplace members NOT receiving a subsidy or NOT enrolled in a Marketplace product, existing business rules and processes will continue to apply. As required by state law, the grace period will remain 31 days and Florida Blue may take no action including member delinquency notification to providers.

**How will a provider know if a member is in a grace period?**

For Marketplace members with subsidies, providers will receive a grace period notification when they do an eligibility and benefits or authorization inquiry on Availity. Letters will also be sent as part of the claim process to notify providers of the member’s delinquency.

There will NOT be a notification for members who do not receive a subsidy or for members who are not enrolled in a Marketplace product.

**How will claims be impacted during the grace period?**

For Marketplace members **with subsidies:**

- Florida Blue will pay claims during the first month of the three-month grace period and will notify providers of the member’s delinquency through Availity (when Availity is checked) and by letter (when claims are processed for services during this period.)
- During the second and third months of the three-month grace period, claims will be pended and providers will be notified of the member’s delinquency through Availity messages and letters from Florida Blue.
• If premiums for all delinquent months are not paid in full by the end of the grace period, Florida Blue will cancel the member’s contract and deny all pended claims. Providers may then seek payment for denied claims directly from the member.
• Amounts paid to providers for services rendered during the first month of the three-month grace period will not be subject to recoupment/recovery from Florida Blue.

For Marketplace members **without a subsidy** or for members **not enrolled in a Marketplace product**:

• For members who are not receiving a subsidy or who are not enrolled in a Marketplace product, existing business rules and processes apply. The grace period will remain 31 days as required by state law.
• Florida Blue is required by law to take no action during this period, including not notifying providers when members are delinquent in paying claims.
• The member’s coverage will remain in effect during the grace period. However, if full payment is not received by the end of the grace period, coverage will terminate as of the grace period start date, and all pending claims will deny. Providers may then seek payment for denied claims directly from the provider.

**What about out-of-area Blue Plan members enrolled in Marketplace products?**

Providers can verify eligibility and benefits (E&B) for out-of-area Blue Plan members by:

• Requesting a BlueExchange eligibility and benefits inquiry electronically through Availity® at availity.com. Submit a complete ID number with the alpha prefix; do not include spaces or hyphens.
• Calling the BlueCard® Eligibility line at (800) 676-BLUE (2583) or by calling the number on the back of the member’s ID card.
  – You will be asked for the alpha prefix on the ID card to be routed to the member’s home plan.

While the BlueCard BlueExchange inquiry does not include grace period information in the E&B transaction, some Blue Plans will provide grace period information during telephonic E&B calls.

If services are rendered to out-of-area Blue Plan members, providers can check the status of their claims through BlueExchange to determine if a claim is pended because the member has not paid their premiums. If the member pays their premiums in full by the end of the third month, pended claims will process. Otherwise, pended claims will deny and the provider may then seek payment for these services directly from the member.

**Please Note:** This information does not apply to employer group or over 65 (Medicare) BlueCard members.

**Can providers refuse to see/treat patients who are in the grace period?**

Per contractual agreements with Florida Blue and or Florida Blue HMO (Health Options, Inc.), providers have agreed to see all Florida Blue on or off-Marketplace (Exchange) members if they are enrolled in a product that uses a network in which the provider participates.

Florida Blue Marketplace plans are based on existing product portfolios and use existing provider network arrangement such as BlueOptions℠ (NetworkBlue), BlueCare® (Health Options, Inc. and BlueSelect).

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Can providers collect payment in full when services are rendered during the grace period?

In-network providers who render services to members during the grace period are limited to collecting only the amounts due at the time of service based on the member’s Florida Blue benefits (i.e., deductible, coinsurance and copayments.)

If a delinquent member is in the provider’s office, can the provider ask the patient to pay their premium before being seen?

A provider can ask a member who is in the office to make a premium payment to Florida Blue. However, it may take up to 48 hours for the payment information to show in the system.

Can a provider make the premium payment for a member?

The U.S. Department of Health & Human Services (HHS) published guidelines that discourage providers from making a premium payment on behalf of the patient. If we identify that a provider sent a check to Florida Blue as payment for a member’s premium, the check will be rejected and returned to the provider.

What if I have more questions about health care reform?

Visit the Florida Blue health care reform website. You can access our website through the health care reform icon on our main floridablue.com page or at hcr.floridablue.com.