Horizon Blue Cross Blue Shield of New Jersey

HEALTH CARE REFORM & you

Affordable Care Act

Frequently Asked Questions and Answers - 3rd Edition

The health care industry is in a time of change. The Affordable Care Act (ACA) will increase the number of people covered by health insurance. Horizon Blue Cross Blue Shield of New Jersey is here to help you and your clients navigate the changes that lie ahead. This is the third edition of Frequently Asked Questions for you and your clients. For more information, please visit **HorizonBlue.com/reform**.

1. If an individual can receive coverage through an employer, can that person buy insurance through the Health Insurance Marketplace instead?

Individuals who are eligible for employer-sponsored coverage are eligible to purchase plans through the Health Insurance Marketplace.

However, they may not qualify for premium tax credits or cost-sharing subsidies. Eligibility depends on:

- Their income and household size; and
- Whether the insurance offered by their employer is affordable and qualifies as minimum essential coverage.

If a person chooses a plan other than one offered by their employer, the employer does not have to contribute toward premiums.

2. Are husband/wife groups eligible for group coverage through the Small Business Health Options Program (SHOP) if they both enroll as single employees?

Sole proprietors with no employees (or whose only employee is a spouse) are not eligible to purchase coverage through SHOP. To be considered a group health plan, the plan must have employees among its participants. In determining if a group health plan exists, federal law does not classify an individual and his or her spouse as employees when the trade or business is wholly-owned by the individual or by the individual and his or her spouse. When a sole proprietor and/or a spouse-employee are the only enrolled employees, the health plan is not considered a group health plan.

3. Will sibling-owned companies count as affiliates?

In New Jersey, when a company is affiliated with one or more other companies, the affiliated companies are treated as one. Eligible employees of the affiliated companies – including employees of out-of-state affiliates – are considered in determining small employer status for the New Jersey Department of Business and Insurance (DOBI) Small Employer Health Benefits Program (SEH). An employer must obtain a statement from a tax accountant or tax attorney stating if multiple companies are considered affiliated for federal tax purposes.

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4. Are LLCs, LLPs and S-Corps allowed on the SHOP Marketplace?

Yes. A business' legal structure does not impact SHOP eligibility.

5. Will pre-existing condition limitations be in effect if the person is a late entry?

No. For plan years beginning on or after January 1, 2014 (policy year for individual coverage), the ACA removes all restrictions related to pre-existing conditions for individuals of all ages. Coverage may not be denied or delayed based on pre-existing conditions, and the individuals cannot be charged more based on pre-existing conditions.

6. Does SHOP have an open enrollment period where no participation limit applies?

Starting in the 2013 open enrollment period, if a small group is unable to meet the minimum participation rate, they may apply for coverage during an annual enrollment period from November 15, 2013 through December 15, 2013. This period is designed to allow employers who don't meet the required participation threshold to offer a SHOP plan. Outside of this period, the minimum participation requirement will be enforced for new groups applying for SHOP coverage.

Outside of the annual special enrollment period, the SHOP will hold an employer's application until the employer meets the minimum participation requirement. If an employer signs up during the special enrollment period, they still must meet minimum participation requirements upon renewal.

7. Are the small group rating changes applied both on and off the SHOP Marketplace?

Yes. The changes to the rating methodology (from subscriber level to member level) will impact the entire small group market, both on and off the SHOP Marketplace.

8. Will Horizon BCBSNJ list the amount of the taxes/fees on a separate line on a renewal, so brokers and groups know how much the taxes/fees are?

No, we will not list the taxes/fees on a separate line on the renewals.

9. Is training available for agents and brokers?

All agents and brokers must register with the Centers for Medicaid and Medicare Services (CMS) so that they may assist qualified individuals for Marketplace coverage. CMS also encourages agents and brokers working exclusively in SHOPs to register and complete training.

Agent/broker training for the Federally-Facilitated Marketplace (FFM) occurs online at **Marketplace.MedicareLearningNetworkLMS.com.**

The second part of the agent/broker FFM registration process will be available in late August 2013. Agents/brokers will obtain an active FFM User ID by completing an online identity verification process.

10. What impact will the ACA have on Horizon BCBSNJ's current plan portfolio? Will any of the plans currently used be in compliance? How soon will any "new" plans be available?

Starting January 1, 2014, the ACA requires individual and small group plans to include all essential health benefits, limit consumers' out-of-pocket costs and meet the Bronze, Silver, Gold and Platinum coverage level standards (however, grandfathered, self-insured and large group insured plans will be exempt).

Because changing the existing products to conform to these guidelines would have required significant changes, Horizon BCBSNJ will introduce a new set of individual and small group products for 2014. These plans will be available for purchase starting on October 1, 2013, for a January 1, 2014 effective date. To help with the transition, Horizon BCBSNJ will provide additional information on these new products.

11. How does the ACA impact wellness programs?

The ACA identifies two types of wellness programs:

- Participatory wellness programs.
- Health-contingent wellness programs.

Participatory wellness programs do not provide a reward or do not include conditions for obtaining a reward other than participation. Most employee wellness programs are participatory, such as:

- Reimbursement of a fitness center membership cost.
- A reward for attending a diagnostic testing program or health risk assessment.

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- A premium reduction for attending a free health education seminar.

Health-contingent wellness programs require individuals to satisfy a standard related to a health factor to obtain a reward. Health-contingent programs include activity-only wellness programs and outcome-based wellness programs.

Activity-only programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward like a cash payment, but do not require an individual to attain or maintain a specific health outcome. Examples of these programs include walking or diet programs.

Outcome-based wellness programs require employees to attain or maintain a specific health outcome to obtain a reward. For example, an outcome-based program may offer cash payment to an employee who stops using tobacco products or attains cholesterol, blood pressure or body mass index (BMI) improvements at regular screenings. These programs generally have an initial measurement or testing phase. Individuals who do not meet the initial standard can be required to participate in one or more wellness activities to receive the reward.

To comply with the final regulations, health-contingent wellness programs must:

- Give eligible individuals the opportunity to qualify for the reward at least once per year.
- Not reward more than the applicable percentage of the total cost of employee-only coverage under the plan.
- Be reasonably designed to promote health or prevent disease.
- Be uniformly available, with an alternative standard for those with a medical condition who can't participate.
- Disclose the availability of an alternative in all plan materials describing the terms of the program.

The government's 2006 HIPAA regulations required that rewards for a health-contingent wellness program could not exceed 20 percent of the total cost of employee-only health insurance coverage. The final regulations increased the maximum "applicable percentage" from 20 percent to 30 percent, with an increase from 30 percent to 50 percent for wellness programs designed to prevent or reduce smoking.

For more broker-specific questions and answers about the ACA visit HorizonBlue.com/Brokers.

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