

HEALTH CARE REFORM:



A GUIDE FOR GROUP ADMINISTRATORS



How the laws may affect:

- NJ Non-Reform Small Employer Plans
- Small Employer Health (SEH) and Midsize (51 to 99) Plans
- Insured 51+ Custom Plans that are Grandfathered
- Insured 51+ Custom Plans that are not Grandfathered
- Self-Insured Plans that are Grandfathered
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Horizon Blue Cross Blue Shield of New Jersey

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How Health Care Reform applies to New Jersey Non-Reform Small Employer Plans

In March 2010, President Barack Obama signed into law two acts that have become the basis for federal health care reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care & Educational Reconciliation Act (HCERA), which amended the PPACA, was signed into law on March 30, 2010.

For New Jersey Non-Reform Small Employer (two to 50) health plans, federal health care reform requirements will be effective January 1, 2011.

This document provides some information on the federal requirements that may affect your group’s Horizon Blue Cross Blue Shield of New Jersey health coverage. This document is only a brief summary for informational purposes. For more information, please contact your broker or your Horizon BCBSNJ account representative. This document is not intended to serve as legal advice. For legal issues and advice regarding health care reform, please contact your legal counsel.

Q1. When will federal health care reform changes become effective for my group’s Horizon BCBSNJ coverage?

A1. Federal health care reform changes will become effective on January 1, 2011 for New Jersey Non-Reform Small Employer plans.

Q2. Can my group health plan “grandfather” its current Horizon BCBSNJ health coverage?

A2. No. Federal health care reform permits that coverage that was in force on or before March 23, 2010, may be “grandfathered” so that it does not have to include some provisions required by the new law. However, Horizon BCBSNJ has made the decision to provide all of health care reform’s benefit enhancements to health plans in the small employer market no later than January 1, 2011.



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Q3. How will federal health care reform affect Horizon BCBSNJ coverage?

- A3. Several health care reform provisions may affect your group’s health coverage in the coming months, including:
- Changes to lifetime and annual dollar limits.
 - Increased access to preventive care.
 - Patient Protections related to Primary Care Provider (PCP) selection and Emergency Room (ER) visits.
 - The elimination of pre-existing condition limitations for individuals under age 19 years.
 - Coverage for dependents under age 26 years.

What actual changes must be made to comply with the law will be determined by your group’s plan design.

Q4. How will lifetime dollar limits change?

- A4. Health plans can no longer apply lifetime dollar limits to “essential” benefits. However, health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

Q5. How will annual dollar limits change?

- A5. Horizon BCBSNJ health plans will no longer apply annual dollar limits to essential benefits. However, health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

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Q6. What are “essential” benefits?

A6. Health care reform defines essential benefits as the following health care service categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

Q7. How will benefits for preventive care services change?

A7. Health care reform requires certain preventive care services received in network or under a non-network-based plan (such as an Indemnity plan) be covered with no cost sharing and no dollar maximum. That means employees and their dependents who are covered under your group’s health plan will have a \$0 copayment for such preventive care services.

However, if your group’s health plan has in-network and out-of-network coverage, preventive care services received out of network will continue to be covered under your group’s current cost-sharing arrangement.

For a list of preventive care services affected by this requirement, please visit the U.S. Department of Health and Human Services’ website, <www.HealthCare.gov>.

Q8. What are “Patient Protections?” How does this affect my employees and their dependents?

A8. Under New Jersey state law, employees and their dependents who are covered under your group’s Horizon BCBSNJ health plan, already have the Patient Protections defined by federal health care reform.

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Federal health care reform’s Patient Protections pertain to access to:

- Participating Primary Care Providers (PCPs).
- Participating pediatricians as PCPs.
- Ob/Gyn care provided by participating Ob/Gyn providers.
- Emergency care.

If your group health plan requires or allows members to choose a PCP, members must be allowed to choose a participating pediatrician as a PCP for a child.

A health plan cannot require female members to obtain prior authorization or a referral to visit a participating Ob/Gyn health care professional. The health plan may require Ob/Gyn professionals to follow the plan’s policies and procedures, including referrals and prior authorization. These requirements apply if your health plan provides coverage for Ob/Gyn care and it requires you to choose a PCP.

Coverage for emergency department services must be provided without prior authorization of services, even if the services are provided out of network. Coverage determinations must be based on a prudent layperson standard. Horizon BCBSNJ uses the following definition of a medical emergency:

A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily functions; or*
- *Serious dysfunction of a bodily organ or part.*

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With respect to a pregnant woman who is having contractions, an emergency exists when there is not adequate time to safely transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child.

Out-of-network emergency services must be covered the same as in-network emergency services, including cost sharing (i.e., copayments or coinsurance) for both in-network and out-of-network services.

Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning October 1, 2010, there will be no pre-existing condition limitations for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person's enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents' coverage for plan years beginning on or after September 23, 2010.

To help reduce gaps in coverage for our members, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent's health coverage, to remain on their parent's health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.

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Horizon BCBSNJ's early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents' coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- If a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent's employer.

In addition, group health plans and insurers in the group and individual markets:

- May charge premiums based on tiers of coverage (e.g., Single plus one, Family, etc.).
- Cannot vary rates based on the age of a child under age 26 years.
- Cannot limit children to certain benefit packages.

Group health plans must give eligible dependents written notice of a 30-day special open enrollment period. The special open enrollment period must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:



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- Notice to employees serves as the communication to the dependent. The notice may be provided with other open enrollment materials; however, it must also be prominently displayed.
- Coverage must be effective no later than the first day of the plan year and be retroactive, if necessary.
- Parents with a choice of coverage will be able to change their coverage option.

For more information about how health care reform will affect your group’s health plan, please contact your broker or your Horizon BCBSNJ account representative.



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How Health Care Reform and the Minimum Standards Mandate apply to Small Employer Health (SEH) and Midsize (51 to 99) Plans

In March 2010, President Barack Obama signed into law two acts that have become the basis for federal health care reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care & Educational Reconciliation Act (HCERA), which amended the PPACA, was signed into law on March 30, 2010.

In addition to federal health care reform, the state of New Jersey passed legislation called the Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans (NJAC 11:22-5.1 through 5.9). This legislation is often referred to as the Minimum Standards mandate, and applies only to insured health plans, including Small Employer Health (SEH) plans offered to small employer (two to 50 employees) groups and health plans offered to midsize employer (51 to 99 employees) groups.

Provisions of both federal health care reform and the Minimum Standards mandate will apply to your group’s health plan. In those instances where the provisions conflict, Horizon Blue Cross Blue Shield of New Jersey has applied the provision that provides the greater benefit for our members.

This document provides some information on the federal requirements that may affect your group’s Horizon BCBSNJ health coverage. This document is only a brief summary for informational purposes. For more information, please contact your broker or your Horizon BCBSNJ account representative. This document is not intended to serve as legal advice. For legal issues and advice regarding health care reform, please contact your legal counsel.



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Q1. When will the health care reform and Minimum Standards mandate changes become effective for Horizon BCBSNJ health plans?

A1. To answer this question, it is important to understand upcoming changes in Horizon BCBSNJ’s product portfolio. These changes will affect the dates on which we implement federal health care reform and the Minimum Standards mandate.

To streamline our products and administrative requirements, Horizon BCBSNJ filed with, and received approval from, the New Jersey Department of Banking and Insurance (DOBI) to withdraw certain small employer products from the market. Small employer product withdrawals are occurring upon renewal beginning October 1, 2010 through September 30, 2011.

In addition, for the same reason, Horizon BCBSNJ is withdrawing certain products from the midsize market. This will occur upon renewal beginning October 1, 2010 through September 30, 2011.

The products we will continue to sell are referred to as our “maintained” products. The products that we are withdrawing are referred to as our “non-maintained” products.

Members enrolled in our maintained products will receive the benefits and protections of health care reform and the Minimum Standards mandate, effective September 8, 2010.

For our non-maintained small employer products, we will implement the Minimum Standards requirements effective, September 8, 2010 and federal health care reform requirements, effective January 1, 2011.



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Q2. Can my group health plan “grandfather” its current Horizon BCBSNJ health coverage?

A2. No. Generally, the language for the basic SEH health plans is controlled by the New Jersey Small Employer Health Coverage Program Board. Horizon BCBSNJ will provide all of health care reform’s benefit enhancements to health plans in the small employer and midsize (51 to 99 employees) markets.

Q3. How will federal health care reform and the Minimum Standards mandate affect Horizon BCBSNJ health plans?

A3. Several health care reform provisions may affect your group’s health coverage in the coming months, including:

- Changes to lifetime and annual dollar limits.
- Increased access to preventive care.
- Patient Protections related to Primary Care Provider (PCP) selection and Emergency Room (ER) visits.
- The elimination of pre-existing condition limitations for individuals under age 19 years.
- Coverage for dependents under age 26 years.

The Minimum Standards mandate may affect your health plan’s:

- In-network copayments.
- In-network coinsurance.
- Maximum out-of-pocket limits.
- Benefit maximums.

What actual changes must be made to comply with the laws will be determined by your group’s plan design and type of plan. The SEH Benefits Program Board controls the plan documents for these products.

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Q4. How will lifetime dollar limits change?

A4. Health plans can no longer apply lifetime dollar limits to “essential” benefits. However, health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

For health plans that offer in-network benefits, the Minimum Standards mandate requires that no lifetime dollar limit be applied for any benefit.

For health plans that offer in- and out-of-network benefits, there can be no lifetime dollar limit on benefits that are considered essential. For nonessential out-of-network benefits, the lifetime dollar limit must be \$5 million or greater.

For health plans that are not network based (such as Indemnity plans), there can be no lifetime dollar limits on benefits that are considered essential benefits. For nonessential benefits, the lifetime dollar limit must be \$5 million or greater.

In addition, health plans can no longer apply benefit-specific dollar maximums to out-of-network inpatient and outpatient hospital services and supplies.

Q5. How will annual dollar limits change?

A5. Horizon BCBSNJ health plans will no longer apply annual dollar limits to “essential” benefits. However, health plans can apply annual dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

For health plans that offer in-network benefits, the Minimum Standards mandate requires that no annual dollar limit be applied for any benefit.

For health plans that offer in- and out-of-network benefits, Horizon BCBSNJ will no longer apply annual dollar limits on benefits that are considered essential. For nonessential out-of-network benefits, the lifetime dollar limit must be \$1 million or greater.



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For health plans that are not network based (such as Indemnity plans), Horizon BCBSNJ will no longer apply annual dollar limits on benefits that are considered essential benefits. For nonessential benefits, the lifetime dollar limit must be \$1 million or greater.

In addition, health plans can no longer apply benefit-specific dollar maximums to out-of-network inpatient and outpatient hospital services and supplies.

Q6. What are “essential” benefits?

A6. Health care reform defines essential benefits as the following health care service categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

The Minimum Standards mandate does not differentiate between essential and nonessential benefits; it distinguishes between in-network and out-of-network benefits. The Minimum Standards mandate does not allow annual dollar limits on in-network services. Because your group’s health plan is affected by both federal health care reform and the Minimum Standards mandate, annual dollar limits will be removed from in-network benefits.

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Q7. How will benefits for preventive care services change?

A7. Health care reform requires certain preventive care services received in network or under a non-network-based plan (such as an Indemnity plan) be covered with no cost sharing and no dollar limit. That means employees and their dependents who are covered under your group’s Horizon BCBSNJ health plan will have a \$0 copayment for such preventive care services.

However, if your group health plan has in-network and out-of-network coverage, preventive care services received out of network will continue to be covered under your group’s current cost-sharing arrangement.

For a list of preventive care services affected by this requirement, please visit the U.S. Department of Health and Human Services’ website, <www.HealthCare.gov>.

Q8. What are “Patient Protections?” How does this affect my employees?

A8. Under New Jersey state law, employees and their dependents who are covered under your group’s Horizon BCBSNJ health plan, already have the Patient Protections defined by federal health care reform.

Federal health care reform’s Patient Protections pertain to access to:

- Participating Primary Care Providers (PCPs).
- Participating pediatricians as PCPs.
- Ob/Gyn care provided by participating Ob/Gyn providers.
- Emergency care.

If your health plan requires or allows you to choose a PCP, you must be allowed to choose a participating pediatrician as a PCP for a child.

A health plan cannot require female members to obtain prior authorization or a referral to visit a participating Ob/Gyn health care professional. The health plan may require Ob/Gyn professionals to follow the plan’s policies



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and procedures, including referrals and prior authorization. These requirements apply if your health plan provides coverage for Ob/Gyn care and it requires you to choose a PCP.

Coverage for emergency department services must be provided without prior authorization of services, even if the services are provided out of network. Coverage determinations must be based on a prudent layperson standard. Horizon BCBSNJ uses the following definition of a medical emergency:

A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily functions; or*
- *Serious dysfunction of a bodily organ or part.*

With respect to a pregnant woman who is having contractions, an emergency exists when there is not adequate time to safely transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child.

Out-of-network emergency services must be covered the same as in-network emergency services, including cost sharing (i.e., copayments or coinsurance) for both in-network and out-of-network services.

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Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning October 1, 2010, there can be no pre-existing condition limitations for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents’ coverage for plan years beginning on or after September 23, 2010.

To help reduce gaps in coverage for our members, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent’s health coverage, to remain on their parent’s health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.

Horizon BCBSNJ’s early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

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For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents' coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- If a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent's employer.

In addition, group health plans and insurers in the group and individual markets:

- May charge premiums based on tiers of coverage (e.g., Single plus one, Family, etc.).
- Cannot vary rates based on the age of a child under age 26 years.
- Cannot limit children to certain benefit packages.

Group health plans must give eligible dependents written notice of a 30-day special open enrollment period. The special open enrollment period must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:

- Notice to employees serves as the communication to the dependent. The notice may be provided with other open enrollment materials; however, it must also be prominently displayed.
- Coverage must be effective no later than the first day of the plan year and be retroactive, if necessary.
- Parents with a choice of coverage will be able to change their coverage option.



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Horizon BCBSNJ will implement this federal health care reform requirement effective September 8, 2010, for all maintained small employer plans and all midsize (51 to 99 employees) plans. This means that all federally eligible, under age 26 dependents can enroll in these coverages beginning effective September 8, 2010 provided applications are submitted on or by October 8, 2010.

Q11. How are in-network copayments changing?

A11. Under the Minimum Standards mandate, in-network copayments in health benefit plans and stand-alone prescription drug plans may not exceed certain dollar amounts. However, federal health care reform legislation may require different network copayments. In any instance where state and federal legislation require different in-network copayments, Horizon BCBSNJ members will pay the lower copayment maximum.

Listed below is a brief summary of certain in-network copayment maximums required by state and federal law:

- Preventive care services – \$0 copayment, as required by health care reform.
- Primary Care Provider (PCP) office visit – \$50.
- Specialist physician office visit – \$75.
- Emergency Room visit – \$100.
- Outpatient surgery – \$500.
- Inpatient admission – \$500 per day, up to a maximum of \$2,500 per admission.
- Magnetic Resonance Imaging (MRI), computerized axial tomography and positron emission tomography – \$100.
- Generic drug – \$25 per 30-day supply.
- Preferred drug – \$50 per 30-day supply.
- Non-Preferred drug – \$75 per 30-day supply.

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Generally, in-network copayments cannot be applied to any service or supply to which in-network coinsurance is also applied. Horizon BCBSNJ has decided to keep copayments on PCP and specialist office visits and laboratory services. Horizon BCBSNJ will remove copayments and keep coinsurance for inpatient hospital and certain outpatient services (same-day surgery, ambulatory surgical centers). Emergency Room copayments can be maintained.

Q12. How is in-network coinsurance changing?

A12. Effective September 8, 2010, for maintained group health plans of 99 and fewer employees, network coinsurance, generally, cannot be applied to any service or supply:

- To which a network copayment is applied.
- Provided by a health care professional who is reimbursed through capitation. (Capitation is a reimbursement arrangement that pays the physician a set fee each month for each member who selects the physician as a PCP whether or not the member actually receives services.)

Please refer to *Question and Answer 11* for more information on how Horizon BCBSNJ will apply changes to in-network copayments and coinsurance.

Q13. How are maximum out-of-pocket limits changing?

A13. For individual in-network, family in-network and individual out-of-network out-of-pocket limits, all amounts paid as copayment, coinsurance and deductible count toward the maximum out-of-pocket limit. Cost sharing for prescription drug coverage may be excluded from the maximum out-of-pocket limit.

Horizon BCBSNJ already counts these amounts toward members' maximum out-of-pocket limit, so members will not experience any changes as a result of this requirement.

For more information about the health care reform provisions and the Minimum Standards mandate and how they apply to your group's health plan, please contact your broker or your Horizon BCBSNJ account representative.



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In March 2010, President Barack Obama signed into law two acts that have become the basis for federal health care reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care & Educational Reconciliation Act (HCERA), which amended the PPACA, was signed into law on March 30, 2010.

In addition to federal health care reform, the state of New Jersey passed legislation called the Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans (NJAC 11:22-5.1 through 5.9). This legislation is often referred to as the Minimum Standards mandate, and applies only to insured health plans, including insured health plans offered to employer groups with 51 or more employees.

Certain provisions of both federal health care reform and the Minimum Standards mandate will apply to your health coverage. In those instances where the provisions conflict, Horizon Blue Cross Blue Shield of New Jersey has applied the provision that provides the greater benefit for our members.

This document provides some information on the federal requirements that may affect your group’s Horizon BCBSNJ health coverage. This document is only a brief summary for informational purposes. For more information, please contact your broker or your Horizon BCBSNJ account representative. This document is not intended to serve as legal advice. For legal issues and advice regarding health care reform, please contact your legal counsel.

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Q1. When will the health care reform and Minimum Standards changes become effective for my group's Horizon BCBSNJ health plan?

A1. Federal health care reform changes will become effective upon your group's plan year date, beginning on or after September 23, 2010.

Minimum Standard mandate changes will become effective upon your group's renewal date, beginning on or after September 8, 2010.

Q2. Can health plans "grandfather" their current Horizon BCBSNJ health coverage?

A2. Yes. The federal health care reform law permits that a health plan's coverage that was in force on or before March 23, 2010, may be "grandfathered" so that it does not have to include some provisions required by the new law. Grandfathered status applies separately to each benefit option offered under a group health plan.

Your group has opted to grandfather its current health coverage, so only some of health care reform's changes will apply to your group's health plan.

Q3. Are there changes that may cause a group health plan to lose its grandfathered status?

A3. The following are some examples of changes that may cause a health plan to lose its grandfathered status:

- A merger, acquisition or similar business restructuring, if the principle purpose of such action is to cover new individuals under the grandfathered plan;
- The elimination of all (or substantially all) benefits to diagnose or treat a particular condition;
- Any increase in cost-sharing percentage (e.g., coinsurance) above the level in effect on March 23, 2010;
- Certain increases in fixed-amount cost sharing requirements, other than a copayment;
- Certain increases in a fixed-amount copayment;

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- Certain decreases by an employer or employee organization in its contribution rate;
- The imposition of a newly added overall annual limit on the dollar value of benefits.

There are separate rules for collectively bargained plans.

For legal issues and advice regarding grandfathering and health care reform in general, please contact your legal counsel.

Q4. What plan changes can group health plans make and maintain grandfathered status?

A4. Provided changes are made without exceeding the health care reform grandfathering rules, generally, the following changes can be made without the group health plan losing its grandfathered status:

- The addition of family members of an individual who is enrolled in a grandfathered plan;
- The addition of new employees of an employer who are enrolled in a grandfathered plan;
- Changes in premiums;
- Changes required to conform to federal and state requirements;
- Voluntary compliance with PPACA;
- Changing third-party administrators (TPAs).

There are separate rules for collectively bargained plans.

For legal issues and advice regarding grandfathering and health care reform in general, please contact your legal counsel.

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Q5. How will federal health care reform and the Minimum Standards mandate affect group health plans?

A5. Several health care reform provisions may affect your group's health plan in the coming months, including:

- Changes to lifetime and annual dollar limits.
- The elimination of pre-existing condition limitations for individuals under age 19 years.
- Coverage for dependents under age 26 years.

The Minimum Standards mandate may affect your group's health plan's:

- In-network copayments.
- In-network coinsurance.
- Maximum out-of-pocket limits.
- Benefit maximums.

What actual changes must be made to comply with the laws will be determined by your group's plan design.

Q6. How will lifetime dollar limits change?

A6. Health plans can no longer apply lifetime dollar limits to "essential" benefits. However, health plans can apply lifetime dollar limits to "nonessential" benefits. Please refer to *Question and Answer 8* for more information on essential benefits.

For health plans that offer in-network benefits, the Minimum Standards mandate requires that no lifetime dollar limit be applied for any benefit.

For health plans that offer in- and out-of-network benefits, there can be no lifetime dollar limits on benefits that are considered essential. For nonessential out-of-network benefits, the lifetime dollar limit must be \$5 million or greater.



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For health plans that are not network based (such as Indemnity plans), there can be no lifetime dollar limits on benefits that are considered essential benefits. For nonessential benefits, the lifetime dollar limit must be \$5 million or greater.

In addition, health plans can no longer apply benefit-specific dollar maximums to out-of-network inpatient and outpatient hospital services and supplies.

Q7. How will annual dollar limits change?

A7. Generally, prior to January 1, 2014, group health plans can apply annual dollar limits to out-of-network essential benefits according to the following schedule:

Plan Year beginning on or after	Annual dollar limit on essential benefits
September 23, 2010	\$1,000,000 or higher
September 23, 2011	\$1,250,000 or higher
September 23, 2012	\$2,000,000 or higher

In addition, group health plans can apply certain minimum threshold annual dollar limits to out-of-network nonessential benefits. Please refer to *Question and Answer 8* for more information on essential benefits.

Please note: The imposition of newly added annual limits, or revision to existing annual limits, could affect a plan's grandfathered status.

In addition, group health plans can no longer apply benefit-specific dollar limits to out-of-network inpatient and outpatient hospital services and supplies.

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Q8. What are “essential” benefits?

A8. Health care reform defines essential health benefits as the following health care service categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

The Minimum Standards mandate does not differentiate between essential and nonessential benefits; it distinguishes between in-network and out-of-network benefits. The Minimum Standards mandate does not allow annual dollar limits on in-network services. Because your group’s health plan is affected by both federal health care reform and the Minimum Standards mandate, annual dollar limits will be removed from in-network benefits.

Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning with plan years on or after September 23, 2010, there can be no pre-existing condition exclusions for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.



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Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents' coverage for plan years beginning on or after September 23, 2010.

To help reduce gaps in coverage for our members, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent's health coverage, to remain on their parent's health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.

Horizon BCBSNJ's early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents' coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- Generally, if a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent's employer. However, for plan years beginning before January 1, 2014, a grandfathered group health plan that offers dependent coverage to children may exclude an adult child who has not attained

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age 26 years from coverage only if the adult child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.

In addition, group health plans and insurers:

- May charge premiums based on tiers of coverage (e.g., Single plus one, Family, etc.).
- Cannot vary rates based on the age of a child under age 26 years.
- Cannot limit children to certain benefit packages.

Group health plans must give eligible dependents written notice of a 30-day special open enrollment period. The special open enrollment period must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:

- Notice to employees serves as the communication to the dependent. The notice may be provided with other open enrollment materials; however, it must also be prominently displayed.
- Coverage must be effective no later than the first day of the plan year and be retroactive, if necessary.
- Parents with a choice of coverage will be able to change their coverage option.

Q11. How are in-network copayments changing?

A11. Under the Minimum Standards mandate, in-network copayments in health plans and stand-alone prescription drug plans may not exceed certain dollar amounts.

Listed below is a brief summary of certain in-network copayment maximums required by state and federal law:

- Preventive care services – \$30.
- Primary Care Provider (PCP) office visit – \$50.
- Specialist physician office visit – \$75.

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- Emergency Room visit – \$100.
- Outpatient surgery – \$500.
- Inpatient admission – \$500 per day, up to a maximum of \$2,500 per admission.
- Magnetic Resonance Imaging (MRI), computerized axial tomography and positron emission tomography – \$100.
- Generic drug – \$25 per 30-day supply.
- Preferred drug – \$50 per 30-day supply.
- Non-Preferred drug – \$75 per 30-day supply.

Due to the Minimum Standards mandate, generally, in-network copayments cannot be applied to any service or supply to which in-network coinsurance is also applied. Horizon BCBSNJ has decided to keep copayments on PCP and specialist office visits and laboratory services. Horizon BCBSNJ will remove copayments and keep coinsurance for inpatient hospital and certain outpatient services (same-day surgery, ambulatory surgical centers). Emergency Room copayments can be maintained.

Q12. How is in-network coinsurance changing?

A12. Effective upon your group’s renewal date, beginning on or after September 8, 2010, network coinsurance, generally, cannot be applied to any service or supply:

- To which a network copayment is applied.
- Provided by a health care professional who is reimbursed through capitation. (Capitation is a reimbursement arrangement that pays the physician a set fee each month for each member who selects the physician as a PCP whether or not the member actually receives services.)

Please refer to *Question and Answer 11* for more information on how Horizon BCBSNJ will apply changes to in-network copayments and coinsurance.

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Q13. How are maximum out-of-pocket limits changing?

A13. For individual in-network, family in-network and individual out-of-network out-of-pocket limits, all amounts paid as copayment, coinsurance and deductible count toward the maximum out-of-pocket limit. Cost sharing for prescription drug coverage may be excluded from the maximum out-of-pocket limit.

Horizon BCBSNJ already counts these amounts toward members' maximum out-of-pocket limits, so members will not experience any changes as a result of this requirement.

For more information about the health care reform provisions and the Minimum Standards mandate and how they apply to your group health plan, please contact your broker or your Horizon BCBSNJ account representative.



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In March 2010, President Barack Obama signed into law two acts that have become the basis for federal health care reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care & Educational Reconciliation Act (HCERA), which amended the PPACA, was signed into law on March 30, 2010.

In addition to federal health care reform, the state of New Jersey passed legislation called the Minimum Standards for Health Benefit Plans, Prescription Drug Plans and Dental Plans (NJAC 11:22-5.1 through 5.9). This legislation is often referred to as the Minimum Standards mandate, and applies only to insured health plans, including health plans offered to employer groups with 51 or more employees.

Certain provisions of both federal health care reform and the Minimum Standards mandate will apply to your group’s Horizon Blue Cross Blue Shield of New Jersey health coverage. In those instances where the provisions conflict, Horizon BCBSNJ has applied the provision that provides the greater benefit for our members.

This document provides some information on the federal requirements that may affect your group’s Horizon BCBSNJ health coverage. This document is only a brief summary for informational purposes. For more information, please contact your broker or your Horizon BCBSNJ account representative. This document is not intended to serve as legal advice. For legal issues and advice regarding health care reform, please contact your legal counsel.



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Q1. When will the health care reform and Minimum Standards mandate changes become effective for my group’s Horizon BCBSNJ health plan?

A1. Federal health care reform changes will become effective upon your group’s plan year date, beginning on or after September 23, 2010.

Minimum Standard mandate changes will become effective upon your group’s renewal date, beginning on or after September 8, 2010.

Q2. Can group health plans “grandfather” their current Horizon BCBSNJ health coverage?

A2. The federal health care reform law permits that a health plan’s coverage that was in force on or before March 23, 2010, may be “grandfathered” so that it does not have to include some provisions required by the new law. Your group has opted not to grandfather its existing health coverage. Your group will adopt all of health care reform’s benefit enhancements.

Q3. How will federal health care reform and the Minimum Standards mandate affect my group’s Horizon BCBSNJ health plan?

- A3. Several health care reform provisions may affect your group’s health plan in the coming months, including:
- Changes to lifetime and annual dollar limits.
 - Increased access to preventive care.
 - Patient Protections related to Primary Care Provider (PCP) selection and Emergency Room (ER) visits.
 - The elimination of pre-existing condition limitations for individuals under age 19 years.
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The Minimum Standards mandate may affect your group’s health plan’s:

- In-network copayments.
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- Maximum out-of-pocket limits.
- Benefit maximums.

What actual changes must be made to comply with these laws will be determined by your group’s plan design.

Q4. How will lifetime dollar limits change?

A4. Health plans can no longer apply lifetime dollar limits to “essential” benefits. However, health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

For health plans that offer in-network benefits, the Minimum Standards mandate requires that no lifetime dollar limit be applied for any benefit.

For health plans that offer in- and out-of-network benefits, there can be no lifetime dollar limits on benefits that are considered essential. For nonessential out-of-network benefits, the lifetime dollar limit must be \$5 million or greater.

For health plans that are not network based (such as Indemnity plans), there can be no lifetime dollar limits on benefits that are considered essential benefits. For nonessential benefits, the lifetime dollar limit must be \$5 million or greater.

In addition, health plans can no longer apply benefit-specific dollar maximums to out-of-network inpatient and outpatient hospital services and supplies.

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Q5. How will annual dollar limits change?

A5. Generally, prior to January 1, 2014, group health plans can apply annual dollar limits to out-of-network essential benefits according to the following schedule:

Plan Year beginning on or after	Annual dollar limit on essential benefits
September 23, 2010	\$1,000,000 or higher
September 23, 2011	\$1,250,000 or higher
September 23, 2012	\$2,000,000 or higher

In addition, group health plans can apply certain minimum threshold annual dollar limits to out-of-network nonessential benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

In addition, group health plans can no longer apply benefit-specific dollar limits to out-of-network inpatient and outpatient hospital services and supplies.

Q6. What are “essential” benefits?

A6. Health care reform defines essential benefits as the following health care service categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

The Minimum Standards mandate does not differentiate between essential and nonessential benefits; it distinguishes between in-network and out-of-network benefits. The Minimum Standards mandate does not allow annual dollar limits on in-network services.

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Coverage for dependents under age 26

In-network copayments

In-network coinsurance

Maximum out-of-pocket limits

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Self-Insured Plans that are not Grandfathered

Because your group’s health plan is affected by both federal health care reform and the Minimum Standards mandate, annual dollar limits will be removed from in-network benefits.

Q7. How will benefits for preventive care services change?

A7. Health care reform requires certain preventive care services received in network or under a non-network-based health plan (such as an Indemnity plan) be covered with no cost sharing and no dollar limit. That means employees and their dependents who are covered under your group’s health plan will have a \$0 copayment for such preventive care services.

However, if your group’s health plan has in-network and out-of-network coverage, preventive care services received out of network will continue to be covered under your group’s current cost-sharing arrangement.

For a list of preventive care services affected by this requirement, please visit the U.S. Department of Health and Human Services’ website, <www.HealthCare.gov>.

Q8. What are “Patient Protections?” How does this affect my employees?

A8. Under New Jersey state law, employees and their dependents who are covered under your group’s Horizon BCBSNJ health plan, already have the Patient Protections defined by federal health care reform.

Federal health care reform’s Patient Protections pertain to access to:

- Participating Primary Care Providers (PCPs).
- Participating pediatricians as PCPs.
- Ob/Gyn care provided by participating Ob/Gyn providers.
- Emergency care.

If your group’s health plan requires or allows members to choose a PCP, members must be allowed to choose a participating pediatrician as a PCP for a child.

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A health plan cannot require female members to obtain prior authorization or a referral to visit a participating Ob/Gyn health care professional. The health plan may require Ob/Gyn professionals to follow the plan’s policies and procedures, including referrals and prior authorization. These requirements apply if your health plan provides coverage for Ob/Gyn care and it requires you to choose a PCP.

Coverage for emergency department services must be provided without prior authorization of services, even if the services are provided out of network. Coverage determinations must be based on a prudent layperson standard. Horizon BCBSNJ uses the following definition of a medical emergency:

A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily functions; or*
- *Serious dysfunction of a bodily organ or part.*

With respect to a pregnant woman who is having contractions, an emergency exists when there is not adequate time to safely transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child.

Out-of-network emergency services must be covered the same as in-network emergency services, including cost sharing (i.e., copayments or coinsurance) for both in-network and out-of-network services.

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Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning with plan years on or after September 23, 2010, there can be no pre-existing condition exclusions for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents’ coverage for plan years beginning on or after September 23, 2010.

To help reduce gaps in coverage for our members, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent’s health coverage, to remain on their parent’s health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.

Horizon BCBSNJ’s early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

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For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents' coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- If a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent's employer.

In addition, group health plans and insurers:

- May charge premiums based on tiers of coverage (e.g., Single plus one, Family, etc.).
- Cannot vary rates based on the age of a child under age 26 years.
- Cannot limit children to certain benefit packages.

Group health plans must give eligible dependents written notice of a 30-day special open enrollment period. The special open enrollment period must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:

- Notice to employees serves as the communication to the dependent. The notice may be provided with other open enrollment materials; however, it must also be prominently displayed.
- Coverage must be effective no later than the first day of the plan year and be retroactive, if necessary.
- Parents with a choice of coverage will be able to change their coverage option.

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Q11. How are in-network copayments changing?

A11. Under the Minimum Standards mandate, in-network copayments in health plans and stand-alone prescription drug plans may not exceed certain dollar amounts. However, federal health care reform legislation may require different network copayments. In any instance where state and federal legislation require different in-network copayments, Horizon BCBSNJ members will pay the lower copayment maximum.

Listed below is a brief summary of certain in-network copayment maximums required by state and federal law:

- Preventive care services – \$0 copayment, as required by health care reform.
- Primary Care Provider (PCP) office visit – \$50.
- Specialist physician office visit – \$75.
- Emergency Room visit – \$100.
- Outpatient surgery – \$500.
- Inpatient admission – \$500 per day, up to a maximum of \$2,500 per admission.
- Magnetic Resonance Imaging (MRI), computerized axial tomography and positron emission tomography – \$100.
- Generic drug – \$25 per 30-day supply.
- Preferred drug – \$50 per 30-day supply.
- Non-Preferred drug – \$75 per 30-day supply.

Generally, in-network copayments cannot be applied to any service or supply to which in-network coinsurance is also applied. Horizon BCBSNJ has decided to keep copayments on PCP and specialist office visits and laboratory services. Horizon BCBSNJ will remove copayments and keep coinsurance for inpatient hospital and certain outpatient services (same-day surgery, ambulatory surgical centers). Emergency Room copayments can be maintained.

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Q12. How is in-network coinsurance changing?

- A12. Effective upon your group’s renewal date, beginning on or after September 8, 2010, network coinsurance, generally, cannot be applied to any service or supply:
- To which a network copayment is applied.
 - Provided by a health care professional who is reimbursed through capitation. (Capitation is a reimbursement arrangement that pays the physician a set fee each month for each member who selects the physician as a PCP whether or not the member actually receives services.)

Please refer to *Question and Answer 11* for more information on how Horizon BCBSNJ will apply changes to in-network copayments and coinsurance.

Q13. How are maximum out-of-pocket limits changing?

- A13. For individual in-network, family in-network and individual out-of-network out-of-pocket limits, all amounts paid as copayment, coinsurance and deductible count toward the maximum out-of-pocket limit. Cost sharing for prescription drug coverage may be excluded from the maximum out-of-pocket limit.

Horizon BCBSNJ already counts these amounts toward members’ maximum out-of-pocket limit, so members will not experience any changes as a result of this requirement.

For more information about the health care reform requirements and the Minimum Standards mandate and how they apply to your group’s health plan, please contact your broker or your Horizon BCBSNJ account representative.



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How Health Care Reform applies to Self-Insured Plans that are Grandfathered

In March 2010, President Barack Obama signed into law two acts that have become the basis for federal health care reform. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care & Educational Reconciliation Act (HCERA), which amended the PPACA, was signed into law on March 30, 2010.

This document provides some information on the federal requirements that may affect your group’s coverage, which is administered by Horizon Blue Cross Blue Shield of New Jersey. This document is only a brief summary for informational purposes. For more information, please contact your broker or your Horizon BCBSNJ account representative. This document is not intended to serve as legal advice. For legal issues and advice regarding health care reform, please contact your legal counsel.

Q1. When will the health care reform changes become effective for my group health plan?

A1. Federal health care reform changes will become effective upon your group’s plan year date, beginning on or after September 23, 2010.

Q2. Can group health plans “grandfather” their current health coverage?

A2. Yes. The federal health care reform law provides that a health plan’s coverage that was in force on or before March 23, 2010, may be “grandfathered” so that it does not have to include some provisions required by the new law. Grandfathered status applies separately to each benefit option offered under a group health plan.

Your group has opted to grandfather its current health coverage, so only some of health care reform’s changes will apply to your group’s health plan.

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Q3. Are there changes that may cause a group health plan to lose its grandfathered status?

- A3. The following are some examples of changes that may cause a health plan to lose its grandfathered status:
- A merger, acquisition or similar business restructuring, if the principle purpose of such action is to cover new individuals under the grandfathered plan;
 - The elimination of all (or substantially all) benefits to diagnose or treat a particular condition;
 - Any increase in cost-sharing percentage (e.g., coinsurance) above the level in effect on March 23, 2010;
 - Certain increases in fixed-amount cost sharing requirements, other than a copayment;
 - Certain increases in a fixed-amount copayment;
 - Certain decreases by an employer or employee organization in its contribution rate;
 - The imposition of a newly added overall annual limit on the dollar value of benefits.

There are separate rules for collectively bargained plans.

For legal issues and advice regarding grandfathering and health care reform in general, please contact your legal counsel.

Q4. What plan changes can group health plans make and maintain grandfathered status?

- A4. Provided changes are made without exceeding the health care reform grandfathering rules, generally, the following changes can be made without the group health plan losing its grandfathered status:
- The addition of family members of an individual who is enrolled in a grandfathered plan;
 - The addition of new employees of an employer who are enrolled in a grandfathered plan;
 - Changes in premiums;
 - Changes required to conform to federal and state requirements;
 - Voluntary compliance with PPACA;
 - Changing third-party administrators (TPAs).

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There are separate rules for collectively bargained plans.

For legal issues and advice regarding grandfathering and health care reform in general, please contact your legal counsel.

Q5. How will federal health care reform affect group health plans?

A5. Several health care reforms provisions may affect your group’s health plan in the coming months, including:

- Changes to lifetime and annual dollar limits.
- The elimination of pre-existing condition limitations for individuals under age 19 years.
- Coverage for dependents under age 26 years.

What actual changes must be made to comply with the laws will be determined by your group health plan design.

Q6. How will lifetime dollar limits change?

A6. Group health plans can no longer apply lifetime dollar limits to “essential” benefits. However, group health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 8* for more information on essential benefits.

Q7. How will annual dollar limits change?

A7. Generally, prior to January 1, 2014, group health plans can apply annual dollar limits to essential benefits according to the following schedule:

For Plan Years beginning on or after	Annual dollar limit on essential benefits
September 23, 2010	\$750,000 or higher
September 23, 2011	\$1,250,000 or higher
September 23, 2012	\$2,000,000 or higher

In addition, health plans can apply annual dollar limits to nonessential benefits. Please refer to *Question and Answer 8* for more information on essential benefits.

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Please note: The imposition of newly added annual limits, or revision to existing annual limits, could affect a plan's grandfathered status.

Q8. What are “essential” benefits?

A8. Health care reform defines essential benefits as the following health care service categories:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning with plan years on or after September 23, 2010, there can be no pre-existing condition exclusions for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person's enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents' coverage for plan years beginning on or after September 23, 2010.



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To help reduce gaps in coverage for our members, for Horizon BCBSNJ’s insured plans and as requested by our self-insured plan customers, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent’s health coverage, to remain on their parent’s health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.

Horizon BCBSNJ’s early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents’ coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- Generally, if a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent’s employer. However, for plan years beginning before January 1, 2014, a grandfathered group health plan that offers dependent coverage to children may exclude an adult child who has not attained age 26 years from coverage only if the adult child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.



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In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:

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A1. Federal health care reform changes will become effective upon your group’s plan year date, beginning on or after September 23, 2010.

Q2. Can group health plans “grandfather” their current health coverage?

A2. The federal health care reform law permits that a health plan’s coverage that was in force on or before March 23, 2010, may be “grandfathered” so that it does not have to include some provisions required by the new law. Your group has opted not to grandfather its existing plan. Your group will adopt all of health care reform’s benefit enhancements.

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Q3. How will federal health care reform affect group health plans?

- A3. Several health care reform provisions may affect your group health plan in the coming months, including:
- Changes to lifetime and annual dollar limits.
 - Increased access to preventive care.
 - Patient Protections related to Primary Care Provider (PCP) selection and Emergency Room (ER) visits.
 - The elimination of pre-existing condition limitations for individuals under age 19 years.
 - Coverage for dependents under age 26 years.

What actual changes must be made to comply with the laws will be determined by your group health plan design.

Q4. How will lifetime dollar limits change?

- A4. Group health plans can no longer apply lifetime dollar limits to “essential” benefits. However, group health plans can apply lifetime dollar limits to “nonessential” benefits. Please refer to *Question and Answer 6* for more information on essential benefits.

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- Rehabilitative and habilitative services and chronic care management.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

Q7. How will benefits for preventive care services change?

A7. Health care reform requires certain preventive care services received in network or under a non-network-based health plan (such as an Indemnity plan) be covered with no cost sharing and no dollar limit. That means your employees and their dependents who are covered under your group health plan will have a \$0 copayment for such preventive care services.

However, if your group health plan has in-network and out-of-network coverage, preventive care services received out of network will continue to be covered under your group health plan’s current cost-sharing arrangement.

For a list of preventive care services affected by this requirement, please visit the U.S. Department of Health and Human Services’ website, <www.HealthCare.gov>.

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Q8. What are “Patient Protections?” How does this affect my employees?

A8. Federal health care reform’s Patient Protections pertain to access to:

- Participating Primary Care Providers (PCPs).
- Participating pediatricians as PCPs.
- Ob/Gyn care provided by participating Ob/Gyn providers.
- Emergency care.

If your group health plan requires or allows members to choose a PCP, members must be allowed to choose a participating pediatrician as a PCP for a child.

A group health plan cannot require female members to obtain prior authorization or a referral to visit a participating Ob/Gyn health care professional. The group health plan may require Ob/Gyn professionals to follow the plan’s policies and procedures, including referrals and prior authorization. These requirements apply if your group health plan provides coverage for Ob/Gyn care and it requires members to choose a PCP.

Coverage for emergency department services must be provided without prior authorization of services, even if the services are provided out of network. Coverage determinations must be based on a prudent layperson standard. Horizon BCBSNJ uses the following definition of a medical emergency:

A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
- *Serious impairment to bodily functions; or*
- *Serious dysfunction of a bodily organ or part.*

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With respect to a pregnant woman who is having contractions, an emergency exists when there is not adequate time to safely transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child.

Out-of-network emergency services must be covered the same as in-network emergency services, including cost sharing (i.e., copayments or coinsurance) for both in-network and out-of-network services.

Q9. When will the pre-existing condition limitation be removed for individuals under age 19 years?

A9. Beginning with plan years on or after September 23, 2010, there can be no pre-existing condition exclusions for individuals under age 19 years.

A pre-existing condition is defined as an illness or injury, whether physical or mental, which manifests itself in the six months before a covered person’s enrollment date, and for which medical advice, diagnosis, care or treatment would have been recommended or received in the six months before his/her enrollment date.

Q10. How is Horizon BCBSNJ implementing the provision that makes coverage available to dependents under age 26 years?

A10. All children who are under age 26 years are eligible under the law to be covered under their parents’ coverage for plan years beginning on or after September 23, 2010.

To help reduce gaps in coverage for our members, for Horizon BCBSNJ’s insured plans and as requested by our self-insured plan customers, Horizon BCBSNJ began to allow dependents under age 26 years without health coverage or those aging out of their parent’s health coverage, to remain on their parent’s health coverage, effective May 1, 2010. This was initiated before the federal effective date which corresponds to plan years beginning on or after September 23, 2010.



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Horizon BCBSNJ’s early extension of coverage does not include dependent children who currently have other health insurance including, but not limited to:

- New Jersey Dependent Under Age 31 (DU31) coverage.
- An individual (IHC) policy.
- Employer-based coverage.
- COBRA and other (state) continuation coverages.

For plan years beginning on or after September 23, 2010, the exceptions Horizon BCBSNJ applied to its early extension of coverage will no longer apply. Generally, that means:

- Dependent children who are already covered by health insurance will be able to enroll in their parents’ coverage during open enrollment.
- Dependent children cannot be denied coverage based on eligibility for other coverage.
- If a dependent child is eligible for coverage under the employer health plans of both parents, neither health plan may exclude the child from coverage based on the fact that the child is eligible to enroll in the health plan of the other parent’s employer.

In addition, group health plans and insurers:

- May charge premiums based on tiers of coverage (e.g., Single plus one, Family, etc.).
- Cannot vary rates based on the age of a child under age 26 years.
- Cannot limit children to certain benefit packages.

Group health plans must give eligible dependents written notice of a 30-day special open enrollment period. The special open enrollment period must begin no later than the first day of the first plan year beginning on or after September 23, 2010.



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In addition to the eligibility, benefit and rate information listed above, group health plans should consider the following key points when they communicate to members and eligible dependents:

- Notice to employees serves as the communication to the dependent. The notice may be provided with other open enrollment materials; however, it must also be prominently displayed.
- Coverage must be effective no later than the first day of the plan year and be retroactive, if necessary.
- Parents with a choice of coverage will be able to change their coverage option.

For more information about the health care reform requirements and how they apply to your group health plan, please contact your broker or your Horizon BCBSNJ account representative.

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