HorizonBlue.com

Brief Notes

News for Brokers and Consultants

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Applies to: All markets, excluding senior market

Overview of ACA Mandates Affecting Health Plans in 2014

Several mandates under the Affordable Care Act (ACA) will affect health plans in 2014. This *Brief Notes* provides information about the mandates listed below and the impact each will have on health plans:

- 90-day Waiting Period Limitation.
- Maximum Out-of-Pocket (MOOP) Limits.
- Mandatory Coverage for Clinical Trials.
- Removal of Pre-existing Condition Limitations.
- Coverage for Dependents up to Age 26 Years.

Horizon Blue Cross Blue Shield of New Jersey is working with relevant stakeholders to understand the full impact of other ACA requirements and to implement business practices related to the topics listed below and others. We will provide this information as it becomes available.

- Late enrollees.
- Small groups (e.g., "Mom and Pop" shops) enrolling on the Small Business Health Options Program (SHOP) versus off SHOP.
- Small groups moving to the 51-plus market.
- Stand-alone Pediatric Dental Benefits (SAPD).

Please read this *Brief Notes* and contact your Horizon BCBSNJ sales executive or account manager with any questions.

90-day Waiting Period Limitation

Effective for plan years beginning on or after January 1, 2014, the ACA prohibits group health plans and health insurance issuers from imposing waiting periods greater than 90 days. A waiting period is the period of time that must pass before a person is eligible to receive benefits under the group health plan.

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For group health plans with waiting periods greater than 90 days, Horizon BCBSNJ will adjust the waiting period to be 90 days to ensure that plans comply with this new rule. Group health plans may choose a different compliant waiting period on their anniversary date by notifying us in writing.

For the groups in the Small Employer (two to 50 employees) and Mid-Size Standard (51 to 99 employees) markets, this change is effective January 1, 2014. Additionally, effective January 1, 2014, any person who has fulfilled 90 days or more of the group health plan's current waiting period requirement will be enrolled effective January 1, 2014.

For groups with 51 or more employees that have custom group health plans, this change will be effective upon the first plan year on or after January 1, 2014. Any person who has fulfilled 90 days or more of the group health plan's current waiting period requirement will be enrolled upon the first day of the group's new plan year.

The regulations impose a shared responsibility for compliance with this rule. As such, Horizon BCBSNJ expects group health plans to supply Horizon BCBSNJ with enrollment forms and member eligibility information so the member may be timely enrolled in accordance with the 90-day waiting period limitation. This means group health plans may have to submit member enrollment information to Horizon BCBSNJ earlier than in the past to ensure that group health plans do not enroll a member with a waiting period greater than 90 days.

Some group health plans that previously had waiting periods longer than 90 days may be required to start their premium contribution sooner for these members who are eligible sooner than in the past.

Maximum Out-of-Pocket (MOOP) Limits
The maximum out-of-pocket (MOOP) is the annual limit on the amount of cost sharing individuals are required to pay out of pocket for covered health care costs, excluding premiums.

Effective for plan and policy years beginning on or after January 1, 2014, the ACA prevents an employer and a health insurance issuer from imposing cost sharing greater than the current out-of-pocket limits for high-deductible health plans with respect to in-network Essential Health Benefits (EHBs). As of 2014, those limits are $6,350 for an individual policy or $12,700 for a family policy. These amounts may be adjusted annually by the Internal Revenue Service (IRS).

In addition to changes to the limits, there are changes to the costs that contribute to the MOOP:

- Copayments, coinsurance and deductibles for all in-network plan benefits generally apply toward the MOOP.
- For 2014 plan years, when a plan uses a separate administrator for carve-out benefits, such as prescription drug and mental health, each separately administered benefit may have a separate MOOP so long as each is capped at $6,350 for an individual policy and $12,700 for a family policy. Additionally, if the separately administered prescription drug benefit did not previously have a MOOP limit, plans are not generally required to set a MOOP limit specific to that benefit for its 2014 plan year only under the current federal safe harbor guidance.
- All benefits are intended to accumulate toward a single MOOP for plan years that begin on or after January 1, 2015 unless otherwise later modified by the appropriate regulatory bodies. For purposes of Horizon BCBSNJ individual and small employer health plans in 2014, both medical and prescription drug in-network benefits will count toward the MOOP.

This mandate affects non-grandfathered plans, and currently applies to in-network benefits only. Please note that some plans may have a separate MOOP for out-of-network benefits in amounts consistent with applicable state rules.

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Health plan contracts will be updated to conform with this mandate. Groups affected by this mandate will be notified by their account manager to initiate changes.

Mandatory Coverage for Clinical Trials
Effective for plan and policy years beginning on or after January 1, 2014, a health insurance issuer and a group health plan must cover the routine-care costs in connection with a qualified individual's participation in a Phase I through Phase IV clinical trial for cancer or other life-threatening disease or condition.

Routine care is defined as services that are otherwise covered under the plan and does not include:

- The investigational item, device or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Investigational procedures are not covered.

Removal of Pre-existing Condition Limitations
Under the ACA, health insurance issuers cannot refuse to sell coverage or renew coverage because of a pre-existing medical condition and cannot deny claim reimbursements because of a pre-existing medical condition.

Pre-existing medical condition limitations do not apply to any new ACA-compliant health plans effective for plan and policy years beginning on or after January 1, 2014.

For existing health plans, the pre-existing condition limitation will be removed as follows:

- Individual Market – Limitation removed upon renewal on or after January 1, 2014.
- Small Employer, Mid-Size (51 to 99 employees; standard plan designs) and Public Sector Markets – Limitation removed effective January 1, 2014.
- Mid-Size/Large Group Markets (51 or more employees; custom plan designs) – Limitation removed upon renewal on or after January 1, 2014.

The removal of the pre-existing condition limitation has been in place since 2010 for members under age 19 years and is now expanded to members ages 19 years and older.

Coverage for Dependents up to Age 26 Years
Effective for plan and policy years beginning on or after January 1, 2014, a grandfathered health plan that provides dependent coverage may not exclude an adult child who has not attained age 26 years from coverage even if the child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.