BlueCross BlueShield Nebraska

Questions and Answers

For members of
NMA Group Health Plan*

For plans effective Jan. 1, 2024, and after

NEBRASKA MEDICAL ASSOCIATION
group health plan

*NMA Employers Insurance Consortium d/b/a NMA Group Health Plan

NMA Group Health Plan
Questions and Answers

In conjunction with the NMA Group Health Plan, Blue Cross and Blue Shield of Nebraska (BCBSNE) is offering a variety of health care coverage options to NMA-member groups and employees. NMA is excited to make this plan available to you! Throughout the plan development process, a number of questions have been received, which are addressed below.

What are some advantages of the NMA Group Health Plan?

Advantages of this plan include:

- Physician early retiree benefit
- Physician surviving spouse benefit
- Subgroups may consist of the clinic's staff without the physician

What are the criteria to determine if a subgroup is eligible for group coverage with BCBSNE?

There are certain eligibility requirements each subgroup must meet to be eligible to participate in the NMA Group Health Plan offered through BCBSNE. These include employer contribution requirements, employee participation requirements and employee eligibility requirements. The specifics of each are described below. In addition, three examples are provided to illustrate situations where groups meet or do not meet eligibility and participation requirements. Examples A and C are scenarios where the group does meet the requirements and Example B is one where the group does not meet the requirement.

NMA Membership – Each physician covered under the NMA Group Health Plan must have an active NMA membership.

Employer Contribution Requirement – Groups must contribute a minimum of 50% of the single-employee premium for all eligible employees enrolled with the subgroup excluding shareholders, partners and owners.

Eligibility Requirement – Employees of groups with less than 50 employees must work at least 17.5 hours per week to satisfy the eligibility requirement. Groups with 50 or more employees may set the minimum threshold to determine employee eligibility as low as 17.5 work hours per week, but no higher than 30 hours per week.

Participation Requirement – Each subgroup must meet minimum participation requirements of 75% of net eligible employees, less valid waivers, but with no less than 25% of total eligible employees; or 50% of gross total eligible employees.

› EXAMPLE A – 75% net/gross participation rule IS NOT met, but the 50% gross participation rule IS. This group WOULD QUALIFY.

This group has six employees; five meet eligibility requirements and one does not.

Physician #1 is married, meets eligibility, has an individual policy elsewhere and is declining coverage (invalid waiver).

Physician #2 is single, meets eligibility and is applying for coverage.

Nurse #1 is married, meets eligibility, has an individual policy elsewhere and is declining coverage (invalid waiver).

Nurse #2 is married, meets eligibility and is applying for coverage.

Office assistant #1 works 20 hours per week, is single, meets eligibility and is applying for coverage.

Office assistant #2 works 15 hours per week, which doesn't meet the minimum requirement, so they are ineligible.

Although this group does not satisfy the 75% net/gross due to low gross participation, it is eligible because its 60% gross participation does satisfy the 50% gross rule.

EXAMPLE 1	75% Net/Gross Rule	50% Gross Rule
1. Total eligible employees on the payroll on the effective date of the contract	5	5
2. Eligible employees not enrolling due to other group coverage, Medicare or Medicaid (valid waivers)	0	N/A
3. Eligible employees not enrolling due to individual coverage, other or unknown reasons (invalid waivers)	2	N/A
4. Total employees enrolling	3	3
5. Total employees eligible minus valid waivers (line 1 - line 2)	5	N/A
6. Gross percentage of employees enrolling (line 4 ÷ line 1)	60%	60%
7. Net percentage of employees enrolling (Enrolling employees ÷ eligible employees - line 4 ÷ line 5)	60%	N/A

› EXAMPLE B – Neither net/gross participation of 75% nor participation of 50% is met – GROUP WOULD NOT QUALIFY.

This group has five employees; five meet eligibility requirements.

Physician #1 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Physician #2 is single, meets eligibility, but has Medicare and is declining coverage (valid waiver).

Nurse #1 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Nurse #2 is married, meets eligibility and is applying for coverage.

Office assistant #1 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

In this case, NEITHER PARTICIPATION RULE IS MET. In order to meet the 75% net rule, at least 50% gross total participation must be met.

EXAMPLE 2	75% Net/Gross Rule	50% Gross Rule
1. Total eligible employees on the payroll on the effective date of the contract	5	5
2. Eligible employees not enrolling due to other group coverage, Medicare or Medicaid (valid waivers)	3	N/A
3. Eligible employees not enrolling due to individual coverage, other or unknown reasons (invalid waivers)	0	N/A
4. Total employees enrolling	1	1
5. Total employees eligible minus valid waivers (line 1 - line 2)	2	5
6. Gross percentage of employees enrolling (line 4 ÷ line 1)	20%	20%
7. Net percentage of employees enrolling (Enrolling employees ÷ eligible employees - line 4 ÷ line 5)	50%	N/A

› EXAMPLE C – Net participation of 75% is met but gross 50% of eligible is not.

This group of seven employees; ALL meet eligibility requirements.

Physician #1 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Physician #2 is single, meets eligibility, but has Medicare and is declining coverage (valid waiver).

Physician #3 is married, meets eligibility and is applying for coverage.

Nurse #1 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Nurse #2 is married, meets eligibility and is applying for coverage.

Office assistant #1 is married, meets eligibility, has coverage through an individual plan and is declining coverage (invalid waiver).

Office assistant #2 is single, meets eligibility and is applying for coverage.

75% net/gross met, 50% gross NOT met.

EXAMPLE 3	75%/25% Net/Gross Rule	50% Gross Rule
1. Total eligible employees on the payroll on the effective date of the contract	7	7
2. Eligible employees not enrolling due to other group coverage, Medicare or Medicaid (valid waivers)	3	N/A
3. Eligible employees not enrolling due to individual coverage, other or unknown reasons (invalid waivers)	1	N/A
4. Total employees enrolling	3	3
5. Total employees eligible minus valid waivers (line 1 - line 2)	4	N/A
6. Gross percentage of employees enrolling (line 4 ÷ line 1)	43%	43%
7. Net percentage of employees enrolling (Enrolling employees ÷ eligible employees - line 4 ÷ line 5)	75%	N/A

What is the definition of a "valid waiver"?

A valid waiver is the opportunity to opt out of a health plan by making a formal request under certain circumstances. Approved circumstances include coverage under another group policy, Medicare, Medicaid or TRICARE. Individual policies are not considered valid.

How do the rate bands work?

BCBSNE will assign your group to one of 12 rating bands (1-12) based on the risk score for your group.

The rate band assigned to the subgroup will be dependent upon the medical risk factor developed from the individual medical questionnaires or from the GRx census. If additional information is available, i.e., paid claims experience, large claims activity, prior carrier data, etc., this will also be factored in when determining the rate band.

Once you complete and submit your health enrollment application to your broker, each group will be reviewed by BCBSNE's Medical Underwriting team and placed into a rate band based on the overall health risk of the group.

Will a subgroup covered under the NMA Group Health Plan ever have the opportunity to change rate bands?

Subgroups that are renewing will be subject to rate band adjustments as long as they have 13 months of paid claims experience with the NMA Group Health Plan. Changes will be limited to up to two rate bands in any one rating period.

BCBSNE will also review the overall health risk of each group with the potential to move groups up to two rate bands per year based on the overall health status of enrolled employees and dependents within each group. Limiting the group to up to two rate bands, will help stabilize the experience and rates for the NMA Group Health Plan, and the individual groups within the health plan. This will only be done annually as part of the NMA Group Health Plan renewal.

Is enrollment the only way we can find out how much coverage costs? Can we decline coverage after receiving our rate quote, or do we have to accept it?

If you choose not to enroll based on the rate table assigned to your group, your group can decline coverage. You may reconsider enrolling at a future enrollment period. Updated health enrollment applications will be required.

Is the assigned rate band the same for the entire group or does it depend on each enrollee?

The assigned rate band will be the same for the entire group.

Does the plan require eligible employees to enroll in coverage in order for their dependents and spouses to obtain coverage?

Yes.

Who is the plan available to?

Each applicant subgroup employer must meet the following requirements:

a. Is a Nebraska duly organized and validly existing corporation, limited liability company, partnership, sole proprietorship, or other entity that complies with the laws of the State of Nebraska;

b. Qualifies as an entity that provides medical care, treatment, and/or services in the State of Nebraska;

c. Constitutes an employer as defined under ERISA § 3(5);

d. Employs at least one common law employee in the State of Nebraska;

e. Is controlled by physician(s) who are member(s) in good standing of the Nebraska Medical Association (NMA); and

f. Elects to participate in the Plan and executes a Plan Subgroup Application.

Are there limitations on pre-existing conditions?

There are no pre-existing condition limitations with the NMA Group Health Plan.

I am a sole proprietor. Can I be covered under this plan?

Not currently. However, if you have an employee working 17.5 or more hours per week, you are not considered a sole proprietor and are eligible for coverage as a two-person group.

Are 1099 employees allowed on the plan?

Seasonal employees are eligible to obtain coverage through a subgroup only during the period they are actively employed and only if their scheduled work hours during that period of time will exceed an average of the same number of hours per week over an entire year as required for the subgroup.

If my group moves to the NMA Group Health Plan from our current insurance plan, will there be a gap in coverage or double coverage?

In order to ensure there is no gap in coverage or double coverage, cancellation of a current policy will need to take place the day before this policy goes into effect.

Who is considered an eligible employee?

BCBSNE's underwriting guidelines define eligible employees as all regular full-time and permanent part-time employees (not including seasonal or temporary employees), who are actively performing the duties of their principal occupation for the required hours per week. "Actively at work" requirements shall be applied in a manner consistent with HIPAA nondiscrimination rules.

Example for groups 2-49 – An eligible employee for coverage is defined as an employee actively performing duties for a minimum of 17.5 hours per week and no cap as a maximum.

Example for groups 50+ – Groups may set the minimum work hour threshold to determine employee eligibility as low as 17.5 hours per week or as high as 30 hours per week.

We have an employee who currently has coverage with her spouse's plan. She may want NMA Group Health Plan coverage at a later date if the spouse retires early. Is that OK?

Yes, if an employee currently has coverage through their spouse, and subsequently loses coverage as a result of the spouse's retirement, that is considered a special enrollment period. That person could then enroll in the NMA Group Health Plan at that time, provided their group is participating in the health plan. They will have 31 days to enroll in the coverage.

If a subgroup terminates NMA Group Health Plan coverage, can the subgroup reapply at a later date?

If a subgroup discontinues coverage, they must wait 24 months from the date of cancellation to re-apply.

What are my plan and network options?

- **Groups with 2-49 enrolled employees** can select up to two medical plan options and any combination of our three networks.
- **Groups with 50+ enrolled employees** can select up to three medical plan options and any combination of our three network options.

Can employer and employee premiums be paid with pre-tax dollars?

Typically they can both pay for medical coverage through the NMA Group Health Plan using pretax dollars. The NMA Group Health Plan is a group health plan that qualifies for positive tax treatment. Employers should seek guidance from their own tax counsel on their specific terms.

Is more detailed information available on the options?

Yes, please contact FNIC Group at 402-861-7059 or email scott.morris@fnicgroup.com to receive a complete schedule of benefits for the plan(s) that interest you.

GET STARTED

Contact:

Scott Morris, Sr. Vice President

FNIC Group

P: 402-861-7059

scott.morris@fnicgroup.com

Include the following:

- Group or office name, address and phone number
- Total number of eligible employees

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