BlueCross BlueShield Nebraska

LIGHT FAQs

For members of the League Insurance Government Health Team

For plans effective July 1, 2023, and after

LIGHT
Frequently Asked Questions

In conjunction with the League of Nebraska Mutualities (LONM), Blue Cross and Blue Shield of Nebraska (BCBSNE) is offering a variety of health care coverage options available to LONM member municipalities and their employees. This plan is known as the League Insurance Government Health Team (LIGHT), which is supported by LONM. LIGHT 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 is the eligibility criteria for group coverage with BCBSNE?

There are certain eligibility requirements to be eligible to participate in the LIGHT Association Health Plan (AHP) offered through BCBSNE. These include employer contribution requirements, employee participation requirements and employee eligibility requirements. The specifics of each of these requirements are described below. In addition, three examples are provided to illustrate situations where subgroups meet or do not meet eligibility and participation requirements. Examples 1 and 3 are scenarios where the subgroup does meet the requirements and Example 2 is one where the subgroup does not meet the requirement.

Employer Contribution Requirement – Subgroups must contribute a minimum of 50% of the single employee premium for all eligible employees enrolled with the subgroup.

Eligibility Requirement – Employees must work at least 17.5 hours per week to satisfy the eligibility requirements, and subgroups with 50 or more employees, cannot set the minimum hours of work for eligibility higher than 30 hours per week.

Participation Requirement – Each subgroup must meet one of the two following criteria: 1) 75% (net) of all eligible employees less valid waivers, but with no less than 25% (gross) of total eligible employees, or 2) 50% (gross) of total eligible employees.

› EXAMPLE 1 – 75%/25% net/gross participation rule IS NOT met, but the 50% gross participation rule IS. This subgroup WOULD QUALIFY.

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

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

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

Employee #3 is married, meets eligibility, has an individual policy elsewhere and is declining coverage (invalid waiver).

Employee #4 is married, meets eligibility and is applying for coverage.

Employee #5 works 20 hours per week, is single, meets eligibility and is applying for coverage.

Employee #6 works 15 hours per week, which doesn't meet the minimum requirement, so they are ineligible.

Although this subgroup does not satisfy the 75%/25% net/gross due to low gross participation, it is eligible because its 60% gross participation does satisfy the 50% gross rule.

EXAMPLE 1	75%/25% 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 2 – Neither net/gross participation of 75%/25% nor gross participation of 50% is met – SUBGROUP WOULD NOT QUALIFY.

This subgroup has five employees; five meet eligibility requirements.

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

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

Employee #3 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Employee #4 is married, meets eligibility and is applying for coverage.

Employee #5 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 25% gross total participation must be met.

EXAMPLE 2	75%/25% 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)	4	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)	1	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)	100%	N/A

› EXAMPLE 3 – Net/gross participation of 75%/25% IS met, but gross participation of 50% is NOT met – SUBGROUP WOULD QUALIFY.

This subgroup of seven employees; ALL meet eligibility requirements.

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

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

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

Employee #4 is married, meets eligibility, has coverage through spouse's employer group plan and is declining coverage (valid waiver).

Employee #5 is married, meets eligibility and is applying for coverage.

Employee #6 is married, meets eligibility, has coverage through an individual plan and is declining coverage (invalid waiver).

Employee #7 is single, meets eligibility and is applying for coverage.

75%/25% 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 and what qualifies as one?

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 tables work?

BCBSNE will assign your subgroup to one of 15 rating tables (1-15) based on the risk score for your subgroup.

The rate band assigned to the subgroup will be dependent upon the medical risk factor developed from the individual medical questionnaires or from the 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 McInnes Group or your current agent/broker, each subgroup will be reviewed by BCBSNE's Medical Underwriting team and placed into a rate table based on the overall health risk of the subgroup.

Will a subgroup covered under the LIGHT ever have the opportunity to change rate tables?

Subgroups that are renewing will be subject to rate band adjustments if they have 13 months of paid claims experience with LIGHT. Changes will be limited to two rate bands, up or down, in any one rating period. BCBSNE will review the overall health risk of each subgroup with the potential to move subgroups up or down one or two rate tables per year based on the overall health status of enrolled employees and dependents within each subgroup. Limiting the subgroup to two rate bands up or down, will help stabilize the experience and rates for the LIGHT health plan, and the individual subgroups within the health plan. This will only be done annually as part of the LIGHT health plan's renewal.

BCBSNE will also review the overall health risk of each subgroup with the potential to move subgroups up or down one or two rate tables per year based on the overall health status of enrolled employees and dependents within each subgroup. Limiting the subgroup to one or two rate bands up or down, will help stabilize the experience and rates for the LIGHT health plan, and the individual subgroups within the health plan. This will only be done annually as part of the LIGHT 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 subgroup, your subgroup 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 subgroup or does it depend on each enrollee?

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

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

Yes.

Who is the plan available to?

Each subgroup applicant employer must meet the following requirements to be eligible for coverage:

a. Is a city or village in Nebraska;

b. Constitutes an employer as defined under ERISA Section 3(5);

c. Employs at least one common law employee in Nebraska; and

d. Is a dues-paying member in good standing with the League of Nebraska Municipalities.

Are there limitations on pre-existing conditions?

There are no pre-existing condition limitations on the LIGHT group health plan.

Are seasonal employees allowed on the plan?

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

If my subgroup moves to the LIGHT plan from our current insurance plan, will there be a gap in coverage or double coverage?

To ensure there is no gap in coverage or double coverage, cancellation of a current policy will need to take place before coverage under the LIGHT health plan 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 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 non-discrimination rules and with the terms of the LIGHT membership agreement.

Example for subgroups 2-49 – An eligible employee is defined as an employee actively performing work for a minimum of 17.5 hours per week.

Example for subgroups 50+ – An eligible employee is defined as an employee actively performing work for a minimum of 17.5 hours per week and a maximum of 30 hours per week.

We have an employee who currently has coverage with her spouse's plan. She may want LIGHT coverage later if the spouse retires early. Is that OK?

Yes, if an employee currently has coverage through his or her 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 LIGHT health plan at that time, provided his or her subgroup is participating in the health plan. They will have 31 days to enroll in the coverage.

If a subgroup terminates coverage through LIGHT, 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?

› **Subgroups with 2-49 enrolled employees** can select up to two medical plan options and any combination of our three networks.

› **Subgroups 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 AHPs using pretax dollars. The LIGHT 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 Dennis Maggart at (Dennis@McInnesGroup.com) or Jane Limbach (Jane@McInnesGroup.com) for more information.

GET STARTED

Contact:

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Include the following:

- Municipality's, address and phone number
- Total number of eligible employees