Legislative Highlights
March 2014

BlueCross BlueShield of Illinois

Federal Government Releases Final Rule on Employer Shared Responsibility

On Feb. 10, 2014, the Internal Revenue Service released its **final rule** on the Employer Shared Responsibility provisions of the Affordable Care Act (ACA).

Highlights from the new guidance include the following:

- Exempts employers with between 50 and 99 full-time employees from the shared responsibility penalty until 2016, if the employer provides an appropriate certification and meets certain conditions.
- To avoid a penalty in 2015, employers subject to the mandate must offer coverage to 70 percent of their full-time employees or risk penalties for failure to offer coverage to all full-time employees and dependents.

To avoid a penalty in 2016, employers subject to the mandate must offer coverage to 95 percent of their full-time employees (and dependents).*

*Note: This rule applies whether the failure to offer coverage is intentional or unintentional. However, this rule does not shield the employer from the penalty for offering inadequate coverage if any of the full-time employees, including those who are not offered coverage at all, receive a premium tax credit or cost-sharing subsidy for purchasing coverage through the Health Insurance Marketplace.

Federal Government Releases Final Rule and Separate Proposed Rule on 90-day Waiting Period

The U.S. Departments of Health and Human Services, Labor and the Treasury released a **final rule** on Feb. 20, 2014, on the 90-day waiting period provision of the Affordable Care Act. The provision mandates that health insurance coverage be made available to "otherwise eligible" employees and their dependents no later than 90 calendar days from an employee's eligibility date.

The federal agencies also released a separate proposed rule on what constitutes a "reasonable and bona fide employment-based orientation period" related to meeting a plan's substantive eligibility conditions for the 90-day waiting period.

We are currently reviewing the final rule and **proposed rule** and will provide more information as it becomes available.

Health Care Reform Overview Charts Available

New Health Care Reform Overview Charts provide a summary of the major Affordable Care Act (ACA) provisions in an easy-to-read format. These charts include effective dates, a brief description of the provisions, and their applicability based on market segment, grandfathering status and funding type.

Two versions have been created:

- **Individual and Small Group (1-50) Plans**
- **Large Group (51+) Plans** — includes information for both fully insured and self-insured plans

These charts are for informational purposes only and do not include all ACA provisions and regulations. The information provided is subject to change. Please note that the charts were published in January; we will be updating them soon to provide the latest information on the 90-day waiting period provision and Employer Shared Responsibility. Clients should consult their own legal counsel and tax professionals to ensure that they comply with the law.

Updated Open and Special Enrollment FAQs on Marketplace Available

We have recently released updated **frequently asked questions** about open and special enrollment on the Health Insurance Marketplace. We removed information that was not relevant now that the Marketplace has launched and added information about switching plans after enrolling.

Among the questions answered in the FAQs:

- When does coverage on the Marketplace take effect?
- If a person is covered as an individual in the Marketplace, can he decide to drop his Marketplace coverage?
- If a person has employer-provided coverage, can he seek coverage on the Marketplace?
- How will ACA affect COBRA eligibility?

SBC Fee Announcement for ASO Foreign Language Translations Request – Reminder for ASO Groups 151+

As part of the Summary of Benefits and Coverage (SBC) request process, foreign language translations are available upon request. We wanted to remind you that, as of July 1, 2013, the RR Donnelley (RRD) invoiced fees plus a flat $350 translation processing fee will apply to all ASO accounts requesting SBC translations. All charges will be applied to the account's monthly Billing and Accounts Receivable System (BARS) bill.

Based on the language selected, the RRD invoiced fee ranges will vary:

WORD COUNT RANGE: LOW-HIGH*	LOW WORD COUNT SBC	HIGH WORD COUNT SBC
Spanish: 2,223-2,846 words per file	$241	$293
Chinese: 2,071-2,843 words per file	$295	$379
Navajo: 2,546-2,991 words per file	$936	$1,087
Tagalog: 2,546-2,988 words per file	$417	$477

*Please note the range of invoiced fees may vary based on word count per file. The above ranges are based on low and high word counts from previously submitted translation requests.

Example: XYZ Group has two SBCs — one PPO and one HMO. The PPO SBC is requested in Spanish and Chinese; the HMO is requested in Spanish.

PPO: Spanish Range: $241 - $293; Chinese Range: $295 - $379
HMO: Spanish Range: $241 - $293

The group will be billed for each request (two Spanish and one Chinese) plus a flat $350 translation processing fee if the requests are submitted together. **Please note:** If the requests are submitted separately, then a $350 processing fee per individual request will apply.

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SBC Revisions

For translations already in process, or for those that have been completed, the RRD invoiced fees plus a flat $350 translation processing fee will be charged.

The RRD invoiced fee for revisions is $150 per request. The above word count fees will not be applied on translation revisions.

Example: XYZ Group has three SBCs, two PPO and one HMO. XYZ Group decides that the two PPO SBCs require translation revisions. Because both SBCs are submitted at the same time, XYZ Group will be charged a total of $500 (a flat $150 revision fee, plus a flat $350 processing fee).

XYZ Group decides that the one HMO also requires translation revisions. Because this request is submitted separately at a later date, XYZ Group will be charged a total of $500 (a flat $150 revision fee plus a flat $350 processing fee).

Note for all requests/revisions: If the requests are submitted separately, then a $350 processing fee per individual request will apply.

Translation Request Process

Groups must coordinate the process with their account executive. Foreign language translations are only available in Spanish, Chinese, Navajo and Tagalog, and delivery time frames will vary based on the foreign language requested.

SBC Translation Guidance for Fully Insured Groups 151+

The Summary of Benefits and Coverage (SBC) regulations require that the SBC be provided in a culturally and linguistically appropriate manner. The regulations require group health plans and issuers to make certain accommodations for SBCs sent to an address in a county meeting a threshold percentage of people who are literate only in the same non-English language. This threshold percentage is set at 10 percent or more of the population residing in the member's/prospect's county, as determined on American Community Survey (ACS) data published by the U.S. Census Bureau.

Currently, language literacy requirements include the following languages: Spanish, Chinese, Tagalog and Navajo.

Per the regulation, the U.S. Department of Health and Human Services has published the list of counties that meet or exceed the 10 percent threshold to determine if translations are required and can be requested.

SBC Print and Mail Fee Increase for ASO Accounts – Reminder for ASO Groups 151+

This is a reminder that the cost for printing and mailing the Summary of Benefits and Coverage (SBC) for ASO accounts **is $1.50 per SBC. The pricing for print and mail services went into effect on July 1, 2013.** Please refer to the following update when requesting printing and mailing services.

SBC Printing and Mailing Requests

Blue Cross and Blue Shield of Illinois' (BCBSIL) preferred method for distributing SBCs is to provide the SBCs to the employer groups who will then provide them to participants and beneficiaries. However, if an ASO group requests that BCBSIL mail SBCs to a member's home, the group must coordinate the process with their account executive. Upon approval of the final SBC, all requests require five-to-seven business days to complete processing and shipment.

SBCs will be mailed first-class via the U.S. Postal Service. A cover letter will be attached to the SBC. All charges will be applied to the account's Billing and Accounts Receivable System (BARS) bill.

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Pre-existing Condition Exclusions FAQs Now Available in Printed Version

The pre-existing condition exclusions FAQs that previously ran as a newsletter article is now also available as a **flier** that you can print. The FAQs provide an overview of the pre-existing condition exclusion provision of the Affordable Care Act.

Stay Informed about ACA – What You Need to Know

We have been updating our 2014 Affordable Care Act communications materials—and developing new pieces—to help you stay on top of what is happening this year.

As a reminder, we recently rolled out these new items:

- Health Care Reform Overview Charts Individual and Small Group (1-50) Plans
- Health Care Reform Overview Charts Large Group (51+) Plans
- Pre-existing Condition Exclusions FAQs

We have also recently updated these materials, to keep the information current:

2014 ACA Timeline

Marketplace Open and Special Enrollment FAQs

Health Insurance Marketplace Fact Sheet

Updates that are coming soon include:

Small Business Health Options Program (SHOP) FAQs

90-Day Waiting Period Implementation Update

Women's Preventive Services Fact Sheet

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February 2014

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The Affordable Care Act: 2014 and Beyond

This timeline explains how and when the Affordable Care Act (ACA) provisions will be implemented over the next few years.

2014

Get Covered Illinois, the Official Health Marketplace of Illinois

While enrollment began on Oct. 1, 2013, the Marketplace became operational on Jan. 1, 2014.

Individual Requirement to Have Insurance

Nearly all U.S. citizens and lawfully present individuals are required to maintain qualifying health coverage or pay a penalty.

Guaranteed Availability and Renewability

All carriers in the individual and group markets will be required to offer all products approved for sale in a particular market and accept any individual or group that applies for any of those products. Plans and policies are guaranteed renewable.

Pre-existing Conditions

Beginning on the policy/plan date on or after Sept. 23, 2010, pre-existing condition limitations were waived for all enrollees up to age 19. Beginning on plan years on or after Jan. 1, 2014, pre-existing condition limitations will be eliminated for enrollees of all ages.

Essential Health Benefits (EHBs)

Certain health benefits that are deemed "essential" must be offered by non-grandfathered individual plans and non-grandfathered, fully insured small group plans offered both on and off the Marketplace in 2014. The final rule released by the U.S. Department of Health and Human Services (HHS) provides additional details including the benchmark plan for each state.

Did You Know?

There are 10 categories of benefits considered essential to good health.

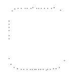
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health disorder services
- Substance use disorder services
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services

Deductible Limits for EHBs

For plan years beginning on or after Jan. 1, 2014, non-grandfathered, fully insured small group plans must limit deductibles to $2,000 for individuals and $4,000 for families. This applies only to in-network EHBs. A health plan may exceed the deductible limit if it cannot reasonably reach a given level of coverage (metallic level) without exceeding the deductible limit (see Page 2 for more on metallic levels.)

Out-of-Pocket Maximums for EHBs

For plan years beginning on or after Jan. 1, 2014, all non-grandfathered plans that cover EHBs must limit annual out-of-pocket member expenses for in-network EHBs. Expenses for EHBs, including coinsurance, deductibles, copays and similar charges cannot exceed 2014 out-of-pocket limits set by the IRS for High Deductible Health Plans. The 2014 out-of pocket maximum for EHBs is $6,350 for self-only coverage and $12,700 for family coverage.



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A safe harbor for the 2014 plan year allows groups and issuers to maintain separate out-of-pocket maximums for EHBs administered by more than one service provider—as long as they individually do not exceed $6,350 for individual coverage and $12,700 for family coverage. Member EHB expenses for medical/surgical and mental health/substance use disorder benefits must still cross-accumulate up to a single out-of-pocket maximum to comply with the federal mental health parity law.

Annual Dollar Limits

For plan years on or after Jan. 1, 2014, restricted annual dollar limits on EHBs are no longer permitted.

Actuarial Value (Metallic Levels)

Non-grandfathered individual and non-grandfathered, fully insured small group plans must fit within four metallic levels that correspond to plan actuarial value in 2014. These Bronze, Silver, Gold and Platinum "metallic plans" are meant to make it easier for consumers to compare plans with similar levels of coverage. All metallic plans offered in a state must cover at least the package of EHBs set by that state's benchmark plan.

Bronze	• Lower monthly payments • Higher out-of-pocket costs when you receive medical care
Silver	• Higher monthly payment than a Bronze plan • Lower out-of-pocket costs than a Bronze plan when you receive medical care • Silver plans eligible for cost-sharing assistance based on income
Gold	• Higher monthly payment than a Silver plan • Lower out-of-pocket costs than a Silver plan when you receive medical care
Platinum	• Highest monthly payments • Lowest out-of-pocket costs when you receive medical care

Waiting Periods

A group health plan cannot apply any waiting period that exceeds 90 days for plan years starting on or after Jan. 1, 2014. A waiting period is the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. (The rules for this provision are still proposed and subject to change, pending final rules.)

PCORI Fee

The Patient-Centered Outcomes Research Institute Fee increases to $2 multiplied by the average number of lives covered under the plan or policy for plan or policy years ending on or after Oct. 1, 2013, and before Oct. 1, 2014.

Provider Non-discrimination

Health care providers will not be prevented from participation in an insurer's provider network if willing to abide by the terms and conditions for participation and are acting within the limits of their medical license or certification.

Coverage for Clinical Trials

For plan years beginning on or after Jan. 1, 2014, if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. This only applies to non-grandfathered plans.

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2014

Small Business Health Tax Credits

ACA increases the small business health tax credit. Small group employers with 25 or fewer employees (with an average wage of less than $50,000 a year) may be eligible for a tax credit. The tax credit will cover up to 50 percent of the employer's cost (up to 35 percent for small nonprofit organizations) and is available for the first two years an employer offers coverage through the Small Business Health Options Program (SHOP). (The rules for this provision are still proposed and subject to change, pending final rules.)

Tax Credits for Individuals

Premium tax credits and other cost-sharing assistance are available to qualifying individuals and families purchasing coverage on the Marketplace.

Community Rating

Health insurance issuers can only use the following rating factors: geographic area, family demographics, age and tobacco use. Applies only to individual plans and small group plans unless large group coverage is offered through the Marketplace.

Insurer Fee

The Health Insurer Fee is designed to help fund premium tax credits and/or cost-sharing assistance for eligible individuals purchasing a qualified health plan through the Marketplace. This annual fee will be determined by the federal government and will be based on a health insurer's premiums from the previous year.

Did You Know?

A new kind of tax credit may be available for individuals who purchase individual coverage on the Marketplace and whose 2013 household income is between $11,490 and $45,960 ($23,550 and $94,200 for a family of four). Additional cost-sharing assistance is available for those Silver plan enrollees whose household incomes ranges anywhere from $11,490 to $28,725 ($23,550 to $58,875 for a family of four).

Dependent to Age 26 for Grandfathered Plans

ACA requires group health plans and insurers that offer health insurance for dependent children to make coverage available for children (married or unmarried) until age 26. This provision is already effective under most policies; however, it does not fully apply to grandfathered group health plans until Jan. 1, 2014. For plan years beginning on or after Jan. 1, 2014, a grandfathered group health plan that offers dependent coverage for children may no longer exclude an adult child under age 26 from coverage, even if the child is eligible for another employer-sponsored health plan other than that of a parent.

Wellness Incentive Increases

ACA changes the maximum reward that can be provided under HIPAA's health factor–based wellness program from 20 to 30 percent. The reward under such a program can be up to 30 percent of the cost of employee coverage. Additionally, the secretaries of Health and Human Services, Labor and Treasury can expand the reward up to 50 percent of cost of coverage if deemed appropriate.

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2014

The 3Rs

Beginning in 2014, ACA will create three risk-mitigation programs (Transitional Reinsurance, Temporary Risk Corridors and Risk Adjustment) intended to stabilize premiums in the market as insurance reforms and Marketplaces are implemented.

- Transitional Reinsurance is a temporary program (2014–2016) that provides partial reinsurance coverage for issuers that incur high claims costs for individual market enrollees. It will require all issuers and third-party administrators (on behalf of self-funded groups) to make contributions to a reinsurance entity to support payments to non-grandfathered individual market plans.
- Risk Corridors is a temporary program (2014–2016) that protects the uncertainty in rate setting by limiting health issuers' gains and losses in excess of 3 percent of target premiums. Issuers share the risk with the government and will receive either a portion of the gain or a subsidy for loss.
- Risk Adjustment is a permanent program that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees (such as individuals with chronic conditions). The Risk Adjustment calculation will result in payments between insurance issuers. Risk Adjustment applies to individual and small group insured markets, on and off the Marketplace, for non-grandfathered plans.

2015

Employer Shared Responsibility

Generally, under Employer Shared Responsibility (ESR), applicable large employers face a potential penalty if they don't provide minimum essential coverage to full-time employees that has both minimum value (company is paying at least 60 percent of covered health care expenses for a typical population) and is affordable (full-time employees cannot pay more than 9.5 percent of their income for the lowest-cost, self-only coverage). Employers with fewer than 50 full-time employees are not subject to ACA's ESR provisions.

In February 2014, the Internal Revenue Service released a final rule on the ESR provisions. For 2015, employers with between 50 and 99 full-time employees are exempt from the ESR penalty if the employer provides an appropriate certification and meets certain conditions. Employers subject to the mandate must offer coverage to 70 percent of their full-time employees or risk penalties for failure to offer coverage to all full-time employees and dependents.

To avoid a penalty in 2016, employers subject to ACA's Employer Shared Responsibility provisions must offer coverage to 95 percent of their full-time employees and dependents.

Note: This rule applies whether the failure to offer coverage is intentional or unintentional. However, this rule does not shield the employer from the penalty for offering inadequate coverage if any of the full-time employees, including those who are not offered coverage at all, receive a premium tax credit or cost-sharing assistance for purchasing coverage through the Marketplace.

The Affordable Care Act:
2014 and Beyond

BlueCross BlueShield of Illinois

2016

Small Group Market Increases to 100 Employees

Small group market definition increases to employers with up to 100 employees.

2017

Marketplace Opens to Large Group Market

Large Group (100+) may be allowed to use the Marketplace beginning in 2017 if a state allows it.

2018

'Cadillac Plan' Tax

ACA imposes a 40 percent excise tax on high-cost, employer-sponsored health coverage, or plans with an annual cost exceeding $10,200 for individuals or $27,500 for a family.

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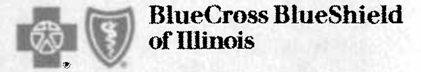
Publication date: March 2014

Health Care Reform Overview
for Large Group (51+) Plans



The following chart provides a breakdown of key Affordable Care Act (ACA) provisions by year for large group plans, based on the plan's funding type (fully insured versus self insured). A basic description of each provision is included, as well as information on which provisions apply to grandfathered plans and non-grandfathered plans. This handout is current as of March 2014. It is subject to change based on subsequent federal and state laws, regulations and guidance. Please note that this information is not comprehensive and is for general informational purposes only. Blue Cross and Blue Shield of Illinois clients are advised to consult qualified legal counsel and/or tax professionals to ensure compliance.

		Does this apply to grandfathered plans?		Does this apply to non-grandfathered plans?	
Provision	**Description**	**Fully Insured**	**Self Insured**	**Fully Insured**	**Self Insured**
First plan year beginning on or after 9/23/2010					
Lifetime Dollar Limits	Prohibits group health plans and insurers that offer health insurance coverage from imposing lifetime limits on the dollar value of essential health benefits	Yes	Yes	Yes	Yes
Annual Dollar Limits	Generally prohibits group health plans and insurers that offer health insurance coverage from imposing annual limits on the dollar value of essential health benefits. Restricted annual dollar limits are allowed until 2014.[1]	Yes	Yes	Yes	Yes
Pre-existing Condition Exclusions for Children Under Age 19	Prohibits group health plans and insurers that offer health insurance coverage from imposing a pre-existing condition exclusion on enrollees under age 19	Yes	Yes	Yes	Yes
Rescissions	Group health plans and insurers that offer health insurance coverage cannot rescind coverage except in the case of fraud or intentional misrepresentation.	Yes	Yes	Yes	Yes
Dependent Coverage to Age 26	Requires group health plans and insurers that offer coverage for dependent children to make such coverage available for children (married or unmarried) until they reach 26 years of age	Yes[2]	Yes[2]	Yes	Yes
Appeals and External Review	Requires group health plans and health insurers to have an effective internal appeals and external review process to allow individuals to appeal adverse benefit determinations. The appeals process must be explained in notifications of these adverse decisions.	No	No	Yes	Yes
Prohibition on Discrimination in Favor of Highly Compensated Individuals[3]	Internal Revenue Code 105(h) prohibits self-insured plans from discriminating in favor of highly compensated individuals in terms of eligibility and benefits. Fully insured, non-grandfathered group health plans may be required to follow similar rules under ACA. The federal government has a non-enforcement policy in place until regulations or further guidance is issued.	No	No	Yes	No

Provision	Description	Does this apply to grandfathered plans?		Does this apply to non-grandfathered plans?	
		Fully Insured	Self Insured	Fully Insured	Self Insured
First plan year beginning on or after 9/23/2010					
Preventive Services	Requires group health plans and insurers that offer health insurance coverage to provide certain preventive health services without cost sharing, such as copay, coinsurance or deductibles, when delivered by a network provider	No	No	Yes	Yes
Physician Choice/ Direct Access Requirements	Gives individuals the ability to choose any available participating primary care provider. Parents can choose any available participating pediatrician as their children's primary care provider. Insurers and employer plans cannot require a referral for obstetrical or gynecological (OB-GYN) care.	No	No	Yes	Yes
Emergency Services	Group health plans and insurers must cover emergency room services without pre-authorization, even for out-of-network providers, and apply prudent layperson definition of an emergency medical condition. If services are rendered out of network, ACA cost-sharing requirements apply.	No	No	Yes	Yes
First reporting year: 2011					
Medical Loss Ratio (MLR) Reporting and Rebates	Medical Loss Ratio, also referred to as MLR, is the percentage of insurance premium dollars spent on reimbursement for clinical services or medical expenses and activities to improve health care quality. ACA provisions set MLR standards for different markets, as do some state laws. Insurers may have to issue rebates to enrollees if the insurer's MLR does not meet or exceed the MLR standard for the particular market of a state. The federal MLR standard for rebates for the large group market is 85 percent and the MLR standards for small group and individual markets are 80 percent.	Yes	No	Yes	No
First plan year beginning on or after 8/1/2012					
Women's Preventive[4]	Expands coverage pertaining to women's preventive services, contraceptives and breastfeeding. Under ACA, certain preventive health services are covered without patient cost share—there is no copay, coinsurance or deductible—when using a network provider.	No	No	Yes	Yes
First plan year beginning on or after 9/23/2012					
Summary of Benefits and Coverage	Requires insurers and group health plans to provide individuals with a uniform summary of benefits outlining coverage upon request, upon application, upon material modification and upon renewal	Yes	Yes	Yes	Yes
Plan years that end on or after 10/1/2012 and before 10/1/2019					
Patient-Centered Outcomes Research Institute Fee	Requires sponsors of group health plans and insurers that offer health insurance coverage to pay an annual fee to help fund comparative clinical effectiveness research	Yes	Yes	Yes	Yes

Provision	Description	Does this apply to grandfathered plans?		Does this apply to non-grandfathered plans?	
		Fully Insured	Self Insured	Fully Insured	Self Insured
10/1/2013					
Marketplace Notification Requirement for Employers	Employers subject to the Fair Labor Standards Act must provide employees written notice of the existence of the Health Insurance Marketplace, which will become operative as of Jan. 1, 2014, of their potential eligibility for federal assistance if the employer's plan does not meet affordability and minimum value criteria and if employee household income is below certain thresholds, and that the employee may lose the employer's contribution to health coverage if they purchase health insurance through the Marketplace. Employers are required to provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, the Department of Labor will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice not later than Oct. 1, 2013.	Yes	Yes	Yes	Yes
Beginning 1/1/2014					
Health Insurer Fee	Requires covered entities providing health insurance ("health insurers") to pay an annual fee to the federal government. These fees are designed to support programs that will stabilize premiums and provide subsidies to qualified individuals to help them purchase coverage.	Yes	No	Yes	No
Reinsurance Fee	The Reinsurance Fee was designed to pay for a temporary transitional reinsurance program that will run from 2014 through 2016 and will be funded by reinsurance contributions (reinsurance fees) from health insurance issuers and self-funded group health plans.	Yes	Yes	Yes	Yes
First plan year beginning on or after 1/1/2014					
Waiting Periods	A group health plan cannot apply any waiting period that exceeds 90 days. A waiting period is the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.	Yes	Yes	Yes	Yes
Clinical Trials	Requires that if a "qualified individual" is in an "approved clinical trial," the plan may not: (1) deny the individual participation in the clinical trial; (2) deny the coverage of routine patient costs for items and services furnished in connection with the trial; and (3) discriminate against the individual on the basis of the individual's participation in such trial.	No	No	Yes	Yes
Community Rating	Health insurance issuers can only use the following rating factors: geographic area, family demographics, age and tobacco use.	No	No	No	No

Provision	Description	Does this apply to grandfathered plans?		Does this apply to non-grandfathered plans?	
		Fully Insured	Self Insured	Fully Insured	Self Insured
First plan year beginning on or after 1/1/2014					
Guaranteed Issue and Renewability	All carriers in the individual and group markets will be required to offer all products approved for sale in a particular market and accept any individual or group that applies for any of those products. Plans and policies are guaranteed renewable.	No	No	Yes	No
Non-discrimination Regarding Health Care Providers	Health care providers can participate in an insurer's provider network as long as they follow the terms and conditions for participation and act within the limits of their medical license or certification.	No	No	Yes	Yes
Essential Health Benefits (EHBs)[5]	Certain health benefits that are deemed "essential" must be offered by non-grandfathered individual plans and non-grandfathered, fully insured small group plans sold both on and off the Marketplace. The minimum package of items and services that must be covered by these plans is generally defined by each state's EHB benchmark plan. Large, self-funded or grandfathered plans do not have to cover EHBs. However, if these groups offer EHBs, they must meet applicable EHB cost-sharing requirements (i.e., no annual or lifetime dollar limits on EHBs, an annual limit on out-of-pocket member expenses for in-network EHBs and out-of-network emergency services).	No	No	No	No
Metallic Plans/ Actuarial Value	Non-grandfathered individual and non-grandfathered fully insured small group plans must fit within four metallic levels that correspond to plan actuarial value in 2014. These Bronze, Silver, Gold and Platinum "metallic plans" are meant to make it easier for consumers to compare plans with similar levels of coverage. All metallic plans offered in a state must cover at least the package of EHBs set by that state's benchmark plan.	No	No	No	No
Deductible Limits for EHBs	Non-grandfathered, fully insured small group plans sold on and off the Marketplace must cap the deductible on in-network EHBs at $2,000 for individuals and $4,000 for families. However, a health plan may exceed the deductible limit if it cannot reasonably reach a given level of coverage (metallic level) without exceeding the deductible limit.	No	No	No	No
Out-of-pocket Maximum for EHBs	All non-grandfathered plans that cover EHBs must limit annual out-of-pocket member expenses for any in-network EHBs (and out-of-network emergency services) that happen to be covered by these plans. Member liability cannot exceed 2014 out-of-pocket limits set by the IRS for High Deductible Health Plans –$6,350 for self-only coverage and $12,700 for family coverage. The federal government provides a safe harbor in 2014 to allow time for coordination between multiple providers that help administer EHBs (carve outs).	No	No	Yes	Yes

Provision	Description	Does this apply to grandfathered plans? Fully Insured	Does this apply to grandfathered plans? Self Insured	Does this apply to non-grandfathered plans? Fully Insured	Does this apply to non-grandfathered plans? Self Insured
First plan year beginning on or after 1/1/2014					
Pre-existing Condition Exclusions for All Members	Prohibits group health plans and insurers that offer health insurance coverage from imposing a pre-existing condition exclusion on enrollees of any age	Yes	Yes	Yes	Yes
Wellness Incentive Increases	Health-contingent wellness programs that reward people who meet specific health goals such as cholesterol level or body mass index can increase incentives up to 30 percent of the cost of health plan coverage for 2014 plan years. Programs designed to prevent or reduce tobacco use can further increase rewards up to 50 percent of the cost of coverage. The maximum "permissible reward" for health-contingent wellness programs was previously 20 percent.	Yes	Yes	Yes	Yes
Beginning 1/1/2015					
Employer Shared Responsibility	Generally, under Employer Shared Responsibility (ESR), applicable large employers face a potential penalty if they don't provide minimum essential coverage to full-time employees that has both minimum value (company is paying at least 60 percent of covered health care expenses for a typical population) and is affordable (full-time employees cannot pay more than 9.5 percent of their income for the lowest-cost, self-only coverage). Employers with fewer than 50 full-time employees are not subject to ACA's ESR provisions. In February 2014, the Internal Revenue Service released a final rule on the ESR provisions. For 2015, employers with between 50 and 99 full-time employees are exempt from the ESR penalty if the employer provides an appropriate certification and meets certain conditions. In 2015, employers subject to the mandate must offer coverage to 70 percent of their full-time employees or risk penalties for failure to offer coverage to all full-time employees and dependents. To avoid a penalty in 2016, employers subject to ACA's ESR provisions must offer coverage to 95 percent of their full-time employees and dependents.[8]	Yes	Yes	Yes	Yes
First plan year beginning on or after 1/1/2018					
Cadillac Tax	Places a tax on so-called "high-cost" employer-sponsored coverage, which ACA defines, for 2018, as coverage costing more than $10,200 for individuals and more than $27,500 for families. Those coverage cost thresholds are increased for retirees and those employed in high-risk professions.	Yes	Yes	Yes	Yes

		Does this apply to grandfathered plans?		Does this apply to non-grandfathered plans?	
Provision	Description	Fully Insured	Self Insured	Fully Insured	Self Insured
Unknown					
Quality Reporting[7]	HHS will develop reporting requirements that plans and insurers will use to report whether their plan benefits, coverage and health care provider reimbursement structures satisfy new requirements to improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors and implement wellness and health promotion activities.	No	No	Yes	Yes
Automatic Enrollment[7]	Employers with more than 200 full-time employees that offer enrollment in one or more health plans are required to automatically enroll new employees and re-enroll current employees in one of the plans offered. Enrollment is subject to applicable waiting periods and automatic enrollment programs must include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. The federal government has delayed this provision until further guidance is issued.	Yes	Yes	Yes	Yes

Footnotes

1. For plan years beginning on 1/1/2014 and after, annual limits on essential health benefits are prohibited.
2. For plan years prior to 1/1/2014, not applicable for grandfathered plans if dependent is eligible for other employer-sponsored coverage. State mandates may also apply.
3. This provision is subject to change based on subsequent federal and state laws, regulations and guidance.
4. ACA regulations provide for an exemption from the ACA requirement to cover contraceptive services without cost sharing for certain group health plans of organizations that qualify as religious employers or eligible organizations, provided they meet certain criteria as specified in the regulations.
5. Generally, large group plans cannot set dollar limits for any essential health benefits that happen to be covered by the plan. Visit and frequency limits are allowed.
6. This rule applies whether the failure to offer coverage is intentional or unintentional. However, this rule does not shield the employer from the penalty for offering inadequate coverage if any of the full-time employees, including those who are not offered coverage at all, receive a premium tax credit or cost-sharing assistance for purchasing coverage through the Marketplace.
7. Federal guidance on these provisions is still pending.

For the purposes of this chart, we are showing whether a grandfathered plan is subject to each provision. However, grandfathered status may not directly apply to the provisions that are contained in certain subtitles of ACA that primarily amended, rearranged and added to Parts A and C, Title XXVII of the Public Health Service Act (e.g., certain insurance market reforms), which were also incorporated into ERISA and Internal Revenue Code. Some of the provisions identified in this chart are not contained in such ACA subtitles and, therefore, would generally not be thought of as being or not being applicable to grandfathered plans.

This communication is intended for informational purposes only. It is not intended to provide, does not constitute, and cannot be relied upon as legal, tax or compliance advice. The information contained in this communication is subject to change based on future regulation and guidance.