April 1, 2014

The Affordable Care Act:

2014 Renewal Checklist for *Small Group (1-50) Plans*

BlueCross BlueShield of Illinois

Many key provisions of the Affordable Care Act (ACA) go into effect in 2014. This checklist gives you a quick look at the changes that affect non-grandfathered and grandfathered plans. It also will help you understand ACA-related changes if a health plan is losing grandfathered status. Please note the following:

- These changes go into effect on **the first plan year beginning on or after Jan. 1, 2014,** unless otherwise noted.
- This information is subject to change. This document was published on April 1, 2014, and changes may have occurred since its publication date.
- This information is not intended to be comprehensive. It does **not** encompass all ACA requirements and regulations for the 2014 plan year.
- Blue Cross and Blue Shield of Illinois (BCBSIL) clients are advised to consult qualified legal counsel and/or tax professionals to ensure compliance.

Key Provisions

Effective beginning 10/1/2013	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Exchange notice –** Provide employees with written notice of the Health Insurance Marketplace. For 2014, employers are required to provide the notice to each new employee within 14 days of an employee's start date. The notice is required to be provided automatically, free of charge. It can be provided in writing either by first-class mail, or electronically if the Department of Labor's electronic disclosure safe harbor requirements are met. The required information can be found on the first page of the model employer Marketplace notice that the Department of Labor has provided: • Model Notice for Employers who Provide a Health Plan • Model Notice for Employers without a Health Plan	Yes	Yes
Effective date for fee increase: Plan years ending on or after 10/1/2013 and before 10/1/2014		
☐ **PCORI –** The Patient-Centered Outcomes Research Institute (PCORI) fee increases to $2 multiplied by the average number of lives covered under the plan or policy for plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014. BCBSIL will report and remit the fee for specified fully insured business.	Yes	Yes
Effective beginning 1/1/2014		
☐ **Health Insurer Fee –** Beginning with the group's bill for January 2014 coverage, the premium will be adjusted to reflect the effects of the **Health Insurer Fee**, which will be inclusive of any additional applicable federal and state taxes. This provision 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	Yes

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Key Provisions *CONTINUED*

Effective beginning 1/1/2014 *CONTINUED*	**Applies to grandfathered plans?**	**Applies to non-grandfathered plans?**
☐ **Reinsurance Fee –** Beginning with the group's bill for **January 2014** coverage, the premium will be adjusted to reflect the effects of the **Reinsurance Fee**, which will be inclusive of any additional applicable federal and state taxes. 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
Effective first plan year beginning on or after 1/1/2014		
☐ **Waiting periods –** Limit waiting periods for employees eligible for group coverage to no longer than 90 calendar days. The effective date of coverage cannot exceed 91 calendar days from the date of hire (unless an employee or dependent is late in electing coverage).	Yes	Yes
☐ **Pre-existing condition exclusions –** Eliminate pre-existing condition limitations for enrollees of all ages.	Yes	Yes
☐ **Essential health benefits (EHBs) –** Certain health benefits that are deemed "essential" must be covered. The minimum package of items and services that must be covered by these plans is generally defined by each state's EHB benchmark plan.	No	Yes
☐ **Out-of-pocket maximums for essential health benefits (EHBs) –** Limit out-of-pocket member liability for in-network EHBs (and out-of-network emergency services) to no more than $6,350 for individual coverage and $12,700 for family coverage. Generally, member liability that is considered part of the out-of-pocket maximum includes: • Deductibles for in-network EHBs • Coinsurance for in-network EHBs • Copayments for in-network EHBs • Any other expenditure required by, or on behalf of, an enrollee for in-network EHBs, including out-of-network emergency services. 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 to comply with the federal Mental Health Parity law.	No	Yes
☐ **Deductible limits for EHBs –** Limit deductible for in-network EHBs to $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 doing so.	No	Yes
☐ **Actuarial value (metallic levels) –** Actuarial value (AV) measures the average portion of expected health care expenses that will be paid for by the insurer. Non-grandfathered health insurance plans in the individual and small group market must meet AV or "metallic level" coverage requirements for EHBs. Health care reform establishes metallic levels so that people can compare plans that offer different levels of EHB coverage. The metallic levels are Platinum (90% AV), Gold (80% AV), Silver (70% AV) and Bronze (60% AV), where the percentages reflect the portion of expenses paid by the insurer.	No	Yes

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Key Provisions *CONTINUED*

Effective first plan year beginning on or after 1/1/2014 *CONTINUED*	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **Clinical trials –** If a "qualified individual" is in an "approved clinical trial," then 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 3. Discriminate against the individual on the basis of the individual's participation in such trial	No	Yes
☐ **Community rating –** Health insurance issuers can only use the following rating factors: geographic area, family demographics, age and tobacco use.	No	Yes
☐ **Guaranteed issue and renewability –** Carriers 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	Yes

Reminders

☐ **Summary of Benefits and Coverage –** ACA requires all health insurers and group health plans to provide individuals with a uniform Summary of Benefits and Coverage (SBC) outlining coverage upon application, open enrollment, annual renewal, upon request, at special enrollment, and upon material modification. For fully insured/premium groups that request our services per the Benefit Program Application (BPA), BCBSIL will complete the minimum essential coverage and minimum value sections of the SBC.
☐ **Grandfathered plans –** Renew grandfathered status by completing Grandfathered Health Plan Status Certification Form.

Plans Losing Grandfathered Status

In addition to the provisions listed above that are required for non-grandfathered plans, plans losing grandfathered status must also implement changes that went into effect prior to 2014. For more information on grandfathered health plans and what changes or events may cause a plan to lose grandfathered health plan status, go to **bcbsil.com/PDF/aca_grandfathered_plans_il.pdf**.

If the plan is losing grandfathered status, notify your account representative of the group's intent to waive grandfathered status.

☐ **Preventive services –** Remove cost-sharing requirements on certain recommended preventive services.
☐ **Appeals and reviews –** Amend process for appeals by implementing appeals and external review requirements.
☐ **Emergency services –** Cover emergency room (ER) 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. This is for the initial ER services in the emergency room, including the emergency room physicians fee – and **does not** include ambulance or facility/professional fees for follow-up medical treatment.
☐ **Physician choice –** Allow members to choose any participating primary care physician or pediatrician.
☐ **Direct access –** Allow direct access to OB/GYNs for female enrollees without pre-authorization or referral.

The information in this handout is subject to change based on subsequent federal and state laws, regulations and guidance. This information is a high-level summary and for general informational purposes only. The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.