April 1, 2014

The Affordable Care Act:

2014 Renewal Checklist
For *Self-Funded Large Group 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: **Plans 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. For an applicable self-insured health plan, including Cost Plus HMO, the plan sponsor, generally the employer, will be responsible for paying the fee.	Yes	Yes
Effective beginning 1/1/2014		
☐ **Reinsurance Fee –** Beginning in 2014, plan sponsors of self-funded plans will be responsible for contributing to the funding of the Transitional Reinsurance Programs established by ACA. 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

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Key Provisions *CONTINUED*

Effective first plan year beginning on or after 1/1/2014	Applies to grandfathered plans?	Applies to non-grandfathered plans?
☐ **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
☐ **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 (OOPM) 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 and member liability on reference-based pricing (RBP) claims. A safe harbor for the 2014 plan year allows groups and issuers to maintain separate OOPMs 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
☐ **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
☐ **Wellness incentives –** Maximum "permissible reward" for health-contingent wellness programs can increase up to 30 percent of the cost of health plan coverage. Programs designed to prevent or reduce tobacco use can further increase rewards up to 50 percent of the cost of coverage.	Yes	Yes

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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. BCBSIL will create the SBC for self-insured groups that request our services per the Benefit Program Application (BPA). Self-insured groups will complete the minimum essential coverage field and minimum value calculations themselves. BCBSIL will include form fields on the SBC for minimum essential coverage and minimum value for the group to input the answers (same process for carved-out benefits).
- ☐ **Grandfathered plans –** Renew grandfathered status by completing Grandfathered Health Plan Status Certification Form.
- ☐ **Essential health benefits (EHBs) –** Large employers (51+) do not have to offer EHBs. However, a health plan must remove annual and lifetime dollar limits on any EHBs it covers. Other types of limits may be put in place, including visit limits, day limits, occurrence limits, and per-episode or per-service limits. However, they must still comply with any applicable state or federal laws (e.g., Mental Health Parity). Non-grandfathered plans that cover EHBs must also meet certain OOPM requirements.
- ☐ **Dependent to age 26 –** Must fully extend coverage to dependents. Previously, grandfathered group health plans that offered dependent coverage for children could exclude an adult child under age 26 from coverage if the child was eligible for another employer-sponsored health plan other than that of a parent.

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.

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