February 2014

BlueCross BlueShield of Illinois

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.

(CONTINUED)

2014

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.

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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.