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

BlueCross BlueShield of Texas

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 Texas 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

		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					
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?		Does this apply to non-grandfathered plans?	
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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.[6]	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.