informed on reform

KEEPING YOU up-to-date on the PPACA

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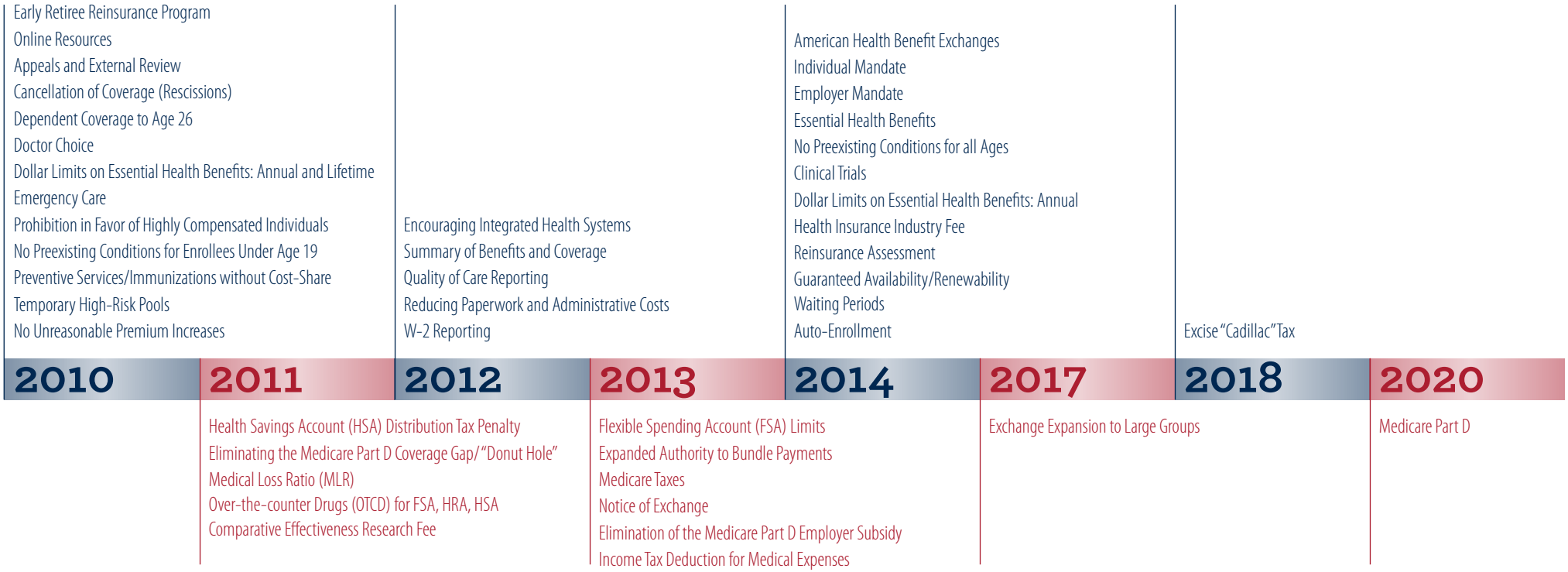
Health Care Provisions

Last updated: March 2013

The following chart outlines provisions of the Patient Protection and Affordable Care Act (PPACA). Here you'll find a summary of the provisions – organized by their effective date – along with updated details on the regulations and who is impacted.

We are committed to keeping you informed and updated on the new health reform laws and will continue to provide updates as additional provisions and regulations are announced. In the meantime, if you have questions or need more detail, please contact your Cigna sales representative.

Click on the provision(s) from the list below to jump to the detail in the chart.



Grandfathered Status

The Patient Protection and Affordable Care Act (PPACA) includes a provision that treats health plans that existed on March 23, 2010 as "grandfathered." Grandfathered plans are not required to comply with some of the PPACA provisions.

Grandfathered plans can make routine changes to plan designs without losing grandfathered status. However, plans will lose their grandfathered status if they make changes that significantly cut benefits, increase out-of-pocket spending for individuals or reduce the employer contribution toward the cost of the plan. A November 2010 amendment allows employers to switch insurance carriers (Fully Insured Funding) and/or change their funding from Administrative Services Only (ASO) to Fully Insured Funding without losing their grandfathered status for accounts effective November 17, 2010 or later.

Provisions Effective 2010

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Early Retiree Reinsurance Program *Note: Cigna is supporting our client needs. Questions should be directed to your Cigna account team or through Cigna's dedicated email box: **EarlyRet@Cigna.com***	• Employers can receive a subsidy for a portion of the cost of health benefits provided to retirees ages 55 and over and their spouses, surviving spouses and dependents that are not Medicare-eligible as defined by the plan. • Congress appropriated funding of $5 billion for this temporary program, which became effective June 1, 2010. • The program ends no later than January 1, 2014. • The federal government will reimburse employers for up to 80% of reimbursements made with respect to claims between $15,000 and $90,000 (amounts are indexed for plan years starting on or after October 1, 2011). • The subsidy must be used to lower health costs for retirees.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**N/A**
Online Resources	• Health insurance companies must provide online resources to give consumers access to information on coverage options available to them.	• Individual Plans/Policies • Small Group Plans	• Fully Insured	**N/A**

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Appeals and External Review *Note: Cigna implemented requirements for this provision as defined by HHS and DOL for 7/1/2011 and 1/1/2012 effective dates.*	• All insurers and plans must have a standard internal claims and appeal process and an external review process. • All individual and group plans must comply with the existing ERISA claim and appeal regulations with several changes, including: urgent claim timing, information to be provided to claimants, independence and impartiality of decision makers, information to be included in the notice of claim determination, a strict adherence requirement and an external review process. • Individual plans must also apply the requirements to the initial eligibility determination, have only one level of appeals and retain records for six years. • There is a foreign language requirement for notices under certain circumstances.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Non-grandfathered only
Cancellation of Coverage (Rescissions) *Note: Cigna voluntarily complied with this provision on May 1, 2010.*	• Part of the Patient's Bill of Rights. • Plans and insurers are prohibited from rescinding (i.e. retroactively terminating) coverage for a plan or individual except in the case of fraud or intentional misrepresentation of a material fact provided the policy permits rescission. • If coverage is rescinded, 30 days advance notice to all enrollees is required.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Dependent Coverage to Age 26 *Note: Cigna implemented an extension of coverage to enrolled dependents on June 1, 2010.*	• Health plans and policies that cover dependents are required to cover young adults to age 26. • Dependents under the age of 26 must be covered regardless of marital status, student status, residency, financial status, etc., and include: – Dependents currently enrolled on the plan under the age of 26; – Dependents that were previously terminated from the plan and are under the age of 26; and – Dependents that have never been enrolled on the plan and are under the age of 26. • Grandfathered plans are not required to extend coverage to dependents who have access to another employer-sponsored plan other than that of a parent, until 2014. • Spouses of dependents and children of dependents (employees' grandchildren) are not eligible unless the plan already covers these individuals under their definition of dependent. • A one-time 30-day special enrollment period for dependents is required for the first plan year starting on or after September 23, 2010. **Additional Notes:** • Funds from Health Reimbursement Accounts (HRAs) and Flexible Spending Accounts (FSAs) may be used for dependents to age 26. • Plans may also offer retroactive FSA reimbursement for expenses incurred by a dependent to age 26 – as far back as March 30, 2010. The IRS Ruling (2010–38) allows for this exception as long as you amended your cafeteria plan documents by December 31, 2010.* • Health Savings Account (HSA) funds may not be used to pay the expenses of covered dependents who are not claimed as dependents for tax purposes. ** Under certain circumstances, extending FSA coverage to dependents up to age 26 may be optional. Please speak to your own legal counsel to determine if your FSA plan is required to provide this extension of coverage.*	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered
Doctor Choice	• Part of the Patient's Bill of Rights. • Enrollees must be allowed to select the primary care physician (PCP), including a pediatrician, of their choice. • Enrollees must be permitted to access an OB/GYN for services without a referral from the PCP.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Dollar Limits on Essential Health Benefits: Annual and Lifetime	**Annual** • Part of the Patient's Bill of Rights. • Restricted annual limits are allowed on the dollar value of essential health benefits until 2014. After 2014, annual dollar limits will be prohibited on the dollar value of essential health benefits. • The following minimum annual limits are allowed for plan years beginning on or after these dates: – September 23, 2010 – $750,000 – September 23, 2011 – $1.25 million – September 23, 2012 – $2 million – 2014 – No annual dollar limits allowed • Limited benefit plans in effect before September 23, 2010, may apply for a waiver of the annual limits provision if compliance would significantly increase premiums or decrease access to coverage for current enrollees. **Lifetime** • Lifetime dollar limits are not permitted on the dollar value of essential health benefits. • Plans and insurers must offer a one-time, 30-day special enrollment period to any individual whose coverage previously ended due to reaching the lifetime dollar limit. This applies if that individual would otherwise still be eligible for coverage.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Annual Dollar Limits** **Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Grandfathered • Non-grandfathered **Lifetime Dollar Limits** **Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Emergency Care	• Part of the Patient's Bill of Rights. • Coverage of emergency services in an emergency room generally must be provided at the in-network level if care is received from an out-of-network provider. • Prior authorization cannot be required even if the services are provided out-of-network. • Plans must adopt a standard "prudent layperson" definition of emergency services. • Copays and coinsurance for out-of-network services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network; providers may balance bill, but only after a plan or issuer pays an amount equal to the greatest of: – The amount negotiated with in-network providers for the emergency service furnished [this option is eliminated if there is no per-service amount negotiated with in-network providers (e.g., under a capitation agreement)]. If there is more than one amount negotiated, then the payment is the median amount; – The amount calculated using the same method the plan generally uses to determine payment for out-of-network services [e.g., Usual and Customary Rate (UCR)], but applies to in-network cost-sharing provision (without reduction for out-of-network cost-sharing that generally applies); or – The amount that would be paid by Medicare.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only
Prohibition in Favor of Highly Compensated Individuals	Insured plans cannot discriminate in favor of highly compensated employees unless the distinction is based on a reasonable job classification such as hourly, salaried and geographic location. Previously, this prohibition applied only to self-funded plans. • Employers may be fined $100 per day per violation. (While not yet clear, penalty will likely be determined by multiplying the $100 per-day penalty by the number of employees denied participation in the discriminatory plan.) However, unlike the penalty for self-funded plans, the coverage is not included as taxable income for employees. • The Department of Treasury has delayed enforcement of this requirement until regulations or other guidance is issued.	• Small Group Plans • Large Group Plans	• Fully Insured *A similar prohibition already exists for self-funded plans.*	**Group Plans:** • Non-grandfathered only
No Preexisting Conditions for Enrollees Under 19	• Part of the Patient's Bill of Rights. • A preexisting condition limitation cannot be applied to any enrollee (employee, spouse or dependent) who is under the age of 19. • For plan years beginning on or after January 1, 2014, this requirement applies to all enrollees, regardless of age.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Preventive Services/ Immunizations without Cost-Share	• Preventive care services and immunizations must be covered with no cost sharing by non-grandfathered plans. Cost sharing includes deductibles, coinsurance, copayments or any other payment required when care is received. Dollar limits are also prohibited for both grandfathered and non-grandfathered plans. • Cost sharing does not include premiums, balance billing amounts for out-of-network providers or costs for non-covered services. • Preventive care is not required to be covered out-of-network; however, if a plan includes out-of-network coverage, cost sharing is allowed regardless of grandfathered status (example: deductible and coinsurance). *Note: Dollar limits are prohibited out-of-network.* • Preventive care services and immunizations include: – Evidence-based preventive services taken from the current recommendations of the United States Preventive Services Task Force with a rating of A or B. – Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. – Preventive care guidelines developed by the Health Resources and Services Administration with the American Academy of Pediatrics. – On August 1, 2011, HHS adopted additional Guidelines for Women's Preventive Services that require well-woman visits, breastfeeding equipment, contraception and domestic violence screening to be covered without cost sharing. These new services are covered for non-grandfathered plans for plan years beginning on or after August 1, 2012. Certain religious employers are exempt from the requirement to cover contraceptives, and there was a one-year delay in the effective date for contraceptive coverage for non-profit religious organizations. For non-profit religious organizations, contraceptive coverage will be provided through a separate individual insurance policy for plan years beginning on or after August 1, 2013. • Please visit **www.hrsa.gov/womensguidelines** to read the Guidelines for Women's Preventive Services. • Please refer to **www.healthcare.gov/center/regulations/prevention/taskforce.html** for a full list of covered preventive services issued as part of the Interim Final Regulations.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only

Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Temporary High-Risk Pools	• Temporary high-risk pools will be established to provide coverage for individuals with preexisting conditions who have been uninsured for at least six months. These pools will be available until state Exchanges are established in 2014. • Insurers and employers will be held responsible for health care expenses paid by a high-risk pool if they engage in actions that encourage individuals to leave their current plan to join a high-risk pool.	**N/A**	**N/A**	**N/A**
No Unreasonable Premium Increases	• In conjunction with states, the federal government will establish an annual process to review "unreasonable increases" in premiums for health coverage. • Issuers of health insurance coverage will be impacted by this provision.	• Individual Plans/Policies • Small Group Plans	• Fully Insured	**N/A**

Provisions Effective 2011

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Health Savings Account (HSA) Distribution Tax Penalty	• If an individual uses HSA funds for expenses that do not satisfy the federal tax definition of eligible medical expenses, the IRS may impose a 20% tax penalty on the disbursed amount. (Prior to January 1, 2011, this penalty had been 10%.) • This requirement was effective as of January 1, 2011.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	**N/A**	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered
Eliminating the Medicare Part D Coverage Gap/"Donut Hole"	• The law gradually closes the gap between now and 2020. In 2010, enrollees received a $250 rebate from the government if they entered the Part D coverage gap. • Starting in 2011, there is progressively lower beneficiary coinsurance for generic drugs and coverage for brand-name drugs (with discounts from pharmaceutical manufacturers) in the gap. • By 2020, Part D beneficiaries' coinsurance will be approximately 25% of the cost of drugs.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**N/A**

Provisions Effective 2011 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Medical Loss Ratio (MLR)	• MLR is the percent of premium a carrier spends on claims and other medical services. Carriers must provide an annual rebate to covered individuals if the medical loss ratio of the block of business to which the individual or group belongs is less than 85% for large groups or 80% for small groups or individuals. • For the 2011 reporting year, issuers of limited medical and expatriate international plans were subject to separate calculation rules. The plan's numerator of the total claims incurred and expenditures for activities that improve health care quality would be multiplied by two. • Carriers were required to complete additional quarterly reporting through 2011. After reviewing this additional reporting, HHS adjusted the calculation for limited medical plans through 2014 and extended the adjustment for expatriate plans indefinitely. • Consistent with recent NAIC recommendations, HHS concluded that broker commissions should be included as part of the denominator of the MLR calculation, with no adjustment to the numerator (commissions will be included in the non-claims portion of MLR).	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured, including shared returns	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2011 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Over-the-counter (OTC) Drugs for FSA, HRA, HSA	• Purchases of most OTC drugs and medicines can no longer be reimbursed from health spending accounts (HRA, HSA and FSA) unless the individual has a doctor's prescription for the drug. • Certain OTC products such as contact lens solutions and first aid supplies will continue to be eligible for reimbursement without a prescription. • Prescription drugs (non-OTC), insulin and diabetic supplies will continue to be eligible for reimbursement. • FSA debit cards may no longer be used to purchase OTC drugs or medicines. If an individual has a prescription for an OTC drug, the cost can be reimbursed by submitting the prescription and receipt manually. However, if a pharmacy does process the OTC drug as a prescription (meeting the criteria defined in IRS NOTICE 2011-05), the FSA Debit Card will allow the charge to go through as an eligible item. • For HSAs, copies of prescriptions and receipts should be maintained for federal income tax purposes in the event of an Internal Revenue Service (IRS) audit. • This requirement is effective for any OTC drugs purchased on or after January 1, 2011.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	**N/A**	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered
Comparative Effectiveness Research Fee	• Revenue from this fee will fund research to determine the effectiveness of various forms of medical treatment. • Effective for plan years that began on and after October 2, 2011. • Annual fee is $1.00 per covered life, increasing to $2.00 in 2013, then to an amount indexed to national health expenditures. • Phases out by 2019. Only applies with respect to covered persons residing in the US.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2012

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Encouraging Integrated Health Systems	• Provides incentives for physicians to form "Accountable Care Organizations (ACOs)" to allow physicians to better coordinate patient care and improve quality. • Helps prevent disease and illness. • Reduces unnecessary hospital admissions.	Incentives paid by Centers for Medicare & Medicaid Services (CMS) for Medicare patients, but many ACOs will also contract for other patients.	• Fully Insured • Self-funded	**N/A**
Summary of Benefits and Coverage *Note: The final regulations regarding the SBC were issued on February 9, 2012. The provision is effective for plan/policy years and open enrollments beginning on or after September 23, 2012.*	Requires that the summary of benefits and coverage: • Must not exceed four two-sided pages and not have print smaller than 12-point font. • Has language that is presented in a culturally and linguistically appropriate manner and uses terminology understandable by the average enrollee. • Includes uniform definitions of standard insurance terms. • Provides estimated customer costs for two medical scenarios – having a baby and managing type 2 diabetes. • Includes a website and phone number where individuals can get additional information. • Is provided at these times: – When an individual enrolls in coverage for the first time. – At the beginning of each new plan year. – Within seven business days if an individual requests a copy. • $1,000 per enrollee penalty for "willful" non-compliance.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2012 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Quality of Care Reporting	HHS to develop reporting requirements with respect to plan or coverage benefits and health care provider reimbursement structures that will: • Improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management and medication and care compliance initiatives, including through the use of the medical homes model for treatment or services under the plan or coverage. • Implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post discharge reinforcement by an appropriate health care professional. • Implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine and health information technology under the plan or coverage. • Implement wellness and health promotion activities.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only
Reducing Paperwork and Administrative Costs	• Series of changes to standardize billing and require health plans to adopt rules for the secure, confidential, electronic exchange of health information. • This will reduce paperwork and administrative duties, decrease costs, lessen the chance for medical errors and improve the quality of care.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only
W-2 Reporting	• Starting with the 2012 tax year, employers who distribute 250 or more W-2 Forms for the tax year are required to include the value of employer-sponsored coverage on each employee's W-2 Form. This requirement applies to employers who **distribute** 250 or more W-2s, not just to employers with 250 or more employees. • The amount reported includes both employer and employee contributions. This is not considered taxable income to the employee and is for information purposes only.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2013

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Flexible Spending Account (FSA) Limits	• Contributions to health FSAs limited to $2,500 a year per employed person indexed for inflation.	• Small Group Plans • Large Group Plans	**N/A**	**Group Plans:** • Grandfathered • Non-grandfathered
Expanded Authority to Bundle Payments	• Establishes a national pilot program to encourage hospitals, doctors and other providers to work together to improve the coordination and quality of patient care.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**N/A**
Medicare Taxes	• Employers are required to withhold an additional 0.9% Medicare tax on employee wages exceeding $200,000. While the 1.45% income tax withholding is still in place for all employees and employers, the new Medicare tax adds an additional 0.9% on wages and self-employment income above $200,000. • The additional tax is only assessed on the individual, who is ultimately responsible for the tax. However, employers who do not withhold this additional income tax will be liable. • There is an additional Medicare tax of 3.8% on investment income for Adjusted Gross Income (AGI) over $200,000/individual or $250,000/joint filers.	**N/A**	**N/A**	**N/A**
Notice of Exchange	• **All employers** are required to notify **all employees** (regardless of whether the employer provides or the employee is enrolled in health coverage) of the new Health Insurance Exchange marketplace. • Employers are expected to distribute the notice in late summer or fall of 2013 based on pending regulations.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2013 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Elimination of the Medicare Part D Employer Subsidy for Prescription Drug Coverage	• Employers can no longer claim a deduction for Medicare Part D employer subsidies for retiree prescription drug coverage.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered
Income Tax Deduction for Medical Expenses	The amount of medical expenses required to claim a tax deduction for medical expenses is increasing. • For those under age 65, the amount increases to 10% of Adjusted Gross Income (AGI) for 2013. • For those age 65 or older and spouses, the amount remains at 7.5% through 2016, then increases to 10%.	**N/A**	**N/A**	**N/A**

Provisions Effective 2014

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
American Health Benefit Exchanges	By 2014, states are required to operate a health care Exchange(s) that will be a new option for individuals and "small employers" to purchase health insurance or defer to the federal government to establish an Exchange for its citizens. (Prior to plan years beginning on or after 1/1/16, states have the option of defining "small employer" as 1–50. For plan years beginning on or after 1/1/16, it's uniformly 1–100.) • Carriers should have flexibility in product, cost sharing and network design to meet the needs of consumers. • The main objective of the Exchanges is to make health insurance coverage more affordable, accessible and easier to purchase for small businesses and individuals. • In 2017, states may allow employers with more than 100 employees to purchase coverage on the Exchange. • There are still many critical details yet to be determined by HHS and the states.	• Individual Plans/Policies • Small Group Plans • Large Group Plans (2017)	• Fully Insured	**N/A**

Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Individual Mandate	• All U.S. citizens and legal residents are required to have "minimum essential coverage." Individuals who fail to maintain coverage will be subject to a tax penalty calculated monthly and paid annually. This penalty is called a "shared responsibility payment." • An individual has minimum essential coverage for any month in which he or she is enrolled in one of the following types of plans for at least one day: – An employer group health plan – An individual health insurance policy – A government plan such as Medicare or Medicaid • The annual penalties for 2014 through 2016 are shown below. Beginning in 2017, penalties will increase based on the cost of living. – 2014: Greater of $95 per adult and $47.50 per child under age 18 (maximum of $285 per family) or 1% of income over the tax-filing threshold – 2015: Greater of $325 per adult and $162.50 per child under age 18 (maximum of $975 per family) or 2% over the tax-filing threshold – 2016: Greater of $695 per adult and $347.50 per child under age 18 (maximum of $2,085 per family) or 2.5% over the tax-filing threshold • Individuals who cannot afford coverage are exempt from paying the penalty. Coverage is considered unaffordable if the contribution toward minimum essential coverage is more than 8% of the annual household income. There are other exemptions as well.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**N/A**

Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Employer Mandate	• The employer mandate applies to employers with 50 or more full-time or full-time equivalent employees. • Employers must offer medical coverage that is "affordable" (costs no more than 9.5% of an employee's wages) and provides "minimum value" (covers 60%+ of total costs). • Coverage must be offered to full-time employees and their dependent children up to age 26. Spouses are not considered dependents per the legislation. • Employers will meet the requirement to offer coverage to "substantially all" full-time employees if they offer coverage to 95% of full-time employees and their dependents. • If no coverage is offered to full-time employees AND any full-time employee receives premium assistance from the federal government, the employer penalty is: – $2,000 annually for each full-time employee minus 30 • If coverage is offered to full-time employees BUT any full-time employee still receives premium assistance from the federal government, the employer penalty is the lesser of: – $3,000 for each employee receiving premium assistance OR – $2,000 per employee for each full-time employee minus 30 • These are the penalties for 2014. The penalties will be adjusted in 2015 and future years. • For employers whose plan year, as of December 27, 2012, began on a date other than January 1, no penalties will apply if they offer the required coverage as of the first day of their plan year beginning in 2014. • If an employer does not currently offer dependent coverage, no penalty is due for the plan year beginning in 2014 if the employer takes steps to offer dependent coverage during the 2014 plan year.	• Small Group Plans (with 50 or more employees) • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Essential Health Benefits	On December 19, 2011, HHS issued a bulletin outlining proposed policies and the approach it intends to pursue in rulemaking for defining Essential Health Benefits (EHB). • Beginning on January 1, 2014, non-grandfathered Individual and Small Group plans offered inside and outside the Exchanges must cover the EHB. • No lifetime or annual limits on the dollar amount of EHB. • EHB must include items and services within the following 10 benefit categories: – Ambulatory patient services – Emergency services – Hospitalization – Maternity and newborn care – Mental health and substance abuse disorder services (including behavioral health treatment) – Prescription drugs – Rehabilitative and habilitative services and devices – Laboratory services – Preventive and wellness services and chronic disease management – Pediatric services, including oral and vision care • States will select an existing health plan as a "benchmark" to establish the services and items included in the Essential Health Benefits package for 2014 and 2015. • States will choose from one of four health insurance plan options as a benchmark: – the largest plan based on enrollment in any of the three largest small group products in the state – any one of the three largest state employee health plans – any one of the three largest federal employee health plan options – the largest HMO plan offered in the state's commercial market • For states that do not choose, the benchmark will be the small group plan with the largest enrollment in the state. • For 2016 and beyond, HHS will reassess the proposed benchmark process.	• Individual Plans/Policies • Small Group Plans (to 100 Lives) • Large Group Plans	• Fully Insured	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only

Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
No Preexisting Conditions for all Ages	• Part of the Patient's Bill of Rights. • A preexisting condition limitation cannot be applied to any enrollee (employee, spouse or dependent), regardless of age.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Grandfathered • Non-grandfathered
Clinical Trials	• If a plan or issuer's coverage provides coverage to a qualified individual, then such plan or issuer: – May not deny the individual participation in the clinical trial; – May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and – May not discriminate against the individual on the basis of the individual's participation in such trial. • Coverage of benefits for routine patient care services must be provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided by the plan. • Approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only
Dollar Limits on Essential Health Benefits: Annual	• Part of the Patient's Bill of Rights. • Restricted annual limits are allowed on the dollar value of essential health benefits until 2014. After 2014, annual dollar limits will be prohibited on the dollar value of essential health benefits.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Grandfathered • Non-grandfathered
Health Insurance Industry Fee	This annual fee on health insurers applies to insured individual and group medical, dental and vision plans. It is paid by insurers based on each insurer's share of health insurance premiums. The fee is being built into rates and is expected to add 2% to 2.5% to premiums in 2014 and 3% to 4% in future years.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Reinsurance Assessment	• This annual fee will apply to insured and self-insured health plans from 2014 through 2016. The funds will be used to lessen the impact of high-risk individuals entering the individual market. • Insurers are responsible for paying the fee for insured plans. Employers with self-insured plans may choose to pay the fee directly or have their administrator pay the fee on their behalf. • The estimated cost is: – $60–$90 per member per year (PMPY) in 2014 – $40–$60 PMPY in 2015 – $25–$35 PMPY in 2016	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Individual Plans/Policies:** • Grandfathered • Non-grandfathered **Group Plans:** • Grandfathered • Non-grandfathered
Guaranteed Availability/Renewability	• Each health insurance issuer that offers health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for such coverage. • If a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured	**Individual Plans/Policies:** • Non-grandfathered only **Group Plans:** • Non-grandfathered only
Waiting Periods	• The PPACA prohibits group health plans and health insurance issuers offering group health coverage from applying any waiting period that exceeds 90 days.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered
Auto-Enrollment	• The legislation requires employers with more than 200 full-time employees that offer enrollment in one or more health benefit plans to automatically enroll new full-time employees in one of the plans and to continue the enrollment of current employees in a health benefit plan provided by the employer. The automatic enrollment program must include adequate notice and opportunity to opt out. This provision is not required to be implemented until additional regulations expected in 2014 are issued.	• Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2017

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Exchange Expansion to Large Groups	In 2014–2016, only individuals and small group employers are eligible to purchase coverage through Exchanges. Beginning in 2017, states may permit employers in the large group market to participate.	• Large Group Plans	• Fully Insured	**N/A**

Provisions Effective 2018

Provision	Provision Highlights	Market/Segment Impacted	Funding Impacted	Grandfathered Status
Excise "Cadillac" Tax on employer-sponsored health plans that offer policies with generous coverage levels.	• Imposes a 40% excise tax on high cost health plans that exceed $10,200 for individual and $27,500 for family coverage. • Family coverage threshold ($27,500 or $30,950) applies to single and family coverage under a multi-employer plan.	• Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**Group Plans:** • Grandfathered • Non-grandfathered

Provisions Effective 2020

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Medicare Part D	"Donut Hole" coverage gap in Medicare prescription benefit is fully phased out. Seniors continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage.	• Individual Plans/Policies • Small Group Plans • Large Group Plans	• Fully Insured • Self-funded	**N/A**