Keeping up with the new health care reform law

Helping you better understand what to expect and when to expect it.

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Staying up to date

Here's a timeline of what you can expect from the health care reform law.

A year-by-year look at the health care reform law

2010

As of March 23

- Early retiree reinsurance program, operational as of June 29, 2010
- Temporary high-risk pool for individuals with pre-existing conditions, operational as of July 1, 2010

Implemented on the next plan year for all plans (grandfathered or not) on or after September 23, 2010

- Dependent coverage for adult children up to age 26
- No lifetime coverage limits
- 100% coverage for preventive services in network*
- No annual limits on certain types of benefits
- No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services
- No pre-existing condition exclusions for children
- Revised appeals process
- Nondiscrimination in favor of highly compensated employees*

2011

- No pre-tax reimbursements from health account for non-prescribed, over-the-counter medications
- 20% tax for nonqualified HSA withdrawals
- Reporting the value of employer-sponsored coverage on W-2s
- Automatic enrollment in new long-term care program, with ability for employees to opt out

2012

- Uniform explanation of coverage
- Pre-enrollment document sent explaining benefits and exclusions
- 60-day notice for material modifications, if not provided in uniform explanation of coverage

2013

- Employee notification of exchanges, premium subsidies and free choice vouchers
- FSA contributions limited to $2,500 per year
- Fee for comparative effectiveness research agency for Fiscal Year 2013, which technically begins October 1, 2012

2014

- Individual mandate
- Free choice voucher required to be provided to qualifying employees
- Guaranteed issue
- Employer requirement to offer minimum essential coverage (50+ employees)
- HIPAA nondiscrimination rules on wellness programs
- 30% incentive cap for wellness programs
- Large groups required to auto-enroll employees into health benefits
- New fee on fully insured coverage
- 90-day limit on waiting periods for coverage

2018

- 40% excise tax on high-cost "Cadillac" plans

* Does not apply to grandfathered plans.

Knowing when the law applies

The health care reform law will impact many types of plans. But there are exceptions. This chart shows the applicability of the law's provisions for different types of health care plans.

Type of plan	Does the law apply?	Details
Self-funded ERISA plans	Yes	Certain provisions do not apply, including the medical loss ratio provision
Insured group health plans, including HMOs, subject to ERISA	Yes	
Collectively bargained ERISA plans (fully insured and self funded)	Yes	Provisions applicable to grandfathered plans also apply to a grandfathered collectively bargained agreement plan ratified before 3/23/10, both before and after the plan terminates. After termination of the agreement, if the plan loses grandfathered status, all health care reform provisions apply. If no changes are made between termination and renewal, health care reform would apply to first renewal after termination (and after loss of grandfathered status.)
Church plans (fully insured and self funded)	Yes	
Self-funded state and local government plans (including public school plans)	Yes	Self-funded, non-ERISA, non-federal government plans are not permitted to opt out of the new insurance market reforms.
Insured state and local government plans	Yes	Subject to the law because the health insurance issuer underwriting the plan is subject to it.
Medigap and Medicare Supplement plans	No	
Retiree-only plans (fully insured and ASO)	No	Health care reform will not be enforced for retiree-only plans. This exclusion is based on language saying that plans covering fewer than two current employees are exempt from certain federal laws, such as health care reform. By definition, retiree-only plans only cover retirees and sometimes dependents, so there can be no current employees in the plan. States are encouraged to adopt a similar position, but states may make a different interpretation for issuers of retiree-only plans and non-federal government-only plans.
Individual health plans	Yes	
Pharmacy	Yes	Subject to the law because pharmacy benefits are not HIPAA-exempted.
Vision and dental	Yes (if not HIPAA-exempted) No (if HIPAA-exempted)	Dental and vision are not subject to the law if they meet the definition of a HIPAA-exempted benefit.
Excepted benefits – disability and life	No	Not subject to the law.
Health savings accounts (HSAs)	Yes (provisions specific to HSAs) No (other provisions)	The actual HSAs are not ERISA plans, so they are exempt from the law except certain provisions specific to HSAs, such as qualifying mid-year events and penalty changes. The actual high-deductible health plan is subject to the law, including the mandate for preventive services.
Health reimbursement accounts (HRAs)	Yes	Subject to ERISA so subject to the law.
Executive medical plans	Yes	These plans must comply with the same provisions as all grandfathered plans. Also, these plans cannot be offered only to highly compensated individuals. The group is responsible for complying.

Being informed

Plan changes. Coverage requirements. Benefit subsidies. When it comes to the health care reform law, there's a lot to know. The more you understand the law and its provisions, the more you can get from it. Here's a look at what you can expect now and in the coming years.

As of March 23, 2010

Early retiree reinsurance program: $5 billion has been set aside to help employers continue to provide coverage to certain retirees. The employer can be reimbursed up to 80% for an early retiree claim, between $15,000 and $90,000. The funds must be used to help lower health care costs (such as premium contributions, copays and deductibles) for enrollees. Self-funded and fully insured groups are eligible. This is a temporary program, beginning in June 2010 and ending in 2014 or when the funds are exhausted – whichever comes first.

YOU CAN START REDUCING COSTS NOW

The early retiree reinsurance program is available to employers now. This is a temporary program that ends in 2014 or when funds run out. Think about taking advantage of it right away. Go to the U.S. Department of Health and Human Services (HHS) website at www.hhs.gov/ociio/regulations/index.html#early_retiree for forms and submission instructions. We'll help you apply for these funds by supplying required reporting and information like:

- **A tool to help you estimate reimbursement amounts for the first two plan-year cycles**
- **Ongoing data to submit claims eligible for reimbursement**
- **Information about programs that generate savings for members with chronic and high-cost conditions**
- **Information about our fraud, waste and abuse programs and procedures**

As of September 23, 2010

Implementation of changes: As of September 23, 2010, certain changes will be made to a plan as of its next plan year start date. So, if a group's plan year start date is December 1, then the changes will be implemented December 1, 2010. If a group's plan year start date is July 1, then the changes must be implemented July 1, 2011.

Grandfathered plans: Plans that existed on or before March 23, 2010 – the date the law took effect – and that continue after that date are considered "grandfathered" plans. This means the plans may be exempt from some of the requirements of the health care reform law. However, certain changes must be made to all plans, whether they're grandfathered or not.

The following changes must be made to all plans:

- No lifetime benefit maximum limits
- Dependent coverage for adult children up to age 26
- No annual limits on certain types of benefits
- No pre-existing conditions exclusions for children under age 19

If certain changes in coverage are made after the law's effective date, the plan will likely not be a grandfathered plan. This means the plan must also include the following changes:

- 100% coverage for preventive care in network
- No prior authorization for emergency services or higher cost-sharing for out-of-network emergency services
- Coverage of routine patient costs for clinical trials of life-threatening diseases, starting in 2014

Note: While not all health care reform changes are required in grandfathered plans, in some cases our company has decided to adopt health care reform provisions in both grandfathered and non-grandfathered plans. Per Health and Human Services, adoption of these additional provisions has no impact on the grandfathering status of those plans. For specific benefit plan impacts of health care reform, please refer to plan materials provided to you.

Keeping grandfathered status: According to interim final rules, there is some flexibility to modify a plan without losing the grandfathered status. This includes:

- Changes to comply with federal or state laws
- Routine premium changes of a policy or plan to keep pace with medical inflation
- Adding new benefits and making modest adjustments to existing benefits
- Changes to voluntarily comply with the health care reform law
- Changes in third-party administrators
- Changes in premiums

Losing grandfathered status: The following changes to a plan will result in the loss of a grandfathered status:

- Eliminating all (or substantially all) benefits to diagnose or treat a particular condition
- Increasing coinsurance by any amount above the level set on March 23, 2010
- Increasing fixed amount cost sharing (other than copays) more than the sum of medical inflation plus 15 percentage points from the level of March 23, 2010
- Increasing copays by an amount that exceeds the greater of (1) a total percentage (measured from March 23, 2010) that is more than the sum of medical inflation plus 15 percentage points, or (2) $5 multiplied by medical inflation, plus $5
- Reducing employer or employee organization contributions based on the cost of coverage or a formula by more than 5 percentage points below the contribution rate on March 23, 2010
- Reducing an overall annual dollar limit or adding a new overall annual dollar limit, compared with what was in effect on March 23, 2010
- Ensuring that consumers switch to a grandfathered plan that, compared with the current plan, has fewer benefits or higher cost sharing as a means of avoiding new consumer protections
- Buying and/or merging with another plan to avoid complying with the health care reform law

Note: According to the Interim Final Regulations, it appears that groups that have changed benefits between March 23, 2010, and June 14, 2010, may have the opportunity to change back to their previous plan and regain grandfathered status at their next renewal date in 2011.

Appeals process for non-grandfathered plans: The revised appeals process for coverage determinations and claims must, at minimum:

- Have an internal claims appeal process.
- Provide notice of any external appeals mechanism that exists in the state.
- Allow the enrollee to review file, present evidence and continue to receive coverage pending outcome.
- Implement an external review process at least as good as the NAIC model law.

Here's a more detailed look at the provisions that apply to grandfathered plans, as compared to non-grandfathered plans:

Provision	Grandfathered plans	Non-grandfathered plans
No lifetime benefit maximum limits	✔	✔
Dependent coverage for adult children up to age 26	✔	✔
No annual limits on certain types of benefits for group plans	✔	✔
100% coverage for preventive care in network		✔
No prior authorization for emergency services or higher cost sharing for out-of-network emergency services		✔
No pre-existing limitations for children under the age of 19 for group plans	✔	✔
Coverage of routine patient costs for clinical trials of life-threatening diseases		✔
Reporting the value of employer-sponsored coverage on W-2s (2011)	✔	✔
Automatic enrollment in long-term care program	✔	✔
Uniform explanation of coverage (2012)	✔	✔
Pre-enrollment document sent explaining benefits and exclusions (2012)	✔	✔
60-day notice for material modifications (2012), if not already disclosed in uniform explanation of coverage	✔	✔
90-day limit on waiting periods for coverage (2014)	✔	✔
Employer requirement to offer minimum essential coverage (50+ employees) (2014)	✔	✔
Nondiscrimination in favor of highly compensated employees		✔

We are making grandfathered plans available in all markets. However, specific discontinued plans and portfolios may not be available in some markets, even if employers want to grandfather them. Also, employers with 1-100 employees (as defined by Health and Human Services) will not be able to combine a grandfathered plan and a non-grandfathered plan in their employee offering. Please contact your account representative for details.

As of January 1, 2011

Automatic enrollment in assisted living programs: Employers will automatically enroll employees into the Community Living Assistance Services and Supports long-term care program. Employees may opt out. More guidance to come.

Additional W-2 reporting: Employers must start reporting the value of the employer-sponsored coverage on their employees' W-2s. However, employees are not taxed on this amount.

No pre-tax reimbursements for members on over-the-counter drugs: Account holders will stop receiving pre-tax reimbursements from their FSA, HRA or HSA for non-prescribed, over-the-counter medications.

Tax increase on non-qualified HSA withdrawals: The excise tax for nonqualified HSA withdrawals will increase from 10% to 20%.

Research funding: Employers with self-funded health care plans will start paying a fee to fund a comparative effectiveness research agency. If the health care plan is fully insured, the health insurer will be assessed this fee. This charge will be $1 times the average number of covered lives. In 2014, it will be $2 times the average number of covered lives. The fee ends on September 30, 2019. This is based on Fiscal Year 2013, which starts in 2012.

As of 2013

Employee notification: Employers will need to start telling employees about exchanges, premium subsidies and free choice vouchers.

Contribution cap for FSAs: Employee contributions for FSAs will be capped at $2,500 annually, with the cap adjusted annually to the Consumer Price Index.

As of 2014

Small group redefined: Small group will be redefined from 2-50 to 1-100. (States may defer the implementation of the increase to 100 until 2016.)

Requirement to offer coverage: Employers with 50 or more full-time employees will be required to offer minimum essential coverage. This coverage must have a 60% actuarial value minimum. (Basically, this means the plan covers at least 60% of covered health care costs.) Employers will be subject to penalties if they provide no health coverage to full-time employees or provide coverage that is not "affordable." These penalties will range from $2,000 to $3,000 per employee.

Automatic enrollment in health care plans: Employers with more than 200 employees will start automatically enrolling full-time employees into their health care plans. Employees may opt out.

Free choice voucher: Employers will have to allow for the use of free choice vouchers if the employee's premium cost sharing is between 8% and 9.8% of his or her household income. The voucher is paid by the employer and goes toward the cost of coverage through the exchange.

Incentives: The law codifies the HIPAA nondiscrimination rules on wellness programs and increases the incentive cap to 30% of the premium. The cap can increase to 50% at the discretion of the HHS secretary.

Fee on health insurance providers: A new fee will be built into the cost of fully insured coverage.

Treasury reporting: Effective for tax years beginning after December 31, 2013, employers will be required to annually report information, such as:

- Whether minimum essential coverage is offered to full-time employees
- Any waiting periods for health coverage
- The monthly premium for the lowest cost option in each enrollment category under the plan
- The employer's share of the total allowed cost of benefits provided under the plan
- Number of full-time employees during each month
- Name, address and taxpayer identification number (or Social Security number) of each full-time employee, and the months each employee was covered under the employer's plan
- Other information that HHS may require (which will likely be refined in later regulations)

Waiting period: Group health plans cannot require waiting periods of more than 90 days.

As of 2018

High-cost plans: There will be a 40% excise tax on high-cost plans – also known as "Cadillac" plans – that cost more than $10,200 for single coverage or $27,500 for family coverage. The insurer or employer will be responsible for the tax.

There's a lot to know when it comes to the health care reform law. And there's more to come as this law continues to take shape. For the latest developments, check in at anthem.com. You'll also find the latest news, as well as other important health-related information at healthcare.gov.

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