Health care reform checklist (For California employers 51-100)

Anthem BlueCross

For 2015-2016 plan years

If you provide health coverage to employees, you are responsible for complying with many of the provisions of the Affordable Care Act (ACA). Some provisions of the federal health care reform law took effect for plan years beginning on or after September 23, 2010. Other provisions will take effect through 2018. The checklist below will help you determine whether or not a health plan complies with the health care reform law in 2015 and into 2016.

For 2015: Employers with 51-100 full-time workers do not have to offer minimum value, affordable health coverage until 2016, if they meet certain conditions.

For 2016: As of January 1, 2016, groups with 51-100 full-time employees will be redefined as "small groups" and will have to switch to a small group metal plan (as required by the ACA).

Use this checklist to determine which provisions apply by checking "Yes" or "No" in the right-hand columns. This chart is a high-level reference document only. See details about specific provisions at makinghealthcarereformwork.com.

Provision	Applies To	Yes	No
Benefits and administration			
Metal levels • Plan must meet 1 of 4 actuarial value levels – 60%, 70%, 80%, 90% • May vary +/- 2% either way	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Out-of-pocket maximum limits applied to essential health benefits (effective plan year beginning on or after January 1, 2014): • $6,350 for individuals and $12,700 for families for 2014 plan years • 2015: — Traditional plans: $6,600 self only/$13,200 other than self only — High-Deductible Health Plans (HDHPs) with deductibles no less than $1,300 self only/$2,600 other than self only: $6,450 self only/$12,900 other than self only • Includes deductible, coinsurance and copayments • Rx and other services provided by vendors other than the medical plan administrator can have separate out-of-pocket maximum limits up to $6,350 for individuals and $12,700 for families in 2014: — In 2015, total out-of-pocket maximum for all services when added together cannot be more than $6,600 self only/$13,200 other than self only for traditional plans, or $6,450 self only/$12,900 other than self only for HDHPs — Separate out-of-pocket maximums can be set for different vendors as long as the amounts are not more than the OOPM for the year when added together	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
No pre-existing condition exclusions regardless of age	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Coverage waiting period not to exceed 90 calendar days: • Coverage waiting period options include: — First of the month following date of hire — First of the month following one month from date of hire — First of the month following two months from the date of hire, not to exceed 90 days[1]	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Coverage of routine care costs for patients in clinical trials (effective January 1, 2014)	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		

Provision	Applies To	Yes	No
Benefits and administration (continued)			
Essential health benefits package required (effective plan year beginning on or after January 1, 2014)	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
HIPAA nondiscrimination rules on wellness programs	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Wellness program maximum incentive can increase to 30%: • Up to 50% for programs designed to prevent or reduce tobacco use	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Guaranteed issue (employer level effective January 1, 2014) **(Insurance companies are not allowed to decline based on health status or employer contributions.)**	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Rating limitations (effective plan year beginning on or after January 1, 2014)	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Summary of benefits and coverage (SBC): • Update information in the document based on any plan design changes • Add information about minimum value	☐ Grandfathered[2] ☑ Non-grandfathered ☑ Fully insured		
Notice of material modification: • Requires plan sponsors or issuers to give 60 days advance notice when making material modifications to the plan • Modifications include any change to the coverage, such as enhanced or reduced benefits, increased premiums or cost sharing, and new referral requirements • Can be satisfied by sending an updated *Summary of Benefits and Coverage* or separate written notice	☐ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Taxes and fees			
Comparative effectiveness research fee (CER): • CER will explore the effectiveness, risk and benefits of medical treatments through the Patient-Centered Outcomes Research Institute • For plan years that end October 1, 2013, through September 30, 2014, the fee is $2 per member per year (includes dependents) • For policy and plan years beginning on or after October 1, 2014, and before October 1, 2019, the amount will be adjusted for inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services • To be paid by the plan issuer (fully insured) or plan sponsor (self-insured) based on the number of covered lives • Payment must be made by July 31 of the calendar year immediately following the last day of the plan year	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Reinsurance fee: • To be paid by the plan issuer (fully insured) or plan sponsor (self-insured) based on the number of covered lives	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Insurer fee (or health insurance tax): • Funds premium subsidies and Medicaid expansion • Insurer of fully insured plans pays this fee (included in premium) • The fee is based on the insurer's market share of net premiums written for the previous year	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		

Provision	Applies To	Yes	No
Reporting			
Minimum Essential Coverage Reporting (IRS Code Section 6055): • Reports due in 2016 or 2015 plan year and each year after: — February 28 — March 31 if filing electronically • Provide Minimum Essential Coverage data to IRS using Form 1095-C: — Insurer will file for fully insured plans • Give statement of Minimum Essential Coverage to workers who have information reported: — Has to include all people covered by the plan during the year – workers and dependents	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		
Employer Mandate Reporting (IRS Code Section 6056): • Employers with 50 or more full-time workers must report: — Reports due in 2016 or 2015 plan year and each year after: • February 28 • March 31 if filing electronically • Report Employer Mandate data to IRS using form 1094-B • Employer is responsible for this filing • Give employer mandate statement to workers who have had information reported: — Has to include all people covered by the plan during the year – workers and dependents	☑ Grandfathered ☑ Non-grandfathered ☑ Fully insured		

More tools and resources

For the latest information on health care reform and our implementation efforts, please visit makinghealthcarereformwork.com. The site also includes many useful tools such as:

- A tool that can help large groups make decisions about how to comply with health care reform rules.
- An easy-to-use library.
- Podcasts, recordings and presentations about health care reform.
- An interactive timeline to help your business prepare for upcoming health care reform changes.

Ask your Sales or account representative for more information about the resources above.

This content is provided solely for informational purposes. It is not intended as and does not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisors.

1 If the waiting period exceeds 90 days, the effective date will be first of the month following one month from the date of hire.

2 SBCs for closed plans are not yet required. The safe harbor continues to apply until further guidance is provided.