Health care reform checklist
(for small employers)

Updated for 2018-2019 plan years

An Anthem Company

Keeping things running smoothly at your business, starts with getting the answers to the questions that matter most to you — especially when it comes to health care reform. That's why we'll give you everything we can to make sure you're on track.

First, let's get down to the basics. If you offer health benefits to your employees, you're in charge of meeting the provisions of the Affordable Care Act (ACA). Some terms of the federal health care reform law took effect for plan years that began on or after September 23, 2010. Other provisions may take effect through 2020.

To get ready for the next plan year, you need to know whether the plan is grandfathered. A plan is grandfathered if it went into effect **before** March 23, 2010, and hasn't had certain changes since then. **Keep in mind grandfathered status is based on the plans and benefits in place on March 23, 2010.**

Under the law, grandfathered status may apply separately to each benefit plan offered under a group health plan. Once you know if the plan is grandfathered, use this checklist to find out if it includes the terms that apply to the plan.

This chart is a high-level reference document only.

Provision	Applies to		Yes	No
Benefits and administration				
Metal plan levels: • Plans must meet 1 of 4 actuarial value levels – 60%, 70%, 80%, 90%. • May vary +/- 2% either way.	Grandfathered Fully insured	Nongrandfathered Self-insured		
ACA Maximum Out-of-Pocket (MOOP) Guidelines Beginning January 1, 2016, the annual limit on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only (family plan). Requirement applies to Individual and Small Group plans, on- and off-exchange, and Large Group and ASO plans. Deductible, coinsurance (an employee's share of the costs) and copayments all apply to the out-of-pocket limits on all impacted plans. **Out-of-pocket maximum limits:** • **HHS** sets the ACA maximum out-of-pocket limits for non-grandfathered plans on a yearly basis. • **IRS** sets the out-of-pocket limits for HSA High-Deductible Health Plans (HDHPs) on a yearly basis. **2018 ACA MOOP limits:** • $7,350 for self-only and/or individual tier in a family plan. • $14,700 for family tier. **2018 IRS MOOP limits:** • HSA-qualified HDHPs: $6,650 self-only/$13,300 family. **2019 ACA MOOP limits:** • $7,900 for self-only and/or individual tier in a family plan. • $15,800 for family tier. **2019 IRS MOOP limits:** • HSA-qualified HDHPs: $6,750 self-only/$13,500 family.	Grandfathered Fully insured	Nongrandfathered Self-insured		
No pre-existing condition exclusions regardless of age	Grandfathered Fully insured	Nongrandfathered Self-insured		

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Provision	Applies to	Yes	No
Benefits and administration (continued)			
Coverage waiting period not to exceed 90 calendar days: • An orientation period of one calendar month minus one day can be applied on top of the 90 days. • The 90-day waiting period must begin on the next calendar day after the orientation period ends. • Coverage must start on the 91st day, not the first of the month following 90 days.	Grandfathered Nongrandfathered Fully insured o Self-insured		
Coverage of routine care costs for patients in clinical trials (effective January 1, 2014)	Grandfathered Nongrandfathered Fully insured Self-insured		
Essential health benefits and state-specific benchmark plans required (effective plan year beginning on or after January 1, 2014)	Grandfathered Nongrandfathered Fully insured o Self-insured		
Wellness programs maximum incentive is 30% of self-only premium: • 2017 and forward: — Children (including adult children) will not be able to earn an incentive.	Grandfathered Nongrandfathered Fully insured Self-insured		
Guaranteed issue at employer level **Insurance companies are not allowed to decline based on health status. Additionally, they are not allowed to decline based on employer contributions and participation limits during the open enrollment period.**	Grandfathered Nongrandfathered Fully insured Self-insured		
Nondiscrimination in health programs and activities (ACA Section 1557) • Plan years January 1, 2017 and after: — Cannot have explicit, categorical (or automatic) exclusions or limitation of coverage for all health services related to gender transition when medical necessity criteria is met. — Must ensure that there are no arbitrary limits or exclusions that are discriminatory based on age, gender, disability, race or national origin.	Grandfathered Nongrandfathered Fully insured Self-insured		
Summary of Benefits and Coverage (SBC): • Compliance with SBC templates required.	Grandfathered Nongrandfathered Fully insured Self-insured		
Notice of material modification: • Requires plan sponsors or issuers to provide 60 days advance notice when making material modifications to the plan outside of the renewal. • Includes 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 Nongrandfathered Fully insured Self-insured		
Taxes and fees			
Patient-Centered Outcomes Research Institute (PCORI) tax: • PCORI explores the effectiveness, risk and benefits of medical treatments through the Patient-Centered Outcomes Research Institute. • For plan years that end October 1, 2017, through September 30, 2018, the fee is $2.39 per member per year (includes dependents). The rate goes up each year based on medical inflation. • ASO: Calculate amount due based on the average number of covered lives during the plan year (including retirees and dependents). — ASO: Submit to IRS by July 31 of the year following the end of the plan year. — Fully insured: Fee is included in rates. — Combined funding arrangements: we will pay the fee for the fully insured plan, but not the self-funded plan. — Health reimbursement accounts (HRAs) are considered a self-funded arrangement. We will pay the fee for the insured business. Clients need to calculate and pay the fee for the HRA portion of the arrangement.	Grandfathered Nongrandfathered Fully insured Self-insured		

Provision	Applies to		Yes	No
Taxes and fees (continued)				
Reinsurance fee (the ACA reinsurance fee is no longer applicable in 2017 and beyond): • To be paid by the plan issuer (fully insured) or plan sponsor (self-insured) based on the number of covered lives. • Self-insured (ASO) clients paid directly to HHS and choose from four calculation options for the number of covered lives: — Report number of covered lives, due to HHS by November 15. — HHS notified client of payment due by December 15. — Client was required to pay within 30 days of getting the notice from the HHS.	Grandfathered Fully insured	Nongrandfathered Self-insured		
Health Insurance Tax (HIT)/(ACA Insurer Fee): • 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. *The short-term spending bill, signed into law on January 22, 2018, suspends the ACA insurer fee for 2019.*	Grandfathered Fully insured	Nongrandfathered Self-insured		
Reporting				
Minimum Essential Coverage (MEC) Reporting (IRS Code Section 6055): • To make sure people have MEC, the IRS requires reports be sent by those who provide MEC. This is called Minimum Essential Coverage Reporting, or IRS Code Section 6055 Reporting. Applies to: • Insurers (on fully insured business). • Employers with self-funded (ASO) health plans. — Employers can hire third parties to do reporting for them, but the company is legally responsible. Anthem will not act as the third party and will not file the report for a fee. How it works: • Insurer files form 1095-B with MEC data to the IRS for fully insured plans and provides a copy to plan members. • Employer, or plan sponsor, files form 1095-C with MEC data to the IRS for ASO plans. Timing: • Reports due in the current year for the previous plan year: — Statements to plan members due by January 31 • Statements to IRS due by March 31 for electronic filing (e-file): — Employers with 250 or more returns must e-file	Grandfathered Fully insured	Nongrandfathered Self-insured		
Employer Mandate Reporting (IRS Code Section 6056): • To check if employers are offering minimum value, affordable coverage to their full-time workers, the IRS requires reports be sent by applicable large employers. This is called Employer Mandate Reporting or IRS Code Section 6056 Reporting. Applies to: • Applicable large employers (50 or more full-time workers). • Employers can hire third parties to do reporting for them, but the company is legally responsible. How it works: • Employer provides mandate data to the IRS using form 1094-C transmittal form. • Statements are sent to workers using form 1095-C, with a copy sent to the IRS. Timing: • Reports due in in the current year for the previous plan year: — Statements to workers due by January 31. • March 31 for electronic filing (e-file): — Employers with 250 or more returns must e-file.	Grandfathered Fully insured	Nongrandfathered Self-insured		

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