informed on reform

KEEPING YOU UP-TO-DATE ON THE PPACA

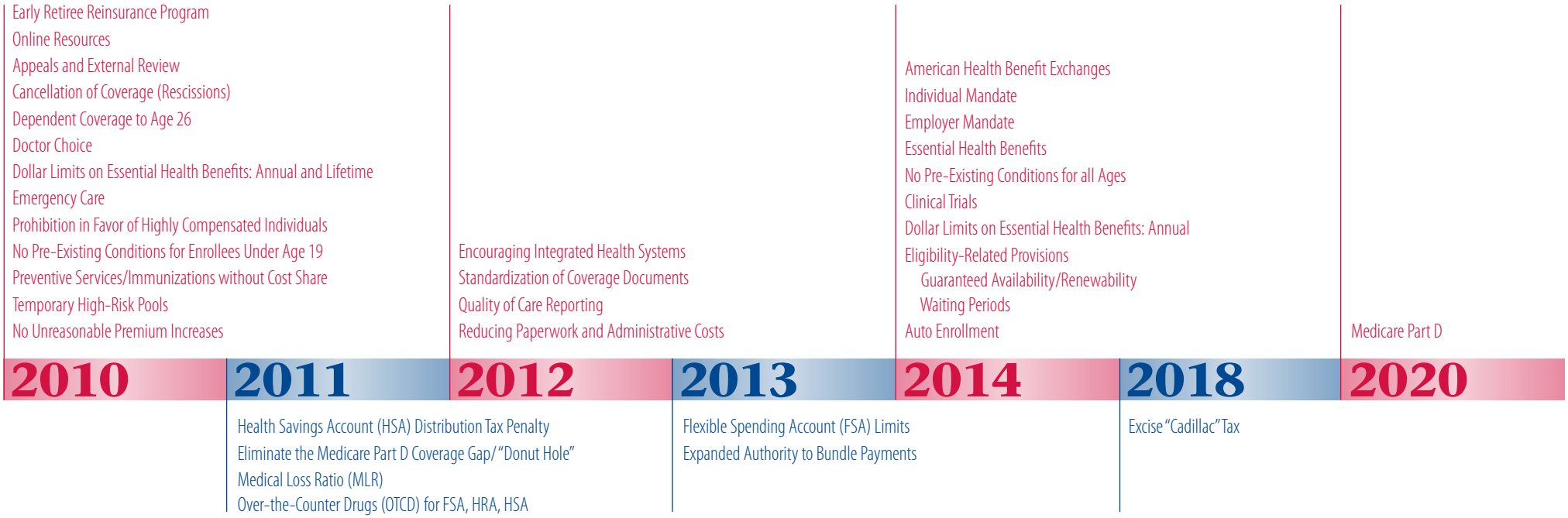
CIGNA

Health Care Provisions
Last updated: February, 2011

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

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Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Appeals and External Review	■ 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. ■ Implementation is in a safe harbor period granted by HHS and DOL with full implementation of the provision set for July, 2011.	■ 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

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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 (employee's 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 amend 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

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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	**Lifetime Dollar Limits:** **Individual Plans/Policies:** ■ Grandfathered ■ Non-Grandfathered **Group Plans:** ■ Grandfathered ■ Non-Grandfathered **Annual Dollar Limits:** **Individual Plans/Policies:** ■ Non-Grandfathered Only **Group Plans:** ■ Grandfathered ■ Non-Grandfathered

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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., 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

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Provisions Effective 2010 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
No Pre-Existing Conditions for Enrollees Under 19	■ Part of the Patient's Bill of Rights. ■ A pre-existing 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
Preventive Services/ Immunizations without Cost Share	■ Preventive care services and immunizations must be covered with no cost-sharing. 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. • Certain preventive care measures for women. These recommendations will be in place until new requirements for preventive care for women are issued by the United States Preventive Services Task Force or appear in comprehensive guidelines supported by the Health Resources and Services Administration. ■ 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

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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 pre-existing 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**

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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 dispersed amount. (Prior to January 1, 2011, this penalty had been 10%.) ■ This requirement is effective immediately 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**

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Provisions Effective 2011 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Medical Loss Ratio (MLR)	■ 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 are 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 will be required to complete additional quarterly reporting through 2011. After reviewing this additional reporting, these adjustments will be revisited by the HHS Secretary for 2012 and beyond. ■ 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

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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

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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. ■ Help prevent disease and illness. ■ Reduce 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**
Standardization of Coverage Documents *Note: Additional guidance expected to be issued by 3/23/2011.*	Requires that the outline of coverage: ■ Must not exceed four 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. ■ Has a description of coverage, including the dollar amount for the following benefits: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, physician services, prevention and wellness services, prescription drugs and other benefits. ■ Includes the exceptions, reductions and limitations on coverage, the cost-sharing provision, the renewability and continuation of coverage provisions, a statement indicating whether the plan provides minimum essential coverage, a statement indicating that the outline is a summary of the policy and that the coverage document itself should be consulted to determine the governing contractual provisions, a contact number for the consumer to call with additional questions, and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. ■ $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

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Provisions Effective 2012

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 **Group Plans:** ■ Non-Grandfathered
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 **Group Plans:** ■ Non-Grandfathered

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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 – 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**

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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 other 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**
Individual Mandate	■ All U.S. citizens and legal residents would be required to have "minimum essential" coverage. Individuals who fail to maintain coverage will be subject to a tax penalty calculated monthly and paid annually.	■ Individual Plans/ Policies ■ Small Group Plans ■ Large Group Plans	■ Fully Insured ■ Self-Funded	**N/A**
Employer Mandate	■ If no coverage is offered to full-time employees AND any full-time employee receives premium assistance from federal government: • $2,000 annual fee 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 federal government: • The lesser of: (i) $3,000 for each employee receiving premium assistance OR (ii) $2,000 per employee for each full-time employee minus 30. ■ 50 or more full-time employees.	■ Small Group Plans ■ Large Group Plans	■ Fully Insured ■ Self-Funded	**N/A**

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Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
Essential Health Benefits	We are still awaiting guidance from the U.S. Department of Health and Human Services on the definition of "essential health benefits," but the law includes the following 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	■ Individual Plans/ Policies ■ Small Group Plans (to 100 Lives) ■ Large Group Plans	■ Fully Insured	**Individual Plans/Policies:** ■ Non-Grandfathered **Group Plans:** ■ Non-Grandfathered
No Pre-Existing Conditions for all Ages	■ Part of the Patient's Bill of Rights. ■ A pre-existing 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

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Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
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 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
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

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Provisions Effective 2014 (continued)

Provision	Provision Highlights	Market / Segment Impacted	Funding Impacted	Grandfathered Status
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	■ 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	■ 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.	■ Large Group Plans	■ Fully Insured ■ Self-Funded	**Individual Plans/Policies:** ■ Non-Grandfathered Only **Group Plans:** ■ Grandfathered ■ Non-Grandfathered

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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**

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