To-Do List, Part 2

ACA requirements to consider for 2014

In our last column, we noted that many plan sponsors had been waiting for the Supreme Court's decision on the Affordable Care Act (ACA) to fully launch the next phase of compliance and that they should review the upcoming requirements to make sure they are prepared to comply.

That column focused on "to-do" items for 2012 and 2013. Here, we provide a checklist of ACA requirements that apply to group health plans and plan sponsors for 2014.

Except where noted, these requirements generally apply to all group health plan coverage—insured and self-funded—including grandfathered plans. However, each requirement may have its own set of exceptions for more limited benefits, such as those excepted under the Health Insurance Portability and Accountability Act (HIPAA) or retiree-only coverage. Plan sponsors should review this checklist and make sure they have a strategy for completing their own "to-do" lists.

2014 CHECKLIST

❑ **Individual mandate.** Starting January 1, 2014, most U.S. taxpayers must be enrolled in "minimum essential coverage" or pay a penalty. Minimum essential coverage includes exchange coverage, individual insurance coverage, Medicare and most employer-sponsored coverage. We are waiting for guidance as to a more specific meaning of minimum essential coverage.

❑ **Exchange coverage begins.** Starting January 1, 2014, state-based exchanges will be up and running. Where a state does not create an exchange, the U.S. Department of Health and Human Services (HHS) will create a federal exchange. Health coverage may be purchased on an individual basis through the exchange, even if an individual is eligible for employer coverage. Those who fall below certain income thresholds may qualify for a premium credit under the exchange. Small employers may be able to purchase group coverage through special Small Business Health Operations Program (SHOP) exchanges.

❑ **Employer mandate: Play or pay.** Beginning in 2014, employers will be required to offer minimum essential coverage or face a penalty. Coverage will be considered to meet this standard if it passes an affordability test, stipulating that employee premiums not exceed 9.5% of the employee's income, and a minimum value test stipulating coverage must have a value of 60%, presumably when compared to the employee cost share.

❑ **Waiting periods of 90 days.** For plan years starting on or after January 1, 2014, waiting periods under group health plans may be no longer than 90 days.

❑ **Coverage for clinical trials.** For plan years starting on or after January 1, 2014, group health plans must cover certain clinical trial costs and may not discriminate against individuals who participate in qualified clinical trials. We are waiting for more guidance on this provision. Grandfathered plans are excluded from this requirement.

❑ **Increased wellness program incentives.** For plan years starting on or after January 1, 2014, the incentive amount that group health plans may offer under health-based wellness programs governed by the HIPAA wellness rules is increased from 20% of the cost of employee coverage to 30%.

❑ **No annual dollar limits on essential health benefits.** For plan years starting on or after January 1, 2014, group health plans may no longer impose annual dollar limits on essential health benefits. Similar lifetime dollar limits were prohibited starting for plan years on or after September 23, 2010. Since then, plans have been permitted three years to phase in the restrictions; however, this policy will end, beginning in 2013.

❑ **No pre-existing condition exclusions (PCEs).** For plan years starting on or after January 1, 2014, group health plans must eliminate all PCEs.

❑ **Cost-sharing limits.** For plan years starting on or after January 1, 2014, group health plans must limit cost-sharing or out-of-pocket maximums to $5,950 for individuals and $11,900 for families; these are today's numbers and will be adjusted for cost of living before 2014. Grandfathered plans are excluded from this requirement.

❑ **Deductible limits.** For plan years starting on or after January 1, 2014, group health plans may not impose a deductible higher than $2,000 per individual or $4,000 per family (indexed). There is much debate about whether this provision applies only to the small group market or to the large group market, as well, and more guidance would be welcome. Grandfathered plans are excluded.

❑ **Essential health benefits.** Starting in 2014, insured plans in the individual and small group markets must cover each of the essential benefits categories listed under the ACA. Grandfathered plans, self-funded plans and insured plans in the large group market are excluded.

❑ **Reinsurance fee.** HHS will assess a fee on "contributing entities" to fund a reinsurance program to help cover costs for high-risk individuals in the individual market during the rollout of the exchange. A "contributing entity" is defined as a health insurance issuer or third party administrator (TPA) on behalf of self-insured group health plan coverage. The reinsurance fee will be payable for only three years—2014 to 2016—and will be collected on a quarterly basis starting January 15, 2014. The fee will be based on the number of covered lives under the plan, but HHS has yet to provide more specific guidance on the amount or how to calculate the fee. However, in the first year, the fee must total at least $10 billion on a national basis.

❑ **Insurer provider fee.** Starting in 2014, insurers must pay an annual fee on net written health insurance premiums, calculated by dividing the covered entity's net premiums by the net premiums of all covered entities and then multiplying this fraction by a set annual amount. In 2014, this amount will be $8 billion.

❑ **IRS reporting for employers (Sections 6055 and 6056).** Starting in 2014, there will be an Internal Revenue Service (IRS) annual reporting requirement that applies to any entity that provides minimum essential coverage, which generally includes any "eligible employer-sponsored plan" (Internal Revenue Code [IRC] Section 6055). A separate reporting requirement requires large employers (generally, those with at least 50 full-time workers) to report to the IRS whether they offer full-time employees minimum essential coverage (IRC Section 6056).

This checklist first appeared on www.plansponsor.com in September. Because health care law is evolving rapidly, there may have been further developments since the initial publication.

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