# Stay Compliant with ACA

## Medical Employer Groups

Dec. 1, 2013

The Affordable Care Act (ACA) requires businesses to take on a number of new tasks, from making sure you're providing the required level of health insurance to providing new reports to your employees and the government. Use this checklist to make sure you're staying on track.

### Make sure you've addressed these requirements, which have been in effect since 2012 or earlier:

- Provide your employees with a Summary of Benefits and Coverage, clearly explaining what their plan covers and what it costs.
- Make sure any health accounts you have set up for your employees, such as flexible spending accounts (FSAs), health reimbursement accounts (HRAs) or health savings accounts (HSAs), comply with new rules:
- They can no longer be used to buy over-the-counter drugs (except insulin) without a prescription.
- Employees are limited to contributing no more than $2,500 to FSAs.
- Employees will pay higher penalties (20 percent) for withdrawing HSA funds for non-medical expenses.
- You should have begun paying a $1 per enrollee Patient Center Outcomes Research Institute (PCORI) fee in 2012. This fee, to fund comparative effectiveness research, increased to $2 per enrollee in 2013, and in subsequent years will be adjusted based on the percentage increase in the projected per capita amount of national health expenditures. The fee ends in 2019.

### Prepare to comply with these requirements in 2013 and beyond:

- If you have not been providing insurance, investigate your options now. If you have fewer than the full-time equivalent (FTE) of 50 employees, you do not have to offer coverage. If you have 50 or more employees, you may have to pay a fee if you don't offer insurance.
- If you do provide insurance, make sure your health plan meets these new requirements:
- Does not exclude people with pre-existing medical conditions.
- Does not put annual or lifetime limits on coverage.
- Does not cancel employees' insurance coverage solely because of an honest mistake made on their insurance application.
- Does not make new employees wait more than 90 days for coverage.
- Provides coverage for employees' adult children up to age 26.
- Allows children to use a pediatrician as their primary care provider.*
- Allows women to use an ob-gyn as their primary care provider.*
- Allows patients to receive emergency care at a non-network hospital without preauthorization and without paying a higher copay or coinsurance.*
- Provides required preventive care with no copay.*
- Notify your employees about the availability of health insurance marketplace (exchange) plans and that they may be eligible for subsidies to help pay for coverage. Develop communication materials in time for a probable third-quarter 2013 deadline.
- Inform your high-wage employees ($200,000 for individuals; $250,000 for joint filers) of new Medicare payroll and investment income taxes — effective in 2013 — and adjust your payroll system accordingly.
- Report to the federal government on whether you offer health coverage, the total number and names of those receiving coverage, and the cost of the plan. The first report is due in 2015 for the year 2014.
- If you have more than 200 employees, prepare to automatically enroll all new employees in your health plan, giving them the choice of opting out rather than opting in. Because regulations have not been finalized, this requirement will not go into effect until at least 2015.
- Decide whether you want to offer expanded wellness incentives. Starting in 2014, businesses can offer discounts of up to 30 percent off insurance premiums to employees who take part in employer-sponsored wellness programs. This is an increase from the 20 percent discount previously allowed. Find more information here.
- Begin paying transitional reinsurance fees. Fees are assessed for a three-year period beginning Jan. 1, 2014. The amount of fees to be collected over the three-year period is $25 billion. Contribution rates are expected to be finalized by 2014.
- Pay a "Cadillac plan" tax, if applicable, beginning in 2018. If premiums exceed $10,200 for individual coverage or $27,500 for family coverage, you must pay a non-deductible 40 percent excise tax on the annual value of those health plan costs.

*Requirements don't apply to grandfathered plans — those that were in effect on March 23, 2010, and have not changed substantially. For information on grandfathered plans, see this government website


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