The Affordable Care Act Checklist

5/13/13

Small groups (2-49 employees)

Since health care reform and the Affordable Care Act (ACA) became law in 2010 the health care industry has witnessed a flood of new rules issued by the Department of Health and Human Services (HHS). These rules have major impacts on everyone, especially employers. At Florida Blue, we want to help you understand health reform and simplify it the best we can. This checklist provides a summary of the provisions to help employers prepare for the health plan changes required by the ACA.

2012 – 2013 ACA Provisions

Description	Employer	Insurer
Offer Small Business Tax Credit for employers with fewer than 25 employees. The employer must contribute at least 50% of the cost toward each employee's single health insurance. For tax years beginning in 2014, the credit will be available only to small businesses that purchase health coverage through the exchange (SHOP). The maximum credit will increase to 50% for small business employers and 35% for small tax-exempt employers.	✓	
Limit employee contributions to health flexible spending accounts (FSAs) to $2,500. Indexed increases will be allowed in future years to adjust for inflation.	✓	
Furnish written notice about the federal exchange. By late 2013, employers must provide written notice to current employees and, going forward, new employees to inform them of the federal exchange and the circumstances under which they may be eligible for health insurance subsidies.	✓	
Pay Patient-Centered Outcomes Research Institute (PCORI) Fee. Also known as the Comparative Effectiveness Fee. It funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The research will help patients, health care professionals and policymakers make better informed decisions about treatment options. An estimated $150 million will be raised from the PCORI research fees over the life of the fee. This annual fee will go to a trust fund that will pay for research on the effectiveness of pharmacological and medical treatments. It is effective October 2012 through October 2019. Starting October 2012, insurers will pay $1.00 per member, increasing to $2.00 the second year and then indexed medical inflation until 2019. This fee applies to medical coverage only, and not to hospital indemnity or Medicare Supplement.		✓
Provide a Summary of Benefits and Coverage (SBC). On or after Sept. 23, 2012, group health plans offering health coverage are required to use standards in compiling and providing a SBC that accurately describes the benefits and coverage for a specific health plan. The SBC must be provided to the employer upon request for information on a health plan, to group employees during enrollment for each plan the employee is eligible to enroll in, 30 days in advance of the renewal of the health plan, and upon request by an enrollee.	✓	✓

2014 ACA Provisions

Description	Employer	Insurer
No pre-existing health condition exclusions allowed. No health plans are allowed to refuse to cover applicants due to pre-existing conditions. This applies to grandfathered and non-grandfathered plans.		✓
Maximum 90 day employer waiting period. For plan years starting in 2014, group employers cannot apply a waiting period for health coverage that exceeds 90 days. "Waiting period" is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.	✓	
Adjusted rating and underwriting requirements. There will be changes in rating and underwriting requirements, such as guaranteed issue and renewability, no minimum participation requirements, no pre-existing exclusions, no medical history or gender used in rating, and a single risk pool for the small group market. As of 2014, the only rating factors used to determine premiums will be age, geographic area and tobacco use. The rate for each family member to be covered will be added together to determine a total rate (only the first three children under age 20 will be counted for rating purposes).		✓
Ensure plans provide Essential Health Benefits (EHBs). The ACA requires all non-grandfathered small group employers to provide EHBs, a set of ten health care service categories that must be covered by certain plans and not have any annual or lifetime limits.		✓
Ensure cost-sharing toward services accumulate to a plan's out-of-pocket maximum. This includes flat-dollar copayments for services that are defined as Essential Health Benefits (EHBs), a set of health care service categories that must be covered by certain plans.		✓
The out-of-pocket maximum will be capped at the same level as health savings account (HSA) plans. For 2014, these levels will be $6,350 single/$12,700 family and include pharmacy, pediatric dental and vision.		✓
Enforce an annual limitation on plan deductibles of $2,000 single/$4,000 family. This applies to non-grandfathered small group plans.		✓
Incorporate fees into fully insured plan premiums. These fees will not be individually identified on invoices.		✓

- The **Health Insurer Fee**, also called the Health Insurance Industry Tax or Premium Tax, is an annual, permanent fee on health insurance issuers beginning in 2014. This annual fee will fund premium tax subsidies for low-income individuals and families purchasing insurance through the exchanges launching in 2014. Health insurers will be assessed a portion of the total industry fee based on their market share. Health insurers expect to pay $8 billion in fees in 2014, with the fees increasing to $14.3 billion by 2018. After that, the amount will increase in proportion to overall premium growth. It applies to fully-insured health, dental and vision plans.

Description	Employer	Insurer
• The **Transitional Reinsurance Fee** is collected to fund the Transitional Reinsurance Program. The program distributes the funds to insurers in the non-grandfathered individual market that attracts high-risk individuals. This annual assessment is designed to help offset large medical claims in the individual market due to the health care requirement that all insurers accept members regardless of health status. The intent is to spread the financial risk across all health insurers to provide greater financial stability. Beginning in 2014, the assessment for each enrollee will be $63 annually.		
• A **Risk Adjustment Fee** of less than $1 per member per year is assessed on issuers in the non-grandfathered individual and small group markets, in and out of the federal exchange. The permanent fee helps fund the administrative costs of administering the Risk Adjustment Program, which is intended to protect insurers against adverse selection by redistributing premiums from plans with low-risk populations to plans with high-risk populations.		

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5/13/13

Fully insured large groups (50+ employees)

Since health care reform and the Affordable Care Act (ACA) became law in 2010 the health care industry has witnessed a flood of new rules issued by the Department of Health and Human Services (HHS). These rules have major impacts on everyone, especially employers. At Florida Blue, we want to help you understand health reform and simplify it the best we can. This checklist provides a summary of the provisions to help employers prepare for the health plan changes required by the ACA.

2012 – 2013 ACA Provisions

Description	Employer	Insurer
Review health plan offerings. Employers should assess their health plan offerings to determine if they meet the Minimum Value requirements that are effective in 2014. Minimum Value determinations will be based on the percentage of the total allowed costs of benefits provided under a group health plan. Whether a plan provides Minimum Value is determined by either entering the plan's design in to the IRS Minimum Value calculator, showing the plan's benefits are more generous than the IRS safe harbor or getting an actuarial attestation that the plan offers minimum value. Florida Blue will perform this testing for all of its standard health plans and provide the results for each plan. Employers will be responsible for performing this testing for any plans with non-standard benefits.		✓
Report the cost of employees' health benefit coverage on the employees' 2012 W-2. This applies to employers who file 250 or more W-2 forms. This requirement is informational only and does not mean that employees will be taxed on these dollars.	✓	
Limit employee contributions to health flexible spending accounts (FSAs) to $2,500. Indexed increases will be allowed in future years to adjust for inflation.	✓	
Furnish written notice about the federal exchange. By late 2013, employers must provide written notice to current employees and, going forward, new employees to inform them of the federal exchange and the circumstances under which they may be eligible for health insurance subsidies.	✓	
Pay Patient-Centered Outcomes Research Institute (PCORI) Fee. Also known as the Comparative Effectiveness Fee. It funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The research will help patients, health care professionals and policymakers make better informed decisions about treatment options. An estimated $150 million will be raised from the PCORI research fees over the life of the fee. This annual fee will go to a trust fund that will pay for research on the effectiveness of pharmacological and medical treatments. It is effective October 2012 through October 2019. Starting October 2012, insurers will pay $1.00 per member, increasing to $2.00 the second year and then indexed medical inflation until 2019. This fee applies to medical coverage only, and not to hospital indemnity or Medicare Supplement.		✓

Description	Employer	Insurer
Provide a Summary of Benefits and Coverage (SBC). On or after Sept. 23, 2012, group health plans offering health coverage are required to use standards in compiling and providing a SBC that accurately describes the benefits and coverage for a specific health plan. The SBC must be provided to the employer upon request for information on a health plan, to group employees during enrollment for each plan the employee is eligible to enroll in, 30 days in advance of the renewal of the health plan, and upon request by an enrollee.	✓	✓

2014 ACA Provisions

Description	Employer	Insurer
No pre-existing health condition exclusions allowed. No health plans are allowed to refuse to cover applicants due to pre-existing conditions. This applies to grandfathered and non-grandfathered plans.		✓
Maximum 90 day employer waiting period. For plan years starting in 2014, group employers cannot apply a waiting period for health coverage that exceeds 90 days. "Waiting period" is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.	✓	
Ensure cost-sharing toward services accumulate to a plan's out-of-pocket maximum. This includes flat-dollar copayments for services that are defined as Essential Health Benefits (EHBs), a set of health care service categories that must be covered by certain plans. Large groups do not have to cover EHB services, but if they choose to do so, they are prohibited from having annual dollar limits and cost-sharing for EHB services and all services must accumulate to the plan's out-of-pocket maximum.		✓
The out-of-pocket maximum will be capped at the same level as health savings account (HSA) plans. For 2014, these levels will be $6,350 single/$12,700 family and include pharmacy, pediatric dental and vision.		✓
Offer Minimum Essential Coverage (MEC). A large employer (50+) may be subject to a penalty of $2,000 per full-time employee (FTE) minus 30 if they fail to offer their FTEs at least one sponsored plan and at least 1 FTE receives a subsidy in the federal exchange (Marketplace). The penalty is calculated as follows: **Employers not offering coverage:** If an employer does not offer MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the federal exchange, the penalty is $2,000 per year per FTE, minus the first 30 FTEs. **Example:** An employer with 100 full-time employees would pay a penalty of $140,000 [(100-30) x $2,000].	✓	
Offer Minimum Value and Affordable Coverage. Large employers (50+) who offer coverage may be subject to a separate penalty of $3,000 per FTE who receives subsidized coverage from the exchange if their coverage does not meet Minimum Value and/or Affordability requirements. Employers need to consider whether they need to make changes to the cost and quality of the coverage	✓	

offered to avoid penalties. The penalty is calculated as follows:

Employers offering coverage: If an employer offers MEC to 95% of their FTEs but it does not meet Minimum Value or is not Affordable, and one or more full-time employees receive a premium credit or cost-sharing subsidy through the federal exchange (Marketplace), the penalty is $3,000 per employee receiving the subsidy, up to maximum of $2,000 times the number of FTE's, minus the first 30 FTEs. **Example:** An employer with 100 full-time employees offers coverage that fails either test. They would pay a penalty of $3,000 for each full-time employee that receives a subsidy, up to a maximum of $140,000 [(100-30) x $2,000].

To be ACA compliant, an employer-sponsored plan must:

- Be affordable to the employee (premium for employee-only coverage may not exceed 9.5% of their annual W-2 income).
- Provide at least one plan with an actuarial value of at least 60% ("Minimum Value").

	Employer	Insurer
Incorporate fees into fully insured plan premiums. These fees will not be individually identified on invoices.		✓

- The **Health Insurer Fee**, also called the Health Insurance Industry Tax or Premium Tax, is an annual, permanent fee on health insurance issuers beginning in 2014. This annual fee will fund premium tax subsidies for low-income individuals and families purchasing insurance through the exchanges launching in 2014. Health insurers will be assessed a portion of the total industry fee based on their market share. Health insurers expect to pay $8 billion in fees in 2014, with the fees increasing to $14.3 billion by 2018. After that, the amount will increase in proportion to overall premium growth. It applies to fully-insured health, dental and vision plans.
- The **Transitional Reinsurance Fee** is collected to fund the Transitional Reinsurance Program. The program distributes the funds to insurers in the non-grandfathered individual market that attracts high-risk individuals. This annual assessment is designed to help offset large medical claims in the individual market due to the health care requirement that all insurers accept members regardless of health status. The intent is to spread the financial risk across all health insurers to provide greater financial stability. Beginning in 2014, the assessment for each enrollee will be $63 annually.

The Affordable Care Act Checklist

5/13/13

Self-insured (ASO) large groups (50+ employees)

Since health care reform and the Affordable Care Act (ACA) became law in 2010 the health care industry has witnessed a flood of new rules issued by the Department of Health and Human Services (HHS). These rules have major impacts on everyone, especially employers. At Florida Blue, we want to help you understand health reform and simplify it the best we can. This checklist provides a summary of the provisions to help employers prepare for the health plan changes required by the ACA.

2012 – 2013 ACA Provisions

Description	Plan Sponsor	TPA
Review health plan offerings. Employers should assess their health plan offerings to ascertain if they meet the Minimum Value requirements that become effective in 2014. Minimum Value determinations will be based on the percentage of the total allowed costs of benefits provided under a group health plan. Whether a plan provides Minimum Value is determined by either entering the plan's design in to the IRS Minimum Value calculator, showing the plan's benefits are more generous than the IRS safe harbor or getting an actuarial attestation that the plan offers minimum value.		
Report the cost of employees' health benefit coverage on the employees' 2012 W-2. This applies to employers who file 250 or more W-2 forms. This requirement is informational only and does not mean that employees will be taxed on these dollars.		
Limit employee contributions to health flexible spending accounts (FSAs) to $2,500. Indexed increases will be allowed in future years to adjust for inflation.		
Furnish written notice about the federal exchange. By late 2013, employers must provide written notice to current employees and, going forward, new employees to inform them of the federal exchange and the circumstances under which they may be eligible for health insurance subsidies.		
Pay Patient-Centered Outcomes Research Institute (PCORI) Fee Also known as the Comparative Effectiveness Fee. It is effective October 2012 through October 2019. Starting October 2012, insurers and plan sponsors will pay $1 per member per year, increasing to $2 the second year and then indexed medical inflation until 2019. This fee applies to medical coverage only, and not to hospital indemnity or Medicare Supplement. It funds research that evaluates and compares health outcomes, clinical effectiveness, risks and benefits of medical treatments and services. The research will help patients, health care professionals and policymakers make better informed decisions about treatment options. An estimated $150 million will be raised from the PCORI research fees over the life of the fee. This annual fee will go to a trust fund that will pay for research on the effectiveness of pharmacological and medical treatments.		

Description	Plan Sponsor	TPA
Provide a Summary of Benefits and Coverage (SBC). On or after Sept. 23, 2012, group health plans offering health coverage are required to use standards in compiling and providing a SBC that accurately describes the benefits and coverage for a specific health plan. The SBC must be provided to the employer upon request for information on a health plan, to group employees during enrollment for each plan the employee is eligible to enroll in, 30 days in advance of the renewal of the health plan, and upon request by an enrollee.	✓	

2014 ACA Provisions

Description	Plan Sponsor	TPA
No pre-existing health condition exclusions allowed. No health plans are allowed to refuse to cover applicants due to pre-existing conditions. This applies to grandfathered and non-grandfathered plans.	✓	✓
Maximum 90 day employer waiting period. For plan years starting in 2014, group employers cannot apply a waiting period for health coverage that exceeds 90 days. "Waiting period" is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.	✓	
Ensure cost-sharing toward services accumulate to a plan's out-of-pocket maximum. This includes flat-dollar copayments for services that are defined as Essential Health Benefits (EHBs), a set of health care service categories that must be covered by certain plans. For 2014, a safe harbor will allow health plans to maintain separate out-of-pocket maximums for medical, pharmacy, dental and vision benefits administered by separate entities.	✓	✓
The out-of-pocket maximum will be capped at the same level as health savings account (HSA) plans. For 2014, these levels will be $6,350 single/$12,700 family and include pharmacy, pediatric dental and vision.	✓	
Remove annual or lifetime dollar limits for covered services defined as EHBs. The ACA requires all insurers to provide coverage for the ten categories of EHBs. Self-funded groups are not required to cover any of the EHB services, but if they do offer them, they cannot have any dollar limits on them.	✓	
Offer Minimum Essential Coverage (MEC). A large employer (50+) may be subject to a penalty of $2,000 per full-time employee (FTE) minus 30 if they fail to offer their FTEs at least one sponsored plan and at least 1 FTE receives a subsidy in the federal exchange (Marketplace). The penalty is calculated as follows: **Employers not offering coverage:** If an employer does not offer MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the federal exchange, the penalty is $2,000 per year per FTE, minus the first 30 FTEs. **Example:** An employer with 100 full-time employees would pay a penalty of $140,000 [(100-30) x $2,000].	✓	

Description	Plan Sponsor	TPA
Offer Minimum Value and Affordable Coverage. Large employers (50+) who offer coverage may be subject to a separate penalty of $3,000 per FTE who receives subsidized coverage from the exchange if their coverage does not meet Minimum Value and/or Affordability requirements. Employers need to consider whether they need to make changes to the cost and quality of the coverage offered to avoid penalties. The penalty is calculated as follows: **Employers offering coverage:** If an employer offers MEC to 95% of their FTEs but it does not meet Minimum Value or is not Affordable, and one or more full-time employees receive a premium credit or cost-sharing subsidy through the federal exchange (Marketplace), the penalty is $3,000 per employee receiving the subsidy, up to maximum of $2,000 times the number of FTE's, minus the first 30 FTEs. **Example:** An employer with 100 full-time employees offers coverage that fails either test. They would pay a penalty of $3,000 for each full-time employee that receives a subsidy, up to a maximum of $140,000 [(100-30) x $2,000]. To be ACA compliant, an employer-sponsored plan must: • Be affordable to the employee (premium for employee-only coverage may not exceed 9.5% of their annual W-2 income). • Provide at least one plan with an actuarial value of at least 60% ("Minimum Value").	✓	
Transitional Reinsurance Fee. This capitated fee is collected from self-funded group health plans to fund the Transitional Reinsurance Program. Beginning in 2014, the assessment for each enrollee will be $5.25 per member per month. Like the PCORTF fee, The plan sponsor is responsible for accruing the fee and providing HHS with a count of the members and the corresponding payment. This fee applies to medical coverage only, and not to hospital indemnity or Medicare Supplement. The program distributes the funds to insurers in the non-grandfathered individual market that attracts high-risk individuals. This annual assessment is designed to help offset large medical claims in the individual market due to the health care requirement that all insurers accept members regardless of health status. The intent is to spread the financial risk across all health insurers to provide greater financial stability.	✓	
Obtain a health plan identifier (HPID). HPIDs are used to facilitate the routing of covered transactions. Self-funded customers are required to have their own HPIDs. Florida Blue is unable to obtain a HPID on behalf of self-funded customers. Entities have until Nov. 5, 2014, to comply.	✓	