The Affordable Care Act (ACA), Part 2

In part two of our "mini series" we will focus on what you need to do if you have 50 + employees. At the end of the day, your best advice may come from a fully engaged benefits professional, as well as engaging your CPA and Tax Attorney. **At The O'Connor Insurance Group, we can put you in touch with an engaged and professional benefits advisor. Please call our office to discuss further, 504-262-8900.**

First if you have between 50 + employees, here is what you need to know:

- Employers who file 250 or more employee W-2 forms will be required to report the cost of employee's health benefit coverage beginning on the employee's 2012 W-2 distributed in January 2013.
- Limit employee contributions to health Flexible Spending Accounts (FSA) to $2,500 per year.
- Provide written notice about Health Care Benefit Exchanges by Fall 2013.
- Assess health plan offerings to determine whether they meet the minimum value requirements that will become effective in 2014 or risk paying assessments.

The following provisions take effect beginning 2014:

1. Offer Minimum Essential Coverage (MEC) to avoid penalties if coverage is considered unaffordable or low in value.

- **Employers not offering MEC and one or more full time employees receive premium credit or cost-sharing subsidy through the Exchange pays a penalty of $2,000 per year per full time worker. The first 30 full time workers would be subtracted from the payment calculation.**
- **Employers offering coverage (MEC) and one or more full time employees receive premium credit or cost-sharing subsidy through the Exchange pays a penalty of $3,000 per employee who receives a premium credit or cost sharing subsidy.**
- **In order for the MEC to be considered "affordable" to the employee, the share of self-only coverage can not exceed 9.5% of his or her household income and the plan MUST pay more than 60% of medical costs across a typical population.**

2. All carriers will remove plan exclusions for those of any age.

3. Be aware that carriers will start progressively incorporating the Insurer Fee and the Transitional Reinsurance Fee into premiums beginning February 1, 2013. The 2014 fee for all insurers will be $8 billion, increasing each year to $14.3 billion in 2018 and indexed thereafter.

4. The Transitional Reinsurance Fee will be collected from health insurance providers for years 2014 to 2016. The funds are distributed to insurers in the non-grandfathered individual market that disproportionately attract individuals at risk for high medical costs. The impact the first year is about $5 to $6 per member per month.

5. Understand that out-of-pocket maximums for all non-grandfathered plans will be capped at the same level of HSAs for 2013, which is $6,250 single/$12,500 family.

6. Be aware of the Patient Centered Outcomes Research Institute Fee (PCORI) – a $1 per member per year fee. On fully insured health plans this is rolled into the premium rates and not shown on invoices.

7. Understand that cost-sharing toward services must accumulate to a plan's out-of-pocket maximum, including flat dollar co-payments for services that are defined as Essential Health Benefits. 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 EHB services and all services must accumulate to the plan's out-of-pocket maximum.

8. Understand the delivery requirements for providing the Summary of Benefits (SBC) to your employees. These should have been sent out on or after Sept. 23, 2012 and provided in instances such as:

- **upon application**
- **by the first day of coverage (if there are any changes)**
- **special enrollees**
- **upon renewal**
- **upon request**
- **off-renewal changes**

Additional resources:

www.uhc.com/reform

www.healthcarereformlouisiana.com