Large Employer-Sponsored Plan Obligations

Issue Brief

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Considerable attention has been focused on a recent announcement that the Affordable Care Act's (ACA) so-called "play or pay" rule, whereby employers must offer affordable healthcare coverage or pay a penalty, has been delayed until 2015.

Despite this delay, it is important that employers are aware of the provisions within the ACA that impact employee benefits and that some of those provisions become operative over the next few months. A few changes have gone into effect, such as the requirement that employer-sponsored health benefit plans must offer certain preventative services without requiring a cost-share payment, and that employers must provide employees with both a uniform explanation of coverage (EOC) and information in the employee's W2 on the value of the health benefits.

Below is a list of several important requirements within the ACA that impact employer-offered insurance coverage. The list also notes instances where self-funded plans are required to comply with a provision. Previously, self-funded plans were largely unregulated under the Employee Retirement Income Security Act (ERISA); however specific language within the ACA makes clear that self-funded plans are expected to adhere to some requirements within the law.

Effective Jan. 1, 2014, insurance plans must:

- Eliminate waiting periods to enroll in an insurance plan of more than 90 calendar days. The ban includes part-time workers who are offered coverage.*

- Limit out-of-pocket costs. For 2014, the out-of-pocket maximum are the same as those that apply to high-deductible health plans (HDHPs) combined with Health Savings Accounts (HSAs). These maximums are $6,350 for an individual and $12,700 for a family. For 2015 and beyond, the out-of-pocket maximum will be adjusted based on increases in the average per capita premium for health insurance coverage.

While all health plans must apply this cap to major medical expenses, for those plans that use more than one company to administer their major medical and pharmacy benefits, consumers may experience separate out-of-pocket caps for each benefit line.

- Cover "essential health benefits," defined as preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/surgical care, prescription drugs, laboratory, mental health and substance abuse.

- Eliminate any lifetime limits on the dollar value of essential health benefits, for both in- and out-of-network services.*

- Offer stand-alone Health Reimbursement Arrangements, which are employer-contribution-only accounts that have no annual limits and can be used to pay premiums, only to retirees.

Employers must now provide specific information about the Marketplace availability to all employees. The notice must include information stating whether the plan meets the 60 percent minimum value standard and whether coverage is "intended" to be affordable for employees. A model of the required notice can be found at: http://www.dol.gov/ebsa/healthreform/index.html. All new hires must be provided this information within 14 days of the hire date.

ACA implementation continues to evolve and change the healthcare delivery system. Employers must continue to monitor the new rules of the land to ensure appropriate compliance and avoid any potential penalties.

*Requirement also applies to self-funded plans.