Regulatory Resources

centrix BENEFIT ADMINISTRATORS

Provisions Impacting Employer-Sponsored Health Coverage Starting in 2017

A number of Affordable Care Act (ACA) requirements for employer-sponsored self-funded health benefits are provided in the chart below.

Provision	Effective Date	Description
2022		
Cadillac tax	Delayed until 2022	The ACA imposes a 40 percent excise tax on the cost of coverage exceeding $10,200 for single coverage and $27,500 for family coverage.
2018		
Anti-Discrimination Regulations (Section 1557)	Renewal date on or after Jan. 1, 2017	Covered entities must remove discriminatory exclusions from Plan Documents.
Benchmark Plan Election Rules	2018 plan year	If a company's health plan includes an annual or lifetime dollar maximum, the company must select a benchmark plan from one of the 51 EHB benchmark plans in a state or Washington, D.C., or in one of the three Federal Employee Health Benefit Programs that supports applying such dollar maximums for plan years on or after Jan. 1, 2017.
Cost sharing*	2018 plan year	In-network out-of-pocket maximum for Essential Health Benefits cannot exceed $7,350 for self-only coverage and $14,700 for other than single coverage.
Employer Mandate	2018	An employer with 50 or more full-time equivalent employees may be subject to a financial penalty if it either does not provide minimum essential coverage[1] to its employees, or if that coverage is unaffordable[2] or does not provide minimum value[3].
Essential Health Benefits	2018	Essential Health Benefits are: ambulatory patient service; emergency services; hospitalization; maternity and newborn services; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory service; prevention and wellness services and chronic disease management; and pediatric services (including oral and vision care). Self-funded employers are not required to provide 10 Essential Health Benefits. But if they do, then no annual or lifetime dollar maximums may be applied.
Patient-Centered Outcomes Research Institute Fee	Report on IRS form 720 by July 31 of the calendar year immediately following the last day of the plan year.	Plan sponsors pay a fee of $2.39 per average number of covered lives for plan years ending on or after Jan. 1, 2018, through Sept. 30, 2018. Thereafter, the fee is based on increases in the projected per capita amount of the National Health Expenditures. The fee will not apply to policy or plan years that begin after Sept. 30, 2019.

Provision	Effective Date	Description
2018 (continued)		
Preventive Health Services	Plan years on or after Dec. 20, 2017	Updated guidelines for coverage of women's preventive health services without cost sharing were released by the Health Resources and Services Administration.
Reporting Requirements	2018 for the 2017 coverage period	Regulations implementing minimum essential coverage reporting for Section 6055 and 6056 of the Internal Revenue Code require certain employers to provide detailed information about their health plan coverage and enrollees.
Summary of Benefits and Coverage	2018	Employers are required to provide a Summary of Benefits and Coverage (SBC) for each benefit package offered by a plan for which a participant is eligible. The SBC and Glossary of Health Coverage and Medical Terms must be provided to all members by the first day of open enrollment (or eligible enrollment). Employers can face a penalty for each employee who fails to receive the SBC.
2017		
Anti-Discrimination Regulations (Section 1557)	Renewal date on or after Jan. 1, 2017	Covered entities must remove discriminatory exclusions from Plan Documents.
Benchmark Plan Election Rules	2017 plan year	If a company's health plan includes an annual or lifetime dollar maximum, the company must select a benchmark plan from one of the 51 EHB benchmark plans in a state or Washington, D.C., or in one of the three Federal Employee Health Benefit Programs that supports applying such dollar maximums for plan years on or after Jan. 1, 2017.
Cost sharing*	2017 plan year	In-network out-of-pocket maximum for Essential Health Benefits cannot exceed $7,150 for self-only coverage and $14,300 for other than single coverage.
Employer Mandate	2017	An employer with 50 or more full-time equivalent employees may be subject to a financial penalty if it either does not provide minimum essential coverage[1] to its employees, or if that coverage is unaffordable[2] or does not provide minimum value[3].
Essential Health Benefits Package	2017	Essential Health Benefits are: ambulatory patient service; emergency services; hospitalization; maternity and newborn services; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory service; prevention and wellness services and chronic disease management; and pediatric services (including oral and vision care). Self-funded employers are not required to provide 10 Essential Health Benefits. If they do, then no annual or lifetime dollar maximums may be applied.
Patient Centered Outcomes Research Institute Fee	Report on IRS form 720 by July 31 of the calendar year immediately following the last day of the plan year.	Plan sponsors pay a fee of: • $2.26 per average number of covered lives for plan years ending on or after Jan. 1, 2017, through Sept. 30, 2017. • $2.39 per average number of covered lives for plan years ending on or after Oct. 1, 2017, through Dec. 31, 2017. The fee is based on increases in the projected per capita amount of the National Health Expenditures. The fee will not apply to policy or plan years that begin after Sept. 30, 2019.

Provision	Effective Date	Description
2017 (continued)		
Preventive Health Services	Plan years on or after Dec. 20, 2017	The Health Resources and Services Administration released updated guidelines for coverage of women's preventive health services without cost sharing.
Reporting requirements	2017 for the 2016 coverage period	Regulations implementing minimum essential coverage reporting for Section 6055 and 6056 of the Internal Revenue Code require certain employers to provide detailed information about their health plan coverage and enrollees.
Summary of Benefits and Coverage	On or after April 1, 2017	Revised SBC and support documents are mandated for use.

*Provision does not apply to grandfathered plans.

[1] Minimum essential coverage refers in general to health coverage under a government-sponsored program, such as Medicare or Medicaid; an eligible employer-sponsored plan; a plan offered in the individual market; or other coverage described in applicable regulations. It does not include HIPAA-excepted benefits such as critical illness or hospital indemnity insurance.

[2] Employer-sponsored health coverage is considered affordable if an employee's required contribution to the plan does not exceed 9.69 percent in 2017 (9.56 percent in 2018) of the employee's household income for the taxable year. (Rather than trying to determine household income, there are three safe harbors to use to determine whether an employer-sponsored health plan is affordable.)

[3] A group health benefit plan provides minimum value if the percentage of the total allowed costs of benefits provided under the plan is at least 60 percent, and it includes substantial coverage of both inpatient hospital and physician services

PLEASE NOTE: This material represents a high-level summary of ACA laws, rules or regulatory guidelines and is not comprehensive. It may not be construed as tax, legal or compliance advice. Please consult your professional benefits adviser or legal counsel regarding how these provisions may impact your specific benefit plan.