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AFFORDABLE CARE ACT | TOOLKIT

SMALL EMPLOYERS

Provided by: Trusted Advisors Group

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This Toolkit is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. The contents of this document may be affected by future regulations and sub-regulatory guidance.

Introduction

The health care reform law—the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Because many of the ACA's major provisions took effect in 2014, it is more important than ever for employers to understand these rules.

This Affordable Care Act Toolkit is your one-stop guide for ACA concerns. It is designed to help you address ACA issues, topic-by-topic, step-by-step.

Each section of the Toolkit focuses on a single subject and includes:

- An executive summary;
- An action checklist to help you take the appropriate actions to achieve compliance; and
- A list of supporting documents that Trusted Advisors Group can provide upon request.

As new regulations and guidance are released, the Affordable Care Act Toolkit will continue to expand and be updated. Please contact Trusted Advisors Group as new regulations are released to request an updated copy.

This Affordable Care Act Toolkit is centered on small employers, and will take you through the ACA considerations for these employers.

What is a small employer?

The ACA doesn't have a consistent answer for that. An employer might be considered "small" for one rule, but not another. For this Toolkit, a small employer is one that has **fewer than 50 employees**.

Most of the sections in this guide apply to these small employers. Certain sections of this Toolkit briefly describe some of the rules for large employers. Those sections can help you understand which ACA provisions apply to your company now, and which ones may apply in the future if your business grows.

Plan Design and Coverage Issues: 2014 and Beyond

The provisions in this section took effect in 2014. Some of these issues have been addressed in agency guidance; others are still awaiting more information. As developments on these topics occur, additional content will be provided.

Annual Limits

Who is Covered?	When?
Health plans	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, health plans may not place annual dollar limits on essential health benefits (EHBs). However, plans may impose annual limits on specific covered benefits that are not EHBs. “Restricted annual limits” were permitted for EHBs for plan years beginning before Jan. 1, 2014. **However, restricted annual limits are no longer allowed for plan years beginning on or after Jan. 1, 2014**.

EHBs are a core set of items and services intended to reflect the scope of benefits covered by a typical employer. Each state selects a benchmark insurance plan and, as a general rule, the items and services included in a state’s benchmark plan comprise the EHBs that insured health plans in the state’s individual and small group markets must cover.

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered plans in the individual and small group markets are required to cover EHBs. The requirement to cover EHBs does not apply to grandfathered plans, self-insured group health plans and health plans offered in the large group market. To determine which benefits are EHBs for purposes of removing annual limits, a self-insured group health plan, large group market health plan or grandfathered plan may choose any benchmark plan from any state that was approved by HHS. Also, self-insured group health plans, large group market health plans and grandfathered plans can still exclude all benefits for a condition without being considered an annual limit, as long as no benefits are provided for the condition.

Action Items:

☐ Ensure that no annual limit is imposed on EHBs for the 2015.

☐ For a non-GF plan in the individual or small group market, use the state’s benchmark plan to determine which benefits are EHBs. For a self-insured group health plan, large group market health plan or GF plan, choose a benchmark plan from any state that was approved by HHS to determine which benefits are EHBs.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Lifetime and Annual Limits
- Health Care Reform: Compliance Checklist for Lifetime and Annual Limits
- Health Care Reform: Temporary Waiver Program for Annual Limits
- Health Care Reform: Application of Annual Limit Restrictions to HRAs

Limits on Cost-sharing (Non-GF Plans Only)

Who is Covered?	When?
Out-of-pocket maximum—all non-GF health plans and issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans are subject to limits on total enrollee cost-sharing for essential health benefits (EHBs), known as an out-of-pocket maximum.

- For 2015, out-of-pocket expenses may not exceed **$6,600 for self-only coverage** and **$13,200 for family coverage**.
- For 2016, out-of-pocket expenses may not exceed **$6,850 for self-only coverage** and **$13,700 for family coverage**.

Beginning with the 2016 plan year, HHS clarified that the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. Thus, HHS' guidance effectively embeds an individual out-of-pocket maximum in group health coverage with a family deductible that exceeds the ACA's out-of-pocket maximum for self-only coverage.

For the first plan year beginning on or after Jan. 1, 2014, special transition relief was available for plans that use more than one service provider to administer benefits. Under this transition relief, where a group health plan or group health insurance issuer uses more than one service provider to administer benefits that are subject to the out-of-pocket maximum, the annual limit will be satisfied if:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), this maximum does not exceed the ACA's out-of-pocket maximum.

For plan years beginning on or after Jan. 1, 2015, non-grandfathered group health plans and group health insurance coverage are required to have an out-of-pocket maximum which limits overall out-of-pocket costs on all EHBs. Because the cost-sharing limit applies only to EHBs, plans are not required to apply the annual limitation to benefits that are not EHBs.

Action Item:

☐ Be aware that non-GF plans have limitations on out-of-pocket expenses.

Document Available from Trusted Advisors Group:

- Health Care Reform: Cost-Sharing Limits for Health Plans

Excessive Waiting Periods

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Currently effective

A group health plan or issuer may not impose a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll becomes effective.

Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. However, other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit. Permissible eligibility conditions include:

- Being in an eligible job classification;
- Achieving job-related licensure requirements specified in the plan's terms; or
- Satisfying a reasonable and bona fide employment-based orientation period.

A special rule applies if a group health plan conditions eligibility on an employee regularly working a specified number of hours per pay period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time).

In this type of situation, the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition. This may include a measurement period that is consistent with the employer shared responsibility provisions (even if the employer is not a large employer). The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with the 90-day waiting period limit if coverage is effective no later than 13 months from the employee's start date, except where a waiting period that exceeds 90 days is imposed after the measurement period. If an employee's start date is not the first of the month, the time period can also include the time remaining until the first day of the next calendar month.

Action Items:

☐ Review whether your plans impose a waiting period for participation.

☐ If a waiting period is imposed, ensure that it does not exceed 90 days.

☐ If it is unclear that a new employee will work the required number of hours, set a measurement period to determine whether the hours requirement will be met in the future.

Documents Available from Trusted Advisors Group:

- Health Care Reform: 90-day Waiting Period Limit
- Final Regulations Released on ACA Waiting and Orientation Periods

- Health Care Reform: 90-day Waiting Period Limit—Permitted Orientation Periods

Pre-existing Condition Exclusions

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age. Prior to the 2014 plan year, pre-existing condition exclusions were already prohibited for individuals under age 19. A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the individual's date of enrollment in the employer's plan.

Action Item:

☐ Ensure that no pre-existing condition exclusion is imposed on any individual.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Pre-existing Condition Exclusions
- Health Care Reform: Compliance Checklist for Pre-existing Condition Exclusions

Comprehensive Benefits Coverage (Non-GF Plans Only)

Who is Covered?	When?
Non-GF insured group health plans Health insurance issuers	Currently effective

Beginning in 2014, health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance Exchanges. This requirement does not apply to grandfathered plans.

Action Item:

☐ Be aware that insured plans will have to offer the essential health benefits package, even if they are purchased outside of an Exchange.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Comprehensive Health Coverage—Essential Health Benefits Package
- Health Care Reform: Approach for Defining Essential Health Benefits

Coverage for Clinical Trial Participants (Non-GF Plans Only)

Who is Covered?	When?
Group Health plans—insured and self-funded Health insurance issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans and insurance policies may not:

- Terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases; or
- Deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Action Item:

☐ Ensure that plan terms and operations do not discriminate against participants who participate in clinical trials.

Document Available from Trusted Advisors Group:

- Health Care Reform: Coverage for Participants in Clinical Trials

Health FSAs, HRAs and Cafeteria Plans

Who is Covered?	When?
Health flexible spending accounts (health FSAs) Health reimbursement arrangements (HRAs) Cafeteria plans	Currently effective

For plan years beginning in 2014, the availability of health FSAs and HRAs is limited, although the IRS has relaxed the "use-or-lose" rule for health FSAs. The IRS also provided a special mid-year election change rule for cafeteria plans with non-calendar year plan years. For these plans to meet all ACA requirements:

- Health FSAs must qualify as "excepted benefits" to be permissible. Health FSAs qualify as excepted benefits if they satisfy availability and maximum benefit requirements.
- HRAs must be integrated with other group health coverage to be permissible. The IRS and DOL have provided specific guidance on two ways for an HRA to be considered integrated with another group health plan. Stand-alone HRAs (other than retiree-only HRAs and limited-scope vision or dental HRAs) will be prohibited in 2014.

Under the relaxed "use-or-lose" rule for health FSAs, beginning with the 2013 play year, employers may allow participants to carry over up to $500 in unused funds into the next year. However, the relaxed “use-or-lose” rule only applies if a plan does not also incorporate an extended deadline—or grace period—after the end of the plan year to use health FSA funds.

Also, the IRS is allowing cafeteria plans to permit mid-year election changes in certain situations related to the availability of Exchange coverage. A cafeteria plan may allow an employee to prospectively revoke his or her election for coverage under the employer’s group health plan during a period of coverage, as long as the plan provides minimum essential coverage and is not a health FSA, in the following situations:

- The employee’s hours of service are reduced so that the employee is expected to average less than 30 hours per week, but the reduction does not affect eligibility for coverage under the employer’s group health plan; or
- The employee would like to cease coverage under the employer’s group health plan and purchase coverage through an Exchange, without having a period of either duplicate coverage or no coverage.

Certain conditions must be met for the change to be permitted. Also, an election to revoke coverage on a retroactive basis is not allowed.

Action Items:

☐ Ensure that your health FSA or HRA is designed to comply with the ACA.

☐ If you have a health FSA, consider amending the plan to allow for carryovers.

☐ If you have a cafeteria plan, consider amending your plan for the mid-year election change rules. Cafeteria plans can be amended retroactively to implement these rules, if the retroactive amendment is made on or before the last day of the plan year and is communicated to participants.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Health FSAs—Changes for 2014
- Health Care Reform: Health Reimbursement Arrangements (HRAs)—Changes for 2014
- Health FSA Carryovers
- Health Care Reform: Pay or Play Penalty—Cafeteria Plan Elections

Nondiscrimination for Fully-Insured Plans (Non-GF Plans Only)

Who is Covered?	When?
Non-GF insured group health plans	When regulations are issued and applicable

Non-grandfathered fully-insured group health plans will have to comply with federal nondiscrimination rules related to compensation, which prohibit discrimination in favor of highly-compensated employees. Under the ACA, these plans will have to follow rules similar to the nondiscrimination rules applicable to self-funded plans (found in Internal Revenue Code Section 105(h)), which require plans to pass both an eligibility test and a nondiscrimination test.

Because these restrictions will apply to non-grandfathered plans only, grandfathered plans that discriminate in favor of highly compensated employees may wish to retain their grandfathered status.

Compliance with the new nondiscrimination rules will not be required until after guidance is issued. **Therefore, this nondiscrimination requirement has been delayed indefinitely, pending the issuance of regulations**.

Action Items:

☐ Identify whether your organization’s plans are GF or non-GF.

☐ Monitor IRS guidance for further rules on nondiscrimination requirements.

☐ For GF plans, consider maintaining GF status if the current plan design is potentially discriminatory.

Document Available from Trusted Advisors Group:

- Health Care Reform: Nondiscrimination Rules for Fully-Insured Group Health Plans

Employer Obligations

Additional Medicare Tax

Who is Covered?	When?
All employers	Currently effective

Effective Jan. 1, 2013, the Medicare Part A (hospital insurance) tax rate increased by 0.9 percent (from 1.45 percent to 2.35 percent) on wages over $200,000 for individual taxpayers, and $250,000 for married couples filing jointly.

An employer must withhold the additional Medicare tax on wages or compensation it pays to an employee in excess of $200,000 in a calendar year. An employer has this withholding obligation even though an employee may not be liable for the additional Medicare tax because, for example, the employee's wages or other compensation together with that of his or her spouse (when filing a joint return) does not exceed the $250,000 liability threshold. Any withheld additional Medicare tax will be credited against the total tax liability shown on the individual's income tax return (Form 1040).

Action Items:

- ☐ Monitor employee wages to be aware of the date an employee reaches $200,000 in wages in a single year.
- ☐ Once an employee has earned $200,000, change the Medicare hospital insurance tax withholding rate to 2.35 percent.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Final Rules on the Additional Medicare Tax
- Health Care Reform: Questions and Answers on Additional Medicare Tax

High Cost Plan Excise Tax (Cadillac Tax)

Who is Covered?	When?
Applicable employer-sponsored coverage	Taxable years beginning in 2018

A 40 percent excise tax (the "Cadillac tax") will be imposed on the excess benefit of high cost employer-sponsored health insurance. The annual limit for purposes of calculating the excess benefit is $10,200 for individuals and $27,500 for other than individual coverage.

The amount of the tax for each employee's coverage will be calculated by the employer and paid by the coverage provider who provided the coverage. The "coverage provider" can be the insurer, the employer or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

Action Item:

- Monitor ACA developments for additional guidance on the Cadillac tax.

Document Available from Trusted Advisors Group:

- Health Care Reform: Cadillac Tax on High-cost Health Coverage
- IRS Invites Comments on Cadillac Tax Implementation for 2018

Employer Reporting of Health Coverage (Code Sections 6055 and 6056)

Who is Covered?	When?
Applicable large employers (those with 50 or more full-time and FTE employees) Employers with self-insured health plans	First due in 2016, related to 2015 coverage

The ACA created new reporting requirements under Internal Revenue Code Sections 6055 and 6056. Under these new reporting rules, certain employers will be required to provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees (such as information on the design and cost of their plans, as well as employees covered by the plan). Related statements must also be provided to employees.

These new reporting requirements apply to:

- **Employers with self-insured health plans (Code Section 6055)**—Every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage must file information returns with the IRS reporting information for each individual who is provided with this coverage during the calendar year. Related statements must also be provided to covered individuals.

- **Applicable large employers (ALEs) (Code Section 6056)**—ALEs subject to the ACA's employer shared responsibility rules must file information returns with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the calendar year. Related statements must also be provided to full-time employees.

These reporting requirements were set to take effect in 2014. However, on July 2, 2013, the Treasury **delayed these requirements for one year, until 2015**. The first returns will be due in 2016 for coverage offered or provided in 2015. Returns must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year following the calendar year to which the return relates. Individual statements must be provided on or before Jan. 31 of the year immediately following the calendar year to which the statements relate.

The employer shared responsibility rules were delayed for medium-sized ALEs (those with 50-99 full-time and FTE employees in 2014) for one year, until 2016. **ALEs eligible for this delay must still report under Section 6056 for 2015**.

ALEs reporting under Section 6056 will use Forms 1094-C and 1095-C. In general, entities reporting under Section 6055 will use Forms 1094-B and 1095-

B. However, ALEs that sponsor self-insured plans must report under both Section 6055 and Section 6056. These employers will use a combined reporting method on Forms 1094-C and 1095-C to report the information required under both Section 6055 and Section 6056.

Penalties of $100 per return generally apply for any failures to file correct information returns or provide correct individual statements by the deadlines. However, short term relief from penalties is available in 2015 for reporting entities that make good faith efforts to comply with the reporting requirements.

Action Items:

☐ Determine whether your organization is a sponsor of a self-insured health plan or an ALE.

☐ Begin tracking and recording the information that must be reported for the calendar year under Section 6055 and/or Section 6056, as applicable.

☐ When the reporting requirements become effective, provide required information regarding plan coverage and participation to the IRS and to individuals, in accordance with information return requirements.

Documents Available from Trusted Advisors Group:

- HCR: Employer Reporting of Health Coverage—Code Sections 6055 & 6056
- Q&As on Employer Reporting of Health Coverage (Section 6056)
- Health Care Reform: Code Section 6056—What Information Must Be Reported?
- Affordable Care Act—Reporting Requirements for Applicable Large Employers (Section 6056)
- &As on Reporting by Health Coverage Providers (Section 6055)
- Health Care Reform: Code Section 6055—What Information Must Be Reported?
- QAffordable Care Act—Responsibilities for Health Coverage Providers (Section 6055)
- IRS Releases Final Forms and Instructions for ACA Reporting

Tools Available from Trusted Advisors Group:

- Section 6056 Reporting Workbook
- Section 6055 Reporting Workbook

Employer Penalties for Not Offering Required Coverage (Large Employers Only)

Who is Covered?	When?
Applicable Large Employers—employers with 50 or more full-time employees (including full-time equivalent employees, or FTEs)	Starting in **2015** for employers with **100 or more** full-time employees (including FTEs) Starting in **2016** for employers with **50-99** full-time employees (including FTEs)

Applicable large employers (ALEs)—those with 50 or more full-time employees (including full-time equivalent employees, or FTEs) —that do not offer affordable, minimum value health coverage to their full-time employees (and dependents) will be subject to penalties if any full-time employee receives a subsidy for health coverage through an Exchange. These employer mandate requirements are known as the “employer shared responsibility” or “pay or play” rules.

Delayed Effective Date

The employer shared responsibility rules were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury **delayed the employer mandate penalties and related reporting requirements for one year, until 2015**. Therefore, these payments did not apply for 2014.

On Feb. 10, 2014, the IRS released final regulations on the ACA’s employer shared responsibility rules. Under the final regulations:

- ALEs with 100 or more full-time and FTE employees must comply with the employer shared responsibility rules starting in 2015.
- However, **medium-sized ALEs (those with fewer than 100 full-time and FTE employees) generally have an additional year, until 2016, to comply with the employer shared responsibility rules**. Medium-sized ALEs must satisfy specific criteria to qualify for this delay.

Determining Employer Size

The employer’s size for purposes of the employer shared responsibility rules is based on the average employee count for the prior calendar year. Part-time employees are included in the calculation according to a formula, but do not have to be offered coverage. Special rules apply for counting certain types of employees, including seasonal employees, volunteer employees and foreign employees. Companies with common ownership may have to be combined for purposes of this rule.

Penalty Amount

The penalty amount for not offering health coverage to substantially all full-time employees (and dependents) is **$2,000 annually for each full-time employee**, excluding the first 30 employees. For 2015, an ALE with at least 100 full-time and FTE employees may exclude the first 80 full-time employees, instead of the first 30, under this calculation. An ALE will not be liable for this penalty for 2015 if it offers coverage to at least **70 percent** of its full-time employees. In 2016 and beyond, an ALE will not be liable for this penalty if it offers coverage to all but **5 percent** (or, if greater, five) of its full-time employees and dependents.

The penalty for ALEs who offer health coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, is **$3,000 annually for each full-time employee receiving a tax credit**, with a maximum annual fine of $2,000 per full-time employee, excluding the first 30 full-time employees (80 employees for 2015 for employers with 100 or more full-time and FTE employees).

These penalty amounts will be adjusted annually for inflation, beginning in years after 2014. According to the IRS, the one-year delay for the employer shared responsibility rules, until 2015, does not affect this inflation adjustment.

Action Items:

☐ Confirm that your organization has fewer than 50 full-time and FTE employees. (See the recommended documents below for information on how to calculate full-time and full-time equivalent employees).

☐ Continue to monitor employer size if employees are added to payroll.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Pay or Play—Employer Shared Responsibility Penalties
- Health Care Reform: FAQs on the Employer Shared Responsibility Rules
- Health Care Reform: One Year Delay of Employer Mandate Penalties & Reporting Requirements
- Health Care Reform: Employer Mandate Delayed Until 2016 for Medium-sized Employers
- Health Care Reform: Large Employers Subject to the Pay or Play Penalties
- Affordable Care Act—Are You an Applicable Large Employer?

Automatic Enrollment (Large Employers Only)

Who is Covered?	When?
Employers subject to the FLSA with more than 200 full-time employees	Unknown (after regulations are issued and became effective)

Large employers that are subject to the Fair Labor Standards Act (FLSA) will be required to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to re-enroll current employees in a health benefits plan offered through the employer.

For purposes of this rule, a large employer is one that has more than 200 full-time employees. Employees must be notified of the enrollment and given the opportunity to opt out of any coverage in which the employee was automatically enrolled.

Before this requirement can take effect, the DOL must issue implementing regulations. According to the DOL, employers are not required to comply with automatic enrollment requirement until final regulations are issued and become applicable.

Action Items:

- ☐ Monitor ACA developments for DOL regulations on automatic enrollment.
- ☐ Once regulations are issued clarifying how employees should be counted, determine whether your organization is a large employer under this rule.
- ☐ If your organization qualifies as a large employer, implement processes to automatically enroll and re-enroll employees in your organization's health plan in accordance with the regulations.
- ☐ Establish a process for notifying employees of their automatic enrollment and right to opt out of coverage in accordance with the regulations.
- ☐ Establish a process for dis-enrolling employees that opt out of coverage in accordance with the regulations.

Document Available from Trusted Advisors Group:

- Health Care Reform: Automatic Enrollment Requirements

Notice of Exchange

Who is Covered?	When?
Employers subject to the FLSA	Currently effective—provide to new hires at time of hiring

Employers must provide all new hires and current employees with a written notice about the ACA's health insurance exchanges (Exchanges). Employers were required to provide the notice to current employees no later than **Oct. 1, 2013**. As an ongoing requirement, employers must provide the notice to each new employee **at the time of hiring**.

In general, the notice must:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- Explain how employees may be eligible for a subsidy if the employer's plan does not meet certain requirements; and
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

The DOL also provided model Exchange notices for employers to use, which require some customization. The notice may be provided by first-class mail, or may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor are met.

According to the DOL, there is **no fine or penalty under the ACA for failing to provide the notice**. This means that employers cannot be fined for failing to provide employees with notice about the Exchanges.

Action Items:

☐ Customize the appropriate model Exchange notice.

☐ Confirm that the notice has been provided to all current employees.

☐ Prepare to provide the customized notice to all new employees when hired.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Exchange Notice Requirements for Employers
- Health Care Reform: Model Exchange Notice for Employers that Offer Health Plans
- Health Care Reform: Model Exchange Notice for Employers that Do Not Offer Health Plans

Summary of Benefits and Coverage

Who is Covered?	When?
Health insurance issuers Health plans—insured and self-funded	Currently effective—provide at various points after first effective date

Health plans (both insured and self-funded) must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries. The SBC is a succinct document that provides simple and consistent information about health plan benefits and coverage in plain language. For insured plans, issuers must provide an SBC to the plan sponsor and may also send the SBC to participants and beneficiaries on behalf of an insured health plan.

Plans and issuers were initially required to provide the SBC to participants and beneficiaries for plan years beginning on or after Sept. 23, 2012. In addition, ongoing requirements for providing the SBC also apply. For group health plans, there are two different scenarios under which the SBC must be provided: (1) by a group health insurance issuer to a group health plan; and (2) by the issuer or plan to participants and beneficiaries.

A health insurance issuer must provide an SBC to a group health plan (or the plan's sponsor):

- Upon application for health coverage;
- By the first day of coverage, if there was any change in information required to be in the SBC that was provided upon application and before the first day of coverage;
- When the issuer renews or reissues the policy; and
- Upon request.

A health insurance issuer or health plan must provide an SBC to participants and beneficiaries with respect to each benefit package for which the participant or beneficiary is eligible. The SBC must be provided:

- As part of any written application materials that are distributed by the plan or issuer for enrollment;
- If the plan or issuer does not distribute written application materials, no later than the first date that the participant is eligible to enroll in coverage;
- By the first day of coverage, if there was any change to information required to be in the SBC that was provided upon application and before the first day of coverage;
- To special enrollees, no later than the deadline for providing the summary plan description (SPD) (that is, within 90 days of enrollment);
- Upon renewal, if participants and beneficiaries must renew in order to maintain coverage; and

- Upon request (the uniform glossary must also be provided upon request).

The Departments provided an updated SBC template and sample completed SBC for later years of applicability. Until further guidance is issued, health plans and issuers should continue to use these documents. In addition, certain safe harbors and other enforcement relief that were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first year of applicability have been extended until further guidance is issued.

The Departments have stated that their approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. Therefore, until further guidance is issued, the Departments have said that they **will not impose penalties** on plans and issuers that are working diligently and in good faith to comply with the SBC requirement.

Action Items:

☐ Confirm that an SBC has been developed for each health plan that the company offers.

☐ Confirm that the SBC is being provided to participants and beneficiaries in accordance with the required deadlines.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage for the Second Year of Applicability and Beyond
- Health Care Reform: Template for Summary of Benefits and Coverage
- Health Care Reform: Instructions for Summary of Benefits and Coverage
- Health Care Reform: Compliance Checklist for Providing the SBC and Uniform Glossary

60-Day Notice of Plan Changes

Who is Covered?	When?
Health insurance issuers Health plans—insured and self-funded	Currently effective—provide 60 days in advance of material modifications

A health plan or issuer must provide 60 days' advance notice of any material modifications to the plan that are not related to renewals of coverage. Specifically, the advance notice must be provided when a material modification is made that would affect the content of the SBC and the change is not already included in the most recently provided SBC.

A “material modification” is any change to a plan’s coverage that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage.

A material modification may include an enhancement in covered benefits or services or other more generous plan or policy terms, a material reduction in covered services or benefits or more strict requirements for receiving benefits.

Notice can be provided in an updated SBC or a separate summary of material modifications. This 60-day notice requirement becomes effective when the SBC requirement goes into effect for a health plan.

Action Items:

☐ Analyze proposed plan changes that are not related to renewal to determine if they are material modifications to the plan.

☐ If the mid-year changes are material modifications, provide notice of the change using a new SBC or a summary of material modifications at least 60 days before the change is scheduled to be effective.

☐ For insured plans, determine whether the carrier will provide this notice.

Document Available from Trusted Advisors Group:

- Health Care Reform: 60-Day Advance Notice of Plan Changes

Statement of Grandfathered Status (GF Plans Only)

Who is Covered?	When?
Grandfathered plan administrators and issuers	Currently effective—provide periodically with participant materials

Grandfathered (GF) plans are those that existed on March 23, 2010 and have not made certain prohibited changes. In order to retain GF status, these plans must provide a statement of GF status to participants. The first statement was required to be provided before the first plan year beginning on or after Sept. 23, 2010. The statement must continue to be provided on a periodic basis with participant materials describing plan benefits.

If certain prohibited changes are made to the plan, the plan will no longer be considered GF. A statement of GF status does not have to continue to be provided to plan participants if the plan loses GF status.

Action Items:

☐ Confirm whether the plan is GF or non-GF.

☐ If GF, include the model statement in participant plan materials.

☐ If the plan loses GF status, a statement does not have to be provided to plan participants. Confirm that the plan includes all of the additional patient rights and benefits required by the ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Overview of Grandfathered Plans
- Health Care Reform: Grandfathered Plans—Permitted and Prohibited Changes
- Health Care Reform: Model Notice for Grandfathered Plans

Notice of Rescission

Who is Covered?	When?
Group health plans Health insurance issuers	Currently effective—provide 30 days before any rescission

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant's failure to pay required premiums or contributions for the coverage.

This prohibition applies to grandfathered and non-grandfathered health plans, whether in the group or individual market, and whether coverage is insured or self-funded.

If a rescission is permitted, the plan administrator or issuer must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.

Action Items:

- ☐ Before terminating coverage for a participant, review whether the termination will have a retroactive effect.
- ☐ If yes, confirm that the retroactive termination is due to fraud, intentional misrepresentation or non-payment for coverage. Rescissions are not permitted based on an inadvertent misstatement or to correct a plan error (such as mistakenly covering an ineligible employee).
- ☐ Before terminating coverage retroactively, provide 30 days' advance notice to the affected participant.

Document Available from Trusted Advisors Group:

- Health Care Reform: Prohibition on Rescissions

Notice of Patient Protections and Selection of Providers (Non-GF Plans Only)

Who is Covered?	When?
Non-GF group health plans Health insurance issuers of non-GF plans	Currently effective—provide with SPD or similar description of benefits

Non-GF group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Non-GF group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

Plan administrators or issuers of these plans must provide a notice of patient protections/selection of providers whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. The first notice should have been provided no later than the first day of the plan year beginning on or after Sept. 23, 2010.

Action Items:

☐ Determine whether the plan is GF or non-GF.

☐ If non-GF, incorporate the Notice of Patient Protections into the SPD or benefits description.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Patient Protections
- Health Care Reform: Compliance Checklist for Patient Protections
- Health Care Reform: Model Notice on Patient Protections

Form W-2 Reporting (Large Employers Only)

Who is Covered?	When?
Employers that had to file 250 or more Forms W-2 in the prior calendar year (see exceptions below)	Currently effective

Large employers are required to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. Smaller employers may be subject to this reporting in the future. The IRS has delayed the reporting requirement for these smaller employers by making it optional for these employers until further guidance is issued.

An employer is considered a small employer if it had to file fewer than 250 Forms W-2 for the prior calendar year. Thus, if an employer was required to file fewer than 250 Forms W-2 for 2013, the employer would not be subject to the reporting requirement for 2014. The IRS has indicated that the Internal Revenue Code's corporate aggregation (common ownership) rules do not apply for purposes of determining whether an employer filed fewer than 250 Forms W-2 for the prior year. However, if an employer files fewer than 250 Forms W-2 only because it uses an agent to file them, the employer does not qualify for the small employer exemption.

The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. The reporting does not mean that the cost of the coverage is taxable to employees.

Action Items:

- ☐ Confirm that your organization is a small employer under this rule by reviewing the number of W-2 forms filed for the prior tax year.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Form W-2 Reporting Requirements
- Health Care Reform: Types of Coverage Subject to Form W-2 Reporting
- Health Care Reform: IRS Q&As on Form W-2 Reporting

Wellness Programs

Who is Covered?	When?
Health-contingent wellness programs	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, employers may offer increased incentives to employees under health-contingent wellness programs. Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward. There are two types:

- **Activity-only wellness programs** require an individual to perform or complete an activity related to a health factor in order to obtain a reward (for example, walking, diet or exercise programs).
- **Outcome-based wellness programs** require an individual to attain or maintain a certain health outcome in order to obtain a reward (for example, not smoking, attaining certain results on biometric screenings or meeting exercise targets).

To protect consumers from unfair practices, health-contingent wellness programs are required to follow certain nondiscrimination standards, including a limit on the maximum reward that can be offered. The maximum reward is generally 30 percent of the cost of coverage. However, the maximum permissible reward may be up to 50 percent of the cost of health coverage for programs designed to prevent or reduce tobacco use.

The other common type of wellness programs, participatory wellness programs, does not require an individual to meet a standard related to a health factor in order to obtain a reward or does not offer a reward at all (such as a fitness center reimbursement program or a program that reimburses employees for the costs of smoking cessation programs, regardless of whether the employee quit smoking). There is no limit on financial rewards for participatory wellness programs.

Action Items:

- [ ] Review your organization’s current wellness program offerings to determine whether they are health-contingent or participatory wellness programs.
- [ ] If the wellness program is health-contingent, consider whether to raise the reward and ensure that it complies with applicable nondiscrimination rules.

Document Available from Trusted Advisors Group:

- Health Care Reform: Implications for Workplace Wellness Programs
- Health Care Reform: Workplace Wellness Program Nondiscrimination Rules
- Health Care Reform: Workplace Wellness Program Incentives

Health Plan Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Currently effective—will not apply for plan years ending on or after Oct. 1, 2019

Health insurance issuers and self-funded group health plans must pay fees to finance comparative effectiveness research. These research fees are called Patient-Centered Outcomes Research Institute fees (PCORI fees), although they may also be called research fees, PCOR fees or comparative effectiveness research (CER) fees. The fees apply for plan years ending on or after Oct. 1, 2012. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the research fees are effective for the 2012 through 2018 plan years. The PCORI fees are due by July 31 of the calendar year following the plan year to which the fee applies.

For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee was $1 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is $2 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2014, and before Oct. 1, 2015, the fee amount was adjusted to $2.08. For plan years ending on or after Oct. 1, 2015, the PCORI fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

A health reimbursement arrangement (HRA) is not subject to a separate research fee if it is integrated with another self-insured plan providing major medical coverage, as long as the HRA and the plan are established and maintained by the same plan sponsor and have the same plan year. If an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor. The same analysis applies to health flexible spending accounts (FSAs) that do not qualify as excepted benefits.

Action Items:

- ☐ Review your organization’s health coverage to determine the plan(s) subject to the research fees.
- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to your organization through a premium increase.
- ☐ If there is an HRA, determine whether it qualifies for the exception for multiple self-funded plans, or whether it is subject to the research fee.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Patient-Centered Outcomes Research Institute Fees (PCORI Fees)
- Health Care Reform: PCORI Fees Due July 31, 2014
- Health Care Reform Fees—Special Rules for HRAs

Reinsurance Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Currently effective—three-year period from 2014 through 2016

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of health insurance exchange operation (2014-2016). The fees will be used to help stabilize premiums for coverage in the individual market. Fully-insured plan sponsors do not have to pay the fee directly.

Certain types of coverage are excluded from the reinsurance fees, including HRAs that are integrated with major medical coverage, HSAs, health FSAs and coverage that consists solely of excepted benefits under HIPAA (such as stand-alone vision and dental coverage). Also, self-insured group health plans that do not use a third party administrator for their core administrative functions are exempt from the requirement to make reinsurance contributions for the 2015 and 2016 benefit years.

The reinsurance program's fees will be based on a national contribution rate, which HHS will announce annually. The reinsurance fee is calculated by multiplying the average number of covered lives by the national contribution rate. The annual contribution rate is: $5.25 per month ($63 per enrollee per year) for 2014; $3.67 per month ($44 per enrollee per year) for 2015; and $2.25 per month ($27 per enrollee per year) for 2016.

The reinsurance contributions will be collected by HHS in two installments—one at the beginning of the calendar year following the applicable benefit year, and one at the end of that calendar year. For example, the $63 per capita reinsurance contribution for 2014 will be collected in two installments: $52.50 in January 2015 and $10.50 late in the fourth quarter of 2015.

Action Items:

- ☐ Review your organization's health coverage to determine the plan(s) subject to the reinsurance fees.
- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to your organization through a premium increase.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Reinsurance Fees Will Cost Group Health Plans
- Health Care Reform Fees—Special Rules for HRAs
- Health Care Reform: Reinsurance Fees—Exemption for Certain Self-Insured Plans

Health Insurance Providers Fee

Who is Covered?	When?
Any entity that provides health insurance for any U.S. health risk	Sept. 30 of each calendar year, beginning in 2014

Beginning in 2014, the ACA imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee, which is treated as an excise tax, is required to be paid by Sept. 30 of each calendar year.

The health insurance providers fee applies to all "covered entities," defined as entities that provide health insurance for any United States health risk. The fee will be assessed on health insurers' premium revenue with respect to health insurance above $25 million. The fee program specifically excludes self-insured employers.

The term "health insurance" does not include coverage for specific diseases, accident or disability only, hospital indemnity, long-term care or Medicare supplemental health insurance. However, limited dental and vision coverage are included for purposes of this fee.

The aggregate annual fee for all covered entities will be apportioned among the covered entities according to their respective market shares, as measured by net premiums written for health insurance. The aggregate annual fee for all covered entities is expected to be $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for 2017 and $14.3 billion for 2018. Beginning in 2019, the cost of the fee will increase based on the rate of premium growth.

Action Item:

☐ Watch for communications from the insurance carrier as to how this fee might impact costs for the plan.

Document Available from Trusted Advisors Group:

- Health Care Reform: Health Insurance Providers Fee

$2,500 Contribution Limit for Health FSAs

Who is Covered?	When?
Health FSAs	Currently effective

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) through a cafeteria plan must be limited to $2,500. The health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, the limit increased to $2,550 for taxable years beginning in 2015. The health FSA limit will potentially be further increased for cost-of-living adjustments for later years.

Health FSA plan sponsors are free to impose an annual limit that is lower than the ACA limit for employees' health FSA contributions. Also, the $2,500 limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

In addition, the IRS relaxed the "use-or-lose" rule for health FSAs. Under the relaxed rule, employers may allow participants to carry over up to $500 in unused funds into the next year. This modification applies only if the plan does not also incorporate the grace period rule. This carryover rule does not affect the $2,500 limit on salary reduction contributions. This means the plan may permit the individual to elect up to $2,500 in salary reductions in addition to the $500 that may be carried over.

Action Items:

- ☐ Determine whether the health FSA limits the amount of money an employee can set aside into the FSA on a pre-tax basis per plan year.
- ☐ If yes, ensure that the limit is at or below $2,500 for 2014, or $2,550 for 2015.
- ☐ If there is no limit or a limit above the permitted dollar amount for the year, establish a limit that does not exceed $2,500 for 2014, or $2,550 for 2015.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Changes to Health Accounts
- Health Care Reform: The $2,500 Health FSA Limit
- Health FSA Limit Will Increase for 2015
- Health FSA Carryovers

Preventive Care Services (Non-GF Plans Only)

Who is Covered?	When?
Non-GF health plans	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, non-GF health plans must cover specific preventive care services without cost-sharing requirements. The covered preventive care services include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA (for plan years beginning on or after Aug. 1, 2012).

The complete list of recommended preventive services that must be covered can be found at www.HealthCare.gov/center/regulations/prevention.html.

Action Item:

☐ Confirm that non-GF health plans cover the recommended preventive services without imposing any cost-sharing (such as deductibles, copayments or coinsurance) for the services.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Preventive Care Coverage Guidelines
- Health Care Reform: Preventive Care Guidelines for Women
- Health Care Reform: Contraceptive Coverage Requirements for Religious Employers
- Religious Accommodations Expanded Under the Contraceptive Mandate

Dependent Coverage Up to Age 26

Who is Covered?	When?
Group health plans and health insurance issuers that provide dependent coverage of children	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, group health plans and health insurance issuers that provide dependent coverage of children must make coverage available for adult children up to age 26, regardless of the child’s student or marital status. There is no requirement to cover the child or spouse of a dependent child.

This requirement applies to GF and non-GF plans. However, prior to the 2014 plan year, GF plans were not required to cover adult children who were eligible for other employer-sponsored coverage, such as coverage through their own employer.

ACA also added a tax provision related to health insurance coverage for these adult children. Effective March 30, 2010, amounts spent on medical care for an eligible adult child can generally be excluded from taxable income. In addition, all states should now be in conformity with this federal tax law change.

Action Items:

☐ Confirm that the plan provides dependent coverage up to age 26 on a tax-free basis.

☐ If the plan is GF, confirm that it will make coverage available to adult children up to age 26 regardless of whether they are eligible for other employer-sponsored group health coverage, effective for the 2014 plan year and beyond.

Documents Available from Trusted Advisors Group:

- Health Care Reform: Dependent Coverage Up to Age 26
- Health Care Reform: IRS Guidance on Tax-Free Coverage for Children Under Age 27

Patient Protections (Non-GF Plans Only)

Who is Covered?	When?
Non-GF group health plans Health insurance issuers of non-GF plans	Currently effective

The ACA imposes three new requirements on group health plans and health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and requirements relating to benefits for emergency services.

- Non-GF group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).

- Non-GF group health plans and health insurance issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

- Non-GF group health plans and health insurance issuers that provide hospital emergency room benefits must provide those benefits without requiring prior authorization, and without regard to whether the provider is an in-network provider. Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates imposed for out-of-network emergency services, cannot exceed the cost-sharing requirements for in-network emergency services.

Action Items:

☐ If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician.

☐ Permit participants to obtain OB/GYN care without a pre-authorization or referral.

☐ Eliminate pre-authorization requirement for emergency services.

☐ Eliminate increased coinsurance or copayment requirements for out-of-network emergency services.

Document Available from Trusted Advisors Group:

- Health Care Reform: Patient Protections

Lifetime Limits

Who is Covered?	When?
Health plans Health insurance issuers	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, health plans and health insurance issuers are prohibited from imposing lifetime limits on the dollar value of essential health benefits.

Action Item:

☐ Confirm that the plan does not impose lifetime limits on essential health benefits.

Document Available from Trusted Advisors Group:

- Health Care Reform: Lifetime and Annual Limits

Rescissions

Who is Covered?	When?
Group health plans Health insurance issuers	Currently effective

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant’s failure to pay required premiums or contributions for the coverage.

This prohibition applies to GF and non-GF health plans, whether in the group or individual market, and whether coverage is insured or self-funded.

Action Item:

☐ Confirm that the plan does not rescind coverage except in the case of fraud or intentional misrepresentation of fact.

Document Available from Trusted Advisors Group:

- Health Care Reform: Prohibition on Rescissions