Health Care Reform Checklist for 2014

This checklist is designed to help employers who sponsor group health plans review their compliance with key provisions of the Affordable Care Act (ACA) taking effect in 2014. If you have questions regarding your responsibilities, please contact a knowledgeable employment law attorney, benefits advisor, or your carrier.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements or amendments to the law. Additionally, your company or group health plan may be exempt from certain requirements described below.

1. Evaluate Grandfathered Status of Group Health Plan

A grandfathered plan is one in existence as of March 23, 2010 that has covered at least one person continuously from that day forward. Grandfathered plans do not have to comply with certain ACA rules.

- Determine whether any changes to the plan that reduce benefits or increase costs to employees and dependents enrolled in coverage result in a loss of grandfathered status.
- **If the plan loses grandfathered status**, confirm that the plan design and benefits offered reflect all ACA requirements that previously did not apply because the plan was exempt (such as coverage of preventive services without cost-sharing).
- **To maintain grandfathered status (if the plan remains grandfathered)**, provide a statement indicating the plan believes it is a grandfathered health plan, along with contact information for questions and complaints, whenever a summary of benefits under the plan is provided to participants and beneficiaries. A model notice is available here. Continue to maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify grandfathered status.

2. Review Plan Documents for Required Changes to Plan Benefits

Certain requirements apply on a plan year basis, meaning the changes take effect when a group health plan begins a new plan year. As a result, compliance deadlines may vary.

All Group Health Plans:

- Ensure the plan does not apply any **waiting period**—the time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible to enroll in the plan—that exceeds 90 days for plan years beginning in 2014. (Other conditions for eligibility that are not based solely on the lapse of a time period are generally permissible.)
- Confirm that **no annual dollar limits** apply to coverage of "essential health benefits" for plans issued or renewed beginning January 1, 2014. If the plan limits the number of visits to health providers or days of treatment, verify that the visit or day limit does not amount to a dollar limit.
- Eliminate **preexisting condition exclusions** for all individuals—regardless of age—for plan years beginning in 2014. (The prohibition on exclusions of children under 19 years of age on the basis of preexisting conditions became effective in 2010.)

Non-Grandfathered Group Health Plans Only:

- For small group plans, confirm the plan covers "**essential health benefits**," a comprehensive package of items and services, for plan years beginning on or after January 1, 2014. (This requirement does not apply to self-insured plans or plans offered in the large group market.)
- Ensure that **cost-sharing** under the plan for coverage of "essential health benefits" provided in-network does not exceed certain limitations:
    - Annual out-of-pocket expenses (including coinsurance and copayments, but not premiums) for a plan year beginning in 2014 may not exceed **$6,350 for self-only coverage** or **$12,700 for other than self-only coverage**.

Note: Certain small businesses were permitted to renew existing group coverage for 2014 that does not comply with the requirements to cover essential health benefits and limit annual cost-sharing under the plan. Businesses that were eligible to continue existing coverage should have received a notice from their insurance companies.

Grandfathered Group Health Plans Only:

- If the plan covers **dependents**, confirm that coverage is made available until a child reaches age 26, regardless of other coverage options, for plan years beginning on or after January 1, 2014. While most group plans were required to comply with this requirement since 2010, a temporary exception allowed grandfathered plans to exclude adult children who were eligible to enroll in employer-based coverage other than the group health plan of a parent.

3. Analyze Tax-Favored Arrangements

As a result of several ACA changes, employers who maintain cafeteria plans, HRAs, and health FSAs may need to modify these arrangements in order to comply with certain requirements under the law.

Health Reimbursement Arrangements (HRAs)

- An HRA (other than a retiree-only HRA or an HRA consisting solely of excepted benefits) **must be "integrated" with other group health plan coverage** in order to satisfy the preventive services requirements and the annual dollar limit prohibition, effective for plan years beginning in 2014.
    - To be "integrated," an HRA must meet specific requirements under either of two methods described in agency guidance. Both methods require that the employer offer a group health plan (other than the HRA) to employees—either a plan that does not consist solely of excepted benefits or a plan that provides minimum value.
- HRAs **may no longer be used to reimburse an employee's individual insurance policy premiums**, because an HRA cannot be "integrated" with individual market coverage in order to meet the ACA requirements.

Health Flexible Spending Arrangements (FSAs)

- A health FSA **must qualify as excepted benefits** or the arrangement will fail to comply with the preventive services requirements, effective for plan years beginning in 2014.
    - Health FSAs will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).
- Confirm that the health FSA is **offered through a cafeteria plan** (a plan which meets specific requirements to allow employees to receive certain benefits on a pre-tax basis) in order to comply with the annual dollar limit prohibition.
- Ensure plan documents are amended by December 31, 2014 to reflect the $2,500 annual limit on salary reduction contributions to health FSAs (which became effective for plan years beginning in 2013).
- Determine whether you will allow employees to carryover up to $500 of unused health FSA amounts to use in the following plan year under the modified "use-or-lose" rule, and adopt appropriate plan amendments. (A plan incorporating the carryover provision **may not also provide for a grace period** in the plan year to which unused amounts may be carried over.)

Cafeteria Plans Generally

- Amend section 125 plan documents to reflect the **prohibition on providing a qualified health plan** offered through a Health Insurance Exchange (Marketplace) as a benefit under an employer-sponsored cafeteria plan, effective for taxable years beginning after December 31, 2013. (For plans that, as of September 13, 2013, operate on a non-

calendar plan year, this restriction does not apply before the first plan year that begins after December 31, 2013.)

- For non-calendar year plans, determine whether you will allow employees to make **mid-year changes in salary reduction elections** to accommodate certain ACA changes in 2014 pursuant to transition relief, and adopt appropriate plan amendments. In particular, employees may wish to enroll in employer-sponsored coverage to comply with the individual mandate or terminate coverage to purchase a plan through a Marketplace, neither of which would constitute a "change in status" for the purpose of permitted election changes.

4. Provide Required Notices to Employees and Dependents

Please contact your carrier or an employment law attorney if you have questions regarding these notices.

Availability of Health Insurance Exchanges (Notice of Coverage Options)

- Provide a written notice with information about a Health Insurance Exchange (Marketplace) to each new employee at the time of hiring, **within 14 days of the employee's start date**. Employers are not required to provide a separate notice to dependents.
    - Two model notices are available to help employers comply with this requirement—one notice for employers that offer a health plan, and another notice for those that do not.

Summary of Benefits & Coverage (SBC) and Notice of Plan Changes

- Confirm contractual arrangements with the carrier (insured group health plans) or third party administrator (self-insured plans) to prepare and provide the SBC. If the carrier or TPA does not assume responsibility, the employer should provide this notice (without charge) to employees and beneficiaries at specified times during the enrollment process and upon request.
- Update SBCs for **coverage starting on or after January 1, 2014** to include language indicating whether the plan provides "minimum essential coverage" (the type of coverage an individual needs to satisfy the ACA's individual mandate), and whether the plan meets the ACA's "minimum value" standard (meaning the plan pays for at least 60% of covered health care expenses).
    - An updated SBC template, which includes the new language, is available for use. A plan that is unable to modify the SBC template for coverage starting on or after January 1, 2014 and before January 1, 2015 may use the previously authorized template, **so long as** the SBC is furnished with a cover letter or similar disclosure stating whether the plan does or does not provide "minimum essential coverage" and "minimum value."

- Ensure that enrollees are provided with notice of any material modification that would affect the content of the SBC (and that occurs other than in connection with coverage renewal or reissuance) **no later than 60 days prior to the effective date of the change**.

5. Other Action Items for 2014

The following outlines actions required for continued ACA compliance, as well as additional items that may be of significance for certain employers and group health plans.

- **Additional Medicare Tax for High Earners.** Remember to withhold Additional Medicare Tax (0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year.
- **Coverage of Preventive Services.** Continue to monitor guidelines for preventive services, which are regularly updated to reflect new scientific and medical advances. As new services are approved, non-grandfathered group health plans will be required to cover them with no cost-sharing for plan years beginning one year later.
- **Medical Loss Ratio (MLR) Rebates.** Distribute rebates received from insurance companies to eligible plan enrollees as appropriate. Rebates are due to employer-policyholders by August 1st (starting in 2015, rebates are due by September 30th). These rules do not apply to employers who operate self-insured plans.
- **PCORI Fees.** Employers sponsoring certain self-insured health plans (including HRAs and FSAs not treated as excepted benefits) are responsible for fees to fund the Patient-Centered Outcomes Research Institute (PCORI). IRS Form 720 must be filed annually to report and pay the fees no later than July 31st of the year following the last day of the plan year to which the fee applies.
- **Reporting of Employer-Provided Health Coverage.** Continue to report the cost of health coverage provided to each employee annually on Form W-2, which must be furnished to employees by January 31st each year, unless transition relief applies. (This requirement **does not apply to employers required to file fewer than 250 Forms W-2 for the preceding calendar year**.)
- **Simple Cafeteria Plans.** If eligible, consider whether your company could benefit from establishing a simple cafeteria plan, which may be treated as meeting certain IRS nondiscrimination requirements.
- **Small Business Health Care Tax Credit.** Determine if your company qualifies for the small business health care tax credit. Beginning in 2014, the maximum credit increases to 50% for small business employers; however, only premiums paid for qualified health plans offered through a Small Business Health Options Program (SHOP) count for the credit. (Until online functionality for the federally-facilitated SHOP is available, small businesses may work with an agent or broker to enroll employees in a qualified health plan and apply for SHOP eligibility.)
- **Transitional Reinsurance Program Fees.** The Transitional Reinsurance Program is a three-year program, beginning in 2014 and continuing through 2016, that reimburses insurers in the individual market for high claims costs. The program will be funded through fees to be paid by issuers of insured health plans and employers sponsoring

certain self-insured plans providing major medical coverage. Employers with self-insured plans may utilize a third party administrator or administrative-services-only contractor for transfer of the contributions.

- **Wellness Programs.** If your company sponsors a wellness program that requires an individual to satisfy a standard related to a health factor in order to obtain a reward, confirm the program complies with revised nondiscrimination rules for plan years beginning on or after January 1, 2014. Determine whether to increase the maximum permissible reward (up to 30% of the cost of coverage, or 50% for programs designed to prevent or reduce tobacco use).
- **Start Preparing for 2015.** Employers with 50 or more full-time employees (including full-time equivalents) should consult with a knowledgeable benefits advisor or legal counsel to determine the necessary actions to comply with the ACA's "pay or play" requirements in 2015. (**Special Update:** Final rules have been issued which delay the "pay or play" requirements until 2016 for large employers who have fewer than 100 full-time employees and who meet specific eligibility conditions.)

Be prepared for compliance requirements to change. Stay up-to-date on the latest information regarding Health Care Reform by visiting http://www.dol.gov/ebsa/healthreform/.