Employer Health Reform Checklist

<50 Employees
Employers that provide health coverage to employees are responsible for complying with many of the provisions of the Affordable Care Act (ACA). Some of the provisions took effect for plan years beginning on or after September 2010. Other provisions will take effect through 2018. The checklist below is designed to help small employers comply with the provisions taking effect in 2013 and 2014.

**2013 Health Reform Provisions**

**What Employers Need to Do**

- **Provide a Summary of Benefits and Coverage (SBC)** – Group health plans and health insurance issuers offering coverage are required to provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. ACA regulations require that the SBC be provided in several instances (by the first day of open enrollment, by the first day of coverage if there are any changes, special enrollees, upon request, and prior to off-renewal changes).

- **Provide written notice about Health Insurance Exchanges (Marketplaces)** – Employers must provide a written notice to current employees and new hires informing them of the Exchanges (Marketplaces) and the circumstances under which they may be eligible for health insurance subsidies.

Employers must provide the notice to all current employees (including part-time and full-time employees regardless of whether eligible for coverage) by October 1, 2013. For new hires, the notice must be provided within 14 days of hire. This requirement applies to all employers covered by the Fair Labor Standards Act (FLSA).
The DOL provides the following two model notices:

✔ Employers who currently offer health insurance to any or all employees can use this notice:  

✔ Employers who do not offer health insurance to any employees can use this notice:  

The Model Notice does not have to be used. Employers have the option to draft their own notice as long as it informs the employee:

1. About the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;

2. That if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and

3. That the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

☐ **Limit employee contributions to health flexible spending accounts (FSA)** – Employee salary reduction contributions to health FSAs are limited to $2,500 per plan year, with indexed increases allowed in future years to adjust for inflation.

☐ **W-2 Reporting of Employee Health Coverage Cost** – Starting with tax year 2012, employers must report the cost of each employee's health coverage on Form W-2. This item is informational only and has no tax consequences. Note: This reporting requirement does not apply to employers that filed fewer than 250 Forms W-2 for the prior tax year.

☐ **Check Eligibility for Small Business Tax Credit** – Employers with fewer than 25 employees should check to see if they qualify for the Small Business Tax Credit. For tax years beginning in 2014, the credit will be available only to small businesses that purchase health coverage through the Health Insurance Exchange (Marketplace).

☐ **Review Grandfathered Plan Status** – Employers that have a grandfathered plan should review it to confirm that it still qualifies for grandfathered status. Plans that lose grandfathered status become subject to the same health reform requirements as non-grandfathered plans.
2014 Health Reform Provisions

“Small Employers” (generally those with fewer than 50 employees) are not subject to the employer shared responsibility provision (employer mandate) that was originally scheduled to go into effect in 2014 (now 2015). However, employers need to be aware of the important changes that the ACA makes to health plans in 2014.

What Employers Need to Know

☐ Plan exclusions for pre-existing conditions are no longer allowed – Health plans are prohibited from imposing pre-existing condition exclusions on any enrollees.

☐ No waiting periods longer than 90 days – Employers that offer health coverage cannot impose a waiting period that exceeds 90 calendar days. The waiting period begins on the employee’s eligibility date, such as a full-time employee’s hire date. State insurance laws – applying only to policies issued in that state – may impose shorter limits.

☐ Coverage for Clinical Trials – Non-grandfathered health plans cannot 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 would otherwise be provided just because an individual is enrolled in a clinical trial.

☐ Plans must provide Essential Health Benefits (EHB) - All non-grandfathered “small group” health insurance plans must cover all Essential Health Benefits (EHBs). This requirement does not apply to grandfathered plans, self-funded plans, or insured plans in the large group market.

Each state, though its state insurance code or laws, may establish a detailed definition of EHBs for purposes of small group policies issued in that state. The general EHB definition includes health care services in the following ten benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (services for individuals under 19 years of age)
☐ **Limit on Annual Out-of-Pocket Maximums** – All non-grandfathered health plans, including small and large group insurance policies and self-funded health plans, are subject to the annual out-of-pocket maximum limit. For plan year 2014, the limits are $6,350 (single coverage) or $12,700 (family coverage). All cost-sharing, such as copays, deductibles, and coinsurance, for Essential Health Benefits (EHBs) must accumulate to a plan’s out of pocket maximums.

For plan year 2014 only, there is a one-year safe harbor for certain plans that utilize more than one service provider to administer benefits (e.g., one claims payer for medical services and a separate PBM for outpatient Rx).

☐ **Limit on Annual Deductibles** – All non-grandfathered “small group” health insurance policies are subject to the annual deductible limit. The limits are $2,000 (single coverage) or $4,000 (family coverage). This provision does not apply to large group insured plans or self-funded plans.

☐ **Wellness program incentives** – Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward (for example, not smoking or meeting exercise targets). Starting with plan year 2014, the maximum permissible reward increases from 20% to 30% of the coverage cost (or up to 50% for tobacco-contingent rewards).

☐ **New Fees on Health Plans** – The Affordable Care Act imposes certain fees on health insurance plans in order to raise revenue for various purposes, including clinical research, stabilization of high-risk insurance markets, and expansion of health coverage. Some fees apply for a few years, while others are permanent. The insurance provider or HMO (carrier) is responsible for paying any required fees and will factor the fee(s) into their premium charges. Certain fees also apply to uninsured or self-funded plans; in those cases, the plan sponsor (employer) is responsible for payment.

✔ **The Patient-Centered Outcomes Research Institute (PCORI) Fee.** – The Patient-Centered Outcomes Research Institute (PCORI) is a private non-profit corporation established to study clinical effectiveness and health outcomes. To finance the Institute’s work, a small Fee – called the “Comparative Effectiveness Research Fee” or the “PCORI Fee” – will be imposed on group health plans. For the first plan year ending after September 30, 2012, the Fee is $1 per year per health plan participant (i.e., each covered employee and dependent). The Fee increases to $2 the following year, and will be adjusted for inflation each subsequent year until it expires in 2019. The insurer or HMO pays the PCORI Fee for each health insurance policy. For a self-funded health plan, however, the plan sponsor (employer) is responsible for paying the Fee.

✔ **The Transitional Reinsurance Program (TRP) Fee** will be collected from health plans for years 2014 to 2016. The funds will be distributed to individual market insurers that disproportionately attract high-risk individuals in order to spread the financial risk across all health insurers. For 2014, the TRP Fee is estimated at $5.25 per member per month.
The insurer or HMO pays the TRP Fee for each health insurance policy. For a self-funded health plan, however, the plan sponsor (employer) is responsible for paying the Fee.

✔ The Health Insurer Provider (HIP) Fee will be collected from health insurance providers and HMOs (carriers) based on a percentage of the carrier’s net written premiums for insured groups. This annual fee is permanent and is expected to impact premiums by approximately 2.3% in the first year. The HIP Fee does not apply to self-funded plans.

✔ A Risk Adjustment Fee of about $1 per member per year is assessed on carriers issuing risk-adjusted plans in the non-grandfathered small group markets, whether in or out of the Exchanges. This permanent fee is intended to help fund the administrative costs of running the Risk Adjustment Program and begins in 2014. This Fee does not apply to large group plans or self-funded plans.

☐ Adjusted community rating (ACR) – Health insurance in the small group markets will only be able to vary premiums by family size, geography and age. Other rating factors currently used, such as gender, industry, group size, health status and medical history, will be prohibited. The impact of age factors will be limited to a range of 3 to 1. Also, in certain states, tobacco users may have their premium varied by up to 50% higher than non-tobacco users.

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50+ Employees
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**2013 Health Reform Provisions**

**What Employers Need to Do**

- **Provide a Summary of Benefits and Coverage (SBC)** – Group health plans and health insurance issuers offering coverage are required to provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. ACA regulations require that the SBC be provided in several instances (by the first day of open enrollment, by the first day of coverage if there are any changes, special enrollees, upon request, and prior to off-renewal changes).

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The DOL provides the following two model notices:

- Employers who currently offer health insurance to any or all employees can use this notice: http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf
- Employers who do not offer health insurance to any employees can use this notice: http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

The Model Notice does not have to be used. Employers have the option to draft their own notice as long as it informs the employee:

1. About the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;

2. That if the employer plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through the Marketplace; and

3. That the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

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☐ **W-2 Reporting of Employee Health Coverage Cost** – Starting with tax year 2012, employers must report the cost of each employee’s health coverage on Form W-2. This item is informational only and has no tax consequences. Note: This reporting requirement does not apply to employers that filed fewer than 250 Forms W-2 for the prior tax year.

☐ **Review Grandfathered Plan Status** – Employers that have a grandfathered plan should review it to confirm that it still qualifies for grandfathered status. Plans that lose grandfathered status become subject to the same health reform requirements as non-grandfathered plans.
Large Employers” (generally those with 50 or more full-time-equivalent employees) will be subject to the ACA’s employer shared responsibility provision (“employer mandate” or “play or pay”), but this provision has been delayed until 2015. In the meantime, employers need to be aware of the important changes that the ACA makes to health plans in 2014.

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“Large Employers” (generally those with 50 or more full-time-equivalent employees) will be subject to the ACA’s employer shared responsibility provision (“employer mandate” or “play or pay”), but this provision has been delayed until 2015. In the meantime, employers need to be aware of the important changes that the ACA makes to health plans in 2014.

What Employers Need to Know

□ Plan exclusions for pre-existing conditions are no longer allowed – Health plans are prohibited from imposing pre-existing condition exclusions on any enrollees.

□ No waiting periods longer than 90 days – Employers that offer health coverage cannot impose a waiting period that exceeds 90 calendar days. The waiting period begins on the employee’s eligibility date, such as a full-time employee’s hire date. State insurance laws – applying only to policies issued in that state – may impose shorter limits.

□ Coverage for Clinical Trials – Non-grandfathered health plans cannot 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 would otherwise be provided just because an individual is enrolled in a clinical trial.

□ No Annual Dollar Limits on Essential Health Benefits (EHB) - Group health plans, whether insured or self-funded, are prohibited from imposing lifetime or annual dollar limits on all Essential Health Benefits (EHBs). “Small group” insured plans are required to cover all EHBs. Large group and self-funded plans are not required to cover EHBs, but cannot impose lifetime or annual dollar limits on any EHBs that are covered. Each state, through its state insurance code or laws, may establish a detailed definition of EHBs for purposes of policies issued in that state. The general EHB definition includes health care services in the following ten benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
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The Transitional Reinsurance Program (TRP) Fee will be collected from health plans for years 2014 to 2016. The funds will be distributed to individual market insurers that disproportionately attract high-risk individuals in order to spread the financial risk across all health insurers.

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