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2014 Compliance Checklist

The Affordable Care Act (ACA) implemented comprehensive health coverage reforms with effective dates spread out over a period of four years and beyond. Some of ACA's reforms are already in effect for employers and their group health plans, such as the Form W-2 reporting requirement for large employers and the requirement for non-grandfathered health plans to cover certain preventive care services without cost-sharing.

Many of ACA's key reforms become effective in 2014. These include health plan design changes, increased wellness program incentives and a new reinsurance fee. To prepare for this next phase of ACA reforms, employers should review upcoming requirements and make sure they have a compliance strategy in place.

This Legislative Brief provides a health care reform compliance checklist for 2014. Please contact Burkhardt Consulting, LLC for assistance or if you have questions about changes that were required in previous years.

PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was in existence when health care reform was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact Burkhardt Consulting, LLC if you have questions about changes you have made, or are considering making, to your plan.

- ☐ If you **have a grandfathered plan**, determine whether it will maintain its grandfathered status for the 2014 plan year. Grandfathered plans are exempt from some of ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year.

- ☐ If you **move to a non-grandfathered plan**, confirm that the plan has all of the additional patient rights and benefits required by ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

Annual Limits

Effective for plan years beginning on or after Jan. 1, 2014, health plans are prohibited from placing annual limits on essential health benefits. (ACA's prohibition on annual limits was phased in over a three-year period; restricted annual limits were permitted for plan years beginning before Jan. 1, 2014.)

- ☐ Confirm that no annual limit will be placed on essential health benefits for the 2014 plan year and beyond.

Pre-existing Condition Exclusions

Effective for plan years beginning on or after Jan. 1, 2014, ACA prohibits health plans from imposing pre-existing condition exclusions (PCEs) on any enrollees. PCEs for enrollees under 19 years of age were eliminated by ACA for plan years beginning on or after Sept. 23, 2010.

☐ Confirm that PCEs will not be imposed on any enrollees for the 2014 plan year and beyond.

Dependent Coverage to Age 26

Effective for plan years beginning on or after Sept. 23, 2010, ACA requires health plans that provide dependent coverage of children to make coverage available for adult children up to **age 26**. However, for plan years beginning before Jan. 1, 2014, grandfathered plans were not required to cover adult children under age 26 if they were eligible for other employer-sponsored group health coverage.

☐ If your plan is grandfathered, 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.

Excessive Waiting Periods

Effective for plan years beginning on or after Jan. 1, 2014, a health plan 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 in the plan becomes effective. Other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit.

☐ If your plan has a waiting period for coverage, confirm that the waiting period is 90 days or less for the 2014 plan year and beyond.

Coverage for Clinical Trial Participants

Effective for plan years beginning on or after Jan. 1, 2014, 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.

☐ For the 2014 plan year and beyond, confirm that plan terms and operations will not discriminate against participants who participate in clinical trials.

Limits on Cost-sharing

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost-sharing or out-of-pocket costs. The cost-sharing limits include both an overall annual limit (or an out-of-pocket maximum) and an annual deductible limit.

> On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014 (H.R. 4302), which **repeals the annual deductible limit** under the ACA. This repeal is effective as of the date that the ACA was enacted, back on March 23, 2010. Due to the actuarial value exception provided under the final rule, this repeal may not significantly impact small employers. However, it will give small employers with insured plans more flexibility to offer higher deductible health plans (which typically come with lower premiums).

Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs (for 2014, **$6,350** for self-only coverage and **$12,700** for family coverage). Deductibles could not exceed **$2,000** (single coverage) or **$4,000** (family coverage). These amounts are indexed for subsequent years.

The deductible requirement applied only to non-grandfathered plans in the insured small group market, while the out-of-pocket cost limit will apply to all non-grandfathered health plans (including self-insured plans and plans and issuers

in the large group market). Also, a health plan's annual deductible was permitted to exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier—bronze, silver, gold or platinum) without exceeding the limit.

In addition, special transition relief for the out-of-pocket maximum has been provided for plans that use more than one service provider to administer benefits. Under this transition relief, **only for the first plan year beginning on or after Jan. 1, 2014**, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the ACA's out-of-pocket maximum, the annual limit will be satisfied if **both** of the following conditions are met:

- 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.

☐ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2014 plan year ($6,350 for self-only coverage and $12,700 for family coverage). If your plan uses multiple service providers to administer benefits, confirm that the plan's out-of-pocket maximum complies with the transition relief for the 2014 plan year.

☐ Be aware that the ACA's annual deductible limit no longer applies.

Comprehensive Benefits Package

Starting in 2014, insured plans in the individual and small group market must cover each of the essential benefits categories listed under ACA. This requirement does not apply to grandfathered plans, self-funded plans or insured plans in the large group market.

☐ If you have an insured plan subject to ACA's comprehensive benefits package mandate, confirm with the health insurance issuer that the plan will cover the essential health benefits package, effective for the 2014 plan year.

WELLNESS PROGRAM INCENTIVES

Under current law, the reward under a health-contingent wellness program is limited to 20 percent of the cost of coverage. 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, attaining certain results on biometric screenings or meeting exercise targets).

For 2014 plan years, the maximum permissible reward increases to **30 percent** of the cost of coverage. In addition, the maximum permissible reward increases to 50 percent of the cost of health coverage for programs designed to prevent or reduce tobacco use. On May 29, 2013, federal agencies released final regulations that generally implement ACA's nondiscrimination requirements for wellness programs.

☐ For a health-contingent wellness program, confirm the program complies with nondiscrimination requirements and consider whether to increase the reward in 2014.

REINSURANCE FEES

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).

The reinsurance program's fees will be based on a national contribution rate, which HHS will announce annually. For 2014, HHS announced a national contribution rate of **$5.25 per month** ($63 per year). The reinsurance fee is calculated by multiplying the number of covered lives (employees and their dependents) for all of the entity's plans and coverage that must pay contributions, by the national contribution rate for the year.

☐ Review the health coverage you provide to your employees to determine the plan(s) subject to the reinsurance fees.

EMPLOYER "PAY OR PLAY" MANDATE

Employers with 50 or more employees (including full-time and full-time equivalent employees) that do not offer health coverage to their full-time employees (and dependents) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

The sections of the health care reform law that contain the employer penalty requirements are known as the "shared responsibility" or "pay or play" provisions. Employers that are subject to the pay or play rules are known as "applicable large employers."

The employer mandate provisions were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury announced the **delay of the employer mandate penalties and related reporting requirements for one year, until 2015.** Therefore, these payments will not apply for 2014. On July 9, 2013, the IRS issued Notice 2013-45 to provide more formal guidance on the delay. No other provisions of the ACA were affected by the delay.

On Feb. 10, 2014, the Treasury released final regulations implementing the ACA's employer shared responsibility provisions. The final regulations include transitional relief to help employers comply with the new requirements.

- Applicable large employers with 100 or more full-time employees will be subject to the employer mandate rules starting in 2015.
- However, the final regulations delay implementation for medium-sized employers that are covered by the employer mandate. **In general, applicable large employers with fewer than 100 full-time employees will have an additional year, until 2016, to comply with the shared responsibility rules**.

The penalty amount for not offering health coverage is up to $2,000 annually for each full-time employee, excluding the first 30 employees. For 2015, instead of excluding the first 30 employees, an employer with at least 100 full-time employees may exclude the first 80 employees under this calculation. Under the final regulations, an employer 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 employer will not be liable for this penalty if it offers coverage to all but five percent (or, if greater, five) of its full-time employees and dependents.

Employers who offer health coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of up to $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 employees (80 employees for 2015 for employers with 100 or more full-time employees).

The IRS provided safe harbor guidance for employers on determining who is considered a full-time employee (and must be offered coverage), how to measure a plan's affordability and how penalties will apply when there is a waiting period for coverage. Guidance has also been issued on ways to determine a plan's minimum value, including a minimum value calculator. The IRS also provided transition relief for non-calendar year plans.

☐ Count the number of employees to determine if you are an applicable large employer and if you qualify for the 2015 transition relief for medium-sized employers (that is, large employers with fewer than 100 full-time employees, including equivalents).

☐ If you are an applicable large employer, take the following additional steps:

- Determine whether health coverage is offered to substantially all full-time employees and dependents;
- Assess the affordability of the health coverage under one of the IRS' affordability safe harbors (Form W-2, rate of pay or federal poverty line);
- Review whether the plan provides minimum value by using one of the three available methods (minimum value calculator, safe harbor checklists or actuarial certification); and
- If you have a non-calendar year plan, determine if you qualify for the transition relief for the period in 2015 before the start of the 2015 plan year.

REPORTING OF COVERAGE

Effective for 2014, ACA requires health insurance issuers and sponsors of self-insured plans that provide "minimum essential coverage" to report certain health coverage information to the IRS. A separate IRS reporting requirement will apply to applicable large employers subject to ACA's shared responsibility rules.

On March 5, 2014, the IRS released two final rules on the ACA's health coverage reporting requirements.

- The first **final rule**, on the section 6055 reporting requirements, requires health insurance issuers, self-insured health plan sponsors, government agencies that administer government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to report information on that coverage to the IRS and covered individuals. This rule finalizes proposed regulations issued on Sept. 5, 2013.
- The second **final rule**, on the section 6056 reporting requirements, requires applicable large employers (ALEs) subject to the pay or play rules to report to the IRS and covered individuals information on the health coverage offered to full-time employees. This rule finalizes proposed regulations issued on Sept. 5, 2013.

The final regulations apply for calendar years beginning after **Dec. 31, 2014**. This date reflects the one-year delay provided in IRS Notice 2013-45. The first returns will be due in 2016 for coverage provided in 2015. However, the IRS is encouraging voluntary compliance for 2014.

The final regulations allow reporting entities to use a single, combined form for reporting the information required under both section 6055 and 6056.

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