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2014 Compliance Checklist

The Affordable Care Act (ACA), which was signed into law in March 2010, put in place 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 will become effective in 2014. Key ACA reforms that will affect employers in 2014 include health plan design changes, increased wellness program incentives, a new reinsurance fee, the employer "pay or play" mandate and additional reporting requirements. 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 The Robbins Group 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 The Robbins Group 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. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs. Deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage). These amounts are indexed for subsequent years.

Final guidance on this requirement provides that the deductible requirement will apply only to 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).

☐ Review your plan's limits on cost-sharing to make sure they comply with ACA's limits on cost-sharing, effective for the 2014 plan year.

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, proposed regulations would increase the maximum permissible reward to 50 percent of the cost of health coverage for programs designed to prevent or reduce tobacco use. More guidance is expected on the reforms for wellness programs.

☐ For a health-contingent wellness program, confirm the program complies with current law 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

Effective Jan. 1, 2014, 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" provisions.

- The penalty amount for not offering health coverage is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Under proposed IRS regulations, an employer would 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.
- 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).

The IRS provided safe harbor guidance for employers on determining who is considered a full-time employee (and must be offered coverage), along with 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 proposed transition relief for non-calendar year plans, or fiscal year plans.

☐ Count the number of your employees to determine if you are a large employer subject to ACA's shared responsibility provisions.

☐ If you are a 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 fiscal year plan, determine if you qualify for the transition relief for plan years beginning in 2013.

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 large employers subject to ACA's shared responsibility rules. Large employers will have to report information on the design and cost of their plans, applicable waiting periods and employees covered by the plan.

It is expected that the IRS will use this information to verify data related to ACA's individual and employer mandates. The first information returns under these new reporting provisions will be due in 2015. Further guidance on these new reporting requirements is anticipated.

☐ In 2015, provide required information regarding plan coverage and participation in accordance with information return requirements.