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AFFORDABLE CARE ACT

LARGE EMPLOYER HEALTH REFORM CHECKLIST

Edition: August 2015

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HEALTH REFORM CHECKLIST

Employers that offer health care coverage to employees are responsible for complying with many of the provisions of the Affordable Care Act (ACA). Most health reform changes apply regardless of the employer's size, but some changes apply only to small employers and other changes apply only to large employers. Even employers that do not offer any coverage need to comply with certain requirements to distribute notices to workers or submit reports to federal agencies.

This edition of our Health Reform Checklist summarizes the provisions applying to large employers.

Starting with Basics

The effective dates of most ACA provisions usually are based on the employer's group health "plan year" starting date. Other items take effect on a specific calendar date. Further, whether or not a provision applies often depends on the employer's size or on the type of group policy.

"Large Employer" generally means an organization (including subsidiaries) with 50 or more full-time and full-time-equivalent employees.

"Large Group" refers to the type of group health insurance policy that is sold only to groups with 50 or more employees. Policy requirements, and the provisions that determine the group's size, are defined by each state according to its state insurance law. Most states currently limit "large group" policies to groups over 50 employees. For 2016 and later, the definition of "large group" will change to mean groups with at least 100 employees. Some states will allow exceptions, however, such as permitting renewal of a "large group" policy for an employer with 51 – 99 employees.

"Plan Year" is the period (usually a 12-month period) that is identified in the plan's ERISA document or Form 5500. For non-ERISA plans, the plan year is the benefit year or policy year.

Ongoing Requirements for Notices and Reports

- ✔ **Employer Notice about Health Insurance Exchanges (Marketplaces)** — Employers must provide a written notice to all full-time and part-time employees, whether or not benefits eligible, within **14 days of hire**. The federal notice explains the availability of the Health Insurance Exchanges (Marketplaces) and the circumstances under which employees may be eligible for subsidies to buy coverage through an Exchange.

  This requirement applies to all employers covered by the Fair Labor Standards Act (FLSA), including employers that do not offer health coverage.

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Employers can satisfy the Employer Exchange Notice requirement by using one of the following DOL model notices, filling in the blank sections as needed, and distributing the completed notice to all employees within 14 days of hire:

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

- **Summary of Benefits and Coverage (SBC)** — Health insurers, and employers with self-funded health plans, must provide an SBC for each plan describing its benefits and coverage using a standardized format. 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, upon special enrollment events, upon request, and prior to off-renewal changes). The DOL provides samples and instructions at **www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html**.

- **Grandfathered Plan Notice** — Employers with a grandfathered plan must review it to confirm that it still qualifies for grandfathered status. If so, materials describing the plan's benefits must include a notice regarding the plan's status as a grandfathered plan. The notice must include contact information for questions or complaints. Note that plans that lose grandfathered status immediately become subject to the same health reform requirements as nongrandfathered plans.

- **Patient Protection Notice** — Nongrandfathered health plans must include a notice regarding each participant's right to designate a primary care physician and to obtain obstetrical or gynecological care without prior authorization.

- **W-2 Reporting of Employee Health Coverage Cost** — Employers must report the total cost of each employee's health coverage on Form W-2 (box 12). This item is informational only and has no tax consequences. The requirement does not apply to employers that filed fewer than 250 Forms W-2 for the prior tax year.

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Health Plan Fees and Taxes

The ACA imposes certain fees on health 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.

For insured plans, the carrier or HMO is responsible for reporting and paying any applicable fees. The employer (policyholder) is not responsible for any duties. For a self-funded (uninsured) health plan, the employer sponsor must report and pay the PCORI fee and TRP fee explained below, if applicable:

- The **Patient-Centered Outcomes Research Institute (PCORI) Fee**, also called the Comparative Effectiveness Research (CER) Fee, is imposed on group health plans to help fund studies on clinical effectiveness and health outcomes. Dental or vision only plans, and most health flexible spending accounts (HFSAs), are exempt. The small fee is an annual amount multiplied by the average number of plan participants:

  - Plan year ending between October 1, 2013 and September 30, 2014: $2.00
  - Plan year ending between October 1, 2014 and September 30, 2015: $2.08
  - Plan year ending between October 1, 2015 and September 30, 2019: TBD based on inflation

  Payment is due July 31 following the calendar year in which the plan year ended (e.g., July 31, 2015 for plan years ending in 2014) using **Form 720**.

- **The Transitional Reinsurance Program (TRP)** Fee is collected from group medical plans for calendar years 2014 to 2016 to help fund state reinsurance programs in the individual insurance market. The fee is an annual amount multiplied by the average number of plan participants:

  - Calendar year 2014: $63
  - Calendar year 2015: $44
  - Calendar year 2016: $27

  Enrollment count reports are due by November 15 of the current year and payment is due in installments the following year. For instance, for 2015, the report is due November 15, 2015 and the fee will be due January 15, 2016 (or January 15, 2016 and November 15, 2016, if paying in two installments).

- The **Health Insurer Provider (HIP)** Fee is collected from health insurance providers and HMOs (carriers) based on a percentage of the carrier's net written premiums for insured groups. The fee began in 2014 and is permanent. It applies only to insurers and is expected to impact premiums by approximately 2.3 percent.

- A **Risk Adjustment Fee** does not apply to "large group" policies or self-funded plans. For "small group" policies, $1 per member per year may be assessed on carriers issuing risk-adjusted plans in the nongrandfathered "small group" insurance markets, whether in or out of the Exchanges.

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Limits on Annual Out-of-Pocket Maximums

All nongrandfathered health plans, whether insured or self-funded, are subject to limits on annual out-of-pocket maximums. All cost-sharing, such as co-pays, deductibles, and co-insurance, for Essential Health Benefits (EHBs) must accumulate to the plan's out-of-pocket maximums up to the following limits:

For Plan Year beginning in:	Self-Only Coverage	Coverage other than self-only
2014 [1]	$6,350	$12,700
2015	$6,600	$13,200
2016	$6,850	$6,850 per person $13,700 per family

[1] For plan year 2014, some exceptions were allowed for plans that utilized multiple service providers (e.g., different providers for medical benefits versus pharmacy benefits).

Each state, through its state insurance laws, may establish a detailed definition of EHBs for purposes of group health insurance policies issued in that state. Self-funded plans may define EHBs based on general federal guidelines or a state benchmark plan. Generally, an EHB definition includes health care services in the following 10 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)

Insurance Market Reforms

The ACA requires nongrandfathered group health insurance policies sold in the "small group" market to adopt several reforms. Examples include required coverage of all 10 categories of EHBs and adjusted community rating (unless a state's insurance law allows exceptions). "Large group" policies, currently sold only to employers with at least 50 employees, and self-funded health plans are exempt from the market reforms. Starting in 2016, the definition of "small group" will expand to include groups with 51 – 99 employees although some states will continue allowing renewals of existing "large group" policies without adopting the market reforms. For details about your state's insurance law and policy options, consult an agent or broker licensed in that state.

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Employer Shared Responsibility Provision

Starting January 1, 2015, the ACA's Employer Shared Responsibility provision takes effect. There are two parts:

- **Employer Reporting Requirements:**
  - Under IRC § 6056, large employers must report information about health coverage offered to full-time employees. To comply with the reporting requirement, prepare and distribute Form 1095-C to the employee and file copies, along with transmittal Form 1094-C, with the IRS.
  - Under IRC § 6055, large employers with self-funded plans must report information about the coverage provided to each individual. To comply with this reporting requirement, prepare and distribute Form 1095-B to plan enrollees and file copies, along with transmittal Form 1094-B, with the IRS. If also subject to § 6056, Forms 1095-C and 1094-C may be used to satisfy both the § 6055 and § 6056 requirements.

  For calendar year 2015, the first reports are due in early 2016.

- **Employer Coverage Offer** (often called "the Employer Mandate" and "Play or Pay"): Employers may be assessed a penalty for failure to offer health coverage to full-time employees if at least one employee receives a government subsidy to buy individual coverage through an Exchange (Marketplace).

Applicable Large Employer: Employers with 50 or more full-time-equivalent (FTE) employees are subject to the Employer Shared Responsibility provision for 2015. Small employers are exempt. The employer must determine its FTE count for 2014 in order to confirm its responsibilities for 2015. Related employers in a controlled group are counted together to determine the number of FTEs. Generally, each full-time employee (i.e., 120 hours of service or more per month) counts as one FTE. Each part-time employee counts as a fraction of one FTE (i.e., divide the employee's hours of service per month by 120). Employers with seasonal workers, usually in the agricultural or retail industries, may be able to take advantage of a special rule to subtract the seasonal workers from the employer's FTE count.

Employers that are subject to the Employer Shared Responsibility provision for 2015 (based on their 2014 FTE count) may qualify for one of several available transition relief provisions to delay compliance under the Play or Pay portion for several months or into 2016. For example, transition relief is available for certain employers with 50 – 99 FTEs and/or for certain employers with non-calendar year health plans.

For more information about coverage requirements, transition relief provisions, and potential penalties, see our detailed "Play or Pay" guide for employers. Brokers and clients who are registered to receive ThinkHR services may obtain copies by contacting the HR Hotline at 877-225-1101.

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