NAPEO National Association of Professional Employer Organizations

healthcare insights

# ACA Employer Compliance Checklist

**as of March 25, 2014**

- **W-2 Reporting.** W-2 reporting of employer-provided healthcare coverage is now required for all employers filing 250 or more W-2s for the prior calendar year. These employers are required to report the value of employer-sponsored healthcare coverage regardless of whether it is paid by an employer on behalf of the employee (as excludable income), by an employee through a cafeteria plan, or by an employee on an after-tax basis. Employers filing fewer than 250 W-2s may be required to start reporting in January 2015 (for calendar year 2014), but only if guidance is issued by July 1, 2014. Specific information about what and how to report is available at *www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage*.

  For NAPEO members, a NAPEO Best Practice paper is available at *www.napeo.org/members/docs/W-2%20Reporting%20Requirement%20Final.pdf*.

- **Healthcare Exchanges.** Employers subject to the Fair Labor Standards Act (FLSA) are required to notify all employees of the availability of exchange-based coverage (whether through an exchange administered by a state or by the federal government on behalf of a state), although there is no fine, or penalty, for failure to do so. The notice requirement applies to any employer that is a "covered enterprise" under the FLSA. The notification must be in writing—model forms are available online at www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html. There is a continuing requirement for new employees requiring the employer to notify employees of the availability of exchanges within 14 days of hire.

  NAPEO members can review the NAPEO Best Practice paper on this subject at *www.napeo.org/members/docs/Exchange%20Notice%20Sept.%209%20Final2.pdf*.

- **Summary of Benefits and Coverage.** Enrollees must receive an annual Summary of Benefits and Coverage (SBC), very generally at open enrollment or upon hire. Detailed information about the SBC (not to be confused with the longstanding Summary Plan Description requirement, or SPD) is available at *www.dol.gov/ebsa/healthreform/index.html* (scroll down to "Summary of Benefits and Coverage and Uniform Glossary"). For a good explanation of the difference between the SBC and SPD obligations, see *www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_0712_patterson.html*.

- **Advance Notification of Certain Benefit Changes.** Outside of policy renewal or reissuance, employers generally must provide notice to employees 60 days in advance of any material change in coverage to the extent the change would need to be reflected on the respective SBC. (See "Final Regulations" in above link.)

- **Preventive Care.** All non-grandfathered health plans must cover a variety of preventive care services for women with no participant cost-sharing. These services include contraceptive methods and counseling, well-woman visits, and screening and counseling for interpersonal domestic violence, among others. For additional information, see *www.hhs.gov/news/press/2013pres/02/20130201a.html*.

- **Health FSAs.** The limit for employee contributions to medical flexible spending accounts is now $2,500 (employer flex credits are disregarded). Contribution limits for 2014 and beyond will be indexed to cost-of-living ad-

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justments using increments of $50. Information about the limitations on FSAs is available at www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions (Scroll down to "Health Flexible Spending Arrangements").

- **Medicare and FICA.** For individuals earning more than $200,000 and joint filers earning more than $250,000, the Medicare Part A (hospital insurance) tax has increased to 2.35 percent. To apply the new tax increase, employers should use $200,000 as a baseline income for each employee because they will not know the total household income for those filing jointly. For additional information, see www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax.
- **Group Plan Waiting Period.** No waiting period longer than 90 days may be applied to group health benefits coverage for an otherwise-eligible employee if the employer offers such coverage. However, under a proposed rule, the 90-day clock may be delayed by a "reasonable and bona fide employment-based orientation period" of no longer than one month. Employee indecision on coverage election following the 90 days doesn't count against the employer. For links to the final and proposed rules on this, see www.dol.gov/opa/media/press/ebsa/EBSA20140297.htm.
- **Medical Loss Ratio (MLR) Rebates.** The Patient Protection and Affordable Care Act (ACA) requires issuers of fully insured plans to provide rebates if they do not spend at least 85 percent of the prior year's health insurance premiums on healthcare services. Employers who sponsor insured plans should be prepared to receive an MLR rebate by September 30 if the issuer fails to meet the 85 percent MLR requirement. MLR rebates can be shared with the affected (prior year) employees as cash or used to reduce their health insurance costs prospectively. Employers need to take care in understanding MLR issues. There is guidance from three separate agencies about how MLR is to be treated, and each varies depending upon the topic.
  - **Health & Human Services:** Explains the complex calculation and payment of MLR rebates. See www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf.
  - **ERISA:** Under Department of Labor (DOL) standards, MLR rebates may constitute Employee Retirement Income Security Act (ERISA) plan assets, depending on how the insurance coverage is paid for and what the relevant plan document/policy provides. Employers should be careful to handle any MLR rebates they receive in accordance with any ERISA fiduciary duties (see DOL Technical Release at www.dol.gov/ebsa/newsroom/tr11-04.html) to ensure they do not run afoul of ERISA.
  - **Tax Consequences:** The IRS also has issued questions and answers about the MLR. These are available at http://1.usa.gov/1igZTc1.
- Pay-or-Play Provision. The ACA generally imposes penalties upon employers of 50 or more full-time employees, or full-time equivalent employees, who fail to provide qualifying healthcare coverage to those FT/FTE employees and their children (up to age 26). This requirement has been deferred twice; entirely for 2014 and then again for 2015 for certain small employers. For 2015, employers with 50 to 99 FT/FTE employees that meet certain additional requirements (such as maintaining existing coverage and not reducing workforce simply to evade the penalty) will not be subject to the coverage requirement.

  To determine the number of employees, businesses may calculate head counts using as little as a consecutive six-month period during 2014 (but note that additional requirements apply). A full-time employee is one who is employed (work and paid leave and vacation) an average of at least 30 hours a week, or 120 hours in a month. To calculate the number of full-time equivalents in a given month, add up all the hours worked by non-full-time employees (capped at 120 hours of service per month for any given employee), and divide the total hours by

120. Under this calculation, to the extent that an applicable large employer fails to offer qualifying coverage to at least 70 percent (95 percent after 2015) of its full-time employees and their children (up to age 26), the employer could be subject to a penalty, generally equal to $2,000 per full-time employee (less the first 80 full-time employees in 2015 or 30 after 2015).

Even if an employer complies with the requirement to offer coverage, if an employer fails to provide affordable, minimum value, self-only coverage to each full-time employee (and their children up to age 26), the employer generally will be subject to a $3,000 penalty for each employee who then goes and enrolls in exchange-based coverage and receives a federal premium subsidy or cost-sharing reduction. This will not happen when an employee's share-of-cost of adequate employer coverage doesn't exceed 9.5 percent of the employee's adjusted gross household income (or an appropriate safe harbor such as Form W-2 wages). This penalty is also waived in the 2015 plan year for employers with fewer than 100 full-time employees. Additional information is available at *www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act*.

- **Patient-Centered Outcomes Research Institute (PCORI) Fee.** Insurance carriers and sponsors of self-insured plans, retiree-only plans, and grandfathered plans are required to fund PCORI through the payment of certain per-capita fees. HIPAA-excepted coverages (such as stand-alone dental) are generally not subject to the fee. For policy or plan years ending on, or after, October 1, 2013, the fee will be $2 multiplied by the average number of covered lives under the plan or policy. The fee, which will be adjusted for inflation in the future, is due by July 31 of the year following the last day of the policy or plan year. Employers will only be directly liable for the fee if they sponsor a self-insured plan, although insurers will seek to pass through the cost of the fee for insured coverage through to employers in the form of higher premiums. For more information, see *www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers*.

## Items for Insured Plans that Will Fall Mainly on the Carrier/Underwriter:

- **Stricter Annual Dollar Limits on Essential Health Benefits.** Beginning with the 2011 plan year, the ACA limited the extent of any annual dollar limits that could apply under a plan to benefits that are "essential health benefits." Additionally, ACA prohibited the use of any lifetime dollar limits on the 10 "essential health benefits." For plan years beginning on, or after, September 23, 2013, plans are subject to a complete bar on the use of not only lifetime limits, but also any annual limits on "essential health benefits." Employers and plans can continue to impose annual and lifetime dollar limits on non-essential health benefits.
- **Cost-Sharing Limitations for Non-Grandfathered Plans.** For plan years beginning on or after January 1, 2014, non-grandfathered individual and small group insurance policies cannot impose maximum deductible limits that exceed $2,000 for self-only and $4,000 for family coverage. Large group insurance and self-funded plans are not subject to these maximum deductible limits (as well as small group insured plans that cannot reach the actuarial value of a given level of coverage, such as bronze, silver, gold, or platinum), regardless of whether the plan or policy is grandfathered.

  Except for the transition relief noted below, for plan years beginning on, or after, January 1, 2014, all non-grandfathered plans and policies cannot impose a maximum out-of-pocket limit on cost sharing that exceeds $6,350 for self-only coverage and $12,700 for family coverage. Exception: For the first plan year beginning on, or after, January 1, 2014 only, a large group or self-funded plan is not required to provide a coordinated out-of-pocket limit on cost-sharing for ancillary or carve-out plan coverage (such as Rx or pediatric dental) if such coverage is provided by a service provider *separate* from that responsible for the major medical coverage under the plan or policy. Such a multiple-vendor plan will be required, however, to impose the out-of-pocket limit on the plan's major medical coverage—which cannot be separated from mental health coverage.

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