Health Care Reform
Employer Action Item Quick Reference Chart
Updated May 1, 2016

1.	**Summary of Benefits and Coverage (SBC)**	Distribution Requirements: An employer must provide an SBC at specified times (and upon request) at no charge. Such specified times include the following: ➢ *Upon application*, as part of the written application or enrollment materials. If the plan does not distribute written enrollment materials, the SBC must be distributed no later than the first date on which the participant is eligible to enroll for coverage; ➢ *By the first day of coverage*, if there are any changes to the initial SBC; ➢ *Within 90 days from enrollment* for any special enrollee after a special enrollment event (i.e. marriage, etc.); ➢ *If a participant must actively elect to maintain coverage, or has the opportunity to change coverage options during an annual open enrollment period,* an SBC must be distributed as part of the open enrollment materials; ➢ *If renewal of coverage is automatic,* no later than 30 days before the beginning of the plan year; and ➢ *Within 7 business days after receipt of request* **Note:** Employers are only required to furnish the SBC to re-enrolling participants for the benefit option previously selected, unless the participant requests otherwise Electronic Distribution: Permitted in three situations: 1. For employees who are eligible but not yet enrolled (they must be notified via paper or email); 2. For employees already enrolled in a plan, if the DOL requirements for electronic distribution are satisfied; and 3. In connection with an employee's online enrollment or online request for an SBC Important Notes: ➢ Failure to comply may result in $1,000 fine *per occurrence* ➢ Changes for 2014 include the addition of statements regarding whether the plan provides minimum essential coverage and minimum value ➢ **New** SBC templates and associated documents were proposed in **February 2016** and apply starting with the first open enrollment period that begins on or after April 1, 2017 ➢ Changes include revisions to the templates, instruction guides, uniform glossary, and other supporting materials
2.	**60-Day Notice of Modifications to the SBC's content**	If any material modification in coverage is made *that would affect the content of the SBC:* ➢ Notice must be provided at least 60 days prior to the modification's effective date (other than a modification made in connection with the plan's renewal)

Mandates and Market Reforms Currently in Effect		
3.	**90 Day Limit on Waiting Periods**	➢ Employees cannot be made to wait longer than 90 days to enroll in group health plan coverage (other than excepted benefits, such as stand-alone dental or vision plans) once they satisfy the plan's substantive eligibility requirements ➢ If eligibility is conditioned on working a certain number of hours (e.g., 30 hours per week or 250 hours per quarter) or on a full-time basis, and it's not known if a newly hired employee will meet the requirements, an employer may use a "reasonable time period" to determine eligibility o For example, an employer may use up to 13 months (plus a fraction of a month) to determine if a new variable-hour employee will work, on average, at least 30 hours or more per week ➢ Employers may apply an orientation period that precedes the waiting period o Orientation periods are limited to a calendar month, minus a day, and must be reasonable and employment-based o Employers using an orientation period and a 90-day waiting period should ensure that full-time employees are offered coverage by the first day of the fourth full calendar month of employment to avoid potential pay-or-play penalties
4.	**Prohibition on Annual Dollar Limits**	➢ Group health plans may no longer include annual dollar limits on essential health benefits. ➢ Employers seeking to impose annual limits on non-essential benefits must select a benchmark plan in order to identify which benefits are "essential"
5.	**Continued coverage for participants in clinical trials**	➢ Group health plans may not deny individual participation, discriminate against an individual on the basis of participation or deny coverage of routine patient costs for services rendered in a clinical trial for a life-threatening disease

6.	**Elimination of all pre-existing condition exclusions**	➢ Group health plans (other than excepted benefits, such as stand-alone dental or vision plans) must no longer contain any preexisting condition exclusions or limitations
7.	**Modified Community Rating Rules**	➢ Health insurance issuers providing individual or small group policies must abide by certain strict community rating rules, with premium variations allowed only for age (3:1 ratio), tobacco use (1.5:1 ratio), level of coverage (e.g., single/family), and geographic rating area ➢ Experience rating based on health factors is prohibited o Transitional relief may be available in states that have adopted the CMS "fix" permitting carriers to continue to offer non-compliant small group plans for policy years ending by December 31, 2017
8.	**Limit on employee out-of-pocket expenses**	➢ All non-grandfathered group health plans must limit out-of-pocket costs for essential health benefits received in-network o 2016 limits are $6,850/$13,700 (single/family) o 2017 limits are $7,150/$14,300 (single/family) Important Note: ➢ **New for plan years beginning in 2016**: Plans offering other than single coverage must contain an embedded individual out-of-pocket limit that does not exceed $6,850 per individual
9.	**Increased Wellness Program Incentives**	➢ The wellness program incentive cap for outcome-based wellness programs is increased from 20% to 30% of the total cost of coverage (50% for smoking cessation programs) Note: Proposed regulations released by the EEOC limit rewards under a wellness program to 30% of the cost of single coverage (limit does not apply to tobacco cessation programs that do not include a medical exam or inquiry)
ACA Taxes, Fees and Reporting		

10.	**Comparative Effectiveness Fee to Fund the Patient-Centered Outcomes Research Institute (PCORI)**	➢ The ACA imposes fees on plan sponsors of group health plans to fund the PCORI. The PCORI was established to conduct research to evaluate the effectiveness of medical treatments, procedures and other items or strategies that treat, manage, diagnose or prevent illness or injury. ➢ The annual fee is **$2.08** per participant for plan years ending **after September 30, 2014** and **before October 1, 2015** ➢ The annual fee is **$2.17** per participant for plan years ending **after September 30, 2015** and **before October 1, 2016** ➢ For plan years ending after Sept. 30, 2016, and before Oct. 1, 2019, the fee is further adjusted to reflect inflation in National Health Expenditures, as determined by HHS ➢ The fee will phase out in 2019 ➢ The fee applies to insured and self-insured medical plans, regardless of grandfathered status. This includes retiree-only plans and most HRAs. HIPAA-excepted benefits, such as stand-alone dental or vision plans, and most health FSAs are excluded ➢ Plan sponsors must report and pay the fee annually on the IRS Form 720 ➢ Reporting and payment will be **due by July 31st of each year** o In 2016, forms are due by August 1 because July 31 is a Sunday ➢ If a plan is self-insured, the plan sponsor pays the fee. For insured plans, the payment responsibility belongs to the carrier Note**:** There are various complex rules for counting members for the purpose of this fee
11.	**Transitional Reinsurance Program Fee**	➢ For the 2014-2016 calendar years (irrespective of plan year), a fee is assessed and imposed on both insured and self-insured plans. All carriers and self-insured group health plans are required to make contributions under this program to support payments to individual market issuers that cover high-cost individuals. ➢ The fee applies on a per member basis ➢ 2015 Fee: $3.67 per member per month (PMPM) ($44 PMPY) ➢ 2016 Fee: $2.25 PMPM ($27 PMPY) ➢ The fee does not apply to coverage that does not constitute major medical coverage o Therefore, HRAs, HSAs, FSAs, employee assistance programs (EAPs), certain wellness programs and prescription drug-only plans, as well as plans that do not provide "minimum value" are excluded. In addition, certain self-insured plans offering limited benefits such as dental and vision are exempt. ➢ HHS has exempted self-insured, self-administered plans from the fee for 2015 and 2016. Such plans that do not use a TPA in connection with claims processing or adjudication (including managing appeals) or for plan enrollment will not be subject to the fee ➢ TPAs may complete the contribution process, including payment, on behalf of a self-insured plan ➢ Payments will be remitted on the **pay.gov** website <u>Key Dates for 2016</u>:

		• **January 15, 2016**: Payment deadline if making a single payment ($44 per covered life; $33 per covered life if making a two-part payment) • **November 15, 2016**: Payment deadline for second payment for employers making a two-part payment ($11 per covered life)
12.	**Health Insurance Industry Tax**	➢ This tax will be a fixed dollar amount distributed across carriers based on each carrier's net premiums ➢ It is expected that carriers will pass this fee through to employers, and the impact of the fee will vary by carrier ➢ The fee applies to fully insured medical, dental and vision coverage ➢ The fee was deferred for 2017 through an appropriation measure but will return in 2018 absent additional action by Congress
13.	**Individual Mandate**	➢ Individuals will be required to obtain "minimal essential coverage" for themselves and their dependents or pay a monthly penalty tax for each month without coverage ➢ Penalty for calendar year 2015 is greater of (a) $325 per adult per year, up to a maximum of three adults (penalty is halved for children under 18), or (b) 2% of the individual's household income in excess of the filing threshold ➢ Penalty for calendar year 2016 is greater of (a) $695 per adult per year, up to a maximum of three adults (penalty is halved for children under 18), or (b) 2.5% of the individual's household income in excess of the filing threshold ➢ The percentage of income penalty is capped at the national average premium for bronze coverage available in the Exchange based on the individual's family size (for 2015, the maximum percentage of income penalty was $2,484 for a single individual and $12,420 for a family of five or more)
14.	**Employer Mandate and Transition Relief**	<u>Employer "Pay-or-Play" Mandate</u>: ➢ Employers with 50 or more full-time employees (including full-time equivalent employees (FTEs)) who do not offer "minimum essential coverage" to full-time employees (and their children under age 26) or who offer coverage that is not "affordable" or that does not provide "minimum value," may be exposed to a penalty if at least one full-time employee receives a federal premium subsidy for Exchange coverage ➢ See **Transition Relief** below for delayed effective dates for employers with 50-99 FTEs on average in 2014, and employers with 100+ FTEs on average in 2014 that maintain non-calendar year plans ➢ The penalty is $2,000 per year for each full-time employee minus 30 (minus 80 for 2015 plan years if the employer had 100+ FTEs on average in 2014) if **coverage is not offered to at least 95% of full-time employees (70% for 2015 plan**

		years) ➢ The penalty is *the lesser* of $3,000 per year for each full-time employee receiving a federal subsidy for Exchange coverage because the employer's plan was not "affordable" or did not provide "minimum value" OR $2,000 per year for each full-time employee minus 30 (minus 80 for 2015 plan years). ➢ Indexed penalties are $2,080 and $3,120 for 2015, $2,160 and $3,240 for 2016 ➢ They are anticipated to be $2,260 and $3,390 for 2017; however, the IRS has not officially confirmed these numbers at this time <u>"Pay-or-Play" Transition Relief **(50-99 FTEs)**</u>: ➢ Employers with 50-99 full-time employees (including FTEs) that meet certain eligibility requirements will not have to comply with the Employer Mandate until 2016. In addition, if an eligible employer has a non-calendar year plan, it will be exempt from the Employer Mandate for any calendar month during the portion of a 2015 plan year that falls in 2016. <u>Requirements</u>: 1. The employer must have 50-99 full-time employees (including FTEs) on business days during 2014 (the employer can make this determination based on any consecutive 6-month period in 2014). 2. From Feb. 9, 2014 through Dec. 31, 2014, the employer cannot reduce its workforce size or overall hours of service (other than for bona fide business reasons) in order to satisfy #1, above. 3. The employer cannot materially reduce the health coverage, if any, that it offered from Feb. 9, 2014 through the last day of the plan year that began in 2015 (the "coverage maintenance period"). 4. The employer will have to certify that it meets these requirements in conjunction with its Code Section 6056 reporting requirement. With regard to #3, above, an employer will not be treated as eliminating or materially reducing such coverage if: (i) It continues to offer each employee who is eligible for coverage during the coverage maintenance period an employer premium contribution that is either (A) at least 95% of the dollar amount offered on Feb. 9, 2014, or (B) the same or higher percentage of the cost of coverage that the employer was offering to contribute as of Feb. 9, 2014. (ii) In the event the employee-only coverage is changed, it must continue to provide minimum value coverage after the change; and (iii) It does not narrow or reduce the classes of employees (or dependents) to whom coverage was offered on Feb. 9, 2014. <u>For Non-Calendar Year Plans **(50-99 FTEs)**</u>: • The relief described above is not available for an employer that modifies the plan year of its plan after Feb. 9, 2014 to begin on a later calendar year. • An employer with a non-calendar year plan meeting the coverage maintenance period requirements for 2015 may be

		eligible for this relief for 2015 even if the employer does not meet that requirement later (i.e. during the portion of the year that falls in 2016). "Pay-or-Play" Transition Relief **(100+ FTEs)**: ➢ If an employer maintained a non-calendar year plan as of Dec. 27, 2012 and the plan year was not changed after such date to begin at a later date, then no penalty will apply with respect to that employee for the period between Jan. 1, 2015 and the first day of the 2015 plan year if: 1. The employee would have been eligible for coverage under the plan on the first day of the 2015 plan year under the plan's eligibility terms in effect on Feb. 9, 2014 and such employee is not otherwise eligible for coverage under a plan maintained by the employer as of Feb. 9, 2014 that has a calendar year plan; and 2. The coverage offered to the employee as of the first day of the 2015 plan year is "affordable" and offers "minimum value." NOTE: if the employer does not cover a significant percentage (i.e. at least 70%) of full-time employees as of the first day of the 2015 plan year, the employer could still be subject to the $2,000 penalty for any calendar month in 2015. ➢ However, if an employer maintained a non-calendar year plan as of Dec. 27, 2012 (or two or more non-calendar year plans that have the same plan year as of Dec. 27, 2012) and the plan year was not changed after such date to begin at a later date, then no penalty will apply until the beginning of the 2015 plan year with respect to an employee if: 1. The coverage offered to the employee as of the first day of the 2015 plan year is "affordable" and offers "minimum value"; and 2. The employee would not have been eligible for coverage under any calendar plan maintained by the employer as of Feb. 9, 2014; provided, that with respect to all employees of the employer, the non-calendar year plans: a. had, as of any date between Feb. 9, 2013 and Feb. 9, 2014, at least 1/4 of employees covered under those non-calendar year plans; or b. offered coverage under such plans to 1/3 or more employees during the open enrollment period that ended most recently before Feb. 9, 2014. Alternatively, employers with 100+ FTEs may run this test based only on full-time employees. Under this alternative, the fractions above change to 1/3 of full-time employees covered or 1/2 of full-time employees offered coverage. The 30-hour threshold for full-time employees is used for this purpose.

15.	**Employer and Provider Reporting Requirements (Code §§ 6055 & 6056)**	• Applicable Large Employers (ALEs), including those with 50-99 FTEs in 2014, must certify to the IRS whether all full-time employees were offered health care coverage starting in 2015 (Code Section 6056)
		  • Applicable large employers (ALEs) will use Forms 1094-C and 1095-C to fulfill their obligations
		  • ALEs with self-insured plans will also use these forms to report on any covered employees (full-time or part-time) to fulfill Section 6055 reporting requirements
		  • Copy of Form 1094-C sent to IRS
		  • Copies of Forms 1095-C sent to IRS and full-time employees (and any employees covered under a self-insured plan)
		• Reporting is effective in 2015, with the first reports due to employees by March 31, 2016
		  • Reporting to IRS due May 31, 2016, or June 30, 2016 if filing electronically
		  • Electronic reporting required for employers filing 250 or more Forms 1095-C
		  • For calendar year 2016 filings and future years, dates will be January 31 for reporting to individuals and the last day of February (March 31 if filing electronically) for reporting to the IRS
		• Insurance carriers send Forms 1095-B to covered participants on behalf of small and large employers with fully insured plans
		• Small employers (non-ALEs) with fully insured plans (or that do not offer coverage) do not have a reporting obligation under Code §§ 6055 or 6056
		• **Small employers (non-ALEs) with self-insured plans** use Forms 1094-B and 1095-B to fulfill Section 6055 reporting, but do not have a Section 6056 reporting obligation

Mandates that are Currently Delayed		
16.	**Health Plan Identifier (HPID)** ***DELAYED***	➢ Employers that sponsor self-insured plans must obtain a health plan identifier (HPID) for their Controlling Health Plans (CHPs) ➢ Employers with multiple self-insured plans will need to determine which plan or plans are Controlling Health Plans (CHPs) and which are Sub-health Plans (SHPs) o A CHP controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan o A SHP is a plan whose business activities, actions or policies are directed by a CHP ▪ For example, an employer with a self-insured major medical plan and a self-insured dental plan may treat its medical plan as the CHP and the dental plan as the SHP o SHPs are not required to obtain their own HPIDs ➢ For purposes of the HPID requirement, CMS considers **health FSAs** to be individual accounts directed by the consumer to pay health care costs. As such, they do not require an HPID. ➢ **Health reimbursement arrangements (HRAs)** may require an HPID if they meet the definition of a CHP; however, HRAs that cover only deductibles or out-of-pocket costs do not require HPIDs, as CMS considers these types of arrangements to be closer to additional plan benefits than stand-alone plans. ➢ Employers that consolidate their plans using a **wrap document** will apply the HPID rules in the same manner as the rules would apply to non-consolidated plans. For example, a wrap plan that includes a fully-insured medical plan, self-insured dental plan, and an HRA that covers deductibles, would require the employer to obtain an HPID only for the self-insured dental plan. ➢ Employers with self-insured plans will need to access the CMS Enterprise Portal at https://portal.cms.gov/ to obtain an HPID ➢ **Small plans** (those with less than $5M in paid claims) may have an additional time to obtain an HPID once the requirement is effective

17.	**Automatic Enrollment** ***REPEALED***	➢ Employers with more than 200 employees who maintain one or more group health plans would have been required to automatically enroll all full-time employees as soon as they are eligible for coverage ➢ This provision was repealed as part of the Bipartisan Budget Act of 2015
18.	**Nondiscrimination Rules for Insured Plans** ***DELAYED***	➢ Non-grandfathered fully insured group health plans will need to comply with IRC §105(h) rules that prohibit discrimination in favor of "highly-compensated individuals" ➢ Similar requirements currently apply to self-insured group health plans ➢ Compliance with this requirement has been delayed indefinitely pending further guidance

Appendix A Considerations for Multiemployer Plans and Employers with Collective Bargaining Agreements		
1.	**W-2 Reporting**	An employer that contributes to a multiemployer plan maintained pursuant to a CBA is not required to report the cost of coverage under that multiemployer plan ➢ If the only applicable employer-sponsored coverage provided to an employee is provided under a multiemployer plan, the employer is not required to report any amount with respect to that employee
3.	**Transitional Reinsurance Program Fee**	Self-insured and self-administered plans are exempt from the transitional reinsurance fee for 2015 and 2016. This exemption could apply to any self-insured and self-administered plan, but it is generally perceived that larger multiemployer plans are most likely to satisfy these requirements. ➢ A self-insured plan is not considered self-administered if it uses a TPA in connection with its core functions, which include claims processing or adjudication (including the management of internal appeals) and plan enrollment ➢ However, a self-insured plan can still be considered self-administered if it only uses the TPA with respect to pharmacy benefits or excepted benefits ➢ A plan is not considered to be using a TPA if it outsources a de minimis amount of its non-pharmacy benefits ➢ A plan is also not considered to be using a TPA merely because it leases its network and has the network provider reprice its claims
4.	**Employer "Pay-or-Play" Mandate**	An employer that is required by a collective bargaining agreement to contribute to a multiemployer plan will generally satisfy its responsibilities under the mandate with respect to the collectively bargained employees as long as the following conditions are met: ➢ the plan offers dependent coverage; ➢ the plan provides minimum value coverage; and ➢ the coverage is affordable Employers may treat multiemployer plan coverage as affordable using the Rate of Pay, W-2 or Federal Poverty Level safe harbors. In addition, coverage is affordable if the employee's required contribution toward self-only coverage does not exceed 9.66% (as indexed for 2016) of the wages reported to the multiemployer plan (using actual wages or an hourly wage rate under the agreement requiring contributions)

5.	**ACA Reporting**	**For 2015 reporting**, an employer relying on the interim rule for multiemployer plans (see #4 above) should enter code 1H on line 14 for any month for which it enters code 2E on line 16 The employer may enter Code 1H without regard to whether the employee was eligible to enroll in coverage
6.	**Cadillac Tax**	Starting in 2020, the ACA imposes a tax of 40% on the value of health benefits exceeding $10,200 for single coverage and $27,500 for family coverage (indexed to inflation) ➢ The thresholds are higher for qualified retirees and "high risk" professions ($11,850 for single and $30,950 for family) ➢ **Any coverage provided under a multiemployer plan is treated as family coverage (e.g., the $27,500 threshold will apply for self-only coverage)**