Employee Benefits Series

Health Care Reform

2016 COMPLIANCE CHECKLIST

A publication of HR 360, Inc.

2016 Health Care Reform Checklist

This checklist is designed to help employers who sponsor group health plans review their compliance with key provisions of the federal Affordable Care Act (ACA) for 2016. If you have any questions regarding your responsibilities, please contact a knowledgeable employment law attorney, benefits advisor, or your carrier.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements or amendments to the law. Additionally, your company or group health plan may be exempt from certain requirements and/or subject to more stringent rules under your state's laws.

1. Evaluate Grandfathered Status of Group Health Plan

*A grandfathered plan is one in existence as of March 23, 2010 that has covered at least one person continuously from that day forward. Grandfathered plans **do not have to comply with certain ACA rules**.*

- ❑ Determine whether any changes to the plan that reduce benefits or increase costs to employees and dependents enrolled in coverage result in a loss of grandfathered status.
- ❑ **If the plan loses grandfathered status**, confirm that the plan design and benefits offered reflect all ACA requirements that previously did not apply because the plan was exempt (such as coverage of preventive services without cost-sharing).
- ❑ **If the plan remains grandfathered**, provide a Notice of Grandfathered Status whenever a summary of plan benefits is provided to participants and beneficiaries. Continue to maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify grandfathered status.

2. Review Plan Documents for Required Changes to Plan Benefits

Certain requirements apply to particular plan designs, as noted below.

All Group Health Plans:

- ❑ Ensure that any **waiting period**—the time that must pass before coverage can become effective for an employee or dependent that is otherwise eligible to enroll in the plan—does not exceed 90 days. (Other conditions for eligibility that are not based solely on the lapse of a time period are generally permissible.)
  - ➢ If the plan requires completion of a reasonable and bona fide employment-based orientation period as a condition for eligibility, ensure the orientation period **does not exceed one month** and the maximum 90-day waiting period begins on the first day after the orientation period. (Note: Employers subject to "pay or play" may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to a penalty.)
- ❑ Confirm that **no annual dollar limits** apply to coverage of "essential health benefits." If the plan limits the number of visits to health providers or days of treatment, verify that the visit or day limit does not amount to a dollar limit.
- ❑ Verify that **no preexisting condition exclusions** are imposed on any individual, regardless of age.

2. Review Plan Documents for Required Changes to Plan Benefits (cont'd)

All Group Health Plans (cont'd):

- ❑ Ensure that an **employer payment plan** is not in place (an arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or uses its funds to directly pay the premium for an individual policy). (Transition relief granted to small employers sponsoring employer payment plans **expired on June 30, 2015**.)

Non-Grandfathered Group Health Plans Only:

- ❑ For small group plans, confirm the plan covers "**essential health benefits**," a comprehensive package of items and services. (This requirement does not apply to self-insured plans or plans offered in the large group market.)
- ❑ Ensure that annual out-of-pocket costs for coverage of **all** "essential health benefits" (EHBs) provided in-network do not exceed **$6,850 for self-only coverage** or **$13,700 for other than self-only coverage** for plan years beginning in 2016.
  - ➢ **Note:** For plan years that begin in 2016, the self-only maximum annual limitation on cost-sharing applies to **each individual**, regardless of whether the individual is enrolled in self-only coverage or other coverage that is not self-only coverage under a group health plan.
  - ➢ Plans with more than one service provider may structure a benefit design using separate out-of-pocket limits across multiple categories of benefits (rather than reconcile claims across multiple service providers), provided the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limit.
  - ➢ A plan that includes a network of providers may, but is not required to, count out-of-pocket spending for out-of-network and non-covered items and services towards the plan's annual maximum out-of-pocket limit.

Note: Certain businesses may be allowed to renew existing group coverage that does not comply with the requirements to cover essential health benefits and limit annual cost-sharing under the plan, through policy years beginning **on or before October 1, 2016**. Not all states and insurers will permit coverage to renew. Businesses that are eligible to continue existing coverage will receive a notice from their insurance companies for each policy year.

3. Analyze Tax-Favored Arrangements

Employers who maintain cafeteria plans, HRAs, and health FSAs should confirm that these arrangements comply with several ACA changes that took effect in 2014.

Health Reimbursement Arrangements (HRAs)

- ❑ Confirm that the HRA (other than a retiree-only HRA or an HRA consisting solely of excepted benefits) **is "integrated" with other group health plan coverage** in order to satisfy the preventive services requirements and the annual dollar limit prohibition.
  - ➢ To be "integrated," an HRA must meet specific requirements under either of two methods described in agency guidance. Both methods require that the employer offer a group health plan (other than the HRA) to employees—either a plan that does not consist solely of excepted benefits or a plan that provides minimum value.

3. Analyze Tax-Favored Arrangements (cont'd)

Health Reimbursement Arrangements (HRAs) (cont'd)

- ❑ Confirm that the HRA **is not being used to reimburse an employee's individual insurance policy premiums**. Such an arrangement may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee).

Health Flexible Spending Arrangements (FSAs)

- ❑ Confirm that the health FSA **qualifies as excepted benefits** to comply with the preventive services requirements.
  - ➢ Health FSAs are considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).
- ❑ Confirm that the health FSA is **offered through a cafeteria plan** (a plan which meets specific requirements to allow employees to receive certain benefits on a pre-tax basis) in order to comply with the annual dollar limit prohibition.
- ❑ Ensure plan documents are amended to reflect that employee salary reduction contributions to health FSAs are limited to **$2,550 annually** for tax years 2015 and 2016.
  - ➢ The amendment to the written cafeteria plan may be expressed as a maximum dollar amount, a maximum percentage of compensation, or by another method of determining the maximum salary reduction contribution.
- ❑ Determine whether you will allow employees to carry over up to $500 of unused health FSA amounts to use in the following plan year under the modified "use-or-lose" rule, and adopt appropriate plan amendments. (A plan incorporating the carryover provision **may not also provide for a grace period** in the plan year to which unused amounts may be carried over.)

Cafeteria Plans Generally

- ❑ Determine whether you will allow employees to make **additional mid-year changes in salary reduction elections** in the event of an employee's enrollment in Health Insurance Marketplace coverage and/or a reduction in an employee's hours of service, as permitted in agency guidance, and adopt appropriate plan amendments.
- ❑ Confirm that section 125 plan documents were amended to comply with the **prohibition on providing a qualified health plan** offered through the Health Insurance Marketplace as a benefit under an employer-sponsored cafeteria plan.

2016 Health Care Reform Checklist

4. Provide Required Notices to Employees and Dependents

Please contact your carrier or an employment law attorney if you have questions regarding these notices.

Availability of Health Insurance Marketplaces (Notice of Coverage Options)

- ❑ Provide a written notice with information about a Health Insurance Marketplace to each new employee at the time of hiring, **within 14 days of the employee's start date**. Employers are not required to provide a separate notice to dependents.
  - ➢ Two model notices are available to help employers comply with this requirement—one notice for employers that offer a health plan, and another notice for those that do not.

Summary of Benefits & Coverage (SBC)[+] and Notice of Plan Changes

- ❑ Confirm contractual arrangements with the carrier (insured group health plans) or third party administrator (self-insured plans) to prepare and provide the SBC. If the carrier or TPA does not assume responsibility, the employer should provide this notice (without charge) to employees and beneficiaries at specified times during the enrollment process and upon request.
  - ➢ For SBCs with respect to coverage that begins **on or after September 1, 2015**, employers that enter into a binding contract with another party to provide the SBC must satisfy additional obligations, including monitoring compliance.
- ❑ If not already done, **update SBCs** to include language indicating whether the plan provides "minimum essential coverage" (the type of coverage an individual needs to satisfy the ACA's individual mandate), and whether the plan meets the ACA's "minimum value" standard (meaning the plan pays for at least 60% of covered health care expenses).
  - ➢ An SBC template that includes the additional language is available for use. Until further guidance is issued, a plan that is unable to modify its current SBC template may continue to use the previously authorized template, **so long as** the SBC is furnished with a cover letter or similar disclosure stating whether the plan does or does not provide "minimum essential coverage" and "minimum value."
- ❑ Ensure that enrollees are provided with notice of any material modification that would affect the content of the SBC (and that occurs other than in connection with coverage renewal or reissuance) **no later than 60 days prior to the effective date of the change**.

[+] Proposed rules to **revise** the templates are generally expected to be finalized by January 2016, and will apply to SBCs for coverage beginning **on or after January 1, 2017**. Click here for a list of all available templates.

5. Comply With "Pay or Play" Responsibilities

Large employers—generally, those with 50 or more full-time employees, including full-time equivalents—are subject to the ACA employer shared responsibility ("pay or play") requirements. Due to the complexity of the law in this area, employers are strongly advised to work with knowledgeable employment law counsel to ensure full compliance.

- ❑ Determine **"large employer" status** for the upcoming calendar year by calculating the average number of full-time employees and full-time equivalents (FTEs) across the months in the current year. (Special counting rules apply for seasonal workers.)
  - ➢ **Employer Aggregation Rules:** Small employers that individually do not employ 50 or more full-time employees or FTEs **may still be subject to the requirements if they meet the threshold when combined with other companies under common ownership** or that are otherwise related.

5. Comply With "Pay or Play" Responsibilities (Cont'd)

- **Note:** The rules for combining related employers do not apply for purposes of determining whether a particular company owes a penalty or the amount of any penalty. That is determined separately for each related company.

❑ Determine when any applicable **transition relief** expires.

- As a reminder, transition relief delayed compliance with the "pay or play" requirements until 2016 for large employers with **50 to 99 full-time employees** (including FTEs) that certified that they met certain eligibility criteria related to workforce size, maintenance of workforce and aggregate hours of service, and maintenance of previously offered health coverage. (For employers with **non-calendar year health plans**, this transition relief continues to apply for any calendar month during the 2015 plan year that falls in 2016.)

❑ Determine whether group health plan coverage will be offered to **full-time employees** (and their dependents), using the measurement methods and rules for calculating hours of service described in the "pay or play" final regulations.

- An employee is full-time for a calendar month if he or she averages at least 30 hours of service per week (or 130 hours for the month). The final regulations describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and employees of educational organizations.

❑ For employers offering coverage, review the cost of your group health plan coverage to determine whether it is **affordable**.

- Coverage is affordable if an employee's required contribution for self-only coverage does not exceed 9.5% of his or her household income for the taxable year. (Employers may use a number of safe harbors to determine affordability, including reliance on Form W-2 wages.)

❑ For employers offering coverage, determine whether your group health plan coverage provides **minimum value**.

- A plan generally provides minimum value if it pays for at least 60% of covered health care expenses. (Federal agencies have produced a minimum value calculator for employers to enter certain information about the plan. Other methods available to determine minimum value are described in proposed regulations. However, results of the calculator—or any other method chosen—should be carefully reviewed with benefits counsel.)

❑ **Determine if a penalty may apply.** For 2015 and 2016, a large employer subject to "pay or play" may be liable for a penalty if it does not offer affordable health insurance that provides minimum value to its full-time employees (and their dependents), and any full-time employee receives a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace. (Note: In determining if a penalty applies, employers should be aware of limited non-penalty periods provided for in the "pay or play" final regulations, during which an employer generally will not be subject to a penalty.)

2016 Health Care Reform Checklist

6. Satisfy New Information Reporting Requirements (Forms 1094 & 1095)

Information reporting is used to determine compliance with the ACA individual responsibility and "pay or play" provisions. While the information reporting requirements are first effective for coverage offered (or not offered) in 2015, the initial deadlines for reporting entities are in early 2016.

- ❑ Determine if you are a reporting entity (and what type) to understand applicable reporting requirements:
  - ➢ **"Section 6055" Reporting Entities.** Self-insuring employers (regardless of size) that provide **minimum essential health coverage** are required to report information on this coverage to the IRS and to covered individuals under section 6055 of the Internal Revenue Code.
  - ➢ **"Section 6056" Reporting Entities.** Employers with **50 or more full-time employees** (including FTEs) are required to report information to the IRS and to their employees about their compliance with "pay or play" under Internal Revenue Code section 6056—even those that qualified for 2015 transition relief from the "pay or play" provisions.
- ❑ Compile the required information for section 6055 reporting and/or the required information for section 6056 reporting.
- ❑ Review the 2015 IRS Forms and Instructions:
  - ➢ Forms 1094-B and 1095-B, along with Instructions, are available for **section 6055** reporting entities.
  - ➢ Forms 1094-C and 1095-C, along with Instructions, are available for **section 6056** reporting entities (or employers that are subject to **both** reporting provisions).
- ❑ Determine whether to hire a **third party** to fulfill reporting responsibilities (reporting entities will still be liable for the failure to report information and furnish statements).
- ❑ For section 6056 reporting entities, determine whether you will use the general method of reporting or the simplified alternative method to satisfy the reporting requirements.
- ❑ If the reporting entity plans to furnish statements **electronically** in 2016, ensure that affirmative consent is obtained from employees prior to furnishing (section 6056 reporting entities **must also** ensure that certain notice, hardware, and software requirements are met).
- ❑ Remember to comply with the information reporting deadlines for calendar year 2015.

  Section 6055 Deadlines:
  - ➢ First information returns must be filed **no later than February 29, 2016** (or March 31, 2016, if filed electronically).
  - ➢ First individual statements must be furnished **on or before January 31, 2016**.

  Section 6056 Deadlines:
  - ➢ First information returns must be filed **no later than February 29, 2016** (or March 31, 2016, if filed electronically).
  - ➢ First employee statements must be furnished **on or before January 31, 2016**.

2016 Health Care Reform Checklist

7. Other Action Items for 2016

The following outlines actions required for continued ACA compliance, as well as additional items that may be of significance for certain employers and group health plans.

- ❑ **Additional Medicare Tax for High Earners.** Remember to withhold Additional Medicare Tax (0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year.
- ❑ **Coverage of Preventive Services.** Continue to monitor guidelines for preventive services, which are regularly updated to reflect new scientific and medical advances. As new services are approved, non-grandfathered group health plans will be required to cover them with no cost-sharing for plan years beginning one year later.
- ❑ **Medical Loss Ratio (MLR) Rebates.** Distribute rebates received from insurance companies to eligible plan enrollees as appropriate. Rebates are due to employer-policyholders by **September 30th**. These rules do not apply to employers who operate self-insured plans.
- ❑ **PCORI Fees.** Employers sponsoring certain self-insured health plans (including HRAs not treated as excepted benefits) are responsible for fees to fund the Patient-Centered Outcomes Research Institute (PCORI). IRS Form 720 must be filed annually to report and pay the fees no later than July 31st of the year following the last day of the plan year to which the fee applies.
- ❑ **Form W-2 Reporting of Employer-Provided Health Coverage.** Continue to report the cost of health coverage provided to each employee annually on Form W-2, which must be furnished to employees by January 31st each year, unless transition relief applies. (This requirement **does not apply to employers required to file fewer than 250 Forms W-2 for the preceding calendar year**.)
- ❑ **Simple Cafeteria Plans.** If eligible, consider whether your company could benefit from establishing a simple cafeteria plan, which may be treated as meeting certain IRS nondiscrimination requirements.
- ❑ **Small Business Health Care Tax Credit.** Determine if your company qualifies for the small business health care tax credit. For tax years beginning in 2014 or later, the credit is available to eligible employers for two consecutive taxable years. The maximum credit is 50% for small business employers; however, only premiums paid for qualified health plans offered through a Small Business Health Options Program (SHOP) count for the credit.
- ❑ **Transitional Reinsurance Program Fees.** The Transitional Reinsurance Program collects contributions from employers sponsoring certain self-insured plans that provide major medical coverage. Employers with self-insured plans may utilize a third party administrator or administrative-services-only contractor for transfer of the contributions. (Note: For 2015 and 2016, a self-insured plan that does not use a third party administrator to perform its claims processing, claims adjudication, and enrollment functions generally **does not** have to pay these fees.)
  - ➢ The 2015 benefit year contribution may be made in one payment (if remitted **no later than January 15, 2016**, reflecting $44.00 per covered life)—or may be made in two separate payments, with the first contribution amount of $33.00 per covered life remitted **no later than January 15, 2016**, and the second contribution amount of $11.00 per covered life to be remitted **no later than November 15, 2016**.

Be prepared for compliance requirements to change. Stay up-to-date on the latest information regarding Health Care Reform by visiting http://www.dol.gov/ebsa/healthreform/.

2016 Health Care Reform Checklist

Created and provided by HR 360, Inc. | Last Updated: November 18, 2015

Note: The information and materials herein are provided for general information purposes only and are not intended to constitute legal or other advice or opinions on any specific matters and are not intended to replace the advice of a qualified attorney, plan provider or other professional advisor. This information has been taken from sources believed to be reliable, but there is no guarantee as to its accuracy. In accordance with IRS Circular 230, this communication is not intended or written to be used, and cannot be used as or considered a 'covered opinion' or other written tax advice and should not be relied upon for any purpose other than its intended purpose.

