UBA PPACAAdvisor

Acadia BENEFITS INC.

Effect of the

Patient Protection and Affordable Care Act

on

[Enter client's name here]

Revised March 2015

Date Prepared: _____

The Patient Protection and Affordable Care Act (the ACA) affects employers of all types and sizes in many ways. Requirements first became effective in 2010, and will continue to be phased in through 2018. Penalties for non-compliance can be significant.

This law is complicated, and affects different employers in different ways. Additionally, details of some of the requirements are not yet available. This report reflects our understanding of the available guidance as of the date shown and is subject to change. It is not intended to provide legal or tax advice. Employers should not act on this information without consulting legal counsel or other knowledgeable advisors.

Several terms are important to understanding the ACA requirements described in this report. They include:

"Essential health benefits" – services in each of these 10 categories:

- Ambulatory (i.e. outpatient) patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (e.g., speech, physical and occupational therapy, for both those who had mastered the skill and lost it due to illness or injury, or for those who have not yet mastered the skill)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral (dental) and vision care

Each state has determined the essential health benefits package to be offered in the exchange and by individual and small group policies in its state, based on the benefits provided by a benchmark plan in the state. The Department of Health and Human Services (HHS) has posted a listing of each state's benchmark plan at: Additional Information on Proposed State Essential Health Benefits Benchmark Plans | cciio.cms.gov.

Note that while large employer and self-funded plans may not impose lifetime or annual dollar limits on "essential health benefits," they do not have to provide all 10 of the essential health benefits in order to provide "minimum value" benefits; the plan simply must be designed to pay at least 60% of covered costs. A plan will not be considered "minimum value" if it fails to provide coverage for in-hospital care and physicians' services.

"Grandfathered plan" – a plan that has only made permissible changes since March 23, 2010. Impermissible changes include:

- Eliminating or significantly eliminating benefits to treat or diagnose a specific condition.
- Any increase in co-insurance percentages, or any other cost-sharing based on percentage.
- Increases in co-payments, or other fixed-amount cost-sharing, of more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points.
- Increases in deductibles by more than medical inflation plus 15 percentage points.
- Reductions in the employer contribution percentage by more than 5 percentage points.
- Adding or tightening an annual limit on an essential health benefit.

A plan may change TPAs, or may change insurers after November 15, 2010, and still maintain grandfathered status, as long as the above guidelines are followed. Changes made to meet government requirements will not affect grandfathered status.

Each plan option is viewed separately when determining whether grandfathered status has been maintained. Adding additional contribution/coverage tiers will not affect grandfathered status if the employer's contribution level for individuals in the tier is not reduced.

A plan that claims grandfathered status must maintain records to verify that no impermissible changes have been made, and provide notice of grandfathered status to participants in most plan materials.

Important: If a plan ceases to be grandfathered, it will need to comply with all requirements that were not applicable due to grandfathered status.

"Grandmothered plan" – a plan that does not meet the 2014 insurance market requirements of the ACA, but which has been allowed by the federal government and state insurance department as a permitted renewal of an existing policy. Grandmothered plans may be renewed through October 1, 2016, renewals.

"Large employer plan" means the employer employed an average of at least 101 employees during the preceding calendar year (unless the employer's state has elected to use 50 employees as the cut-off; this option ends in 2016. All states have elected to use 50 employees as the cut-off for 2014 and 2015.).

"Small employer plan" means the employer employed an average of 100 or fewer employees during the calendar year (unless the employer's state has elected to use 50 employees as the cut-off; this option ends in 2016. All states have elected to use 50 employees as the cut-off for 2014 and 2015.).

Effective in 2010

Requirement	Status	Comments	Action Steps for Compliance
Dependent children (natural, step, adopted, and foster) must be offered coverage up to age 26, regardless whether the child is employed, married, or financially dependent on the employee or a student. (There is a limited exception for grandfathered plans – until 2014 those plans do not need to offer coverage to children who have access to coverage through the child's employer.) A special 30-day enrollment period applied to children under age 26 who had been terminated for failing to meet the prior eligibility requirements. The IRS has issued assurance that covering dependents to age 26 will not create imputed income for federal income tax purposes.	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ Notice of one-time special enrollment for over-age dependents was due with the first open enrollment on or after the effective date. Keep a copy of this notice.
Pre-existing condition limitations may not be applied to children under the age of 19.	❑ In compliance. ❑ Work is needed. ❑ N/A – no pre-existing condition limitation.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ Update open enrollment notice to provide that pre-existing condition only applies to adults. (See 2014 for additional changes.)
Lifetime dollar maximums are not permitted on essential health benefits. A 30-day special enrollment period applied to covered persons who had previously met the plan's prior lifetime maximum.	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ Notice of one-time special enrollment for covered persons who had previously reached their lifetime maximum was due with the first open enrollment on or after the effective date. Keep a copy of this notice.

Requirement	Status	Comments	Action Steps for Compliance
Annual dollar maximums are limited on essential health benefits. For plan years beginning between Sept. 23, 2010, and Sept. 22, 2011, the annual limit is $750,000. Until Sept. 22, 2011, plans could apply for a waiver if compliance would cause a significant decrease in access to benefits or a significant increase in premiums. The waiver was renewable through the 2013 plan year. Plans with waivers must provide an annual notice to participants and file an Annual Limit Update with HHS in 2012 and 2013. There is a blanket waiver through the 2013 plan year for standalone HRAs that were in effect on Sept. 23, 2010.	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ If waiver has been obtained, provide the required notice with enrollment materials each year. ✓ If waiver was obtained, file Annual Limit Update forms by Dec. 31, 2012, and Dec. 31, 2013. ✓ If waiver was obtained, maintain all records relating to applications and notice, in case of audit.
Coverage may not be rescinded (cancelled retroactively) except for fraud or intentional misrepresentation. There is a limited right to retroactively terminate coverage of ineligible individuals who have not paid their premiums and for late notice of divorce. Prospective terminations are allowed for ineligible individuals who have paid premiums even after becoming ineligible.	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	✓ Amend plan and SPD or verify policy and certificate have been updated. ✓ Verify administering correctly (must provide 30 days advance written notice of any retroactive cancellation).
Emergency department services must always be paid as an in-network benefit. The usual in-network deductible, coinsurance, etc. may be applied.	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	✓ Amend plan and SPD or verify policy and certificate have been updated. ✓ Verify administering correctly.
Enrollees must be allowed to choose any primary care physician (PCP) who participates in the plan's network. Pediatricians must be allowed as a child's PCP. Women must be allowed to access care from an obstetrician-gynecologist without a referral.	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered. ❑ N/A – plan does not require a designated PCP or referrals.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011 for calendar year plans).	If plan requires that a PCP be chosen: ✓ Amend plan and SPD or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ Notice must be provided to participants in the SPD or similar benefits description (a model notice is available). Keep a copy of this notice.

Requirement	Status	Comments	Action Steps for Compliance
First dollar coverage of in-network preventive services must be provided. Preventive services are determined from time to time by HHS based on recommendations of the United States Preventive Services Task Force (USPSTF) and generally include immunizations, preventive care and screenings. The current recommendations are posted at: Affordable Care Act: USPSTF A and B Recommendations. Any change in requirements due to new recommendations will not apply until the start of the plan year after at least 12 months have elapsed since the new recommendation was effective. If both preventive care and treatment are provided in a single visit and are not billed separately, the primary purpose of the visit will determine how benefits will be paid. Reasonable frequency limits are permissible.	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly.
Plans must implement required processes for internal and external appeals of denied claims, including rescissions of coverage. Internal reviews must be made by an independent reviewer and the claimant must be allowed to submit information. Coverage must continue during the appeals process. Denial notices must include specific information (a model is available). External review must be available for denials based on medical necessity. Generally, insured plans must use any available state review process. Self-funded plans must rotate external reviewers.	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011, for calendar year plans). Effective dates for external review requirements were extended.	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify insurer, TPA and plan administrator are administering correctly.
Grandfathered plans must regularly provide a notice disclosing their grandfathered status to plan participants. A model notice is available.	❑ In compliance. ❑ Work is needed. ❑ N/A – plan is not grandfathered.	Applies as of the first day of the first plan year beginning on or after Sept. 23, 2010 (i.e., as of Jan. 1, 2011, for calendar year plans).	✓ Notice of grandfathered status must be included in all plan materials (e.g., SPDs, enrollment materials); however this information does not need to be included in the SBC. Keep a copy of the notices.

Requirement	Status	Comments	Action Steps for Compliance
A temporary program called the Early Retiree Reinsurance Program was available to employers who offer coverage to retired employees and their spouses between the ages of 55 and 64 who were not eligible for Medicare. The government agreed to reimburse 80% of claims between $15,000 and $90,000. The program discontinued reimbursements in February 2012 as its funding was exhausted. Employers who received reimbursements must share the reimbursements with participants in the manner they described in their application for the program as soon as possible, and not later than Dec. 31, 2014. A notice describing the plan's participation in the program must be provided to participants. A model notice is available.	❑ In compliance. ❑ Work is needed. ❑ N/A – no early retiree benefits. ❑ N/A – offer early retiree benefits, but did not apply to program.	Applications were accepted from June 29, 2010, through May 5, 2011.	✓ Apply reimbursements in the manner described in the application. ✓ Maintain employer contribution at pre-program level until all reimbursements are applied. ✓ Maintain records of use of reimbursement as audits are expected. ✓ Provide notice of participation in the program to participants until reimbursement has been applied. Keep a copy of the notices.
A limited tax credit is available to small employers (those with fewer than 25 full-time equivalent employees) who have employees who average less than $50,000 per year per full-time equivalent employee. The employer must make a uniform contribution to covered employees of at least 50% of the cost. The maximum credit for 2010 through 2013 is 35% of the employer's premium contribution and for 2014 and later it is 50%. For 2014 and later the credit is only available to employers participating in a SHOP exchange. The maximum credit applies to employers with 10 full-time equivalent employees who earn less than $25,000 (indexed) and is graded for those with more or more highly paid employees. Additional limits apply. Smaller credits are available for not-for-profits.	❑ In compliance. ❑ Work is needed. ❑ N/A – over 25 employees. ❑ N/A – chose not to pursue.	Available Jan. 1, 2010.	✓ Make uniform contributions of at least 50% of the cost. ✓ Request tax credit on Form 8941 (on Form 990-T if tax-exempt).

Requirement	Status	Comments	Action Steps for Compliance
The Medicare Part D subsidy will not be deductible after 2012. However, under accounting rules, this loss of deduction was to be reflected immediately in liability and income statements.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not offer benefits to retirees. ❑ N/A – offer benefits to retirees, but do not receive subsidy payments because of plan design.		✓ Verify any needed accounting disclosure was made correctly.

Effective in 2011

Requirement	Status	Comments	Action Steps for Compliance
Over-the-counter drugs may not be reimbursed under a health FSA, an HRA, or an HSA unless prescribed by a health practitioner.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not offer a health FSA, HRA or HSA.	Effective Jan. 1, 2011, regardless of plan year.	✓ Amend plan and SPD. ✓ Verify administering correctly. ✓ Update open enrollment materials.
Annual dollar maximums are limited on essential health benefits. For plan years beginning between Sept. 23, 2011, and Sept. 22, 2012, the annual limit is $1,250,000. Plans could apply for a waiver until Sept. 22, 2011, if compliance would cause a significant decrease in access to benefits or a significant increase in premiums. The waiver is available through the 2013 plan year. Plans with waivers must provide an annual notice to participants and file an Annual Limit Update with HHS in 2012 and 2013. Plans with waivers must provide an annual notice to participants. There is a blanket waiver through the 2013 plan year for standalone HRAs that were in effect on Sept. 23, 2010.	❑ In compliance. ❑ Work is needed. ❑ N/A – no annual dollar limits on essential health benefits.	Applies as of the first day of the first plan year beginning after Sept. 23, 2011 (i.e., as of Jan. 1, 2012, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ If waiver has been obtained, provide the required notice with enrollment materials each year. ✓ If waiver was obtained, file Annual Limit Update forms by Dec. 31, 2012, and Dec. 31, 2013. ✓ If waiver was obtained, maintain all records relating to applications and notices, in case of audit.

Effective in 2012

Requirement	Status	Comments	Action Steps for Compliance
Insurers must provide rebates if their medical loss ratio (essentially claims and wellness costs) is less than 85% in the large employer market and 80% in the small employer market. Plans that receive rebates must share them with participants based on the relative share of cost paid by the employer and employees. Insurers must provide a notice describing the plan's eligibility for a rebate based on the previous year's experience of the relevant block (not the plan's specific experience) to employers, which employers must then distribute. (Beginning in 2013 if the rebate will be used to reduce premiums, the insurer must apply the rebate to the next premium due.)	❑ In compliance. ❑ Work is needed. ❑ N/A – self-funded.	2012 rebates were based on 2011 experience and were due by Aug. 1, 2012. Beginning with 2014 rebates must be issued by Sept. 30.	✓ Must distribute rebate to participants on an equitable basis and generally within 90 days of receipt to avoid need to put rebate in a trust account. ✓ Must distribute insurer's notice regarding rebate unless the insurer sends the notice directly to participants.
Preventive care coverage must include women's wellness services, including contraception. Religious organizations that object to contraception are exempt from the requirement to cover contraceptives. Religious-affiliated not-for-profit employers are not required to provide or pay for coverage. The religious-affiliated employer must either self-certify its objection to its insurer or administrator or notify HHS of its objection. The insurer or administrator is obligated to offer separate coverage for contraception at no cost to interested members. Closely-held for profit organizations with a religious objection to covering contraception also need not comply, and likely can use a process similar to that used by religious-affiliated employers.	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered. ❑ Relying on religious exemption.	Applies as of the first day of the first plan year beginning on or after Aug. 1, 2012 (i.e., as of Jan. 1, 2013, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ Be prepared to demonstrate the employer qualifies as a religious employer if declining to provide contraceptive coverage. ✓ If a religious-affiliated employer, provide insurer or administrator with the required self-certification for the applicable plan year or notify HHS.

Requirement	Status	Comments	Action Steps for Compliance
Summaries of Benefits Coverage (SBCs) must be provided in connection with all medical plans. SBCs are needed for employee assistance programs (EAPs), wellness programs, and HRAs if they are "group health plans" but their reporting may be included in the SBC for the main plan if they interact. SBCs are not needed for standalone dental and vision plans. The SBCs must follow a template prescribed by the Department of Labor (DOL). Premium information is not required. Multiple designs or cost tiers may be shown on a single SBC if that can be done with clarity. Mid-year changes to the SBC require 60 days' prior notice.	❑ In compliance. ❑ Work is needed.	Applies to all plan years and open enrollment periods beginning on or after Sept. 23, 2012.	✓ The insurer is responsible for preparing the SBC for fully insured plans. Distribution is the joint responsibility of the employer and insurer. ✓ The employer is responsible for preparing and distributing the SBC for self-funded plans. ✓ Verify that are using the correct year's SBC template. (The template is being revised for plan years and open enrollment periods beginning on or after Sept. 1, 2015.)
Annual dollar maximums are limited on essential health benefits. For plan years beginning between Sept. 23, 2011, and Sept. 22, 2012, the annual limit is $1,250,000. Plans could apply for a waiver until Sept. 22, 2011, if compliance would cause a significant decrease in access to benefits or a significant increase in premiums. The waiver is available through the 2013 plan year. Plans with waivers must provide an annual notice to participants. There is a blanket waiver through the 2013 plan year for standalone HRAs that were in effect on Sept. 23, 2010.	❑ In compliance. ❑ Work is needed. ❑ N/A – no annual limits on essential health benefits.	Applies as of the first day of the first plan year beginning after Sept. 23, 2012 (i.e., as of Jan. 1, 2013, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ If waiver has been obtained, provide the required notice with enrollment materials each year. ✓ If waiver was obtained, file Annual Limit Update forms by Dec. 31, 2012, and Dec. 31, 2013. ✓ If waiver was obtained, maintain all records relating to applications and notices, in case of audit.

Effective in 2013

Requirement	Status	Comments	Action Steps for Compliance
Employers that issued more than 250 W-2s in the prior calendar year (e.g., W-2s issued in 2011 determines if reporting is needed for 2012 W-2s issued in January 2013) must include the total value (employer and employee contributions) of the employee's health coverage on their W-2 (in box 12). This reporting is informational; i.e., these amounts are not taxable. Generally, the premium cost is used to report the value of insured plans and the COBRA cost (excluding the 2% administrative charge) is used to report the value of self-funded coverage.	❑ In compliance. ❑ Work is needed. ❑ N/A – issued fewer than 250 W-2s in prior calendar year.	Applies Jan. 1, 2013, regardless of plan year.	✓ Verify payroll administrator/W-2 issuer has included the needed information on the W-2.
Employers must withhold an additional 0.9% FICA for employees once the employee's wages for the year exceed $200,000. There is no maximum income to which this withholding applies. The employer's contribution is NOT increasing.	❑ In compliance. ❑ Work is needed.	Applies Jan. 1, 2013, regardless of plan year.	✓ Verify payroll administrator is withholding the additional tax as needed. ✓ Consider whether to provide education to higher compensated employees on this requirement.
FSAs may not allow participants to contribute more than $2,500/year (indexed) to their health FSA. If the employee and spouse both work, each may have an FSA and contribute $2,500 to it. The $2,500 limit does not include flex credits provided by an employer or amounts reimbursed during any claims grace period. The $2,500 limit is indexed to $2,550 for 2015.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not offer a health FSA. ❑ N/A – health FSA already has an annual contribution limit that does not exceed $2,500, indexed.	Applies to the first plan year beginning on or after Jan. 1, 2013.	✓ Amend plan and SPD by Dec. 31, 2014. ✓ Update enrollment materials. ✓ Verify administrator is prepared to administer correctly.

Requirement	Status	Comments	Action Steps for Compliance
A Patient Centered Outcomes Research Institute (PCORI) fee is due by July 31 based on enrollment during the preceding plan year. The fee is $1 per covered life for the first year, $2 per covered life for the second year, and $2 (indexed) in years three through eight. The fee for year three will be $2.08. The IRS has provided several options for determining the number of covered lives. The insurer must report and pay the fee for insured plans and the employer must report and pay the fee (on IRS Form 720) for self-funded plans. For purposes of the fee, HRAs are considered self-funded plans.	❑ In compliance. ❑ Work is needed. ❑ Insurer has/will file for plan.	The fee is due by July 31 of the year following the calendar year in which the plan/policy year ended. The first fee was due July 31, 2013, for calendar year plans and for plans ending on Oct. 2, 2012, and Dec. 31, 2012. The first fee is not due until July 31, 2014, for those with plan years that end Jan. 1, 2013, through Oct. 1, 2013.	✓ If self-funded, calculate and pay the fee (note that HRAs are considered self-funded plans and may require a separate filing from an insured medical plan). ✓ Budget for this cost.
Employers may not deduct Medicare Part D drug subsidies.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not receive Part D subsidies.	Applies with the 2013 tax year.	✓ Verify tax preparer is aware of this change. ✓ Adjust budget for additional tax liability.
A notice giving details about the coming exchange must be given to all current employees by Oct. 1, 2013. Beginning Oct. 1, 2013, the notice must be provided to new hires within 14 days after they start work. A model notice (which requires some employer-specific information) is available.	❑ In compliance. ❑ Work is needed.	The notice originally was due March 1, 2013, but the due date has been delayed to Oct. 1, 2013. The DOL has announced no penalty will apply to employers that fail to provide the notice.	✓ Prepare and distribute the notice. Keep a copy of the notice. ✓ Prepare for employee questions about the exchange.
Health FSAs may allow a rollover of up to $500 to the next year as long as the plan does not also have a grace period.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not offer a health FSA. ❑ N/A – do not want to add a rollover option.	A plan that currently has a grace period should consider participant reliance issues before eliminating the grace period in favor of a rollover for the current year.	If choose to offer this option: ✓ Amend plan and SPD by Dec. 31, 2014. ✓ Update enrollment materials. ✓ Verify administrator is prepared to administer correctly.

Effective in 2014

Requirement	Status	Comments	Action Steps for Compliance
The limited exception for grandfathered plans which allowed them to not offer coverage to a child who has access to coverage through the child's employer expires. All dependent (natural, step, adopted, and foster) children who are eligible must be offered coverage up to age 26, regardless of whether the child is employed, married, financially dependent on the employee, or a student.	❑ In compliance. ❑ Work is needed. ❑ N/A – not grandfathered.	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administration is correct. ✓ Update enrollment materials.
Annual dollar maximums on essential health benefits are prohibited. Waivers are no longer effective. HRAs for active employees must be integrated with a group medical plan to satisfy this requirement. In order for an HRA to be integrated, the HRA must only be available to employees covered under either the employer's or the spouse's employer's group health plan and the employee must have an annual opportunity to opt out of the HRA.	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administration is correct. ✓ Update enrollment materials.
Waiting periods for coverage generally may not be longer than 90 days after the person becomes eligible. There is a limited exception for those who have variable hours or seasonal jobs. (An entry date of the first of the month after 90 days will not be allowed.)	❑ In compliance. ❑ Work is needed.	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated as needed. ✓ Update enrollment materials. ✓ Update processes so administer correctly.
Plans must cover routine costs for patients in approved clinical trials and may not deny a qualified individual the right to participate in a clinical trial.	❑ In compliance. ❑ Work is needed ❑ Currently N/A – plan is grandfathered. ❑ Currently N/A – plan is "grandmothered."	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administration is correct. ✓ May discontinue HIPAA certificates of creditable coverage after Dec. 31, 2014.

Requirement	Status	Comments	Action Steps for Compliance
Cost sharing limits apply. Annual out-of-pocket limits (deductible, coinsurance, and co-pays) cannot exceed $6,600 single and $13,200 family for 2015 in any plan. (HDHPs linked to HSAs may need a lower out-of-pocket limit.)	❑ In compliance. ❑ Work is needed. ❑ Currently N/A – plan is grandfathered. ❑ Currently N/A – plan is "grandmothered."	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administration is correct. ✓ Verify SBC and enrollment materials are updated as needed.
Small, insured plans must cover "essential health benefits." Essential benefits will be determined by each state. (Compliance with this requirement largely will be the insurer's responsibility.) Small, insured plans also are subject to modified community rating.	❑ In compliance. ❑ Work is needed. ❑ N/A – large or self-funded employer (but note that annual and lifetime limits cannot be imposed on essential health benefits; self-funded plans may need to elect a reference EHB plan). ❑ Currently N/A – plan is grandfathered. ❑ Currently N/A – plan is "grandmothered."	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Verify policy and certificate are updated. ✓ Update enrollment materials. ✓ If self-funded, designate which state's EHB will use as a reference plan.
Employers may offer financial incentives of up to 30% of the cost of coverage for participating in wellness programs. The incentive may be as much as 50% for incentives related to non-use of tobacco. Wellness program requirements, including offering reasonable alternatives, must be followed.	❑ In compliance. ❑ Work is needed. ❑ N/A – do not offer a bona fide wellness program.	Applies as of the first day of the first plan year beginning after Jan. 1, 2014 (i.e., as of Jan. 1, 2014, for calendar year plans).	✓ Determine if want to increase the wellness incentive. ✓ If so, update program materials and premium payment data.
Pre-existing condition limitations may not be applied to any covered person, regardless of age.	❑ In compliance. ❑ Work is needed. ❑ N/A – no pre-existing condition limitation.	Applies as of the first day of the first plan year beginning on or after Jan. 1, 2014.	✓ Amend plan and SPD, or verify policy and certificate have been updated. ✓ Verify administering correctly. ✓ May discontinue HIPAA certificates of creditable coverage after Dec. 31, 2014.

Requirement	Status	Comments	Action Steps for Compliance
Premium assistance tax credits will be available to individuals who (1) receive coverage through the exchange, (2) have income below 400% of the federal poverty level, **and** (3) do not have access to affordable, minimum value coverage through their employer. The exchange or HHS will contact the employer if an employee applies for a premium tax credit.	❑ Work is needed. ❑ In compliance.	Applies Jan.1, 2014.	✓ Respond to state inquiries regarding employee eligibility for exchange. ✓ Review determinations of premium tax credit eligibility, and appeal if appropriate.
Small employers may enroll in a SHOP exchange. For 2014 and 2015 the exchange may require the employer to choose one plan for all employees – all federally facilitated exchanges and a few state exchanges will have this limitation during 2014. For electing state and federal exchanges in 2015, the employer will choose a coverage level (60% to 90%) and employees will elect a plan within that level (in the remaining exchanges the employer will continue to choose one plan for all employees). The SHOP will provide a list bill to the employer if employee choice is allowed. The small business health tax credit is only available if coverage is provided through a SHOP exchange.	❑ Work is needed. ❑ N/A – employ more than 50 employees. ❑ Meet size guidelines but not interested.	Applies Jan.1, 2014 (may enroll at any time during year; open enrollment, if cannot meet participation requirements, is from Nov. 15 through Dec. 15).	✓ Determine whether SHOP is best option. ✓ If yes, complete application and notify employees.
Employers with non-calendar year medical plans may amend their Section 125 plan to allow a mid-year change to enroll in the exchange as a change in status event. (The IRS has stated that the individual penalty will be delayed until the start of the 2014 plan year for those eligible for coverage under an employer plan that operates on a non-calendar year.)	❑ Work is needed. ❑ N/A – calendar year plan. ❑ N/A – no Section 125 pre-tax plan. ❑ N/A – do not want to allow mid-year change. ❑ In compliance.		✓ Amend plan and SPD by Dec. 31, 2015. ✓ Update enrollment materials. ✓ Verify change is acceptable to insurer/administrator/stop loss carrier.

Requirement	Status	Comments	Action Steps for Compliance
All plans will be required to contribute to a transition reinsurance fund for 2014, 2015, and 2016. The fee will be per covered life, based upon average employee count during the first nine months of the year. Insurers will report/pay on fully insured plans and employers will report/pay on self-funded plans. The fee for 2014 is $5.25/month/covered life. The fee will be $3.67/month/covered life in 2015 and decline to $2.25/month/covered life in 2016.	❑ Work is needed. ❑ In compliance.	Reporting will be due Dec. 5, 2014, through www.pay.gov, with most of the fee payable by Jan. 15, 2015, and the rest by Nov. 15, 2015; on Nov. 15, 2015, with most of the fee payable by Jan. 15, 2016, and the rest by Nov. 15, 2016; and on Nov. 15, 2016, with most of the fee payable Jan. 15, 2017, and the rest by Nov. 15, 2017. Fee does not apply to self-funded plans that are self-administered for 2015 and 2016.	✓ If self-funded, file and authorize payment by Dec. 5, 2014. ✓ Budget for this cost (insurers likely will pass cost on).

Effective in 2015

Requirement	Status	Comments	Action Steps for Compliance
Self-funded employers that offer minimum essential coverage must provide reporting to the IRS and each employee, including the name and Social Security number of each covered employee and dependent and the number of months the person had minimum essential coverage. Employers with 50 or more full-time or full-time equivalent employees will report this on Form 1095-C. Small employers will report on Form 1095-B. (Insurers will report on insured lives using Form 1095-B.)	❑ Work is needed. ❑ N/A – fully insured.	First report will be due to employees on Jan. 31, 2016, based on 2015 coverage. Employer summary report will be due by Feb. 29, 2016, if file paper and by March 31, 2016, if file electronically.	✓ Monitor rules. ✓ Begin to consider how to gather needed data.
Employers with 50+ employees will need to report on the number of full-time employees employed each month and, for each full-time employee, the employee's name and Social Security number, the number of months minimum value coverage was offered, and the employee's share of the cost of self-only coverage for each month, why coverage was not offered to ineligible full-time employees, and certain information on coverage offered to those who are not full-time. (Each employer within a controlled/affiliated service group will report separately.) Reporting will be on Form 1095-C.	❑ Work is needed. ❑ N/A – employ fewer than 50 full-time employees or full-time equivalent employees (in the controlled/ affiliated service group).	First report will be due to employees on Jan. 31, 2016, based on 2015 coverage. Employer summary report will be due by Feb. 29, 2016, if file paper and by March 31, 2016, if file electronically.	✓ Monitor rules. ✓ Begin to consider how to gather needed data.
Employers with 100 or more full-time employees or full-time employee equivalents will be subject to one of two penalties if (1) they do not offer minimum essential coverage to at least 70% of their full-time employees or (2) they offer coverage but it is not "affordable" or it does not provide "minimum value." An employee is counted as a full-time employee if the employee is employed an average of 30 hours/week. When calculating the number of full-time equivalent employees, the average hours of all full-time equivalent employees will be totaled each month and then be divided by 120. Employers who do not offer "minimum essential"	❑ Work is needed. ❑ N/A – employ fewer than 100 full-time employees or full-time equivalent employees (in the controlled/ affiliated service group) and if have 50 to 99 employees can meet the maintenance requirements	Applies as of Jan.1, 2015, to calendar year plan. Non-calendar year plan does not need to comply until the start of the 2015 plan year if: • It had a non-calendar year plan on Dec. 27, 2012. • It has not changed its plan year to a date later in the year. • It can meet any one of 4 tests: 1. Actually covered 1/4 of **all** employees on any day between Feb. 10, 2013, and	Determine whether have 100 full-time or full-time equivalent employees ✓ If yes, determine whether current coverage is affordable and provides minimum value. ✓ If not affordable and minimum value, determine whether to pay penalty or redesign plan/contribution levels. ✓ If not currently offering coverage to employees working 30+ hours/week, determine cost of doing so.

Requirement	Status	Comments	Action Steps for Compliance
(basic) coverage to their at least 70% of full-time employees will pay a penalty of $2,000/full-time employee/year (excluding the first 80 employees if the employer has 100 or more full-time and full-time equivalent employees and excluding the first 30 employees if have fewer than 100) if even one employee receives a premium tax credit. Note that coverage does not need to be offered to spouses. For 2015, employers do not need to cover dependent children if they were not covered before. Employers that offer coverage that does not provide minimum value or that is not affordable will pay a penalty of $3,000/year for each employee who receives a premium tax credit. Coverage is considered "minimum value" if the plan's share of covered charges is at least 60%. Coverage that excludes in-patient hospital or physicians' services is not minimum value. Coverage is considered affordable if the employee's cost is not more than 9.5% of household income. (As employers typically don't have access to household income, one of three safe harbors may be used to determine if coverage is affordable for purposes of the employer penalty: 9.5% of W-2 [Box 1] income for single coverage, 9.5% of the employee's rate of pay at the start of the year, or 9.5% of the federal poverty level for a single person at the start of the plan year.)	described in the Action Steps column.	Feb. 9, 2014. 2. Actually covered 1/3 of **full-time** employees on any day between Feb. 10, 2013, and Feb. 9, 2014. 3. Offered coverage to 1/3 of **all** employees during the last open enrollment. 4. Offered coverage to 1/2 of **full-time** employees during the last open enrollment. • It offers affordable, minimum value coverage as of the start of the 2015 plan year. Penalty amounts are indexed.	If have 50 to 99 employees, be prepared to certify that since Feb. 9, 2014, have not: ✓ Reduced the size of the workforce or employees' overall hours of service to qualify for this delay. ✓ Eliminated or materially reduced any coverage in effect on Feb. 9, 2014. A material reduction means: • Employer contribution is less than 95% of dollar amount of its contribution for single-only coverage on Feb. 9, 2014, or is a smaller percentage than employer was paying on Feb. 9, 2014; • A change was made to benefits in place on Feb. 9, 2014, that caused the plan to fall below minimum value; or • The class of employees or dependents eligible for coverage on Feb. 9, 2014, has been reduced. If have 50 to 99 employees and cannot certify follow steps for employer with 100 or more employees.

Effective in 2016

Requirement	Status	Comments	Action Steps for Compliance
States must define a small employer as 1 to 100 employees for purposes of the insurance market (both inside and outside the exchange). Note that "large employer" will remain at 50 or more employees for purposes of the employer-shared responsibility/play or pay requirements and reporting.	❑ Work is needed. ❑ N/A – have more than 100 employees. ❑ N/A – plan is self-funded.	Applies as of the first day of the plan year beginning on or after Jan. 1, 2016.	✓ Consider additional compliance obligations (EHBs, metal levels, modified community rating) if in the affected employer size range.
Cost-sharing (typically the out-of-pocket limit) for an individual may not exceed the self-only limit ($6,850 for 2016) even if family coverage is in effect.	❑ Work is needed. ❑ N/A – plan is grandfathered.	Limit for HDHP connected to an HSA may be less than $6,850.	✓ Verify plan is being administered correctly and any needed changes are made to plan document, SPD and SBC.

Requirement	Status	Comments	Action Steps for Compliance
Employers with 50 or more full-time employees or full-time employee equivalents will be subject to one of two penalties if (1) they do not offer minimum essential coverage to at least 95% of their full-time employees and dependent children or (2) they offer coverage but it is not "affordable" or it does not provide "minimum value." An employee is counted as a full-time employee if the employee is employed an average of 30 hours/week. When calculating the number of full-time equivalent employees, the average hours of all full-time equivalent employees will be totaled each month and then be divided by 120. Employers who do not offer "minimum essential" (basic) coverage to their at least 95% of full-time employees (or to 5 employees, if greater) and dependent children to age 26 will pay a penalty of $2,000/full-time employee/year (excluding the first 30 employees) if even one employee receives a premium tax credit. Note that coverage does not need to be offered to spouses. Employers that offer coverage that does not provide minimum value or that is not affordable will pay a penalty of $3,000/year for each employee who receives a premium tax credit. Coverage is considered "minimum value" if the plan's share of covered charges is at least 60%. Coverage that excludes in-patient hospital or physicians' services is not minimum value. Coverage is considered affordable if the employee's cost is not more than 9.5% of household income. (As employers typically don't have access to household income, one of three safe harbors may be used to determine if coverage is affordable for purposes of the employer penalty: 9.5% of W-2 [Box 1] income for single coverage, 9.5% of the employee's rate of pay at the start of the year, or 9.5% of the federal poverty level for a single person at the start of the plan year.)	❑ Work is needed. ❑ N/A – employ fewer than 50 full-time employees or full-time equivalent employees (in the controlled/ affiliated service group).	Applies in 2016. It is likely, but not totally clear that non-calendar year plans may delay to the start of their 2016 plan year, if they meet the transition rules described in the Comments on page 19. Penalty amounts are indexed.	✓ Determine whether have 50 full-time or full-time equivalent employees. ✓ If yes, determine whether current coverage is affordable and provides minimum value. ✓ If not affordable and minimum value, determine whether to pay penalty or redesign plan/ contribution levels. ✓ If not currently offering coverage to those working 30+ hours/week, determine cost of doing so.

Effective in 2018

Requirement	Status	Comments	Action Steps for Compliance
Employers who provide health plans that are too rich ("Cadillac plans") must pay a non-deductible 40% excise tax on the value of health plan coverage that exceeds $10,200 (indexed) for individual coverage and $27,500 (indexed) for family coverage. Value is expected to be based on both employer and employee contributions for medical coverage, health FSAs, HRAs, most onsite clinics and employer and pre-tax employee HSA contributions.	❑ Work is needed.	Applies Jan. 1, 2018.	✓ Monitor total health benefit costs. ✓ Monitor new rules.

Effective Date is Uncertain

Requirement	Status	Comments	Action Steps for Compliance
Employers with more than 200 employees will be required to automatically enroll new employees in a health plan if the employee does not affirmatively elect or decline coverage. Very few details are available yet.	❑ Work is needed. ❑ N/A – employ fewer than 200 employees.		✓ Monitor new rules. ✓ Amend plan and SPD, or verify policy and certificate are updated as needed. ✓ Develop method to automatically enroll as needed. ✓ Prepare and distribute participant notices.
Nondiscrimination requirements will apply to fully insured plans (they already apply to self-funded plans). Employers most likely will not be able to provide highly compensated employees with better benefits, different benefits or more subsidized contribution levels than other employees.	❑ Work is needed. ❑ N/A – all plans are self-funded. ❑ Currently N/A – plan is grandfathered.		✓ Monitor new rules. ✓ Evaluate current plans that may be affected.
Reporting on health coverage quality, including improved outcomes and wellness activities, will be required to IRS and participants	❑ Work is needed. ❑ Currently N/A – plan is grandfathered.		✓ Monitor new rules. ✓ Create and issue reports as required.

Note: The ACA does not affect the exemption of church and government plans from ERISA, so these plans are not required to provide or update SPDs. They should make sure that accurate information is provided to participants, however. All other requirements of the ACA apply to these entities, because the ACA amends the Internal Revenue Code and the Public Health Service Act, in addition to ERISA.

Rev. 3/18/2015

Notes

Although originally included in the ACA, these requirements have been repealed or implementation has been suspended or significantly changed:

- 1099-MISC reporting of payments to corporations (repealed)
- Free choice voucher (repealed)
- CLASS program (repealed)
- Small employer wellness credits (evolved into the National Healthy Worksite Program)
- Deductible limit for small group plans

The implementation date was delayed for:

- W-2 reporting
- Summaries of Benefits and Coverage
- Exchange notice
- Employer-shared responsibility/play or pay penalties
- Employer/insurer reporting to IRS on coverage offerings and employee elections
- Transitional reinsurance fee filing (but not payment date)
- Non-discrimination
- Automatic enrollment
- Quality reporting

The following new taxes have been imposed that for the most part do not directly affect plans, but that likely will be passed on:

- Fees on pharmaceutical manufacturers and importers of name brand prescription drugs. Fees are based on market share, and begin at $2.5 billion in 2011, increase each year to $4.1 billion in 2018, and reduce to $2.8 billion per year thereafter.
- 2.3% excise tax on certain durable medical equipment
- Reinsurance fees will be assessed from 2014 through 2016 on insurers (and sponsors of self-funded plans), based on the number of enrollees, to support changes to the individual insurance market and exchanges. The aggregate national fee is $12 billion for 2014, $8 billion for 2015 and $5 billion for 2016.
- Health insurer tax (not applicable to self-funded plans). The aggregate national fee is $8 billion for 2014, $11.3 billion for 2015 and 2016, 13.9 billion for 2017, and 14.3 billion (indexed) for 2018 and later. Each insurer's fee is based on its market share.

Other relevant information:

- For 2015, the Federal Poverty Level (FPL) is $11,770 for a one-person household and $24,250 for a four-person household in the 48 contiguous states and the District of Columbia.
- Modified community rating will affect the small employer market. Premium rating adjustments will only be allowed for:
  - Age (maximum of 3 to 1)
  - Family composition (individual or family)
  - Tobacco (maximum of 1.5 to 1)
  - Geography (rating area to be established by states; will use address of primary insured)

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