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2015 Compliance Checklist

The Affordable Care Act (ACA) has made a number of significant changes to group health plans since the law was enacted over four years ago. Many of these key reforms became effective in 2014, including health plan design changes, increased wellness program incentives and reinsurance fees.

Additional reforms become effective in 2015 for employers sponsoring group health plans. For 2015, the most significant ACA development impacting employers is the **shared responsibility penalty** for applicable large employers and related reporting requirements. To prepare for 2015, employers should review upcoming requirements and develop a compliance strategy.

This Legislative Brief provides a health care reform compliance checklist for 2015. Please contact Ahart Insurance Services for assistance or if you have questions about changes that were required in previous years.

PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was in existence when the ACA was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact Ahart Insurance Services if you have questions about changes you have made, or are considering making, to your plan.

Review your plan's grandfathered status:

- ☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2015 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year.
- ☐ If your plan will lose its grandfathered status for 2015, confirm that the plan has all of the additional patient rights and benefits required by the ACA for non-grandfathered plans. This includes, for example, coverage of preventive care without cost-sharing requirements.
- ☐ If your plan will keep its grandfathered status, continue to provide the Notice of Grandfathered Status in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (for example, the plan's summary plan description and open enrollment materials). Model language is available.

Cost-sharing Limits

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost-sharing for essential health benefits (EHB).

As enacted, the ACA included an overall annual limit (or an out-of-pocket maximum) for all health plans and an annual deductible limit for small insured health plans. On April 1, 2014, the ACA's annual deductible limit was repealed. This repeal is effective as of the date that the ACA was enacted, back on March 23, 2010.

The out-of-pocket maximum, however, continues to apply to all non-grandfathered group health plans, including self-insured health plans and insured plans.

Effective for plan years beginning on or after Jan. 1, 2015, a health plan's out-of-pocket maximum for EHB may not exceed

- **$6,600** for self-only coverage; and
- **$13,200** for family coverage.

Special transition relief for the out-of-pocket maximum was provided for plans that use more than one service provider to administer benefits. This transition relief only applies for the first plan year beginning on or after Jan. 1, 2014. It does not apply for plan years beginning on or after Jan. 1, 2015.

For 2015 plan years, health plans with more than one service provider may divide the out-of-pocket maximum across multiple categories of benefits, rather than reconcile claims across multiple service providers. Thus, health plans and issuers may structure a benefit design using separate out-of-pocket maximums for EHB, provided that the combined amount does not exceed the annual out-of-pocket maximum limit for that year. For example, a health plan's self-only coverage may have an out-of-pocket maximum of $5,000 for major medical coverage and $1,600 for pharmaceutical coverage, for a combined out-of-pocket maximum of $6,600.

Check your plan's cost-sharing limits:

- ☐ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2015 plan year ($6,600 for self-only coverage and $13,200 for family coverage).
- ☐ If you have a health savings account (HSA)-compatible high-deductible health plan (HDHP), keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2015, the out-of-pocket maximum limit for HDHPs is **$6,450** for self-only coverage and **$12,900** for family coverage.
- ☐ If your plan uses multiple service providers to administer benefits, confirm that the plan will coordinate all claims for EHB across the plan's service providers, or will divide the out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2015.
- ☐ Be aware that the ACA's annual deductible limit no longer applies to small insured health plans.

Health FSA Contributions

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to $2,500.

The $2,500 limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

On Oct. 31, 2013, the Internal Revenue Service (IRS) announced that the health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, the $2,500 limit is expected to be indexed for cost-of-living adjustments for later years. The IRS is expected to release the health FSA limit for 2015 later this year.

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Update your health FSA's contribution limit:

- ☐ Work with your advisors to monitor IRS guidance on the health FSA limit for 2015.
- ☐ Once the 2015 limit is announced by the IRS, confirm that your health FSA will not allow employees to make pre-tax contributions in excess of that amount for 2015. Also, communicate the 2015 health FSA limit to employees as part of the open enrollment process.

REINSURANCE FEES

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of the Exchanges' operation (2014-2016). The fees will be used to help stabilize premiums for coverage in the individual market. Fully insured plan sponsors do not have to pay the fee directly.

Certain types of coverage are excluded from the reinsurance fees, including HRAs that are integrated with major medical coverage, HSAs, health FSAs and coverage that consists solely of excepted benefits under the Health Insurance Portability and Accountability Act (HIPAA) (such as stand-alone vision and dental coverage).

Also, for 2015 and 2016, self-insured health plans are exempt from the reinsurance fees if they do not use a third-party administrator in connection with the core administrative functions of claims processing or adjudication (including the management of appeals) or plan enrollment.

The reinsurance program's fees will be based on a national contribution rate, which the Department of Health and Human Services (HHS) announces annually. For 2015, HHS announced a national contribution rate of **$44 per enrollee per year** (about $3.67 per month). The reinsurance fee is calculated by multiplying the number of covered lives (employees and their dependents) for all of the entity's plans and coverage that must pay contributions by the national contribution rate for the year.

Determine whether your health plan is subject to reinsurance fees:

- ☐ Taking into account the new exception for self-insured plans, or self-administered health plans, review the health coverage you provide to your employees to determine the plan(s) subject to the reinsurance fees for 2015.

HIPAA CERTIFICATION

Health plans must file a statement with HHS certifying their compliance with HIPAA's electronic transaction standards and operating rules. The ACA specified an initial certification deadline of Dec. 31, 2013, for the following transactions:

- Eligibility for a health plan;
- Health care claim status; and
- Health care electronic funds transfers (EFT) and remittance advice.

HHS extended the first certification deadline to **Dec. 31, 2015**, although small health plans may have additional time to comply.

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Controlling health plans (CHPs) are responsible for providing the initial HIPAA certification on behalf of themselves and their subhealth plans, if any.

Based on HHS' definition of CHPs, an employer's self-insured plan will likely qualify as a CHP, even if it does not directly conduct HIPAA-covered transactions. For employers with insured health plans, the health insurance issuer will likely be the CHP responsible for providing the certification. However, more definitive guidance from HHS on this point would be helpful.

Analyze your obligations for the HIPAA certification:

- ☐ Confirm whether your health plan is a CHP that is required to provide the initial HIPAA certification.
  - If you have a self-insured plan, work with your third-party administrator (TPA) to complete the certification by the deadline.
  - If you have an insured plan, confirm that the issuer will be providing the HIPAA certification on your plan's behalf.
- ☐ Work with your advisors to monitor additional guidance from HHS on the HIPAA certification requirement.

EMPLOYER PENALTY RULES

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

The ACA sections that contain the employer penalty requirements are known as the "employer shared responsibility" provisions or "pay or play" rules. The pay or play rules were set to take effect on Jan. 1, 2014. However, the IRS delayed the employer penalty provisions and related reporting requirements for one year, until **Jan. 1, 2015**.

On Feb. 10, 2014, the IRS released **final regulations** implementing the ACA's employer shared responsibility rules. Among other provisions, the final regulations establish a one-year delay for medium-sized ALEs, include transition relief for non-calendar plans and clarify the methods for determining employees' full-time status.

This checklist will help you evaluate your possible liability for a shared responsibility penalty for 2015.

Please keep in mind that this summary is a high-level overview of the shared responsibility rules. It does not provide an in-depth analysis of how the rules will affect your organization. For more information on the employer penalty rules and how they may apply to your situation, please contact Ahart Insurance Services.

ALE Status

The ACA's employer penalty rules apply only to ALEs. ALEs are employers with **50 or more** full-time employees (including full-time equivalent employees, or FTEs) on business days during the preceding calendar year. Employers determine each year, based on their current number of employees, whether they will be considered an ALE for the next year.

Under a special rule to determine ALE status for 2015, an employer may select a period of **at least six consecutive calendar months** during the 2014 calendar year (rather than the entire 2014 calendar year) to count its full-time employees (including FTEs).

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Determine your ALE status for 2015:

- ☐ To count your employees, determine whether you will use the entire 2014 calendar year or the special transition rule that allows you to use any period of at least six consecutive calendar months during 2014.
- ☐ Calculate the number of full-time employees for each calendar month in the counting period. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.
- ☐ Calculate the number of FTEs for each calendar month in the counting period by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- ☐ Add the number of full-time employees and FTEs (including fractions) calculated above for each month in the counting period.
- ☐ Add up the monthly numbers from the preceding step and divide the sum by the number of months in the counting period. Disregard fractions.
- ☐ If your result is 50 or more, you are likely an ALE for 2015. Keep in mind that there is a special exception for employers with seasonal workers. If your workforce exceeds 50 full-time employees (including FTEs) for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that time were seasonal workers, the employer does not qualify as an ALE.

One-year Delay for Medium-sized ALEs

Eligible ALEs with fewer than 100 full-time employees (including FTEs) have an additional year, until 2016, to comply with the shared responsibility rules. This delay applies for all calendar months of 2015 plus any calendar months of 2016 that fall within the 2015 plan year.

ALEs that change their plan years after Feb. 9, 2014, to begin on a later calendar date are not eligible for the delay. To qualify for this delay, an employer:

- Must employ a **limited workforce** of at least 50 full-time employees (including FTEs), but fewer than 100 full-time employees (including FTEs) during 2014
- May not **reduce its workforce size or overall hours of service** of its employees in order to satisfy the limited workforce size condition during the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2014
- May not **eliminate or materially reduce the health coverage**, if any, it offered as of Feb. 9, 2014, during the coverage maintenance period (that is, the period ending Dec. 31, 2015, or the last day of the plan year that begins in 2015)

An applicable large employer must certify that it meets the three eligibility conditions to be eligible for this transition relief. This certification will be made as part of the transmittal form (Form 1094-C) that the ALE is required to file with the IRS under the Internal Revenue Code (Code) Section 6056 reporting requirements. Code Section 6056 requires ALEs subject to the pay or play rules to report to the IRS certain information about the health care coverage provided to the employer's full-time employees for the calendar year. ALEs eligible for the additional one-year delay will still

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report under Section 6056 for 2015. Further information on this certification will be available in the instructions for the Section 6056 transmittal form.

Determine whether you qualify for the one-year delay for medium-sized ALEs:

- ☐ Review whether you have fewer than 100 full-time employees (including FTEs) for 2014 and meet the other requirements for the one-year delay.
- ☐ Work with your advisors to monitor IRS information on the certification process for medium-sized ALEs.
- ☐ Keep in mind that ALEs eligible for the one-year delay must still report under Section 6056 for 2015.

Transition Relief for Non-calendar Year Plans

The final regulations include transition relief for non-calendar plans that allow sponsors of these plans to begin complying with the pay or play rules at the start of their 2015 plan years, rather than on Jan. 1, 2015. The transition relief applies to employers that maintained non-calendar year plans as of Dec. 27, 2012, if the plan year was not modified after Dec. 27, 2012, to begin at a later date.

The following groups of employees may be covered under the transition relief:

- Employees (whenever hired) who would be eligible for coverage effective beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on Feb. 9, 2014;
- All employees, if a significant percentage of the employer's workforce was eligible for coverage under one or more non-calendar year plans; and
- All full-time employees, if a significant percentage of the employer's full-time employees were eligible for coverage under one or more non-calendar year plans.

If you have a non-calendar year plan:

- ☐ Determine whether you qualify for the transition relief that allows you to delay complying with the pay or play rules until the start of your 2015 plan year and confirm whether all full-time employees are covered by the transition relief. The following checklists will help you determine which employees are covered by the transition relief.

Pre-2015 Eligible Employees	Transition relief is provided for employees who would be eligible for coverage as of the first day of the 2015 plan year under the plan's eligibility terms in effect on Feb. 9, 2014, if the following requirements are met: ☐ The applicable large employer maintained a non-calendar year plan as of Dec. 27, 2012, and the plan year was not modified after Dec. 27, 2012, to begin at a later calendar date; ☐ Employees are offered coverage that meets the ACA's affordability and minimum value requirements no later than the first day of the 2015 plan year; and

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	☐ The employees would not have been eligible for coverage under any calendar year group health plan maintained by the employer as of Feb. 9, 2014. If this relief applies, the employer will not be liable for a penalty for these employees for any period prior to the 2015 plan year.
Significant Percentage (All Employees)	Transition relief is provided when employers have a **significant percentage** of their employees eligible for or covered under one or more non-calendar year plans that have the same plan year as of Dec. 27, 2012. To qualify for this relief, the following requirements must be met: ☐ The 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 did not change the plan year after Dec. 27, 2012, to begin at a later calendar date; and ☐ The employer must have either: o Had at least **one quarter of its employees covered** under those non-calendar year plans as of any date in the 12 months ending on Feb. 9, 2014; OR o **Offered coverage under those plans to one-third or more of its employees** during the open enrollment period that ended most recently before Feb. 9, 2014. If this relief applies, the employer will not be liable for a penalty for any period prior to the 2015 plan year with respect to employees who are offered affordable, minimum-value coverage no later than the first day of the 2015 plan year and who would not have been eligible for coverage under any calendar-year group health plan maintained by the employer as of Feb. 9, 2014.
Significant Percentage (Full-time Employees)	Transition relief is provided when employers have a significant percentage of their **full-time employees** eligible for or covered under one or more non-calendar-year plans that have the same plan year as of Dec. 27, 2012. To qualify for this relief, the following requirements must be met: ☐ The 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 did not change the plan year after Dec. 27, 2012, to begin at a later calendar date; and ☐ The employer must have either: o Had at least **one-third of its full-time employees covered** under those non-calendar-year plans as of any date in the 12 months ending on Feb. 9, 2014; OR

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	○ **Offered coverage under those plans to one half or more of its full-time employees** during the open enrollment period that ended most recently before Feb. 9, 2014. If this relief applies, the employer will not be liable for a penalty for any period prior to the 2015 plan year with respect to employees who are offered affordable, minimum-value coverage no later than the first day of the 2015 plan year and who would not have been eligible for coverage under any calendar-year group health plan maintained by the employer as of Feb. 9, 2014.

However, despite this transition relief, if an applicable large employer member does not offer coverage to "substantially all" of its full-time employees (and their dependents) as of the first day of the 2015 plan year, an employer may be subject to a penalty for any calendar month in 2015, without regard to the transition relief for non-calendar-year plans. The monthly penalty assessed for employers that do not offer health plan coverage to "substantially all" full-time employees and their dependents is equal to the number of full-time employees (excluding 30 full-time employees) multiplied by 1/12 of $2,000. For 2015 (plus any calendar months of 2016 that fall within an employer's 2015 plan year), if an employer has 100 or more full-time employees, the penalty is calculated by reducing the employer's number of full-time employees by 80 rather than 30.

Health Plan Coverage

An ALE is only liable for a penalty under the employer shared responsibility rules if at least one full-time employee receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is affordable and provides minimum value are not eligible for these Exchange subsidies.

Full-time Employees

A full-time employee is an employee who was employed on average at least **30 hours of service per week.** The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week. The IRS has provided two methods for determining full-time employee status—the monthly measurement method and the look-back measurement method.

Monthly Measurement Method	Involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.

Look-back Measurement Method	An optional safe harbor method for determining full-time status that is intended to give employers flexible and workable options and greater predictability for determining full-time status. The details of the safe harbor vary based on whether the employees are ongoing or new, and whether new employees are expected to work full-time or are variable, seasonal or part-time. This method involves a measurement period for counting hours of service, an administrative period that allows time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement period. **If an employer meets the requirements of the safe harbor, it will not be liable for penalties for employees who work full-time during the stability period, if they did not work full-time hours during the measurement period.**

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Affordability of Coverage

Under the ACA, an employer's health coverage is considered affordable if the employee's required contribution to the plan does not exceed **9.5 percent** of the employee's household income for the taxable year. "Household income" means the modified adjusted gross income of the employee and any members of the employee's family, including a spouse and dependents.

Because an employer generally will not know an employee's household income, the IRS provided three affordability safe harbors that employers may use to determine affordability based on information that is available to them. The final regulations provide safe harbor approaches for assessing whether an employer's coverage is affordable. These safe harbors allow an employer to measure affordability based on:

- The employee's W-2 wages;
- The employee's rate of pay; or
- The federal poverty level for a single individual.

Minimum Value

Under the ACA, a plan provides minimum value if the plan's share of total allowed costs of benefits provided under the plan is **at least 60 percent** of those costs. The IRS and HHS provided the following three approaches for determining minimum value:

- MV Calculator (provided by HHS);
- Design-based safe harbor checklists; and
- Actuarial certification.

In addition, any plan in the small group market that meets any of the "metal levels" of coverage (that is, bronze, silver, gold or platinum) provides minimum value.

Review your health plan design:

- ☐ Use the monthly measurement method or the look-back measurement method to confirm that health plan coverage will be offered to all full-time employees (and dependent children). If you have employees with varying hours, the look-back measurement method may be the best fit for you. To use the look-back measurement method, you will need to select your measurement, administrative and stability periods. Please contact Ahart Insurance Services for more information on the look-back measurement method.

- ☐ Review the cost of your health plan coverage to determine whether it's affordable for your employees by using one or more of the affordability safe harbors. Coverage is affordable if the employee portion of the premium for the lowest-cost, self-only coverage that provides minimum value does not exceed 9.5 percent of an employee's W-2 wages, rate-of-pay income or the federal poverty level for a single individual. The cost of family coverage is not taken into account.

- ☐ Determine whether the plan provides minimum value by using one of the four available methods (minimum value calculator, safe harbor checklists, actuarial certification or metal level).

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REPORTING OF COVERAGE

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage. The IRS will use the information that ALEs report to verify employer-sponsored coverage and administer the employer shared responsibility provisions. This reporting requirement is found in Code **Section 6056**.

All ALEs with full-time employees, even medium-sized ALEs that qualify for the one-year delay from the pay or play rules, must report under Section 6056 for 2015.

In addition, the ACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals. This reporting requirement is found in Code **Section 6055.**

Both of these reporting requirements become effective in 2015. The first returns will be due in 2016 for health plan coverage provided in 2015.

- The Section 6055 and 6056 returns must be filed with the IRS by **Feb. 28** (or **March 31**, if filed electronically) of the year after the calendar year to which the returns relate.
- Written statements must be provided to employees no later than **Jan. 31** of the year following the calendar year in which coverage was provided.

ALEs with self-funded plans will be required to comply with both reporting obligations, while ALEs with insured plans will only need to comply with Section 6056 reporting. To simplify the reporting process, the IRS will allow ALEs with self-insured plans to use a single combined form for reporting the information required under both Section 6055 and Section 6056.

Prepare for Health Plan Reporting:

- ☐ Determine which reporting requirements apply to you and your health plans.
- ☐ Start analyzing the information you will need for reporting and coordinate internal and external resources to help track the required data.

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