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Year-end Checklist for 2015 Compliance

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 take effect in 2015 for employers sponsoring group health plans. In 2015, the most significant ACA development impacting employers is the **shared responsibility penalty** and related reporting requirements for applicable large employers.

This Legislative Brief provides a short checklist of the ACA's key reforms that will take effect in 2015. As 2014 draws to a close, employers should review this checklist to help confirm they are ready to comply with the ACA's 2015 reforms. Please contact Risk Management Advisors, Inc. if you would like more information about the ACA's reforms.

PLAN DESIGN CHANGES	
ACA REQUIREMENT	**ACTION ITEMS**
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.	☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2015 plan 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. ☐ If your plan will keep 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.
Cost-sharing Limits: Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans must comply with an overall annual limit (or an out-of-pocket maximum) on cost-sharing for essential health benefits (EHB). The cost-sharing limit is updated by the Department of Health and Human Services (HHS) each year.	☐ 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.
Health FSA Contributions: Effective for plan years beginning on or after Jan. 1, 2013, the ACA placed an	☐ Consider increasing the limit on employees' pre-tax

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annual limit on an employee's pre-tax salary reduction contributions to a health flexible spending account (FSA). The health FSA limit was $2,500 for 2013 and 2014, but it will increase to $2,550 for 2015.	contributions to your health FSA from $2,500 to $2,550 for the plan year that begins on or after Jan. 1, 2015.

REINSURANCE FEES	
ACA REQUIREMENT	**ACTION ITEMS**
Health insurance issuers and self-funded group health plans that provide major medical coverage must pay fees to a reinsurance program for the first three years of the Exchanges' operation (2014-2016). Fully insured plan sponsors do not have to pay the fee directly. Certain self-insured plans are exempt from the reinsurance fees, such as health FSAs and health reimbursement arrangements (HRAs) that are integrated with major medical coverage. 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 or plan enrollment.	☐ Taking into account the new exception for self-insured, 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. ☐ For self-funded group health plans subject to the reinsurance fee in 2014, prepare to pay the fee for 2014 by the two-installment payment deadlines in 2015 (Jan. 15, 2015 and Nov. 15, 2015) based on the enrollment count submitted to HHS by Dec. 5, 2014.

HIPAA CERTIFICATION	
ACA REQUIREMENT	**ACTION ITEMS**
Health plans must file a statement with HHS certifying their compliance with HIPAA's electronic transaction standards and operating rules. The first certification deadline is **Dec. 31, 2015**. 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. It is likely that HHS will issue additional guidance on the HIPAA certification requirement in the future.	☐ Confirm whether your health plan is a CHP that is required to provide the initial HIPAA certification. o If you have a self-insured plan, work with your third-party administrator (TPA) to complete the certification by the deadline. o If you have an insured plan, confirm that the issuer will be providing the HIPAA certification on your behalf. ☐ Work with your advisors to monitor additional guidance from HHS on the HIPAA certification requirement.

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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. An ALE is only liable for a penalty under the pay or play rules if at least one full-time employee receives a subsidy for coverage purchased through an Exchange. Employees who are offered health coverage that is affordable and provides minimum value are generally not eligible for these Exchange subsidies. *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. Please contact Risk Management Advisors, Inc. for more information on the employer penalty rules and how they may apply to your situation.*	
ACA REQUIREMENT	**ACTION ITEMS**
Applicable Large Employer 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 following 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).	☐ Determine your ALE status for 2015 by counting your full-time employees (including FTEs) on business days during the entire 2014 calendar year, or use the special transition rule that allows you to use any period of at least six consecutive calendar months during 2014 to count your full-time employees (including FTEs).
One-year Delay for Medium-sized Employers: 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. For more information on the eligibility rules for the one-year delay, contact Risk Management Advisors, Inc..	☐ Determine if you qualify for the one-year delay for medium-sized ALEs.
Transition Relief for Non-calendar Year Plans: IRS transition relief allows eligible sponsors of non-calendar 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. For more information on the eligibility rules for the transition relief, contact Risk Management Advisors, Inc..	☐ 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.
Full-time Employees: A full-time employee is an employee who was employed on average for at least 30 hours of 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.	☐ 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 their dependent children).

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Health Plan Affordability: 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 (adjusted to 9.56 percent for plan years beginning in 2015). 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. These safe harbors allow an employer to measure affordability based on: the employee's W-2 wages; the employee's rate-of-pay income; or the federal poverty level for a single individual. ALEs that use an affordability safe harbor may continue using a contribution percentage of 9.5 percent (instead of the adjusted 9.56 percent) to measure their plan's affordability.	☐ 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.
Minimum Value Coverage: 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 approaches for determining minimum value: a Minimum Value Calculator; 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.	☐ Determine whether your health plan provides minimum value by using one of the four available methods (minimum value calculator, safe harbor checklists, actuarial certification or metal level).

REPORTING OF COVERAGE	
ACA REQUIREMENT	**ACTION ITEMS**
The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage. This reporting requirement is found in **Code section 6056**. All ALEs with full-time employees—even medium-sized ALEs that qualify for the additional one-year delay from the pay or play rules—must report under section 6056 for 2015. In addition, the ACA requires health insurance issuers and sponsors of self-insured health plans 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. 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. 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 6056.	☐ 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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