2016 Employer Compliance Guide

Affordable Care Act (ACA) rules, clarifications, and requirements continue to evolve and impact employers sponsoring health plans. Understanding these changes, their impact to your business and benefits strategy, and complying with these requirements requires continued analysis. A comprehensive strategic analysis will include a review of all employer laws and responsibilities, including ACA, ERISA, and HIPAA.

Business Attribute	Compliance Impact	Consult Your Trusted Advisor To
Average more than 50 full-time and full-time equivalent employees in the preceding calendar year	Penalties may result for failure to offer affordable, minimum value coverage to full-time employees and their dependent children	Document the ACA applicable large employer (ALE) calculation for 2015 to determine employer responsibilities for 2016 for the Pay or Play mandate
Have less than 50 full-time equivalent employees that are part of Controlled or Affiliated Group	Failure to count employees accurately may result in tax penalties for each member of the controlled group	Partner with your tax advisor for determination of large employer status based on controlled group rules
Have or gain more variable hour employees	Inability to produce accurate records will result in significant administration and potential for penalties	Develop appropriate eligibility program, its corresponding recordkeeping and communications
"Applicable large employer" (ALE) or employer with a self-funded plan	Obligation to provide new annual IRS reports	Institute and document procedures and process to gather and track information for reporting
Employer sponsoring one or more benefit plans	Lack of plan documents create potential for employer liability	Finalize plan documents, making sure to incorporate any new employee classifications
Annual compliance requirements under ACA, ERISA, and HIPAA	Failure to comply with employer responsibilities may result in fines, taxes, penalties, and increased administrative costs	Complete a compliance assessment to itemize all obligations and set compliance schedule

2016 Employer 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 and 2015, including health plan design changes, increased wellness program incentives and the employer shared responsibility penalties.

Additional reforms take effect in 2016 for employers sponsoring group health plans. To prepare for 2016, employers should use this health care reform compliance checklist to review upcoming requirements and develop a compliance strategy.

Checklist	ACA Provision	Compliance Action Items	Applies To	Effective Date
☐	Determine ALE Status for Employer Shared Responsibility ("Pay or Play")	• Calculate the number of full-time employees for all 12 calendar months of 2015. • Calculate the number of FTEs for all 12 calendar months of 2015 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 all 12 calendar months of 2015. • Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions. □ If your result is 50 or more, you are likely an ALE for 2016. □ 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 the 2015 calendar year, and the employees in excess of 50 who were employed during that time were seasonal workers, you do not qualify as an ALE for 2016.	• Employers who employed 50 or more full-time and full-time-equivalent (FTE) employees in the prior calendar year. • Certain ALEs with 50-99 FTEs, or with non-calendar year plans, that meet specific criteria are exempt from penalties for all or part of 2015 (and part of 2016, in some cases.)	Plan years on or after January 1, 2015

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☐	Health Benefits Plan Requirements	• Offer a group health plan with minimum essential coverage (MEC) • Satisfy the minimum value requirement • Be affordable to the employee	Applicable large employers (ALEs) offering health plans to employees	Plan years on or after January 1, 2015
☐	ACA – Determine Penalties (Employer Mandate)	• Offer health insurance coverage to at least 95% of full time employees and dependent children • Coverage meets the minimum value requirement of 60% • Coverage is affordable and employees must not have to pay more than 9.66% of their household income for the employer coverage	Applicable large employers (ALEs) offering health plans to employees	Plan years on or after January 1, 2016 <u>4980H(a) Penalty:</u> Not offering coverage $180.00/mo. ($2160) per FT EE (not counting first 30) if coverage not offered to 95% of FT EEs. <u>4980H(b) Penalty:</u> Not offering coverage that is affordable and provides minimum value coverage Employer pays $270/mo. ($3240) per FT EE receiving subsidized coverage if coverage is unaffordable (9.66% of EE household income) (minus up to 30).
☐	ACA – Measurement of Plan Affordability (Employer Mandate)	Plan affordability is calculated as the percentage of premium the employee pays for the employee-only rate as compared to their compensation, i.e. W2, rate of pay, and Federal Poverty Level (FPL)	Applicable large employers offering health plans to employees	• 9.5% for 2014 plan years • 9.56% for 2015 plan years • 9.66% for 2016 plan years

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☐	Annual out-of-pocket limits	• Maximum for 2016 plan years = $6,850 for individual and $13,700 for family • Out-of-pocket limit must include all copays and deductibles • Each individual maximum cannot exceed the out-of- pocket amount for self-only coverage • No separate maximum for Rx copays even if plan has separate pharmacy service	• All self-funded plans • Fully-insured small group plans • Large group plans • Excludes grandfathered plans	Plan years on or after January 1, 2016
☐	ACA Health Plan Reporting - §6055	• Reporting of plan information and participant information • IRS Forms 1094-B & 1095-B for insurance carriers and small employers (non-ALE) with self-funded plans • Employers who are ALEs may use IRS Forms 1094-C and 1095-C	Insurance providers, government agencies, multiemployer plans, and employers that are not applicable large employers (ALEs) and who sponsor self-insured plans	Due to IRS on or before: • Paper filing – May 31, 2016 • Electronic filing - June 30, 2016
☐	ACA Health Plan Reporting - §6056	• Reporting of employer sponsor information, employer offer of coverage, and compliance with employer mandate, i.e. minimum value and affordability • IRS Forms 1094-C and 1095-C	ACA applicable large employers (ALEs)	Due to IRS on or before: • Paper filing – May 31, 2016 • Electronic filing - June 30, 2016
☐	ACA – Employee Statements	• Statement confirming offer of coverage, type of coverage, months coverage was offered, and enrollment status • IRS Forms 1095-B and 1095-C	Must be sent to all employees	Due to IRS on or before March 31, 2016

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☐	Cafeteria Plan Elections	May allow cafeteria plan election changes for employees who(se): o Hours are reduced to less than 30 o Desire to enroll or actually enroll in other minimum essential coverage (MEC) o Are eligible for Marketplace coverage during annual open enrollment or a special enrollment period	• Reduction in hours – applies even if there is no loss of coverage • New MEC plan – coverage must be effective no later than the 1st of the second month following revocation • Marketplace – coverage must be effective no later than the 1st day after the group plan terminates	Plan documents must be amended prior to December 31, 2016
☐	Flexible Spending Accounts	• New cap is $2,550 for 2016 • Resolve any FSA overpayments • Review carryover provisions with offer of HSA plan	• Must amend cafeteria plan • Not eligible for HSA if carryover FSA in play unless opt-out or limited purpose	• Plan amendment and overpayments by 12/31/15 • Beginning January 1, 2016
☐	Grandfathered plan status	Provide annual notice to all employees if plan is, or ceases to be grandfathered	Employers with grandfathered plans	At open enrollment
☐	Health Plan Identifier	Must apply through CMS for unique plan identifier for conducting standardized transactions	All self-insured plans	*Delayed until further notice*
☐	Individual Premium Reimbursement	Employers cannot reimburse employees for the premium cost of individual insurance coverage	Prohibition on all pre-tax and post-tax reimbursements	Plan years on or after January 1, 2014

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☐	Marketplace notification	Indicates existence of Marketplace, eligibility for subsidies and contact information	All group health plans, including grandfathered plans	Must provide to all new hires within 14 days of hire date
☐	Patient Centered Outcomes/ Comparative Effectiveness Fees (PCORI)	Fee per each covered life for plan years ending: o 1/1/15-9/30/15 = $2.08 o 10/1/15-12/31/15 =$2.17 o Report on IRS Form 720	• Insurers and plan sponsors of self-insured plans • Play years ending on or after 10/1/12 and before 10/1/19	Due by July 31, 2016
☐	Summary of Benefits and Coverage (SBC)	Provide at first day of open enrollment, on first day of plan year (if no open enrollment) or at time of application	All group health plans, including grandfathered plans	Enrollment or plan years on or after September 23, 2012
☐	Summary Plan Description (SPD)	Update SPD with any new plan changes and provide to each participant (beneficiaries on request)	All employers with ERISA plans	Within 120 days of plan effective date
☐	Transitional Reinsurance Fees	• Fees collected for 2014-2016 • 2015 fee (payable in 2016) = $44 per plan member	Applies to health insurance issuers and self-funded plan administrators	• 1st installment of $33.00 or full $44 due 1/15/16 • 2nd installment of $11.00 due November 2016
☐	Waiting Periods	• Maximum waiting period of 90 calendar days • Can have bona fide orientation period of one month prior to start of 90-day waiting period	All group health plans, including grandfathered plans	Plan years on or after January 1, 2014
☐	W-2 reporting	Report aggregate cost of employer-sponsored group health benefits (employer + employee contributions)	Employers filing 250 or more W-2s in the preceding year	• First applicability - 2012 • Due January 31, 2016 for Form W-2s issued for the 2015 tax year

Employee Notices Checklist

There are a number of Notices and documents which must be distributed by the employer to employees in order to be in compliance with the ACA and ERISA. Most must be distributed to newly hired employees, at Open Enrollment, Special Enrollment, or upon request. Review the checklist on the following pages.

Notice or Action Item	Details	Applies To	Provided by / Provided to	Delivered by Date (Timing)
Notice of Grandfathered (GF) Status	Examples of actions that will cause loss of GF status include: any increase in employee co-insurance rate, Decrease in ER contribution rate by > 5 percentage points below rate on 3/23/10. A Model Notice is available from the DOL.	Group health plans that have been grandfathered or will lose grandfather status.	Employer to all participants: The disclosure must state that the plan is grandfathered and must provide contact information for questions and complaints, OR if losing grandfathered status, amend your plan to comply with requirements on non-grandfathered plans and comply in operation. Can use Model Notice issued by DOL.	At Open Enrollment or new eligibility. Notice can be included in the SPD. Any required amendments should be made prior to beginning of plan year (but plan must comply even if not yet formally amended.)
Notice of Coverage Options (Exchange Notice)	Tells employees that Health Insurance Exchanges / Marketplaces became operative in 2014; that employees might be eligible for federal subsidies; info about employer coverage, if available.	All plans	Employers: Provide Notice to all employees (full-time & part-time, whether eligible for coverage or not) • model notice for employers who offer a health plan to some or all employees, • model notice for employers who do not offer a health plan	At time of hire. Can include (as a separate notice) with open enrollment materials. Also must give to non-eligible employees.
HIPAA Notice of Special Enrollment Rights	Tells all eligible employees what circumstances give rise to special mid-year enrollment rights (even if they do not enroll). A model notice is available from the DOL (see “page 138”).	All plans	Plan Administrator (Sponsor), can be delegated to Carrier: Send or give to eligible employees.	• Initial Eligibility • Each Open Enrollment Also must be in SPD

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Notice or Action Item	Details	Applies To	Provided by/ Provided to	Delivered by Date (Timing)
Summary Plan Description (SPD)	Tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits become vested, when and in what form benefits are paid, and how to file a claim for benefits. Model notice unavailable.	All plans	Employers: Provide to all plan participants automatically when becoming a participant of an ERISA-covered retirement or health benefit plan or to beneficiaries receiving benefits under such a plan.	• Within 90 days after they become covered, whether they request it or not. • Plan administrators of a new plan must distribute an SPD within 120 days after the plan is established. • An updated SPD must be furnished to all covered participants every 5 years, and every 10 years even if the SPD has not changed. • Must be delivered within 30 days if requested by participant.
Uniform Summary of Benefits & Coverage (SBC) & Glossary of Terms	Summary of covered benefits, and it also provides examples of how plan will pay benefits in specific circumstances. Glossary is of common health plan terms.	All plans	Plan sponsor or carrier: Provides to all participants and eligible employees. Most carriers are preparing SBCs but requiring plan sponsors to provide them to participants. Self-insured plans: TPA or employer must prepare. Can use Model Notices issued by the DOL. May be distributed electronically if certain requirements are met (see Q&A10 at http://www.dol.gov/ebsa/pdf/faq-aca8.pdf).	• With Open Enrollment materials; • Also at initial enrollment; • Within 7 business days after requested; • Within 90 days after HIPAA special enrollment; • At least 60 days prior to the effective date of any mid-year material change to benefits/coverage; • If auto re-enrollment, at least 30 days before 1st of Plan Year
Women's Health and Cancer Rights Act	Informs participants about benefits covering mastectomies and related services and how to get detailed information on available benefits.	All plans	Plan Administrator (can be delegated to the carrier): Send to all plan participants.	• Annually & upon initial enrollment. • Usually sent at Open Enrollment.

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Notice or Action Item	Details	Applies To	Provided by / Provided to	Delivered by Date (Timing)
HIPAA Privacy Notice (Carrier's Notice, or self-insured Plan's Notice, or Employer's Notice for plan overall)	Tells plan participants about their HIPAA Privacy rights, the plan's Privacy obligations, and the contact information for the Privacy Official if a participant wants to file a complaint.	All plans	Insured plan: Carrier must send to all plan participants if employer does not get Protected Health Information (PHI). Self-funded plan: Employer or TPA must send to all plan participants	General distribution rules: • At initial enrollment; • If relevant information changes; • Upon request; • and every 3 years must notify of right to request new Notice
General Notice of COBRA Rights	Tells plan participants of their right to purchase a temporary extension of group health coverage when coverage is lost due to certain qualifying events, as well as other health coverage options that may be available (such as the Health Insurance Marketplace) A model notice is available from the DOL.	All group health plans sponsored by employers with than 20 or more employees	Plan Administrator (Sponsor), can be delegated to TPA: Send or give to covered employees and their spouses.	• Within 90 days after the date group health plan coverage commences • May include at annual Open Enrollment • May include in the SPD as long as SPD is given to employee and spouse within the time limit
CHIP Notice – Medicaid and Children's Health Insurance Program	Informs employees about possible state financial assistance for health insurance coverage. A model notice is available from the DOL.	All plans	Plan sponsor: Send to all eligible employees who reside in a state with CHIP financial assistance.	Annually, before beginning of plan year. Recommend to include with Open Enrollment materials; and upon initial eligibility.
Medicare Part D Creditable or Non-Creditable Coverage Notice	Indicates whether the plan's prescription drug coverage is creditable or non-creditable with Medicare prescription drug coverage. Model notices are available from CMS.	All plans	Plan sponsor: Only required to send to all Medicare-eligible participants (including COBRA participants and eligible dependents), but usually just sends to all participants.	Annually, must send before October 15 (regardless of plan year); If included with Open Enrollment materials before Oct 15, need not send again until next year.

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Notice or Action Item	Details	Applies To	Provided by / Provided to	Delivered by Date (Timing)
Newborns' and Mothers' Health Protection Act	Explains federal and state hospitalization time provisions for newborns and mothers.	All plans	Must be in SPD. Often sent by Plan Administrator or carrier: Send to all plan participants.	• Must include in SPD. • May want to send annually with Open Enrollment materials.
Wellness Program disclosures Applies only for certain types of Wellness Programs	Tells eligible individuals they can satisfy an alternate standard if they are medically unable to meet Wellness Program's standard that is related to a health factor. A model notice is available from the DOL (see "page 139").	Wellness programs with a reward or penalty that affects employee's cost for coverage under the GHP & requires achievement of performance standards.	Plan administrator: Send to all plan participants.	• Annually, at open enrollment; • And prior to or at offering of Wellness Program.
HIPAA/HITECH Breach Notice (if breach involved more than 500 individuals)	Notifies affected participants and Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI) during the prior 60 days.	Plans that had a breach of PHI during the past 60 days.	Plan sponsor: Must provide notice to Affected Plan participants (directly) and HHS (on HHS website.)	Without unreasonable delay & not more than 60 days after discovery of breach.
HIPAA/HITECH Breach Notice (if breach involved 500 or fewer individuals)	Notifies affected participants & Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI)	Plans that had a breach of PHI (During the past plan year for notice to HHS; During past 60 days for notice to participants.)	Plan sponsor: Must provide notice to Affected Plan participants (directly) and HHS (on HHS website).	Notice to HHS: Within 60 days after end of plan year. Notice to affected participants: without unreasonable delay & not more than 60 days after discovery of breach.
Self-certification of Religious Organization Status	Applies only to religious organizations that do not want to cover women's contraceptive services.	Religious employers and religiously-affiliated employers	Religious employer to insurers and/or TPA.	Must self-certify and provide copy to insurer or TPA prior to beginning of plan year. This is not an annual requirement.