Employers that offer health care coverage to employees are responsible for complying with many of the provisions of the Affordable Care Act (ACA). Most health reform changes apply regardless of the employer’s size, but some changes apply only to small employers and other changes apply only to large employers. Even employers that do not offer any coverage need to comply with certain requirements to distribute notices to workers or submit reports to federal agencies.

This edition of our Health Reform Checklist summarizes the following health reform provisions for small employers:

- Ongoing requirements for notices and reports
- Requirements starting in the 2014 Plan Year
- New requirements for January 1, 2015

**Starting with Basics**

The effective dates of most ACA provisions usually are based on the employer’s group health “plan year” starting date. Other items take effect on a specific calendar date. Further, whether or not a provision applies often depends on the employer’s size or on the type of group policy.

“Small Employer” generally means an organization (including subsidiaries) with fewer than 50 full-time-equivalent employees. “Small Group,” on the other hand, is an insurance term referring to group health policies that can only be marketed to small businesses. Group policies are subject to the state insurance laws of the state in which the policy is issued. Most state insurance laws at this time limit “small group” policies to groups under 50 employees at issuance (or under 100 employees at renewal), although there are exceptions. “Plan Year” is the period (usually a 12-month period) that is identified in the plan’s ERISA document or Form 5500. For non-ERISA plans, the plan year is benefit year or policy year.

**Ongoing Requirements for Notices and Reports**

- **Employer Notice about Health Insurance Exchanges (Marketplaces)** – Employers must provide a written notice to all full-time and part-time employees, whether or not benefits eligible, within 14 days of hire. The federal notice explains the availability of the Health Insurance Exchanges (Marketplaces) and the circumstances under which employees may be eligible for subsidies to buy coverage through an Exchange.
This requirement applies to all employers covered by the Fair Labor Standards Act (FLSA), including employers that do not offer health coverage.

Employers can satisfy the notice requirement by using one of the following DOL model notices, filling in the blank sections as needed, and distributing the completed notice to all employees within 14 days of hire:

- Employers who currently offer health insurance to any or all employees can use this notice: http://www.dol.gov/ebsa/FLSAwithplans.doc
- Employers who do not offer health insurance to any employees can use this notice: http://www.dol.gov/ebsa/FLSAwithoutplans.doc

Summary of Benefits and Coverage (SBC) – Health insurers, and employers with self-funded health plans, must provide an SBC for each plan describing its benefits and coverage using a standardized format. ACA regulations require that the SBC be provided in several instances (by the first day of open enrollment, by the first day of coverage if there are any changes, upon special enrollment events, upon request, and prior to off-renewal changes). The DOL provides samples and instructions at http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

Grandfathered Plan Notice – Employers with a grandfathered plan must review it to confirm that it still qualifies for grandfathered status. If so, materials describing the plan's benefits must include a notice regarding the plan’s status as a grandfathered plan. The notice must include contact information for questions or complaints. Note that plans that lose grandfathered status immediately become subject to the same health reform requirements as non-grandfathered plans.

Patient Protection Notice – Non-grandfathered health plans must include a notice regarding each participant's right to designate a primary care physician and to obtain obstetrical or gynecological care with prior authorization.

W-2 Reporting of Employee Health Coverage Cost – Employers must report the total cost of each employee’s health coverage on Form W-2 (box 12). This item is informational only and has no tax consequences. The requirement does not apply to employers that filed fewer than 250 Forms W-2 for the prior tax year.

Small Business Tax Credit (Optional) – Employers with fewer than 25 employees should check whether they qualify for the Small Business Tax Credit to help with the expense of offering health coverage to employees. Starting with tax year 2014, the credit is available only to small businesses choosing a certified “Small Business Health Options Program (SHOP)” plan. For information, see http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit:-Questions-and-Answers.
Requirements starting in the 2014 Plan Year

“Plan Year” is the period (usually a 12-month period) that is identified in the plan’s ERISA document or Form 5500. For non-ERISA plans, the plan year is benefit year or policy year. The following requirements take effect on the first day of the Plan Year beginning in 2014 unless otherwise noted:

- **Plan Exclusions for Pre-Existing Conditions** – Health plans are prohibited from imposing pre-existing condition exclusions on any enrollees.

- **No Waiting Periods longer than 90 days** – Employers that offer health coverage cannot impose a waiting period that exceeds 90 calendar days. The waiting period begins on the employee's eligibility date, such as a full-time employee’s hire date, and ends on the day before coverage starts. If the employer imposes an orientation period (i.e., a probationary period of up to one month for orientation or training), the waiting period begins upon completion of the orientation period.

- **Coverage for Clinical Trials** – Non-grandfathered health plans cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases and cannot deny coverage for routine care that would otherwise be provided just because an individual is enrolled in a clinical trial.

- **Employee Contributions to Health Flexible Spending Accounts (FSA)** – Employee salary reduction contributions to health FSAs are subject to an IRS limit for each 12-month plan year:
  - Plan year beginning in 2014: $2,500
  - Plan year beginning in 2015: $2,550
  - Subsequent plans years: TBD based on inflation

- **Wellness Program Incentives** – Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward (for example, not smoking or meeting exercise targets). The maximum permissible reward is 30% of the coverage cost (or 50% of the coverage cost for wellness programs designed to prevent or reduce tobacco use).

- **Fees on Health Plans** – The ACA imposes certain fees on health plans in order to raise revenue for various purposes, including clinical research, stabilization of high-risk insurance markets, and expansion of health coverage. Some fees apply for a few years, while others are permanent. For insured plans, the carrier or HMO is responsible for reporting and paying any applicable fees. For self-funded (uninsured) plans, however, the employer sponsor is responsible for reporting and paying the first two fees explained below:
The Patient-Centered Outcomes Research Institute (PCORI) Fee, also called the Comparative Effectiveness Research (CER) Fee, is imposed on group health plans to help fund studies on clinical effectiveness and health outcomes. The small fee is an annual amount multiplied by the average number of plan participants:

- Plan year ending between 10/1/2013 and 9/30/2014: $2.00
- Plan year ending between 10/1/2014 and 9/30/2015: $2.08
- Plan year ending between 10/1/2015 and 9/30/2019: TBD based on inflation

Payment is due July 31 following the calendar year in which the plan year ended (e.g., July 31, 2015 for plan years ending in 2014) using Form 720.

The Transitional Reinsurance Program Contribution (Fee) is collected from group medical plans for calendar years 2014 to 2016 to help fund state reinsurance programs in the individual insurance market. The fee is an annual amount multiplied by the average number of plan participants:

- Calendar year 2014: $63
- Calendar year 2015: $44
- Calendar year 2016: $27 (proposed)

Enrollment count reports are due November 15 (extended to December 5 for calendar year 2014) and payment is due in installments the following year.

The Health Insurer Provider (HIP) Fee is collected from health insurance providers and HMOs (carriers) based on a percentage of the carrier’s net written premiums for insured groups. The fee begins in 2014 and is permanent. It is expected to impact premiums by approximately 2.3% (first year estimate). The HIP fee does not apply to self-funded plans.

A Risk Adjustment Fee of about $1 per member per year is assessed on carriers issuing risk-adjusted plans in the non-grandfathered “small group” insurance markets, whether in or out of the Exchanges. The fee begins in 2014 and it is permanent. It is intended to help fund the administrative costs of running the Risk Adjustment Program. This fee does not apply to large group plans or self-funded plans.

NOTE: The following requirements also apply starting with the plan year beginning in 2014. If permitted under state insurance law, however certain pre-2014 “small group” policies may be renewed after 2014 without adopting one or more of provisions indicated below by an asterisk (*). For details about your state’s insurance law and available options, consult an insurance agent or broker licensed in that state.
Essential Health Benefits (EHB)* – All non-grandfathered “small group” health insurance plans must cover all Essential Health Benefits (EHBs). This requirement does not apply to grandfathered plans, self-funded plans, or insured plans in the large group market. Each state, through its state insurance code or laws, may establish a detailed definition of EHBs for purposes of “small group” policies issued in that state. The general EHB definition includes health care services in the following ten benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (services for individuals under 19 years of age)

Limits on Annual Out-of-Pocket Maximums* – All non-grandfathered health plans, including “small group,” large group and self-funded plans, are subject to limits on annual out-of-pocket maximums. All cost-sharing, such as copays, deductibles, and coinsurance, for Essential Health Benefits (EHBs) must accumulate to the plan’s out-of-pocket maximums up to the following limits:

<table>
<thead>
<tr>
<th>For Plan Year beginning in:</th>
<th>Self-Only Coverage</th>
<th>Coverage other than self-only</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$6,350</td>
<td>$12,700</td>
</tr>
<tr>
<td>2015</td>
<td>$6,600</td>
<td>$13,200</td>
</tr>
<tr>
<td>Future years</td>
<td>TBD based on inflation</td>
<td></td>
</tr>
</tbody>
</table>

For plan year 2014 only, there is a one-year safe harbor for certain plans that utilize more than one service provider to administer benefits (e.g., one claims payer for medical services and a separate pharmacy benefit manager (PBM) for outpatient prescription drugs).

Adjusted community rating (ACR)* – Health insurers may use only family size, geography, and age as rating factors for non-grandfathered “small group” plans. The impact of age factors is limited to a range of 3 to 1. Also, in certain states, tobacco users may have their premium varied by up to 50% higher than non-tobacco users.
New Requirements for January 1, 2015

Starting January 1, 2015, the ACA’s Employer Shared Responsibility provision takes effect. There are two parts:

- **Employer Reporting Requirement:** Under IRC §6056, employers must report information about health coverage offered to full-time employees. To comply with the reporting requirement, prepare and distribute Form 1095-C to the employee and file a copy with the IRS. For calendar year 2015, the first reports are due in early 2016.

- **Employer Coverage Offer:** (often called “the Employer Mandate” and “Play or Pay”): Employers may be assessed a penalty for failure to offer health coverage to full-time employees if at least one employee receives a government subsidy to buy individual coverage through an Exchange (Marketplace).

**Most Small Employers are Exempt!** Employers with fewer than 50 full-time-equivalent (FTE) employees in 2014 are exempt from both parts of the Employer Shared Responsibility provision for 2015. The employer should determine its FTE count for 2014 in order to confirm that the employer has no responsibilities for 2015. Related employers in a controlled group are counted together to determine the number of FTEs. Generally, each full-time employee (i.e., 120 hours of service or more per month) counts as one (1) FTE. Each part-time employee counts as a fraction of one FTE (i.e., divide the employee’s hours of service per month by 120). Employers with seasonal workers, usually in the agricultural or retail industries, may be able to take advantage of a special rule to subtract the seasonal workers from the employer’s FTE count.


1 In the unlikely event that the employer has a self-funded (uninsured) group medical plan, the small employer should consult with a tax advisor regarding reporting requirements under IRC §6055.