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AFFORDABLE CARE ACT TOOLKIT

LARGE EMPLOYERS

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Introduction

The health care reform law—the Affordable Care Act (ACA)—has many complex requirements for employers and health plans. Because many of the ACA's major provisions have now taken effect, it is more important than ever for employers to understand these rules.

This Affordable Care Act Toolkit is your one-stop guide for ACA concerns. It is designed to help you address ACA issues, topic-by-topic, step-by-step.

Each section of the toolkit focuses on a single subject and includes:

- An executive summary;
- An action checklist to help you take the appropriate actions to achieve compliance; and
- A list of supporting documents that Employers Select Insurance Services can provide, upon request.

As new regulations and guidance are released, the ACA Toolkit will continue to expand and be updated. Please contact Employers Select Insurance Services as new regulations are released to request an updated copy.

This ACA Toolkit is centered on large employers, and will take you through the ACA considerations for these employers.

What is a large employer?

The ACA doesn't have a consistent answer for that. An employer might be considered "large" for one rule, but not another. For this ACA Toolkit, a large employer is one that has **50 or more employees**.

Most of the sections in this guide apply to employers of this size. However, certain provisions apply only to even larger employers (such as those with 200 or more employees). Certain sections of this Toolkit briefly describe some rules that apply to these larger employers. Those sections can help you understand which ACA provisions apply to your company now, and which ones may apply in the future if your business grows.

Plan Design and Coverage Issues: 2014 and Beyond

The provisions in this section took effect in 2014. Some of these issues have been addressed in agency guidance; others are still awaiting more information. As developments on these topics occur, additional content will be provided.

Annual Limits

Who is Covered?	When?
Health plans	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, health plans may not place annual dollar limits on essential health benefits (EHBs). However, plans may impose annual limits on specific covered benefits that are not EHBs. "Restricted annual limits" were permitted for EHBs for plan years beginning before Jan. 1, 2014. **However, restricted annual limits are no longer allowed**.

EHBs are a core set of items and services intended to reflect the scope of benefits covered by a typical employer. Each state selects a benchmark insurance plan and, as a general rule, the items and services included in a state's benchmark plan comprise the EHBs that insured health plans in the state's individual and small group markets must cover.

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered plans in the individual and small group markets are required to cover EHBs. The requirement to cover EHBs does not apply to grandfathered plans, self-insured group health plans and health plans offered in the large group market. To determine which benefits are EHBs for purposes of removing annual limits, a self-insured group health plan, large group market health plan or grandfathered plan may choose any benchmark plan from any state that was approved by HHS. Also, self-insured group health plans, large group market health plans and grandfathered plans can still exclude all benefits for a condition without being considered an annual limit, as long as no benefits are provided for the condition.

Action Items:

☐ Ensure that no annual limit is imposed on EHBs.

☐ For a non-GF plan in the individual or small group market, use the state's benchmark plan to determine which benefits are EHBs. For a self-insured group health plan, large group market health plan or GF plan, choose a benchmark plan from any state that was approved by HHS to determine which benefits are EHBs.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Lifetime and Annual Limits
- Health Care Reform: Application of Annual Limit Restrictions to HRAs

Limit on Cost-sharing (Non-GF Plans Only)

Who is Covered?	When?
Out-of-pocket maximum—all non-GF health plans and issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans are subject to limits on total enrollee cost-sharing for essential health benefits (EHBs), known as an out-of-pocket maximum.

- For 2016, out-of-pocket expenses may not exceed **$6,850 for self-only coverage** and **$13,700 for family coverage**.
- For 2017, out-of-pocket expenses may not exceed **$7,150 for self-only coverage** and **$14,300 for family coverage**.

Beginning with the 2016 plan year, HHS clarified that the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. Thus, HHS' guidance effectively embeds an individual out-of-pocket maximum in group health coverage with a family deductible that exceeds the ACA's out-of-pocket maximum for self-only coverage.

For the first plan year beginning on or after Jan. 1, 2014, special transition relief was available for plans that use more than one service provider to administer benefits. Under this transition relief, where a group health plan or group health insurance issuer uses more than one service provider to administer benefits that are subject to the out-of-pocket maximum, the annual limit will be satisfied if:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), this maximum does not exceed the ACA's out-of-pocket maximum.

For plan years beginning on or after Jan. 1, 2015, non-grandfathered group health plans and group health insurance coverage are required to have an out-of-pocket maximum which limits overall out-of-pocket costs on all EHBs. Because the cost-sharing limit applies only to EHBs, plans are not required to apply the annual limitation to benefits that are not EHBs.

Action Item:

☐ Be aware that non-GF plans have limitations on out-of-pocket expenses.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Cost-Sharing Limits for Health Plans

Excessive Waiting Periods

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Currently effective

A group health plan or issuer may not impose a waiting period that exceeds 90 days. A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll becomes effective.

Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. However, other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit. Permissible eligibility conditions include:

- Being in an eligible job classification;
- Achieving job-related licensure requirements specified in the plan's terms; or
- Satisfying a reasonable and bona fide employment-based orientation period.

A special rule applies if a group health plan conditions eligibility on an employee regularly working a specified number of hours per pay period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time).

In this type of situation, the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition. This may include a measurement period consistent with the employer shared responsibility rules (even if the employer is not an applicable large employer). The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with the 90-day waiting period limit if coverage is effective no later than 13 months from the employee's start date, except where a waiting period that exceeds 90 days is imposed after the measurement period. If an employee's start date is not the first of the month, the time period can also include the time remaining until the first day of the next calendar month.

Action Items:

☐ Review whether your plans impose a waiting period for participation.

☐ If a waiting period is imposed, ensure that it does not exceed 90 days.

☐ If it is unclear that a new employee will work the required number of hours, set a measurement period to determine whether the hours requirement will be met in the future.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: 90-day Waiting Period Limit
- Health Care Reform: 90-day Waiting Period Limit—Permitted Orientation Periods

Pre-existing Condition Exclusions

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age. Prior to the 2014 plan year, pre-existing condition exclusions were already prohibited for individuals under age 19. A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the individual's date of enrollment in the employer's plan.

Action Item:

☐ Ensure that no pre-existing condition exclusion is imposed on any individual.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Pre-existing Condition Exclusions

Coverage for Clinical Trial Participants (Non-GF Plans Only)

Who is Covered?	When?
Group Health plans—insured and self-funded Health insurance issuers	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans and insurance policies may not:

- Terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases; or
- Deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Action Item:

☐ Ensure that plan terms and operations do not discriminate against participants who participate in clinical trials.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Coverage for Clinical Trial Participants

Health FSAs, HRAs and Cafeteria Plans

Who is Covered?	When?
Health flexible spending accounts (health FSAs) Health reimbursement arrangements (HRAs) Cafeteria plans	Currently effective

For plan years beginning in 2014, the availability of health FSAs and HRAs is limited, although the IRS has relaxed the "use-or-lose" rule for health FSAs. The IRS also provided a special mid-year election change rule for cafeteria plans with non-calendar year plan years. For these plans to meet all ACA requirements:

- Health FSAs must qualify as "excepted benefits" to be permissible. Health FSAs qualify as excepted benefits if they satisfy availability and maximum benefit requirements.
- HRAs must be integrated with other group health coverage to be permissible. The IRS and DOL have provided two ways for an HRA to be considered integrated with another group health plan. Stand-alone HRAs (other than retiree-only HRAs and limited-scope vision or dental HRAs) are prohibited.

Under the relaxed "use-or-lose" rule for health FSAs, employers may allow participants to carry over up to $500 in unused funds into the next year. This relaxed "use-or-lose" rule only applies if a plan does not also incorporate an extended deadline—or grace period—after the end of the plan year to use health FSA funds.

Also, the IRS allows cafeteria plans to permit mid-year election changes in certain situations related to the availability of Exchange coverage. A cafeteria plan may allow an employee to prospectively revoke his or her election for coverage under the employer's group health plan during a period of coverage (as long as the plan provides minimum essential coverage and is not a health FSA) in the following situations:

- The employee's hours of service are reduced so that the employee is expected to average less than 30 hours per week, but the reduction does not affect eligibility for coverage under the employer's group health plan; or
- The employee would like to cease coverage under the employer's group health plan and purchase coverage through an Exchange, without having a period of either duplicate coverage or no coverage.

Certain conditions must be met for the change to be permitted. Also, an election to revoke coverage on a retroactive basis is not allowed.

Action Items:

☐ Ensure that your health FSA or HRA is designed to comply with the ACA.

☐ If you have a health FSA, consider amending the plan to allow for carryovers.

☐ If you have a cafeteria plan, consider amending the plan for the mid-year election change rules. Cafeteria plans can be amended retroactively to implement these rules, if the retroactive amendment is made on or before the last day of the plan year and is communicated to participants.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Impact of the ACA's Market Reforms on Health FSAs
- Health Care Reform: Impact of the ACA's Market Reforms on HRAs
- Health FSA Carryovers
- Health Care Reform: Pay or Play Penalty—Cafeteria Plan Elections

Nondiscrimination for Fully-Insured Plans (Non-GF Plans Only)

Who is Covered?	When?
Non-GF insured group health plans	When regulations are issued and applicable

Non-grandfathered fully-insured group health plans will have to comply with federal nondiscrimination rules related to compensation, which prohibit discrimination in favor of highly-compensated employees. Under the ACA, these plans will have to follow rules similar to the nondiscrimination rules currently applicable to self-funded plans (found in Internal Revenue Code Section 105(h)), which require plans to pass both an eligibility test and a nondiscrimination test.

Because these rules will apply only to non-grandfathered plans, grandfathered plans that discriminate in favor of highly compensated employees may wish to retain their grandfathered status.

Compliance with the new nondiscrimination rules will not be required until after guidance is issued. **Therefore, this nondiscrimination requirement has been delayed indefinitely, pending the issuance of regulations**.

Action Items:

☐ Identify whether your organization's plans are GF or non-GF.

☐ Monitor IRS guidance for further rules on nondiscrimination requirements.

☐ For GF plans, consider maintaining GF status if the current plan design is potentially discriminatory.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Nondiscrimination Rules for Fully-Insured Group Health Plans

Employer Shared Responsibility Rules

Who is Covered?	When?
Applicable Large Employers (ALEs)—employers with, on average, 50 or more full-time and full-time equivalent (FTE) employees in the prior calendar year	**2015** for ALEs with **100 or more** full-time (and FTE) employees **2016** for ALEs with **50-99** full-time (and FTE) employees

Applicable large employers (ALEs)—those with, on average, 50 or more full-time (and FTE) employees during the prior calendar year—that do not offer affordable, minimum value health coverage to their full-time employees (and their dependent children) will be subject to penalties if any full-time employee receives a subsidy for health coverage through an Exchange. These employer penalties are known as the "employer shared responsibility" or "pay or play" rules.

Delayed Effective Date

The employer shared responsibility rules and related reporting requirements were delayed for one year, until 2015. In addition, medium-sized ALEs (those with fewer than 100 full-time and FTE employees in 2014) generally had an additional year, until 2016, to comply with the employer shared responsibility rules, if they satisfied specific criteria to qualify for this delay.

Determining Employer Size (ALE Status)

The employer's size for purposes of the employer shared responsibility rules is based on the average employee count over the prior calendar year. Part-time employees are included in the calculation according to a formula, but do not have to be offered coverage. Special rules apply for counting certain types of employees, including seasonal, volunteer and foreign employees. Companies with common ownership may have to be combined for purposes of this rule.

Penalty Amount

An ALE will be subject to an employer shared responsibility penalty only if one or more full-time employees obtain a subsidy through an Exchange.

The penalty amount for ALEs that do not offer health coverage to substantially all full-time employees (and dependents) is **$2,000 annually for each full-time employee**, excluding the first 30 employees. For 2015 (and any months in 2016 that fall within the ALE's 2015 plan year), an ALE with at least 100 full-time (and FTE) employees may exclude the first 80 full-time employees, instead of the first 30, under this calculation. An ALE will not be liable for this penalty for 2015 if it offers coverage to at least **70 percent** of its full-time employees. In 2016 and beyond, an ALE will not be liable for this penalty if it offers coverage to all but **5 percent** (or, if greater, five) of its full-time employees and dependents.

The penalty for ALEs that offer health coverage to substantially all full-time employees (and dependents), but do not offer coverage to all full-time employees, or offer coverage that is unaffordable or does not provide minimum value, is **$3,000 annually for each full-time employee receiving an Exchange**

subsidy, with a maximum annual fine of $2,000 per full-time employee, excluding the first 30 full-time employees (80 employees for 2015, for employers with 100 or more full-time and FTE employees).

These penalty amounts are adjusted annually for inflation, beginning after 2014. For 2015, the adjusted penalty amounts are **$2,080** and **$3,120**. For 2016, the adjusted penalty amounts are **$2,160** and **$3,240**. Adjustments for future years will be posted on www.IRS.gov.

Safe Harbor Guidance and Transition Relief

The IRS has provided guidance for ALEs on determining who is considered a full-time employee (and must be offered coverage), how penalties will apply when there is a waiting period for coverage, how to measure a plan's affordability and how to determine a plan's minimum value (including a calculator).

The final regulations also provide transition relief for 2015, many of which have now expired. Limited transition relief continues to apply under certain circumstances, and only for limited periods of time.

Action Items—Determine Employer Size:

☐ Count the number of employees according to the steps below to determine whether your organization is subject to the employer shared responsibility rules. Include all common law employees in the calculation, and count employees of all related companies according to the controlled group and affiliated service group rules in Code Section 414.

- Calculate the number of full-time employees (including seasonal employees) for each calendar month in the preceding calendar year. A full-time employee for a month is an employee who is employed, on average, at least 30 hours of service per week (or 130 hours per month).
- Calculate the number of FTE employees (including seasonal employees) for each calendar month in the preceding calendar year by adding up 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 up the number of full-time and FTE employees (including fractions) calculated above for each month in the preceding calendar year.
- Add up the 12 monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.

Action Items—Determine Whether Coverage Is Offered to Full-time Employees (and Dependents):

☐ To predict whether your organization will be subject to an employer shared responsibility penalty, determine whether your organization offers coverage to substantially all full-time employees (and dependents). Coverage need not be provided during a permissible waiting period.

- ☐ All common law employees that work an average of at least 30 hours per week (or 130 hours per calendar month) must be considered full-time.

- ☐ If your organization has variable hour or seasonal employees, where it is uncertain if they will work the requisite number of hours, establish a measurement period of 3-12 months to determine the average hours worked, in accordance with the separate rules for ongoing and new employees.

- ☐ If measurement periods are established for a group of employees, establish a stability period that is at least six months long, and is as long as the measurement period, for treating the employees as full-time or not, depending on the results of the measurement period. An administrative period of up to 90 days may be established as well.

Action Items—Determine Whether Coverage Is Affordable:

- ☐ To predict whether your organization will be subject to a penalty for not providing affordable coverage, assess the affordability of your organization's health coverage under one of the IRS's affordability safe harbors.

    - Under the Form W-2 safe harbor, determine if the employee portion of the lowest cost self-only premium does not exceed 9.5 percent (as adjusted) of the employee's W-2 wages.

    - Under the rate of pay safe harbor, determine if coverage is affordable based on an employee's rate of pay. The employee's monthly contribution amount for the lowest cost self-only premium is affordable if it is equal to or lower than 9.5 percent (as adjusted) of the computed monthly wages.

    - Under the federal poverty line (FPL) safe harbor, determine if coverage is affordable based on the FPL for a single individual in effect six months prior to the beginning of the plan year. Employer-provided coverage is affordable if the employee's contribution for the lowest cost self-only coverage does not exceed 9.5 percent (as adjusted) of the single FPL.

Action Items—Determine Whether Coverage Provides Minimum Value:

- ☐ Review whether the plan provides minimum value by covering at least 60 percent of the cost of benefits, using one of the four available methods.

    - Under the MV calculator approach, enter plan design data into the minimum value calculator to determine minimum value.

    - Under the safe harbor checklist approach, if the plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan will be treated as providing minimum value.

    - If neither the calculator nor the checklists can be used because a plan has nonstandard features, seek an actuary's certification that the plan provides minimum value.

    - In addition, any plan in the small group market that meets any of the "metal levels" of coverage provides minimum value.

☐ Ensure that the plan provides substantial coverage for in-patient hospitalization and physician services.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Pay or Play—Employer Shared Responsibility Penalties
- Health Care Reform: FAQs on the Employer Shared Responsibility Rules
- Health Care Reform: Employer Mandate Delayed Until 2016 for Medium-sized Employers
- Health Care Reform: Large Employers Subject to the Pay or Play Penalties
- Affordable Care Act—Are You an Applicable Large Employer?
- Pay or Play Penalty—Transition Relief Provisions
- Identifying Full-Time Employees Using the Look-Back Measurement Method
- Identifying Full-Time Employees Using the Monthly Measurement Method
- Health Care Reform: Pay or Play Penalty – When to Begin Tracking Employee Hours
- Health Care Reform: Pay or Play Penalty—The "Substantially All" Requirement
- Health Care Reform: Pay or Play Penalty—Common Ownership Aggregation Rules
- Health Care Reform: Pay or Play Penalty—Transition Relief for Non-calendar Year Plans
- Health Care Reform: Pay or Play Penalty—Affordability Safe Harbors
- Health Care Reform: Determining Minimum Value of Health Plan Coverage

Tools Available from Employers Select Insurance Services:

- Health Care Reform Pay or Play Calculator
- Health Care Reform Large Employer Calculator
- Health Care Reform Full-time Employee Tracker (Standard Edition and Expanded Edition)

Reporting of Health Coverage (Code Sections 6055 and 6056)

Who is Covered?	When?
Applicable large employers (those with 50 or more full-time and FTE employees in the prior year) Employers with self-insured health plans	First due in early 2016, related to 2015 coverage

The ACA created reporting requirements under Internal Revenue Code Sections 6055 and 6056. Under these rules, certain employers will be required to provide information to the IRS and to individuals about the health plan coverage they offer (or do not offer) to their employees.

These reporting requirements apply to:

- **Employers with self-insured health plans (Section 6055)**—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 must file information returns with the IRS reporting information for each individual who is provided with this coverage during the calendar year. Related statements must also be provided to covered individuals.
- **Applicable large employers (ALEs) (Section 6056)**—ALEs subject to the ACA's employer shared responsibility rules must file information returns with the IRS reporting the terms and conditions of the health coverage offered to the ALE's full-time employees for the calendar year. Related statements must also be provided to full-time employees.

The first returns were due in early 2016 for coverage offered or provided in 2015. Returns must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year following the calendar year to which the return relates. Individual statements must be provided on or before Jan. 31 of the year immediately following the calendar year to which the statements relate. However, for individual statements furnished in 2017 (related to 2016 coverage), the IRS delayed the furnishing deadline for 30 days, until March 2, 2017.

ALEs reporting under Section 6056 will use Forms 1094-C and 1095-C. In general, employers reporting under Section 6055 will use Forms 1094-B and 1095- B. However, ALEs that sponsor self-insured plans must report under both Section 6055 and Section 6056. These ALEs will use a combined reporting method on Forms 1094-C and 1095-C to report the information required under both Section 6055 and Section 6056.

Penalties generally apply for failures to file correct information returns or provide correct individual statements by the deadlines.

Action Items:

☐ Determine whether your organization is a sponsor of a self-insured health plan or an ALE.

☐ Track and record the information that must be reported for the calendar year under Section 6055 and/or Section 6056, as applicable.

☐ Provide required information regarding plan coverage and participation to the IRS and to individuals, in accordance with the reporting requirements.

Documents Available from Employers Select Insurance Services:

- HCR: Employer Reporting of Health Coverage—Code Sections 6055 & 6056
- Health Care Reform: Employer Reporting of Health Coverage—Code Section 6056
- Health Care Reform: Q&As on Employer Reporting of Health Coverage (Section 6056)
- Health Care Reform: Code Section 6056—What Information Must Be Reported?
- ACA Section 6056 Employer Reporting Guide
- Health Care Reform: Provider Reporting of Health Coverage—Code Section 6055
- Health Care Reform: Q&As on Reporting by Health Coverage Providers (Section 6055)
- Health Care Reform: Code Section 6055—What Information Must Be Reported?

Tools Available from Employers Select Insurance Services:

- Section 6056 Reporting Workbook
- Section 6055 Reporting Workbook

Additional Medicare Tax

Who is Covered?	When?
All employers	Currently effective

Effective Jan. 1, 2013, the Medicare Part A (hospital insurance) tax rate increased by 0.9 percent (from 1.45 percent to 2.35 percent) on wages over $200,000 for individual taxpayers, and $250,000 for married couples filing jointly.

An employer must withhold the additional Medicare tax on wages or compensation it pays to an employee in excess of $200,000 in a calendar year. An employer has this withholding obligation even though an employee may not be liable for the additional Medicare tax because, for example, the employee's wages or other compensation together with that of his or her spouse (when filing a joint return) does not exceed the $250,000 liability threshold.

Any withheld additional Medicare tax will be credited against the total tax liability shown on the individual's income tax return (Form 1040).

Action Items:

☐ Monitor employee wages to be aware of the date an employee reaches $200,000 in wages in a single year.

☐ Once an employee has earned $200,000, change the Medicare hospital insurance tax withholding rate to 2.35 percent.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: The Additional Medicare Tax

High Cost Plan Excise Tax (Cadillac Tax)

Who is Covered?	When?
Applicable employer-sponsored coverage	**Delayed to taxable years beginning in 2020**

A 40 percent excise tax (the "Cadillac tax") will be imposed on the excess benefit of high cost employer-sponsored health insurance. The annual limit for purposes of calculating the excess benefit is $10,200 for individuals and $27,500 for other than individual coverage. The amount of the tax for each employee's coverage will be calculated by the employer and paid by the coverage provider who provided the coverage. The "coverage provider" can be the insurer, the employer or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

Although originally intended to take effect in 2013, the Cadillac tax was immediately delayed until 2018 following the ACA's enactment. However, a federal budget bill for 2016 enacted on Dec. 18, 2015, **further delays implementation of this tax for an additional two years, until 2020**.

Action Item:

- Monitor ACA developments for additional guidance on the Cadillac tax.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Cadillac Tax on High-cost Health Coverage

Notice and Disclosure Requirements

Notice of Exchange

Who is Covered?	When?
Employers subject to the FLSA	Currently effective—provide to new hires at time of hiring

Employers must provide all new hires and current employees with a written notice about the ACA's health insurance exchanges (Exchanges). Employers were required to provide the notice to current employees no later than **Oct. 1, 2013**. As an ongoing requirement, employers must provide the notice to each new employee **at the time of hiring**.

In general, the notice must:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- Explain how employees may be eligible for a subsidy if the employer's plan does not meet certain requirements; and
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

The DOL also provided model Exchange notices for employers to use, which require some customization. The notice may be provided by first-class mail, or may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor are met.

According to the DOL, there is **no fine or penalty under the ACA for failing to provide the notice**. This means that employers cannot be fined for failing to provide employees with notice about the Exchanges.

Action Items:

☐ Customize the appropriate model Exchange notice.

☐ Confirm that the notice has been provided to all current employees.

☐ Prepare to provide the customized notice to all new employees when hired.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Exchange Notice Requirements for Employers
- Health Care Reform: Model Exchange Notice for Employers that Offer Health Plans
- Health Care Reform: Model Exchange Notice for Employers that Do Not Offer Health Plans

Summary of Benefits and Coverage

Who is Covered?	When?
Health insurance issuers Health plans—insured and self-funded	Currently effective—provide at various points after first effective date

Health plans (both insured and self-funded) must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries. The SBC is a succinct document that provides simple and consistent information about health plan benefits and coverage in plain language. For insured plans, issuers must provide an SBC to the plan sponsor and may also send the SBC to participants and beneficiaries on behalf of an insured health plan.

Plans and issuers were initially required to provide the SBC to participants and beneficiaries for plan years beginning on or after Sept. 23, 2012. In addition, ongoing requirements for providing the SBC also apply. For group health plans, there are two different scenarios under which the SBC must be provided: (1) by a group health insurance issuer to a group health plan; and (2) by the issuer or plan to participants and beneficiaries.

A health insurance issuer must provide an SBC to a group health plan (or the plan's sponsor):

- Upon application for health coverage;
- By the first day of coverage, if there was any change in information required to be in the SBC that was provided upon application and before the first day of coverage;
- When the issuer renews or reissues the policy; and
- Upon request.

A health insurance issuer or health plan must provide an SBC to participants and beneficiaries with respect to each benefit package for which the participant or beneficiary is eligible. The SBC must be provided:

- As part of any written application materials that are distributed by the plan or issuer for enrollment;
- If the plan or issuer does not distribute written application materials, no later than the first date that the participant is eligible to enroll in coverage;
- By the first day of coverage, if there was any change to information required to be in the SBC that was provided upon application and before the first day of coverage;
- To special enrollees, no later than the deadline for providing the summary plan description (SPD) (that is, within 90 days of enrollment);
- Upon renewal, if participants and beneficiaries must renew in order to maintain coverage; and

- Upon request (the uniform glossary must also be provided upon request).

The Departments provided an updated SBC template and related materials for use related to coverage provided after April 1, 2017. Plans with annual open enrollment periods must start using the new template on the first day of the first open enrollment period that begins on or after April 1, 2017, with respect to coverage for plan or policy years beginning on or after that date. Plans without an annual open enrollment period must start using the new template on the first day of the first plan or policy year that begins on or after April 1, 2017.

The Departments have stated that their approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. Therefore, until further guidance is issued, the Departments have said that they **will not impose penalties** on plans and issuers that are working diligently and in good faith to comply with the SBC requirement.

Action Items:

☐ Confirm that an SBC has been developed for each health plan that the company offers.

☐ Confirm that the SBC is being provided to participants and beneficiaries in accordance with the required deadlines.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage for the Second Year of Applicability and Beyond
- Health Care Reform: Template for Summary of Benefits and Coverage
- Health Care Reform: Instructions for Summary of Benefits and Coverage

60-Day Notice of Plan Changes

Who is Covered?	When?
Health insurance issuers Health plans—insured and self-funded	Currently effective—provide 60 days in advance of material modifications

A health plan or issuer must provide 60 days' advance notice of any material modifications to the plan that are not related to renewals of coverage. Specifically, the advance notice must be provided when a material modification is made that would affect the content of the SBC and the change is not already included in the most recently provided SBC.

A “material modification” is any change to a plan’s coverage that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage. A material modification may include an enhancement in covered benefits or services or other more generous plan or policy terms, a material reduction in covered services or benefits or more strict requirements for receiving benefits.

Notice can be provided in an updated SBC or a separate summary of material modifications. This 60-day notice requirement becomes effective when the SBC requirement goes into effect for a health plan.

Action Items:

☐ Analyze proposed plan changes that are not related to renewal to determine if they are material modifications to the plan.

☐ If the mid-year changes are material modifications, provide notice of the change using a new SBC or a summary of material modifications at least 60 days before the change is scheduled to be effective.

☐ For insured plans, determine whether the carrier will provide this notice.

Document Available from Employers Select Insurance Services:

- Health Care Reform: 60-Day Advance Notice of Plan Changes

Statement of Grandfathered Status (GF Plans Only)

Who is Covered?	When?
Grandfathered plan administrators and issuers	Currently effective—provide periodically with participant materials

Grandfathered (GF) plans are those that existed on March 23, 2010 and have not made certain prohibited changes. In order to retain GF status, these plans must provide a statement of GF status to participants. The first statement was required to be provided before the first plan year beginning on or after Sept. 23, 2010. The statement must continue to be provided on a periodic basis with participant materials describing plan benefits.

If certain prohibited changes are made to the plan, the plan will no longer be considered GF. A statement of GF status does not have to continue to be provided to plan participants if the plan loses GF status.

Action Items:

☐ Confirm whether the plan is GF or non-GF.

☐ If GF, include the model statement in participant plan materials.

☐ If the plan loses GF status, a statement does not have to be provided to plan participants. Confirm that the plan includes all of the additional patient rights

and benefits required by the ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Overview of Grandfathered Plans
- Health Care Reform: Grandfathered Plans—Permitted and Prohibited Changes
- Health Care Reform: Model Notice for Grandfathered Plans

Form W-2 Reporting

Who is Covered?	When?
Employers that had to file 250 or more Forms W-2 in the prior calendar year (see exceptions below)	Currently effective

Large employers are required to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. The reporting does not mean that the cost of the coverage is taxable to employees.

In general, all employers that provide applicable employer-sponsored coverage must comply with the Form W-2 reporting requirement. This includes government entities, churches and religious organizations, but does not include Indian tribal governments or tribally chartered corporations wholly owned by an Indian tribal government.

Employers that do not meet the definition of "large employer" for this section may be subject to this reporting in the future. The IRS has delayed the reporting requirement for these smaller employers by making it optional for these employers until further guidance is issued.

An employer is considered a small employer if it had to file fewer than 250 Forms W-2 for the prior calendar year. Thus, if an employer was required to file fewer than 250 Forms W-2 for 2013, the employer would not be subject to the reporting requirement for 2014. The IRS has indicated that the Internal Revenue Code's corporate aggregation (common ownership) rules do not apply for purposes of determining whether an employer filed fewer than 250 Forms W-2 for the prior year. However, if an employer files fewer than 250 Forms W-2 only because it uses an agent to file them, the employer does not qualify for the small employer exemption.

The coverage that must be reported is "applicable employer-sponsored coverage," which is group health plan coverage provided to an employee by the employer and which is excludable from the employee's gross income. The IRS has excluded certain types of coverage from the reporting requirement and has made reporting of other types optional.

The amount that must be reported is the aggregate cost of the coverage, including both the employer and employee portions of the cost. The cost must be determined on a calendar years basis. The IRS has identified a few different methods for calculating the cost, which are also used for calculating the cost of COBRA coverage.

Action Items:

- ☐ Determine whether your organization is subject to the requirement by reviewing the number of W-2 Forms filed for the prior tax year.
- ☐ If your organization is subject to the reporting requirement, identify the types of coverage provided that must be reported.
- ☐ Calculate the total cost of coverage (employer plus employee portions) under each plan.
- ☐ Determine the coverage that was provided to each employee over the course of the applicable tax year.
- ☐ Include the value amount of that coverage during the W-2 preparation process.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Form W-2 Reporting Requirements
- Health Care Reform: Types of Coverage Subject to Form W-2 Reporting
- Health Care Reform: IRS Q&As on Form W-2 Reporting

Notice of Rescission

Who is Covered?	When?
Group health plans Health insurance issuers	Currently effective—provide 30 days before any rescission

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant’s failure to pay required premiums or contributions for the coverage.

This prohibition applies to grandfathered and non-grandfathered health plans, whether in the group or individual market, and whether coverage is insured or self-funded. If a rescission is permitted, the plan administrator or issuer must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.

Action Items:

☐ Before terminating coverage for a participant, review whether the termination will have a retroactive effect.

☐ If yes, confirm that the retroactive termination is due to fraud, intentional misrepresentation or non-payment for coverage. Rescissions are not permitted based on an inadvertent misstatement or to correct a plan error (such as mistakenly covering an ineligible employee).

☐ Before terminating coverage retroactively, provide 30 days' advance notice to the affected participant.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Prohibition on Rescissions

Notice of Patient Protections and Selection of Providers (Non-GF Plans Only)

Who is Covered?	When?
Non-GF group health plans Issuers of non-GF plans	Currently effective—provide with SPD or similar description of benefits

Non-GF group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Non-GF group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

Plan administrators or issuers of these plans must provide a notice of patient protections/selection of providers whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. The first notice should have been provided no later than the first day of the plan year beginning on or after Sept. 23, 2010.

Action Items:

☐ Determine whether the plan is GF or non-GF.

☐ If non-GF, incorporate the Notice of Patient Protections into the SPD or benefits description.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Patient Protections
- Health Care Reform: Model Notice on Patient Protections

Wellness Programs

Who is Covered?	When?
Health-contingent wellness programs	Currently effective

Effective for plan years beginning on or after Jan. 1, 2014, employers may offer increased incentives to employees under health-contingent wellness programs. Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward. There are two types:

- **Activity-only wellness programs** require an individual to perform or complete an activity related to a health factor in order to obtain a reward (for example, walking, diet or exercise programs).
- **Outcome-based wellness programs** require an individual to attain or maintain a certain health outcome in order to obtain a reward (for example, not smoking, attaining certain results on biometric screenings or meeting exercise targets).

To protect consumers from unfair practices, health-contingent wellness programs are required to follow certain nondiscrimination standards, including a limit on the maximum reward that can be offered. The maximum reward is generally 30 percent of the cost of coverage. However, the maximum permissible reward may be up to 50 percent of the cost of health coverage for programs designed to prevent or reduce tobacco use.

The other common type of wellness programs, participatory wellness programs, does not require an individual to meet a standard related to a health factor in order to obtain a reward or does not offer a reward at all (such as a fitness center reimbursement program or a program that reimburses employees for the costs of smoking cessation programs, regardless of whether the employee quit smoking). There is no limit on financial rewards for participatory wellness programs.

Action Items:

☐ Review your organization's current wellness program offerings to determine whether they are health-contingent or participatory wellness programs.

☐ If the wellness program is health-contingent, consider whether to raise the reward and ensure that it complies with applicable nondiscrimination rules.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Implications for Workplace Wellness Programs
- HIPAA Wellness Program Nondiscrimination Rules
- Health Care Reform: Workplace Wellness Program Incentives

Patient-Centered Outcomes Research Institute (PCORI) Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Currently effective—will not apply for plan years ending on or after Oct. 1, 2019

Health insurance issuers and self-funded group health plans must pay fees to finance comparative effectiveness research. These research fees are called Patient-Centered Outcomes Research Institute fees (PCORI fees), although they may also be called research fees, PCOR fees or comparative effectiveness research (CER) fees. The fees apply for plan years ending on or after Oct. 1, 2012. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the research fees are effective for the 2012 through 2018 plan years. The PCORI fees are due by July 31 of the calendar year following the plan year to which the fee applies.

- For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee was $1 multiplied by the average number of lives covered under the plan.
- For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is $2 multiplied by the average number of lives covered under the plan.
- For plan years ending on or after Oct. 1, 2014, and before Oct. 1, 2015, the fee amount was adjusted to $2.08.
- For plan years ending on or after Oct. 1, 2015, and before Oct. 1, 2016, the fee amount was adjusted to $2.17.
- For plan years ending on or after Oct. 1, 2016, and before Oct. 1, 2017, the fee amount was adjusted to $2.26.

For plan years ending on or after Oct. 1, 2017, the PCORI fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

A health reimbursement arrangement (HRA) is not subject to a separate research fee if it is integrated with another self-insured plan providing major medical coverage, as long as the HRA and the plan are established and maintained by the same plan sponsor and have the same plan year. If an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor. The same analysis applies to health flexible spending accounts (FSAs) that do not qualify as excepted benefits.

Action Items:

☐ Review your organization's health coverage to determine the plan(s) subject to the research fees.

- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to your organization through a premium increase.
- ☐ If there is an HRA, determine whether it qualifies for the exception for multiple self-funded plans, or whether it is subject to the research fee.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Patient-Centered Outcomes Research Institute Fees (PCORI Fees)
- Health Care Reform: Coverage Subject to PCORI Fees
- Health Care Reform Fees—Special Rules for HRAs

Reinsurance Fees

Who is Covered?	When?
Health insurance issuers Self-funded health plans	Currently effective—three-year period from 2014 through 2016

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of health insurance exchange 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 HIPAA (such as stand-alone vision and dental coverage). Also, self-insured group health plans that do not use a third party administrator for their core administrative functions are exempt from the requirement to make reinsurance contributions for the 2015 and 2016 benefit years.

The reinsurance program's fees will be based on a national contribution rate, which HHS will announce annually. The reinsurance fee is calculated by multiplying the average number of covered lives by the national contribution rate. The annual contribution rate is: $5.25 per month ($63 per enrollee per year) for 2014; $3.67 per month ($44 per enrollee per year) for 2015; and $2.25 per month ($27 per enrollee per year) for 2016.

The reinsurance contributions will be collected by HHS in two installments—one at the beginning of the calendar year following the applicable benefit year, and one at the end of that calendar year. For example, the $27 per capita reinsurance contribution for 2016 will be collected in two installments: $21.60 in January 2017 and $5.40 in November 2017.

Action Items:

- ☐ Review your organization's health coverage to determine the plan(s) subject to the reinsurance fees.
- ☐ If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to your organization through a premium increase.
- ☐ If your organization is required to pay the fee for any self-funded plans, select a method for counting covered lives.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Reinsurance Fees
- Health Care Reform Fees—Special Rules for HRAs
- Health Care Reform: Reinsurance Fees—Examples of Counting Methods

Health Insurance Providers Fee

Who is Covered?	When?
Any entity that provides health insurance for any U.S. health risk	Sept. 30 of each calendar year, beginning in 2014 **One-year moratorium imposed for 2017**

Beginning in 2014, the ACA imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee, which is treated as an excise tax, is required to be paid by Sept. 30 of each calendar year.

The health insurance providers fee applies to all "covered entities," defined as entities that provide health insurance for any United States health risk. The fee will be assessed on health insurers' premium revenue with respect to health insurance above $25 million. The fee program specifically excludes self-insured employers.

The term "health insurance" does not include coverage for specific diseases, accident or disability only, hospital indemnity, long-term care or Medicare supplemental health insurance. However, limited dental and vision coverage are included for purposes of this fee.

The aggregate annual fee for all covered entities will be apportioned among the covered entities according to their respective market shares, as measured by net premiums written for health insurance. The aggregate annual fee for all covered entities is expected to be $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for 2017 and $14.3 billion for 2018. Beginning in 2019, the cost of the fee will increase based on the rate of premium growth.

Enacted Dec. 18, 2015, the 2016 federal budget suspends collection of the health insurance providers fee for the 2017 calendar year. **Thus, health insurance issuers are not required to pay these fees for 2017.**

Action Item:

☐ Watch for communications from the insurance carrier as to how this fee might impact costs for the plan.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Health Insurance Providers Fee

Contribution Limit for Health FSAs

Who is Covered?	When?
Health FSAs	Currently effective

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) through a cafeteria plan must be limited to $2,500 (as adjusted). The health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, the limit increased to $2,550 for taxable years beginning in 2015 and 2016. For taxable years beginning in 2017, the health FSA limit increased further, to $2,600. The health FSA limit will potentially be further increased for cost-of-living adjustments for later years.

Health FSA plan sponsors are free to impose an annual limit that is lower than the ACA limit for employees' health FSA contributions. Also, the 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 health FSA limit.

In addition, the IRS relaxed the "use-or-lose" rule for health FSAs. Under the relaxed rule, employers may allow participants to carry over up to $500 in unused funds into the next year. This modification applies only if the plan does not also incorporate the grace period rule. This carryover rule does not affect the limit on salary reduction contributions. This means the plan may permit the individual to elect up to $2,500 (as adjusted) in salary reductions in addition to the $500 that may be carried over.

Action Items:

- ☐ Determine whether the health FSA limits the amount of money an employee can set aside into the FSA on a pre-tax basis per plan year.
- ☐ If yes, ensure that the limit is at or below $2,550 for 2016, or $2,600 for 2017.
- ☐ If there is no limit or a limit above the permitted dollar amount for the year, establish a limit that does not exceed $2,550 for 2016, or $2,600 for 2017.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Changes to Health Accounts
- Health Care Reform: The Health FSA Limit
- Health FSA Limit Will Increase for 2017
- Health FSA Carryovers

Preventive Care Services (Non-GF Plans Only)

Who is Covered?	When?
Non-GF health plans	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, non-GF health plans must cover specific preventive care services without cost-sharing requirements. The covered preventive care services include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA (for plan years beginning on or after Aug. 1, 2012).

The complete list of recommended preventive services that must be covered can be found at www.HealthCare.gov/center/regulations/prevention.html.

Action Item:

☐ Confirm that non-GF health plans cover the recommended preventive services without imposing any cost-sharing (such as deductibles, copayments or coinsurance) for the services.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Preventive Care Coverage Guidelines
- Health Care Reform: Preventive Care Guidelines for Women
- Health Care Reform: Contraceptive Coverage Requirements for Religious Employers

Dependent Coverage Up to Age 26

Who is Covered?	When?
Group health plans and health insurance issuers that provide dependent coverage of children	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, group health plans and health insurance issuers that provide dependent coverage of children must make coverage available for adult children up to age 26, regardless of the child's student or marital status. There is no requirement to cover the child or spouse of a dependent child.

This requirement applies to GF and non-GF plans. However, prior to the 2014 plan year, GF plans were not required to cover adult children who were eligible for other employer-sponsored coverage, such as coverage through their own employer.

ACA also added a tax provision related to health insurance coverage for these adult children. Effective March 30, 2010, amounts spent on medical care for an eligible adult child can generally be excluded from taxable income. In addition, all states should now be in conformity with this federal tax law change.

Action Items:

- ☐ Confirm that the plan provides dependent coverage up to age 26 on a tax-free basis.
- ☐ If the plan is GF, confirm that it will make coverage available to adult children up to age 26 regardless of whether they are eligible for other employer-sponsored group health coverage, effective for the 2014 plan year and beyond.

Documents Available from Employers Select Insurance Services:

- Health Care Reform: Dependent Coverage Up to Age 26
- Tax-Free Health Coverage for Children Under Age 27

Patient Protections (Non-GF Plans Only)

Who is Covered?	When?
Non-GF group health plans Health insurance issuers of non-GF plans	Currently effective

The ACA imposes three new requirements on group health plans and health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and requirements relating to benefits for emergency services.

- Non-GF group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).
- Non-GF group health plans and health insurance issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.
- Non-GF group health plans and health insurance issuers that provide hospital emergency room benefits must provide those benefits without requiring prior authorization, and without regard to whether the provider is an in-network provider. Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates imposed for out-of-network emergency services, cannot exceed the cost-sharing requirements for in-network emergency services.

Action Items:

☐ If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician.

☐ Permit participants to obtain OB/GYN care without a pre-authorization or referral.

☐ Eliminate pre-authorization requirement for emergency services.

☐ Eliminate increased coinsurance or copayment requirements for out-of-network emergency services.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Patient Protections

Lifetime Limits

Who is Covered?	When?
Health plans Health insurance issuers	Currently effective

Effective for plan years beginning on or after Sept. 23, 2010, health plans and health insurance issuers are prohibited from imposing lifetime limits on the dollar value of essential health benefits.

Action Item:

☐ Confirm that the plan does not impose lifetime limits on essential health benefits.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Lifetime and Annual Limits

Rescissions

Who is Covered?	When?
Group health plans Health insurance issuers	Currently effective

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant’s failure to pay required premiums or contributions for the coverage.

This prohibition applies to GF and non-GF health plans, whether in the group or individual market, and whether coverage is insured or self-funded.

Action Item:

☐ Confirm that the plan does not rescind coverage except in the case of fraud or intentional misrepresentation of fact.

Document Available from Employers Select Insurance Services:

- Health Care Reform: Prohibition on Rescissions