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2013 Compliance Checklist

In light of the Supreme Court's June 28, 2012, decision to uphold the health care reform law, or Affordable Care Act (ACA), employers must continue to comply with ACA mandates that are currently in effect. Employers must also prepare to comply with the ACA changes that will go into effect in the future. To prepare for upcoming changes, employers need to be aware of the ACA mandates that will go into effect in 2013.

This Legislative Brief provides a compliance checklist for employers for 2013. Please contact Morris & Reynolds Insurance for assistance or if you have questions about changes that were required in previous years.

GRANDFATHERED PLAN STATUS

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

- ☐ If you **have a grandfathered plan**, determine whether it will maintain its grandfathered status for the 2013 plan year. Grandfathered plans are exempt from some of the health care reform requirements. A grandfathered plan's status will affect its compliance obligations from year-to-year.

- ☐ If you **move to a non-grandfathered plan**, confirm that the plan has all of the additional patient rights and benefits required by the ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.

ANNUAL LIMITS

Effective for plan years beginning on or after Jan. 1, 2014, health plans will be prohibited from placing annual limits on essential health benefits. Until then, however, restricted annual limits are permitted.

- ☐ Unless a health plan received an annual limit waiver, its annual limit on essential health benefits for the 2013 plan year cannot be less than **$2 million**. (This limit applies to plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014.)

SUMMARY OF BENEFITS AND COVERAGE

Health plans and health insurance issuers must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries. The SBC is a relatively short document that provides simple and consistent information about health plan benefits and coverage in plain language. A template for the SBC is available, along with instructions and examples, and a uniform glossary of terms.

Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period beginning with the **first open enrollment period that begins on or after Sept. 23, 2012**. The SBC also must be provided to participants and beneficiaries who enroll other than through an open enrollment period

(including individuals who are newly eligible for coverage and special enrollees) effective for **plan years beginning on or after Sept. 23, 2012**.

- ☐ If your plan has an open enrollment period beginning on or after Sept. 23, 2012, confirm that the SBC is included with the open enrollment package. For participants and beneficiaries who enroll outside of the open enrollment period, confirm that the SBC will be provided to these individuals beginning with the plan year starting on or after Sept. 23, 2012.
    - If you have a self-funded plan, the plan administrator is responsible for providing the SBC.
    - If you have an insured plan, both the plan and the issuer are obligated to provide the SBC, although this obligation is satisfied for both parties if either one provides the SBC. Thus, if you have an insured plan, you should work with your health insurance issuer to determine which entity will assume responsibility for providing the SBC. Please contact Morris & Reynolds Insurance for assistance.

60-DAY NOTICE OF PLAN CHANGES

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. 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.

PREVENTIVE CARE SERVICES FOR WOMEN

Effective for plan years beginning on or after **Aug. 1, 2012**, non-grandfathered health plans must cover specific preventive care services for women without cost-sharing requirements.

- ☐ The covered preventive care services for women include:
    - Well-woman visits;
    - Gestational diabetes screening;
    - Human papillomavirus (HPV) testing;
    - Sexually transmitted infection (STI) counseling;
    - Human immunodeficiency virus (HIV) screening and counseling;
    - FDA-approved contraception methods and contraceptive counseling;
    - Breastfeeding support, supplies and counseling; and
    - Domestic violence screening and counseling.
- ☐ Exceptions to the contraception coverage requirement apply to certain religious employers. The preventive care guidelines for women are available at: www.hrsa.gov/womensguidelines/.

$2,500 CONTRIBUTION LIMIT FOR HEALTH FSAS

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to **$2,500**. On Oct. 31, 2013, the IRS announced that the health FSA limit will remain unchanged at $2,500 for the taxable years beginning in 2014. However, the $2,500 limit is expected to be indexed for cost-of-living adjustments for later years.

- ☐ 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 $2,500 limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary

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reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

W-2 REPORTING

Beginning with the **2012 tax year**, employers that are required to issue 250 or more W-2 Forms must report the aggregate cost of **employer-sponsored group health coverage** on employees' W-2 Forms. The cost must be reported beginning with the 2012 W-2 Forms, which are issued in **January 2013**.

- ☐ The ACA's W-2 reporting requirement is optional for smaller employers until further guidance is issued. Also, the reporting is for informational purposes only; it does not affect the taxability of benefits.

RETIREE DRUG SUBSIDY

The Medicare Part D program includes a Retiree Drug Subsidy (RDS) to encourage employers to continue providing prescription drug coverage to Medicare-eligible retirees. The RDS is available to certain employers that sponsor group health plans covering retirees who are entitled to enroll in Medicare Part D but elect not to do so. Employers receive RDS payments tax-free. In addition, before 2013, employers receiving the RDS could take a tax deduction for their retiree prescription drug costs, unreduced for the subsidy amount.

- ☐ Beginning in 2013, employers receiving the RDS will no longer be permitted to take a tax deduction for the subsidy amount.

MEDICARE TAX INCREASES

Effective Jan. 1, 2013, the Medicare Part A (hospital insurance) tax rate increases by **0.9 percent** (from 1.45 percent to 2.35 percent) on wages over $200,000 for an individual taxpayers and $250,000 for married couples filing jointly. (The tax is also expanded to include a **3.8 percent tax** on unearned income in the case of individual taxpayers earning over $200,000 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).

EMPLOYEE NOTICE OF EXCHANGE

Employers will be required to provide all new hires and current employees with a written notice about the ACA's health insurance Exchanges (Exchanges). The ACA required employers to provide the Exchange notice by March 1, 2013, but the DOL delayed this deadline.

- ☐ On May 8, 2013, the DOL set a compliance deadline for providing the Exchange notices that matches up with the start of the first open enrollment period under the Exchanges, as follows:
  - ***Current Employees***—With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice no later than **Oct. 1, 2013**.
  - ***New Hires***—Employers must provide the notice to each new employee at the time of hiring beginning **Oct. 1, 2013**. For 2014, the DOL will consider a notice to be provided at the time of hiring if the notice is provided within **14 days** of an employee's start date.

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- ☐ 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 premium tax credit or a cost-sharing reduction 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 the employer contribution to employer-provided coverage may be excludable for federal income tax purposes.
- ☐ The DOL also provided **model Exchange notices** for employers to use, which will 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.

PCORI FEES

The ACA created the Patient-Centered Outcomes Research Institute (Institute) to help patients, clinicians, payers and the public make informed health decisions by advancing comparative effectiveness research. The Institute's research is to be funded, in part, by fees paid by health insurance issuers and sponsors of self-insured health plans. These research fees are called Patient-Centered Outcomes Research Institute fees (PCORI fees), although they may also be called PCOR fees or comparative effectiveness research (CER) fees.

- ☐ Self-funded plans and health insurance issuers must pay a **$1 per covered life** fee for comparative effectiveness research. Fees increase to $2 the next year and will be indexed for inflation after that.
- ☐ Fees are effective for **plan years ending on or after Oct. 1, 2012**. Full payment of the research fees will be due by July 31 of each year. It will generally cover plan years that end during the preceding calendar year. Thus, the first possible deadline for paying the CER fees is **July 31, 2013**.

HIPAA CERTIFICATION

Health plans must file a statement with the Department of Health and Human Services (HHS), certifying their compliance with HIPAA's electronic transaction standards and operating rules. Under the ACA, the first deadline for certifying compliance with certain HIPAA standards and rules is **Dec. 31, 2013**. On Dec. 31, 2013, HHS issued a proposed rule on the health plan certification requirement and the penalties for noncompliance. Under the proposed rule, the initial certification deadline is generally extended to **Dec. 31, 2015**.

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