Health Care Reform Toolkit

Small Employers

Updated: 4/2/14

Table of Contents

Introduction 3

Plan Design and Coverage Issues:
2014 and Beyond 4

Employer Obligations.. 12

Notice and Disclosure Requirements 17

Wellness Programs 24

Health Plan Fees.. 25

Plan Design and Coverage Issues:
Prior to 2014.. 28

This Toolkit is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. The contents of this document may be affected by future regulations and sub-regulatory guidance.

© 2012-2014 Zywave, Inc. All rights reserved.

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 take effect in 2014, it is more important than ever that employers understand these rules.

This Health Care Reform Toolkit is your one-stop guide for health care reform concerns. It is designed to help you address health care reform 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 Pacific Group can provide upon request.

As new regulations and guidance are released, the Health Care Reform Toolkit will continue to expand and be updated. Please contact Pacific Group as new regulations are released to request an updated copy.

This Health Care Reform Toolkit is centered on small employers, and will take you through the health care reform considerations for these employers.

What is a small employer?

The health care reform law doesn't have a consistent answer for that. An employer might be considered small for one rule but not another. For this Toolkit, a small employer is one that has **fewer than 50 employees**.

Most of the sections in this guide apply to these small employers. Certain sections of this Toolkit briefly describe some of the rules for large employers. Those sections can help you understand which health care reform 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 become effective in 2014. Some of these issues have been addressed in agency guidance; others are still awaiting more information. As developments related to these topics occur, additional content will be provided.

Annual Limits

Who is Covered?	When?
Health plans	Annual limits eliminated for plan years beginning on or after Jan. 1, 2014 Plans that have plan years beginning before Jan. 1, 2014, may apply restricted annual limits

Effective for plan years beginning on or after Jan. 1, 2014, health plans are prohibited from placing annual dollar limits on essential health benefits (EHBs). Although annual dollar limits are generally prohibited, “restricted annual limits” are permitted for EHBs for plan years beginning before Jan. 1, 2014.

Until then, however, restricted annual limits are permitted. Unless a health plan received an annual limit waiver, its annual limit on EHBs for the 2013 plan year must be at least $2 million (applies to plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014).

Action Items:

- ☐ Ensure that no annual limit will be imposed on essential health benefits for the 2014 plan year and beyond.
- ☐ For non-calendar year plans that may still impose restricted annual limits:
    - Determine whether the health plan imposes an annual limit on EHBs.
    - If yes, confirm that the annual limit is at least $2 million for the 2013 plan year.
    - If the annual limit for the 2013 plan year is less than $2 million, determine whether the plan has a valid waiver of the annual limit requirement.
    - If the plan has a valid waiver of the annual limit requirement, confirm that the required notice has been provided to plan participants.
    - If the annual limit is less than $2 million for the 2013 plan year and the plan does not have a valid waiver, the annual limit must be revised.

Documents Available from Pacific Group:

- Health Care Reform: Lifetime and Annual Limits
- Health Care Reform: Temporary Waiver Program for Annual Limits
- Health Care Reform: Application of Annual Limit Restrictions to HRAs
- Health Care Reform: Model Notice of Annual Limit Waiver

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

Who is Covered?	When?
Deductible limit (**repealed**)—non-GF plans and issuers in the small group market Out-of-pocket maximum—all non-GF health plans and issuers	Plan years beginning on or after Jan. 1, 2014 Transition relief may apply **Deductible limit was repealed April 1, 2014, effective as of the date the ACA was enacted (March 23, 2010)**

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered group health plans are subject to limits on cost-sharing or out-of-pocket costs.

- For 2014, out-of-pocket expenses may not exceed $6,350 for self-only coverage and $12,700 for family coverage. Deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage).
- For 2015, out-of-pocket expenses may not exceed $6,750 for self-only coverage and $13,500 for family coverage. Deductibles may not exceed $2,150 (single coverage) or $4,300 (family coverage).

On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014 (H.R. 4302), which **repeals the annual deductible limit under the ACA**. This repeal is effective as of the date that the ACA was enacted, back on March 23, 2010. Due to the actuarial value exception provided under the final rule, this repeal may not significantly impact small employers. However, it will give small employers with insured plans more flexibility to offer higher deductible health plans (which typically come with lower premiums).

The deductible requirement applied only to non-grandfathered plans in the insured small group market, while the out-of-pocket cost limit applies to all non-grandfathered health plans (including self-insured plans and plans and issuers in the large group market).

Final rules allowed a health plan's annual deductible to exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier—bronze, silver, gold or platinum) without exceeding the limit.

In addition, special transition relief for the out-of-pocket maximum is available for plans that use more than one service provider to administer benefits. Under this transition relief, only for the first plan year beginning on or after Jan. 1, 2014, where a group health plan or group health insurance issuer uses more than one service provider to administer benefits that are subject to the ACA's 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.

On Jan. 9, 2014, the Departments issued FAQs clarifying the out-of-pocket maximum limit following the first year of applicability. For plan years beginning on or after Jan. 1, 2015, these FAQs require non-grandfathered group health plans and group health insurance coverage to have an out-of-pocket maximum which limits overall out-of-pocket costs on all essential health benefits (EHBs). Because the cost-sharing limits apply only to EHB, plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not EHBs.

Action Items:

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

☐ Be aware that the annual deductible limit no longer applies.

Document Available from Pacific Group:

- 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	Plan years beginning on or after Jan. 1, 2014

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 in the plan becomes effective. Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. Other conditions for eligibility are allowed, if 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 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 new employee is reasonably expected to meet that condition. In this 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 that is consistent with the employer mandate (even if the employer is not a large employer).

The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with the ACA's 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.

With respect to individuals who are in a waiting period when this requirement becomes effective, the waiting period can no longer apply to the individual if it would exceed 90 days.

Action Items:

- ☐ Review whether your organization's plans contain a waiting period for participation.
- ☐ If the waiting period exceeds 90 days, amend the waiting period to 90 days or less for plan years beginning on or after Jan. 1, 2014.
- ☐ If it is unclear that a newly-hired 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 Pacific Group:

- Health Care Reform: 90-day Waiting Period Limit
- Final Regulations Released on the 90-day Waiting Period Limit

Pre-existing Condition Exclusions

Who is Covered?	When?
Group health plans—insured and self-funded Health insurance issuers	Plan years beginning on or after Jan. 1, 2014 For plan years beginning before Jan. 1, 2014, pre-existing condition exclusions cannot apply to individuals under age 19.

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. Pre-existing condition exclusions are already prohibited for individual's 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 Items:

- ☐ Review each plan to determine whether it imposes a pre-existing condition exclusion on any individual.
- ☐ If yes, amend the plan to delete the pre-existing condition exclusion for plan years beginning on or after Jan. 1, 2014.

Document Available from Pacific Group:

- Health Care Reform: Pre-existing Condition Exclusions

Comprehensive Benefits Coverage (Non-GF Plans Only)

Who is Covered?	When?
Non-GF insured group health plans Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

Beginning in 2014, health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance Exchanges. This requirement does not apply to grandfathered plans.

Action Item:

☐ Be aware that insured plans will have to offer the essential health benefits package, even if they are purchased outside of an Exchange.

Document Available from Pacific Group:

- Health Care Reform: Approach for Defining Essential Health Benefits

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

Who is Covered?	When?
Group Health plans—insured and self-funded Health insurance issuers	Plan years beginning on or after Jan. 1, 2014

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 Pacific Group:

- Health Care Reform: Coverage for Participants in Clinical Trials

Health FSAs, HRAs and Cafeteria Plans

Who is Covered?	When?
Health flexible spending accounts (health FSAs) Health reimbursement arrangements (HRAs) Cafeteria plans (with non-calendar year plan years)	Plan years beginning on or after Jan. 1, 2014 The new carryover provision for health FSAs is available beginning with the 2013 plan year. In addition, the permissible mid-year election change rule for cafeteria plans with non-calendar year plan years is effective for the 2013 plan year.

Effective for plan years beginning on or after Jan. 1, 2014, the availability of health FSAs and HRAs is limited, although the IRS has relaxed the "use-or-lose" rule for health FSAs. In addition, the IRS has provided a special mid-year election change rule for cafeteria plans with non-calendar year plan years.

Effective for 2014 plan years, in order 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 specific guidance on 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) will be prohibited in 2014.

Under the relaxed "use-or-lose" rule for health FSAs, beginning with the 2013 play year, employers may allow participants to carry over up to $500 in unused funds into the next year. However, the 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, because the individual mandate and coverage under the Exchanges became effective on Jan. 1, 2014, the IRS provided a transition rule for sponsors of cafeteria plans with non-calendar year plan years. Under this rule, an employer may amend its cafeteria plan to permit either (or both) of the following changes in salary reduction elections, which apply regardless of whether employees experience a change of status event:

- An employee who made a salary reduction election through his or her employer's cafeteria plan for health plan coverage with a non-calendar year plan year beginning in 2013 can prospectively revoke or change his or her election regarding the plan during that plan year.
- An employee who did not make a salary reduction election under his or her employer's cafeteria plan for health plan coverage with a deadline beginning in 2013 (before the applicable deadline under the cafeteria plan regulations)

can make a prospective salary reduction for coverage on or after the first day of the cafeteria plan's 2013 plan year.

Action Items:

- ☐ Ensure that your health FSA or HRA is designed to comply with the ACA's requirements for the 2014 plan year.
- ☐ If you have a health FSA, consider amending your plan to allow for the new carryover rule.
- ☐ If you have a non-calendar year cafeteria plan, consider amending your plan for the special mid-year election change rule for 2013. Cafeteria plans can be amended retroactively to implement this special rule. The retroactive amendment must be made by Dec. 31, 2014, and must be effective retroactively to the date of the first day of the cafeteria plan's 2013 plan year.

Documents Available from Pacific Group:

- Health Care Reform: Health FSAs—Changes for 2014
- Health Care Reform: Health Reimbursement Arrangements (HRAs)—Changes for 2014
- 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. These rules prohibit discrimination in favor of highly-compensated employees.

Under the ACA, these plans will have to follow rules similar to the nondiscrimination rules applicable to self-funded plans. These rules are found in Internal Revenue Code section 105(h) and require plans to pass both an eligibility test and a nondiscrimination test.

In December 2010, the IRS acknowledged that plans needed additional clarification to be able to comply with the new law. Compliance with the new nondiscrimination rules will not be required until after guidance is issued.

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

The IRS has still not issued regulations (or other administrative guidance) on the ACA's nondiscrimination requirement for non-grandfathered fully insured plans. Because the nondiscrimination requirement has been delayed indefinitely pending the issuance of regulations**, IRS officials have confirmed that the requirement will not be enforced during 2014.**

Action Items:

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

☐ Continue to monitor IRS guidance for further rules on nondiscrimination requirements.

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

Documents Available from Pacific Group:

- Health Care Reform: Nondiscrimination Rules for Fully-Insured Group Health Plans
- IRS Confirms Delay of Nondiscrimination Rules for Fully Insured Health Plans

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 Pacific Group:

- Health Care Reform: Final Rules on the Additional Medicare Tax
- Health Care Reform: Questions and Answers on Additional Medicare Tax

High Cost Plan Excise Tax (Cadillac Tax)

Who is Covered?	When?
Applicable employer-sponsored coverage	Taxable years beginning in 2018

A 40 percent excise tax (the "Cadillac tax") is to 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, employer or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

Action Item:

- Monitor health care reform developments for additional guidance on the Cadillac tax.

Document Available from Pacific Group:

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

Employer Reporting of Health Coverage (Code Sections 6055 and 6056)

Who is Covered?	When?
Employers with 50 or more employees (including full-time equivalent employees, or FTEs) Employers with self-insured health plans	**Delayed until 2015**

The ACA created new reporting requirements under Internal Revenue Code (Code) sections 6055 and 6056. Under these new reporting rules, certain employers will be required to provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees (such as information on the design and cost of their plans, as well as employees covered by the plan). Related statements must also be provided to employees.

These new reporting requirements apply to:

- **Employers with self-insured health plans (Code § 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 an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals.
- **Applicable large employers with at least 50 full-time employees, including FTEs (Code § 6056)**—Applicable large employers subject to the ACA's shared responsibility provisions must file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the calendar year. Related statements must also be provided to employees.

These reporting requirements were set to take effect in 2014. However, on July 2, 2013, the Treasury **delayed these requirements for one year, until 2015**. The first returns will be due in 2016 for coverage provided in 2015. However, short term relief from penalties is available in 2015 for reporting entities that make good faith efforts to comply with the information reporting requirements.

Final rules were released on the reporting requirements on March 5, 2014. In an effort to minimize burden and streamline the reporting process, the final rules allow reporting entities to use a single, combined form for reporting the information required under both section 6055 and 6056. Due to the one-year delay, the final rules apply for calendar years beginning after **Dec. 31, 2014**.

In preparation for the application of the employer mandate provisions beginning in 2015, the IRS is encouraging employers and other affected entities to **voluntarily comply for 2014** with the information reporting provisions and to maintain or expand health coverage in 2014.

Action Items

- ☐ Confirm that your organization has fewer than 50 full-time and FTE employees.
- ☐ If your organization is a sponsor of a self-insured health plan, when the reporting requirements become effective, provide required information regarding plan coverage and participation in accordance with information return requirements.

Documents Available from Pacific Group:

- HCR: Employer Reporting of Health Coverage—Code Sections 6055 & 6056
- Health Care Reform: Reporting Requirements for Employers and Health Plans
- One Year Delay of Employer Mandate Penalties and Reporting Requirements

Employer Penalties for Not Offering Required Coverage (Large Employers Only)

Who is Covered?	When?
Employers with 50 or more full-time employees (including full-time equivalent employees, or FTEs)	Starting in **2015** for employers with **100 or more** full-time employees (including FTEs) Starting in **2016** for employers with **50-99** full-time employees (including FTEs)

Applicable large employers—those with 50 or more full-time employees (including full-time equivalent employees, or FTEs) —that do not offer health coverage to their full-time employees (and dependents) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange.

The sections of the health care reform law that contain the employer penalty requirements are known as the "employer shared responsibility" provisions or "pay or play" rules.

Delayed Effective Date

The employer mandate provisions were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury announced that the employer mandate penalties and related reporting requirements will be **delayed for one year, until 2015**. Therefore, these payments will not apply for 2014.

On Feb. 10, 2014, the Treasury released final regulations implementing the ACA's shared responsibility provisions. The final regulations include transitional relief to help employers comply with the new requirements. Applicable large employers with 100 or more full-time employees (including FTEs) will be subject to the employer mandate rules starting in 2015. However, the final regulations

delay implementation for medium-sized employers that are covered by the employer mandate. **In general, applicable large employers with fewer than 100 full-time employees (including FTEs) will have an additional year, until 2016, to comply with the shared responsibility rules**. To qualify for this delay, medium-sized employers must satisfy specific criteria described in the final regulations.

Determining Employer Size

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

Penalty Amount

The penalty amount for not offering 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, instead of excluding the first 30 employees, an employer with at least 100 full-time employees may exclude the first 80 employees under this calculation. Under the final regulations, an employer 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 employer will not be liable for this penalty if it offers coverage to all but **five percent** (or, if greater, five) of its full-time employees and dependents.

Applicable large employers who offer health coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of $3,000 annually for each full-time employee receiving a tax credit, with a maximum annual fine of $2,000 per full-time employee, excluding the first 30 employees (80 employees for 2015 for employers with 100 or more full-time employees).

Action Items:

☐ Confirm that your organization has fewer than 50 full-time and FTE employees. (See the recommended documents below for information on how to calculate full-time and full-time equivalent employees).

☐ Continue to monitor employer size if employees are added to payroll.

Documents Available from Pacific Group:

- Final Employer Shared Responsibility Regulations Issued
- Employer Mandate Delayed Until 2016 for Medium-sized Employers
- Health Care Reform: Pay or Play—Employer Shared Responsibility Penalties
- Health Care Reform: Large Employers Subject to Pay or Play Penalty

Automatic Enrollment (Large Employers Only)

Who is Covered?	When?
Employers subject to the FLSA with more than 200 full-time employees	Unknown (after regulations issued and effective)

Large employers that are subject to the Fair Labor Standards Act (FLSA) will be required to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in a health benefits plan offered through the employer.

For purposes of this rule, a large employer is one that has more than 200 full-time employees. Employees must be notified of the enrollment and given the opportunity to opt out of any coverage in which the employee was automatically enrolled.

Before this requirement can take effect, the Department of Labor (DOL) must issue implementing regulations. According to the DOL, employers are not required to comply with automatic enrollment requirement until final regulations are issued and become applicable.

Action Items:

☐ Monitor health care reform developments for DOL regulations on the automatic enrollment requirement.

☐ Once regulations are issued clarifying how employees should be counted, confirm that your organization is not a large employer under this rule.

Document Available from Pacific Group:

- Health Care Reform: Automatic Enrollment Requirements

Notice of Exchange

Who is Covered?	When?
Employers subject to the FLSA	Currently effective—provide to new hires at time of hiring (for 2014, within 14 days of hire date)

Employers must 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 matched up with the start of the first open enrollment period under the Exchanges, as follows:

- 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.
- Current Employees—With respect to employees who are current employees before Oct. 1, 2013, employers were required to provide the notice no later than **Oct. 1, 2013**.

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 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.

On Sept. 11, 2013, the DOL issued an FAQ on the penalties for failing to provide an Exchange Notice. The DOL stated that 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 Exchange notice has been provided to all current employees.

☐ Prepare to provide the customized notice to all new employees at the time of hire (or within 14 days of their hire date, for 2014).

Documents Available from Pacific Group:

- 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 (for example, during open enrollment and upon request)

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 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.

For group health plans, the final regulations outline 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 the 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 for enrollment, 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 the 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).

On April 23, 2013, the Departments issued FAQs on the SBC requirement for the second year of its applicability, which include an updated SBC template and sample completed SBC. In addition, certain safe harbors and other enforcement relief that were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first year of applicability have been extended to apply through the end of the second year of applicability.

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, during the first and second years of applicability, 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 has been updated for the second year of applicability.

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

Documents Available from Pacific Group:

- Health Care Reform: Summary of Benefits and Coverage
- Health Care Reform: FAQs on Summary of Benefits and Coverage

- Health Care Reform: FAQs on Year 2 Applicability for Summary of Benefits and Coverage
- Health Care Reform: Year One Template for Summary of Benefits and Coverage
- Health Care Reform: Year Two 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 Pacific Group:

- 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 Pacific Group:

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

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 Pacific Group:

- 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 Health insurance 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 Pacific Group:

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

Form W-2 Reporting (Large Employers Only)

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. Smaller employers 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 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.

Action Items:

☐ Confirm that your organization is a small employer under this rule by reviewing the number of W-2 forms filed for the prior tax year.

Documents Available from Pacific Group:

- 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

Wellness Programs

Who is Covered?	When?
Health-contingent wellness programs	Plan years beginning on or after Jan. 1, 2014

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. For 2014 plan years, the maximum reward increases from 20 percent to 30 percent of the cost of coverage. In addition, 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.

Recommended Documents:

- Health Care Reform: Implications for Workplace Wellness Programs
- Health Care Reform: Workplace 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.

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, 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.

The PCORI fees are due by July 31 of the calendar year following the plan year to which the fee applies.

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 Pacific Group:

- Health Care Reform: Patient-Centered Outcomes Research Institute Fees (PCORI Fees)
- Health Care Reform: IRS Updated Form 720 for 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. For 2014, HHS announced a national contribution rate of $5.25 per month ($63 per year). For 2015, the annual contribution rate is $44 per enrollee per year, or about $3.67 per month. The reinsurance fee is calculated by multiplying the average number of covered lives by the national contribution rate.

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 $63 per capita reinsurance contribution for 2014 will be collected in two installments: $52.50 in January 2015 and $10.50 late in the fourth quarter of 2015.

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 Pacific Group:

- Health Care Reform: Reinsurance Fees Will Cost Group Health Plans
- Reinsurance Program Changes for 2015
- Health Care Reform Fees—Special Rules for HRAs
- Health Care Reform: Reinsurance Fees—Exemption for Certain Self-Insured Plans

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

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.

Action Item:

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

Document Available from Pacific Group:

- Health Care Reform: Health Insurance Providers Fee

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

In addition, on Oct. 31, 2013, the IRS released Notice 2013-71, which relaxes 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 $2,500 limit on salary reduction contributions. This means the plan may permit the individual to elect up to $2,500 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, confirm that the limit is $2,500 or lower.
- ☐ If there is no limit or a limit above $2,500, establish a limit that does not exceed $2,500.

Documents Available from Pacific Group:

- Health Care Reform: Changes to Health Accounts
- Health Care Reform: The $2,500 Health FSA Limit

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 Pacific Group:

- Health Care Reform: Preventive Care Coverage Guidelines
- Health Care Reform: Recommended Preventive Care Services
- Health Care Reform: Preventive Care Guidelines for Women
- Health Care Reform: Contraceptive Coverage Requirements—Nonprofit 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 Pacific Group:

- Health Care Reform: Dependent Coverage Up to Age 26
- Health Care Reform: IRS Guidance on Tax-Free Coverage 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 Pacific Group:

- 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 Pacific Group:

- 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 Pacific Group:

- Health Care Reform: Prohibition on Rescissions