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Upcoming Health and Welfare Plan Requirements Checklist for Employers: December 2014

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As 2014 draws to a close, employers should turn their attention to several upcoming compliance obligations for the health and welfare benefit plans they sponsor. Below is a list of upcoming health and welfare compliance initiatives that require action by employers, including preparation for upcoming fees and penalties under the Affordable Care Act (ACA), filing of required forms and distribution of relevant notices.

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December 31 – Deadline to execute the required amendment limiting the maximum annual health flexible spending account salary reduction to $2,500 (as indexed)

Under the ACA, the maximum annual contribution limit permissible under a health flexible spending account, effective for plan years starting on or after January 1, 2013, is $2,500. This amount has increased to $2,550 for 2015. Plan sponsors must adopt a plan amendment on or before December 31, 2014, to reflect this maximum contribution amount.

December 31 – Deadline to execute an optional amendment adopting a carry-over feature for a health flexible spending account

A health flexible spending account can be amended to provide for a carry-over of up to $500 in unused flexible spending account contributions to subsequent plan years. This carry-over feature is optional and cannot be implemented if the plan also contains a grace period feature. Plans must be amended to permit this carry-over.

December 31 – Deadline to execute an optional amendment for new change-in-status events

The Internal Revenue Service (IRS) recently approved two new change-in-status events (permissible but not required) to reflect mid-year election changes to enable employees to enroll in Health Marketplace Exchange coverage or other minimum essential coverage. Plans must be amended to reflect these new change-in-status event(s).

Annual notices

Plan sponsors should ensure that all required annual notices have been provided to participants. Examples of required annual notices include the Children's Health Insurance Program Notice and the Women's Health and Cancer Rights Act Notice.

New hires – Exchange notice and COBRA notices

Plan sponsors should develop a strategy for providing notice to employees that the Health Marketplace Exchanges exist; that employees may be eligible for a subsidy under the Exchanges if the employer's share of the total cost of benefits is less than 60 percent or is not affordable; and that if an employee purchases a policy through the Exchanges, he or she will lose the employer contribution to any health benefits offered by the employer. New hires must receive this notice within 14 days of the date of hire. In addition, plan sponsors should

update their plans' COBRA notices to reflect changes made in the most recent model notices related to the Health Marketplace Exchanges.

Preparation for the employer shared responsibility requirements

Large employers should prepare for the employer shared responsibility requirements under Code Section 4980H by completing the following tasks:

- Establish a system for identifying full-time employees (those working 30 or more hours per week).
- Adopt an hours-counting methodology for variable, part-time, temporary and seasonal employees.
- Establish and document adoption of a monthly measurement or look-back measurement method.
- Document and communicate plan eligibility rules.
- Test plans for affordability and minimum value.
- Examine the design of any health reimbursement account/health flexible spending account plans to ensure compliance with the ACA, including agency guidance addressing stand-alone and integrated arrangements and how to count health reimbursement accounts for purposes of affordability requirements under Code Section 4980H.
- Adopt a process for collecting 2015 data (including social security numbers of employees and dependents) for reporting of full-time employees and covered individuals on Forms 1094 and 1095. Confirm whether any safe harbor methods for reporting can be met.

January 2015

January 1 – ACA requirements

- Confirm that all individuals identified as full-time employees during the look-back period for the 2015 plan year have been offered qualifying health coverage under the plan, or be prepared for assessment of applicable penalties.
- Begin tracking data for individuals provided minimum essential coverage by month for Code Section 6055 reporting for the 2015 plan year.
- Begin tracking coverage offers made to full-time employees by month for Code Section 6056 reporting for the 2015 plan year.
- For non-grandfathered plans:
    - Confirm that plan design covers all required preventive care services.
    - Verify that the 2015 in-network out-of-pocket limits on essential health benefits are met ($6,600 for self-only coverage and $13,200 for other coverage).
    - Ensure that out-of-pocket accumulators under separate benefit plans, such as medical and prescription drug plans, are combined.
    - Make sure there are no annual or lifetime limits on essential health benefits (all plans).
    - Check that there are no pre-existing condition clauses (all plans).
    - Confirm that waiting periods have been reduced to 90 days or less (all plans).
    - Confirm that coverage of clinical trials is permissible under the plan.
- Confirm that the plan's in-network out-of-pocket maximums for high-deductible health plans offered in connection with health savings accounts are correct ($6,450 for self-only and $12,900 for other coverage).

January 15 – Payment of first installment (or both installments) of 2014 transitional reinsurance fee

The first installment of the transitional reinsurance fee for 2014 is due January 15. The total fee for 2014 is $63 per covered life in the plan and may be made in two installments. The first installment of $52.50 per covered life is due on January 15, and the second installment of $10.50 per covered life is due on November 15, 2015. Both

installments may be paid together on January 15. Contributing entities were required to submit headcounts for 2014 to the U.S. Department of Health and Human Services (HHS) by November 15, 2014, and payment is made through the pay.gov website.

January 31 – Deadline to provide Form W-2 with required ACA information

Employers are required to report the cost of group health plan coverage on an employee's Form W-2, Wage and Tax Statement, in Box 12, using Code DD.

March 2015

Disclosure to CMS to report creditable coverage status of prescription drug plans

The Online Disclosure to the U.S. Centers for Medicare and Medicaid Services (CMS) should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status.

July 2015

July 31 – Deadline to pay PCORI fee for 2014 plan year

The Patient-Centered Outcomes Research Institute (PCORI) fee is assessed on self-insured and fully insured health plans in the amount of $2.08 per participant to fund research regarding patient-centered outcomes for medical treatment. The PCORI fee is due July 31 following the end of the plan year for which the fee is collected. For 2014, the fee is due July 31, 2015. Plan sponsors of self-insured health plans pay the fee by filing IRS Form 720.

September 2015

September 30 – Deadline to file the plan's Form 5500 (if no Form 5500 extension was granted)

Calendar year health and welfare plans that were not granted an extension to file the Form 5500 have until September 30 to file the Form 5500.

September 30 – Deadline to provide Summary Annual Report (if no Form 5500 extension was granted)

Calendar year health and welfare plans that were not granted an extension to file the Form 5500 have until September 30 to furnish the related Summary Annual Report to plan participants.

September 30 – Annual fee on health insurance providers

This annual fee is assessed on insurers. The fee is due by September 30 of each applicable "fee year." The annual fee applies to covered entities engaged in the business of providing health insurance in the United States. A covered entity is liable for the annual fee if its aggregate net premiums for covered health insurance policies exceed $25 million in the calendar year immediately preceding the year in which the fee is assessed. The annual fee applies to insured medical, dental and vision plans, as well as insured retiree-only plans. The annual fee does not apply to employers sponsoring self-insured health plans, including employers that fund a self-insured health plan through a VEBA trust. Many insurers, however, are passing this fee on to their fully insured customers.

October – November 2015

Open enrollment – Deadline to provide Summary of Benefits and Coverage

Group health plans must distribute a Summary of Benefits and Coverage (SBC) that accurately describes benefits and coverage under the plan to all plan participants and beneficiaries beginning on the first day of the first open enrollment period. For those participants and beneficiaries who do not enroll in coverage through an open enrollment period, including individuals who are newly eligible for coverage or who are eligible for special enrollment under the Internal Revenue Code, the SBC must be distributed upon eligibility for plan coverage. If a group health plan makes any material modification to the terms of the plan or coverage and the modification is not reflected in the most recently provided SBC, the plan must provide notice of the modification not later than 60 days prior to the date the modification becomes effective.

October 14 – Deadline to provide Medicare Part D notice of creditable coverage

Employer sponsors of group health plans that offer prescription drug coverage to active and retired employees who are Medicare-eligible individuals must provide notice to Medicare Part D eligible individuals stating whether

the expected amount of paid claims is at least as much as the expected amount of paid claims if the individual enrolled under Medicare Part D.

November 15 – Deadline to submit enrollment information for the 2015 transitional reinsurance fee to HHS

For 2015, the transitional reinsurance fee is set at $44 per covered life. The fee is a per capita fee per covered life under the plan. Self-insured, self-administered plans are exempt from the fee in 2015 and 2016. For 2015, enrollment counts are due to HHS by November 15.

November 15 – 2014 transitional reinsurance fee

The second installment of $10.50 per covered life is due on November 15 and payable through pay.gov.

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