**Health Reform Checklist**

**for employers with 2-50 employees**

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### 2012 – 2013 HEALTH REFORM PROVISIONS

- **Small Business Tax Credit** – Employers with fewer than 25 employees should check to see if they qualify for the Small Business Tax Credit. For tax years beginning in 2014, the credit will be available only to small businesses that purchase health coverage through a Health Benefit Exchange. You should seek advice from an accountant and attorney to determine how the credit may affect your specific situation.

- **Limit employee contributions to health flexible spending accounts (FSA).** Beginning in 2013, employee salary reduction contributions to health FSAs will be limited to $2,500 per plan year, with indexed increases allowed in future years to adjust for inflation.

- **Provide written notice about Health Benefit Exchanges.** By October 1, 2013 employers must provide written notice to current employees, and going forward, new employees to inform them of the Exchanges and the circumstances under which they may be eligible for health insurance subsidies.

- **Provide a Summary of Benefits and Coverage (SBC).** On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are required to use standards in compiling and providing an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. These standards ensure that information is presented in a clear and uniform format that helps plans and individuals better understand their health coverage and compare coverage options across different types of plans and insurance products. The final regulations require that the SBC be provided in several instances (upon application, by the first day of coverage if there are any changes, special enrollees, upon renewal, upon request and off-renewal changes).

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### 2014 HEALTH REFORM PROVISIONS

Although the following provisions will not become effective until 2014, it is important for employers to know what is coming and what action is required to decide if any adjustments need to be made and be aware of what carriers will do for you.

**WHAT EMPLOYERS NEED TO KNOW**

Rest assured that upon renewal, your plan will automatically be adjusted to comply with ACA provision requirements applicable to small group plans. The following items become effective Jan. 1, 2014. Note: No action is required of you.

- **Carriers will be removing plan exclusions for those of any age with a pre-existing condition.** This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a pre-existing condition. This applies to grandfathered and non-grandfathered plans; however, grandfathered individual health plans are exempt from this requirement.

- **Carriers will make sure your plan provides Essential Health Benefits (EHB).** The ACA requires all non-grandfathered small group employers to provide EHB.

- **Carriers will make sure that cost-sharing toward services will accumulate to your plan’s out-of-pocket maximum, including flat-dollar copayments for services that are defined as EHB.**

- **Be aware of the Patient-Centered Outcomes Research Institute (PCORI) Fee –** For plan years ending on or after Oct. 1, 2012, the Act imposed a fee, called the PCORI Fee, of $1 per member per year on health insurance issuers and employers sponsoring self-funded group health plans. For fully insured plans, the temporary fee is rolled into the premium rates and is not called out separately on the invoice. The fee began in 2012 and ends in 2019.

- **Be aware that carriers will start progressively incorporating the following three fees under the ACA into fully insured plan premiums and will not be called out separately on the invoice beginning Feb. 1, 2013, as renewals or new business cases begin and state regulatory approvals are received.**

- **Adjusted community rating (ACR) rules will apply to non-grandfathered individual and small group insurance markets effective for plan years (policy years in the individual market) beginning on or after Jan. 1, 2014. Under the ACA’s provisions, the use of actual or expected health status or claims experience to set rates for premiums is prohibited. Other rating factors such as age, geographic area and tobacco use may be used to vary premiums, within certain limits. These rules are still proposed and subject to change before becoming final law.**

- **Annual limitation on plan deductibles is $2,000 single/$4,000 family.** This applies to non-grandfathered small groups with the exception of 50-plus as they are not considered small group.

- **Out-of-pocket maximums for all non-grandfathered plans will be capped at the same level at which health savings account (HSA) plans are capped.** In 2013, these levels are $6,250 single/$12,500 family.

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***See reverse side for Large Group Checklist***

*Source: UnitedHealthcare Group*
2012 – 2013 HEALTH REFORM PROVISIONS

☐ Limit employee contributions to health flexible spending accounts (FSA). Beginning in 2013, employee salary reduction contributions to health FSAs will be limited to $2,500 per plan year, with indexed increases allowed in future years to adjust for inflation.

☐ Employers who file 250 or more employee W-2 forms will be required to report the cost of employees’ health benefit coverage on the employees’ 2012 W-2 forms that are distributed in January 2013. (This requirement is informational only and does not mean that employees will be taxed on these dollars.)

☐ Provide written notice about Health Benefit Exchanges. By October 1, 2013 employers must provide written notice to current employees, and going forward, new employees to inform them of the Exchanges and the circumstances under which they may be eligible for health insurance subsidies.

☐ Assess health plan offerings. Employers should begin assessing their health plan offerings to determine whether they meet the minimum value requirements that will become effective in 2014. If plans do not meet the requirements, employers will need to explore alternative plan options and/or the impact of paying assessments.

2014 HEALTH REFORM PROVISIONS

Although the following provisions will not become effective until 2014, it is important for employers to know what is coming and what action is required to decide if any adjustments need to be made and be aware of what carriers will do for you.

WHAT EMPLOYERS NEED TO DO

☐ Offer Minimum Essential Coverage (MEC) – Employers will want to consider whether they need to make changes to the cost and quality of the coverage offered to avoid penalties that will apply if that coverage is considered unaffordable or low in value. Beginning in 2014, employers with more than 50 full-time equivalent employees may be subject to a penalty if an employee receives a premium credit or cost-sharing subsidy. The penalty is calculated as follows:

  • Employers Not Offering Coverage: If an employer does not offer MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is $2,000 per year per full-time worker. When calculating the penalty, the first 30 full-time workers are subtracted from the payment calculation.

  • Employers Offering Coverage: If an employer offers MEC and one or more full-time employees receive a premium credit or cost-sharing subsidy through the Exchange, the penalty is $3,000 per employee who receives a premium credit or cost-sharing subsidy.

An employer-sponsored plan that satisfies the ACA’s reform requirements must:

1. Be affordable to the employee (premium may not exceed 9.5 percent of household income. The IRS, however, has issued a safe harbor allowing employers to substitute the employee’s W-2 income for household income).

2. Provide minimum value, which is at least 60 percent of the total allowed cost of benefits.

WHAT EMPLOYERS NEED TO KNOW

Rest assured that upon renewal, your plan will automatically be adjusted to comply with ACA provision requirements applicable to large group plans. The following items become effective Jan. 1, 2014. Note: No action is required of you.

☐ Carriers will remove plan exclusions for those of any age with a pre-existing condition. This is an update to the provision from 2010 that did not allow exclusions for children under the age of 19 with a pre-existing condition. This applies to the grandfathered and the non-grandfathered plans.

☐ Be aware of the Patient-Centered Outcomes Research Institute (PCORI) Fee – For plan years ending on or after Oct. 1, 2012, the ACA imposes a fee, called the PCORI Fee, of $1 per member per year on health insurance issuers and employers sponsoring self-funded group health plans. For fully insured plans, the temporary fee is rolled into the premium rates and is not called out separately on the invoice. The fee began in 2012 and ends in 2019.

☐ Be aware that carriers will start progressively incorporating the Insurer Fee and the Transitional Reinsurance Fee into premiums beginning Feb. 1, 2013, as renewals or new business cases begin and state regulatory approvals are received.

☐ Understand that out-of-pocket maximums for all non-grandfathered plans will be capped at the same level at which health savings account (HSA) plans are capped. In 2013, these levels are $6,250 single/$12,500 family.

☐ Understand that cost-sharing toward services must accumulate to a plan’s out-of-pocket maximum, including flat-dollar copayments for services that are defined as Essential Health Benefits (EHB). Large groups do not have to cover EHB services, but if they choose to do so, they are prohibited from having annual dollar limits and cost-sharing for EHB services and all services must accumulate to the plan’s out-of-pocket maximum.

☐ Understand the delivery requirements for providing the Summary of Benefits and Coverage (SBC) to your employees. On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are required to provide an SBC that accurately describes the benefits and coverage under the applicable plan or coverage. The final regulations require that the SBC be provided in several instances (upon application, by the first day of coverage if there are any changes, special enrollees, upon renewal, upon request and off-renewal changes).

*Source: UnitedHealthcare Group

***See reverse side for Small Group Checklist***