HCR CHECKLIST

For fully insured employers with 2-50 employees

☐ **Are you a Small Employer?** Beginning in 2014, employers with 50 or fewer full-time plus full- time equivalent employees will be categorized as a "Small Employer." If you are part of a "Controlled" or "Affiliated Service" group, you may in fact, be a large employer under the law. Your broker can help you determine your status.

☐ **Do you qualify for a 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 an Exchange, also called a Health Insurance Marketplace. Ask your broker if you qualify.

☐ **Are your employees aware of new rules for health flexible spending accounts (FSA)?** Your employees should be aware that 1) 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. 2) funds from these plans can no longer be used to buy over-the-counter drugs (except insulin) without a prescription. 3) employees will pay higher penalties (20%) for withdrawing HSA funds for nonmedical expenses. 4) plans may allow up to $500 of a participant's balance at the end of the plan year to be carried over into the next plan year.

☐ **Are you providing written notice about Exchanges (Health Insurance Marketplaces)?** Employers must provide written notice to new employees within 14 days of their start date to inform them of their coverage options available through the Marketplace (Covered California). The U.S. Department of Labor shared a Model Notice employers may use to meet this requirement that can be found on the Department of Labor website at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf *or* www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

☐ **Have you provided a Summary of Benefits and Coverage (SBC) and Uniform Glossary?** On or after Sept. 23, 2012, group health plans and health insurance issuers offering group or individual health insurance coverage are now required to provide a Uniform Glossary and 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) and can be included as part of the SPD. A model SBC can be downloaded from the Department of Labor website at www.dol.gov/ebsa/pdf/SBCtemplate.pdf. The Uniform Glossary Template is located here: http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

☐ **Do you know the employee eligibility Waiting Period?** A "waiting period" is defined as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. In California, this waiting period is limited to 60 days from date of hire.

☐ **Have you notified your employees if your plan has a "Grandfathered Status"?** To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

☐ **Does your plan provide Essential Health Benefits?** The ACA identifies a range of services that must be included in the benefits package for small group plans. These 10 required benefits include:

Ambulatory Patient Services,	Emergency Services,
Hospitalization,	Preventive, Wellness Services and Chronic Disease Management
Maternity and Newborn Care,	Mental Health and Substance Use Disorder Services,
Prescription Drugs,	Pediatric Services including Oral and Vision Care,
Laboratory Services, and	Rehabilitative and Habilitative Services and Devices

New fees you should be aware of.

Tax/Fee	Party Responsible for Remitting	Effective Date	Amount
PCOR Fees— Used to fund the Patient-Centered Outcomes Research Trust Fund, a private, nonprofit corporation supporting clinical effectiveness research	Insurers of fully-insured health plans Plan sponsors of self-funded health plans	First fees due as early as July 31, 2013 Applies for 7 plan years.	$1.00 multiplied by the average number of covered lives (not just number of employees) in the first plan year $2.00 per covered life in second plan year Indexed by medical inflation thereafter
Transitional Research Fee— Designed to fund re-insurance payments to health insurance issuers that cover high-risk individuals in the individual market	Insurers of fully-insured health plans Plan sponsors of self-funded health plans	A three year program for 2014-16	$5.25/month ($63.00/ year) per covered life
Health Insurance Co. Fee— A fee allocated to all health insurers to help fund premiums subsidies and Medicaid expansion	Health insurers only, but many carriers are expected to shift the cost to those buying policies, by increasing their needed premium to cover risk retention	First payable September 30, 2014	Depends on the carrier's market share of all health insurance policies as among insurers with total premiums of $25 million or more Largest carriers expect fees of 2-3% of premium
Additional Medicare Payroll and Investment Taxes	Employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of $200,000 in a calendar year.	Goes into effect 2013	0.9 percent Additional Medicare Tax applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income that exceeds a threshold amount based on the individual's filing status. The threshold amounts are $250,000 for married taxpayers who file jointly, $125,000 for married taxpayers who file separately, and $200,000 for all other taxpayers.

☐ **Do your plans comply with the Out-of-Pocket Maximums?** Any non-grandfathered plan in the individual, small group or large group market that becomes effective or renews on or after January 1, 2014, must limit annual out-of-pocket costs (for Essential Health Benefits) to $6,350 for Individual coverage, or $12,700 for family coverage.

☐ **Have you considered Wellness Programs?** You need to decide whether you want to offer expanded wellness incentives. Starting in 2014, businesses can offer discounts of up to 50% off insurance premiums to employees who take part in employer-sponsored wellness programs. This is an increase from the 20% discount previously allowed.

☐ **Do your plans discriminate?** Delayed pending further regulatory guidance, the ACA includes a requirement that employer provided benefit plans cannot discriminate in eligibility, waiting period, benefits or contributions in favor of highly compensated employees. Failure to comply carries a penalty of $100 per individual for each day the plan does not comply.

This checklist applies to new regulations under the Affordable Care Act only and does not include additional employer compliance requirements under ERISA, HIPAA and other federal labor laws. Ask your broker for additional information.

This document is not intended to be exhaustive nor should any information be construed as tax or legal advice. Readers should contact a tax professional or attorney if legal advice is needed. Although we have made every effort to provide complete, up-to-date, and accurate information in this document, such information is meant to be used for reference only. We make no warranty or guarantee concerning the accuracy or reliability of the information within this document. If there is any inconsistency between the information contained in this document and any applicable law, then such law will control.