Compliance dashboard®

Health Care Reform Checklist

COMPLIANCE REVIEW: Past Requirements or Provisions (2010 to 2013)

REQUIREMENT OR PROVISION	PLAN	EFFECTIVE DATE	FULLY INSURED PLAN RECOMMENDATIONS	SELF-INSURED PLAN RECOMMENDATIONS	DATE COMPLETED/ COMPLETED BY
Provide **Dependent Coverage for Children Under Age 26** regardless of marital or student status, financial support, residency, etc. (if the plan covers dependent children). Grandfathered plans are not required to provide dependent coverage for children under age 26 who are **eligible for coverage under another employer's plan** (exemption ends in 2014).	AP GP	2010-2011	Review eligibility requirements in SPD or check with Insurer.	Review eligibility requirements in SPD.	
Tax-Free Coverage to Children Under Age 27 so that the age limit, residency, support, and other tests described in Code Section 152(c) do not apply with respect to such a child for determining the tax exclusion.	AP	2010-2011	Verify Cafeteria Plan has been modified (if necessary) to include this tax-free coverage.		
Prohibition of Lifetime Dollar Limits on Essential Heath Benefits (EHB). EHB must be equal in scope to benefits covered by a typical employer plan as determined by each State and must include items and services in ten general categories.	AP	2010-2011	Review eligibility requirements in SPD or check with Insurer.	Review eligibility requirements in SPD.	

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Restriction of Annual Dollar Limits on Essential Heath Benefits (EHB). EHB must be equal in scope to benefits covered by a typical employer plan as determined by each State and must include items and services in ten general categories.	AP	2010-2011	Review benefit limitations in SPD or check with Insurer.	Review benefit limitations in SPD.	
Prohibition of Preexisting Conditions Exclusion for enrollees under age 19 (expands to all enrollees in 2014).	AP	2010-2011	Review pre-existing condition exclusions in SPD or check with Insurer.	Review pre-existing condition exclusions in SPD.	
Prohibition Against Rescission of Coverage except in cases of fraud or intentional misrepresentation of material fact where prohibited in plan documents (rescission is a retroactive cancellation of coverage; this prohibition does not apply to prospective coverage terminations).	AP	2010-2011	Insurers must provide at least 30 days advance written notice to each participant who would be affected before coverage may be retroactively rescinded.	1. Review rescission language. 2. Plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be retroactively rescinded.	
Protection Against Retaliation (Whistle Blower) by employers against employees who received a credit or subsidy or reported an employer violation of Title I of the PPACA. (See also Whistle Blower Protection under Compliance Forecast)	AP	2010-2011	Verify management staff is aware of this protection.		
OTC Drugs Cannot Be Reimbursed from an FSA, HSA, HRA or Archer MSA unless prescribed by a doctor.	AP	2010-2011	Verify plans have been amended to reflect this revision.		

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HSA/Archer MSA Penalty Tax Increase to 20% for nonmedical distributions	AP	2010-2011	No action required; however, employers may want to ensure their employees are aware of the increased penalty.		
Limited Small Business Health Care Tax Credit (35% for most employers) to small employers (25 or less FTEs; $50k or less in avg. annual wages; and, contribute at least 50% toward the cost of coverage) to provide health insurance. Credit amounts increase in 2014.	AP	2010 Taxable Year	Determine eligibility and cost/ benefit of applying for credit.		
Simple Cafeteria Plans can be established by small employers (avg. 100 or fewer employees during either of the preceding 2 years) to provide a safe harbor from nondiscrimination rules if minimum employer contributions are made.	AP	Jan. 1, 2011	Determine eligibility and cost/benefit of establishing plan.		
Small Business Wellness Grants to create comprehensive workplace wellness programs for employers (<100 employees who work 25 or more hours per week) who did not have a wellness program in place on March 23, 2010.	AP	2011 Taxable Year	Determine eligibility and cost/benefit of establishing program.		
To qualify as a Grandfathered Plan, employers must maintain their plan according to established requirements.	GP	2010-2011	1. Review and followrequirements. 2. Verify Grandfathered Plan Disclosure is in SPD.		

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Coverage of Certain Preventive Health Services is required without cost sharing. (See also Women's Preventive Health Care under Compliance Updates)	NGP	2010-2011	Verify insurer has updated plan and SPD in coordination with the Preventive Health Services coverage requirement.	Review preventive coverage benefits in SPD in coordination with Preventive Health Services coverage requirement. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent this information is not specified in a recommendation or guideline.	
Patient Protections allowing participants to designate any participating in network PCP or Pediatrician as primary care provider; access to OB/GYN care without requiring referral; and coverage of emergency services without prior authorization and as though the ER provider is in-network for true emergencies.	NGP	2010-2011	Review referral requirements in SPD or check with Insurer. Ensure distribution of notice as required.	Review referral requirements in SPD. Ensure distribution of notice as required.	
Plans must implement an **Internal Claim Appeals and External Review Process** that satisfy certain requirements.	NGP	2010-2011	No Action Required. Insurer responsibility.	Work with TPA to ensure procedures and external review contracts are in place.	
W-2 Reporting of aggregate cost of employer-sponsored health plan coverage. Certain plans and coverage are exempted. Transitional relief at least through 2012 for employers that filed fewer than 250 Forms W-2 in 2011.	AP	2012 Forms W-2 (furnished in January 2013)	Coordinate reporting with payroll dept. or vendor.		

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If a health insurer's **Medical Loss Ratio (MLR)** fails to meet minimum requirements, the insurer must provide an annual rebate to enrollees. The insurer must send the rebate directly to the employer; the employer must distribute some or all of the rebate to its employees in accordance with applicable rules.	AP	Jan. 1, 2011 First rebates are due Aug. 1, 2012	The employer (policyholder) is responsible for determining what portion (if any) of the rebate belongs to its employees and distributing it accordingly. This determination and distribution must be made within three months after receipt.	No Action Required. Does not apply to self-insured plans.	
Women's Preventive Health Care (such as mammograms, screenings for cervical cancer, prenatal care, and other services) is covered with no cost sharing.	NGP	Plan years beginning on or after Aug. 1, 2012	Verify insurer has updated plan and SPD in coordination with the Preventive Health Services coverage requirement.	Review preventive coverage benefits in SPD in coordination with Preventive Health Services coverage requirement. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent this information is not specified in a recommendation or guideline.	
Summary of Benefits and Coverage (SBC) and a uniform glossary of commonly used health insurance and medical terms must be provided to all applicants.	AP	Generally effective for plan years beginning on or after 9/23/12, although dates may vary according to circumstances.	1. Insurers are responsible for preparing the SBC. 2. Verify with the Insurer how the SBC will be distributed to eligible employees. 3. Review distribution requirements and effective dates. 4. Use updated templates for second year of applicability and note that it must include a statement of whether plan provides "minimum essential coverage."	1. Plan sponsor must prepare and distribute the SBC. 2. Review distribution requirements and effective dates. 3. Use updated templates for second year of applicability and note that it must include a statement of whether plan provides "minimum essential coverage."	

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Modifications made to the plan that are not reflected in the current SBC must be issued in a **Notice of Plan Modifications**, if the change occurs other than in connection with a renewal.	AP	60 days prior to the date the change becomes effective	1. Insurers are responsible for preparing the Notice of Plan Modifications. 2. Employer should verify with the Insurer how the SBC will be distributed to eligible employees.	Plan sponsor must prepare and distribute the Notice of Plan Modifications.	
Health FSA: Lower Annual Cap and $500 Carryover for FSA plans offered under cafeteria plans. Implemented an initial Cap of $2500 in 2013, which is indexed for inflation annually thereafter (2015 limit is $2,550). Employer non-elective contributions (sometimes called flex credits) are not included under the Cap; however, if an employer provides flex credits that employees may elect to receive as cash or as a taxable benefit, those flex credits are subject to the Cap.	AP	The first day of the plan year on or after Jan. 1, 2013	Plans that do not currently reflect the Cap must be amended by 12/31/14 (retroactively). To implement the carryover (up to $500 from one plan year to the next), amend the plan for 2013 plan years, on or before the last day of the plan year that begins in 2014. Otherwise, amend the plan on or before the last day of the plan year from which amounts can be carried over. Note that a health FSA plan that incorporates this carryover provision may not also provide for a grace period in the plan year to which unused amounts may be carried over.		
Patient-Centered Outcomes Research Institute (PCORI) fee, used to fund effectiveness research. For plan or policy years between 10/1/12 and 10/1/13 the fee is $1 multiplied by the average number of covered lives. It increases to $2 between 10/1/13 and 10/1/2014 and is indexed for increases in per capita national health expenditures thereafter.	AP	Reports and payments are due no later than July 31 of the year following the last day of the plan year	No Action Required. The fee is paid by the insurer.	1. The plan sponsor is responsible for filing Form 720 and paying the fee. 2. Self-insured plans have three options for calculating the number of covered lives and must decide which one to use.	

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Retiree Drug Subsidy Deduction is eliminated by requiring the amount the employer could previously take as an allowable deduction to be reduced by the amount of the excludable subsidy payments received.	AP	Jan. 1, 2013	Employers providing retiree prescription drug coverage should analyze the increased future tax liability and the current accounting charges necessary to retain retiree prescription drug coverage.		
Notice of Coverage Options (Exchange Notice) must be provided to new hires and current employees that also includes the consequences of dropping employer provided coverage.	AP	October 1, 2013	Employers subject to the FLSA must provide the notice to employees prior to the effective date, and within 14 days to new hires thereafter. Model notices are available.		

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