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ACA QUICK REFERENCE COMPLIANCE CHECKLIST (Last Edited December 5, 2014)[1]		
ACA Provision	**General Summary**	**Effective Date/ Status**
Health Insurance Exchange Notice	Employers are required to provide notice to employees of coverage options under ACA's health insurance exchanges. Employers must provide the notices to current employees by October 1, 2013, which coincided with the Open Enrollment date for the health insurance exchanges. For new employees hired after October 1, 2013, employers must provide the notice at the time of hire (or within 14 days of the hire date). Model notices are available from the DOL.	Notice due by October 1, 2013. Thereafter - Annual deadline – Oct. 1
Health Insurance Exchanges	These are federal and state "virtual marketplaces" where individuals and small employers have access to health care coverage. Depending upon income and other factors, individuals may be eligible for subsidies from the federal government to assist in purchasing coverage through public exchanges. Exchanges began initial open enrollment for individuals on October 1, 2013 (to run through March 31, 2014.) The effective date of coverage purchased through the exchanges is set for January 1, 2014. Open enrollment for small employers on the Small Business Health Options Programs (SHOP exchange) opened on November 15, 2014.	The federal health insurance exchange began operations on October 1, 2013.
Employer Shared Responsibility **["Employer Mandate"]**	Applicable large employers (those with 50 or more full-time employees) must offer certain minimum levels of health coverage to at least **95%*** of its full-time employees or face penalties if at least one of their full-time employees obtains a subsidy to purchase coverage through a public health insurance exchange. To avoid penalties, the health coverage must provide minimum value (at least 60% actuarial value) and the employee's contribution to premiums must be affordable (may not exceed 9.5% of the employee's household income). *Note that the regulations phase in the percentage of full-time employees who must be offered coverage for employers to avoid penalties (70 percent in 2015 and 95 percent in 2016 and beyond). **For 2015, employers with 100 or more full-time employees must offer affordable, minimum coverage to at least 70% of its full-time employees.**	Deadline - January 1, 2015 for employers with 100 or more full time employees. Deadline - January 1, 2016 for employers with between 50 and 100 employees.
Individual Shared Responsibility **["Individual Mandate"]**	Most individuals will be subject to an excise tax penalty if they do not maintain "minimum essential coverage." Generally, coverage through an exchange or in an employer-sponsored plan constitutes minimum essential coverage.	January 1, 2014. But, if "hardship exemption" applies, delayed until October 2016.
ACA Retaliation &	ACA prohibits an employer from taking an adverse employment action against an employee for, among other things, receiving a subsidy to purchase coverage from a public health insurance exchange.	In effect.

[1] Due to the evolving nature of the ACA, this checklist is continually being updated. Accordingly, there is no representation made as to the accuracy of the information contained herein after the date it was last edited. Furthermore, there is no representation made as to the applicability of this checklist to your business, and advice should be sought from your lawyer or other business advisor.

For additional information regarding ACA and benefits compliance issues, please visit our website at http://www.lehrmiddlebrooks.com/BreakingNews.htm.

Whistleblower Protection		
Summary of Benefits and Coverage (SBC) and Notices of Material Modification	Employer-sponsored health plans must provide a Summary of Benefits and Coverage (SBC) to all plan participants, as well as to all employees who are eligible to participate. If the employer makes a mid-year change in the plan provisions that would change the terms of the SBC, the plan also must provide a Notice of Material Modification at least 60 days before the change takes effect.	In effect.
FICA Medicare Tax Rate Increase	The FICA Medicare tax rate is increased 0.9% (to 2.35%) for wages/earnings over $200,000 ($250,000 for married couples filing jointly). An employer is required to collect the employee's share in the case of wages; however, the law does not increase the employer's share of FICA Medicare tax.	January 1, 2013.
Automatic Enrollment	Employers with more than 200 full-time employees must automatically enroll all full-time employees (working 30 or more hours per week) as soon as they are eligible. Employees may opt out.	Delayed pending further guidance.
Medical Loss Ratio (MLR) Rebates	If health insurers do not meet mandated medical loss ratios, they must issue rebates to employers. Employers are responsible for determining if employees are entitled to a share of the rebate and how to distribute the rebate.	In effect.
Patient Centered Outcomes Research Institute (PCORI) Fee	Employers sponsoring self-funded plans must pay the applicable fee for each covered life per year under the health plan to help fund the Patient Centered Outcomes Research Institute. The annual fee must be paid and reported by July 31st of the calendar year following the end of the plan year. Plan Sponsors of self-funded plans will submit the fee with IRS Form 720. For fully-insured plans, the insurer will pay this temporary fee. The applicable fee is $2.08 for each covered life for plan years ending on or after October 1, multiplied by the average number of covered lives under the policy. The fee will be adjusted upward for subsequent years.	First payment for most plans (including calendar year plans) due by July 31 of the year immediately following the last day of the plan year.
Transitional Reinsurance Program Fee	The Transitional Reinsurance Program fee provides funding to assist health insurers with the additional cost associated with insuring high risk individuals in the individual market. The fee of $63 per covered life per year ($5.25 per month) applies only to major medical plans. The fee may be reduced in subsequent years. For self-funded plans, the plan sponsor is ultimately responsible for the fee, but plan sponsors may contract with a TPA to submit the fee.	First payment due January 15, 2015. Second payment due November 15, 2015.
W-2 Reporting	Employers must report the cost of employer-sponsored health coverage on employees' Form W-2, Wage and Tax Statement, in Box 12, using Code DD.	In effect for employers that generate 250 or more W-2s. Otherwise, the W-2 requirement is delayed pending further guidance.
Large Employer Reporting of Coverage Information to the IRS	Under IRC § 6056, applicable large employers (those subject to the employer mandate) must report certain information to the IRS regarding their employees and the benefits the employer offers, including the number of full-time employees during each month, the employer's share of the total allowed cost of benefits, information about each full-time employee (including name, address & social security number), and the months each employee was covered under the plan. Employers will also be required to provide the individuals with employee statements generally containing the information reported to the IRS regarding each individual.	Delayed until 2015 (The 2015 reports are due to be filed by Feb. 28 or Mar. 31, 2016 if filing electronically). The related information statement will be required to be provided to employees by Jan. 31, 2016.

	There is a related set of reporting and disclosure requirements under IRC § 6055 for providers of minimum essential coverage, which may include employers with self-funded plans. IRS has proposed regulations that may decrease duplicated reports.	
Register for Unique Health Plan Identifier	Health plans must register with HHS for a Health Plan Identifier (HPID) number to use when performing certain transactions, such as claims and eligibility. Health plans were originally required to obtain a HPID no later than November 5, 2014 (November 5, 2015 for small health plans). However, this requirement has been delayed indefinitely.	Delayed pending further guidance.
Certification of Compliance with HIPAA Administrative Simplification Rules	Employers with group health plans must certify that their plans comply with certain HIPAA rules on electronic transactions.	December 31, 2015. (further guidance pending)
40% excise tax on "high cost" or Cadillac coverage	An excise tax of 40% will be imposed on employer-sponsored health benefits that exceed the value of $10,200 times the "health cost adjustment percentage" for self-only coverage and $27,500 times the "health cost adjustment percentage" for family coverage.	January 1, 2018.
Grandfathered Plan Determination	A grandfathered plan is a plan that was in place on March 23, 2010. Only limited changes are permissible while maintaining grandfathered plan status. Since certain ACA provisions differ based on a plan's grandfathered status, a determination should be made for each group health plan that an employer offers. If a plan is grandfathered, the plan must issue a Notice of Grandfathered Status and include the Notice in plan materials.	In effect.

Required Plan Amendments	The section below summarizes the coverage reforms under the ACA.	Effective Date/Status	Applicable to Grandfathered Plans?
Prohibition on Reimbursements for Over-the-Counter Medicine	Participants may no longer be reimbursed from Health Savings Accounts (HSAs), Health Flexible Spending Accounts (FSAs), and/or Health Reimbursement Arrangements (HRAs) for over-the-counter medication (except for insulin) unless prescribed by a doctor.	In effect.	Applicable.
$2,5500 cap per plan year health FSA contribution	Employee contributions to employer-sponsored Health FSAs are limited to $2,550 in a calendar year starting in 2015. Plan documents must be amended to reflect this change by the last day of the 2014 calendar year.	In effect.	Applicable.
Preventive Care Coverage	Group health plans must provide first-dollar coverage for certain preventive care services (no cost-sharing). This includes certain women's preventive services, including, ***with some exceptions***, contraceptive coverage.	In effect.	Not Applicable.
External Review Procedures	Group health plans must adopt internal claims and appeals procedures and external review procedures.	In effect.	Not Applicable.
Patient Protections	Group health plans must provide certain patient protections, including the right to select a participating primary care provider (or pediatrician in the case of a child), direct access to obstetrical or gynecological care without a referral, and access to emergency services without prior authorization or increased cost-sharing.	In effect.	Not Applicable.
Dependent Coverage up to Age 26	If a group health plan provides dependent coverage for children, the plan must make that coverage available until a child turns age 26. Beginning in 2014, such coverage must be offered even if the dependent has coverage available through another employer-sponsored plan, regardless of the plan's grandfathered status (ends this exception for grandfathered plans).	In effect.	Applicable.
Prohibition on Lifetime Dollar Limits	Group health plans may not place lifetime limits on the dollar value of essential health benefits.	In effect.	Applicable.
Prohibitions on Annual Dollar Limits	Beginning in 2014, group health plans may not place annual limits on the dollar value of essential health benefits. Prior to 2014, this requirement is phased in. Currently, the annual limit on the dollar value of essential health benefits cannot be less than $2 million.	Full requirement takes effect for Plan Years beginning on or after January 1, 2014.	Applicable.
Elimination of Pre-Existing Exclusions	Beginning in 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for anyone. Prior to 2014, pre-existing condition exclusions are only prohibited for children under age 19.	Full requirement takes effect for Plan Years beginning on or after January 1, 2014.	Applicable.
90-Day Waiting Period Limitation	Group health plans may not impose a waiting period longer than 90 days for health care coverage. Plans with waiting periods longer than 90 days (including "first day of the month following 90 days") will need to amend their eligibility requirements. Eligibility criteria not based solely on the passage of time are permitted as long as they are not designed to circumvent the 90-day waiting period limit. **NOTE:** On June 6, 2014, the IRS, DOL, and HHS issued regulations clarifying that employers can require up to one month as a "reasonable and bona fide" new employment orientation prior to the maximum 90-day waiting period beginning to run for covered group health plans. However, the "orientation period" is only considered to be permissible for new employees who are hired into a benefit-	Plan Years beginning on or after January 1, 2014.	Applicable.

	eligible position, and employers ***may not*** impose this "orientation period" simply to delay the effective date of coverage.		
Wellness Program Rules	ACA allows plans to increase the reward (or penalty) for wellness programs to 30% of the cost of coverage (50% for programs designed to prevent or reduce tobacco use). Final regulations provide different rules for "participatory," "activity-only," and "outcome-based" wellness programs.	Plan Years beginning on or after January 1, 2014.	Not Applicable.
Coverage of Clinical Trials	Group health plans must cover routine patient costs for care in connection with approved clinical trials for eligible conditions.	Plan Years beginning on or after January 1, 2014.	Not Applicable.
Limits on Out-of-Pocket Expenses	Group health plans may not have out-of-pocket (OOP) maximums greater than those allowed for high deductible health plans (HDHPs). In 2015, the OOP limits are $6,600 (single) and $13,200 (family/other than single).	Plan Years beginning on or after January 1, 2015.	Not Applicable.
Maximum Deductibles	Deductibles can be no greater than $2,000 for single coverage and $4,000 for family coverage.	Plan Years beginning on or after January 1, 2014.	Not Applicable.
Nondiscrimination	Rules prohibiting discriminatory plan provisions in favor of highly compensated individuals are made applicable to fully-insured plans. Although delayed with respect to fully-insured plans, the rules remain applicable to self-funded plans, and fully insured plans are advised to proceed with caution.	Delayed pending further guidance.	Not Applicable.