UBA PPACAAdvisor

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# Preparing for PPACA – A Readiness Checklist

**Updated March 2014**

As we approach the month of April, employers should be taking steps to ensure they are prepared to meet the Patient Protection and Affordable Care Act (PPACA) requirements that begin in 2014 and in 2015. In many instances, employers will need to begin tracking employees' hours in the next month or two. In addition, while some requirements vary based on employer size, other requirements apply to all employers. The most significant upcoming requirements and options for an employer include the following.

**Determining "Large Employer" Status**

Beginning in 2015, the employer-shared responsibility ("play or pay") requirements will apply to employers that had 100 or more full-time or full-time equivalent (FTE) employees during 2014. To satisfy the play or pay requirements, an employer must offer affordable, minimum value coverage to most of its employees who work 30 or more hours per week or the employer must pay a penalty. When counting employees, all of the people employed by employers that are commonly owned (a controlled group) are combined.

Large employer status is always determined on a calendar year basis, even if the plan is a non-calendar year plan. Under a special rule, during 2014, an employer may use any six-consecutive month period it chooses to determine its 2014 employee count, which will determine whether play or pay requirements apply to it for 2015. At a minimum, employers will need to look at their employees' hours from July through December of this year, but it may be better to start sooner to have time to make any needed adjustments.

Employers with 50 to 99 full-time or full-time equivalent employees do not have to meet the play or pay requirements until 2016 if they essentially keep their headcount, eligibility requirements, benefit levels, and employer contribution amount or percentage at the same level it was on February 10, 2014. Employers must certify to the IRS that they have met these requirements.

**2014 Benefit Requirements**

Regardless of the employer's size, if the employer offers group health coverage as of the first day of the 2014 plan year, to comply with PPACA the plan must meet these requirements:

- Waiting periods may not be longer than 90 days from the date the person meets the plan's eligibility requirements
- Pre-existing condition limitations may not apply to either adults or children
- Annual dollar limits may not apply to essential health benefits
- The out-of-pocket maximum for in-network benefits may not be more than $6,350 for single coverage and $12,700 for family coverage. Out-of-pocket maximums include deductibles, coinsurance and copays, but not premiums. A plan with different medical and prescription drug vendors may only need to meet the out-of-pocket requirements with respect to its major medical benefits in 2014. [The out-of-pocket limit does not apply to grandfathered plans. It likely does not apply to renewals of 2013 policies in states that are permitting renewal of 2013 policies that do not meet all PPACA requirements.]

In addition, small employers (generally those with fewer than 50 employees) with insured plans must offer coverage for a variety of medical treatments (called the essential health benefits), with a limited deductible and with premiums that are community rated. [These requirements do not apply to renewals of 2013 policies in states that are permitting renewal of 2013 policies that do not meet all PPACA requirements.]

Stand-alone health reimbursement arrangements (HRAs) are no longer permitted unless benefits are limited to dental and vision care or only provided to retirees. HRAs that reimburse medical expenses are still allowed if they are integrated with a group health plan.

A health care flexible spending account (FSA) must qualify as an excepted benefit. Essentially, this means that the participant also must be eligible for major medical coverage through the employer and the employer’s contribution may not be more than the greater of two times the employee’s salary reduction contribution (that is, an employer match) or $500 more than the employee’s salary reduction.

**Large Employers for 2015**

If the employer is large enough that the play or pay requirements will apply in 2015, it needs to decide how it will determine which of its employees are “full-time” under PPACA. Under the rules, an employer may use one of two methods to determine whether an employee is full-time (that is, the employee averages at least 30 hours per week). Employers need to decide soon if they will use the monthly or look-back measurement method (or if they will use the monthly method for some employee groups and look-back for others; this is permitted, but with some limitations).

Because employers with calendar year plans will need to offer affordable, minimum value coverage to full-time employees starting January 1, 2015, or pay a penalty, employers that choose to use the look-back period generally will need to begin tracking hours not later than July 1, 2014, and many will want to begin this process before then. Employers with non-calendar year plans may wait until the start of their 2015 plan year to meet the play or pay requirements if they meet certain transition requirements, but many of those employers also will need to begin tracking hours in 2014.

- Under the monthly method, the employer will simply look at the hours the employee works each calendar month, and either offer coverage for employees who worked an average of 30 or more hours per week during that month, or pay a penalty.

- Under the look-back method, the employer will use hours worked during a "measurement period" to determine whether the employee will be considered full-time during the following "stability period." The measurement period is chosen by the employer. It must be between three and 12 months. The stability period also is chosen by the employer. In most cases, it must be the same length as the measurement period, although employers with plan years that start January 1 through April 1, 2015, may use a shorter measurement period in 2014 with a 12-month stability period in 2015. (The 2014 measurement period must begin by July 1 and must be at least six consecutive months.) The employer may elect an administrative period to give itself time to determine which employees should be offered coverage and get them enrolled. The administrative period cannot be more than 90 days.

  Note: Employers may find it simplest to use a stability period that is the same as their coverage period and a measurement period that ends shortly before their open enrollment period. So, for instance, a calendar year plan may want to use a measurement period of October 16 - October 15, an administrative period of October 16 through December 31 and a stability period of January 1 through December 31. For 2014, using the special shorter measurement period, it may want to use a measurement period of April 15 through October 15, 2014, and an administrative period of October 16 through December 31, 2014, to determine who is eligible for coverage in 2015, conduct open enrollment, and provide enrollee data to the insurance company, or third party administrator, by the January 1 coverage effective date.

Large employers will need to decide soon if they will provide coverage that meets government standards, or pay the non-deductible penalty instead.

If a large employer does not offer "minimum essential" (basic medical) coverage to at least 70% of its full-time employees in 2015, the employer will owe a penalty of $166.67 per month ($2,000 per year) on all of its full-time employees.

If a large employer does not offer affordable, minimum value coverage to its full-time employees, the employer will owe a penalty of $250 per month ($3,000 per year) for each full-time employee who receives subsidized coverage through a public Marketplace. Coverage is "affordable" if the employee's cost for *single* coverage is less than 9.5% of any of these measures: the employee’s W-2 (Box 1) income, the employee’s rate of pay at the start of the year (hourly rate multiplied by an assumed 130 hours per month or monthly salary), or the Federal Poverty Level (currently $11,670 for a single person in most states). Coverage is "minimum value" if the actuarial value of the benefit is at least 60%. (Most employer-provided plans meet this 60% threshold.)

**Plan Amendments**

Employers should begin thinking about whether their plans will need to be amended.

Many group health plans will need to be amended to reflect the required changes to benefits and waiting periods. Employers also should consider whether eligibility language will need to be updated to reduce

the number of hours the employee must work to be eligible and/or to address look-back periods or actual hours worked instead of the “regularly scheduled to work” language that is common now.

Section 125 plans have until December 31, 2014, to amend the plan for any or all of these changes:

- The required reduction in the maximum employee contribution to a health care FSA of $2,500
- A one-time opportunity to make a mid-year change during the 2013-2014 plan year because of the individual mandate and/or opening of the health Marketplace [available to non-calendar year plans only]
- Adoption of the newly permitted health care FSA rollover (and elimination of any available grace period)

HRAs must be amended to allow an employee, or a former employee, to permanently opt out of and waive future reimbursements from the HRA – at least annually – and to provide that upon termination of employment either the remaining amounts in the HRA will be forfeited or the employee will be permitted to permanently opt out of and waive future reimbursements from the HRA.

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