HEALTH CARE REFORM COMPLIANCE CHECKLIST FOR PLAN SPONSORS

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Caution: *The purpose of this checklist is to provide a summary of the principal requirements under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Act"), that apply to employer-sponsored group health plans. The Act and its related guidance go into much more detail and should always be consulted when considering its application in any particular plan.*

Requirement	*Description*	*All Plans (AP), Grandfathered Plans (GFP) or Non-Grandfathered Plans (NGFP)*	*Effective Date*
Health Care Reform Changes in 2010			
Dependent Coverage for Children Until Age 26	Plans must offer coverage to children of covered employees up to age 26 regardless of marital or student status, financial support, residence, etc.	AP	Plan years beginning on or after Sept. 23, 2010
	Plans are not required to provide coverage to any child up to age 26 who is eligible for coverage under another employer's plan until plan years beginning on or after January 1, 2014.	GFP	
Annual Maximums Restricted	Plans may impose an annual limit on essential health benefits of no less than: - $750,000 for plan years beginning on or after Sept. 23, 2010 - $1,250,000 for plan years beginning on or after Sept. 23, 2011 - $2,000,000 for plan years beginning on or after Sept. 23, 2012 and before January 1, 2014 Annual limits on essential health benefits are completely prohibited for plan years beginning on or after January 1, 2014.	AP	
Lifetime Maximums Prohibited	Plans may no longer impose lifetime limits on essential health benefits.	AP	
Pre-existing Condition Exclusions Prohibited for Children Under Age 19	Plans may no longer impose a pre-existing condition exclusion on children under the age of 19.	AP	Plan years beginning on or after Sept. 23, 2010
Rescission Prohibition	Rescission of coverage is only allowed for an intentional misrepresentation of material fact or fraud.	AP	
Preventive Care	Plans must cover certain preventive care services in-network at no cost to participants.	NGFP	
Choice of Primary Care Provider and OB/GYN Services	Plans must allow participants to choose any participating primary care provider, including pediatricians, and access OB/GYN care without the need for prior authorization or a referral. Plans must include a notice of these patient protections whenever a summary plan description or other similar description of plan benefits is provided to a participant or beneficiary.	NGFP[1]	

[1] Section 102(d)(2) of division BB of the CAA amended Section 1251(a) of ACA to clarify that the new and recodified patient protection provisions of division BB of the CAA, including those related to choice of health care professional apply to grandfathered plans effective for plan years beginning on or after January 1, 2022.

Requirement	*Description*	*All Plans (AP), Grandfathered Plans (GFP) or Non-Grandfathered Plans (NGFP)*	*Effective Date*
Emergency Services[2]	Plans that provide emergency services must cover non-network providers at network rates and not require prior authorization.	NGFP	
Internal Appeals and External Review Processes	Plans must implement internal appeals and external review processes that satisfy certain requirements. The requirements have staggered effective dates.	NGFP	
Grandfathered Plan Notice	Plans must include a grandfathered plan notice in any plan materials describing benefits.	GFP	
Non-Discrimination Rules for Insured Plans	Insured plans must not discriminate in favor of highly compensated employees. Enforcement on hold pending regulations issued by the IRS.	NGFP	Plan years beginning on or after Sept. 23, 2010, but effective date postponed until final regulations issued
Early Retiree Reinsurance Program	Temporary program available to reimburse employer-sponsored plans for some of the benefits provided to early retirees and their dependents. The funding was exhausted and the program closed in 2011.	AP	June 1, 2010
Small Employer Premium Tax Credit	Limited tax credit available to small employers toward the cost of health care premiums.	AP	Jan. 1, 2010
Health Care Reform Changes in 2011			
Over-The-Counter Medicines	Participants must have a prescription for over the counter medications to be eligible for reimbursement under a Health FSA, HSA, or Archer MSA.[3]	AP	Jan. 1, 2011
Medical Loss Ratio Requirements and Rebates	Issuers must comply with medical loss ratio requirements or pay rebates to customers. First rebates are due August 1, 2012. Employers will need to determine how to allocate the rebates.	AP	
Health Care Reform Changes in 2012			
W-2 Reporting	Employers must include the aggregate cost of employer-sponsored health coverage on employee W-2s.	AP	2012 taxable year

[2] Pursuant to the No Surprises Act, ACA's emergency services rules under PHSA Section 2719A sunset for plan years beginning on or after January 1, 2022, when new and expanded patient protections related to emergency services and balance billing take effect.

[3] Section 3702 of the CARES Act amended the Code to allow HSAs, MSAs, FSAs, and HRAs to reimburse all over-the-counter medical products. It also expanded the definition of qualified medical care to include menstrual care products (i.e., a tampon, pad, liner, cup, sponge, or similar product). These changes are permanent and apply to amounts paid after December 31, 2019 for HSAs and Archer MSAs and expenses incurred after December 31, 2019 for FSAs and HRAs.

Requirement	*Description*	*All Plans (AP), Grandfathered Plans (GFP) or Non-Grandfathered Plans (NGFP)*	*Effective Date*
Summary of Benefits and Coverage	Insurers and plan administrators must provide a summary of benefits and coverage that adheres to a format set by the government.	AP	First open enrollment period beginning on or after Sept. 23, 2012 For other enrollees, the first day of the first plan year beginning on or after Sept. 23, 2012
60-Day Advance Notice of Material Changes	Plan must provide 60-days advance notice of material changes to the summary of benefits and coverage.	AP	Effective after SBCs are issued
Patient Centered Outcomes Research Institute Fee	Plan sponsors and issuers must pay an annual fee based on the number of covered lives under health plans and policies to fund the Patient Centered Outcomes Research Institute. The first fee was for plan and policy years ending on or after October 1, 2012 and the last fee is for plan and policy years ending before October 1, 2029.	AP	Plan years ending on or after Oct. 1, 2012 – plan years ending before Oct. 1, 2029
Quality of Care Reporting	Employers will have to comply with reporting requirements disclosing health care benefits and reimbursement structures. Awaiting regulations from the federal government.	NGFP	2012 Postponed pending final regulations
Health Care Reform Changes in 2013			
Health Flexible Spending Account Cap	The annual cap for salary reduction contributions for Health FSAs is limited to $2,500, indexed for cost-of-living adjustments.	AP	Plan years beginning on or after Jan. 1, 2013
Retiree Prescription Drug Coverage	Employers providing medical prescription drug coverage cannot deduct Medicare Part D drug subsidies paid to employers.	AP	Jan. 1, 2013
Health Benefit Exchange Notice	Most employers must provide all employees with a written notice about the Health Benefit Exchange.	AP	Oct. 1, 2013
Health Care Reform Changes in 2014			
Annual Maximums Prohibited	Plans may no longer impose annual limits on essential health benefits.	AP	Plan years beginning on or after Jan. 1, 2014
Pre-existing Condition Exclusions for All Participants	Plans may no longer impose a pre-existing condition exclusion on participants age 19 or over.	AP	
Dependent Coverage for Children Until Age 26	Grandfathered plans may no longer deny coverage to a child who is eligible for coverage under another employer's plan.	GFP	
Waiting Periods	Employer sponsored group health plans cannot impose a waiting period that exceeds 90 days.	AP	

Requirement	*Description*	*All Plans (AP), Grandfathered Plans (GFP) or Non-Grandfathered Plans (NGFP)*	*Effective Date*
Clinical Trial Coverage	Plans must cover routine patient costs for clinical trials.	NGFP	
Nondiscrimination in Health Care Providers	Plans must not discriminate with respect to plan participation or coverage against any health care provider acting within the scope of the provider's license or certification.	NGFP	
Cost Sharing Limitations	Annual out-of-pocket maximums cannot exceed the limits for high deductible health plans.	NGFP	
Essential Health Benefits Coverage	Small, insured plans must cover essential health benefits, limit cost sharing, and cover at least 60% of the actuarial value of the covered benefits.	NGFP	
Wellness Programs	Employers can offer financial incentives up to 30%, or up to 50% if related to a program designed to prevent or reduce tobacco use, of the cost of coverage for participation in wellness programs.	AP	
Reinsurance Contributions	Insurers and self-funded group health plans must make annual reinsurance contributions to HHS to be redistributed to insurers to help stabilize premiums in the individual market from 2014 through 2016. Enrollment counts must be submitted to HHS by November 15 of each year and payment is due (in part or whole) by January 15 of the following year (and November 15 of the following year if payment is made in two installments).	AP	2014-2016
Automatic Enrollment	Repealed.		
Health Care Reform Changes in 2015			
Play or Pay for Large Employers	Large employers may be subject to a penalty tax for: (1) failing to offer health care coverage for all full-time employees and their dependents; or (2) offering minimum essential coverage that is either not affordable or under which the plan's share of the total allowed cost of benefits is not at least 60% of the actuarial value.	AP	2015
Employer Reporting Requirements	Employers must report to the government and employees certain plan specifics and whether minimum essential coverage was offered.	AP	
Health Care Reform Changes in 2016			
Nondiscrimination Under Health Program or Activity	Health programs or activities that receive federal financial assistance from HHS may not discriminate on the basis of race, color, national origin, sex, age, or disability. Regulations implementing this rule (especially with respect to its impact on gender and sexual orientation discrimination) remain in flux.	AP	Subject to change due to final rules and resolution of lawsuits: Plan years beginning on or after January 1, 2017 for plan design changes Otherwise, July 18, 2016
Health Care Reform Changes in 2022			
Excise Tax on Cadillac Plans	Repealed.		

Requirement	*Description*	*All Plans (AP), Grandfathered Plans (GFP) or Non-Grandfathered Plans (NGFP)*	*Effective Date*
Transparency in Coverage Machine Readable Files	Plans must disclose pricing information to the public through three machine readable files regarding payment rates negotiated between plans and providers for all covered items and services (the "In-Network File"), the unique amounts a plan allowed, as well as associated billed charges, for covered items or services furnished by out-of-network providers during a specified time period (the "Out-of-Network File"), and pricing information for prescription drugs (the "Prescription Drug File"). The Departments required plans to disclose the In-Network File and the Out-of-Network File by July 1, 2022 for plan years on or after January 1, 2022, and will not require plans to disclose the Prescription Drug File until further notice.	NGFP	July 1, 2022
Health Care Reform Changes in 2023			
Transparency in Coverage Cost-sharing Disclosures	Plans must disclose to participants, beneficiaries, or enrollees upon request, through an internet self-service tool, cost-sharing information for a covered item or service from a particular provider or providers, and make such information available in paper form upon request effective January 1, 2023 (500 items and services) and January 1, 2024 (all covered items and services).	NGFP	Plan years beginning on or after January 1, 2023
Miscellaneous			
Grandfathered Status	Group health plans that were in existence on or before March 23, 2010, and that have not undergone significant changes since then ("grandfathered plans"), have to comply with some, but not all, of the ACA requirements. If an employer sponsors a grandfathered plan and has made any changes to its health plan or added a wellness component in 2022, or in connection with open enrollment for an upcoming plan year, it may want to consider whether those changes cause the plan to lose grandfathered plan status. A plan that loses grandfathered status is required to comply with additional requirements that apply to non-grandfathered plans as of the date on which it loses grandfathered plan status. Very few plans still have grandfathered plan status. Those that do are required to make sure that they comply with the grandfathered plan notice requirements.	GFP	N/A

Note: This summary is intended to provide general information. It should not be relied on as legal advice or as a legal opinion on any specific facts or circumstances. You are urged to consult legal counsel concerning your situation and any specific legal questions you may have.