2019 ACA Checklist

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This checklist is designed to help employers who sponsor group health plans review their compliance with key provisions of the Affordable Care Act (ACA) for 2019. If you have any questions regarding your responsibilities, please contact a knowledgeable employment law attorney, benefits advisor, or your carrier.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements or amendments to the law. Additionally, your company or group health plan may be exempt from certain requirements and/or subject to more stringent rules under your state's laws.

1. Evaluate Grandfathered Status of Group Health Plan

A grandfathered plan is one in existence as of March 23, 2010 that has covered at least one person continuously from that day forward. Grandfathered plans ***do not have to comply with certain ACA rules.***

- ✓ Determine whether any changes to the plan that reduce benefits or increase costs to employees and dependents enrolled in coverage result in a loss of grandfathered status.
- ✓ **If the plan loses grandfathered status**, confirm that the plan design and benefits offered reflect all ACA requirements that previously did not apply because the plan was exempt (such as coverage of preventive services without cost-sharing).
- ✓ **If the plan remains grandfathered**, provide a Notice of Grandfathered Status whenever a summary of plan benefits is provided to participants and beneficiaries. Continue to maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify grandfathered status.

2. Review Plan Documents for Required Changes to Plan Benefits

Certain requirements apply to particular plan designs, as noted below.

All Group Health Plans:

- ✓ Ensure that any **waiting period**—the time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible to enroll in the plan—does not exceed 90 days. (Other conditions for eligibility that are not based solely on the lapse of a time period are generally permissible.)

- If the plan requires completion of an employment-based orientation period as a condition for eligibility, ensure the orientation period **does not exceed one month** and the maximum 90-day waiting period begins on the first day after the orientation period. (**Note:** Employers subject to "pay or play" may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to a penalty.)

✓ Confirm that no **annual dollar limits** apply to coverage of "essential health benefits" (EHBs), a comprehensive package of items and services. If the plan limits the number of visits to health providers or days of treatment, verify that the visit or day limit does not amount to a dollar limit.

✓ Verify that **no preexisting condition exclusions** are imposed on any individual, regardless of age.

✓ Ensure that an **employer payment plan** is not in place (an arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or uses its funds to directly pay the premium for an individual policy—with the exception of qualified small employer HRAs [QSEHRAs]*).

Non-Grandfathered Group Health Plans Only:

✓ For small group plans, confirm the plan covers EHBs. (This requirement does not apply to self-insured plans or plans offered in the large group market.)

✓ Ensure that annual out-of-pocket costs for coverage of **all** EHBs provided in-network do not exceed **$7,900 for self-only coverage** or **$15,800 for family coverage**.

- **Note:** The self-only maximum annual limitation on cost-sharing applies to **each individual**, regardless of whether the individual is enrolled in self-only coverage or family coverage under a group health plan.
- Plans with more than one service provider may structure a benefit design using separate out-of-pocket limits across multiple categories of benefits (rather than reconcile claims across multiple service providers), provided the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limit.
- A plan that includes a network of providers may, but is not required to, count out-of-pocket spending for out-of-network and non-covered items and services toward the plan's annual maximum out-of-pocket limit.

Note: Certain businesses may be allowed to renew existing group coverage that does not comply with the requirements to cover EHBs and limit annual cost-sharing under the plan, through policy years beginning **on or before October 1, 2019, so long as the policy ends by December 31, 2019**. Not all states and insurers will permit coverage to renew. Businesses that are eligible to continue existing coverage will receive a notice from their insurance company.

3. Analyze Tax-Favored Arrangements

Employers who maintain HRAs, health FSAs, and cafeteria plans should confirm that these arrangements comply with ACA-related requirements.

Health Reimbursement Arrangements (HRAs)

- ✓ Confirm that the HRA (other than a QSEHRA,* a retiree-only HRA, or an HRA consisting solely of excepted benefits) **is properly "integrated" with group health plan coverage** in order to satisfy the preventive services requirements and the annual dollar limit prohibition.
  - To be "integrated," an HRA must meet specific requirements under either of two methods described in agency guidance, as clarified by ACA FAQs.
- ✓ If the HRA does not constitute a QSEHRA,* confirm that the HRA **is not being used to reimburse an employee's individual insurance policy premiums**. Such an arrangement may be subject to a $100 per day excise tax per applicable employee (which is $36,500 per year, per employee).

* Federal law now allows eligible small employers—generally those with **fewer than 50 full-time employees who do not offer a group health plan** and that meet certain notice and benefit requirements—to offer QSEHRAs to reimburse employees for qualified medical expenses, including individual insurance premiums.

Health Flexible Spending Arrangements (FSAs)

- ✓ Confirm that the health FSA **qualifies as excepted benefits** to comply with the preventive services requirements.
  - Health FSAs are considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election).

- ✓ Confirm that the health FSA is **offered through a cafeteria plan** (a plan which meets specific requirements to allow employees to receive certain benefits on a pre-tax basis) in order to comply with the annual dollar limit prohibition.
- ✓ Ensure plan documents are amended to reflect that employee salary reduction contributions to health FSAs are limited to **$2,700 annually**.
    - The amendment to the written cafeteria plan may be expressed as a maximum dollar amount, a maximum percentage of compensation, or by another method of determining the maximum salary reduction contribution.
- ✓ Determine whether you will allow employees to carry over up to $500 of unused health FSA amounts to use in the following plan year, and adopt appropriate plan amendments. (A plan incorporating the carryover provision **may not also provide for a grace period** in the plan year to which unused amounts may be carried over.)

Cafeteria Plans Generally

- ✓ Determine whether you will allow employees to make **additional mid-year changes in salary reduction elections** in the event of an employee's enrollment in Health Insurance Marketplace coverage and/or a reduction in an employee's hours of service, as permitted in agency guidance, and adopt appropriate plan amendments.
- ✓ Confirm that section 125 plan documents were amended to comply with the **prohibition on providing a qualified health plan** offered through the individual Health Insurance Marketplace as a benefit under an employer-sponsored cafeteria plan.

4. Provide Required Notices to Employees and Dependents

Please contact your carrier or an employment law attorney if you have questions regarding these notices.

Health Insurance Marketplace Notice

- ✓ Provide a written notice with information about the Health Insurance Marketplace to each new employee at the time of hiring, **within 14 days of the employee's start date**. Employers are not required to provide a separate notice to dependents.

Summary of Benefits & Coverage (SBC) and Notice of Plan Changes

- ✓ Confirm contractual arrangements with the carrier (insured group health plans) or third party administrator (self-insured plans) to prepare and provide the SBC. If the carrier or TPA does not assume responsibility, the employer should provide this notice (without charge) to employees and beneficiaries at specified times during the enrollment process and upon request.
    - **Note**: Employers that enter into a binding contract with another party to provide the SBC must satisfy additional obligations, including monitoring compliance.
- ✓ Ensure that enrollees are provided with notice of any material modification that would affect the content of the SBC (and that occurs other than in connection with coverage renewal or reissuance) **no later than 60 days prior to the effective date of the change**.

5. Comply With "Pay or Play" Responsibilities, If Applicable

Applicable large employers—generally, those with 50 or more full-time employees, including full-time equivalent employees—are subject to the ACA's employer shared responsibility ("pay or play") requirements. Due to the complexity of the law in this area, employers are strongly advised to work with knowledgeable employment law counsel to ensure full compliance.

- ✓ Determine **"applicable large employer" (ALE) status** for the upcoming calendar year by calculating the average number of full-time employees and full-time equivalents (FTEs) across the months in the current year. (Special counting rules apply for seasonal workers.)
    - **Employer Aggregation Rules:** Small employers that individually do not employ 50 or more full-time employees or FTEs **may still be subject to the requirements if they meet the threshold when combined with other companies under common ownership** or that are otherwise related.
    - **Note:** The rules for combining related employers do not apply for purposes of determining whether a particular company owes a penalty or the amount of any penalty. That is determined separately for each related company.
- ✓ Determine whether group health plan coverage will be offered to **full-time employees** (and their dependents), using the measurement methods and rules for calculating hours of service described in the "pay or play" final regulations.

- An employee is full-time for a calendar month if he or she averages at least 30 hours of service per week (or 130 hours for the month). The final regulations describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and employees of educational organizations.

✓ For ALEs offering coverage, review the cost of your group health plan coverage to determine whether it is **affordable**.

- In general, coverage is affordable for 2019 if an employee's required contribution for self-only coverage does not exceed **9.86%** of his or her household income for the taxable year. ALEs may use a number of safe harbors to determine affordability, including reliance on Form W-2 wages.
- The IRS has stated that until final regulations on **opt-out arrangements** are applicable, employers can rely on the opt-out arrangement guidance provided in IRS Notice 2015-87 and a subsequent proposed rule. That guidance generally provides that, for purposes of "pay or play" and the corresponding information reporting provisions, **employers are only required to increase an employee's required contribution by the amount of an unconditional opt-out arrangement adopted after December 16, 2015**. An unconditional opt-out arrangement provides payments conditioned solely on an employee declining employer-sponsored coverage and not on an employee satisfying any other meaningful requirement related to the provision of health care to employees, such as a requirement to provide proof of other coverage.

✓ For ALEs offering coverage, determine whether your group health plan coverage provides **minimum value**.

- A plan generally provides minimum value if it pays for at least 60% of covered health care expenses and provides substantial coverage of inpatient hospitalization and physician services. Federal agencies have produced a minimum value calculator that allows employers to determine if a place with standard features provides minimum value. However, results of the calculator—or any other method chosen—should be carefully reviewed with benefits counsel.

✓ **Determine whether a penalty may apply.** An ALE subject to "pay or play" may be liable for a penalty if it does not offer affordable health insurance that provides minimum value to its full-time employees (and their dependents), and any full-time employee receives a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace. (Note: In determining whether a penalty applies, ALEs should be aware of limited non-penalty periods provided for in the "pay or play" final regulations, during which an ALE generally will not be subject to a penalty.)

- ✓ **Determine whether to appeal a Marketplace decision regarding a prior year, if applicable.** The Health Insurance Marketplace sends letters to notify certain employers that one or more of their employees was determined eligible for advance premium tax credits and cost-sharing reductions and had enrolled in a Marketplace plan. Because these events may trigger employer "pay or play" penalties, employers must file an appeal **within 90 days** of the date stated on the Marketplace notice.
- ✓ **Review and respond to IRS Letter 226J, if applicable.** The IRS issues **Letter 226J** to an ALE if it determines that, for at least one month in the applicable calendar year, one or more of the ALE's full-time employees was enrolled in a qualified health plan for which a premium tax credit was allowed (and the ALE did not qualify for an affordability safe harbor or other relief for the employee).
- ✓ **Pay assessed "pay or play" penalties, if applicable.** The IRS will assess "pay or play" penalties for prior years and issue a notice and demand for payment via **Notice CP 220J**. That notice will instruct the ALE on how to make a payment. ALEs will not be required to include the payment on any tax return.

6. Satisfy Information Reporting Requirements, If Applicable (Forms 1094 & 1095)

Information reporting is used to determine compliance with the ACA's individual responsibility and "pay or play" provisions. Reporting entities are required to report in early 2019 for coverage offered (or not offered) in calendar year 2018.

- ✓ Determine whether you are a reporting entity (and what type) to understand applicable reporting requirements:
  - **"Section 6055" Reporting Entities.** Self-insuring employers that are not ALEs that provide **minimum essential health coverage** are required to report information on this coverage to the IRS and to covered individuals under section 6055 of the Internal Revenue Code.
  - **"Section 6056" Reporting Entities.** Employers with **50 or more full-time employees** (including FTEs) are required to report information to the IRS and to their employees about their compliance with "pay or play" under Internal Revenue Code section 6056.
- ✓ Compile the required information for section 6055 reporting and/or the required information for section 6056 reporting.
- ✓ Review the IRS Forms and Instructions:

- Forms 1094-B and 1095-B (along with Instructions) are available for **section 6055** reporting entities.
- Forms 1094-C and 1095-C (along with Instructions) are available for **section 6056** reporting entities (or employers that are subject to **both** reporting provisions).

✓ Determine whether to hire a **third party** to fulfill reporting responsibilities (reporting entities will still be liable for the failure to report information and furnish statements).

✓ For section 6056 reporting entities, determine whether you will use the general method of reporting or a simplified alternative method to satisfy the reporting requirements.

✓ If the reporting entity plans to furnish statements **electronically** for the first time, or if prior consents only applied to the statements required to be furnished in prior reporting years, ensure that affirmative consent is obtained from employees prior to furnishing (section 6056 reporting entities **must also** ensure that certain notice, hardware, and software requirements are met).

✓ Remember to comply with the information reporting deadlines.

Section 6055 Deadlines (Forms 1094-B and 1095-B):

- Forms 1094-B and 1095-B must generally be filed with the IRS annually, **no later than February 28** (or April 1, if filing electronically).
- Forms 1095-B must generally be furnished to "responsible individuals" (may be the primary insured, employee, former employee, or other related person named on the application) **by January 31**.

Section 6056 Deadlines (Forms 1094-C and 1095-C):

- Forms 1094-C and 1095-C must generally be filed with the IRS annually, **no later than February 28** (or April 1, if filing electronically).
- Forms 1095-C must generally be furnished to all full-time employees **by January 31**.

7. Other Action Items

This section outlines actions required for continued ACA compliance, as well as additional items that may be of significance for certain employers and group health plans.

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- ✓ **Additional Medicare Tax for High Earners.** Remember to withhold Additional Medicare Tax (0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year.
- ✓ **Coverage of Preventive Services.** Continue to monitor guidelines for preventive services, which are regularly updated to reflect new scientific and medical advances. As new services are approved, non-grandfathered group health plans will be required to cover them with no cost-sharing for plan years beginning one year later.
- ✓ **Medical Loss Ratio (MLR) Rebates.** Distribute rebates received from insurance companies to eligible plan enrollees as appropriate. Rebates are due to employer-policyholders by **September 30, 2019**. These rules do not apply to employers who operate self-insured plans.
- ✓ **PCORI Fees.** Employers sponsoring certain self-insured health plans (including HRAs not treated as excepted benefits) are responsible for fees to fund the Patient-Centered Outcomes Research Institute (PCORI). To report and pay the fees, IRS Form 720 must be filed by **July 31, 2019**.
- ✓ **Form W-2 Reporting of Employer-Provided Health Coverage.** Continue to report the cost of health coverage provided to each employee annually on Form W-2, which must be furnished to employees by January 31. (This requirement **does not apply to employers required to file fewer than 250 Forms W-2 for the preceding calendar year**.)
- ✓ **Section 1557 Nondiscrimination Requirements (If Applicable).** Entities administering any health program or activity **that receives federal financial assistance** (such as hospitals that accept Medicare or doctors who accept Medicaid) must confirm compliance with the final rule implementing section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. In addition, certain **notice and tagline requirements** must be met. For more on this notice requirement, click here (see "Procedural Requirements").

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