2018 ACA Compliance Checklist

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 2018. 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.

Checklist at a Glance:

Following are the topics covered in this checklist. Detailed information is provided below for each section.

1) Evaluate Grandfathered Status of Group Health Plan
2) Review Plan Documents for Required Changes to Plan Benefits
3) Analyze Tax-Favored Arrangements
4) Provide Required Notices to Employees and Dependents
5) Comply With "Pay or Play" Responsibilities
6) Additional Action Items

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.

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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 that 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.

Non-Grandfathered Group Health Plans Only:

- Ensure that annual out-of-pocket costs for coverage of **all** EHBs provided in-network do not exceed **$7,350 for self-only coverage** or **$14,700 for family coverage** ($7,900 for self-only coverage or $15,800 for family coverage in 2019).
    - **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.
    - 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 towards the plan's annual maximum out-of-pocket limit.

3) Analyze Tax-Favored Arrangements

Employers who maintain HRAs, health FSAs, and cafeteria plans should confirm that these arrangements comply with ACA 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 clarified by FAQs.

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Health Flexible Spending Arrangements (FSAs)

- Confirm that the health FSA **qualifies as an excepted benefit** 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).
- Ensure plan documents are amended to reflect that employee salary reduction contributions to health FSAs are limited to **$2,650 annually**.
- Determine whether you will allow employees to carry over up to $500 of unused health FSA amounts to use in the following plan year under the modified "use-or-lose" rule, 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.)

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 Exchanges 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.
- 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**.
- Be sure you are utilizing the new SBC template for use **as of April 1, 2017**.

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5) Comply With "Pay or Play" Responsibilities

Applicable large employers – generally, those with 50 or more full-time employees, including full-time equivalents – are subject to the ACA 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. (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 if an employee's required contribution for self-only coverage does not exceed **9.56%** 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 recent 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.

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- 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 and physician services. Federal agencies have produced a minimum value calculator to determine if a plan with standard features provides minimum value. However, results of the calculator – or any other method chosen – should be carefully reviewed with benefits counsel.
- **Determine if 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 if 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.)

6) Additional Action Items

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

- **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.
- **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, 2018.

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