

# Affordable Care Act

## Large Employer Health Reform Checklist



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Employers that offer health care coverage to employees are responsible for complying with many of the provisions of the Affordable Care Act (ACA). Most health reform changes apply regardless of the employer's size, but some changes apply only to small employers and other changes apply only to large employers. Even employers that do not offer any coverage need to comply with certain requirements to distribute notices to workers or submit reports to federal agencies.

This edition of our Health Reform Checklist summarizes the provisions applying to large employers.

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### Starting with the Basics

The effective dates of most ACA provisions usually are based on the employer's group health "plan year" starting date. Other items take effect on a specific calendar date. Further, whether or not a provision applies often depends on the employer's size or on the type of group policy.

**"Large Employer"** generally means an organization (including subsidiaries) with 50 or more full-time and full-time-equivalent employees.

**"Plan Year"** is the period (usually a 12-month period) that is identified in the plan's ERISA document or Form 5500. For non-ERISA plans, the plan year is the benefit year or policy year.

**"Large Group"** refers to the type of group health insurance policy that is sold to groups over a certain size. Policy requirements, and the provisions that determine the group's size, are defined by each state according to its state insurance law. Generally, "large group" policies are subject to fewer policy design requirements than "small group" policies. In many states, "large group" policies are available to groups with 50 or more employees, while other states require at least 100 employees. For details about a state's insurance law and policy options, consult an agent or broker licensed in that state.



## Ongoing Requirements for Notices and Reports

**Employer Notice about Health Insurance Exchanges (Marketplaces)** — Employers must provide a written notice to all full-time and part-time employees, whether or not benefits-eligible, within **14 days of hire**. The federal notice explains the availability of the Health Insurance Exchanges (Marketplaces) and the circumstances under which employees may be eligible for subsidies to buy coverage through an Exchange.

**This requirement applies to all employers covered by the Fair Labor Standards Act (FLSA), including employers that do not offer health coverage.**

Employers can satisfy the Employer Exchange Notice requirement by using one of the following DOL model notices, filling in the blank sections as needed, and distributing the completed notice to all employees within 14 days of hire:

- [Employers who currently offer health insurance to any or all employees.](#)
- [Employers who currently do not offer health insurance to any or all employees.](#)

**Summary of Benefits and Coverage (SBC)** — Health insurers, and employers with self-funded health plans, must provide an SBC for each plan describing its benefits and coverage using a standardized format. ACA regulations require that the SBC be provided in several

instances (by the first day of open enrollment, by the first day of coverage if there are any changes, upon special enrollment events, upon request, and prior to off-renewal changes). The DOL provides samples and instructions at [SBC Samples and Instructions](#).

**Grandfathered Plan Notice** — Employers with a grandfathered plan must review it to confirm that it still qualifies for grandfathered status. If so, materials describing the plan's benefits must include a notice regarding the plan's status as a grandfathered plan. The notice must include contact information for questions or complaints. Note that plans that lose grandfathered status immediately become subject to the same health reform requirements as nongrandfathered plans.

**Patient Protection Notice** — Nongrandfathered health plans must include a notice regarding each participant's right to designate a primary care physician and to obtain obstetrical or gynecological care without prior authorization.

### W-2 Reporting of Employee Health Coverage

**Cost** — Employers must report the total cost of each employee's health coverage on Form W-2 (box 12). This item is informational only and has no tax consequences. The requirement does not apply to employers that filed fewer than 250 Forms W-2 for the prior tax year.

## Health Plan Fees and Taxes

The ACA imposes certain fees on health plans in order to raise revenue for various purposes, including clinical research, stabilization of high-risk insurance markets, and expansion of health coverage. Some fees apply for a few years, while others are permanent.

For insured plans, the carrier or HMO is responsible for reporting and paying any applicable fees. The employer (policyholder) is not responsible for any duties. For a self-funded (uninsured) health plan, the employer sponsor must report and pay the PCORI fee and TRP fee explained below, if applicable:

- The **Patient-Centered Outcomes Research Institute (PCORI) Fee**, also called the Comparative Effectiveness Research (CER) Fee, is imposed on group health plans to help fund studies on clinical effectiveness and health outcomes. Dental- or vision-only plans, and most health flexible spending accounts (HFSAs), are exempt. The small fee is an annual amount multiplied by the average number of plan participants:

Payment is due July 31 following the calendar year in which the plan year ended (e.g., July 31, 2018 for plan years ending in 2017) using [Form 720](#).

- The **Transitional Reinsurance Program (TRP) Fee** was collected from minimum-value medical plans for calendar years 2014 to 2016 to help fund state reinsurance programs in the individual insurance market. (Self-administered self-funded plans (e.g., union trusts) were exempt for 2015 and 2016.)
- The **Health Insurer Provider (HIP) Fee** is collected from health insurance providers and HMOs (carriers) based on a percentage of the carrier's net written premiums for insured groups. The fee began in 2014. It was waived for 2017, but will resume for 2018.

## Limits on Annual Out-of-Pocket Maximums

All nongrandfathered health plans, whether insured or self-funded, are subject to limits on annual out-of-pocket maximums. All cost-sharing, such as co-pays, deductibles, and co-insurance, for Essential Health Benefits (EHBs) must accumulate to the plan's out-of-pocket maximums up to the following limits:

FOR PLAN YEAR BEGINNING IN:	SELF-ONLY COVERAGE	COVERAGE OTHER THAN SELF-ONLY
2017	\$7,150	\$7,150 per person \$14,300 per family
2018	\$7,350	\$7,350 per person \$14,700 per family
2019	\$7,900	\$7,900 per person \$15,800 per family

Each state, through its state insurance laws, may establish a detailed definition of EHBs for purposes of group health insurance policies issued in that state. Self-funded plans may define EHBs based on general federal guidelines or a state benchmark plan. Generally, an EHB definition includes health care services in the following 10 benefit categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (services for individuals under 19 years of age)



## Insurance Market Reforms

The ACA requires nongrandfathered group health insurance policies sold in the “small group” market to adopt several reforms. Examples include required coverage of all 10 categories of EHBs and adjusted community rating (unless a state’s insurance law allows exceptions). “Large group” policies, which are available only to groups with at least 50 employees (or at least 100 employees, depending on the state), and self-funded health plans are exempt from the market reforms. For details about a state’s insurance law and policy options, consult an agent or broker licensed in that state.

## Employer Shared Responsibility Provision (“Play or Pay”)

The ACA’s Employer Shared Responsibility provision is comprised of two parts:

### Employer Reporting Requirement:

- Under IRC § 6056, employers must report information about health coverage offered to full-time employees. To comply with the reporting requirement, prepare and distribute Form 1095-C to the employee and file copies, along with transmittal Form 1094-C, with the IRS.
- Under IRC § 6055, large employers with self-funded plans must report information about the coverage provided to each individual. To comply with this reporting requirement, prepare and distribute Form 1095-B to plan enrollees and file copies, along with transmittal Form 1094 B, with the IRS. If also subject to § 6056, Forms 1095-C and 1094-C may be used to satisfy both the § 6055 and § 6056 requirements.

For each calendar year, the forms are due early the following year.

### Employer Coverage Offer (often called “the Employer Mandate” and “Play or Pay”):

Employers may be assessed a penalty for failure to offer health coverage to full-time employees if at least one employee receives a government subsidy to buy individual coverage through an Exchange (Marketplace).

**Applicable Large Employer (ALE):** Employers with 50 or more full-time-equivalent (FTE) employees are subject to the Employer Shared Responsibility provision. Small employers are exempt. The employer must determine its FTE count each year to determine whether it is an ALE for the following year. Related employers in a controlled group are counted together to determine the number of FTEs. Generally, each full-time employee (i.e., 120 hours of service or more per month) counts as one FTE. Each part-time employee counts as a fraction of one FTE (i.e., divide the employee’s hours of service per month by 120). Employers with seasonal workers, usually in the agricultural or retail industries, may be able to take advantage of a special rule to subtract the seasonal workers from the employer’s FTE count.

For more information about coverage requirements, transition relief provisions, and potential penalties or any additional questions please call 1-800-451-8519 to talk to a member of our compliance team.

## Additional Employment Laws for Employers with 50+ Employees

Employment Law	Employer Size	Description
<b>Family and Medical Leave Act (FMLA)</b>	50+ employees for at least 20 weeks in a calendar year	Guarantees eligible employees up to 12 workweeks of unpaid leave each year with no threat of job loss. FMLA also requires that employers covered by the law maintain health benefits for eligible employees just as if they were working.
<b>Affordable Care Act (ACA)</b>	50+ full-time equivalent employees, on average, during the previous year	Minimum essential coverage that is affordable and provides minimum value must be offered to all employees working at least 30 hours per week, or potentially make an employer shared responsibility payment to the IRS. In addition, there are annual information reporting responsibilities regarding the minimum essential coverage that is offered to employees.
<b>Form 5500</b>	100+ plan participants at the beginning of the plan year	The Form 5500 is filed with the Department of Labor (DOL) and IRS. This Form is used to collect data on an employer's health and welfare benefit plans and must show the characteristics of the plan, as well as the operations.
<b>EEO-1 Reporting</b>	50+ employees and a prime contractor first-tier subcontract amounting to \$50,000 or more	Compliance survey that requires company employment data to be categorized by race/ethnicity, gender and job category that must be submitted and certified no later than September 30th, annually.
<b>Executive Order 11246 -Affirmative Action</b>	50+ employees and \$50,000 or more in government contracts	Prohibits federal contractors and federally-assisted construction contractors and subcontractors, who do over \$10,000 in Government business in one year from discriminating in employment decisions on the basis of race, color, religion, sex or national origin. Requires government contractors to take affirmative action to ensure that equal opportunity is provided in all aspects of their employment and to develop a written affirmative action program (AAP).
<b>Mental Health Parity and Addiction Equity Act (MHPEA)</b>	50+ employees	Requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are not more restrictive than predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

For more information about which employers are subject to the Employer Shared Responsibility provisions and other ACA-related questions, please contact your Account Manager or Sales Executive.



200 International Circle | Suite 4500 | Hunt Valley, MD 21031 | 800-451-8519 | [www.apbenefitadvisors.com](http://www.apbenefitadvisors.com)

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