Health care reform checklist (For large employers)

Updated for 2018-2019 plan years

Each employer that offers coverage to employees must comply with many provisions of the Affordable Care Act (ACA or health care reform law). Some provisions of the health care reform law took effect for plan years beginning on or after September 23, 2010. Other provisions may take effect through 2020.

The checklist below describes federal health care reform provisions for large group health plans.

To find out which provisions need to be implemented for the next plan year, you need to know whether the plan is grandfathered. In general, a plan is grandfathered if it was in effect before March 23, 2010, and hasn't had certain changes since then. **Remember, grandfathered status is based on the plans and benefits in place on March 23, 2010.**

Under the law, grandfathered status may apply separately to each benefit plan offered under a group health plan.

Once you know whether the plan has grandfathered status, use this checklist to determine whether it includes the provisions that apply to the plan.

Provision	Applies to	Yes	No
Benefits and administration			
ACA Maximum Out-of-Pocket (MOOP) Guidelines Beginning January 1, 2016, the annual limit on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only (family plan). Requirement applies to Individual and Small Group plans, on- and off-exchange, and Large Group and ASO plans. Deductible, coinsurance (an employee's share of the costs) and copayments all apply to the out-of-pocket limits on all impacted plans. **Out-of-pocket maximum limits:** **HHS** sets the ACA maximum out-of-pocket limits for non-grandfathered plans on a yearly basis. **IRS** sets out-of-pocket limits for HSA High-Deductible Health Plans (HDHPs) on a yearly basis. **2018 ACA MOOP limits:** • $7,350 for self-only and/or individual tier in a family plan coverage. • $14,700 for family tier. **2018 IRS MOOP limits:** • HSA-qualified High-Deductible Health Plans (HDHPs): $6,650 self-only/$13,300 family. **2019 ACA MOOP limits:** • $7,900 for self-only and/or individual tier in a family plan coverage. • $15,800 family tier. **2019 IRS MOOP limits**: • HSA-qualified High-Deductible Health Plans (HDHPs): $6,750 self-only/$13,500 family	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Coverage waiting period not to exceed 90 calendar days: • An orientation period of one calendar month minus one day can be applied on top of the 90 days. • The 90-day waiting period must begin on the next calendar day after the orientation period ends. • Coverage must start on the 91st day, not the first of the month following 90 days.	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		

Provision	Applies to	Yes	No
No pre-existing condition exclusions regardless of age	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Coverage of routine care costs for patients in clinical trials (effective January 1, 2014)	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
HIPAA nondiscrimination rules on wellness programs	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Wellness programs maximum incentive is 30% of self-only premium: • 2017 and forward: — Children (including adult children) will not be able to earn an incentive.	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Guaranteed issue at employer level **(Insurance companies are not allowed to decline based on health status.)**	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☐ Self-insured		
Nondiscrimination in health programs and activities (ACA Section 1557) • Plan years January 1, 2017 and after: — Cannot have explicit, categorical (or automatic) exclusions or limitation of coverage for all health services related to gender transition when medical necessity criteria is met. — Must ensure that there are no arbitrary limits or exclusions that are discriminatory based on age, gender, disability, race, or national origin.	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
No annual and lifetime dollar limits on essential health benefits that are covered by the plan (plan year beginning on or after January 1, 2014): • Large Group plans do not have to cover all essential health benefits, although essential health benefits that are covered cannot have a dollar limit. • Out-of-pocket cost shares for essential health benefits must apply to the out-of-pocket maximum (refer to out-of-pocket maximum information on previous page). • Self-insured plans may choose any essential health benefits benchmark plan approved by the Department of Health and Human Services.	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Summary of Benefits and Coverage (SBC): • Compliance with SBC templates required.	☐ Grandfathered[1] ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Notice of material modification: • Requires plan sponsors or issuers to provide 60 days advance notice when making material modifications to the plan outside of the renewal. • Includes any change to the coverage such as enhanced or reduced benefits, increased premiums or cost sharing, and new referral requirements. • Can be satisfied by sending an updated *Summary of Benefits and Coverage* or separate written notice.	☐ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		

Provision	Applies to	Yes	No
Taxes and fees			
Patient-Centered Outcomes Research Institute (PCORI) tax: • PCORI will explore the effectiveness, risk and benefits of medical treatments through the Patient-Centered Outcomes Research Institute. • For plan years that end October 1, 2017, through September 30, 2018, the fee is $2.39 per member per year (includes dependents). The rate goes up each year based on medical inflation. • ASO: Calculate amount due based on the average number of covered lives during the plan year (including retirees and dependents). — ASO: Submit to IRS by July 31 of the year following the end of the plan year. — Fully insured: Fee is included in rates. — Combined funding arrangements: We will pay the fee for the fully insured plan, but not the self-funded plan. 1. Health reimbursement accounts (HRAs) are considered a self-funded arrangement. We will pay the fee for the insured business. Clients need to calculate and pay the fee for the HRA portion of the arrangement.	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Reinsurance fee (The ACA reinsurance fee is no longer applicable in 2017 and beyond): • Paid by the plan issuer (fully insured) or plan sponsor (self-insured) based on the number of covered lives • Self-insured (ASO) clients paid directly to HHS and choose from four calculation options for the number of covered lives: — Report number of covered lives, due to HHS by November 15 — HHS notified client of payment due by December 15 — Client was required to pay within 30 days of getting the notice from the Department of Health and Human Services	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		
Health Insurance Tax (HIT)/(ACA Insurer Fee): • Funds premium subsidies and Medicaid expansion • Insurer of fully insured plans pays this fee (included in premium) • The fee is based on the insurer's market share of net premiums written for the previous year *The short-term spending bill,signed into law on January 22, 2018, suspends the ACA insurer fee for 2019.*	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☐ Self-insured		
Reporting			
Minimum Essential Coverage (MEC) Reporting (IRS Code Section 6055): • To make sure people have MEC, the IRS requires reports be sent by those who provide MEC. This is called Minimum Essential Coverage Reporting, or IRS Code Section 6055 Reporting. Applies to: • Insurers (on fully-insured business). • Employers with self-funded (ASO) health plans. — Employers can hire third parties to do reporting for them, but the company is legally responsible. Anthem will not act as the third party and will not file the report for a fee. How it works: • Insurer files form 1095-B with MEC data to the IRS for fully insured plans and provides a copy to plan members. • Employer, or plan sponsor, files form 1095-C with MEC data to the IRS for ASO plans. Timing: • Reports due in the current year for the previous plan year: — Statements to plan members due by January 31 • Statements to IRS due by March 31 for electronic filing (e-file): — Employers with 250 or more returns must e-file	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		

Provision	Applies to	Yes	No
Employer Mandate Reporting (IRS Code Section 6056): • To check if employers are offering minimum value, affordable coverage to their full-time workers, the IRS requires reports be sent by applicable large employers. This is called Employer Mandate Reporting or IRS Code Section 6056 Reporting. Applies to: • Applicable large employers (50 or more full-time workers). • Employers can hire third parties to do reporting for them, but the company is legally responsible. How it works: • Employer provides mandate data to the IRS using form 1094-C transmittal form. • Statements are sent to workers using form 1095-C, with a copy sent to the IRS. Timing: • Reports due in in the current year for the previous plan year: — Statements to workers due by January 31. • March 31 for electronic filing (e-file): — Employers with 250 or more returns must e-file.	☑ Grandfathered ☑ Nongrandfathered ☑ Fully insured ☑ Self-insured		

More tools and resources

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1 SBCs for closed plans are not yet required. The safe harbor continues to apply until further guidance is provided.