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White Paper

AFFORDABLE CARE ACT:
SMALL 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 small employers.

Starting with 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.

"Small Employer" generally means an organization (including subsidiaries) with fewer than 50 full-time and full-time-equivalent employees.

"Small Group" refers to the type of group health insurance policy that is sold only to small businesses. Policy requirements, and the provisions that determine the group's size, are defined by each state according to its state insurance law. In many states "small group" policies are limited to groups with up to 50 employees, while other states include groups up to 100 employees. For details about a state's insurance law and policy options, consult an agent or broker licensed in that state.

"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.

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.
- **Small Business Tax Credit (Optional) —** Employers with fewer than 25 employees should check whether they qualify for the Small Business Tax Credit to help with the expense of offering health coverage to employees. The credit is available to small businesses that meet various criteria and purchase a certified Small Business Health Options Program (SHOP) plan. For information, see **Small Business Health Care Tax Credit Questions and Answers.**

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:
  - Plan year ending between October 1, 2016 and September 30, 2017: $2.26
  - Plan year ending between October 1, 2017 and September 30, 2018: $2.39

  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.

"Small Group" Insurance Market Reforms

The ACA requires group health insurance policies sold in the "small group" market to adopt several reforms. The following requirements apply to nongrandfathered "small group" policies issued or renewed in 2014 or later, unless a state's insurance law allows exceptions. Many states allow insurance companies to continue renewing certain "small group" policies without adopting one or more of the provisions indicated below by an asterisk (*). For details about a state's insurance law and policy options, consult an agent or broker licensed in that state.

- **Essential Health Benefits (EHB)* —** All nongrandfathered "small group" health insurance plans must cover all Essential Health Benefits (EHBs). This requirement does not apply to grandfathered plans, self-funded plans, or insured plans in the large group market. Each state, through its state insurance code or laws, may establish a detailed definition of EHBs for purposes of "small group" policies issued in that state. The general 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)
- **Limits on Annual Out-of-Pocket Maximums* —** All nongrandfathered health plans, including "small group," large group and self-funded plans, are subject to limits on annual out-of-pocket maximums. All cost-sharing, such as co-pays, deductibles, and co-insurance, for 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

- **Adjusted community rating (ACR)* —** Health insurers may use only family size, geography, and age as rating factors for nongrandfathered "small group" plans. The impact of age factors is limited to a range of 3 to 1. Also, in certain states, premiums for tobacco users may be up to 50 percent higher than for non-tobacco users.

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. 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).

Important: Most small employers are exempt. Employers that employed an average of fewer than 50 full-time employees (including full-time-equivalent (FTE) employees) in a calendar year are exempt from both parts of the Employer Shared Responsibility provision for the following calendar year.[1]

For instance, the employer's average number of employees in 2016 determines whether the employer is exempt for 2017. Then the average number of employees in 2017 will determine whether the employer is exempt for 2018. Related employers in a controlled group are counted together to determine the number of employees. 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 which employers are subject to the Employer Shared Responsibility provision, see **Questions and Answers.**

(1) In the unlikely event that an employer with fewer than 50 employees has a self-funded (uninsured) group medical plan, the small employer should consult with a tax advisor regarding the reporting requirements under IRC § 6055.

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