

2017 Affordable Care Act Compliance Checklist

Simplify Compliance

This Compliance Checklist provides a brief overview of the key Affordable Care Act (ACA) compliance requirements and action items for the 2017 calendar year. Employers should review the checklist and add complying with the 2017 requirements to their list of New Year’s resolutions.

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ACA Requirement	Action Items
<p>Grandfathered Plan Status A “grandfathered” group health plan is one that was already in existence when the ACA became law on March 23, 2010. However, grandfathered status is lost if certain changes are made to the plan beyond specific guidelines. Maintaining grandfathered status means the plan will not be subject to some (but not all) of the ACA’s insurance market reform provisions.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review your plan’s grandfathered status <ul style="list-style-type: none"> <input type="checkbox"/> Determine whether the plan will maintain grandfathered status in 2017 <input type="checkbox"/> If the plan will lose grandfathered status, confirm plan has all additional benefits and rights required by the ACA for non-grandfathered plans <input type="checkbox"/> If the plan will keep grandfathered status, continue to provide a Notice of Grandfathered Status in any plan materials describing benefits under the plan (e.g., SPD and open enrollment guide)—model notice language is available
<p>Cost-Sharing Limits The ACA imposes overall annual out-of-pocket maximum (OOPM) on all non-grandfathered health plans for “essential health benefits.” The OOPM is increasing for plan years beginning on or after January 1, 2017.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review and update your plan’s OOPM <ul style="list-style-type: none"> <input type="checkbox"/> Make sure your plan complies with the ACA OOPM limit for 2017 (\$7,150 for self-only coverage \$14,300 for family coverage) <ul style="list-style-type: none"> <input type="checkbox"/> HSA-compatible high deductible health plans: your plan’s OOPM is lower—it cannot exceed \$6,550 for self-only coverage, \$13,100 for family coverage in 2017 <input type="checkbox"/> If you use multiple service providers to administer benefits, confirm that all claims for EHBs are coordinated or divide OOPMs across different benefit categories (the combined limit must not exceed the 2017 maximum) <input type="checkbox"/> Confirm your plan applies the self-only maximum to each individual in the plan, regardless of whether enrolled in self-only or family coverage

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<p>Summary of Benefits and Coverage Health plans and health insurance issuers must provide SBCs to participants and beneficiaries at initial eligibility and at open enrollment (and to HIPAA special enrollees. The SBC must follow strict formatting requirements. The government agencies issued an updated SBC template and related materials in 2016, which must be used as of the first day of open enrollment period beginning on or after April 1, 2017 (or, if no open enrollment period, by the first day of the plan year beginning on or after April 1, 2017).</p> <p>For fully-insured plans, employer and insurance carrier are both obligated to provide SBC. The obligation can be satisfied for both parties if either one provides the SBC.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Prepare to use new SBC template <ul style="list-style-type: none"> <input type="checkbox"/> New template must be used by the open enrollment period beginning on or after April 1, 2017 (if no annual open enrollment, by the first day of the plan year beginning on or after April 1, 2017) <input type="checkbox"/> For insured plans, confirm whether health insurance carrier will assume responsibility for providing SBCs
<p>Reinsurance Fees Health insurance issuers and self-funded medical plan sponsors must pay transitional reinsurance fees for first three years of Marketplace operations (2014-2016). For 2016, reinsurance fee is \$27 per covered life.</p> <p>The fee may be paid in one lump sum or in two installments during 2017. The first installment payment (or payment in full, if paying in single installment) is due January 15, 2017. The second installment payment is due November 15, 2017.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> If your plan is subject to the transitional reinsurance fee for 2016, prepare to pay the fee as follows: <ul style="list-style-type: none"> <input type="checkbox"/> Determine average number of covered lives for 2016 <input type="checkbox"/> Submit contribution form and schedule payment(s) according to payment schedule (via pay.gov website) <ul style="list-style-type: none"> → \$21.60 per covered life due January 15, 2017 (or \$27 per covered life if paying in single lump sum) → \$5.40 per covered life due November 15, 2017 (if paying in two installments)
<p>PCORI Fees Health insurance issuers and self-funded medical plan sponsors must pay Patient-Centered Outcomes Research Institute (“PCORI”) fees. For plan years ending between October 1, 2015 and September 30, 2016, the PCORI fee is \$2.17 per covered life. For plan years ending between October 1, 2016 and September 30, 2017, the PCORI fee is \$2.26 per covered life.</p> <p>The fee is due July 31 following the end of the plan year (July 31, 2017 for plan years ending in 2016) using IRS Form 720.</p> <p>Note: Health reimbursement arrangements (HRAs) are considered self-funded medical plans for a which a separate PCORI fee may be required.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> If your plan is subject to the PCORI fee for the plan year ending in 2016, prepare to pay the fee as follows: <ul style="list-style-type: none"> <input type="checkbox"/> Determine average number of covered lives for the plan year ending in 2016 <input type="checkbox"/> Complete IRS Form 720 and remit payment by July 31

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<p>Employer Shared Responsibility Rules Under the ACA’s employer shared responsibility rule, “applicable large employers” (“ALEs”) that do not offer affordable, minimum value health coverage to their full-time employees will be penalized if any full-time employee receives a subsidy for coverage purchased through the public Marketplace. An ALE is an employer that employed, on average, at least 50 full-time (including full-time equivalent) employees in the prior calendar year.</p> <p>ALEs must determine which employees are “full-time” under the employer shared responsibility rules. “Full-time” generally means an employee who was employed, on average, 30 hours of service per week (130 hours of service per calendar month). Regulations permit employers to use one of two methods to determine full-time status: the monthly measurement method or the lookback measurement method.</p>	<ul style="list-style-type: none"> ❑ Determine your ALE status for 2017 as follows: <ul style="list-style-type: none"> ❑ Calculate the number of full-time employees for each calendar month (any employee who worked 130 hours of service during a month is a full-time employee for that month) ❑ Calculate the number of full-time equivalent employees for each calendar month by aggregating the hours worked by part-time employees (less than 130 hours of service), but disregard any hours of service in excess of 120, and divide the total by 120 ❑ Determine the number of full-time employees and full-time equivalents for each month in 2016 ❑ Add the totals for each month and divide the sum by 12 ❑ If the result is 50 or more, you are an ALE for the 2017 calendar year ❑ If you are an ALE for 2017, identify your full-time employees as follows: <ul style="list-style-type: none"> ❑ Use the monthly measurement method or the lookback measurement method and confirm that all full-time employees will be offered health coverage ❑ If using the look-back measurement method, select (or review) your measurement, administrative and stability periods and verify that hours of service are being properly tracked ❑ If any full-time employees are not offered health coverage, assess your penalty exposure under Section 4980H(a) of the Internal Revenue Code ❑ If you are an ALE for 2017, confirm the health coverage offered to your full-time employees satisfies the “minimum value” (“MV”) standard and one of the “affordability” safe harbors as follows: <ul style="list-style-type: none"> ❑ Verify your health plan provides MV (i.e., plan’s share of total allowed cost of covered benefits must be at least 60%) using the MV calculator, a design-based safe harbor checklist or by obtaining an actuarial certification ❑ Verify that at least one MV plan option is offered to employees at an “affordable” premium cost by satisfying one of three “safe harbors” (W-2 wages, rate of pay or federal poverty level) ❑ If any full-time employees are offered coverage that either does not provide MV or is not affordable, assess your penalty exposure under Section 4980H(b) of the Internal Revenue Code

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<p>IRS Form 1094/1095 Reporting ALEs are required to report information to the IRS and to employees on IRS Forms 1094-C and 1095-C. The information on these forms is designed to verify the ALE's compliance with the employer shared responsibility rules, individuals' compliance with the individual shared responsibility rules and individuals' potential eligibility for Marketplace subsidies.</p> <p>Form 1095-Cs generally must be distributed to employees by January 31, but the IRS extended the deadline for 2016 to March 2, 2017. Form 1094-C must be filed with the IRS by February 28 (or March 31 if filing electronically). The filing deadlines have not been extended for 2016 filings.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Complete 2016 reporting by the 2017 deadlines and prepare for 2017 reporting: <ul style="list-style-type: none"> <input type="checkbox"/> Determine the information you will need for reporting and coordinate internal and external resources to help compile the required data <input type="checkbox"/> Complete the required forms, furnish them to individuals and file with IRS by applicable deadlines
<p>Health FSA Limits Beginning in 2017, salary reduction contributions to a health flexible spending account may not exceed \$2,600 (increased from \$2,550 in 2016). This limit does not apply to employer health FSA contributions.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Update your plan's health FSA contribution limit: <ul style="list-style-type: none"> <input type="checkbox"/> Confirm that health FSA will not allow employees to make pre-tax contributions in excess of \$2,600 for the 2017 plan year <input type="checkbox"/> Communicate the health FSA limit to employees in the open enrollment process
<p>Section 1557 Non-discrimination Rule Section 1557 of the ACA protects individuals from being excluded from participation, denied benefits or subjected to discrimination under <i>any health program or activity that receives federal financial assistance</i> on the basis of race, color, national origin, sex or disability. The Office of Civil Rights issued final regulations implementing Section 1557 during 2016. Entities covered by the rule generally must comply beginning with the 2017 plan year.</p> <p>The rule focuses on provision of health services to transgender participants. It prohibits blanket exclusions of services designed to treat gender dysphoria and assist in gender transition and provides limited guidance on the scope of services that may need to be offered.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Evaluate whether your organization is subject to Section 1557 and, if so, the potential implications: <ul style="list-style-type: none"> <input type="checkbox"/> Seek counsel to help determine whether you are a covered entity under the rule <input type="checkbox"/> Eliminate any blanket exclusions of coverage related to gender dysphoria or gender transition, if applicable <input type="checkbox"/> Determine what services may be required for transgender participants, if applicable