Employer Compliance Quiz

LKIS provides guidance and/or TPA services to assist with these requirements.

AFFORDABLE CARE ACT (ACA) REQUIREMENTS:

Employer Shared Responsibility ("Play or Pay") Mandate

Are you prepared to comply with the ACA's "Play or Pay" mandate? Yes No N/A

"Applicable large employers" (ALEs) that do not offer "minimum essential coverage" that is affordable and meets minimum value requirements to their full-time employees and dependent children are subject to penalties if a full-time employee receives a subsidy for health coverage through a Marketplace (Exchange). These requirements are known as the "employer shared responsibility" or "play or pay" provisions. An ALE is an entity that employed 50 or more full-time and full-time-equivalent (FTE) employees in the prior calendar year.

Determine your ALE status for 2021 by calculating the number of full-time and FTE employees on business days for each calendar month in 2020 and dividing that number by 12.

Full-time employees are common law employees who average 30 or more hours of service per week, or 130 or more hours of service in a month. Hours of service include all hours for which an employee is paid or entitled to payment. Employers must track hours of service for all employees (full-time, part-time, and seasonal) to determine whether they meet the full-time employee definition.

Regulations provide guidance on how to determine ALE status, how to define full-time employees, how to measure a plan's affordability, and how to determine minimum value.

Are you aware of the applicable penalties? Yes No N/A

An ALE will satisfy the requirement to offer minimum essential coverage to "substantially all" of its full-time employees and their dependents if it offers coverage to at least 95% – or fails to offer coverage to no more than 5% (or, if greater, five) – of its full-time employees (and dependents

The 4980H(a) Penalty: The monthly penalty assessed on ALE's that do not offer coverage to substantially all full-time employees and their dependents is equal to the ALE's number of full-time employees (minus 30) x 1/12 of the annual 4980H(a) penalty for any applicable month. (The 2020 penalty has not yet been announced.)

The 4980H(b) Penalty: ALEs that do offer coverage to substantially all full-time employees (and dependents) may still be subject to a penalty if such coverage is either unaffordable or does not meet minimum value and at least one full-time employee obtains a subsidy through the Marketplace. The

monthly penalty assessed for each full-time employee who receives a subsidy is 1/12 of the annual 4980H(b) penalty for any applicable month. (The 2020 penalty has not yet been announced.)

However, the 4980H(b) Penalty B cannot exceed the amount an employer could be assessed under 4980H(a).

Is your health coverage affordable and does it provide minimum value? Yes No N/A

Under the ACA, an ALE's health coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year (as adjusted each year). The 2020 adjusted percentage is 9.78%.

A plan is considered to provide "minimum value" (MV) if it covers certain types of medical expenses and is designed to pay at least 60% of employees' health care costs. An employer can determine if the plan meets MV by using one of the four available methods.

Annual Information Reporting of Health Plan Coverage

Are you prepared to comply with the health plan coverage reporting requirement for 2020?

Yes No N/A

Health insurance issuers and sponsors of self-insured plans that provide "minimum essential coverage" (MEC) are required to report certain health coverage enrollment and other information on Forms 1095-B or Form 1095-C, respectively, to the IRS and covered individuals.

ALEs are required to report offers of coverage to full-time employees and their dependents and certain health plan information on Form 1095-C.

Form 1094-C is used to transmit Forms 1095-C to the IRS, which includes certain employer data.

Plan Design Changes

Do you know the grandfathered status of your health plan?

Yes No N/A

A grandfathered plan is a health plan that was in existence when the ACA was enacted on March 23, 2010, and that has continuously adhered to certain guidelines. If plan changes go beyond those guidelines, the plan is no longer grandfathered. Grandfathered plans are exempt from some (but not all) of the ACA's requirements.

If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2021 plan year. A grandfathered plan's status will affect its compliance obligations.

If you move to a non-grandfathered plan at any time, confirm that the plan immediately complies with all additional patient rights and benefit provisions required by the ACA (Examples: coverage of in-network preventive care at 100%; limits on out-of-pocket maximums).

Limits on Cost-sharing

Does your plan comply with ACA limits on cost-sharing or out-of-pocket maximums?

Yes No N/A

Non-grandfathered health plans are subject to limits on cost-sharing or out-of-pocket (OOP) maximums. For 2020, the OOP maximums generally are limited to $8,150 per covered person (whether enrolled for self-only or family coverage) and $16,300 for all covered family members combined, with respect to coverage for essential health benefits.

If you have a health savings account (HSA)-compatible high-deductible health plan (HDHP), your plan's OOP maximum cannot exceed IRS limits. For 2020, the IRS limits on HDHP OOP maximums are $6,900 for self-only coverage or $13,800 for family coverage. If the HDHP also is a non-grandfathered plan, it is subject to both the ACA limits and IRS limits.

Ongoing ACA requirements

Is your plan in compliance with the following ACA requirements?

Yes No N/A

No Pre-existing Condition Exclusions: Group health plans may not impose pre-existing condition exclusions.

Child Coverage to Age 26: Group health plans that cover children of employees must extend coverage to children through the end of the month during which they turn 26.

Limited Waiting Periods: Group health plans may not impose a waiting period that exceeds 90 calendar days. Many waiting periods have been shortened to "first of the month following 60 days" to ensure that health plan coverage will start within the maximum allowable 90-day waiting period.

Ongoing General Requirements

Do you have the following documents, plan provisions, and processes in place?

Yes No N/A

Is your ERISA plan document up to date and available to participants and beneficiaries and U.S. Department of Labor (DOL) upon request?

Yes No N/A

Has it been formally adopted?

Yes No N/A

Is your SPD up to date, automatically provided to participants, and available to participants and beneficiaries (and DOL) upon request?

Yes No N/A

Do you provide SPDs in accordance with DOL's distribution rules?

Yes No N/A

Is your cafeteria plan document up to date and has it been formally adopted?

Yes No N/A

Does your cafeteria plan include specific provisions applicable to your benefits plans? For example:

"Cash in lieu" provisions (if applicable)

Carry-over or grace period provisions (if adopted)

Health FSA contribution limit changes to match the federal limit (if adopted)

Health Savings Account (HSA) (if applicable)

Yes No N/A

Do you provide up-to-date health plan notices, the Children's Health Insurance Program (CHIP) notice, Medicare Part D notice(s) and SBCs at enrollment or when otherwise required?

Yes No N/A

Are notices distributed in accordance with applicable distribution rules?

Yes No N/A

Is the annual Form 5500 filed in a timely manner? (if applicable)

Yes No N/A

Are Summary Annual Reports (SARs) distributed as required? (if applicable)

Yes No N/A

Are all required COBRA notices provided to plan participants? (if applicable)

The initial COBRA notice should be mailed to employees' homes to ensure delivery to spouses. If you have a COBRA third party administrator (TPA), confirm that the TPA is issuing the required COBRA notices to plan participants (including the initial COBRA notice).

Yes No N/A

Do you conduct regular testing on tax-favored benefits to ensure the plans do not discriminate, as required under the IRC?

Non-discrimination rules apply to cafeteria plans, self-funded health plans (including health FSAs and HRAs), group term life, and dependent care assistance plans. Non-discrimination testing must also be

conducted on HSAs, if part of the cafeteria plan. Additional non-discrimination rules for insured health plans are not currently enforced.

Yes

No

N/A