2019 Employer Compliance Checklist

Plan Design Changes

-o Grandfathered Plan Status

A grandfathered plan is one that was in existence when the Affordable Care Act (ACA) was enacted on March 23, 2010. Certain changes to your plans that go beyond permitted guidelines, can remove your plan’s grandfathered status.

- If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2019 plan year.
- If your plan will maintain its grandfathered status, make sure you provide the notice of grandfathered status in your open enrollment materials.
- In the event, your plan loses its grandfathered status for 2019, confirm the plan has all the additional patient rights and benefits required by the ACA. For example – Your plan needs to covered preventive care without cost-sharing requirements.

-o ACA Affordability Standard

The ACA defined who was an applicable large employer (ALE). Any qualified ALE must provide coverage that meets the ACA’s affordability standard to all full-time employees. This standard requires an employee’s contributions to the plan to not exceed a designated percentage of the employee’s household income for the taxable year.

- For plan years that begin on or after Jan. 1, 2019, the affordability percentage is 9.86 percent.
- If you’re an ALE, confirm you offer at least one health plan to full-time employees (and their dependents) that satisfies the ACA’s affordability standard above.
- The new affordability percentage is a significant increase from 2018. This increase means employers may have additional flexibility to increase the employee share of the premium while still avoiding a penalty under the pay or play rules.

-o Out-of-Pocket Maximum

The ACA’s out-of-pocket maximum applies to all non-grandfathered group health plans, including self-insured health plans and insured plans.
• Total enrollee cost sharing is **$7,900 for self-only coverage** and **$15,800 for family coverage** for plan years that begin on or after Jan. 1, 2019.

• If you have a high deductible health plan (HDHP) that’s compatible with a health savings account (HSA), keep in mind your plan’s out-of-pocket maximum must be lower than the ACA’s limit. This limit, for the 2019 plan year, is **$6,750 for self-only coverage** and **$13,500 for family coverage**.

• Plans that use multiple service providers to administer benefits, must confirm the plan coordinates all claims for essential health benefits across the plan’s service providers or divides the out-of-pocket maximum across the categories of benefits, with a combined limit that doesn’t exceed the maximum for 2019.

• Group plans with a family out-of-pocket maximum that’s higher than the ACA’s self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual’s out-of-pocket expenses exceed $7,900 for the 2019 plan year.

○ **Preventive Care Benefits**

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (i.e. deductibles, copayments or coinsurance) for the services. Health plans have to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations.

○ **Health FSA Contributions**

Under the ACA, there’s a dollar limit on employees’ salary reduction contributions to a health FSA offered under a cafeteria plan. An employer may impose its own dollar limit on employees’ salary reduction contributions to a health FSA, as long as the employer’s limit doesn’t exceed the ACA’s maximum limit in effect of the plan year.

- The health FSA limit has increased to **$2,700 for the 2019 plan year**.
- Confirm your health FSA won’t allow employees to make pre-tax contributions in excess of $2,700.
- Communicate the health FSA limit to employees as part of the open enrollment process.
**HDHP and HSA Limits**

If you offer an HDHP to employees that’s compatible with an HSA, confirm the HDHP’s minimum deductible and out-of-pocket maximum comply with the 2019 limits. HSA contribution increased effective Jan. 1, 2019, while the HDHP limits will increase effective for plan years beginning on or after Jan. 1, 2019.

- Check whether HDHPs cost-sharing limits need to be adjusted for the 2019 limits
- Update enrollment materials to reflect the increased limits that apply for 2019, if your communicate HSA contribution limits to employees as a part of the enrollment process.
- For plan years beginning on or after Jan. 1, 2019:
  - HDHP Minimum Deductible amount is **$1,250 for self-only coverage** and **$2,700 for family**.
  - HDHP Maximum Out-of-Pocket amount is **$6,750 for self-only coverage** and **$13,500 for family**.
  - HAS Maximum Contribution amount is **$3,500 for self-only coverage** and **$7,000 for family**.

**ACA Disclosure Requirements**

- **Summary of Benefits and Coverage (SBC)**

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees to help them understand their coverage and make coverage decisions. Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period, or those who enroll other than through an open enrollment period (including those who are newly eligible for coverage and special enrollees).

- Include the SBC with the plan's application materials when distributing them during your plan's 2019 open enrollment period. If coverage automatically renews for current participants, you must provide the SBC no later than 30 days before the beginning of the plan year.
- Both the plan and administrator and issuer must provide an SBC, for fully insured plans. Though, if either party provides an SBC, the obligation is satisfied for both.
Grandfathered Plan Notice

If you have a grandfathered plan, make sure to include information about the plan’s grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials.

Notice of Patient Protections

Under the ACA, non-grandfathered group health plans and issuers that require designation of a participating primary care provider must permit each participant, beneficiary, and enrollee to designate any available participating primary care provider (including a pediatrician for children).

Also, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

Whenever an SPD, or similar description of benefits, is provided to a participant the plan administrator or issuer must provide a notice of these patient protections. This notice is only necessary if a non-grandfathered plan requires participants to designate a participating primary care provider. If your plan is subject to this notice requirement, you should confirm that it’s included in your plan’s open enrollment materials.

ACA Employer Mandate and Other Requirements

Applicable Large Employer Status (ALE)

Under the ACA’s employer penalty rules, applicable large employers that don’t offer health coverage to full-time employees (and dependent children) that’s affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through the Exchange.

To qualify as an ALE, an employer must employ, on average, at least 50 full-time equivalent employees (FTEs), during the preceding calendar year.

Determine you ALE status for 2019:

- Calculate the number of full-time employees for all 12 calendar months of 2018.
- Calculate the number of FTEs for all 12 calendar months of 2018 by calculating the aggregate number of hours of service (but not more than 120 hours or service for any employee) for all employees who weren’t full-time employees for that month and dividing the total hours of service by 120.
- Add the number of full-time employees and FTEs calculated above for all 12 calendar months of 2018.
- Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions. If your result is 50 or more, you’re likely an ALE for 2019.

- **Identify Full-Time Employees**

Applicable large employers must offer all full-time employees affordable, minimum value coverage. A full-time employee is anyone your company employed for, on average, at least 30 hours of service per week. Generally, those who reach 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status – the monthly measurement method and the look-back method.

- **Monthly Measurement Method** – Involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method may cause practical difficulties for employers if there are employees with varying hours or employment schedules. And, this difficulty could result in employees moving in and out of employer coverage on a monthly basis.
- **Look-Back Measurement Method** – Allows an employer to determine full-time status based on average hours worked by an employee in a prior period. This method involves a measurement period for counting/averaging hours of service, an administrative period that allows for time for enrollment and disenrollment, and a stability period when coverage may need to be provided, depending on an employee’s average hours of service during the measurement period.

- **Offer of Coverage**

An ALE may be liable for a penalty under the pay or play rules if it doesn’t offer coverage to “substantially all” full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. As previously detailed, this coverage must also be both affordable and provide minimum value.
• Offer minimum essential coverage to all full-time employees
• Ensure at least one of those plans provides minimum value (60% actuarial value)
• Ensure the minimum value plan offered is affordable to all full-time employees by ensuring that the employee contribution for the lowest cost single minimum value plan doesn’t exceed 9.86% of an employee’s earnings based on their W-2 wages, the employee’s rate of pay, or the federal poverty level for a single individual.

Other Notices

○ **Initial COBRA Notice**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees that sponsor group health plans. Plan administrators must provide an initial COBRA notice to new participants and certain dependents within 90 days after plan coverage begins. You may incorporate the initial COBRA notice into your plan’s SPD.

○ **Notice of HIPAA Special Enrollment Rights**

A group health plan must provide each eligible employee with a notice of his or her special enrollment rights under HIPAA. You must provide the notice at, or prior to, the time of enrollment. Also, you may include this notice in the plan’s SPD.

○ **HIPAA Privacy Notice**

The HIPAA Privacy Rule requires covered entities (including group health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who’s the subject of protected health information (PHI).

Health plans must send these Privacy Notices at certain times. These instances include new enrollees at the time of enrollment. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants the Privacy Notice is available and explain how to obtain a copy.

• **Self-Insured Plans** – Must maintain and provide their own Privacy Notices
• **Fully Insured Plans** – Health insurance issuers have primary responsibility for Privacy Notices

• **Special Rules for Fully Insured Plans** – The plan sponsor of a fully insured health plan is limited with respect to the Privacy Notice.
  o Plan sponsors with a fully insured plan, who have access to PHI for plan administrative functions, are required to maintain a Privacy Notice and to provide the notice upon request
  o If the sponsor of a fully insured plan doesn’t have access to PHI for plan administrative functions, it’s not required to maintain or provide a Privacy Notice.

  o **HIPAA Opt-Out for Self-Funded, Nonfederal Governmental Plans**

  Sponsors of self-funded, nonfederal governmental plans may opt out of certain federal mandates. These mandates can include mental health parity requirements and WHRCA coverage requirements. Under an opt-out election, the plan must provide a notice to enrollees regarding the election. You must provide the notice annually and at the time of enrollment.

  o **Annual CHIPRA Notice**

  Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual notice about the available assistance to all employees residing in that state.

  o **WHCRA Notice**

  Plans and issuers must provide notice of participants’ rights to mastectomy-related benefits. This notice is required under the Women’s Health and Cancer Rights Act. Plan issuers need to include this notice at the time of enrollment and on an annual basis.

  o **NMHPA Notice**
Plan administrators must include a statement within the Summary Plan Description timeframe describing requirements relating to any hospital length of stay in connection with childbirth for a mother or newborn child under the Newborns’ and Mothers’ Health Protection Act.

- **Medicare Part D Notices**

  Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals. These individuals include those who are covered by, or who apply for, prescription drug coverage under the health plan.

  - This notice alerts individuals as to whether their prescription drug coverage is at least as good as Medicare Part D coverage. You must provide the notice at various times. These times include when an individual enrolls in the plan and each year before Oct. 15 (when Medicare’s annual open enrollment period begins).

- **Michelle’s Law Notice**

  Certain group health plans condition dependent eligibility on a child’s full-time student status. These group plans must provide a notice of requirements of Michelle’s Law. You must include this notice in any materials describing a requirement for certifying student status for plan coverage.

- **Summary Annual Report**

  Plan administrators, with greater than 100 participants, must file a Form 5500. These administrators must provide participants with a narrative summary of the information in the Form 5500. This narrative summary is a Summary Annual Report (SAR). The plan administrator must provide the SAR within nine months of the close of the plan year. Unless you obtain an extension of time to file Form 5500. If you’re granted an extension, the plan administrator must furnish the SAR within two months after the close of the extension period.

- **Summary Plan Description (SPD)**

  Plan administrators must provide an SPD to new participants within 90 days after plan coverage begins. You must detail any changes made to the plan in an updated SPD.
booklet. Or, you must describe these changes to participants through a summary of material modifications (SMM). Also, you must provide a new SPD every ten years if no changes are made to SPD information. Furnish an updated SPD every five years, if the SPD or plan information is amended.

- **Wellness Plan Notices**

Group health plans that include wellness programs may be required certain notices regarding the wellness program’s design. These notices should be provided when the wellness program is communicated to employees. Or, before employees provide any health-related information or undergo medical examinations.

- **HIPAA Wellness Program Notice**

Group health plans that offer a health-contingent wellness program must furnish a HIPAA wellness program notice. Health-contingent wellness plans require individuals to satisfy standards related to health factors in order to obtain rewards.

The notice must disclose the availability of a reasonable alternative standard to qualify for the reward. And, if applicable, the possibility of waiver of the otherwise applicable standard. Include this notice in any plan materials describing the terms of a health-contingent wellness program.

- **ADA Wellness Program Notice**

Employers with 15 or more employees are subject to the Americans with Disabilities Act (ADA). Wellness programs that include health-related questions or medical examinations must comply with the ADA’s requirements, including an employee notice requirement.

This notice tells employees what information will is collected as a part of the wellness program. This notice must also include with whom the information is shared and for what purpose. Also, the notice must detail the limits on disclosure and the way information will be kept confidential.