February 19, 2025

Introduction to the ACA

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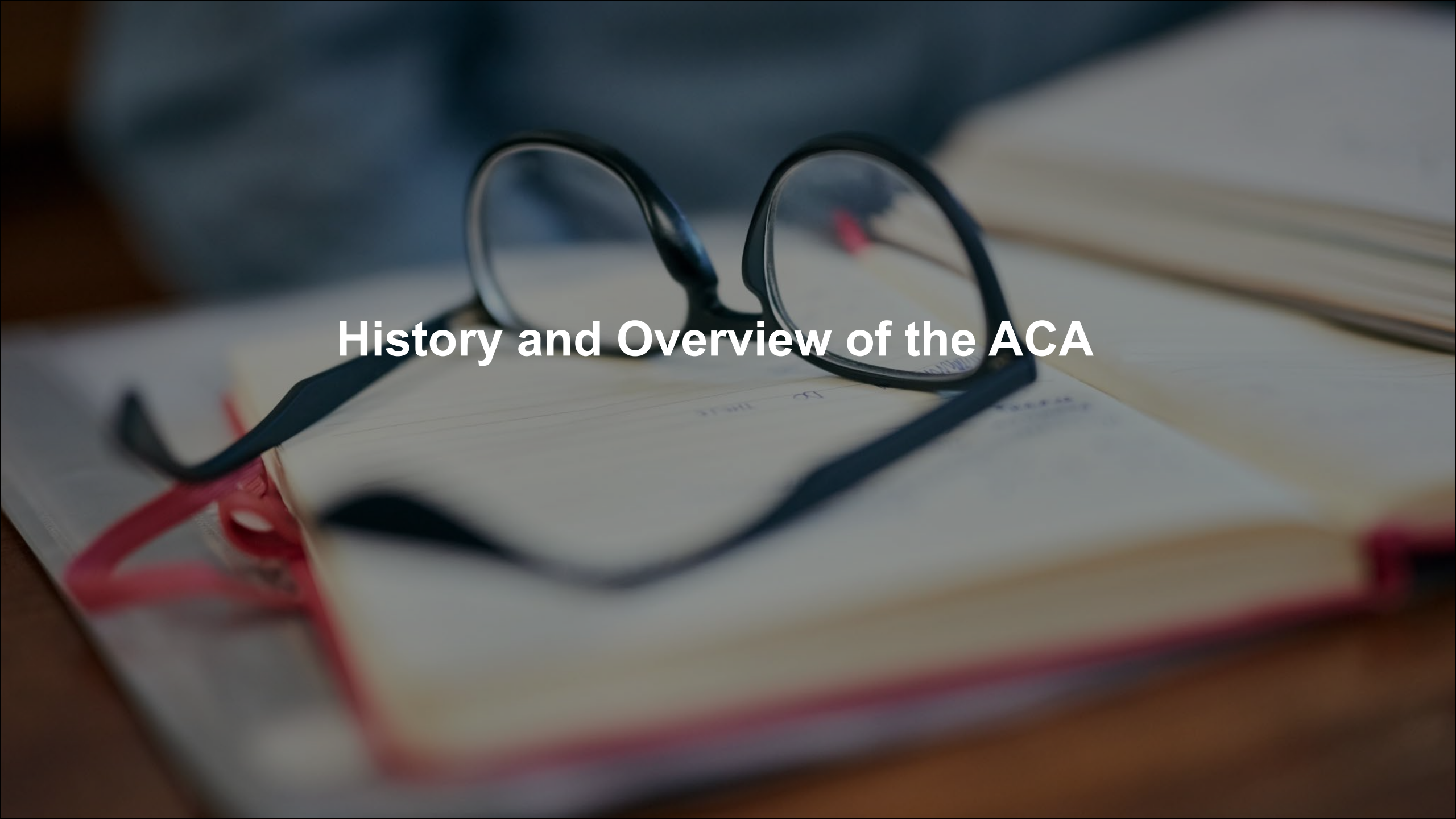
Please note that the following is intended to be used for general guidance purposes only — it is not intended to constitute tax or legal advice. Any question of application of the law should be addressed to legal or tax counsel. The information is current as of February 19, 2025.

Agenda

What we will cover today:

- History and overview of the ACA
- Coverage mandates and patient protections
- Reporting and notice requirements
- Employer mandate basics
- Key takeaways and resources



History and Overview of the ACA

Two Statutes

The Affordable Care Act (ACA) is two statutes enacted in 2010: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

- Signed March 23, 2010.
- Staggered effective date of provisions, with the final items effective in 2016.

These statutes are administered and enforced through rules promulgated by the DOL, IRS, and HHS.

The ACA is also known as "healthcare reform" and as "Obamacare".

Plans Subject to the ACA

- Generally, employer-sponsored group health plans for employees (whether fully insured or self-insured) are subject to the ACA.
- Even plans not subject to ERISA, such as government or church plans, can be subject to the ACA.
- Group health plans that cover two or fewer current employees are exempt, as are stand-alone retiree plans that do not cover current employees.
- Certain excepted benefits, such as dental and vision, are also exempt.

ACA Objectives

- Requires individuals to be covered by health insurance (the "individual mandate").
- Requires applicable large employers (ALEs) to provide affordable coverage to their full-time employees.
- Requires health plans to meet specific requirements to ensure a minimum level and quality of coverage and to provide information to participants. Plans that existed before 2010 ("grandfathered plans") are exempt from some of these requirements if they've maintained certain cost-sharing levels.
- Establishes insurance exchanges (or "Marketplaces") where individuals could obtain coverage.
- Requires insurance to include certain consumer protections.
- Imposes fees on plans and insurers.

Individual Mandate

The ACA originally required individuals to maintain health coverage or pay a penalty.

The individual mandate was almost immediately challenged in the courts. In 2012, the US Supreme Court held that the individual mandate was within the constitutional power of the government to tax its citizens.

In 2019, Congress reduced the penalty for failing to maintain health coverage to $0.

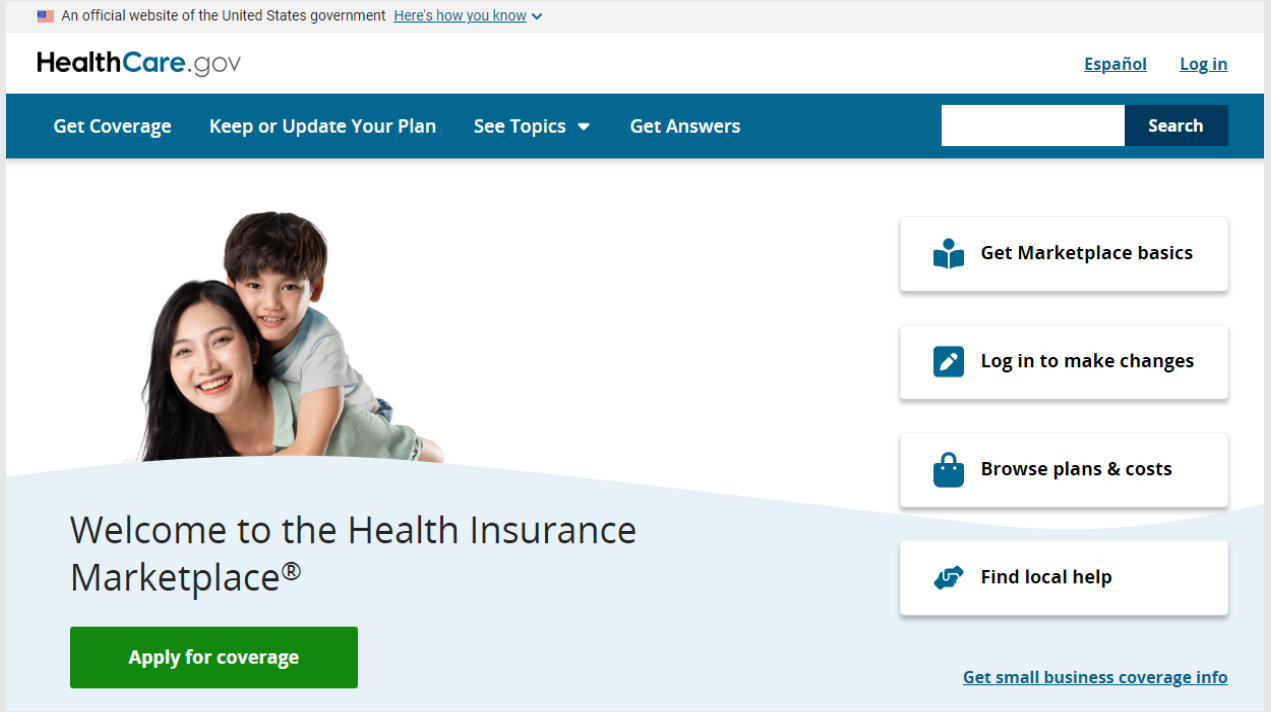
Several states (CA, DC, MA, NJ, RI) impose individual mandate and reporting requirements.

Exchanges

The ACA required states to either create their own exchange or participate in the federal exchange.

The exchanges provide a marketplace where individuals and small businesses can purchase health insurance.

Individuals can enroll in plans offered in an exchange from November 1 through January 15 (the "annual open enrollment period"). Individuals may also enroll during special enrollment periods, which occur when certain events happen (such as when they lose other minimum essential coverage).



ACA Abbreviations

- ACA: Affordable Care Act
- ALE: Applicable Large Employer
- EHB: Essential Health Benefit
- MEC: Minimum Essential Coverage
- MV: Minimum Value
- PCOR: Patient-Centered Outcomes Research
- SBC: Summary of Benefits and Coverage

Coverage Mandates and Patient Protections

ACA Mandates

- Provides financial protection to participants.
- Sets minimum eligibility and access parameters.
- Outlines basic coverage mandates.
- Requires specific claims and appeals steps.
- Mandates apply to all group health plans, except in limited instances with grandfathered plans.

Coverage Mandates and Patient Protections

Mandate	Description
Prohibition on excessive waiting periods	Waiting period cannot exceed 90 days
Annual & lifetime dollar limits	Prohibited for essential health benefits (EHBs)
Dependent coverage until age 26	Doesn't require coverage of dependents, but if you cover them, it must be to age 26 regardless of student status, marital status, residency, etc. Note that the employer mandate (discussed later) does require coverage of dependent children.
Maximum out-of-pocket limits (MOOP)	Sets annual limits for OOP expenses at both self-only and family tier (this is different than HDHP OOP limits)
Pre-existing condition exclusion	Cannot exclude a participant, charge more, or deny services under the plan based on any pre-existing conditions the participant has
Preventive care requirements	Certain preventive services must be covered w/o cost-sharing; certain women's preventive care services must also be covered (some employers can qualify for exemption from contraceptive care mandate)

Coverage Mandates and Patient Protections

Mandate	Description
Prohibition on rescission of coverage	Cannot retroactively cancel coverage except in cases of fraud or intentional misrepresentation
Coverage for clinical trials	Cannot deny qualified individuals coverage because they participate in a clinical trial
Internal claims & appeals and external review	Requires specific claims procedures for internal appeals and adverse benefit determinations. Plans must comply with either a state or federal external review process.
Patient Protections	Plans must adhere to specific coverage and cost-sharing requirements for emergency services; cannot require referrals for OB/GYN or pediatrician; if plan requires designation of a PCP the plan must provide a notice to participants
OTC medicine or drugs	Originally prohibited under ACA for reimbursement from HSA, HRA, or FSA; CARES Act reinstated this so reimbursement is allowed but the employer must opt in for the FSA

Coverage Mandates and Patient Protections

Misc mandates		Mandates NOT applicable to grandfathered plans
Nondiscrimination in plan design (provider networks, health status, etc.)		Nondiscrimination based on health status (but other laws still require it)
Guaranteed availability – insurer must accept employers applying for medical coverage		Rating limits & guaranteed availability/renewability
Required coverage of essential health benefits (EHB) – individual and small group markets only		Coverage for qualified clinical trials
Created small and large group markets		Preventive care services
Disclosure of rate increases from insurers (small group only)		Quality of care reporting to HHS

What happens if a plan violates the mandates?

- Failure to comply with a mandate: excise tax of up to $100/day per affected individual assessed by IRS.
- May trigger DOL involvement since there is a crossover between ACA mandates and ERISA.
- Participant lawsuits for a failure to provide required benefits under the plan.
- Nonfederal government plans may have excise tax penalties imposed by HHS which are similar to the IRS penalties above.

Reporting and Notice Requirements

Summary of Benefits and Coverage (SBC)

- Group health plans are required to provide an SBC describing the plan benefits and coverage to all applicants and enrollees.
- The SBC must be included upon application, with open enrollment materials, at renewal, upon request, and at special enrollment.
- For midyear changes, 60-day advance notice must be provided.

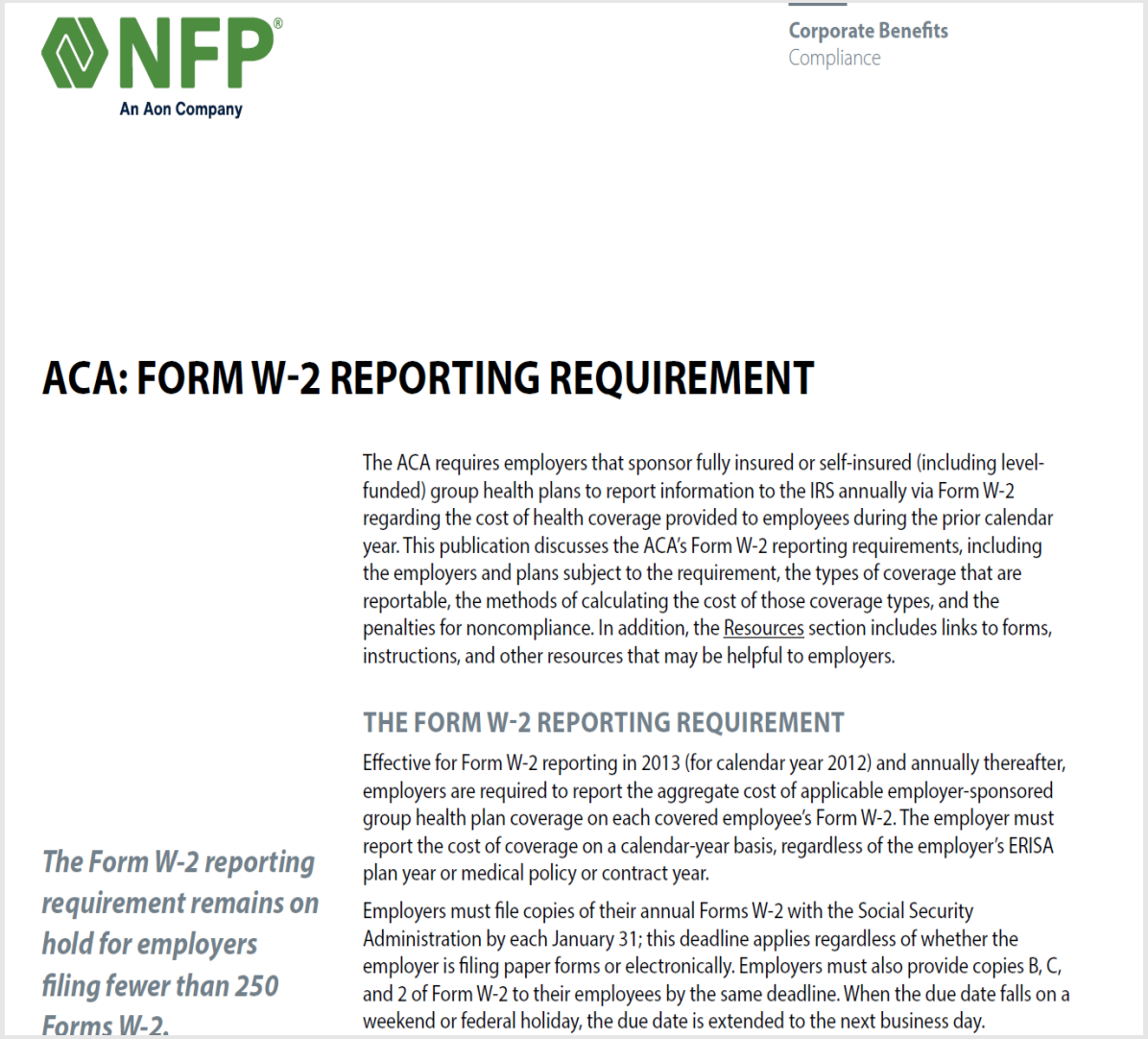
Exchange Notice

- Employers must provide all new hires with a written notice about the health coverage options that are available through the Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.

- The notice must be automatically provided, free of charge, to new employees within 14 days of their start date.
  - Employees who are not benefits-eligible still need to receive this, so providing in benefit packet is not sufficient.

W-2 Reporting

- The ACA requires employers who provide applicable employer-sponsored coverage to their employees to report the aggregate cost of that coverage on each employee's Form W-2.
  - "Applicable employer-sponsored coverage" includes group health coverage that is excluded from the employee's gross income.
- Employers that file fewer than 250 Forms W-2 for one calendar year, self-insured plans that are not subject to COBRA (including church plans), and multiemployer plans continue to be exempted from the Form W-2 reporting requirement until further notice.
- This requirement is informational only.
- The employer includes this information on Box 12.



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ACA: FORM W-2 REPORTING REQUIREMENT

The ACA requires employers that sponsor fully insured or self-insured (including level-funded) group health plans to report information to the IRS annually via Form W-2 regarding the cost of health coverage provided to employees during the prior calendar year. This publication discusses the ACA's Form W-2 reporting requirements, including the employers and plans subject to the requirement, the types of coverage that are reportable, the methods of calculating the cost of those coverage types, and the penalties for noncompliance. In addition, the Resources section includes links to forms, instructions, and other resources that may be helpful to employers.

THE FORM W-2 REPORTING REQUIREMENT

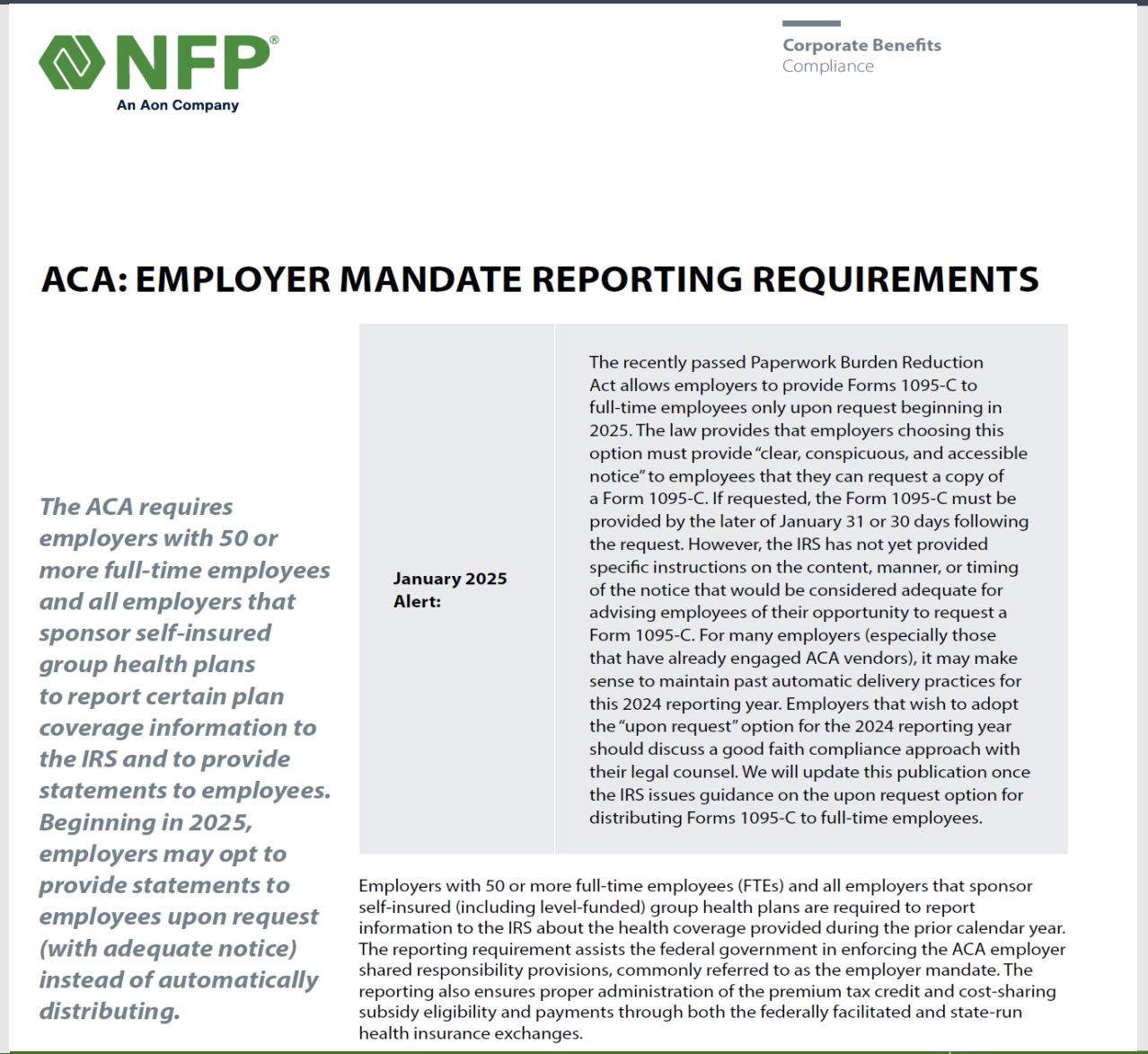
Effective for Form W-2 reporting in 2013 (for calendar year 2012) and annually thereafter, employers are required to report the aggregate cost of applicable employer-sponsored group health plan coverage on each covered employee's Form W-2. The employer must report the cost of coverage on a calendar-year basis, regardless of the employer's ERISA plan year or medical policy or contract year.

The Form W-2 reporting requirement remains on hold for employers filing fewer than 250 Forms W-2.

Employers must file copies of their annual Forms W-2 with the Social Security Administration by each January 31; this deadline applies regardless of whether the employer is filing paper forms or electronically. Employers must also provide copies B, C, and 2 of Form W-2 to their employees by the same deadline. When the due date falls on a weekend or federal holiday, the due date is extended to the next business day.

Information Reporting

- The ACA requires employers to report their compliance with the employer mandate. Employers must report information to the IRS about the health coverage provided to employees during the prior calendar year.
- Employers must also provide this information to their employees.
- The reporting consists of two types of forms. The information reports (Forms 1095-B and 1095-C) and the transmittal forms (Forms 1094-B and 1094-C) that accompany the information reports.
- The forms an employer uses will depend on whether the employer is large (i.e., employs 50 or more employees) and whether the plan is fully insured or self-insured.



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ACA: EMPLOYER MANDATE REPORTING REQUIREMENTS

The ACA requires employers with 50 or more full-time employees and all employers that sponsor self-insured group health plans to report certain plan coverage information to the IRS and to provide statements to employees. Beginning in 2025, employers may opt to provide statements to employees upon request (with adequate notice) instead of automatically distributing.

January 2025 Alert:

The recently passed Paperwork Burden Reduction Act allows employers to provide Forms 1095-C to full-time employees only upon request beginning in 2025. The law provides that employers choosing this option must provide "clear, conspicuous, and accessible notice" to employees that they can request a copy of a Form 1095-C. If requested, the Form 1095-C must be provided by the later of January 31 or 30 days following the request. However, the IRS has not yet provided specific instructions on the content, manner, or timing of the notice that would be considered adequate for advising employees of their opportunity to request a Form 1095-C. For many employers (especially those that have already engaged ACA vendors), it may make sense to maintain past automatic delivery practices for this 2024 reporting year. Employers that wish to adopt the "upon request" option for the 2024 reporting year should discuss a good faith compliance approach with their legal counsel. We will update this publication once the IRS issues guidance on the upon request option for distributing Forms 1095-C to full-time employees.

Employers with 50 or more full-time employees (FTEs) and all employers that sponsor self-insured (including level-funded) group health plans are required to report information to the IRS about the health coverage provided during the prior calendar year. The reporting requirement assists the federal government in enforcing the ACA employer shared responsibility provisions, commonly referred to as the employer mandate. The reporting also ensures proper administration of the premium tax credit and cost-sharing subsidy eligibility and payments through both the federally facilitated and state-run health insurance exchanges.

Reporting and Notice Requirements

Employer Type	6055	6056	IRS Report	Employee Statement
Small Fully Insured	No	No	N/A	N/A
Small Self-Insured	Yes	No	Form 1094-B | Form 1095-B	Copy of Form 1095-B or Substitute
Large Fully Insured	No	Yes	Form 1094-C | Form 1095-C | Parts I & II only	Copy of Form 1095-C or Substitute
Large Self-Insured	Yes	Yes	Form 1094-C | Form 1095-C | Parts I, II, and III	Copy of Form 1095-C or Substitute

Information Reporting

Employers must electronically file their reports on or before March 31 of the year following the calendar year to which the reporting relates.

- As of 2023, virtually all employers must file electronically, not via paper

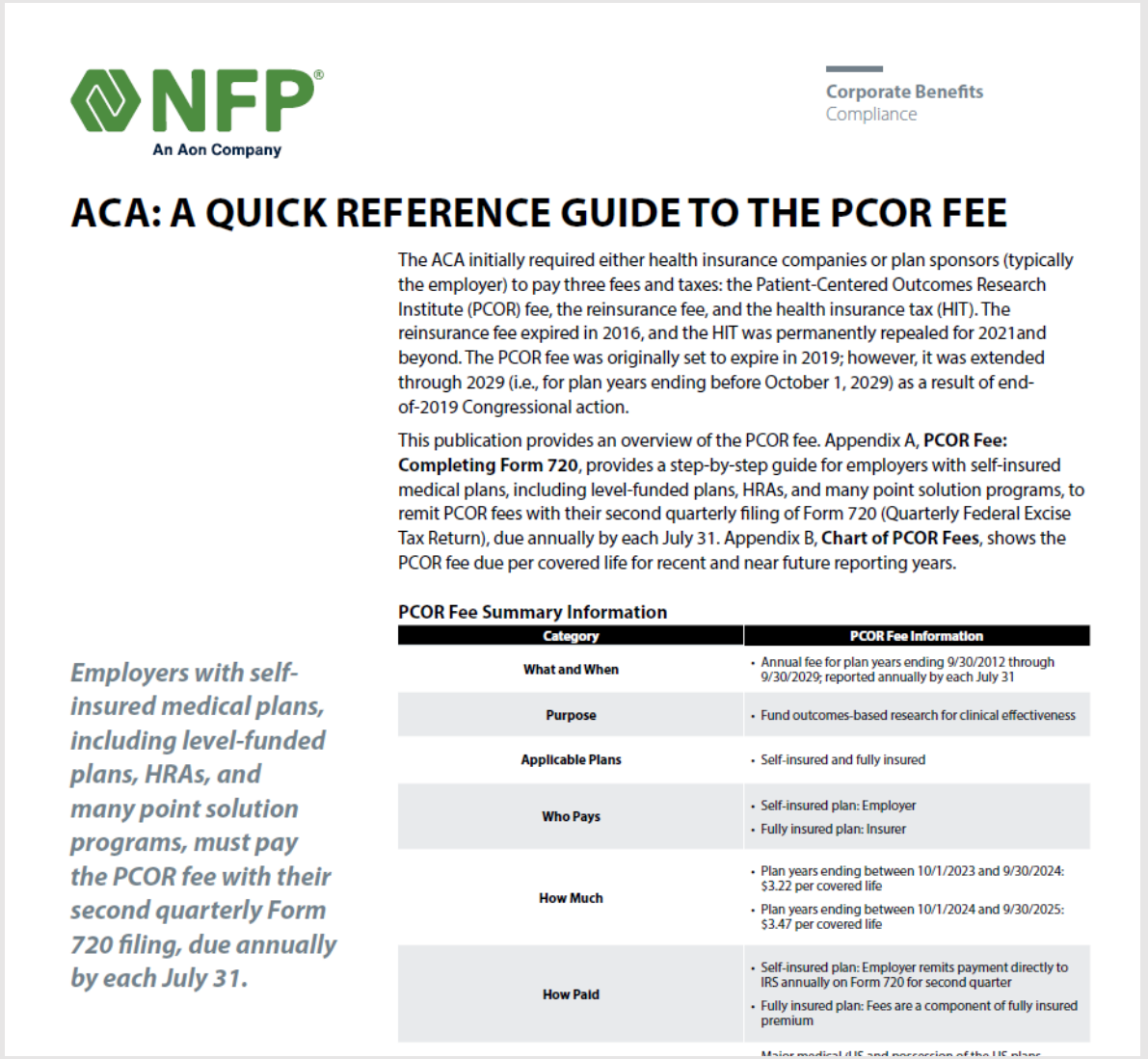
Starting in 2025, employers now have the option to provide Form 1095-C to employees only upon request, if sufficient notice has been provided.

- Currently awaiting further guidance on notice requirements

Reporting and Notice Requirements

PCOR

- Fee paid by insurers and sponsors of self-insured health plans (including HRAs) to fund clinical research.
- The fee is reported and paid by filing IRS Form 720 by the 7/31 deadline.
  - Self-insured plans pay it directly via Form 720
  - Fully insured plans have this handled by the carrier, although the fees are generally baked into premiums
- Fee originally due to sunset but was extended for 10 years in late 2019.



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ACA: A QUICK REFERENCE GUIDE TO THE PCOR FEE

The ACA initially required either health insurance companies or plan sponsors (typically the employer) to pay three fees and taxes: the Patient-Centered Outcomes Research Institute (PCOR) fee, the reinsurance fee, and the health insurance tax (HIT). The reinsurance fee expired in 2016, and the HIT was permanently repealed for 2021and beyond. The PCOR fee was originally set to expire in 2019; however, it was extended through 2029 (i.e., for plan years ending before October 1, 2029) as a result of end-of-2019 Congressional action.

This publication provides an overview of the PCOR fee. Appendix A, **PCOR Fee: Completing Form 720**, provides a step-by-step guide for employers with self-insured medical plans, including level-funded plans, HRAs, and many point solution programs, to remit PCOR fees with their second quarterly filing of Form 720 (Quarterly Federal Excise Tax Return), due annually by each July 31. Appendix B, **Chart of PCOR Fees**, shows the PCOR fee due per covered life for recent and near future reporting years.

Employers with self-insured medical plans, including level-funded plans, HRAs, and many point solution programs, must pay the PCOR fee with their second quarterly Form 720 filing, due annually by each July 31.

PCOR Fee Summary Information

Category	PCOR Fee Information
What and When	• Annual fee for plan years ending 9/30/2012 through 9/30/2029; reported annually by each July 31
Purpose	• Fund outcomes-based research for clinical effectiveness
Applicable Plans	• Self-insured and fully insured
Who Pays	• Self-insured plan: Employer • Fully insured plan: Insurer
How Much	• Plan years ending between 10/1/2023 and 9/30/2024: $3.22 per covered life • Plan years ending between 10/1/2024 and 9/30/2025: $3.47 per covered life
How Paid	• Self-insured plan: Employer remits payment directly to IRS annually on Form 720 for second quarter • Fully insured plan: Fees are a component of fully insured premium

Employer Mandate Basics

Employer mandate basics

ALEs are required to offer coverage to FT employees & dependents or may be subject to a penalty

- Which employers are ALEs
- Who is a FT employee
- How do employers comply
- Penalties for noncompliance

Which employers are ALEs

- An ALE is an employer with 50 or more full-time EEs & equivalents (FTEs) in the **prior calendar year.**
  - Must aggregate headcount for members of same controlled group.
  - An employee averaging 30hrs or more/week counts as 1 EE.
  - Part-time EEs count as fractional share based on # of hrs worked per month.
- If # of FT EEs + FT equivalents = 50 or more the employer is an ALE.
  - All members of controlled group are ALE if the group has 50+.
- Tricky EEs to count:
  - Owners, partners in partnership, and more than 2% S-corp shareholders are not included in headcount.
  - Leased EEs are excluded if the common law employer is staffing firm.
  - International EEs included only if receiving US-sourced income.
  - Volunteers generally excluded.
  - Interns/student workers **are** counted..
  - M&A transactions must involve legal counsel to determine size

[Determining if an employer is an applicable large employer | Internal Revenue Service]

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ACA: APPLICABLE LARGE EMPLOYERS

Under the ACA employer mandate, employers with at least 50 full-time employees (FTEs) (including equivalents) – known as "applicable large employers" (ALEs) – must offer affordable coverage or pay a tax penalty. The requirement, also known as the "employer shared responsibility" provision, has been in effect since 2015. This publication provides information on which entities are considered ALEs; it highlights the process to determine ALE status and notes special considerations. For detailed information about the employer mandate penalties and affordability, see the NFP publication **ACA: Employer Mandate Penalties and Affordability**.

Identifying FT EEs

- Employed on average at least 30 hours per week or 130 hours per month.
  - Hours include any hours in which EE is paid or entitled to payment: vacation, PTO, sick time, disability, holiday, paid leave, etc.

- Hourly EEs track actual hours; salary/non-hourly can use actual hours or an equivalent such as 8 hrs/day.

- Employee types with difficult to track hours:
  - Adjunct faculty: credits 2.25 hours of service for each hour of teaching/classroom time.
  - Commission-based: use reasonable method to credit hours, including travel and prep time.
  - On-call hours: use reasonable method to credit on-call hours.
  - Staffing or leased EEs: depends on common-law employer as to which party tracks hours.
  - Student workers/interns: no exception, should be treated the same as other EEs.
  - Seasonal EEs: may be exempt from definition of FT EE if employment begins/ends around the same time each year, duration does not exceed 6 months (ex: ski instructor, lifeguard, holiday retail); be cautious in applying this exemption.
  - Teachers/educational institution EEs: tracking depends on measurement method being used, but generally breaks are disregarded for purposes of calculating FT status.

Identifying FT EEs

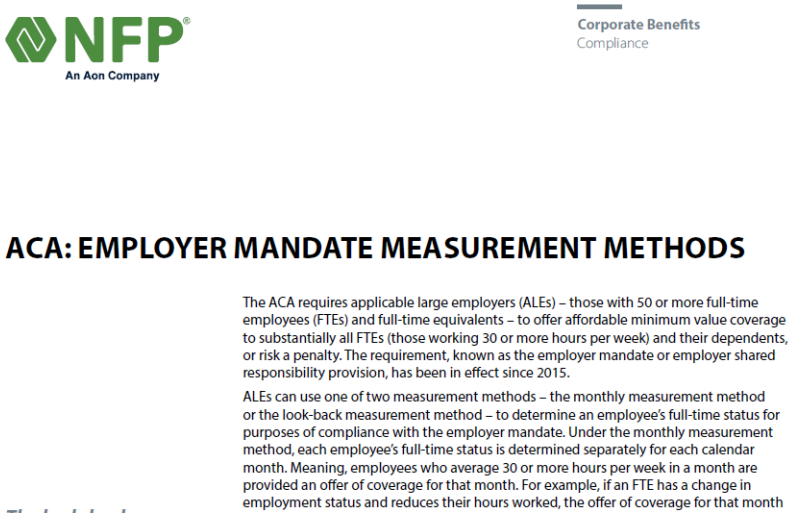
2 methods to determine FT status – monthly & look-back measurement

Monthly:

- Determine before month begins if EE will work 30hrs/week.
- Works for traditional FT EEs; difficult for PT or variable hr EEs with fluctuating schedules.

Look-back:

- Analyze EE hours over a period of time between 6-12 months.
- If avg 30hrs/week or more over that time, offer coverage for entire next plan year.
- Administrative burden to analyze hours and offer coverage.
- Change in status from FT to PT or vice versa can be challenging.
- Should not use as a way to delay offers of coverage – if a new hire is FT they would be offered coverage right away; PT and variable would be analyzed for a future offer of coverage.



How do employers comply?

- Offer coverage to 95% of FT EEs and dependent children.
  - Not required to offer coverage to a spouse.
- Dependent children include biological & adopted children up to age 26; step and foster children not required.
- Coverage must meet minimum value (MV) standards (meaning it pays for at least 60% of total costs) and minimum essential coverage (MEC) standards (eligible employer-sponsored plans).
- Coverage must be affordable based on chosen ACA safe harbor. EE only cost must not exceed 9.02% of:
  - W2 Box 1 wages
  - Rate of pay (based on 130 hrs/month)
  - Federal Poverty Line

How do employers comply?

600120

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
Do not attach to your tax return. Keep for your records.
Go to *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID ☐ CORRECTED

OMB No. 1545-2251
2024

Part I Employee

1 Name of employee (first name, middle initial, last name) | 2 Social security number (SSN)
3 Street address (including apartment no.)
4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer | 8 Employer identification number (EIN)
9 Street address (including room or suite no.) | 10 Contact telephone number
11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code

Part II Employee Offer of Coverage | **Employee's Age on January 1** | **Plan Start Month** (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

120118

Form **1094-C**
Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns
Go to *www.irs.gov/Form1094C* for instructions and the latest information.

☐ CORRECTED

OMB No. 1545-2251
2024

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer) | 2 Employer identification number (EIN)
3 Street address (including room or suite no.)
4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code
7 Name of person to contact | 8 Contact telephone number
9 Name of Designated Government Entity (only if applicable) | 10 Employer identification number (EIN)
11 Street address (including room or suite no.)
12 City or town | 13 State or province | 14 Country and ZIP or foreign postal code
15 Name of person to contact | 16 Contact telephone number

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ACA: FAQs ON IRS LETTER 226-J

Under the ACA employer mandate, employers with at least 50 full-time employees (FTEs) (including full-time equivalents) – known as "applicable large employers" (ALEs) – must offer affordable minimum value coverage to substantially all FTEs (those working 30 or more hours per week) and their dependents, or risk owing penalties through an employer shared responsibility payment (ESRP). Importantly, the IRS notifies employers of a proposed ESRP through Letter 226-J. The following FAQs address how ALEs will be notified of an ESRP, how employers should respond to or dispute the notification, and best practices for ACA reporting and recordkeeping. For more detailed background information regarding ALE status and employer mandate penalties, see the NFP publications ACA: Applicable Large Employers and ACA: Employer Mandate Penalties.

Form **14764**
(February 2018)

Department of the Treasury - Internal Revenue Service

ESRP Response

Complete both sides of this form and return it to the address shown on the letter received.

Provide Your Contact Information

Name

Address *(if you changed your address, make the changes below)*

City | State | Country | Zip code

Primary telephone number | Best time to call

Secondary telephone number | Best time to call

Indicate Your Agreement or Disagreement

Penalties for noncompliance

Penalty A (failure to offer MEC to 95% of FTEs and dependents)

- $2,900 per FT EE (minus a credit of 30 EEs; ex: 100 EEs – 30 credit = penalized on 70).
- Triggered if at least 1 EE enrolls in a subsidized plan on the marketplace.
- Applied to each controlled group member separately – so if only 1 entity in controlled group failed to offer coverage, only that group is penalized, not the entire controlled group.

Penalty B (offered MEC, but failed to meet MV or affordability standards)

- $4,350 per EE who enrolled in a subsidized plan on the marketplace.
- Generally smaller penalty since it is only assessed on those who receive a subsidy.

Failure to file forms with IRS and/or failure to distribute to EEs/participants:

- $330 per form (this essentially doubles if did not distribute and did not file with IRS)
  - $60 per form if corrected within 30 days; $130 if corrected by August 1.
- New rules make it unclear how distribution penalties will be handled since employers may not have to distribute to EEs.

Key Takeaways and Resources

Key Takeaways and Resources

All group health plans must comply with at least some aspects of the ACA.

- Work closely with carrier/TPA to ensure plan meets coverage mandates.
- Identify filing requirements (PCOR, 1095s, etc.).
- Update plan documents and notices/distribution.
- Determine if employer is an ALE and have a plan in place to track EE hours and handle reporting.
- Do not ignore letters from the IRS or state exchanges!
- NFP's *ACA Reporting Toolkit* has a lot of helpful publications on employer mandate compliance, request a copy from your consultant or advisor.


Questions?
Thank you for joining us!