ACA COMPLIANCE OVERVIEW

Affordable Care Act: 2023 Compliance Checklist

The Affordable Care Act (ACA) made a number of significant reforms to group health plan coverage when it was enacted in 2010. Since then, changes have been made to various ACA requirements that employers should be aware of. These changes include annual cost-of-living increases to certain ACA dollar limits, extensions to ACA reporting deadlines and updates to preventive care coverage guidelines.

Changes to some ACA requirements will take effect in 2023 for employers sponsoring group health plans. To prepare for 2023, employers should review these requirements and develop a compliance strategy. Employers should ensure that their health plan documents, including the summary of benefits and coverage (SBC), are updated to reflect any new plan limits and that up-to-date information is communicated to employees at open enrollment time.

This ACA Overview provides an ACA compliance checklist for 2023. Please contact National Insurance Services for assistance or if you have questions about changes that were required in previous years.

LINKS AND RESOURCES

- Department of Health and Human Services' (HHS) guidance established the cost-sharing limits for 2023.
- IRS Rev. Proc. 2022-34 indexed the affordability contribution percentages for 2023.
- IRS Rev. Proc. 2022-38 increased the maximum contribution limit for health flexible spending accounts (FSAs) for 2023.

Plan Design Changes

The following plan design requirements have changed for 2023:

- Limits on cost sharing for essential health benefits
- Health FSA contribution limits
- Coverage affordability percentages under the employer shared responsibility rules
- Dollar amounts for calculating employer shared responsibility penalties

Reporting Deadlines

The following deadlines apply for reporting under Sections 6055 and 6056:

- **Feb. 28, 2023**: Paper IRS returns for 2022 are due by this date.
- **March 2, 2023**: Individual statements for 2022 must be furnished by this date.
- **March 31, 2023**: Electronic IRS returns for 2022 must be filed by this date.

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PLAN DESIGN CHANGES

Overall Cost-sharing Limit	Complete
Confirm that your plan's out-of-pocket limit for essential health benefits (EHB) does not exceed the ACA's limit for the plan year beginning in 2023. Effective for plan years beginning on or after Jan. 1, 2023, a health plan's out-of-pocket limit for EHB may not exceed **$9,100 for self-only coverage and $18,200 for family coverage.** This limit applies to all non-grandfathered group health plans, including fully insured and self-insured plans. If you have an HSA-compatible high deductible health plan (HDHP), keep in mind that the plan's out-of-pocket maximum must be lower than the ACA's limit. For 2023, the out-of-pocket maximum for HDHPs is **$7,500** for self-only coverage and **$15,000** for family coverage.	☐

Health FSA Limits	Complete or N/A
If you have a health FSA, confirm that its dollar limit on employees' salary reduction contributions does not exceed $3,050 for the plan year beginning in 2023. An employer may impose its own dollar limit on employees' pre-tax contributions to the health FSA as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year.	☐
If you have a health FSA that allows carryovers of unused amounts, confirm that the maximum unused amount from a plan year starting in 2023 that is allowed to be carried over to the immediately following plan year beginning in 2024 does not exceed $610.	☐

First-dollar Preventive Care Coverage	Complete
Confirm that your health plan covers the latest recommended preventive care services without imposing any cost sharing. Non-grandfathered health plans must cover certain preventive health services without imposing cost-sharing requirements (that is, deductibles, copayments or coinsurance) for the services. Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. More information on the recommended preventive care services is available from HealthCare.gov.	☐

Excepted Benefit Health Reimbursement Arrangement (HRA)	Complete or N/A
If you offer an excepted benefit HRA, confirm that its maximum benefit amount for the plan year beginning in 2023 does not exceed $1,950. Beginning in 2020, employers that offer traditional group health plans may offer a limited benefit HRA that is exempt from the ACA's market reforms. This HRA, called an excepted	☐

benefit HRA, can be used to reimburse employees' eligible medical care expenses, up to $1,800 each year, as adjusted by the IRS for inflation. For 2023, this maximum limit is $1,950.

Grandfathered Plan Status	Complete or N/A
If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2023 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year. • If a plan will lose its grandfathered status for 2023, confirm that the plan has all of the additional patient rights and benefits required by the ACA for non-grandfathered plans. This includes, for example, coverage of preventive care without cost-sharing requirements. • If a plan will keep its grandfathered status, continue to provide the **Notice of Grandfathered Status** in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (such as the plan's summary plan description and open enrollment materials). A model notice is available from the Department of Labor (DOL).	☐

EMPLOYER SHARED RESPONSIBILITY RULES

ALE Status for 2023	Yes	No
Will you be an applicable large employer (ALE) for 2023? The ACA's employer shared responsibility rules apply only to ALEs. ALEs are employers with **50 or more** full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. Employers determine each year, based on their current number of employees, whether they will be considered an ALE for the following year. Under the ACA's employer shared responsibility rules, ALEs are required to offer affordable, minimum value health coverage to their full-time employees (and dependent children) or pay a penalty. An ALE will be subject to penalties if one or more full-time employees receive a subsidy for purchasing health coverage through an Exchange. An individual may be eligible for an Exchange subsidy either because the ALE does not offer coverage to that individual, or offers coverage that is "unaffordable" or does not provide "minimum value." *If you answered "No," you can stop completing this section of the checklist. Because your company is not an ALE for 2023, the ACA's employer shared responsibility rules do not apply.*	☐	☐

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Offer of Health Plan Coverage	Yes	No
Do you offer health coverage to your full-time employees? To correctly offer coverage to full-time employees, ALEs must determine which employees are full-time employees under the ACA's definition. A full-time employee is an employee who was employed, on average, at **least 30 hours of service per week** (or 130 hours of service in a calendar month). The IRS provides two methods for determining full-time employee status for purposes of offering coverage—the monthly measurement method and the look-back measurement method. *If you answered "No," your company will be subject to penalties if one or more of your full-time employees receives a subsidy to purchase health coverage through an Exchange.*	☐	☐
Is your health plan coverage affordable? Health plan 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 affordability test applies only to the portion of the annual premiums for self-only coverage, and does not include any additional cost for family coverage. Also, if an employer offers multiple health coverage options, the affordability test applies to the lowest-cost option that provides minimum value. The adjusted percentage is **9.12% for 2023**. This is the most substantial decrease in this percentage since these rules were implemented (down from 9.61% in 2022). It is the lowest that this percentage has ever been set, at 0.38% below the statutory affordability percentage of 9.5%. As a result, many employers may have to substantially lower the amount they require employees to contribute for 2023 to meet the adjusted percentage. *If you answered "No," your company will be subject to penalties if one or more of your full-time employees receives a subsidy to purchase health coverage through an Exchange.*	☐	☐
Does your health plan coverage provide minimum value? A health plan provides minimum value (MV) if the plan's share of total allowed costs of benefits provided under the plan is **at least 60%** of those costs. Three approaches may be used for determining MV: a Minimum Value (MV) Calculator, design-based safe harbor checklists or actuarial certification. In addition, any plan in the small group market that meets any of the "metal levels" of coverage (that is, bronze, silver, gold or platinum) provides MV.	☐	☐

In addition, plans that do not provide inpatient hospitalization or physician services (referred to as non-hospital/non-physician services plans) do not provide MV. *If you answered "No," your company will be subject to penalties if one or more of your full-time employees receives a subsidy to purchase health coverage through an Exchange.*		

Possible Penalty Amounts	Complete or N/A
If your company may be liable for an ACA penalty, calculate the possible penalty amount. Depending on the circumstances, one of two penalties may apply under the ACA's employer shared responsibility rules: the 4980H(a) penalty or the 4980H(b) penalty. • Under Section 4980H(a), an ALE will be subject to a penalty if it does not offer coverage to "substantially all" full-time employees (and dependents) and any one of its full-time employees receives an Exchange subsidy. **For 2023, the 4980H(a) monthly penalty is equal to the ALE's number of full-time employees (minus 30) multiplied by 1/12 of $2,880 for any applicable month.** • Under Section 4980H(b), an ALE that offers coverage to substantially all full-time employees (and dependents) may still be subject to penalties if at least one full-time employee obtains an Exchange subsidy because the employer's coverage is unaffordable or does not provide minimum value or the ALE did not offer coverage to all full-time employees. **For 2023, the 4980H(b) monthly penalty assessed on an ALE for each full-time employee who receives a subsidy is 1/12 of $4,320 for any applicable month.** However, the total penalty for an ALE is limited to the 4980H(a) penalty amount.	☐

Reporting of Coverage (Code Sections 6055 and 6056)

Affected Employers	Yes	No
Is your company subject to ACA reporting under Code Sections 6055 or 6056? The following employers are subject to ACA reporting under Internal Revenue Code (Code) Sections 6055 and 6056: • Employers with self-insured health plans (Section 6055 reporting)	☐	☐

- ALEs with either fully insured or self-insured health plans (Section 6056 reporting)

Employers that are not ALEs and have fully insured health plans are not subject to these ACA reporting requirements.

Employers that are subject to this reporting must file certain forms with the IRS each year and provide annual statements to individuals who are covered under the health plan (under Section 6055) and each of the ALE's full-time employees (Section 6056). Note that ALEs with self-funded plans are required to comply with both reporting obligations. However, to simplify the reporting process, the IRS allows ALEs with self-insured plans to use a single combined form to report the information required under both Sections 6055 and 6056.

If you answered "No," you can stop completing this section of the checklist, as your company is not subject to ACA reporting under Sections 6055 or 6056.

File Returns With IRS by Applicable Deadline in 2023	Complete
For the 2022 calendar year, file returns with the IRS by Feb. 28, 2023 (or March 31, 2023, if filing electronically). Under Code Section 6055, reporting entities will generally file Forms 1094-B (a transmittal) and 1095-B (an information return). Under Code Section 6056, entities file Forms 1094-C (a transmittal) and 1095-C (an information return). Employers reporting under both Sections 6055 and 6056 (that is, ALEs with self-insured plans) use a combined reporting method by filing Forms 1094-C and 1095-C. Any reporting entity that is required to file at least 250 returns must file electronically. Reporting entities may receive an automatic 30-day extension to file with the IRS by completing and filing Form 8809 (Application for Extension of Time To File Information Returns) by the due date of the returns.	☐

Provide Individual Statements by Applicable Deadline in 2023	Complete
For the 2022 calendar year, provide individual statements by March 2, 2023. Written statements generally must be provided to individuals no later than Jan. 31 of the year following the calendar year in which coverage was provided. However, the annual deadline for furnishing statements was extended by 30 days each year. As a result, for the 2022 calendar year, the deadline to furnish individual statements is **March 2, 2023**.	☐

PCORI FEES

Pay PCORI Fees (Self-insured Plans Only)	Complete or N/A
Pay PCORI fees by July 31, 2023 for plan years ending in 2022. Under the ACA, employers with self-insured plans must pay Patient-Centered Outcomes Research Institute fees (PCORI fees) each year. The fees are reported and paid using IRS Form 720 (Quarterly Federal Excise Tax Return). For fully insured plans, the health insurance issuer is responsible for reporting and paying these fees. PCORI fees are due each year by July 31 of the year following the last day of the plan year. For plan years ending in 2022, the PCORI fee payment is due July 31, 2023. For plan years ending on or after Oct. 1, 2021, and before Oct. 1, 2022, the PCORI fee amount is $2.79 per covered life. The IRS has not released the PCORI fee for plan years ending on or after Oct. 1, 2022, and before Oct. 1, 2023.	☐

Disclosure Requirements

Summary of Benefits and Coverage (SBC)	Complete
Provide an updated SBC in connection with the plan's open enrollment period for 2023. Health plans and issuers must provide an SBC to applicants and enrollees to help them understand their coverage and make coverage decisions. The SBC should be included with the plan's enrollment materials. If coverage automatically renews for current participants, the SBC must generally be provided no later than 30 days before the beginning of the new plan year. The SBC must follow strict formatting requirements. Federal agencies have provided templates and related materials, including instructions and a uniform glossary of coverage terms, for health plans and health insurance issuers to use. It should be updated before the plan's open enrollment period to reflect any changes in coverage for the upcoming plan year. For self-funded plans, the plan administrator is responsible for providing the SBC. For insured plans, both the plan and the issuer are obligated to provide the SBC; however, this obligation is satisfied for both parties if either one provides the SBC. Typically, the issuer will prepare the SBC for an insured health plan, although the employer may need to provide it to employees.	☐

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Employee Notice of Exchange	Complete
Provide all new hires with a written notice about the ACA's health insurance Exchanges. The DOL has provided model Exchange notices for employers to use, which require some customization.	☐

Notice of Patient Protections	Complete or N/A
Provide a Notice of Patient Protections if your health plan requires participants to designate a participating primary care provider. Under the ACA, group health plans and issuers that require the 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). Additionally, plans and issuers that provide obstetrical/gynecological care and require the designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. If a plan is subject to this notice requirement, it should be confirmed that it is included in the plan's open enrollment materials. Model language is available from the DOL.	☐

Grandfathered Plan Notice	Complete or N/A
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. Model language is available from the DOL.	☐