The John M. Glover Agency

2025 Affordable Care Act (ACA) Compliance Checklist

This checklist is designed to help employers who sponsor group health plans review their compliance with key provisions of the Affordable Care Act (ACA) for 2024. If you have any questions regarding your responsibilities, please contact a knowledgeable employment law attorney, benefits advisor, or your carrier.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements or amendments to the law. Additionally, your company or group health plan may be exempt from certain requirements and/or subject to more stringent rules under your state's laws.

1. Evaluate Grandfathered Status of Group Health Plan

A grandfathered plan is one in existence as of March 23, 2010, that has covered at least one person continuously from that day forward. Grandfathered plans ***do not have to comply with certain ACA rules.***

- Determine whether any changes to the plan that reduce benefits or increase costs to employees and dependents enrolled in coverage result in a loss of grandfathered status.
- **If the plan loses grandfathered status,** confirm that the plan design and benefits offered reflect all ACA requirements that previously did not apply because the plan was exempt (such as coverage of preventive services without cost-sharing).
- **If the plan remains grandfathered,** provide a Notice of Grandfathered Status whenever a summary of plan benefits is provided to participants and beneficiaries. Continue to maintain records documenting the terms of the plan that were in effect on March 23, 2010, and any other documents necessary to verify grandfathered status.

2. Review Plan Documents for Required Changes to Plan Benefits

Certain requirements apply to particular plan designs, as noted below.

All Group Health Plans:

- Ensure that any **waiting period**—the time that must pass before coverage can become effective for an employee or dependent that is otherwise eligible to enroll in the plan—does not exceed 90 days. (Other conditions for eligibility that are not based solely on the lapse of time are generally permissible.)
- If the plan requires completion of an employment-based orientation period as a condition for eligibility, ensure that the orientation period **does not exceed one month** and the maximum 90-day waiting period begins on the first day after the orientation period. (Note: Employers subject to the "pay or play" rules may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to a penalty.)
- Confirm that **no annual dollar limits** apply to coverage of "essential health benefits" (EHBs)—a comprehensive package of specified items and services. If the plan limits the number of visits to health providers or days of treatment, verify that the visit or day limit does not amount to a dollar limit.
- Verify that **no preexisting condition exclusions** are imposed on any individual, regardless of age.
- With the exception of certain HRAs, ensure that an **employer payment plan** is not in place (an arrangement under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or uses its funds to directly pay the premium for an individual policy).

Non-Grandfathered Group Health Plans Only:

- For small group plans, confirm that the plan covers EHBs. (This requirement does not apply to self-insured plans or plans offered in the large group market.)
- Ensure that annual out-of-pocket costs for coverage of **all** EHBs provided in-network do not exceed **$9,200 for self-only coverage or $18,400 for family coverage** for plan years beginning in 2025.
    - **Note:** The self-only maximum annual limitation on cost-sharing applies to **each individual**, regardless of whether the individual is enrolled in self-only coverage or family coverage under a group health plan.
    - Plans with more than one service provider may structure a benefit design using separate out-of-pocket limits across multiple categories of benefits (rather than reconcile claims across multiple service providers), provided that the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limit.
    - A plan that includes a network of providers may, but is not required to, count out-of pocket spending for out-of-network and non-covered items and services towards the plan's annual maximum out-of-pocket limit.

3. Analyze Tax-Favored Arrangements

Employers who maintain HRAs, health FSAs and cafeteria plans should confirm that these arrangements comply with ACA requirements.

Health Reimbursement Arrangements (HRAs)

- Review the additional HRA design options that became available beginning in 2020, determine which type of HRA to offer and ensure appropriate HRA plan design requirements are satisfied.
- If an Individual Coverage HRA or QSEHRA is offered, provide eligible employees with applicable written notice at least 90 days before the beginning of the plan year.

Health Flexible Spending Arrangements (FSAs)

- Confirm that the health FSA **qualifies as excepted benefits.**
    - Health FSAs are considered to provide only excepted benefits if the employer also makes group health plan coverage available that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, $500 plus the amount of the participant's salary reduction election).
- Confirm that the health FSA is **offered through a cafeteria plan** (a plan that meets specific requirements to allow employees to receive certain benefits on a pre-tax basis).
- Ensure that plan documents are amended to reflect that employee salary reduction contributions to health FSAs are limited to a certain amount. For 2025, the contribution limit is **$3,300.**
- The amendment to the written cafeteria plan may be expressed as a maximum dollar amount, a maximum percentage of compensation, or by another method of determining the maximum salary reduction contribution.
- Determine whether you will allow employees to carry over unused health FSA amounts to use in the following plan year, and adopt appropriate plan amendments. (A plan incorporating the carryover provision may not also provide for a grace period in the plan year to which unused amounts may be carried over.) For 2025, the health FSA carryover limit is **$660.**

Cafeteria Plans Generally

- Confirm that Section 125 plan documents comply with the **prohibition on providing a qualified health plan** offered through the Individual Health Insurance Exchange as a benefit under an employer-sponsored cafeteria plan.

4: Provide Required Notices to Employees and Dependents

Health Insurance Exchange Notice

- Provide a written notice with information about the Health Insurance Exchange (Marketplace) to each new employee, **within 14 days of his or her start date**. Employers are not required to provide a separate notice to dependents.

Summary of Benefits & Coverage (SBC) and Notice of Plan Changes

- Confirm contractual arrangements with the carrier (insured group health plans) or third party administrator (self-insured plans) to prepare and provide the SBC. If the carrier or TPA does not assume responsibility, the employer should provide this notice (without charge) to employees and beneficiaries at specified times during the enrollment process and upon request.
    - **Note:** Employers that enter into a binding contract with another party to provide the SBC must satisfy additional obligations, including monitoring compliance.
- Ensure that enrollees are provided with notice of any material modification that would affect the content of the SBC (and that occurs other than in connection with coverage renewal or reissuance) **no later than 60 days prior to the effective date of the change**.

5. Comply with the Pay or Play Rules

Applicable large employers—generally, those with 50 or more full-time employees, including full-time equivalent employees—are subject to the ACA's employer shared responsibility (pay or play) rules. Due to the complexity of the law in this area, employers are strongly advised to work with knowledgeable employment law counsel to ensure full compliance.

- Determine **applicable large employer (ALE) status** for the upcoming calendar year by calculating the average number of full-time employees and full-time equivalent employees (FTEs) across the months in the current year. (Special counting rules apply for seasonal workers.)
    - **Employer Aggregation Rules:** Small employers that individually do not employ 50 or more full-time employees or FTEs **may still be subject to these requirements if they meet the threshold when combined with other companies under common ownership** or that are otherwise related. (The rules for combining related employers do not apply for purposes of determining whether a particular company owes a penalty or the amount of any penalty. That is determined separately for each related company.)
- Determine whether group health plan coverage will be offered to **full-time employees** (and their dependents), using the measurement methods and rules for calculating hours of service described in the pay or play final regulations.
    - An employee is full-time for a calendar month if he or she averages at least 30 hours of service per week (or 130 hours for the month). The final regulations describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees and employees of educational organizations.
- For ALEs offering coverage, review the cost of your group health plan coverage to determine whether it is affordable.
- In general, **coverage is affordable in 2025 if an employee's required contribution for self only coverage does not exceed 9.02%** of his or her household income for the taxable year. ALEs may use a number of safe harbors to determine affordability, including reliance on Form W-2 wages.
- For ALEs offering coverage, determine whether your group health plan coverage provides **minimum value**.
    - A plan generally provides minimum value if it pays for at least 60% of covered health care expenses and provides substantial coverage of inpatient hospitalization and physician services.

- **Determine if a penalty may apply.** An ALE may be liable for a penalty if it does not offer affordable health coverage that provides minimum value to its full-time employees (and their dependents), and any full-time employee receives a premium tax credit for purchasing individual coverage through the Health Insurance Exchange. (Note: In determining if a penalty applies, ALEs should be aware of limited non-penalty periods provided for in the pay or play final regulations, during which an ALE generally will not be subject to a penalty.)
- **Determine whether to appeal an Exchange decision from a prior year, if applicable.** The Exchange sends letters to notify certain employers that one or more of their employees was determined to be eligible for premium tax credits and cost-sharing reductions, as applicable, and had enrolled in an Exchange plan. Because these events may trigger pay or play penalties, employers have the option to file an appeal within 90 days of the date stated on the Exchange notice.
- **Review and respond to IRS Letter 226J, if applicable.** The IRS issues Letter 226J to an ALE if it determines that, for at least one month in the year, one or more of the ALE's full-time employees was enrolled in a qualified health plan for which a premium tax credit was allowed (and the ALE did not qualify for an affordability safe harbor or other relief for the employee). ALEs must complete the response form (Form 14764) indicating their agreement or disagreement, and follow the appropriate instructions.
- **Pay assessed pay or play penalties, if applicable.** The IRS will assess pay or play penalties for prior years and issue a notice and demand for payment via Notice CP 220J. That notice will instruct the ALE on the amount due and payment options.

6. Satisfy Information Reporting Requirements (Forms 1094 & 1095)

Information reporting is used to determine compliance with the pay or play rules and other ACA provisions. Reporting entities are required to report in early 2024 for coverage offered (or not offered) in calendar year 2023.

- Determine if you are a reporting entity (and what type) to understand applicable reporting requirements:
    - **Section 6055 Reporting Entities.** Self-insuring employers that are not ALEs that provide minimum essential coverage (MEC) are required to report information on this coverage to the IRS and to covered individuals under Internal Revenue Code Section 6055.
    - **Section 6056 Reporting Entities.** ALEs with 50 or more full-time employees (including FTEs) are required to report information to the IRS and to their employees about their compliance with the pay or play rules under Internal Revenue Code Section 6056.
- Compile the required information for Section 6055 reporting and/or the required information for Section 6056 reporting.
- Review the IRS Forms and Instructions:
    - Forms 1094-B and 1095-B (along with Instructions) are available for **Section 6055** reporting entities.
    - Forms 1094-C and 1095-C (along with Instructions) are available for **Section 6056** reporting entities (or employers that are subject to **both** reporting provisions).
- Determine whether to hire a **third party** to fulfill reporting responsibilities (reporting entities will still be liable for any failure to report information and furnish statements by the required deadlines).
- Prepare to file ACA returns electronically. (Note that, before 2024, employers who filed fewer than 250 individual statements under Sections 6055 or 6056 could file their ACA returns on paper. However,beginning in 2024, paper filing is only available to employers who file fewer than 10 information returnswith the IRS for the year. This means that only the smallest employers will be able to file using paperreturns.)
- Remember to comply with the information reporting deadlines.

Section 6055 Deadlines (Forms 1094-B and 1095-B):

- Forms 1094-B and 1095-B must generally be filed with the IRS annually, **no later than February 28** (or March 31, if filing electronically).
- Forms 1095-B were generally required to be furnished to responsible individuals (may be the primaryinsured, employee, former employee or other related person named on the application) by January 31. However, the IRS extended the annual furnishing deadlines for Sections 6055 and 6056 reporting by 30 days from **January 31 each year**. This extended deadline is typically March 1; however, because the deadlinefalls on a weekend in 2025, individual statements must be furnished by the next business day, which is **March 3, 2025.**

Section 6056 Deadlines (Forms 1094-C and 1095-C):

- Forms 1094-C and 1095-C must be electronically filed with the IRS by March 31, 2025. Employers may receive an automatic 30-day extension to file with the IRS by completing and filing Form 8809 by the duedate of the returns.
- Forms 1095-C were generally required to be furnished to all full-time employees by January 31. However, the IRS extended the annual furnishing deadlines for Sections 6055 and 6056 reporting by **30 days from January 31 each year.** The extended deadline is typically March 1; however, because the deadline falls on aweekend in 2025, individual statements must be furnished by the next business day, which is **March 3, 2025.**

7. Other Action Items

The following outlines actions required for continued ACA compliance, as well as additional items that may be of significance for certain employers and group health plans.

- **Additional Medicare Tax for High Earners.** Remember to withhold the Additional Medicare Tax (0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year.
- **Coverage of Preventive Services.** Continue to monitor guidelines for preventive services, which are regularly updated to reflect new scientific and medical advances. As new services are approved, non-grandfathered group health plans will be required to cover them with no cost sharing for plan years beginning one year later.
- **Medical Loss Ratio (MLR) Rebates.** Distribute rebates received from insurance companies to eligible plan enrollees as appropriate. Rebates are due to employer-policyholders by **September 30** of each year. These rules do not apply to employers who operate self-insured plans.
- **PCORI Fees**. Employers sponsoring certain self-insured health plans are responsible for fees to fund the Patient-Centered Outcomes Research Institute (PCORI). To report and pay the fees, IRS Form 720 must be filed by Aug. 1, 2024.
- **Form W-2 Reporting of Employer-Provided Health Coverage.** Continue to report the cost of health coverage provided to each employee annually on Form W-2, which must be furnished to employees by January 31. (This requirement **does not apply to employers required to file fewer than 250 Forms W-2 for the preceding calendar year.)**

*Information in this document is general in nature and not intended to replace legal advice in any particular manner.

Contact Us With Any Questions

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