HUNTON& WILLIAMS

Health Care Reform– Compliance Timeline/Checklist For Employers

(As updated April 2015)

Action Items Checklist

Affordable Care Act Requirement	Effective Date	Status/Comments
2010		
Adult child coverage mandate	First plan year beginning on or after 9/23/2010	
Annual limit prohibition (for "essential health benefits") • $2 million minimum for plan years beginning on or after 9/23/12[1]	First plan year beginning on or after 9/23/2010; complete prohibition as of first plan year beginning on or after 1/1/2014	
Coverage rescission prohibition	First plan year beginning on or after 9/23/2010	
Expanded claims review*	First plan year beginning on or after 9/23/2010	
Lifetime limit prohibition (for "essential health benefits")	First plan year beginning on or after 9/23/2010	
Patient protections* • Choice of primary care physician • No advance authorization for out-of-network emergency services • No referrals for OB/GYN access	First plan year beginning on or after 9/23/2010	
Preexisting condition exclusion prohibition • Exclusion may be applied to adults until first plan year beginning after 12/31/2013	First plan year beginning on or after 9/23/2010; complete prohibition as of first plan year beginning on or after 1/1/2014	
Preventive care (with no cost-sharing)*	First plan year beginning on or after 9/23/2010	
Nondiscrimination rules for insured health plans*	First plan year beginning on or after 9/23/2010 (but postponed indefinitely until regulations issued)	

[1] See Appendix A.1

Affordable Care Act Requirement	Effective Date	Status/Comments
2011		
Over-the-counter drug reimbursement prohibition (without a prescription) for flex spending, health reimbursement and health savings account arrangements	1/1/2011	
2012		
Preventive care for women (with no cost-sharing)* [2]	First plan year beginning on or after 8/1/2012	
Summary of benefits and coverage (SBC) disclosure[3]	First open enrollment period beginning on or after 9/23/2012	
Comparative effectiveness research (CER) fee[4]	First plan year ending on or after 10/1/2012 *(for calendar year plans, first fee due 7/31/2013)*	
Form W-2 reporting of value of employer-provided health coverage[5]	Effective 2012 (for W-2s due in 2013)	
2013		
Healthcare flexible spending account $2,500 contribution limitation[6]	First FSA plan year beginning on or after 1/1/2013	
Medicare employment tax increase for high earners[7]	1/1/2013	
Employee exchange notice[8]	10/1/2013	
Adult obesity screening/counseling*	First plan year beginning on or after 7/1/13	
2014		
Adult child coverage mandate[9]	First plan year beginning on or after 1/1/2014	
Annual limit prohibition[10] (for "essential health benefits")	First plan year beginning on or after 1/1/2014	
Essential health benefits coverage mandate*[11] (for small insured GHPs only)	First plan year beginning on or after 1/1/2014	

[2] See Appendix A.2
[3] See Appendix A.3
[4] See Appendix A.4
[5] See Appendix A.5
[6] See Appendix A.6
[7] See Appendix A.7
[8] See Appendix A.8
[9] See Appendix B.1
[10] See Appendix B.2
[11] See Appendix B.3

Affordable Care Act Requirement	Effective Date	Status/Comments
Participant cost-sharing for all GHPs limited to high deductible health plan maximums, while only small insured GHPs are subject to specified deductible limits*[12]	First plan year beginning on or after 1/1/2014	
Preexisting condition exclusion prohibition[13]	First plan year beginning on or after 1/1/2014	
90-day waiting period limitation[14]	First plan year beginning on or after 1/1/2014	
Wellness program incentive increase[15]	First plan year beginning on or after 1/1/2014	
Prohibition on provider discrimination*[16]	First plan year beginning on or after 1/1/2014	
Prohibition on discrimination with respect to clinical trial participation*[17]	First plan year beginning on or after 1/1/2014	
Health insurance exchange coverage available[18]	1/1/2014	
Excise tax (individual coverage mandate)[19]	1/1/2014	
Transitional Reinsurance Program contribution[20] • First contribution due 2015, with initial reporting at 2014 year-end	1/1/2014 (Submission of enrollment counts delayed from November 17, 2014 to December 5, 2014)	
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) rules[21]	First plan year beginning on or after 7/1/2014	
Additional preventive care coverage requirements[22]	First plan year beginning after 9/24/2014	
2015 and Later		
Excise tax/penalties (employer "shared responsibility" coverage mandate)[23] • Penalty for failing to offer coverage to substantially all "full-time" employees and their dependents[24] • Alternative penalty for failure to provide coverage to "full-time" employees that is "affordable" and provides "minimum value"[25] (applies only if not subject to failure to offer coverage penalty)	Originally 1/1/2014; now 2015 for employers with 100 or more full-time employees; 2016 for employers with less than 100 full-time employees	NOTE: Prohibition on use of minimum value calculator for plans that do not provide substantial coverage for in-patient hospitalization services issued November 4, 2014.

[12] See Appendix B.4
[13] See Appendix B.5
[14] See Appendix B.6
[15] See Appendix B.7
[16] See Appendix B.8
[17] See Appendix B.9
[18] See Appendix B.10
[19] See Appendix B.11
[20] See Appendix B.12
[21] See Appendix B.13
[22] See Appendix B.14
[23] See Appendix C.1

Affordable Care Act Requirement	Effective Date	Status/Comments
IRS annual reporting requirements for Health Insurance Issuers and Self-Insured Group Health Plan Sponsors and for Applicable Larger Employers[26]	First returns due in 2016 (for coverage in 2015)	
HHS annual reporting requirements*[27]	Generally effective 1/1/2014 (but reporting to begin no earlier than 2015)	
HIPAA electronic transaction rules – compliance certification requirements[28]	By 12/31/2015 (12/31/2016 for small health plans)	
Auto enrollment[29]	To be determined (under DOL regs)	
Excise tax (employer-sponsored high cost health coverage)[30]	1/1/2018	
HIPAA electronic transaction rules – Health Plan Identifier (HPID) requirement[31]	Originally 11/5/2014 (11/5/2015 for small health plans); indefinitely delayed	

Note that several Affordable Care Act requirements do not apply to plans, policies or benefit packages that constitute excepted benefits. (See "Note Regarding Excepted Benefits," below.)

*Applies only to non-grandfathered health plans – generally, plans established on or after March 23, 2010 and pre-existing health plans that lose grandfathered status on or after March 23, 2010.

[24] See Appendix C.1.a
[25] See Appendix C.1.c
[26] See Appendix C.2 & Appendix C.3
[27] See Appendix C.4
[28] See Appendix C.5
[29] See Appendix C.6
[30] See Appendix C.7
[31] See Appendix C.8

Appendix

A. Compliance Requirements for 2010 – 2013

1. **Restricted Annual Limit on Essential Health Benefits** (effective first plan year beginning on or after September 23, 2010)
   - Annual limit, if any, must not be less than $2,000,000 for plan years beginning on or after September 23, 2012.
2. **Preventive Care Services for Women** *(effective first plan year beginning on or after August 1, 2012)*
   - Specific preventive care services for women must be covered without cost-sharing
     - Breastfeeding support, supplies, and counseling
     - Contraceptive methods and counseling*
     - Counseling and screening for human immune-deficiency virus
     - Counseling for sexually transmitted infections
     - Human papillomavirus testing
     - Screening and counseling for interpersonal and domestic violence
     - Screening for gestational diabetes
     - Well-woman visits

   ***NOTE**: There are exceptions to this requirement for qualifying religious organizations and qualifying nonprofit religious organizations that provide notice to their insurers or third-party administrators, plus a delayed effective date for nonqualifying religious organizations to the first plan year that starts on or after January 1, 2014. Proposed rules seek comment on extending this exception to closely-held for-profit entities.
3. **Summary of Benefits and Coverage (SBC)** *(effective first open enrollment period beginning on or after September 23, 2012)*
   - Coverage descriptions, exceptions, reductions, and limitations must be disclosed, in addition to cost-sharing provisions and other related items; Department of Labor ("DOL") standard template.
   - Notice of coverage modifications must be provided at least 60 days in advance of the effective date of the changes.
   - Uniform glossary of health coverage-related and medical-related terms must be available in paper or electronic form; Health and Human Services ("HHS") standard template.
   - For SBCs for 2014, the SBC must state whether the plan/coverage (1) provides "minimum essential coverage" for purposes of meeting the individual coverage mandate (see B.12 on page 7) and (2) meets the "minimum value" requirements (see B.11 on page 7)
   - In December 2014 the government proposed regulations that would shorten the SBC to 2 ½ pages from 4 pages, add one new example (broken foot and emergency room visit), add several new definitions to the uniform glossary, and make certain clarifications regarding provision of the SBC to plans and participants. The proposed changes will affect SBCs and uniform glossaries for open enrollment periods beginning on or after September 1, 2015.
     - The government indicated in an FAQ in March 2015 that it expects to finalize the regulations in the "near future" and to finalize the template and associated documents by January 2016; the final template is expected to apply for open enrollment starting in fall 2016.

   (*See* July 17, 2012 Hunton Employment & Labor Perspectives (HELP) Blog, FAQS About ACA Implementation (Part XIV), and January 29, 2015 HELP Blog post for additional details)

   SBCs are not required for plans, policies or benefit packages that constitute excepted benefits. (See "Note Regarding Excepted Benefits," on page 12.)
4. **Comparative Effectiveness Research (CER) Fee** *(effective for plan years ending on or after October 1, 2012)*
   - Self-insured plans and health insurance issuers must pay a CER fee (initially, $1 per covered life; $2 for plan years ending on or after 10/1/2013 or before 10/1/2014; and to be determined by HHS thereafter) to help fund the Patient-Centered Outcomes Research Institute. The fee must be reported/paid to the IRS by July 31 of the calendar year following the end of the applicable plan year on IRS Form 720. (See Form 720 Instructions.)

   (*See* July 10, 2012 HELP Blog for additional details.)
5. **Form W-2 Reporting Requirement** *(effective January 1, 2012 for W-2s to be issued in 2013)*
   - In general, aggregate value of employer-provided health coverage must be reported annually on the Form W-2 for each covered person.

   (See August 6, 2012 HELP Blog for additional details.)
6. **Healthcare Flexible Spending Account $2,500 Contribution Limit** (effective for FSA plan years beginning on or after January 1, 2013)
   - Limit applies only to employee elective contributions, and not employer matching or other non-elective contributions to an FSA.
   - Cafeteria/flexible benefits plan must be amended to include the new contribution limit by December 31, 2014.

   (*See* July 11, 2012 HELP Blog for additional details.)
7. **Medicare Employment Tax Increase** *(effective January 1, 2013)*
   - New 0.9% rate increase for earnings over $200,000 for single filers and $250,000 for married joint filers.
   - Employees are liable for payment of the tax, as the increase only applies to the employee-paid portion of FICA taxes.

- Employers are required to collect the additional 0.9% tax only to the extent that the employer pays wages to the employee that exceed $200,000 each calendar year (regardless of the employee's filing status or other income). For example, an employer is not required to collect the additional tax from an employee who earns $100,000, even though the employee's spouse earns $300,000 (and they file a joint return).

(*See* September 18, 2012 HELP Blog for additional details.)

8. **Employee Exchange Notice** *(effective October 1, 2013)*
   - Employers must provide written notice about the health insurance exchanges to current employees and new employees "at the time of hiring." DOL issued guidance that provides that the notice must be given to current employees by October 1, 2013 and new hires thereafter within 14 days of hire. The agency also provided the following model notices -- Notice for employer offering coverage and Notice for employer offering no coverage. (Note that only Part A of the model notice for employers offering coverage is required in order to comply). The DOL guidance also requires actual delivery of the notice – so, simply posting the notice to a company intranet site may not be sufficient.

B. Compliance Requirements for 2014

1. **Adult Child Coverage** *(effective first plan year beginning on or after January 1, 2014)*
   - Grandfathered plans must extend coverage to children, up to age 26, regardless of other available employer-sponsored coverage.
2. **Annual Limit on Essential Health Benefits** *(effective first plan year beginning on or after January 1, 2014)*
   - Annual dollar limits no longer allowed for essential health benefits.
3. **Essential Health Benefits Coverage** *(effective first plan year beginning on or after January 1, 2014)*
   - Non-grandfathered insured group health plans in the small group market ("small insured GHPs") are required to cover essential health benefits.
   - Essential health benefits include: ambulatory patient services; emergency services; hospitalization coverage; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drug coverage; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care; HHS has issued proposed regulations addressing these requirements.
4. **Cost-Sharing Restrictions** *(effective first plan year beginning on or after January 1, 2014)*
   - All non-grandfathered GHPs must limit participant cost sharing expenses to the annual out-of-pocket limits for high deductible health plans (HDHPs). (Note, though, that the required COLA adjustments for these limits are different from those that apply to HDHPs, and, therefore, will not necessarily be the same dollar amount in later years.)
   - However, only small non-grandfathered insured GHPs must comply with the applicable deductible limits ($2,000 for individual coverage; $4,000 for family coverage).

   (See FAQs About ACA Implementation (Part XII) (Q&As 1 & 2) and (Part XIX) (Q&As 2-4) for additional details).
5. **Preexisting Condition Exclusion** *(effective first plan year beginning on or after January 1, 2014)*
   - All preexisting condition exclusions are prohibited.
   - As a result, no certificates of creditable coverage are required to be issued after December 31, 2014.
6. **90-Day Waiting Period Limitation** *(effective first plan year beginning on or after January 1, 2014)*
   - Period in which an otherwise eligible employee can commence health plan participation cannot exceed 90 days.
   - Final regulations provide that a bona fide orientation period, a cumulative hours of service requirement (up to 1,200 hours) and certain other limitations not based solely on the passage of time will generally qualify as a bona fide eligibility requirement that will not be treated as a waiting period.
     - For plan years beginning before January 1, 2015, an orientation period of up to 1 calendar month will be considered bona fide.
     - For plan years beginning on or after January 1, 2015, the 1-month bona fide orientation period is calculated by adding one calendar month and subtracting one calendar day.
     - Note that the orientation period rules do not apply in determining whether coverage is timely offered for purposes of the employer mandate (discussed in Appendix C.1).
   - The final regulations also clarify that former employees who are rehired can be treated as "new" employee and be subject again to a waiting period (as long as the termination was not intended to avoid compliance). The same is also true for employees transferring to and from eligible positions/categories, as they can be treated as newly eligible for this purpose upon transfer to an eligible position/category.

   (See December 4, 2012 HELP Blog, April 21, 2014 HELP Blog, and July 7, 2014 HELP Blog posts for additional details and background on the waiting period rules.)

7. **Increased Wellness Program Incentive** *(effective first plan year beginning on or after January 1, 2014)*
   - Final regulations provide that all plans (and not just non-grandfathered plans) that offer "health-contingent" wellness incentives may provide a reward of up to 30% (up from 20%) of the cost of health coverage (50% for tobacco cessation programs) for such incentives.
   - The final regulations also:
     - Clarify that the incentive may be based on the total cost of the applicable coverage (and not just the employer-paid piece). If only employees may participate in the health-contingent wellness program, the reward must be based on the total cost of employee-only coverage. If, however, dependents may also participate in the program, the reward may be based on the total cost of coverage in which an employee and any dependents are enrolled.
     - Provide that to satisfy the "reasonable alternative" standard, the employer is required to make available and pay the cost of the alternative, *e.g.*, membership fees for a diet program (but not the cost of the food), and the time commitment for the alternative must be reasonable.
     - Distinguish between two types of health-contingent wellness programs: (i) "activity-only" (not based on attaining a specific health outcome); and (ii) "outcome-based" (based on satisfying a measurement, screening or test, such as having a specified BMI or cholesterol level).
     - Provide that the "reasonable alternative standard" requirement applies to both activity-only and outcome-based programs, as follows: (i) activity-only programs must provide the reasonable alternative standard for any individual with a medical condition that prevents them from meeting the initial standard, and (ii) outcome-based programs must provide the reasonable alternative standard for all individuals who do not meet the initial standard, regardless of their medical condition.
8. **Provider Discrimination** *(effective first plan year beginning on or after January 1, 2014)*
   - Non-grandfathered plans may not discriminate against health care providers due to the provider's unwillingness to provide, pay for, cover, or refer for abortions.
9. **Clinical Trial Participation** *(effective first plan year beginning on or after January 1, 2014)*
   - Non-grandfathered plans may not restrict (or engage in any discriminatory practices regarding) participation in federally-funded clinical trials, FDA-studies, or other exempt drug studies.
10. **Health Insurance Exchange** *(effective January 1, 2014)*
    - Health insurance exchange coverage is available.
11. **Individual Excise Tax/Individual Coverage Mandate** *(effective January 1, 2014)*
    - Individuals who do not enroll in minimum essential coverage must, beginning in 2014, pay an excise tax equal to the greater of (i) 1% of household income that exceeds certain threshold amounts and (ii) $95 per uninsured adult in the household. This will increase to the greater of $325 per uninsured adult or 2% of household income in 2015 and $695 per uninsured adult or 2.5% of household income in 2016.
12. **Transitional Reinsurance Program Contribution** *(effective January 1, 2014)*
    - Health insurance issuers and self-insured plans (or third party administrators, on behalf of self-insured plans) must pay annual contributions to HHS to help stabilize premiums in the individual market from 2014 through 2016.
    - HHS will determine a national contribution rate (which HHS has announced will be $63 per covered life for 2014 and $44 per covered life for 2015); States may assess additional amounts if they establish their own reinsurance programs (but these will not apply to ERISA-covered self-insured group health plans).
    - Because the contribution will be based on the numbered of "covered lives" under covered programs, each will be required to submit an annual census count to HHS at the end of each year. Covered lives are determined in a manner similar to that allowed for the CER fee (see A.4 on page 5).
    - The first contribution (for 2014) will be due in 2015. Contributions can be paid from plan assets and are tax deductible to the extent paid by the employer.
    - Under the final rules, plans that are self-insured and self-administered (meaning that the plan does not use a third party administrator for more than 5% of core functions) are exempted from the fee for 2015 and 2016. This will most likely affect large multiemployer plans.
    - The final rules split payments into 2 installments. The first (for reinsurance contributions for reinsurance payments and administrative expenses) is payable in January of the year following the year for which payment is made, and the second (for amounts to be allocated to payments to the U.S. Treasury) is payable in the 4th quarter of the payment year. For 2014, these amounts are $52.50 (due January 2015) and $10.50 (due in Q4 2015); for 2015 the amounts are $33.00 (due January 2016) and $11.00 (due in Q4 2016).
    - The deadline to submit enrollment counts for 2014 was delayed from November 17, 2014 to December 5, 2014, although the payment deadlines remain the same.

    (*See* December 27, 2012 HELP Blog for additional details on the previously issued proposed rules.)

13. **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) rules** *(effective July 1, 2014)*

- The MHPAEA generally requires that, for employers with more than 50 employees, aggregate lifetime and annual limits for mental health and substance use ("MH") benefits be on par with such limits for medical or surgical ("M/S") benefits
- Plans generally may not impose lower lifetime or annual dollar limits on MH benefits than on M/S benefits, and may not impose financial requirements (*e.g*., deductibles, copayments, coinsurance, out-of-pocket maximums) or treatment limitations that are more restrictive than the predominant financial requirement/treatment limitation applied to M/S benefits in the same classification.
- The rules create 6 classifications: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) out-patient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs.
  - In addition, plans may use sub-classifications to differentiate between office visits and other outpatient benefits, and between different tiers of in-network providers.

    NOTE: The final rules require that plans must assign "intermediate" MH benefits (*e.g.*, residential treatment facilities) in the same way they assign comparable M/S benefits (*e.g.*, skilled nursing facilities) to the classifications.
- Cumulative financial or quantitative treatment limitations for MH benefits may not be applied separately from, but must be counted with, any limitations on M/S benefits in the same classification.
- To the extent non-quantitative treatment limitations (NQTLs) apply to MH benefits, the processes, strategies, evidentiary standards and other factors used to apply the standard must be comparable to and applied no more stringently than NQTLs for M/S benefits.

  NOTE: Unlike the interim final rules, the final rules do not include an exception to NQTLs parity for variations related to "recognized clinically appropriate standards of care." The list of NQTLs is also broadened.
- Parity analysis is not required to be done every year unless there is a change in plan benefit design, cost-sharing structure or utilization that would affect financial requirements or treatment within a classification or sub-classification. If a plan has increased costs due to the parity requirements, it may be entitled to limited relief.
- A plan that provides MH benefits only to the extent required as preventive services is not required to provide additional MH benefits. In addition, employee assistance programs that qualify as "excepted benefits" are not subject to the parity rules. (See "Note Regarding Excepted Benefits," on page 12.)

  NOTE also that to the extent MH benefits are "essential health benefits," the ACA prohibition on annual and lifetime limits applies to such benefits (including those offered by employers who are not otherwise subject to MHPAEA).

14. **Additional Preventive Care Coverage Requirements** *(effective first plan year beginning after September 24, 2014)*

- Non-grandfathered plans will be required to cover risk-reducing medications recommended by the United States Preventive Services Task Force in September 2013 for women at increased risk for breast cancer and low risk for adverse side effects. (See FAQs About ACA Implementation (Part XVIII) (Q&A-1) for additional details.)

C. Compliance Requirements Beginning in 2015 and Later

1. **Employer "Shared Responsibility" Coverage Mandate/Excise Tax** *(originally effective January 1, 2014, but implementation has been delayed to 2015 for employers employing 100 or more employees, and 2016 for employers employing fewer than 100 employees)*

a. Penalty for failure to offer coverage

- In general, "applicable large employers" who do not offer coverage to their "full-time" employees (and their dependents) during any month of the year must pay an annual excise tax equal to the employer's total number of full-time employees over 30, multiplied by 1/12 of $2,000 for each month that at least one full-time employee obtains subsidized exchange coverage.

  NOTE: Final regulations provide that the penalty does not apply to a covered employer that offers coverage to at least 70% of its full-time employees during the 2015 plan year, and at least 95% of its full-time employees in the 2016 plan year and beyond. "Dependent" for this purpose only includes children through the end of the month in which the child turns age 26, and not spouses. Under the final regulations, children do not include stepchildren or foster children for purposes of this rule. Additionally, under the final regulations, coverage does not have to be provided to dependents in 2015 if the employer is taking steps to arrange for dependent coverage in 2016.
- An "applicable large employer" includes any employer that has at least 50 full-time employees (or full-time equivalents taking into account part-timers). Certain exceptions also apply for employers with seasonal employees who employ fewer than 50 employees no more than 120 days during the calendar year.

  NOTE: Final regulations provide that in determining whether an employer is subject to these provisions (*i.e.*, is a "large" employer"), the IRS "controlled group" rules are applied – meaning that all affiliated employers for which

there is 80% or greater common ownership will be treated as a single employer. However, compliance with the coverage mandate requirements – and any associated penalties – will generally be assessed on an employer-by-employer basis.

- For large employers with 100 or more employees (which are, therefore, subject to this rule in 2015) who have non-calendar year plans, this rule becomes effective on the first day of the 2015 plan year rather than January 1, 2015.

b. Determining "full-time" status

- In general, a "full-time" employee includes any employee who works on average at least 30 hours per week. Under the statute, this determination generally must be made on a monthly basis. However, the IRS has developed a separate "safe harbor" process for determining full-time status of on-going employees and new employees.

(On-going employees)

- IRS guidance allows employers to determine full-time status of current employees based on hours worked during a defined prior "measurement" period of no less than 3 and no more than 12 months.

  NOTE: Final regulations provide that all hours are to be counted (similar to what is required under ERISA). While actual hours must be counted for hourly employees, certain hours counting conventions can be used for nonhourly employees (8 hours per day or 40 hours per week in which they work at least one hour). Hours performed outside of the U.S., however, need not be counted.

- If the employee averaged 30 hours per week during the measurement period, the employer must treat the employee as "full time" during the "stability" period that follows the measurement period (which must be 6 to 12 months long and no less than the measurement period), regardless of hours worked during the stability period. For 2015, the stability period may be longer than the measurement period if certain requirements are met.
- If the employee did not average 30 hours each week (and, therefore, did not work full-time) during the measurement period, the employee can be treated as "part-time" for the entire stability period regardless of their work schedule during that period.
- Employers may use an administrative period of up to 90 days between the measurement period and stability period to determine coverage eligibility, provide notice, and enroll eligible employees (but note that the administrative period may not reduce or lengthen either the measurement period or stability period).
- Employees with coverage due to working full-time during the prior measurement period must remain covered during the administrative period.

  NOTE: Final regulations also provide special rules for rehired employees and employees who have been absent from work. In general, a returning employee can be treated as "new" employee only if the period of non-employment has been at least 13 consecutive weeks (26 consecutive weeks for educational institutions), or, where the period of non-employment is at least 4 weeks but less than 13 (26 for educational institutions), if it exceeds the employee's period of employment.

(New employees)

- For new variable hour and seasonal employees employers may use an initial measurement period and administrative period that lasts up to the end of the first full month after the first anniversary of the hire date for purposes of determining full-time status. The measurement period may be 3-12 months, but the stability period must be the same as such period for on-going employees.
- Variable hour employees are those for whom it cannot reasonably be determined, as of their hire date, whether they will average 30 hours per week over the initial measurement period.
- Seasonal employees generally are those who perform services on a seasonal basis. Under the final regulations, seasonal employees who customarily work 6 months or less are not considered full-time employees.

  NOTE: Final regulations provide that if a new variable hour or seasonal employee has a material change in status and as a result of such change would, had they started employment in that capacity, have reasonably been expected to work 30 hours per week, the employer must treat the employee as full-time no later than the 1st day of the 4th month following the change (or the end of the initial administrative period, if earlier).

- Newly hired "full-time" employees (unless they are employed seasonally) must be treated as "full-time" from the date of hire for purposes of these rules (and, hence, the initial measurement period rules cannot be applied to them).

(*See* November 19, 2012 HELP Blog and April 21, 2014 HELP Blog for additional details on determining full-time status.)

c. Penalty for coverage that is unaffordable or does not provide minimum value

- Applicable large employers who offer coverage to substantially all (or, for the 2015 plan year, at least 70% of) full-time

employees, but the coverage is either "unaffordable" or does not provide "minimum value", must pay an annual excise tax equal to the number of full-time employees who obtain subsidized exchange coverage, multiplied by 1/12 of $3,000 (subject to a penalty cap) for each month that the employees have such coverage.

NOTE: Final regulations provide that this penalty also applies to any full-time employee who is not offered coverage where the employer is otherwise in substantial compliance with the offer of coverage requirement.

- In general, coverage is "unaffordable" if the premium cost for individual coverage exceeds 9.5% of the employee's household income.

  NOTE: Final regulations (i) provide several alternative safe harbors for calculating whether health coverage is "unaffordable," and (ii) establish that where a plan offers more than one option, the lowest cost option is to be used. The safe harbors are (1) W-2 (Box 1) compensation; (2) monthly rate of pay, or (3) Federal poverty level for single individuals. Health reimbursement account (HRA) contribution credits can only be taken into account in determining affordability if the credits can be used to pay premiums. For wellness program premium reductions, the full premium cost must be used, except in the case of premium reductions related to tobacco use, in which case, the non-smoker premium may be used.

- Coverage does not provide "minimum value" (MV) if the plan pays less than 60% of the covered costs (determined on an actuarial basis). In general, MV can be determined by – (1) using the HHS MV Calculator; (2) meeting IRS/HHS established "safe harbors" (which have not yet been finalized), or (3) actuarial certification from an AAA member actuary. Under proposed regulations, the HHS calculator must be used unless a safe harbor is met or the plan contains nonstandard plan features that are outside the parameters of the HHS calculator, in which case, actuarial adjustments are permitted. While HSA contributions can automatically be taken into account in determining MV, annual HRA credits cannot be counted unless the HRA is "integrated" with the plan and the HRA amounts can only be used for cost sharing. Generally, an HRA will be considered to be "integrated" with the plan only if the HRA is offered to individuals who are covered by the plan and the individuals are offered the opportunity to opt out of the HRA on an annual basis and at termination of employment. See DOL Technical Release No. 2013-03. As for wellness program cost sharing reductions, MV is to be determined without taking those into account (except for cost sharing reductions related to the prevention/reduction of tobacco usage, in which case, the reductions can be counted).

(See April 21, 2014 HELP Blog for additional details on the employer coverage mandate.)

(Prohibition on use of minimum value calculator for plans that do not provide substantial coverage for in-patient hospitalization or physician services)

- The government intends to propose regulations, to be finalized in 2015, providing that health plans that do not provide substantial coverage for in-patient hospitalization services or physician services (or both) (sometimes referred to as "skinny" plans) do not provide minimum value ("MV") as intended by the MV requirements.
- Until the regulations are in place, the government has indicated that such an arrangement may not be used to meet the MV requirement, unless the employer had already entered into a binding written commitment to adopt such a plan or had already begun enrolling employees in such a plan prior to November 4, 2014 (based on the employer's reliance on the results of the HHS MV Calculator).
- Until the regulations are issued, employees will not be required to treat a "skinny" plan as providing MV for purposes of the employee's eligibility for a premium tax credit.
- Employers that offer "skinny" plans, regardless of when put in place, (1) are not permitted to state or imply in any disclosure that the offer of coverage under such plan precludes an employee from obtaining a premium tax credit (including stating that the coverage provides minimum value) and (2) must timely correct any prior disclosures that make such statement or implication.

2. **Annual Information Return Requirement for Health Insurance Issuers and Self-Insured Group Health Plan Sponsors** *(Delayed to 2015, with first filing due in 2016)*

   - Health insurance issuers and self-insured plan sponsors that provide "minimum essential coverage" must file an annual return with the IRS reporting coverage information for all covered individuals.
   - For self-insured group health plans, the required return will (among other things) report for each month of the year involved (i) the name, address, and tax identification number (TIN) for each enrolling individual (participant); and (ii) the name and TIN of any other individual covered with the participant.
   - Reporting is not required for coverage that is not "minimum essential coverage" or is supplemental (*e.g.*, wellness programs, on-site clinics, Medicare Part B).

- Each participant listed on the return must also be provided a statement containing the reported information, along with the contact information for the employer.
- The first information returns (for 2015) will be due in 2016. The due date for the employer return will be February 28th of the following year (March 31st if filed electronically), while the required participant statement will (like the Form W-2) have to be issued by January 31st. (February 1st in 2016, as January 31st in that year is a Sunday).
- Self-insured plan sponsors that are also applicable large employers subject to the reporting requirements described under Item C.3 below may file one form (1095-C) to fulfill both requirements.
- Form 1095-C will be used by plan sponsors who are applicable large employers. Plan sponsors who are not subject to the employer shared responsibility requirements, health insurance issuers, self-insured multiemployer plans and government plans will use Form 1095-B. Filers will also have to submit a Form 1094-B or 1094-C as a transmittal form with the 1095-B or 1095-C.
- Failure to timely and correctly make the filing may result in penalties under Code Sections 6721 and 6722 of $200 per error up to $3 million per year. No penalty will apply for any voluntary filings for 2014 (made in 2015), and no penalty will apply for 2015 filings (made in 2016) as long as a good faith effort is made to comply with the filing requirement.
- The IRS has issued final forms and instructions for voluntary reporting in 2014, which can be used as a reference for required 2015 reporting.

(See September 29, 2014 HELP Blog post for additional details on the reporting requirements and links to the draft forms and instructions, and March 12, 2015 HELP Blog post for details on and links to the final forms and instructions.)

3. **Annual Information Return Requirement for "Applicable Large Employers"** *(Delayed to 2015, with first filing due in 2016)*

- Each applicable large employer (see Item C.1.a. on page 8 for definition) will also be required to file a form annually with the IRS reporting (among other things) the following: (i) the employer's "full-time" employees and their eligibility for health coverage for each month of the year involved; (ii) the lowest employee premium for each such employee for single coverage that provides MV (see Item C.1.c. on page 9), and (iii) a certification that "minimum essential coverage" (basically, group health plan coverage) has been offered to these employees and their dependents.
- Additional information will be required concerning (i) applicable waiting periods, (ii) whether spousal coverage is available and (iii) whether the offered coverage provides MV, among other items (see Item C.1.c. on page 9).
- Alternative reporting methods are available for employers that can certify that (a) they made a "qualifying offer" (*i.e.*, an offer of minimum essential coverage to the employee and spouse/dependents that meets specified affordability requirements) during each month an employee was full-time, and/or (b) they offered affordable coverage with MV to 98% of all employees (full- and part-time) and offered coverage to their dependents. An employer can use different reporting methods for different groups of employees. For 2015, an employer can also use alternative reporting if it makes a "qualifying offer" to 95% of its full-time employees.
- Employers with between 50 and 100 employees who are exempt from shared responsibility coverage for 2015 (see Item C.1c. on page 9) are still required to file with the IRS for 2015.
- Each full-time employee listed on the return must also be provided the reported information pertaining that individual, along with the contact information for the employer.
- The first information returns (for 2015) will be due in 2016. The due date for this employer return will be February 28th of the following year (March 31st if filed electronically), while the required participant statement is to be issued by January 31st (February 1st in 2016, as January 31st in that year is a Sunday).
- Applicable large employers that are self-insured plan sponsors subject to the reporting requirements described under Item C.2 on page 10 may file one Form 1095-C to fulfill both requirements.
- Applicable large employers that are sponsors of insured plans will complete certain sections of Forms 1094-C and 1095-C to comply with the requirements under Item C.3, and their insurers will complete Form 1094-B and 1095-B to comply with the requirements under Item C.2 on page 10.
- Failure to timely and correctly make the filing may result in penalties under Code Sections 6721 and 6722 of $200 per error up to $3 million per year. No penalty will apply for any voluntary filings for 2014 (made in 2015), and no penalty will apply for 2015 filings (made in 2016) as long as a good faith effort is made to comply with the filing requirement.
- The IRS has issued final forms and instructions for voluntary reporting in 2014, which can be used as a reference for required 2015 reporting.

(See September 29, 2014 HELP Blog post for additional details on the reporting requirements and links to the draft forms and instructions, and March 12, 2015 HELP Blog post for details on and links to the final forms and instructions.)

4. **Non-Grandfathered Plan Reporting Requirements** *(generally effective January 1, 2014, but no reporting to be required prior to 2015)*

- Non-grandfathered plans must file an annual report with HHS that discloses various information

concerning the cost and quality of health care provided (for example, whether the coverage improves health outcomes, reduces hospital admissions, improves patient safety, and generally promotes health and wellness); HHS has not issued guidance concerning this reporting requirement, but no reporting likely to be required until after 2014.

- Non-grandfathered plans must also file a separate annual report with HHS and the applicable state insurance commissioner that discloses cost-sharing and claims data (for example, the number of claims denied, rating practices, enrollment/disenrollment data, and information on payments for out-of-network services); HHS has issued guidance that this reporting requirement will not go into effect until at least 2015.

5. **HIPAA Electronic Transaction Rules – Compliance with Certification Requirements** *(effective December 31, 2015)*

- Proposed regulations require that health plans with at least $5 million in net annual revenues must complete one of two testing options and certify compliance with the HHS rules on certain electronic transactions (relating to eligibility for health benefits, claims status, and electronic funds transfers and remittance advice) by December 31, 2015 (December 31, 2016 for plans with less than $5 million in annual receipts).
- HHS will issued rules regarding additional certification requirements for other standard transactions, which will apply no earlier than December 31, 2015.

6. **Auto Enrollment** *(To be effective as provided under DOL regs)*

- Large employers (those with at least 200 "full-time" employees) must auto enroll all eligible "full-time" employees in the employer's health program (subject to a legally permissible waiting period), beginning as of such time provided by DOL. No regulations have been issued on this subject as yet.
- Automatic enrollment must include adequate notice and an opportunity to opt out of the coverage.

7. **High Cost Employer-Sponsored Health Coverage** *(effective January 1, 2018)*

- In general, insurers (for insured plans) and the plan administrator (for self-insured health plans or an HRA or FSA) will be required to pay a 40% excise tax on the total value of employer-sponsored coverage in excess of $10,200 for self-only coverage and $27,500 for non-self-only coverage. Note, though, that in the case of employer contributions to a HSA or Archer MSA, the employer will be responsible for paying the excise tax (as the insurer).
- The annual threshold amounts will be indexed for inflation. Under the statute, the tax is to be determined and applied on a monthly basis.
- In determining the value of coverage, all group health plan coverage offered by the employer that is not taxable is counted (regardless of who pays for the coverage or whether the employee pays for the coverage with after-tax dollars), including executive physical programs and on-site health clinics (unless the clinic only offers a "de minimis" amount of health care). In addition, the value of HRA coverage, pre-tax FSA contributions and employer HSA/MSA contributions (likely including employee pre-tax contributions) will be counted. However, long-term care insurance, separate dental/vision benefits and fixed indemnity health and other similar coverages are excluded.

The IRS has issued Notice 2015-16, which provides preliminary guidance and requests comment on certain aspects of the tax.

(See March 25, 2015 HELP Blog post for details on the preliminary guidance in Notice 2015-16.)

8. **HIPAA Electronic Transaction Rules – Health Plan Identifier (HPID) Requirements** *(originally effective November 5, 2014, but delayed indefinitely)*

- Plans were originally required to obtain an HPID by November 5, 2014 (November 5, 2015 for health plans with less than $5 million in annual receipts).
- Pursuant to the regulations, on or before November 7, 2016, all HIPAA standard transactions regarding health plans must use HPIDs.
- A controlling health plan (CHP) may apply for one HPID on behalf of it and its subhealth plans (SHP), or each SHP may apply for its own HPID.
    - A CHP controls its own business activities, actions or policies, or is controlled by an entity that is not a health plan and exerts control over any SHPs. A SHP is a health plan whose business activities, actions or policies are directed by a CHP.
- On October 31, 2014, the federal government indefinitely delayed enforcement of the HPID requirements, and large plan sponsors were not required to obtain an HPID by November 5, 2014.

(See August 18, 2014 HELP Blog post for additional details on the HPID requirement (note that this was published prior to the enforcement delay).)

Note Regarding Excepted Benefits

Certain types of benefits have been classified as "excepted benefits," and are generally exempt from many of the requirements of the ACA, including limits on pre-existing coverage exclusions, preventive services requirements, restrictions on annual and lifetime limits, SBC obligations, and mental health parity rules. Recent regulations issued by the government have made clarifications regarding what types of benefits constitute "excepted benefits," which fall into four categories:

- Benefits that are not health coverage (*e.g.,* automobile insurance, liability insurance, workers'

compensation, or accidental death and dismemberment coverage).

- "Limited excepted benefits," which includes limited-scope vision or dental benefits and long-term care benefits provided that they are either offered under a separate policy, certificate or contract of insurance, or are not an "integral part" of a group health plan.
  - Final rules issued in October 2014 clarify that a contribution is not required in order for limited scope dental/vision benefits to not be an integral part of a group health plan. In addition, limited-scope dental/vision benefits and long-term care benefits are not an integral part of a group health plan if (i) participants may decline coverage, whether or not a participant contribution is required, or (ii) claims for such benefits are administered under a separate contract from other benefits under the plan.
  - The 2014 final rules also indicate that employee assistance programs (EAPs) are excepted benefits if (i) the EAP does not provide significant medical care benefits, (ii) EAP benefits are not coordinated with benefits under another group health plan (meaning that participants must not be required to exhaust EAP coverage before becoming eligible for other coverage, and that EAP eligibility must not be dependent on participation in another group health plan), (iii) no employee premiums or contributions are required to participate in the EAP, and (iv) the EAP does not impose cost-sharing requirements.
  - Health FSAs can also be excepted benefits if they do not exceed specified dollar limits and if the participants are offered other group health coverage that does not constitute an excepted benefit.
- "Noncoordinated excepted benefits," including coverage for a specified disease or illness (*e.g.,* cancer-only policies) and hospital indemnity or other fixed indemnity insurance, which are only excepted under certain circumstances.
- "Supplemental excepted benefits." Final rules issued in March 2015 indicated that this can include wraparound coverage offered to non-full time employees, retirees, and their respective dependents if certain specified requirements are met: (i) the plan provides meaningful benefits beyond cost sharing; (ii) the wraparound coverage must be limited in amount to the greater of the maximum annual salary reduction contribution limit for FSAs or 15% of the cost of coverage under the primary plan; (iii) the coverage meets certain nondiscrimination requirements; (iv) the participants are not enrolled in a health FSA, and the coverage meets additional eligibility requirements specified in the regulations (which differ depending on the type of coverage being "wrapped" around – *i.e.,* individual health insurance, Basic Health Plan coverage or Multi-State Plan coverage); and (v) the self-insured plan or insurance issuer meets certain reporting requirements.
  - The 2015 final rules apply for wraparound coverage first offered no earlier than January 1, 2016 and no later than December 31, 2018, although prior proposed rules set out a pilot program for coverage first offered no later than December 31, 2017.

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