[COMPLIANCE]

Health Care Reform Compliance Timeline — Quick Reference Guide

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**Effective Date Unclear* ***May contain certain exclusions for Grandfathered Plans* ****Transition Relief Available*

Health Care Reform Employer Guide

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Within a week, Congress passed the Health Care and Education Tax Credit Reconciliation Act of 2010 (HCERA). PPACA and HCERA (collectively referred to as "Health Care Reform") require all employer-sponsored plans – both self-insured and fully-insured group health plans – to comply with certain mandates over the next several years.

This Employer Guide highlights the changes that grandfathered and non-grandfathered plans will need to consider.

I. Effective Immediately Following Enactment

a. Increased Adoption Assistance Exclusion

Health Care Reform increases the tax credit under IRC §23 to $13,170 for all adoptions, including adoptions of children with special needs. It also increases the exclusion for employer-provided adoption assistance under section 137 to $13,170 for all adoptions, including adoptions of children with special needs. In addition, Health Care Reform allows for the credit and exclusion to be adjusted for inflation beginning January 1, 2011. That adjustment is made by multiplying the statutory limit by the cost of living adjustment for the calendar year in which the tax year begins. If the amount as increased is not a multiple of 10, the amount is rounded to the nearest multiple of 10.

[Tax years beginning on or after December 31, 2009]

II. Effective 90 Days Following Enactment

a. Early Retiree Reinsurance Program

Health Care Reform creates a temporary reinsurance program for employers providing benefits for retirees age 55 and older who are not eligible for Medicare. Employers can submit claims to the Secretary of HHS for reimbursement. The program reimburses up to 80% of expenses between $15,000 and $90,000 per retiree. Reinsurance payments must be used to lower the costs of the health plan and are excluded from employer's gross income. This program is financed by a $5 billion appropriation and ends at the earlier of the time the funding runs out or January 1, 2014.

New ERRP applications no longer being accepted after May 5, 2011. As of December 2, 2011 the ERRP had disbursed over $4.5B of the $5B that had been allotted to it. Accordingly, CMS will not accept claim lists that include any claims incurred after December 31, 2011. Even if only one post-12/31 claim is included on a claim list, together with allowable claims, CMS will reject the entire list.

III. Effective Plan Years Beginning On or After September 23, 2010

a. No Lifetime Limits

Group health plans are prohibited from placing lifetime dollar limits on "essential health benefits." For the 2011 plan year, group health plans will need to provide a 30 day special enrollment period for those individuals who have met their lifetime limit but are still eligible for coverage, which may run concurrent with the open enrollment period.

b. Restricted Annual Limits

Health Care Reform restricts annual limits on "essential health benefits." The restricted annual limits are based on plan years until 2014 when annual limits on essential health benefits are prohibited.

For example:

- $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
- $1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
- $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014

c. Child Coverage to Age 26

Health Care Reform allows children under age 26 to remain covered under their parents' medical insurance coverage. Under the federal law, group health plans that provide dependent coverage are required to extend eligibility for dependents to age 26. Employers are not required to offer coverage to an adult child's spouse or children. Health Care Reform extends the exclusion from gross income for coverage of adult children. In order for an older age child to be eligible for coverage, the child may be married or unmarried and must:

- be the child of the employee as defined under IRC §152(f)(1)
- have not yet reached their 26th birthday
- not be eligible for other employer coverage (this exclusion is available only to grandfathered plans, and then only for plan years starting on or before January 1, 2014)

d. No Rescissions

Group health plans may not retroactively cancel coverage after enrolling a participant, except in the event of fraud or intentional misrepresentation of material fact. A discontinuance of coverage is not a rescission if it has only a prospective effect, or is retroactive only to the extent it is attributable to a failure to pay required contributions. Note that 30 days advance written notice must be provided to each participant who would be affected by a rescission.

e. No Pre-Existing Condition Exclusions for Children Under Age 19

Group health plans are required to eliminate pre-existing condition exclusions for children under the age of 19.

[Provision applies to children under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]

f. First Dollar Coverage for Preventive Care

Non-grandfathered group health plans may not impose cost sharing for certain preventive services. This means that the group health plan must pay the full cost of evidence-based preventive care, as recommended by the U.S. Preventive Services Task Force, immunizations recommended by the ACIP of the CDC, breast cancer screenings and other preventive services identified in HRSA guidelines.

In addition, in August 2011, HHS issued additional guidelines regarding women's health care services that group health plans and health insurance policies must cover without cost-sharing. The new guidelines apply to the first plan year that begins on or after August 1, 2012, which means that for calendar year plans the guidelines will be effective beginning January 1, 2013.

These new recommended preventive services for women include: well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies, and counseling; and domestic violence screening and counseling.

In light of the Supreme Court's decision in Sebelius v. Hobby Lobby Stores, Inc., closely-held for profit corporations whose owners have religious objections to providing coverage for some or all contraceptives may be able to avail themselves of an exception afforded to non-profit religious organizations that exclude certain emergency contraceptives from the preventive services otherwise required to be covered by their group health plan under Health Care Reform. Employers seeking to utilize this exception should consult with benefits counsel.

g. Revised Appeals Process

Non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must provide an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process that meets minimum standards or the plan is self-insured, the plan or issuer shall implement an external review process that meets standards established by the Federal government. The group health plan must continue coverage until appeals process is resolved.

h. Grandfathered Status Disclosure Notice

To maintain status as a grandfathered health plan, employers must include a statement, **in any and all** plan materials provided to a participant or beneficiary describing the benefits provided under the group health plan, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints. Plans must maintain records documenting the terms of the plan that were in effect on March 23, 2010 and any other document necessary to support that the plan has maintained grandfather status. Plans are required to make these records available for examination by participants or the agencies on request.

i. Nondiscrimination Rules Extended to Non-grandfathered Insured Plans (Indefinitely Delayed)

Non-grandfathered fully insured group health plans must comply with IRC §105(h) rules that prohibit discrimination in favor of "highly-compensated individuals." Similar non-discrimination requirements applied to self-insured group health plans prior to Health Care Reform (and continue to apply to self-insured plans).

j. Prohibition on Emergency Room Restrictions

Non-grandfathered group health plans may not require prior authorization for emergency room services received in-network or out-of-network and may not include administrative requirements or limitations of benefits for out-of-network emergency services that are more restrictive than those applying to emergency services received in-network. Cost sharing for out-of-network emergency services may not be greater than if the services were provided in-network. Any other cost-sharing requirements (such as a deductible or out-of-pocket maximums) can only be imposed for emergency services if the requirement applies generally to out-of-network benefits.

k . Prohibition on Primary Care Physician Restrictions

Non-grandfathered group health plans that require the employees to select an in-network primary care physician must allow the participants to designate any available participating network primary care provider and see any participating OB/GYN and pediatrician without a primary care provider referral. Summary plan descriptions and other similar descriptions of benefits must include a notice to individuals of these rights.

IV. January 1, 2011

a. No Reimbursement for Non-Prescription OTC Drugs

Employees may no longer purchase non-prescription over-the-counter drugs on a pre-tax basis through health FSAs, HSAs, Archer MSAs or HRAs. This change will not affect insulin or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays, and deductibles.

b. Long-Term Care Program ***(October 14, 2011, HHS halts CLASS Act implementation)***

The Community Living Assistance Services and Support (CLASS) Act is a voluntary, federal program for long-term care insurance. Employee participation is voluntary, and employers who choose to implement the program may automatically enroll employees unless they opt out. Employees pay a monthly premium through payroll deduction. After five years of contributing, the employee becomes eligible to receive assisted living funding in the event the employee is no longer able to perform normal daily activities. Only active workers are eligible to participate.

c. Increased Penalty for Non-Medical Withdrawals from an HSA or Archer MSA

Health Care Reform increases the penalty tax on non-medical withdrawals to 20% from an HSA (currently 10%) or an Archer MSAs (currently 15%).

d. Simple Cafeteria Plans

Employers with100 or fewer employees during either of the two prior years will be permitted to adopt "simple cafeteria plans." These plans are deemed non-discriminatory for purposes of the non-discrimination requirements applicable to life insurance, self-insured plans and dependent care plans, if the employer provides a minimum of 2% of pay contribution for participants and the plan satisfies minimum eligibility and participation requirements. Employees who have completed at least 1,000 hours during the prior year must be allowed to participate. Employees younger than 21 years old with less than one year of service can be excluded. The minimum contribution requirement can be satisfied if the employer contribution for all participants is the lesser of (a) 6% of pay or (b) two times each employee's pre-tax contribution.

V. January 1, 2012

a. Corporate Service Provider Reporting Requirement *(Repealed)*

Employers must issue Form 1099s reflecting any payment over $600 to corporate service providers.

b. Patient-Centered Outcomes Research Institute (PCORI) Fee / Comparative Effectiveness Fee

Employers sponsoring group health plans will be required to pay $1.00 per participant in 2012. The annual fee increases to $2.00 per participant in 2013 and is indexed for inflation beginning in 2014. The comparative effectiveness fee phases out in 2019. Revenue from this fee will fund research to determine the effectiveness of various forms of medical treatment. The fee applies to insured and self-insured medical plans regardless of grandfathered status, including retiree-only plans and most HRAs, but excluding HIPAA-excepted benefits such as stand-alone dental or vision plans and most health FSAs. Insurers and plan sponsors must report and pay the fee annually on IRS Form 720, which will be due by July 31 of each year. Form 720 may be filed electronically. With respect to insured plans, the carrier is responsible for paying the fee. With respect to self-insured plans, the plan sponsor is responsible for paying the fee. Various methods exist for counting members; consult with benefits counsel for assistance.

[Plan years ending after September 2012]

VI. September 23, 2012

a. Uniform Explanation of Coverage

Employers must provide a uniform summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment.

For disclosures to participants and beneficiaries who enroll or re-enroll in group health plan coverage at open enrollment, the SBC must be provided no later than the first day of each open enrollment that begins on or after September 23, 2012. For participants enrolling other than through open enrollment (including newly eligible participants or those subject to a special enrollment opportunity), the SBC must be provided starting on the first day of the plan year beginning on or after September 23, 2012.

The summary may not be longer than four double-sided pages and not include print that is smaller than a 12-point font. The summary must be written in a "linguistically" and "culturally" appropriate manner so it is easy for the participant to understand. The summary must contain information regarding cost sharing, continuation of coverage, limitations on coverage and details on where participants can obtain more information. This summary is required in addition to the ERISA summary plan description. Failure to comply will result in a $1,000 fine per occurrence. Unless the plan has knowledge of a separate

address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

SBCs must disclose whether the plan provides minimum essential coverage and whether the plan meets the minimum value requirements. Plans will use a new SBC template beginning on the first day of the first open enrollment period that begins on or after April 1, 2017.

b. 60-Day Notice of Material Modifications

Employers must provide notice of any material modification in coverage at least 60 days prior to the effective date of the modification (other than a material modification made in connection with the plan's renewal). This requirement is part of the Uniform Explanation of Coverage and is in addition to the ERISA summary plan description. Failure to comply will result in a $1,000 fine per occurrence.

VII. January 1, 2013

a. Medicare Tax Increase for High-Earners

Health Care Reform increases the 1.45% Medicare payroll tax on workers' wages to 2.35% (0.9% increase) on earnings that exceed $200,000 for an individual filer or $250,000 for a married couple filing jointly. The portion of the Medicare payroll tax paid by the employer would remain at 1.45%. Health Care Reform will also impose a new Medicare tax of 3.8% on the lesser of (a) net investment income (including interest, dividends, royalties, rents and other passive income) or (b) the excess of modified gross income that exceeds that threshold ($200,000 for single filers or $250,000 for married couples filing jointly).

b. Form W-2 Reporting of Value of Benefits

Large employers (those that filed 250 or more W-2s in the prior year) are responsible for reporting the total costs incurred for providing health care to employees. Specifically, W-2s must include the "aggregate cost" of employer-sponsored group health insurance coverage, excluding any salary reductions deferred to a flexible spending account and all contributions to an HSA or Archer MSA. "Aggregate cost" is the annual cost of the insurance and includes any portion paid by the employee. Employers may use COBRA rates (without the 2% administrative fee) to determine the value of benefits.

[Tax years beginning on or after January 1, 2012, with the cost of coverage to be first reported on January 2013 Form W-2s]

c. No Deduction for Retiree Drug Subsidy

Although Health Care Reform retains the Retiree Drug Subsidy, it eliminates an employer's ability to deduct the amount of that subsidy. This change increases an employer's income tax liability, in effect increasing the employer's cost of providing prescription drug coverage to retirees. The amount by which an employer's tax liability will increase depends on the total amount of the subsidy and the employer's applicable corporate tax rate, which currently ranges from 15 percent for income below $50,000 to 35 percent for income over $10 million. Although employers will not face the higher tax liability until 2013, under financial accounting rules, employers must now include the present value of the future taxes as a current liability charged against earnings.

d. Cap on Health FSA Contributions

Employee contributions to employer-sponsored health flexible spending account are limited to $2,500 in a calendar year. This limit is indexed to inflation starting in 2014 and is currently $2,550 for 2016.

[Effective for plan years beginning on or after January 1, 2013]

e. New Electronic Transaction Standards

Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with "administrative simplification" rules (to be published) for electronic fund transfer, health claim status and health care payment. The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of $20.00 per covered life per year. A double penalty applies in the case of a misrepresentation by the employer.

[Systems must be effective starting January 1, 2015 and plans must certify compliance by December 31, 2015. The effective date of this requirement is unclear given the delay in the HPID requirement.]

VIII. October 1, 2013

a. Employer Notification Regarding Exchanges

Employers must provide existing employees and new employees on their hire date with information about the existence of state insurance Exchanges, including information on employee eligibility for an Exchange if the actuarial value of the health plan is less than 60%, and the loss of employer contribution toward the value of coverage if the employee purchases coverage through the Exchange.

IX. January 1, 2014

a. State-Based Exchanges

Every state must establish a health insurance Exchange for use by the uninsured and small employers with 50 or fewer employees (the prior 100 employee limit was repealed by the PACE Act in 2015, although states may expand the definition of small employer to include those with 100 or fewer employees, if

desired). The exchanges will offer fully insured contracts that provide essential health benefits at different levels of coverage (i.e. platinum, gold, silver and bronze). Employees may pay for the Exchange premiums on a pre-tax basis only if it is purchased through an employer's cafeteria plan and the employer is participating in a SHOP Exchange. Starting in 2014, all non-grandfathered individual and small group plans (on or off the Exchange) must cover essential health benefits. Grandfathered health plans, self-insured plans and insured large group plans are not required to cover essential health benefits.

[Transition relief from the essential health benefit requirement may be available for plan years beginning on or before October 1, 2016]

b. No Pre-Existing Condition Exclusions

Group health plans and individual insurance policies are required to eliminate pre-existing condition exclusions completely.

[Provision applies to individuals under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]

c. Limit on Small Group Deductibles and Employee Out-of-Pocket Expenses

All non-grandfathered group health plans must limit out-of-pocket expenses for in-network essential health benefits. The limits for plan years beginning in 2016 are $6,850 for single coverage and $13,700 for family coverage. The limits for plan years beginning in 2017 are $7,150 for single coverage and $14,300 for family coverage. The limits for plan years beginning in 2018 are $7,300 for single coverage and $14,700 for family coverage. Also, out-of-pocket limits apply on a per-member basis starting with 2016 plan years.

[The requirement limiting deductibles for small group plans was repealed in March 2014]

d. Required Coverage for Clinical Trials for Life-Threatening Diseases

Group health plans may not deny individual participation, discriminate against an individual on the basis of participation or deny coverage of routine patient costs for items and services rendered in a clinical trial for a life-threatening disease.

e. Individual Mandate

Health Care Reform requires individuals to obtain "minimum essential coverage" (i.e. Medicare, Medicaid, CHIP, individual insurance and eligible employer sponsored plans) for themselves and their dependents or pay a monthly penalty tax for each month without coverage. The monthly penalty is 1/12 of the greater of the dollar penalty or the gross income penalty amounts. The dollar penalty in 2014 was $95.00 per individual to a maximum of $285 per family. The dollar penalty in 2015 is $325 per individual to a maximum of $975 per family. The dollar penalty in 2016 is $695 per individual to a maximum of $2,085 per family. In 2017 the dollar penalties will be indexed for inflation. The gross income penalty in 2014 is 1% of household income in excess of a specified filing threshold, 2% in 2015 and 2 ½% in 2016 and beyond. Waivers are allowed for specified individuals and circumstances.

f. No Annual Limits

Group health plans may no longer include annual limits on "essential health benefits" for participants, but may continue to do so for beneficiaries.

g. 90-Day Limit on Waiting Periods

Group health plans may not impose a waiting period longer than 90 days for health care coverage. For new employees, bona fide employment-based orientation periods that do not exceed one calendar month (minus a day) are permitted prior to the start of the waiting period.

h. Increased Wellness Program Incentives

Health Care Reform increases the wellness program incentive cap for outcome-based wellness programs from 20% of the total cost of coverage to 30% (50% if a wellness program includes a tobacco use prevention or reduction component).

i. Nondiscrimination Rule

Health Care Reform will adopt HIPAA's rules whereby group health plans may not discriminate as to benefits or coverage based on health status.

j. Community Rating

Health insurance issuers providing individual or small group policies covering 50 or fewer individuals (100 or fewer if chosen by the state) must abide by strict community rating rules with premium variations allowed only for age (3:1), tobacco use (1.5:1), level of coverage (single or family) and geographic rating area (regions to be defined by the states). Experience rating will be prohibited. These rating restrictions will also apply to insurers offering large group policies through the Exchange.

k. Transitional Reinsurance Program Fee

This assessment applies from 2014–2016 and is imposed on insured and self-insured plans on a calendar year basis. It generally applies to all group health plans – no exceptions for non-ERISA plans (e.g., governmental or church plans); however, it does not apply to HIPAA-excepted benefits (except for pre-65 retiree plans) such as dental or vision plans, or plans that do not provide minimum value (e.g., most health reimbursement arrangements (HRAs)). The fee applies on a per-member basis. The fee is intended to stabilize premiums in the individual markets. Additional employer recordkeeping will be necessary and cost requirements will apply under this mandate.

HHS has implemented a streamlined process for the collection of the reinsurance fee. An employer, or a third-party administrator (TPA) on behalf of the employer, may complete all required steps for the reinsurance contributions process on Pay.gov: registration, submission of the annual enrollment count, and remittance of contributions. A form is available via www.pay.gov where an employer (or a TPA on its behalf) may provide basic company and contact information, and the annual enrollment count for the applicable benefit year no later than November 15 of each reporting year. The form will auto-calculate the

contribution amounts. To complete the submission, entities will also submit payment information and schedule a payment date for remittance of the contributions.

[The fee was $63 per member per year for 2014, $44 per member per year for 2015, and $27 per member per year for 2016.]

l. Health Insurance Tax

This tax is a fixed dollar amount distributed across carriers based on each carrier's net premiums. The tax is $8B in 2014, $11.3B in 2015-16, deferred in 2017 through an appropriation measure, and, if not once again deferred, then $14.3B in 2018. Thereafter, it rises according to an index based on net premium growth (which causes a cascading effect: as the fee is passed through to employers in the premium, the premium increases enter the index and raises the tax further).

[It is expected that carriers will pass this fee through to employers. The impact of the fee will vary by carrier.]

m. Health Plan Identifier (HPID) (Delayed)

Employers that sponsor self-insured plans must obtain a health plan identifier (HPID) for their "Controlling Health Plans" (CHPs). Employers with multiple self-insured plans will need to determine which plan or plans are Controlling Health Plans (CHPs) and which are Sub-health Plans (SHPs). A CHP controls its own business activities, actions, or policies; or is controlled by an entity that is not a health plan. A SHP is a plan whose business activities, actions or policies are directed by a CHP. For example, an employer with a self-insured major medical plan and a self-insured dental plan may treat its medical plan as the CHP and the dental plan as the SHP. SHPs are not required to obtain their own HPIDs.

For purposes of the HPID requirement, CMS considers health FSAs to be individual accounts directed by the consumer to pay health care costs. As such, they do not require an HPID.

Health reimbursement arrangements (HRAs) may require an HPID if they meet the definition of a CHP; however, HRAs that cover only deductibles or out-of-pocket costs do not require HPIDs, as CMS considers these types of arrangements to be closer to additional plan benefits than stand-alone plans.

Employers that consolidate their plans using a wrap document will apply the HPID rules in the same manner as the rules would apply to non-consolidated plans. For example, a wrap plan that includes a fully-insured medical plan, self-insured dental plan, and an HRA that covers deductibles, would require the employer to obtain an HPID only for the self-insured dental plan.

Employers with self-insured plans will need to access the CMS Enterprise Portal at https://portal.cms.gov/ to obtain an HPID.

[On October 31, 2014, CMS delayed "until further notice" the requirement for a covered entity to obtain an HPID.]

X. 2015 – 2018

2015 – Employer Shared Responsibility Penalty (a/k/a Play or Pay)

Employers with 50 or more full-time employees (including full-time equivalent employees (FTEs)) who do not offer "minimum essential coverage" to full-time employees (and their children under age 26) or who offer coverage that is not "affordable" or that does not provide "minimum value," may be exposed to a penalty if at least one full-time employee receives a federal premium subsidy for Exchange coverage.

The penalty is the lesser of (a) $2,000 per year for each full-time employee minus 30 (minus 80 for 2015 plan years if the employer had 100+ FTEs on average in 2014) if coverage is not offered to at least 95% of full-time employees (70% for 2015 plan years), or (b) $3,000 per year for each full-time employee receiving a federal subsidy for Exchange coverage because the employer's plan was not "affordable" or did not provide "minimum value". Indexed penalties are $2,080 and $3,120 for 2015; $2,160 and $3,240 for 2016; and $2,260 and $3,390 for 2017 (est.).

Effective Date Transition Relief For Employers with 50-99 FTEs:

Employers with 50-99 full-time employees (including FTEs) that meet certain requirements will not be subject to penalties under the mandate until 2016. In addition, if an eligible employer has a non-calendar year plan, it will be exempt from penalties for any calendar month during the portion of its 2015 plan year that falls in 2016.

Requirements:

1. The employer must have 50-99 full-time employees (including FTEs) on business days during 2014 (the employer can make this determination based on any consecutive 6-month period in 2014).
2. From Feb. 9, 2014, through Dec. 31, 2014, the employer cannot reduce its workforce size or overall hours of service (other than for bona fide business reasons) in order to satisfy #1, above.
3. The employer cannot materially reduce the health coverage, if any, that it offered from Feb. 9, 2014, through the last day of the plan year that began in 2015 (the "coverage maintenance period").
4. The employer will have to certify that it meets these requirements as part of its Section 6056 reporting.

With regard to #3, above, an employer will not be treated as eliminating or materially reducing coverage if:

1. It continues to offer each employee who is eligible for coverage during the coverage maintenance period an employer premium contribution that is either (A) at least 95% of the dollar amount offered on Feb. 9, 2014, or (B) the same or higher percentage of the cost of coverage that the employer was offering to contribute as of Feb. 9, 2014;

2. In the event the employee-only coverage is changed, it must continue to provide minimum value coverage after the change; and

3. The employer cannot narrow or reduce the classes of employees (or dependents) to whom coverage was offered on Feb. 9, 2014.

Additional Transition Relief For Employers with 50-99 FTEs and Non-Calendar Year Plans:

The relief described above is not available for an employer that modifies the plan year of its plan after Feb. 9, 2014 to begin on a later calendar year. However, an employer with a non-calendar year plan meeting the coverage maintenance period requirements for 2015 may be eligible for transition relief for 2015 even if the employer does not meet that requirement later (i.e. during the portion of the year that falls in 2016).

Effective Date Transition Relief For Employers with 100+ FTEs and Non-Calendar Year Plans:

Type 1 – Pre-2015 Transition Relief: If an employer maintained a non-calendar year plan as of Dec. 27, 2012, and the plan year was not changed after such date to begin at a later date, then no penalty will apply with respect to that employee for the period between Jan. 1, 2015, and the first day of the 2015 plan year if:

1. The employee would have been eligible for coverage under the plan on the first day of the 2015 plan year under the plan's eligibility terms in effect on Feb. 9, 2014, and such employee is not otherwise eligible for coverage under a plan maintained by the employer as of Feb. 9, 2014 that has a calendar year plan; and

2. The coverage offered to the employee as of the first day of the 2015 plan year is "affordable" and offers "minimum value."

Note that if an employer does not cover a significant percentage (i.e. at least 70%) of full-time employees as of the first day of the 2015 plan year, the employer could still be subject to the $2,000 penalty for any calendar month in 2015.

Type 2 – Significant Percentage Transition Relief: If an employer maintained a non-calendar year plan as of Dec. 27, 2012 (or two or more non-calendar year plans that have the same plan year as of Dec. 27, 2012) and the plan year was not changed after such date to begin at a later date, then no penalty will apply until the beginning of the 2015 plan year with respect to an employee if:

1. The coverage offered to the employee as of the first day of the 2015 plan year is "affordable" and offers "minimum value"; and

2. The employee would not have been eligible for coverage under any calendar plan maintained by the employer as of Feb. 9, 2014; provided, that with respect to **all** employees of the employer, the non-calendar year plan:

a. had, as of any date between Feb. 9, 2013, and Feb. 9, 2014, at least 1/4 of employees covered under those non-calendar year plans; or

b. offered coverage under such plans to 1/3 or more employees during the open enrollment period that ended most recently before Feb. 9, 2014.

Alternatively, employers with 100+ FTEs may apply the Significant Percentage Transition Relief based only on full-time employees. Under this method, the fractions above change to 1/3 of full-time employees covered or 1/2 of full-time employees offered coverage. The 30-hour threshold for full-time employees is used for this purpose.

2015 – Employer Certification of Coverage (Section 6055/6056 Reporting)

Starting in 2015, employers may have two new reporting requirements under the Internal Revenue Code. Section 6055 requires employers that self-insure their group health plan to identify covered employees and dependents and specify the dates of coverage (if the policy is fully insured, the report must be filed by the insurer.) Section 6056 requires employers with 50 or more full-time equivalent employees to certify whether all full-time employees and their dependents were offered health care coverage. A statement containing this information must also be provided to all full-time employees (and any employees covered under a self-insured plan). The Secretary will use the certification to enforce the individual and employer shared responsibility mandates and to administer premium tax credits.

2015 – Automatic Enrollment (Repealed)

Employers with more than 200 employees who maintain one or more group health plans would have been required to automatically enroll all full-time employees as soon as they are eligible for coverage.

[This provision was repealed as part of the Bipartisan Budget Act of 2015.]

2015 – Electronic Records

Group health plans must certify to the Secretary of HHS that they are using electronic systems for processing health claims, enrollment and premium payments and that their systems are in compliance. See Section VII.e for penalties for failure to certify.

[Group health plans must certify compliance by December 31, 2015. New group health plans have one year from the date the HPID is obtained to certify compliance. Current status of this requirement is unclear due to delay of HPID requirement.]

2016 – Change in Size of Small Group Market

In 2016, ACA defines a small employer for group health insurance purposes as one with an average of at least 1 but not more than 100 employees on business days during the preceding calendar year, determined on a controlled group basis. However, the PACE Act (signed into law October 7, 2015)

amends the ACA to allow states to continue defining small employers as those with 50 employees or fewer. In general, state insurance law determines how employees are counted for purposes of qualifying for small group status. There are three ways that states count: Average Total Number of Employees (ATNE); Full-Time Equivalents; and Eligible Employees.

[This provision has been repealed by the PACE Act, as described above.]

2017 – Exchange for Large Employers

States may allow large employers with more than 50 employees to purchase health insurance for their employees through the exchanges (the prior 100 employee threshold for large employer status was repealed by the PACE Act in 2015).

2020 – Cadillac Tax

Health Care Reform imposes a non-deductible excise tax of 40% on the value of health insurance benefits exceeding $10,200 for single coverage and $27,500 for family coverage (indexed to inflation). The thresholds are higher for qualified retirees and "high risk" professions ($11,850 for single and $30,950 for family.) The tax appears to include all employer and employee amounts paid for medical, including pre-tax employee premiums and contributions made to health FSAs, HRAs and HSAs. It does not include standalone dental or vision coverage. The plan administrator is responsible for calculating the value of coverage and dividing the tax pro rata among insurers (including the employer, if self-insured). Plans are allowed to take into account age, gender and certain other factors that impact premium costs.

[This provision has been delayed for two years until 2020 under the Consolidated Appropriations Act. Originally effective for tax years beginning on or after January 1, 2018]

Additional Key Points on Health Care Reform

- Collectively-bargained, multi-employer and single employer plans in effect on March 23, 2010 do not have to evaluate the plans for loss of grandfathered status until the date on which the last collective bargaining agreement relating to the coverage terminates.

- Health Care Reform includes a small business health care tax credit designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. The credit is specifically targeted to help small businesses and tax-exempt organizations that primarily employ moderate- and lower-income workers. In 2010, the credit is generally available to employers with less than 25 full-time equivalent (FTE) employees and average annual wages of less than $50,000. Employers must contribute an amount equivalent to at least half the cost of single coverage. For tax years 2010 to 2013, the maximum credit is 35% of premiums paid by eligible small business employers and 25% of premiums paid by eligible employers that are tax-exempt organizations. Beginning in 2014, the maximum tax credit will go up to 50% of premiums paid by eligible small business employers and 35% of premiums paid by eligible, tax-exempt organizations for two years. Starting in 2014, employers must participate in a SHOP Exchange to receive the credit. The maximum credit goes to smaller employers with 10 or fewer FTE employees paying annual average wages of $25,000 or less. Because the eligibility rules are based in part on the number of FTE employees, and not simply the number of employees, businesses that use part-time help may qualify even if they employ more than 25 individuals. Seasonal workers, self-employed individuals (and family members), 2% shareholders of an S-corporation (and family members) and 5% owners (as defined by section 416(i)(1)(B)(I)) of a small business or family members, are not counted as 'employees'. Leased employees are counted. Any credits received offset deductions for health insurance costs to employer.

- Health Care Reform provides a $250 rebate for all Medicare Part D enrollees who enter the "donut hole" in 2010. The donut hole is created when a Medicare Part D beneficiary exceeds the prescription drug coverage limit but has not had costs that have reached the catastrophic coverage limit, so is personally responsible for the cost of prescription drugs in this gap. Health Care Reform increases discounts in subsequent years and completely closes the donut hole by 2020. This provision is significant for employers providing coverage for retirees to supplement Medicare Part D coverage.

  [Phase out begins January 1, 2011.]

- Health Care Reform provides that a health insurance company cannot deduct compensation paid to an employee in excess of $500,000 per year.

  [Applies to current compensation beginning in 2013; applies immediately to compensation deferred in 2010 and paid on or after 2013]

- States must implement a CHIPRA premium assistance subsidy for individuals under age 19 and/or their parents for premiums paid for employer-sponsored health coverage and extend such assistance to all individuals who qualify for medical assistance under Medicaid or a state medical assistance program, regardless of age. The state will pay the employee cost of coverage and any cost-sharing expenses (i.e. copayments, deductibles, etc.) that otherwise would be covered by the state program. Eligible employees can opt out of the employer's health plan.

  [January 1, 2014]

- The current 7.5% of AGI floor on income-tax deductions for health care expenses is raised to 10% of AGI, effective January 1, 2013. The new floor is waived during 2013, 2014, 2015 and 2016 for individuals who turn 65 before the close of those years.

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