HUNTON& WILLIAMS

Health Care Reform—Compliance Checklist Timeline

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 beginning 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 12/31/2013	First plan year beginning on or after 9/23/2010; complete prohibition beginning 1/1/2014	
Preventive care (with no cost-sharing)*	First plan year beginning on or after 9/23/2010	
Nondiscrmination rules for insured health plans*	First plan year beginning on or after 9/23/2010 (but postponed indefinitely until regulations issued)	
2011		
Over-the-counter drug reimbursement prohibition (without a prescription) for flex spending, health reimbursement and health savings account arrangements	1/1/2011	

[1] See Appendix A.3

Affordable Care Act Requirement	Effective Date	Status/Comments
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 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 W2s 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]	3/1/2013	
HIPAA electronic transaction compliance certification[9]	By 12/31/2013	
Adult obesity screening/counseling*	First plan year beginning on or after 7/1/13	
2014		
Adult child coverage mandate[10]	First plan year beginning on or after 1/1/2014	
Annual limit prohibition[11] (for "essential health benefits")	First plan year beginning on or after 1/1/2014	
Essential health benefits coverage mandate*[12] (for small insured GHPs only)	First plan year beginning on or after 1/1/2014	
Participant cost-sharing limited to high deductible health plan maximums and specified deductible limits*[13] (for small insured GHPs only)	First plan year beginning on or after 1/1/2014	
Preexisting condition exclusion prohibition[14]	1/1/2014	
Prohibition on discrimination with respect to clinical trial participation*[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	

[2] See Appendix A.1
[3] See Appendix A.2
[4] See Appendix A.4
[5] See Appendix A.5
[6] See Appendix A.4
[7] See Appendix A.7
[8] See Appendix A.8
[9] See Appendix A.9
[10] See Appendix A.2
[11] See Appendix B.1
[12] See Appendix B.3
[13] See Appendix B.4
[14] See Appendix B.3
[15] See Appendix B.9
[16] See Appendix B.8

Affordable Care Act Requirement	Effective Date	Status/Comments
Waiting period limitation[17] • Waiting periods cannot exceed 90 days	First plan year beginning on or after 1/1/2014	
Wellness program incentive increase*[18]	First plan year beginning on or after 1/1/2014	
Excise tax (employer "shared responsibility" coverage mandate)[19] • Penalty for failing to offer coverage to "full-time" employees and their dependents • Penalty for providing "insufficient" coverage	1/1/2014	
Excise tax (individual coverage mandate)[20]	1/1/2014	
Health insurance exchange coverage available[21]	1/1/2014	
HHS annual reporting requirements*[22]	1/1/2014	
Transitional Reinsurance Program contribution[23] • First contribution due 2015, with initial reporting at 2014 year-end	1/1/2014	
Post-2014		
IRS annual reporting requirements[24]	First returns due in 2015 (for 2014)	
Auto enrollment [25]	To be determined (under DOL regs)	
Excise tax (employer-sponsored high cost health coverage) [26]	1/1/2018	

*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.

[17] See Appendix B.6
[18] See Appendix B.7
[19] See Appendix B.11
[20] See Appendix B.12
[21] See Appendix B.10
[22] See Appendix B.14
[23] See Appendix B.13
[24] See Appendix C.1 & C.2
[25] See Appendix C.3
[26] See Appendix C.4

Appendix

A. Compliance Requirements for 2012 – 2013

1. **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 is an exemption to this requirement for qualifying religious organizations, plus a delayed effective date for nonqualifying religious organizations to the first plan year that starts on or after August 1, 2013.

2. **Summary of Benefits and Coverage** *(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.

   (*See* July 17, 2012 Hunton Employment & Labor Perspectives (HELP) Blog for additional details.)

3. **Restricted Annual Limit on Essential Health Benefits** *(effective first plan year beginning on or after September 23, 2012)*
   - Annual limit, if any, must not be less than $2,000,000 for PYs beginning on or after September 23, 2013.

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.

   (*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 12/31/2014.

   (*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 March 1, 2013 or later date established by regs)*
   - Employers must provide written notice about the health insurance exchanges to current employees and new employees "at the time of hiring." (The DOL has not yet issued regulations concerning this requirement.)

9. **HIPAA Electronic Transaction Compliance Certification** *(effective December 31, 2013)*
   - Plans must document and report compliance with the HHS rules on electronic transactions between vendors and group health plans by December 31,

2013, and each following December 31; HHS will develop a web-based reporting form.

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)*
   - Non-grandfathered small insured GHPs must limit participant cost sharing expenses to the annual out-of–pocket limits for high deductible health plans and specified deductible limits; HHS has issued proposed regulations addressing these requirements.
5. **Preexisting Condition Exclusion** *(effective first plan year beginning on or after January 1, 2014)*
   - All preexisting condition exclusions are prohibited.
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.

(*See* December 4, 2012 HELP Blog for additional details.)

7. **Increased Wellness Program Incentive** *(effective first plan year beginning on or after January 1, 2014)*
   - Recently proposed regulations provide that all plans (and not just non-grandfathered plans) that offer "health-contingent" wellness incentives may provide a reward equal to 30% (up from 20%) of the cost of health coverage (50% for tobacco cessation programs) for such incentives.
   - The proposed regulations also:
     - Clarify that the incentive is to be based on the total cost of the applicable coverage (and not just the employer-paid piece). For incentives for which only participants are eligible, the cost of individual coverage must be used. However, where the incentive also applies to any dependents, the reward may be based on the total cost of coverage in which the participant and dependents are enrolled.
     - Provide that to satisfy the "reasonable alternative" standard, the employer may be required to make available and pay the cost of the alternative (e.g. a smokenders program).
     - Provide that if the incentive is based upon satisfying a measurement, screening or test (such as having a specified BMI or cholesterol level), the plan must make available a different reasonable means for qualifying – which, if retained in the final rules, would appear to extend the "reasonable alternative" rules to all participants (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 becomes available.
11. **Employer "Shared Responsibility" Coverage Mandate/Excise Tax** *(effective January 1, 2014)*
    - "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**: Proposed regulations provide that (i) this penalty does not apply to any covered employer

that fails to offer coverage to no more than 5% (or, if greater, 5) of its full-time employees and (ii) "dependent" for this purpose only includes children up to age 26, and not spouses.

- An "applicable large employer" includes any employer that has at least 50 full-time employees (or full-time equivalents taking into account part-timers)
  - **NOTE:** Proposed 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 percent 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.
- In general, a "full-time" employee includes any employee who works on average at least 30 hours per week) 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:** Proposed 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 out of the U.S., however, need not be counted.
- If the employee averaged 30 hours each week during the measurement period, the employer must treat the employee as full-time during the subsequent 6 to 12 month "stability" period that follows the measurement period, regardless of hours worked during the stability period, for purposes of offering minimum essential health coverage and/or calculating the appropriate excise tax.
- If the employee did not average 30 hours each week (and, therefore, did not work full-time) during the measurement period, there is no requirement to treat the employee as a full-time employee.
- 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:** Proposed 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 a "new" employee only if the period of non-employment has been at least 26 consecutive weeks (or if period of non-employment is at least 4 but less than 26, it exceeds the employee's period of employment).
- For *new* variable hour and seasonal employees (i.e., employees who are not reasonably expected to work at least 30 hours per week at hire), employers may use an initial measurement period and administrative period that lasts up to 13 months after the hire date for purposes of determining full-time status.
  - Variable hour employees are those who, as of their hire date, cannot be reasonably expected to average 30 hours each week.
  - Seasonal employees generally are those who perform services on a seasonal basis.
  - **NOTE:** Proposed regulations provide that if a new variable hour or seasonal employee has a material change in status that 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).

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

- Applicable large employers who offer coverage to all 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:** Proposed 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 percent of the employee's household income.
  - **NOTE:** Proposed regulations (i) provide several alternative safe harbors for calculating whether health coverage is "unaffordable," including allowing an employee's W-2 earnings to be used for this purpose and (ii) establish that where a plan offers more than one option, the lowest cost option is to be used.
- Coverage does not provide "minimum value" if the plan pays less than 60% of the covered costs (determined on an actuarial basis).
  - **NOTE:** The IRS has indicated that an actuarial value calculator will be made available for this purpose.

12. Individual Excise Tax/Individual Coverage Mandate *(effective January 1, 2014)*

- Individuals who do not enroll in minimum essential coverage must pay an excise tax equal to the greater of (a) 2.5% of household income that exceeds certain threshold amounts and (b) $695 per uninsured adult in the household.

13. 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 an annual contribution to HHS to help stabilize premiums in the individual market from 2014 through 2016.
  - HHS will determine a national contribution rate (which HHS has initially estimated to be $63 per covered life for 2014); 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 number of "covered lives" under covered programs, each will be required to submit an annual census count to HHS each year (at the end of each year). Covered lives are to be determined in a manner similar to that allowed for the CER fee (see A.4 above).
  - The first contribution (for 2014) will be due in 2015. Contributions can be paid from plan assets and will be tax deductible to the extent paid by the employer.

(*See* December 27, 2012 HELP Blog for additional details.)

14. Non-Grandfathered Plan Reporting Requirements *(effective January 1, 2014)*

- 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.
- Non-grandfathered plans also must 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 not issued guidance concerning this reporting requirement.

C. Compliance Requirements for Periods Beginning after 2014

1. Annual Information Return Requirement for Health Insurance Issuers and Self-Insured Group Health Plan Sponsors *(effective for 2014, with first filing due in 2015)*

- Health insurance issuers and self-insured plan sponsors must file an annual return with the IRS reporting specific information for each individual with minimum essential coverage under the plan.
  - For group health plan coverage, the return information includes (i) the primary insured's name, address, tax identification number; (ii) the name and tax identification number of any other individual covered with the primary insured; (iii) the dates that the primary insured received minimum essential coverage (and whether such coverage was provided through a State Exchange); (iv) the employer's name, address, and EIN; (v) the employer's premium amount; and (vi) any other information the IRS requires.
- Each individual listed on the return must also be provided the reported information pertaining to that individual, along with the contact information of the person/entity responsible for filing the return for the employer.
- The first information returns (for 2014) will be due in 2015. IRS will be issuing additional guidance on this reporting obligation.

2. Annual Information Return Requirement for Employers Subject to Employer Contribution Mandate *(effective for 2014, with first filing due in 2015)*

- Applicable large employers subject to the Employer Contribution Mandate must file an annual return with the IRS that includes the following information:

(i) the employer's name, date, and EIN; (ii) a certification regarding whether the employer offers minimum essential coverage to full-time employees; (iii) if the employer offered such coverage, certain specific enrollment and coverage information; (iv) the number of full-time employees for each month of the calendar year; (v) the name, address, and tax identification number of each full-time employee, along with the number of years and months that the employee had coverage; and (vi) any other information the IRS requires.

- Each full-time employee listed on the return must also be provided the reported information pertaining to that individual, along with the contact information of the person/entity responsible for filing the return for the employer.
- The first information returns (for 2014) will be due in 2015. IRS will be issuing additional guidance on this reporting obligation.

3. **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 yet.
   - Automatic enrollment must include adequate notice and an opportunity to opt out of the coverage.
4. **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 $10,000 for self-only coverage and $27,500 for family coverage of any sort. 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). In addition, the value of HRA coverage, pre-tax FSA contributions and employer HSA/MSA contributions will also be counted. However, long-term care insurance, separate dental/vision benefits, on-site health clinics that offer "de minimis" amount of health care and executive physical programs are excluded.

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