The Patient Protection and Affordable Care Act Provisions for Self-Funded Plans

as of August 23, 2013

Provisions Organized by Effective Date
# Table of Contents

2013 (14 total, 9 in effect) ................................................................................................................................................. 1

- Flexible Spending Account Limits ............................................................................................................................... 1
- Employer Retiree Coverage Subsidy .......................................................................................................................... 1
- Retiree Prescription Drug Expenses/Initial Phase of Medicare Part D Coverage Gap/"Donut Hole" Fix, to Eliminate the Coverage Gap by 2020 ................................................................................................................... 1
- State Notification Regarding Exchanges ..................................................................................................................... 1
- Whistleblowing/Prohibition Retaliation ..................................................................................................................... 2
- Financial Disclosure .................................................................................................................................................. 3
- CO-OP Health Insurance Plans ............................................................................................................................... 3
- Patient-Centered Outcomes Research Institute (PCORI) Fee (temporary annual fee) ........................................ 4
- Extension of CHIP ..................................................................................................................................................... 5
- Employee Notice of Exchange .................................................................................................................................. 5
- Open Enrollment for the Health Insurance Exchanges ............................................................................................. 6
- Employee Requests for Premium Subsidies ................................................................................................................ 6
- HIPAA Certification .................................................................................................................................................. 7

2014 (16 total) .......................................................................................................................................................... 9

- Out-of-Pocket Limits .................................................................................................................................................. 9
- Grandfathered Health Plans Cover Dependent Children up to age 26, even if they have other employer-sponsored coverage available ............................................................................................................. 9
- Individual Requirement to Have Insurance—“Pay or Play,” Individual Mandate ............................................. 10
- Health Insurance Exchanges ...................................................................................................................................... 11
- Health Insurance Premium and Cost Sharing Subsidies ......................................................................................... 11
- No Discrimination Due to Pre-Existing Conditions or Gender ............................................................................ 11
- Provider Non-Discrimination .................................................................................................................................. 11
No Annual Limits on Essential Health Benefits ................................................................. 12
Ensuring Coverage for Individuals Participating in Clinical Trials ........................................ 12
Essential Health Benefits ........................................................................................................... 12
Multi-State Health Plans ........................................................................................................... 14
Transitional Reinsurance Program for Health Plans; Transitional Reinsurance Fee ..................... 15
Wellness Programs in Insurance ................................................................................................ 15
Waiting Periods ......................................................................................................................... 15
Automatic Enrollment ............................................................................................................... 16
Nondiscrimination Rule (Executive Medical) ............................................................................ 16
2015 (3 total) ................................................................................................................................ 17
    Employer Requirements—“Pay or Play,” Employer Shared Responsibility ......................... 17
    Quality of Care Reporting ...................................................................................................... 18
    Transparency in Coverage Reporting ...................................................................................... 18
SOURCES: ................................................................................................................................. 20
2013 (14 total, 9 in effect)

January

Flexible Spending Account Limits

Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by the cost of living adjustment.

Implementation: January 1, 2013

Employer Retiree Coverage Subsidy

Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Implementation: January 1, 2013

Retiree Prescription Drug Expenses/Initial Phase of Medicare Part D Coverage Gap/“Donut Hole” Fix, to Eliminate the Coverage Gap by 2020

The Medicare Part D coverage gap (informally known as the Medicare donut hole) lies between the initial coverage limit and the catastrophic-coverage threshold in the Medicare Part D prescription-drug program administered by the United States federal government. After a Medicare beneficiary exits the initial coverage of prescription-drug plan, the beneficiary is financially responsible for a higher cost of prescription drugs until he or she reaches the catastrophic-coverage threshold.

Effective 2013, employers that currently sponsor retiree prescription drug plans will no longer be able to deduct amounts contributed to them.

Implementation: January 1, 2013
2012 W-2 Reporting

PPACA requires that large employers (filed 250 or more W-2s in the prior calendar year) report the value of “applicable employer sponsored coverage” in Box 12 on each employee’s annual Form W-2; this includes both the employer and employee contributions (regardless of the tax status of the contributions). Employers must demonstrate good-faith compliance using a reasonable interpretation of the requirements. There are no new penalties outside of what is already in place for incorrect Forms W-2.

**Implementation:** January 1, 2013

February

State Notification Regarding Exchanges

States indicate to the Secretary of HHS whether they will operate an American Health Benefit Exchange.

**Implementation:** January 1, 2013

**Implementation update:** On May 16, 2012, HHS issued a Blueprint that states must submit to HHS by November 16, 2012 if they wish to operate a state-based exchange or a Partnership exchange. On November 15, 2012, the Obama administration extended the deadline for submitting a state-based exchange blueprint to December 14, 2012. The deadline was extended to February 15, 2013 if a state opted for a state-federal partnership exchange. Coverage through the exchanges will begin on January 1, 2014.

Whistleblowing/Prohibition Retaliation
PPACA prohibits employers (including insurers) from retaliating against an employee for reporting possible violations of PPACA to his employer or to the government, providing testimony about the possible violation or refusing to violate the law. It also prohibits retaliating or taking an unfavorable employment action against an employee because he or she received a premium tax credit. Unfavorable employment actions include firing or laying off, denying benefits, reducing pay or hours, denying overtime or promotion and making threats.

The government has issued procedures that will be followed if an employee believes he or she has been retaliated against. The employee must file a complaint within 180 days after the claimed retaliation occurred. Complaints will be filed with and investigated by the Occupational Safety and Health Administration. (OSHA handles most whistleblowing complaints made with the Department of Labor.) If the complaint is found to be valid, the employer could be required to reinstate the employee, pay back wages, restore benefits, etc.

**Implementation:** February 22, 2013; OSHA has requested comments by April 29, 2013

**April**

**Financial Disclosure**

Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

**Implementation:** Report to Congress due April 1, 2013

**July**

**CO-OP Health Insurance Plans**

Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies.
Implementation: CO-OPs established by July 1, 2013

Implementation update: On March 14, 2011, the Department of Health and Human Services (HHS) issued a report on the Consumer Operated and Oriented Plan Program. The report included recommendations by the CO-OP Advisory Board on governance, finance, infrastructure, and compliance. On July 18, 2011, HHS published a proposed rule that would implement the CO-OP program. On December 13, 2011, HHS issued a final rule. On February 21, 2012, HHS announced that "seven non-profits offering coverage in eight states have been awarded $638,677,300."

Patient-Centered Outcomes Research Institute (PCORI) Fee (temporary annual fee)

The PCORI is charged with promoting research to evaluate and compare the health outcomes and clinical effectiveness, risks, and benefits of medical treatments, services, procedures, and drugs. PCORI is funded, in part, by fees assessed on health insurers and plan sponsors of self-insured group health plans.

The PCORI fee will first be assessed with respect to plan years ending after September 30, 2012 (i.e., that end on or after October 1, 2012, but before October 1, 2013). The initial fee is $1 times the average number of covered lives for that first plan year and $2 per covered life for the plan year ending after September 30, 2013. Fees for subsequent years are subject to indexing. The PCORI fee will not be assessed for plan years ending after September 30, 2019, which means that for a calendar year plan, the last year for assessment is the 2018 calendar year.

Implementation: The PCORI fee is imposed on insurers and plan sponsors of self-insured group health plans, and sponsors of calendar year plans will be required to pay the 2012 fee by July 31, 2013.

June 2013 Update: IRS Form 720, the “Quarterly Federal Excise Tax Return,” has been updated to accommodate the payment of the PCORI fee. Two lines for reporting the fee have been added under Part II of the revised Form 720. The first line is for use by insurance companies, while the second line is meant to be used by sponsors of self-insured health plans subject to the fee. The instructions for Form 720 have also been revised to provide a description of the available calculation methods that self-insured health plans can use in reporting and filing Form 720.
**September**

**Extension of CHIP**

Extends authorization and funding for the Children’s Health Insurance Program (CHIP) through 2015 (current authorization is through 2013). PPACA extended CHIP until October 1, 2015. The current CHIP eligibility standards will remain in place through 2019. PPACA also provided an additional $40 million in federal funding to continue efforts to promote enrollment in Medicaid and CHIP.

**Implementation:** Before end of fiscal year 2013 (September 30, 2013).

**Employee Notice of Exchange**

Employers must provide a notice of coverage options to each employee, regardless of plan enrollment status (if applicable) or of part-time or full-time status. Employers are not required to provide a separate notice to dependents or other individuals who are or may become eligible for coverage under the plan but who are not employees. This notice must include information regarding the existence of a new Marketplace as well as contact information and description of the services provided by a Marketplace. The notice must also inform the employee that the employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Marketplace; and a statement informing the employee that if the employee purchases a qualified health plan through the Marketplace, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

**Implementation:** Employers are required to provide the notice no later than October 1, 2013.

**5/8/13 Implementation Update:** The DOL issued a Technical Release that provides temporary guidance to employers on two Notices (Notice to Employees of Coverage Options and COBRA Election Notice) they will need to provide to their employees prior to Open Enrollment on the Health Insurance Marketplace, which begins October 1st. The
DOL stated it has issued these model notices earlier than expected so that employers can disseminate them now or as soon as possible so that employees know about the upcoming coverage options through the Marketplace. The model Notices are on the DOL website at http://www.dol.gov/ebsa/healthreform/.

**October**

**Open Enrollment for the Health Insurance Exchanges**

**Implementation:** October 1, 2013

**8/16/13 Implementation Update:** The Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, submitted a request to the Office of Management and Budget for an emergency review of the new reporting system that state health insurance exchanges will use. CMS is seeking to fast-track the rollout of a new process that will require state health exchanges to report, within one hour, information security incidents to their designated Center for Consumer Information and Insurance Oversight State Officer. The officer then will notify affected federal agency data sources, which could include the Department of Defense, Department of Homeland Security, Department of Treasury, Internal Revenue Service, Office of Personnel Management, Peace Corps, Social Security Administration, or Veterans Health Administration. CMS is requesting review and approval by September 25, 2013. Public comments and suggestions must be received by September 20, 2013.

**Employee Requests for Premium Subsidies**

An employee will be eligible for a premium subsidy only if:

- His household income is less than 400 percent of federal poverty level,
- He purchases coverage through the public exchange,
- He does not have access to affordable, minimum value coverage through his employer, and
- He is not covered by a plan through his employer that provides minimum essential coverage (even if that coverage is not affordable or it does not provide minimum value)

The employee will be required to provide information to the exchange about his income and access to employer-provided affordable, minimum value coverage. The exchange (or HHS if the state asks HHS to do this) will attempt to verify this information from available data bases, but in all likelihood it will need to contact the employer for verification of information regarding coverage. HHS is considering the use of a one-page template that the employer would complete with respect to the employee’s eligibility for coverage, plan affordability and plan value.

HHS issued a proposed rule on January 14, 2013. Under the proposed rule, HHS or the exchange would notify the employer if an employee is determined to be eligible for a premium subsidy (“certified under Section 1411”). The employer would have 90 days to appeal the determination if it believed the employee should not be eligible for the subsidy. (All employers, regardless of size, would receive the notice that an employee has been found to be eligible for a premium subsidy. Employers large enough to be responsible for paying a penalty on employees who receive a premium subsidy would receive a separate notice from the IRS actually assessing the penalty. The IRS notice most likely would be sent during the second quarter after the calendar year for which the premium subsidy was provided.)

**Implementation:** October 1, 2013

**7/5/13 Implementation Update:** HHS issued a wide-ranging rule (to be published in the *Federal Register* on July 15) that allows the federal government and the state-run exchanges to rely heavily on self-reported information by those seeking tax credits/subsidies for policies purchased through an exchange, while auditing a sample of applications for accuracy (at least until 2015, when stronger verification systems may be in place). The exchange will check the income information submitted by individuals against electronic income data sources such as tax filings, Social Security data and current wage information.
December

HIPAA Certification

Employer group health plans must certify requirements for HHS rules on electronic transactions between providers and health plans.

Implementation: December 31, 2013
2014 (16 total)

Out-of-Pocket Limits

Beginning with the 2014 plan year, non-grandfathered plans may not have an out-of-pocket maximum on essential health benefits (in-network) that is larger than the allowed out-of-pocket limit for high-deductible health plans (HDHP) issued in connection with a health savings account. (The out-of-pocket limit includes the deductible, coinsurance and copays). For plans using provider networks, HHS’s final rule provides that an enrollee’s cost-sharing for out-of-network benefits does not count toward the cost-sharing limit. The out-of-pocket limits are adjusted annually for cost-of-living increases; the 2014 out-of-pocket maximums for HSA-compatible HDHP coverage are $6,350 for individual plans and $12,700 for family plans.

There is one year of transition assistance to plans that have separate major medical and prescription drug vendors. For the 2014 plan year only, those plans may apply the out-of-pocket limit separately to the major medical and prescription drug parts of coverage. Similar flexibility will not be available to plans with separate mental health and substance use disorder benefits, as the Mental Health Parity Act does not allow separate annual out-of-pocket maximums on mental health and substance use disorder benefits.

Implication: Does not apply to grandfathered plans.

Implementation: January 1, 2014

Grandfathered Health Plans Cover Dependent Children up to age 26, even if they have other employer-sponsored coverage available

Beginning in 2014, grandfathered group plans must comply with the dependent coverage requirement and children up to age 26 can stay on the parents’ employer plan even if they have other employer-sponsored coverage available.
Implementation: January 1, 2014

Individual Requirement to Have Insurance—“Pay or Play,” Individual Mandate

Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions).

Implementation: January 1, 2014

6/26/13 Implementation Update: The IRS has issued Notice 2013-42, providing transition relief from the Individual Mandate. However, this transition relief is limited to employees who are eligible for an employer-sponsored group health plan that operates on a non-calendar year.

The IRS will allow employees and their spouses or dependents who are eligible to enroll in a non-calendar year employer-sponsored health plan to avoid Individual Mandate tax penalties for the months between January 1, 2014 and the month that the employer’s 2013-2014 plan year ends. With this new clarification, employees will not be required to enroll early in an employer-sponsored group health plan or enroll in other health insurance coverage through the Health Insurance Marketplace to avoid Individual Mandate tax penalties.

6/26/13 Implementation Update: Hardship exemptions: HHS issued a final rule detailing how individuals could obtain exemptions from penalties for noncompliance with the Affordable Care Act's individual mandate.

The final rule includes a hardship exemption for dependents of a worker who has been offered affordable individual coverage but cannot afford the cost of family coverage. Observers have noted that the affordability of family coverage is a technical problem in the ACA, because the law defines "affordable" individual coverage—plans that costs less than 9.5% of a household's income—but does not delineate affordable family coverage.

Further, the rule states that hardship exemptions will be available on a case-by-case basis for individuals who face other circumstances that prevent them from purchasing a qualified health plan. It also notes that hardship exemptions based on the projected affordability of coverage will be valid for an entire coverage year.
Health Insurance Exchanges

Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Exchanges will have a single form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs.

**Implementation:** January 1, 2014 (Enrollment begins October 1, 2013)

March 2013 Implementation Update: HHS released transitional policy regulations which state that the SHOP Exchanges, for the 33 states in which the Federal Government runs the exchange, have been delayed one year (until 2015) due to “operational challenges.” States running their own exchanges have the option to delay having their SHOP open in 2014. In 2015, it is expected that SHOPs will be fully operational as intended.

Health Insurance Premium and Cost Sharing Subsidies

Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals. Premium subsidies are available to families with incomes between 100-400% of the federal poverty level to purchase insurance through the Exchanges, while cost sharing subsidies are available to those with incomes up to 250% of the poverty level.

**Implementation:** January 1, 2014

No Discrimination Due to Pre-Existing Conditions or Gender

Prohibits insurance companies from refusing to sell coverage or renew policies because of an individuals' pre-existing condition. Eliminates the ability of insurance companies to charge higher rates due to gender or health status.

**Implementation:** January 1, 2014

Provider Non-Discrimination

Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks.
April 29, 2013 Update: The DOL issued FAQs that state that until further guidance is issued plan sponsors are expected to implement the requirements “using a good faith, reasonable interpretation of the law.” This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.

**Implication:** Does not apply to grandfathered plans.

**Implementation:** January 1, 2014

No Annual Limits on Essential Health Benefits

Prohibits annual limits on the dollar value of essential health benefits.

**Implementation:** January 1, 2014

Ensuring Coverage for Individuals Participating in Clinical Trials

Prohibits insurance companies from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases. Group health plans or health insurance issuers also may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial. April 29, 2013 Update: The DOL issued FAQs that state that until any further guidance is issued, group health plans and health insurance issuers are expected to implement the requirements “using a good faith, reasonable interpretation of the law.”

**Implication:** Does not apply to grandfathered plans.

**Implementation:** January 1, 2014

Essential Health Benefits

Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits ($5,950/individual and
$11,900/family in 2010). Creates four categories of plans to be offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover.

Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Implementation:** January 1, 2014

**Implementation Update:** On October 7, 2011, the Institute of Medicine released recommendations on the Essential Health Benefits package. On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) released a bulletin on the Essential Health Benefits rulemaking process. On January 25, 2012, CCIIO issued an illustrative list of the three largest small group products by state to "facilitate a better understanding of the intended approach to EHBs.” On February 21, 2012, HHS issued FAQs on how HHS is intending to approach defining Essential Health Benefits. On November 26, 2012, HHS published proposed regulations defining the “essential health benefits” that must be included in the individual and small group markets.

On February 20, 2013, the Departments of Health and Human Services, Labor and Treasury jointly released a Final Rule which contained clarification as to how self-insured plans are to comply with the ACA's cost-sharing limitations and how self-insured plans are to calculate Minimum Plan Value. The Rule also detailed how the Essential Health Benefits (EHBs) will be determined as well as how self-insured plans are to comply with requirements which are linked with such benefits.

**6/28/13 Update on Preventive Care:** The Administration issued final rules on contraception coverage and religious organizations. The final rules finalize the proposed
simpler definition of “religious employer” for purposes of the exemption from the contraceptive coverage requirement in response to concerns raised by some religious organizations. These employers, primarily houses of worship, may exclude contraceptive coverage from their health plans for their employees and their dependents. The final rules also lay out the accommodation for other non-profit religious organizations - such as non-profit religious hospitals and institutions of higher education - that object to contraceptive coverage. Under the accommodation these organizations will not have to contract, arrange, pay for or refer contraceptive coverage to which they object on religious grounds, but such coverage is separately provided to women enrolled in their health plans at no cost.

With respect to self-insured health plans, the non-profit religious organization provides notice to its third party administrator that objects to contraception coverage. The third party administrator then notifies enrollees in the health plans that it is providing or arranging separate no-cost payments for contraceptive services for them for as long as they remain enrolled in the health plan.

**Implication:** Self-funded plans, and insured plans in the large group market, will not be required to offer the Essential Health Benefits (EHB) package (Preventive care, however, must be covered by all non-grandfathered plans without cost-share). To the extent they provide coverage for any EHB, however, the plans will be subject to the restrictions on dollar limits. And if a plan covers any mental health or substance abuse disorder service it must ensure that it complies with the Mental Health Parity provisions (financial requirements and treatment limitations for mental health must be equal with medical and surgical benefit designs).

**Multi-State Health Plans**

Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.

**Implementation:** January 1, 2014
Transitional Reinsurance Program for Health Plans; Transitional Reinsurance Fee

Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. This fee will fund a three-year reinsurance program designed to reimburse companies that insure high-cost individuals within the individual health insurance market. The total amounts to be assessed are $12 billion in 2014, $8 billion in 2015 and $5 billion in 2016, when the program ends. This fee will be assessed on a per covered person basis, and we anticipate that the assessment rate will be approximately $60 to $90 per covered person in 2014. Applies to both insured and self-funded plans.

Implementation: January 1, 2014 through December 31, 2016

Implementation Update: HHS issued final rule on March 11, 2013.

Wellness Programs in Insurance

Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Implementation: Changes to employer wellness plans effective January 1, 2014; 10-state pilot programs established by July 1, 2014

5/29/13 Implementation Update: The U.S. Departments of the Treasury, Labor (DOL) and Health and Human Services issued final regulations amending the 2006 HIPAA nondiscrimination wellness regulations to implement the employer wellness program provisions of the Affordable Care Act. The final rules retain the two categories of wellness programs – “participatory wellness programs” and “health-contingent wellness programs.”

Waiting Periods

Employer group health plans may not impose waiting periods longer than 90 days.

Implementation: January 1, 2014
3/18/13 Implementation Update: The Departments of the Treasury, Labor, and Health and Human Services released proposed rules regarding the 90-day waiting period limitation. The 90-day limitation includes all calendar days from the date the employee becomes eligible to enroll by satisfying the plan’s substantive eligibility requirements. Coverage must begin no later than the 91st day (assuming the waiting period is the 90-day maximum), regardless of whether the 91st day falls on the weekend or a holiday. For administrative convenience, coverage is permitted to begin earlier, however, the effective date of coverage cannot be later than the 91st day. Thus, plans can no longer impose a waiting period of 90-days from the first day of the month following the date of hire; these plans may want to switch to 60-days from the first day of the month following the date of hire to ensure compliance. Additionally, the proposed rules provide that 90-days cannot be interpreted as 3-months. This is of particular importance for plans with “3-month” waiting periods, as this will no longer be considered compliant with the limitation.

Automatic Enrollment

Large employers (employers with more than 200 full-time employees) must automatically enroll new employees in employers’ group health plan.

Implementation: Compliance is delayed until regulations are issued (expected Jan. 1, 2014)

Nondiscrimination Rule (Executive Medical)

Insured employer group health plans may not discriminate in favor of highly compensated employees.

Implication: Does not apply to fully-insured grandfathered plans. Self-funded plans already comply with Section 105(h) of the Internal Revenue Code.

Implementation: Compliance for fully-insured plans is delayed until regulations are issued (expected Jan. 1, 2014)
Employer Requirements—“Pay or Play,” Employer Shared Responsibility

Assesses a fee of $2,000 per full-time employee, excluding the first 30 employees, on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees. Large employers must file an annual report with the IRS describing health coverage under the pay or play mandate.

Special rule for educational organizations and employees on unpaid leave: The regulation has a special rule for how to determine an employee’s hours of service when an employee was on unpaid leave (such as FMLA or USERRA leave) or when an employee worked for only a portion of the calendar year (such as a teacher who does not work during the summer). Under this rule, an employer may ignore the period of the unpaid leave when averaging the hours, or, alternatively, provide a “credit” for hours worked during that time (even though no hours were, in fact, worked). Educational institutions are subject to this general rule and an additional, special rule. When such institutions have an “employment break period” lasting at least four consecutive weeks (such as summer vacation), that period is ignored when determining an employee’s hours of service.

Implementation: Original implementation date was January 1, 2014; now postponed until January 1, 2015

Implementation Update: IRS had a public hearing re: section 4980H of IRS Code (Employer Shared Responsibility provisions) on 4/23/13 to receive feedback. On 5/2/13, IRS issued proposed minimum value rules.

7/2/13 Implementation Update: The Treasury Department announced on July 2, 2013, that the employer mandate is delayed until Jan. 1, 2015 due to concerns from employers about the challenges of its implementation. Official guidance will be issued within the week of July 8th, and formal rules will be proposed later this summer.
**7/9/13 Implementation Update:** The IRS issued Notice 2013-45, which outlines the transition relief that is available during 2014. In Notice 2013-45, the IRS states that this transition relief will provide additional time for input from employers and other reporting entities in an effort to simplify information reporting consistent with effective implementation of the ACA. In addition, the transition relief is intended to provide time for employers, insurers and other providers of minimum essential coverage to adapt their health coverage and reporting systems.

### Quality of Care Reporting

Employer group health plans must provide a report annually, disclosing information of plan benefits and reimbursement structures that improve health outcomes.

**Implication:** Does not apply to grandfathered plans.

**Implementation:** Though deadline for issuing regulations was March 23, 2012, regulations have not yet been issued and compliance is delayed until such time.

**7/9/13 Implementation Update:** The IRS issued Notice 2013-45, which delays the PPACA penalty-related information-reporting provisions (Section 6055 and 6056) until 2015.

### Transparency in Coverage Reporting

Insurers and employers with self-funded non-grandfathered plans must prepare Transparency in Coverage Disclosures that are intended to help employees understand how reliably the plan reimburses claims for covered services, whether the provider network is adequate to assure access to covered services, and other practical information. Information must be provided in plain language that the intended audience, including individuals with limited English proficiency, can readily understand and use. The law requires plans to disclose information, and for exchanges and the federal Department of Health and Human
Services (HHS) to then make publicly-available accurate and timely disclosure of this information. The disclosure will include the following categories of information:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to out-of-network coverage
- Information on enrollee and participant rights under this title
- Other information as determined appropriate by the Secretary

**Implementation:** Compliance is delayed until regulations are issued. The FAQs from DOL, HHS, and the Treasury on April 29, 2013 clarified that the compliance date has been delayed until 2015.

**7/9/13 Implementation Update:** The IRS issued Notice 2013-45, which delays the PPACA penalty-related information-reporting provisions (Section 6055 and 6056) until 2015.
SOURCES:

Implementation Timeline (The Henry J. Kaiser Family Foundation), on the Internet at http://healthreform.kff.org/timeline.aspx

Key Features of the Affordable Care Act, By Year (HealthCare.gov, website managed by the U.S. Department of Health & Human Services), on the Internet at http://www.healthcare.gov/law/timeline/full.html#2013

Timeline of Highlights for Employer Group Health Plan Compliance with the Affordable Care Act (EpsteinBeckerGreen), on the Internet at http://www.ebglaw.com/showclientalert.aspx?Show=16364
