Current ACA Timeline

Caution: ACA is under constant review. Provisions could be adjusted, re-interpreted and even repealed in the future. This is a snapshot as of December 10, 2014.

2013

W-2 Health Care Value Reporting	January 2013 (for 2012 W-2 Forms). Annual reporting continues for the cost of employer-sponsored health coverage. Employers filing fewer than 250 W-2 Forms are not subject to the requirement until further guidance is issued.
Health FSA Limit	Plan years beginning January 1, 2013. The annual limit on health FSAs is $2500.
Administrative Simplification Eligibility and Claim Status Operating Rules	January 1, 2013
FICA Medicare Tax Rate Increase	January 1, 2013. FICA Medicare tax rate increases for wages over $200,000 ($250,000 for married couples filing jointly).
Medicare Part D Retiree Drug Subsidy Payments	January 1, 2013. Elimination of the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.
Exchange/Marketplace Notice	No later than October 1, 2013. All employers subject to the Fair Labor Standards Act must provide every employee with notice, including part-time employees. Employers covered by the FLSA include those that have at least $500,000 in annual dollar volume of business, based on their gross receipts

	from sales over a 12-month period. The FLSA also covers hospitals, schools, institutions of higher education and federal, state and local government agencies. No penalty for failure to send.
Patient-Centered Outcomes Research Institute (PCORI) Fee on Plans	First fee due July 31, 2013. The fees are effective for each plan year ending on or after October 1, 2012 and before October 1, 2019.

2014

No Annual Dollar Limits on Essential Health Benefits	Plan years beginning on or after January 1, 2014. Mini-med waivers will expire on plan years beginning on or after January 1, 2014.
No Preexisting Condition Exclusions	Plan years beginning on or after January 1, 2014.
90-Day Limitation on Waiting Periods	Plan years beginning on or after January 1, 2014.
Tax on Plans to Fund (Temporary) Transitional Reinsurance Program	**Transitional Reinsurance Contributions** • The Department of Health and Human Services released a Final Rule on March 5, 2014 addressing the Transitional Reinsurance Program fees payable in the benefit years 2014-16. • The Affordable Care Act (ACA) requires self-funded group health plans to pay a temporary per capita transitional reinsurance fee from 2014-2016. The fee is $63 for 2014 and $44 for 2015 per covered life. **Schedule Payments for Reinsurance Contributions:** Contributing entities must also schedule payments for calculated reinsurance contributions. There are two separate deadlines for submitting portions of the full

annual reinsurance contribution amount:

- First collection deadline is January 15, 2015
- Second collection deadline is Nov. 15, 2015
- An entity that chooses to make a combined collection, must submit the contribution on January 15, 2015.

The Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form on Pay.gov requires the following:

- Basic company and contact information
- Annual enrollment count
- Upload supporting documentation (specific information on the annual enrollment count for each contributing entity represented on the form)
- Payment information and payment date

Once Enrolled: Payment Is Initiated:

- Once the payee has enrolled into the account and uploaded the count, the payment form will auto-calculate the contribution amount.
- An Automated Clearing House (ACH) process via Pay.gov is the only vehicle being accepted for reinsurance contributions payment for the 2014 benefit year.
- Note that HHS does not regulate who may submit the reinsurance contribution on behalf of the contributing entity.
- The responsibility to make reinsurance contributions lies with the contributing entity, and the decision to delegate the function of submitting the reinsurance contribution is with the contributing entity.
- A TPA or ASO contractor may perform this function if requested. A TPA's or ASO contractor's obligation to do so would be a function of the arrangement between the TPA or ASO contractor and the contributing entity and applicable state law.

Penalites?

Payment of the reinsurance contribution payment is considered to be a debt owed to the Federal government. Therefore, pursuant to 45 CFR 156.1215(c), any amount owed by an issuer and its affiliates for reinsurance is a determination of a debt and will be subject to the Federal debt collection rules. Additionally, reinsurance

	contributions are considered Federal funds that would be subject to the False Claims Act. **Important Key Deadlines for the 2014 Benefit Year** • Submit Annual Enrollment Count --No later than November 15, 2014 • Remit First Contribution Amount—No later than January 15, 2015 in the amount of $52.50 per covered life • Remit Second Contribution Amount—No later than the Fourth Quarter of 2015 in the amount of $10.50 per covered life. • Total remitted for covered life $63.00 For 2015, the proposed fee amount is $3.67 per person per month or $44 annually per person. The fee generally applies to all "health insurance coverage" and self-funded "group health plans" including FEHB plans and state and local governmental plans However, the following are excepted: • HIPAA-excepted coverage • In the case of health insurance, coverage that is not considered to be part of the issuer's "commercial book of business" • In the case of health insurance, coverage that is not issued on a form filed and approved with a state insurance department • Self-funded group health plans or health insurance that do not provide major medical benefits • Proposed exception for 2015 and 2016 (NOT 2014): Self-insured, self-administered plans. Note: MOST self-insured plans would NOT qualify for the exception. For additional information, go to https://www.regtap.info
Exchange/Marketplace Notice	The ACA requires that employers must provide each employee a written notice at the time of hiring that explains their rights to enroll in the Exchange/ Marketplace. DOL Technical Release 2013/02 requires employers to provide a notice of coverage options to each employee regardless of plan enrollment status or part-time or full-time status. The written notice must be provided by employers at the time of hiring and it must be provided free of charge. The written notice must inform the employee of

	the existence of the Exchange/ Marketplace including a description of the services provided by the Exchange/Marketplace, and the manner in which the employee may contact the Exchange/Marketplace to request assistance. The newly released Model COBRA Notice is to be used by employers to inform Qualified Beneficiaries about options that they have in the Exchange/Marketplace. No penalty for failure to send.
Exchanges/ Marketplaces	**Health Insurance Exchanges (Marketplace)** The ACA created state-based American Health Insurance Marketplace 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. Marketplaces will have a single form for applying for health programs, including coverage through the Marketplace and Medicaid and CHIP programs. • Before Nov. 15, 2014, individuals can enroll in a Marketplace health plan only if they qualify for a Special Enrollment Period. Any plan enrolled in before Nov. 15, 2014 ends on December 31, 2014. Individuals can apply for new coverage, Medicaid and/or CHIP for coverage ending in 2014. Important dates and deadlines: • November 15, 2014: Open enrollment starts. • December 15, 2014: the last date to enroll for coverage that starts Jan. 1, 2015. • December 31, 2015: Date when all 2014 Marketplace coverage ends, no matter when enrolled. • January 1, 2015: The date 2015 coverage can begin if individuals apply by December 15, 2014 or if the participant accepts automatic enrollment in the 2014 plan or a similar plan. • February 15, 2015: The last day to enroll in 2015 coverage. If the individual misses the deadline, they cannot sign up for a health plan inside or outside the Marketplace for the rest of 2015. The only exception is if the individual qualifies for a Special Enrollment Period. Note: There is no limited enrollment period for Medicaid or the Children's Health Insurance Program (CHIP), individuals can apply at any time. Also, there is no limited enrollment period for small businesses to enroll in SHOP coverage for their employees, they can apply at any time. • On May 16, 2012, HHS issued guidance for Federally-facilitated Exchanges (FFE), which will be run by HHS in states that have not established an

	exchange or have selected to run a Partnership exchange. • On May 10, 2013, HHS announced new flexibility to allow states to run the SHOP-only Marketplace. States choosing this option would run the SHOP Marketplace while the federal government would run the individual exchange. The SHOP Marketplace is open to employers with 50 or fewer full-time equivalent employees.
Advance Premium Assistance Tax Credits	January 1, 2014. Advance premium assistance tax credits and cost-sharing subsidies become available for those eligible through the Exchanges.
Coverage of Clinical Trials	• As of Jan. 1, 2014, the Affordable Care Act (ACA) required all self-funded and fully insured, non-grandfathered health plans to provide benefit coverage for patients taking part in approved clinical trials. • The law requires coverage for "routine health care" when these members take part in an approved clinical trial. The clinical trial itself is not required to be covered under the law. • The benefits are effective upon renewal of the non-grandfathered health plan after Jan. 1, 2014. Routine patient care means the range of medical services people with certain diagnosis might need, including other doctor visits, hospital stays, tests, and care related to the illness or disease. It also includes treatment for side effects and other medical issues that may arise as a result of the trial. • Out of network services will be covered at the out-of-network benefit level. In-network benefits will be covered at the in-network benefit level. • Drug trial coverage is dependent on many factors, including federal and state mandates (if applicable), sponsoring organization and self-funded group benefits. It is wise to pre-certify participation in drug trials. • Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. The requirement does not apply to grandfathered plans. The coverage does not apply for the actual device, equipment or drug that is typically given to participating patients free of charge by the medical device or pharmaceutical company sponsoring the trial.

Individual Mandate	January 1, 2014
Out of Pocket Maximums	Plan years beginning on or after January 1, 2014. Non-grandfathered group health plans may not impose cost-sharing amounts (i.e., copays or deductibles) that are more than the maximum allowed for high-deductible health plans (currently these limits are $6,350 for an individual and $12,700 for family coverage). After 2015, these amounts will be adjusted for health insurance premium inflation.
Deductible Maximums	Plan years beginning on or after January 1, 2014. Deductible Maximums for non-grandfathered fully-insured small group health plans inside and outside of the health insurance exchange. Self-only $2,000 and non-self-only $4,000.
Dependent Age 26	Plan years beginning on or after January 1, 2014. Grandfathered group health plans will no longer be able to deny coverage to any dependent to age 26 for being eligible to enroll in other employer sponsored health coverage.
Summary of Benefits & Coverage	Plan years beginning on or after January 1, 2014. Updated and referred to as "the second year of applicability". The only change to the SBC template and sample completed SBC is the addition of statements of whether the plan or coverage provides MEC and whether the plan or coverage meets the MV requirements.
Preventive Services	Plan years beginning on or after January 1, 2014. Preventive Services for Women. TPAs and health insurance issuers must make accommodations for contraceptive benefits for women whose religious employers object to contraceptive coverage. Not applicable to grandfathered group health plans.
Fully-Insured Market Reforms	Guaranteed issue and community rating standards will apply.
W-2 Health Care Value Reporting	Annual reporting continues for the cost of employer-sponsored health coverage. Employers filing fewer than 250 W-2 Forms are not subject to the requirement until further guidance is issued.
Consumer Operated	• ACA Created the CO-OP to foster the creation of non-

& Oriented Plan (CO-OP)	profit, member-run health insurance companies. • Beginning January 1, 2014, CO-OPs are offering health plans through the Health Insurance Marketplace. CMS continues to monitor CO-OPs to ensure they are meeting program goals and will be able to repay loans. For information on the awardees of CO-OP loans, please visit: http://cciio.cms.govresources/factsheets/coop_final_rule.html
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 as of January 1, 2014 • Implementation Update: On March 14, 2014, CMS issued a 2015 Letter to issuers in the Federally-facilitated Marketplace. • The letter provided technical guidance to help them to successfully participate in the Marketplaces and finalizes the policies in the Draft 2015 Letter

2015

Employer Play or Pay	January 1, 2015. Employers with 100 or more full-time employees (including full-time equivalents) are liable for penalty taxes if coverage is offered to fewer than 70% of full-time employees and non-spouse dependents or "unaffordable" coverage is offered and an employee receives a federal subsidy through an Exchange. Non-Calendar Year Plans that meet certain conditions have until the first day of the 2015 plan year to comply. For 2015 plus any calendar months of 2016 that fall within the employer's 2015 plan year, the penalty under section 4980H(a) is calculated by

	reducing the employer's number of full-time employees by 80.
Plan and Insurer Reporting	For coverage provided on or after January 1, 2015, reporting is required (first information returns due January 31, 2016). Sponsors of self-funded plans and health insurers must report individual coverage dates, the portion of the premium the individual must pay and more. Systems should be in place on January 1, 2015 to capture the appropriate data.
Exchanges	Beginning January 1, 2015, state-based exchanges must be self-sustaining. Exchanges may charge assessments or user fees. Shop Exchanges in Federally-run SHOP will become effective.
Small Business Health Options Program (SHOP)	• Beginning Nov. 15, 2014, employers will be able to apply, compare plans and enroll in a SHOP plan online. • Employees will be able to enroll in the employer plan online as well. • In some states, employers will be able to offer more than one plan to their employees—increasing their choices and letting them find a health plan that works for them. States that offer this option include: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin and Wyoming. • Minimum participation rates apply in the following states: Arkansas, Iowa, Nevada, New Hampshire, New Jersey, South Dakota, Tennessee, Texas • Health insurance agents and brokers registered with the SHOP Marketplace will have special online features that make it easier for them to apply, choose

	coverage and enroll in coverage. • Employers who offered a SHOP health plan in 2014 and want to renew it or choose a different SHOP plan in 2015 will need to utilize the online process. They will not be able to renew their SHOP coverage directly through an insurance company. • Paper shop applications are not available after Nov. 15, 2014. • Note: Most states will use the enrollment process described above, but some states that are running their own SHOP Marketplace will use a different process. It is recommended that employers check with the state first.
Out of Pocket Maximums	Plan years beginning on or after January 1, 2015. Non-grandfathered group health plans may not impose cost-sharing amounts (i.e., copays or deductibles) that are more than the maximum allowed for high-deductible health plans (currently these limits are $6,600 for an individual and $13,200 for family coverage). After 2016, these amounts will be adjusted for health insurance premium inflation. For 2015 plan years, health plans with more than one service provider may divide the out-of-pocket maximum across multiple categories of benefits, rather than reconcile claims across multiple service providers, Thus, health plans and issuers may structure a benefit design using separate out-of-pocket maximums for EHB, provided that the combined amount does not exceed the annual out-of-pocket maximum limit for that year. For example, a health plan's self-only coverage may have an out-of-pocket maximum of $5,000 for major medical coverage and $1,600 for pharmaceutical coverage, for a combined out-of-pocket maximum of $6,600.

Plan and Insurer Reporting	For coverage provided on or after January 1, 2015, reporting is required (first information returns due January 31, 2016). Sponsors of self-funded plans and health insurers must report individual coverage dates, the portion of the premium the individual must pay and more. Systems should be in place on January 1, 2015 to capture the appropriate data.

2016

Employer Play or Pay	January 1, 2016. Employers with 50 or more full-time employees (including full-time equivalents) are liable for penalty taxes if coverage is offered to fewer than 95% of full-time employees and non-spouse dependents or "unaffordable" coverage is offered and an employee receives a federal subsidy through an Exchange. For employers with 50 to 99 employees with non-calendar year plans that qualified for the delay in 2015, no Play or Pay penalties will apply to calendar months during the 2015 plan year that fall in 2016. The rules take effect for these employers when the 2016 plan year begins.
Plan and Insurer Reporting	First information returns due January 31, 2016 (for coverage provided on or after January 1, 2015).
Exchanges	All exchanges must be open to employers with up to 100 employees. Until the year 2016, States can limit the small group market to firms with 50 or fewer employees.

2017

Exchanges	Beginning in 2017, States may elect to allow large group plans (100 or more) to be sold in the Exchanges.

2018

Tax on High-Cost Plans	An excise tax of 40% will be imposed on employer-sponsored health benefits that exceed the value of $10,200 times the "health cost adjustment percentage" for self-only coverage and $27,500 times the "health cost adjustment percentage."

Unknown Effective Dates

Automatic Enrollment	IRS Notice 2012-17 states that guidance on automatic enrollment will not be ready to take effect by 2014. The compliance date will be addressed in future guidance.
Nondiscrimination Rules for Insured Plans	Effective date depends on future guidance.
Quality Care Reporting	Effective date depends on future guidance.