

Health Care Reform – Compliance Timeline/Checklist For Employers

(As updated through October, 2013)

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”) <ul style="list-style-type: none"> \$2 million minimum for plan years beginning on or after 9/23/12¹ 	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* <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Exclusion may be applied to <u>adults</u> 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	
Nondiscrimination rules for insured health plans*	First plan year beginning on or after 9/23/2010 (but postponed <u>indefinitely</u> 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 (<i>for calendar year plans, first fee due 7/31/2013</i>)	
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	10/1/2013	
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 for all GHPs limited to high deductible health plan maximums, while only small insured GHPs are subject to specified deductible limits ^{*13}	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](#)

Affordable Care Act Requirement	Effective Date	Status/Comments
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	
Waiting period limitation ¹⁷ <ul style="list-style-type: none"> • 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/penalties (employer “shared responsibility” coverage mandate) ¹⁹ <ul style="list-style-type: none"> • Penalty for failing to offer coverage to substantially all “full-time” employees and (beginning in 2015) their dependents²⁰ • Alternative penalty for failure to provide coverage to “full-time” employees that is “affordable” and provides “minimum value”²¹ (applies only if not subject to failure to offer coverage penalty) 	<i>Now 1/1/2015 [was originally 1/1/2014]</i>	
Excise tax (individual coverage mandate) ²²	1/1/2014	
Health insurance exchange coverage available ²³	1/1/2014	
Transitional Reinsurance Program contribution ²⁴ <ul style="list-style-type: none"> • First contribution due 2015, with initial reporting at 2014 year-end 	1/1/2014	

¹³ [See Appendix B.4](#)

¹⁴ [See Appendix B.3](#)

¹⁵ [See Appendix B.9](#)

¹⁶ [See Appendix B.8](#)

¹⁷ [See Appendix B.6](#)

¹⁸ [See Appendix B.7](#)

¹⁹ [See Appendix B.11](#)

²⁰ [See Appendix B.11.a](#)

²¹ [See Appendix B.11.c](#)

²² [See Appendix B.12](#)

²³ [See Appendix B.10](#)

²⁴ [See Appendix B.13](#)

²⁵ [See Appendix C.1 & C.2](#)

Affordable Care Act Requirement	Effective Date	Status/Comments
Post-2014		
IRS annual reporting requirements ²⁵	<i>Now first returns due in 2016 (for 2015) [Was originally to apply for 2014, with the initial filings due in 2015]</i>	
HHS annual reporting requirements* ²⁶	Generally effective 1/1/2014 (but reporting to begin no earlier than 2015)	
Auto enrollment ²⁷	To be determined (under DOL regs)	
Excise tax (employer-sponsored high cost health coverage) ²⁸	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.

²⁶ See Appendix C.3

²⁷ See Appendix C.4

²⁸ See Appendix C.5

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 immunodeficiency 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 January 1, 2014.)

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.
- For SBCs for 2014, the SBC must state whether the plan/coverage (1) provides “minimum essential coverage” for purposes of meeting the individual coverage mandate (see B.12 below) and (2) meets the “minimum value” requirements (see B.11 below)

[\(See July 17, 2012 Hunton Employment & Labor Perspectives \(HELP\) Blog and FAQs About ACA Implementation \(Part XIV\) 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 on [IRS Form 720](#). (See [Form 720 Instructions](#).)

[\(See July 10, 2012 HELP Blog for additional details.\)](#)

5. **Form W-2 Reporting Requirement** (effective January 1, 2012 for W-2s to be issued in 2013)

- In general, aggregate value of employer-provided health coverage must be reported annually on the Form W-2 for each covered person.

[\(See August 6, 2012 HELP BLOG for additional details.\)](#)

6. **Healthcare Flexible Spending Account \$2,500 Contribution Limit** (effective for FSA plan years beginning on or after January 1, 2013)

- Limit applies only to employee elective contributions, and not employer matching or other non-elective contributions to an FSA.
- Cafeteria/flexible benefits plan must be amended to include the new contribution limit by 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 October 1, 2013)

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

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)*

- All non-grandfathered GHPs must limit participant cost sharing expenses to the annual out-of-pocket limits for high deductible health plans. However, only small non-grandfathered insured GHPs must comply with the applicable deductible limits (\$2,000 for individual coverage; \$4,000 for family coverage).
[\(See FAQs About ACA Implementation \(Part XII\) \(Q&As 1 & 2\) for additional details .\)](#)

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 finalized regulations provide that all plans (and not just non-grandfathered plans) that offer “health-contingent” wellness incentives may provide a reward of up to 30% (up from 20%) of the cost of health coverage (50% for tobacco cessation programs) for such incentives.

- The final regulations also:

- Clarify that the incentive may be based on the total cost of the applicable coverage (and not just the employer-paid piece). If only employees may participate in the health-contingent wellness program, the reward must be based on the total cost of employee-only coverage. If, however, dependents may also participate in the program, the reward may be based on the total cost of coverage in which an employee and any dependents are enrolled.

- Provide that to satisfy the “reasonable alternative” standard, the employer is required to make available and pay the cost of the alternative, e.g., membership fees for a diet program (but not the cost of the food), and the time commitment for the alternative must be reasonable.

- Distinguish between two types of health-contingent wellness programs: (i) “activity-only” (not based on attaining a specific health outcome); and (ii) “outcome-based” (based on satisfying a measurement, screening or test, such as having a specified BMI or cholesterol level).

- Provide that the “reasonable alternative standard” requirement applies to both activity-only and outcome-based programs, as follows: (i) activity-only programs must provide the reasonable alternative standard for any individual with a medical condition that prevents them from meeting the initial standard, and (ii) outcome-based programs must provide the reasonable alternative standard for all individuals who do not meet the initial standard, regardless of their medical condition.

8. Provider Discrimination *(effective first plan year beginning on or after January 1, 2014)*

- Non-grandfathered plans may not discriminate against health care providers due to the provider’s unwillingness to provide, pay for, cover, or refer for abortions.

9. Clinical Trial Participation *(effective first plan year beginning on or after January 1, 2014)*

- Non-grandfathered plans may not restrict (or engage in any discriminatory practices regarding) participation in federally-funded clinical trials, FDA-studies, or other exempt drug studies.

10. Health Insurance Exchange *(effective January 1, 2014)*

- Health insurance exchange coverage becomes available.

11. Employer “Shared Responsibility” Coverage Mandate/Excise Tax *(originally effective January 1, 2014, but implementation has been delayed to 2015)*

a. Penalty for failure to offer coverage

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

NOTE: 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.

b. Determining “full-time” status

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

(On-going employees)

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

NOTE: 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 outside of the U.S., however, need not be counted.

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

measurement period or stability period).

- Employees with coverage due to working full-time during the prior measurement period must remain covered during the administrative period.

NOTE: 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 “new” employee only if the period of non-employment has been at least 26 consecutive weeks (or, where the period of non-employment is at least 4 weeks but less than 26, it exceeds the employee’s period of employment).

(New employees)

- For new variable hour and seasonal employees employers may use an initial measurement period and administrative period that lasts up to 13 months after the hire date for purposes of determining full-time status. The measurement period may be 3-12 months, but the stability period must be the same as such period for on-going employees.
- Variable hour employees are those for whom it cannot reasonably be determined, as of their hire date whether they will average 30 hours per week over the initial measurement period.
- Seasonal employees generally are those who perform services on a seasonal basis.

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).

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

[\(See November 19, 2012 HELP Blog for additional details on determining full-time status.\)](#)

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

- Applicable large employers who offer coverage to substantially all 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,” and (ii) establish that where a plan offers more than one option, the lowest cost option is to be used. The safe harbors are (1) W-2 (Box 1) compensation; (2) monthly rate of pay, or (3) Federal poverty level for single individuals. Health reimbursement account (HRA) contribution credits can only be taken into account in determining affordability if the credits can be used to pay premiums. For wellness program premium reductions, the full premium cost must be used, except in the case of premium reductions related to tobacco use, in which case, the non-smoker premium may be used.

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

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

- Individuals who do not enroll in minimum essential coverage must, beginning in 2014, pay an excise tax equal to the greater of (a) 1% of household income that exceeds certain threshold amounts and (b) \$95 per uninsured adult in the household. This will increase to the greater of \$325 per uninsured adult or 2 percent of household income in 2015 and \$695 per uninsured adult or 2.5% of household income in 2016.

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 contributions to HHS to help stabilize premiums in the individual market from 2014 through 2016.

- HHS will determine a national contribution rate (which HHS has 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 numbered 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 tax deductible to the extent paid by the employer.

[\(See December 27, 2012 HELP Blog for additional details.\)](#)

C. Compliance Requirements for Periods Beginning after 2014

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

- Health insurance issuers and self-insured plan sponsors must file an annual return with the IRS reporting coverage information for employees and their spouses/dependents. Under proposed regulations, separate filings will be required for each employer even if it is part of a “controlled group” (or otherwise affiliated) with other covered employers.
 - For self-insured group health plans, the proposed regulations provide that the required return would (among other things) report for each month of the year involved (i) the name, address, tax identification number for each enrolling individual (participant); and (ii) the name and tax identification number of any other individual covered with the participant.
- Each participant listed on the return must also be provided a statement containing the reported information, along with the contact information for the employer.
- The first information returns (for 2015) will be due in 2016. The proposed regulations provide that the due date for the employer return will be February 28th of the following year (March 31st if filed electronically), while the required participant statement will (like the Form W-2) have to be issued by the following January 31st.

2. Annual Information Return Requirement for Employers Subject to Employer Contribution Mandate (Delayed to 2015, with first filing due in 2016)

- The IRS has issued proposed regulations that currently provide that each employer subject to the “Employer Contribution Mandate” will also be required to file a separate annual with the IRS reporting (among other things) the following:

(i) the employer's "full-time" employees and their eligibility for health coverage for each month of the year involved; (ii) the lowest employee premium for each such employee for single coverage that provides minimum value (see Item B.11.c above), and (iii) a certification that "minimum essential coverage" (basically, group health plan coverage) has been offered to these employees and their dependents.

- In addition, the proposed regulations indicate that additional information will be required concerning (i) applicable waiting periods, (ii) whether spousal coverage is available and (iii) whether the offered coverage is "affordable" (see Item B.11.c above).

- Each full-time employee listed on the return must also be provided the reported information pertaining that individual, along with the contact information for the employer.
- The first information returns (for 2015) will be due in 2016. The proposed regulations provide that the due date for this employer return will be February 28th of the following year (March 31st if filed electronically), while the required participant statement is to be issued by January 31st.

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

- Non-grandfathered plans must file an annual report with HHS that discloses various information concerning the cost and quality of health care provided (for example, whether the coverage improves health outcomes, reduces hospital admissions, improves patient safety, and generally promotes health and wellness); HHS has not issued guidance concerning this reporting requirement, but no reporting likely to be required until after 2014.
- Non-grandfathered plans must also file a separate annual report with HHS and the applicable state insurance commissioner that discloses cost-sharing and claims data (for example, the number of claims denied, rating practices, enrollment/disenrollment data, and information on payments for out-of-network services); HHS has issued guidance that this reporting requirement will not go into effect until at least 2015.

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

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

5. 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), including executive physical programs and on-site health clinics (unless the clinic only offers a "de minimis" amount of health care). In addition, the value of HRA coverage, pre-tax FSA contributions and employer HSA/MSA contributions will be counted. However, long-term care insurance, separate dental/vision benefits and fixed indemnity health and other similar coverages are excluded.

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