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Health Care Reform Overview

The Affordable Care Act (ACA) Delays & Modifications Impacting Group Health Plans

Revised: April, 2017

Effective Date	Provision	Health Care Reform Impact	Status
2010			
6 months after enactment	Medicare Part D "Donut Hole" Closure	Medicare Part D "donut hole" will be closed by providing $250 rebate to senior citizens who reach the donut hole in 2010. It will be gradually phased out until 2020.	Effective
90 days after enactment until January 1, 2014	Early Retiree Reinsurance Program	Establishes a $5 Billion Reinsurance Fund to help employers with the cost of certain early retiree medical claims. For claims incurred for retirees aged 55 through 64, 80% of annual claims between $15,000 and $90,000 are reinsured.	Funding Depleted
Within 90 days of enactment until January 1, 2014	State-Based High-Risk Pools	Creates high-risk pool coverage for those unable to obtain individual coverage due to a pre-existing condition. High-risk pool will collaborate with existing state high-risk pools; and to end when the health insurance exchanges (guaranteed issued insurance) takes effect. High Risk Pool Extended until April 31, 2014.	Modified; yet Effective
* Grandfathered Health Plan rules		Exempts existing health plans in place as of March 23, 2010, from many ACA provisions. Adding or deleting new family members and new enrollees is allowable under Grandfathering rules.	
Plan years 6 months after enactment * (Plan Years on or after Sept 23, 2010)	Preventive Care Services	Requires health plans to cover certain preventive services such as immunizations and infant preventive care and screenings without a cost to the employee. Women's Preventive Care requirements delay until August 2012.	Modified & Delayed; yet Effective
Plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Elimination of Lifetime Dollar Limits	Ban on Lifetime Dollar Limits regarding Essential Health Benefits (EHB). Health and Human Services will issue guidance to define EHB. Annual limits may be restricted (phased out) until 2014.	Modified Definitions of EHB per state; yet Effective
Definitions apply plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Essential Health Benefits (EHB)	"Good Faith Compliance" is the current standard based on 10 broad categories of EHB. States have substantial flexibility in structuring state-based insurance exchanges and selecting EHB benchmarks.	Modified, yet Effective

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Plan years 6 months after enactment * (Plan Years on or after Sept 23, 2010)	Appeals & Reviews	Health plans are required to adopt an internal claims and appeals process that guarantees receipt of benefits during the appeals process and also provides for external review.	Delayed
6 months after enactment	Federal Review of Insurance Rates	HHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases to prevent unreasonable increases and disclose such information. Ongoing Regulatory Changes, including the optional extension of substandard health plans for two additional years.	Modified
October 1, 2010	Wellness Program Grants	Small employers <100 that establish new employer-based wellness programs are eligible for grants for up to 5 years. $200 million in funding from fiscal years 2011-2015.	Delayed Indefinitely
Plan years 6 months after enactment * (Plan Years on or after Sept 23, 2010)	Emergency Out-of-Network Coverage	Coverage of emergency services at in-network level are required.	Effective
Plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Policy Rescissions & Advance Notice of Material Modifications	Prohibits rescissions (cancellation) of health plan coverage except for cases of fraud or intentional misrepresentation; coverage may not be cancelled without prior notice; rescissions are prospective only. Notice of Material Modifications to be provided with 60 days advance notice. This advance notice requirement was modified to NOT apply to renewals, effectively eliminating the requirement.	Modified
Plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Designating Primary Doctor	Allows enrollees to designate any in-network doctor as their primary care physician (including OB/GYN and pediatrician).	Effective
Plan years 6 months after enactment * (Plan Years on or after Sept 23, 2010)	IRS Code 105(h) Nondiscrimination Testing	IRS Code 105(h) self-insured plan nondiscrimination rules now also apply to insured health plans. No discrimination based on salary to the highly compensated is permissible. As of August, 2014, regulatory guidance to implement this provision is not yet issued.	Delayed Indefinitely
Plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Dependent Coverage to Age 26	Extends coverage to dependents until age 26. The federal income tax group health insurance exclusion is extended to dependents through age 26. No HSA Tax exemption for dependents. Note: As of January 1, 2014, a dependent may remain on a parent's even with access to his or her own employer-sponsored coverage, regardless of Grandfathered health plan status.	Effective

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Plan years 6 months after enactment (Plan Years on or after Sept 23, 2010)	Ban on Pre-existing Condition Exclusions	For participant enrollees who are under age 19, pre-existing conditions are prohibited; pre-existing condition exclusions are eliminated for all other individuals in 2014.	Effective
Tax Years 2010 through 2013	Small Employer Tax Credit - Phase I/ Part 1	Tax credit of up to 35% of employer's contribution toward the employee's health insurance premium, if employer contributes at least 50% of the total premium cost. The credit phases out as firm size and average wage increases. <25 employees w/ avg annual wages <$50K	Effective
Tax Years 2010 through 2013	Small Business Tax Credit - Phase I/ Part 2	Full premium credit will be available to very small employers. Credit phases-out as firm size and average wage increases. <10 employees w/ avg annual wages <$25K	Effective
Tax Years 2010 through 2013	Small Business Tax Credit - Phase I/ Part 3	Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. Tax-exempt employers <25 employees w/ avg annual wages <$50K	Effective
Upon Enactment (2010)	10% Tax on Indoor Tanning Services	Tax on Indoor Tanning Services	Effective
2011			
January 1, 2011	Over-Counter Prescription Drugs	Reimbursements under employer-sponsored health plans, HRAs, FSAs and HSAs cannot provide non-taxable reimbursements of over-the-counter medications unless prescribed by doctor. Prescribed drugs, insulin and medical "supplies" will still qualify for nontaxable reimbursements from those accounts.	Effective
January 1, 2011	Minimum Loss Ratios (MLR)	The National Association of Insurance Commissioners (NAIC) is required to establish the Minimum Loss Ratios (MLR) and how rebates are calculated. Carrier rebates apply in the 2011 plan year. MLR: 85% for large group plans; 80% for individual and small group plans (fewer than 100).	Effective
January 1, 2011	SHOP: Small Business Health Plan Options Program	Small employers are to be able purchase coverage in the SHOP exchange. Delayed for one year as SHOP programs are limited to one plan option. Ongoing regulatory changes, including the optional extension of substandard health plans for two additional years.	Delayed One Year

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January 1, 2011	HSA Penalty Increase	Increases the additional tax for nonmedical HSA distributions to 20% (currently 10% for HSAs and 15% for MSAs).	Effective
January 1, 2011	New Fee on RX Companies	$2.5 B Fee on Pharmaceutical Companies	Effective
2012			
September 23, 2012	"Mini" Summary of Benefits (SPD) 4 Page Uniform Summary of Benefits and Coverage (SBC) As of 04.01.17 Shortened to 2 ½ Pages.	In addition to Summary Plan Description (SPD), group and individual health insurers must provide and an SBC to all applicants and enrollees (prior to the time of enrollment or re-enrollment) or at the time of issuance. No more than 4 pages (double spaced). • If self-insured plans, the SBC is provided by plan administrator (employer responsibility). • If fully-insured plans, the SBC is provided by insurance carrier. • Revised SBC Template: Effective plan years on/after 01.01.14 • Revised again, effective as of plan years on or after 04.01.17 Highlighted Changes to SBC: • Template shortened from 4 pages to 2 ½ pages • Adds new example template to illustrate coverage • Revised definitions within the uniform glossary • Provides updated instructions	Effective
January 1, 2012	Form W-2 Reporting for Taxable Years after Dec. 31, 2011	Aggregate cost of employer provided group health coverage (COBRA rules) excluding contributions to MSA, HSA, and FSA's. If fewer than 250 Form W-2 filings in prior year, the effective date is delayed indefinitely.	Delayed Indefinitely if Fewer than 250 Form W-2s
Plan year on or after September 30, 2012 and before October 1, 2019	Patient Centered Outcome Research Institute Fee (PCORI Fee)	Imposition of a new premium tax of $1 per covered life in 2012, $2 per covered life in 2013, $2.08 per covered life 2014. Fee is adjusted for inflation per covered beneficiary to fund comparative research initiatives. Payment & Reporting: $1 for plan years ending Sept. 30, 2012 and before Oct. 1, 2013: Paid by July 31, 2013 $2 for plan years ending Sept. 30, 2014 and before Oct. 1, 2014: Paid by July 31, 2014 $2.08 for plan years ending Sept. 30, 2014 and before Oct. 1, 2015: Paid by July 31, 2015 Reported on IRS Form 720 (Quarterly Federal Excise Tax Return)	Effective
January 1, 2012	CLASS Act - Long Term Care	Employee-funded long-term care benefit known as the "Community Living Assistance Services and Supports Act" (CLASS Act). 5-year vesting period, cash benefits of $50/day; estimated monthly premium of $120-$250.	Repealed

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January 1, 2012	Form 1099 Reporting for Goods / Services	Form 1099 Reporting for goods/services > $600	Repealed
Plan Years on or after August 1, 2012	Women's Preventive Care Non-Grandfathered Plans	Women's Preventive Care without cost sharing is subject to Subject to Revisions through the U.S. Preventive Care Task Force Guidelines, and will be updated overtime, as needed. No Cost Sharing for all other categories of Preventive Care Categories was effective as of plan years on or after 09.23.10 for Non-Grandfathered Plans.	Modified
2013			
January 1, 2013	Flexible Spending Account (FSA) Limit	Maximum health flexible spending account is capped at $2,500 per year and increased annually by the cost of living adjustment.	Effective
January 1, 2013	Taxation of Medicare D Subsidy	Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.	Effective
January 1, 2013	Medicare Part A Tax on High Income Individuals	Increases Medicare Part A (hospital insurance) payroll tax rate on wages by 0.9% on earnings over $200,000 for individuals and $250,000 for married couples filing jointly (from 1.45% to 2.35%).	Effective
October 1, 2013	Exchange (Marketplace) Notice to Employees	Requires Notice of a New Online Insurance Exchange (Marketplace. Must be Provided to All New Hires within 14 Days of Hire • Two Model Notices Issued: 1) If Coverage is Offered 2) If Coverage is not Offered	Delayed from March 2013
2014			
January 1, 2014	Wellness Program Incentives	Wellness programs to improve HIPAA wellness program rules by increasing the value of workplace wellness incentives to 30% of premiums (previously 20%); which may increase to 50% in 2014. A reward may be a discount or rebate of a premium or contribution, or a waiver of all deductibles, copayments, or coinsurance.	Effective
January 1, 2014	Individual Health Insurance Coverage Responsibility	Mandates coverage for individuals or imposes individual tax the higher of $95 or 1% of income in 2014; $325 or 2% of income in 2015 and $695 or 2.5% of income in 2016 (then indexed by COL). Exemptions: financial hardships, religious objections, inmates, incomes below income tax threshold.	Effective

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Plan Year on or after January 1, 2014 or January 1, 2015 (Partially Delayed)	Maximum Out-of-Pocket (OOP)	Applies to Non-Grandfathered (GF) Health Plans. OOP Limits for High Deductible Health Plans (medical, RX, mental health, etc.) $6,600 (individual) $13,200 (families) in 2015. • If the Same Plan uses Multiple Claim Payers, the OOP Limit is delayed until January 1, 2015 (requires the coordination of payers for Medical plans & RX plans). If not, the OOP limit is Effective as of the Plan Year on or after January 1, 2014. • Plan Designs & Cost Sharing Changes May be Necessary	Partially Delayed
Effective Date Unknown (Repealed, as of December 2015)	Automatic Enrollment	Employers with more than 200 employees are required to automatically enroll employees into health insurance plans offered by the employer. As of August, 2014, regulatory guidance to implement this provision is not yet issued.	Repealed
January 1, 2014	Coverage Waiting Period	Waiting periods in excess of 90 days are prohibited.	Modified
January 1, 2014 or Plan Year on or after January 1, 2014	Ban of Pre-existing Conditions Exclusions	No pre-existing conditions apply, creating guaranteed issue and guaranteed renewal policies.	Effective
January 1, 2014 or Plan Year on or after January 1, 2014	Dependents Covered to Age 26	Plans must now allow all dependents up to age 26 to be covered, including those who have another source of employer-sponsored health insurance. Plans must also cover married dependents, but not dependents' spouse. Plans are not required to cover grandchildren. As of a modification in February 2013, coverage is NOT required for foster children or step children.	Modified
January 1, 2014	COBRA Notice Incorporating Exchange Information	COBRA Notices must include New 2014 Options for COBRA Coverage Continuants. Plan document changes may be necessary.	Modified with a One-Time Special Enrollment for Current COBRA Beneficiaries
January 1, 2014 or Plan Year on or after January 1, 2014	Annual Dollar Limits on Essential Health Benefits	Group health plans and insurance carriers may not impose annual dollar limits on Essential Health Benefits. Annual Dollar Limit Restrictions apply until phased out entirely in 2014. Lifetime Dollar Limits were prohibited in 2014. • On or after 09.23.10, but prior to 09.23.11, the annual dollar limit per individual on Essential Health Benefits (EHB): $750,000; on or after 09/23/11, but prior to 09.23.12: $1.25 M; on or after 09.23.12, but prior to 01.01.14: $2 M. • Essential Health Benefits: "Good Faith Compliance" is the current standard based on 10 broad categories of EHB. States have substantial flexibility in structuring state-based insurance exchanges and selecting EHB benchmarks.	Modified Definition of Essential Health Benefits

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January 1, 2014	Transitional Reinsurance Fee	Fee is intended to fund adverse selection in the Exchanges • Carrier/TPA to Administer Fee • $63 Per Covered Life in 2014; Projected to be $44 Per Covered Life in 2015. • Effective for 3 years.	Effective
January 1, 2014	Small Employer Tax Credit - Phase II/ Part 1	<25 employees w/ avg annual wages <$50K For tax years 2014-2016 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years.	Effective
January 1, 2014	Small Employer Tax Credit - Phase II/ Part 2	<10 employees w/ annual avg wages <$25K The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000.	Effective
January 1, 2014	Small Employer Tax Credit - Phase II/ Part 3	Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium. Tax-exempt employers <25 employees w/ avg annual wages of less than $50K	Effective
January 1, 2014	New Industry Fees (Varying Implementation Dates)	• In 2014: $8 B Insurer Fee; $3 B Pharmaceutical Fee; $2.7 B Medical Device Manufacture Fee	Effective

Effective Date	Provision	Health Care Reform Impact	Status
Self-funded Plans ONLY November 5, 2014 or November 5, 2015 (Depending on Self-funded Plan Size) November 7, 2016 Required in HIPAA standard transactions	Health Plan Identifier Number (HPID)	• Effective Dates: 11.5.14 – 11.07.16. • Employers sponsoring self-funded health plans are required to apply for a Health Plan Identifier Number (HPID) from CMS. • Attaining an HPID is required by November 5, 2014, for "large" self-funded health plans and by November 5, 2015, for small self-funded plans. Plans with health benefits receipts more than $5 M (benefits for a self-funded plan) are considered "large" health plans. • Employers sponsoring self-funded health plans will also be required to receive certification from certain vendors of compliance with HIPAA's electronic transaction rules. Self-funded plans will file certifications by 12.31.15. Etc. • For fully-insured health plans, the health insurance company, not the employer/plan sponsor, is responsible for compliance with these new requirements. Employers with fully-insured plans do NOT need to obtain an HPID. Insurers will apply for the HPID for a fully-insured health plan. o November 5, 2014: Large self-funded plans obtain the Health Plan Identifier (HPID). Plans with health benefits receipts more than $5 M are considered "large" health plans. o November 5, 2015: Small self-funded plans obtain their HPID. Plans with health benefits receipts of $5 M or less are considered "small" health plans. o December 31, 2015: All self-funded plans must certify to CMS that HIPAA standard transactions are in compliance with HIPAA rules. o November 7, 2016: HPIDs required in standard HIPAA transactions for health plans	Indefinitely Delay
January 1, 2014 Plan Amendment Options For Employer Consideration Formally Adopted on or before the first day of the first plan year.	Section 125 Cafeteria Plan Modification	Two optional Section 125 Cafeteria Plan modifications for employers to consider following the new coverage option availability within Health Insurance Exchanges. 1.) Revocation due to a reduction in hours 2.) Revocation due to enrollment in a qualified Health Plan (QHP). Providing these new cafeteria plan revocation is optional; however, plan documents must be amended as of the last day of the plan year in which the election changes are allowed; these changes are permitted in the 2014 plan year as long as the amendment is made by the end of the 2015 plan year. NOTE: If employing a substantial number of part-time or variable hour employees, these options will assist with employee and family coverage options. Cafeteria plan elections for stand-alone dental / vision plans or critical illness plans (excepted benefits under HIPAA) are excluded. These new rules also do not apply to Flexible Spending Accounts (FSA) elections.	Effective
2015			

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January 1, 2015	Flexible Spending Account (FSA) Limit	Maximum health flexible spending account is capped at $2,550 per year and increased annually by the cost of living adjustment.	Effective
January 1, 2015 or January 1, 2016 (Depending on the Number of Employees)	Employer Requirement to Offer Qualified, Affordable Coverage to Substantially All Full-Time Employees	Employers with 100 or more employees that do not offer coverage and have at least one full-time equivalent employee who receives a premium tax credit (subsidy) must pay a fee of $2,050 per full-time employee, excluding the first 80 employees. The penalty is the lesser of $3,100 for each employee receiving a premium credit or $2,050 times each full-time employee, as of January 1, 2015. Part-time employees are included and calculated as full-time equivalents, but employers are not required to offer coverage to part-time employees. Full-time employees are defined as working a monthly average of 30 hours per week. Delayed Until January 1, 2016: Employers with 50 or more that do not offer coverage and have at least one full-time equivalent employee who receives a premium tax credit (subsidy), must pay a fee of $2,000 (adjusted) per full-time employee, excluding the first 30 employees. The penalty is the lesser of $3,000 (adjusted) for each employee receiving a premium credit or $2,000 (adjusted) times each full-time employee, as of January 1, 2016. Part-time employees are included and calculated as full-time equivalents, but employers are not required to offer coverage to part-time employees. Full-time employees are defined as working a monthly average of 30 hours per week	Delayed from January 1, 2014 AND Modified
January 1, 2015	Employer "Shared Responsibility" Requirement to Offer Qualified, Affordable Coverage to Substantially All Full-Time Employees	The employer coverage mandate penalty and reporting, collectively known as the employer "shared responsibility" requirements, results in a "play or pay" decision for large employers. As of plan years on or after January 1, 2015, employers with the equivalent of 100 or more full-time employees (determined on a common controlled group basis and accounting for full-time equivalent employees) are large employers and will be subject to an excise tax if coverage is not offered to substantially all full-time employees (and their dependents as defined under the ACA); OR if the offered coverage does not meet certain affordability and minimum value requirements AND at least one full-time employee is certified by the insurance exchange as having received a premium tax credit (subsidy) to purchase subsidized coverage from the exchange.	Delayed from January 1, 2014 AND Modified

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January 1, 2015 or January 1, 2016 (Depending on the Number of Employees)	Definition of a "Large" Employer under the ACA	The definition of large employer varies by the revised employer shared responsibility effective dates, as of regulatory modifications issued on February 10, 2014. • For plan years on or after January 1, 2015, large employers are those with 100 or more full-time employees (accounting for full-time equivalent employees) • For plan years on or after January 1, 2016, large employers are those with 50 or more full-time employees (accounting for full-time equivalent employees). The employer shared responsibility requirements are delayed until 2016 for companies with 50-99 full-time employees, as of 02.10.14.	Delayed from January 1, 2014 AND Modified
January 1, 2015	Definition of a "Substantially All" Full-Time Employees under Employer Coverage Requirements	"Substantially all" is redefined as 70%, rather than 95% of full-time employees, in 2015. As a result, large employers must offer coverage to 70%, of full-time employees, to avoid penalty exposure in 2015 (as of the regulations issued on 02.10.14). This revised definition only applies for one year (2015). Employers with 50 or more full-time employees will need to offer qualified coverage to substantially all full-time employees, defined as 95% of full-time employees, in 2016. Full-time is defined as working, 30 hours/week or 130 hours/month, on average, under the ACA.	Modified
January 1, 2015	Definition of a Dependent / Spouse under Employer Coverage Requirement	The definition of dependent under the ACA continues to exclude spouses. The definition of dependent covers children to age 26. The definition has been revised to exclude stepchildren and foster children, as of 02.10.14	Modified
January 1, 2014	Minimum Essential Coverage (MEC)	Minimum Essential Coverage (MEC) applies to the ACA individual health coverage requirement. Medical coverage provided to current employees through a Group Health Plan is Minimum Essential Coverage. MEC: Employer-Sponsored Plan Coverage; Qualified Individual Market Coverage; Grandfathered Health Plan Coverage; Government Sponsored Programs (Medicare, Medicaid, CHIP & TRICARE) 10 Categories of EHBs: Ambulatory Patient Services Outpatient Care, Emergency Services including Trips to the Emergency Room ,Mental Health Services and Addiction Treatment, Hospitalization for Inpatient Care ,Maternity and Newborn Care, Prescription Drugs ,Rehabilitative Services and Devices Laboratory Services ,Preventative Services , Wellness Services and Chronic Disease Treatment ,Pediatric Services	Modified

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January 1, 2014	Community Rating Requirements	All individual health insurance policies and all fully insured group policies < 100 lives (and larger groups purchasing coverage through the exchanges) must abide by strict modified community rating standards with premium variations (age 3 to 1; tobacco use 1.5 to 1), family composition and geographic regions. Individual policies and fully-insured <100 employees in 2016. This ACA provision was modified from <100 to <50 with state-by-state variations.	Modified
January 1, 2014	Essential Benefit Plan (Minimum Essential Coverage Plans)	Create an Essential Health Benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits. A catastrophic-only plan was initially to be available for those 30 and younger, yet following ACA modifications, substandard plans are extended for an additional 2 years.	Modified
January 1, 2014	Health Insurance Exchange (Marketplace) Created	Requires each state to create an Exchange to sell qualified benefit plans to individuals. Only 17 states created state-based exchanges, and the remaining states are in partnership with the Federal exchange or accessing the Federal exchange, as of August 2014.	Modified
January 1, 2014	Subsidies for Lower Income Individuals	Creates premium assistance (premium tax credits as federal subsidies) for non-Medicaid eligible individuals with incomes up to 400% of federal poverty level (FPL) to buy coverage through the Exchange.	Effective
January 1 , 2014	Free Choice Vouchers	Program to provide premium assistance if coverage remains unaffordable based on the ACA statute, but still a financial hardship for Americans to purchase qualified health insurance coverage within the Exchange.	Repealed

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January 1 , 2015	Employer & Insurer Reporting Requirements	New employer and insurer reporting requirements begin for employers in the 2015 calendar year to assist with enforcement of both individual and employer coverage requirements of the ACA. Initial filings are due in 2016 for the 2015 calendar year to implement two newly issued sections of the IRS Code: Section 6055 and Section 6056. • Employers of all sizes, including those with fewer than 50 full-time employees that offer Minimum Essential Coverage (MEC), are subject to a portion of these new reporting requirements. • Employers with 50-99 Full-Time Employees are required to collect necessary data in advance of the reporting requirements, even though not subject to the ACA employer Shared Responsibility requirements (employer coverage mandate and penalty exposure) until the plan year on or after January 1, 2016. • Employers will file these returns using a single form. The structure will be similar to form W-2 reporting; however, a separate informational statement than the form W-2. o Fully Insured Plans: Returns Filed by the Carrier and the Employer o Self-Funded Plans: Returns Filed by the Employer	Modified
December 5, 2015	Certification of Compliance with HIPAA Transaction Rules	• Effective 12.5.15. All plan sponsors of self-funded health plans are required to file a certification with HHS attesting the plan is in compliance with certain HIPAA transaction requirements by December 31, 2015. The certification process involves a specific system-testing process defined in the regulations. *Additional guidance from HHS on the certification process is anticipated.* • Employers sponsoring fully insured plans will NOT need to file a certification directly	Delayed Indefinitely
2017			
January 1, 2017	Large Groups in the Exchange	Impacts employers with >100 employees. States may choose to allow large groups (over 100) to purchase coverage through the large group SHOP exchanges	Effective
2018			

Effective Date	Provision	Health Care Reform Impact	Status
January 1, 2018	Cadillac Plan Tax	Impose a 40% excise tax on employers whose total of health insurance premiums or equivalents exceed stated threshold $10,200/annually for individual coverage and $27,500/annually for family coverage; total premium includes FSA, HRA and employer contributions to HSA; excludes dental and vision, accident, disability, long-term care, after-tax indemnity and specified disease coverage.	Delayed until 2020

PLEASE NOTE:

The IRS, HHS, CMS and DOL issue guidance to align with effective dates regarding several provisions following enactment. This legislation contains taxes on individuals, employers, insurance companies and healthcare providers, all of which may or may not be indicated here. The impact of these taxes has yet to be fully quantified.

For further guidance and updates, please contact:

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