TIMELINE FOR NEAR-TERM ACA COMPLIANCE ACTIVITIES

ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
FOR THE REMAINDER OF 2012		
MEDICAL LOSS RATIO ("MLR") REBATES AND NOTICES	Generally effective for plan or policy years beginning on or after September 23, 2010, see column at right for details	Pursuant to Public Health Service Act ("PHSA") section 2718, issuers are required to provide rebates to policyholders of insured group plans to the extent that they fail to deliver "value for premium payments." The first round of rebates is scheduled to be paid by issuers to plans or plan sponsors (depending on the identity of the policyholder) by this upcoming August 1st. The Department of Labor ("DOL") has made clear that the rebates may constitute plan assets for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA") in certain circumstances. In addition to having to determine the extent to which any rebates received may qualify as ERISA plan assets, and how to use such rebates (which may implicate ERISA fiduciary duties to the extent such rebates constitute ERISA plan assets), employers should be aware that the issuer of the applicable coverage is required by regulation to send a notice to each plan participant, i.e., employee, enrolled in the coverage, noticing that a rebate was paid to the employer or plan policyholder. Accordingly, employers should give consideration to how they plan to address employee inquiries regarding the use of any rebates. In connection therewith, it may be beneficial for employers to confer with the issuer to coordinate any communication efforts.
SUMMARY OF BENEFITS AND COVERAGE ("SBC")	For group health plan coverage, effective as of the first day of the plan year beginning on or after September 23, 2012 (or, in the case of a plan with open enrollment, the first day of the first open enrollment period beginning on or after September 23, 2012); for issuer disclosures to plans and with respect to individual coverage, effective September 23, 2012	Issuers and plan sponsors of individual and group coverage (whether insured or self-funded) must provide an SBC to enrollees (including participant employees and enrolled beneficiaries). The SBC is intended to be a 4-page, double-sided summary of the material plan terms, in accordance with rigorous form and content requirements as required by regulations. Given that most employers will need to provide an SBC to eligible and enrolled individuals in connection with their Fall 2012 open enrollment, employers should take steps to ensure the preparation and delivery of a timely SBC. The regulators have provided a good faith non-enforcement safe harbor for the first year of compliance with this new rule. This safe harbor is not a "free pass" and employers must undertake good faith efforts to prepare and deliver the SBC. With respect to delivery of the SBC, the agencies recently provided a special e-delivery safe harbor rule, which is separate and apart from the standard ERISA e-delivery rule. This special e-delivery rule permits employers to deliver an SBC "in connection with" online enrollment (even where an individual would not be eligible for e-delivery under ERISA's existing safe harbor).

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
SUMMARY OF BENEFITS AND COVERAGE ("SBC") (CONT'D)		Given that issuers and plan sponsors face joint and several liability for the delivery of an SBC with respect to insured group coverage, employers and issuers should consider working together in advance of Fall 2012 enrollment to ensure successful delivery of SBCs, non-duplication of efforts, and that the appropriate party(ies) have the necessary information to carry out any delivery duties. Many questions remain regarding the application and operation of the new SBC requirements.
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEE	Effective for plan or policy years ending on or after October 1, 2012 (i.e., for calendar year plan or policy years beginning on or after January 1, 2012); the fee will not be assessed for plan or policy years ending after September 30, 2018	The ACA establishes the Patient-Centered Outcomes Research Institute ("PCORI"), which will assist, through research, patients, clinicians, purchasers, and policymakers in making informed decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. PCORI will be funded by the Patient-Centered Outcomes Research Trust Fund ("Fund"). The Fund will be funded via a per capita fee on health insurers and sponsors of self-insured group health plans ("PCORI Fee") ($1 for plan/policy years ending before October 1, 2013, $2 thereafter). Full payment of the PCORI Fee is due annually by July 31 of the following plan or policy year. • *Insured Coverage:* The fee generally does not apply to HIPAA-excepted plans, certain expatriate plans, stop-loss or indemnity reinsurance. The insurer is responsible for calculating and paying the fee. • *Self-Insured Plans*: The fee generally does not apply to HIPAA-excepted coverage, or to EAPs, disease management programs or wellness plans if no "significant" medical benefits are provided. The plan sponsor is responsible for calculating and paying the fee. Currently, only for purposes of self-funded plans, employers can aggregate plans that share the same plan year to avoid having to count participants more than once. No similar rule applies to insured plans. Thus, the potential for double-counting individuals for purposes of the PCORI Fee may arise with respect to insured plans. For sponsors of insured coverage, it should be expected that some issuers may seek to pass on the cost of the PCORI Fee in the form of increased premiums. Significantly, the PCORI Fee does not count against an issuer for purposes of the MLR calculations (but would presumably be counted for purposes of rate review).

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
FORM W-2 REPORTING OF GROUP HEALTH PLAN COVERAGE	Originally effective for the 2011 taxable year; however, pursuant to IRS guidance, the reporting requirement was made optional for 2011, but mandatory for the 2012 taxable year	The new reporting requirement generally will be required with respect to 2012 Forms W-2, i.e., those issued in January of 2013, regarding certain 2012 group health plan coverage. Please note that there is a special small employer exception, which excepts employers that issue fewer than 250 Forms W-2 with respect to a given year (applied on a non-controlled group basis). Additionally, there is no requirement to issue a Form W-2 solely to comply with the new reporting requirement. The reporting requirement is for informational purposes only and does not result in any increased tax liability to the recipient of the Form W-2. Generally, most group health plan coverage that is subject to COBRA continuation requirements will be reportable, regardless of whether it is paid on a pre- or post-tax basis, and regardless of whether it applies to a nonspouse or nondependent beneficiary. By statute and regulation, certain coverages may be excepted. Additionally, IRS guidance provides for certain de minimis rules that may be helpful for employers in avoiding having to report coverages such as on-site medical, wellness programs, and employee assistance programs ("EAPs"). Due care should be taken to properly identify subject and excused coverage.
PLANNING FOR 2013 COVERAGE (*e.g.*, as part of Fall 2012 open enrollment)	N/A	As discussed below, the Act imposes a host of requirements with respect to group coverage offered by employers in 2013. Accordingly, employers should be mindful of these changes to ensure that their coverage options for 2013 are fully in accordance with the Act's requirements.
FOR 2013		
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEE	See above. With respect to calendar year plan or policy years, effective January 1, 2012; not assessed for plan or policy years ending after September 30, 2018	See above. For calendar year plan or policy years, the PCORI Fee will become effective for plan or policy years beginning on or after January 1, 2012. With respect to the 2012 calendar year plan or policy year, payment will be due by July 31, 2013.
HEALTH FSA CONTRIBUTION LIMITATION	Effective for plan years beginning on or after January 1, 2013	Section 9005 of the ACA imposes a $2,500 limit on employee salary-reduction contributions to health flexible spending arrangements ("FSAs"). This limitation does not apply to salary-reduction contributions to dependent care FSAs or to employer "flex" credits into a health FSA (i.e., employer profit sharing or matching contributions to employee health FSAs). The IRS recently clarified that the limitation applies on a plan year basis and not on an individual tax year basis.

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
EMPLOYER NOTICE TO EMPLOYEES REGARDING EXCHANGE	Effective March 1, 2013	Employers generally must provide to their employees at the time of hire (or, with respect to current employees, not later than March 1, 2013) written notice (i) about the Exchange, (ii) that employees may be eligible for premium assistance and cost-sharing reductions if the plan's share of the cost of benefits is less than 60%, and (iii) that if the employee chooses coverage through the Exchange, the employee may lose the employer's contribution to coverage, all or part of which may be excludable from taxable income.
REDUCED PERMISSIBLE ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS	Plan or policy years beginning on or after September 23, 2010	The Act prohibited the application of any lifetime limits to "essential health benefits" beginning with plan years beginning on or after September 23, 2010, i.e., 2011 calendar year plans. The Act did, however, permit the use of certain reduced annual dollar limits for plan or policy years beginning before January 1, 2014. For 2011 calendar year plans, this dollar limit was $750,000. For 2012 calendar year plans, this limit is $1.25 million. For 2013 calendar year plans, this dollar limit is $2 million. Note: These limits do not apply to benefits that are not essential health benefits. Additionally, issuers and plan sponsors continue to be permitted to apply non-dollar limits to essential health benefits.
PLANNING FOR 2014 COVERAGE (*e.g.*, as part of Fall 2013 open enrollment)	N/A	As discussed below, the Act imposes a host of requirements with respect to coverage offered by employers in 2014. Accordingly, employers should be mindful of these changes to ensure that their coverage options for 2014 are fully in accordance with the Act's requirements.

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
FOR 2014		
IMPOSITION OF ADDITIONAL INSURANCE REFORMS	Generally effective for plan or policy years beginning on or after January 1, 2014	Many of the Act's insurance or market reforms initially became effective for plan or policy years beginning on or after September 23, 2010, i.e., 2011 calendar year plans, including the general requirements to make available age 26 dependent coverage, and to provide first-dollar preventive care, among others. A host of additional reforms take effect with respect to 2014 plan year coverage. Accordingly, employers should review their coverage offerings for 2014 to ensure that they comply with all of these requirements.
NEW NONDISCRIMINATION RULES		The Act imposes new nondiscrimination rules on non-grandfathered insured group coverage. Although these rules were technically effective with respect to plan years beginning on or after September 23, 2010, the IRS has delayed their effective date. Based on our conversations with IRS and Treasury officials, we expect these rules to be made effective for the post-2013 period and to potentially prohibit (i) discriminatory insured executive health coverage, (ii) the use of differential employer premium subsidies, and (iii) the provision of more robust minimum essential coverage to higher paid individuals.
NO PRE-EXISTING CONDITION EXCLUSIONS		Effective for plan or policy years beginning on or after September 23, 2010, the Act prohibited the use of pre-existing condition exclusions for minor age individuals. This prohibition is extended to all persons regardless of age effective for plan or policy years beginning on or after January 1, 2014.
COMPLETE PROHIBITION ON ANNUAL AND LIFETIME LIMITS		Effective for plan or policy years beginning on or after September 23, 2010, i.e., 2011 calendar year plans, the Act prohibited the application of lifetime limits to "essential health benefits." As noted above, the Act does permit the use of certain restricted annual dollar limits on "essential health benefits" for plan or policy years beginning before January 1, 2014. For 2011 calendar year plans, this dollar limit was $750,000. For 2012 calendar year plans, this limit is $1.25 million. For 2013 calendar year plans, this dollar limit will be $2 million. Beginning with the 2014 calendar year, such dollar limits are no longer permitted. Thus, beginning in 2014, no annual or lifetime dollar limits will be permitted with respect to "essential health benefits." Note: These limits do not apply to benefits that are not "essential health benefits." Additionally, non-dollar limits may continue to be applied to "essential health benefits."

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
IMPOSITION OF NEW COST-SHARING LIMITATIONS	Generally effective for plan or policy years beginning on or after January 1, 2014	The Act imposes a host of cost-sharing limitations with respect to non-grandfathered individual and small group coverage as well as possibly with respect to large group and self-funded coverage. Very generally, the Act limits (i) the maximum deductible to $2,000 in the case of a plan covering a single individual and $4,000 for any other plan, and (ii) out-of-pocket expenses to those that would apply to qualifying high-deductible health plans for purposes of Code section 223 (the provisions that govern HSA-eligible individuals), subject to annual indexing. Although these new cost-sharing limitations clearly apply to individual and small group coverage, the statute is unclear regarding the extent to which these limits also apply to large group insured and self-funded coverage. It is our understanding that the regulators are aware of this issue, and we expect future clarifying guidance. Please note that to the extent these cost-sharing limitations apply to large group and self-funded coverage, this will restrict the ability of employers to use increased cost-sharing by employee participants (such as through increased copayments and deductibles) as a means to ensure that the employer-provided coverage is affordable for purposes of Code section 4980H, i.e., the employer mandate, which could result in increased penalties for employers (see below for further discussion).
EMPLOYER SHARED RESPONSIBILITY	Generally effective for months beginning on or after January 1, 2014	Very generally, employers with 50 or more full-time employees will be subject to what is commonly referred to as "pay or play" or the "employer mandate." Pursuant to the Act's provisions, such employers will be required to make available to full-time employees (and their dependents) "minimum essential coverage" or face a penalty by reason of Code section 4980H(a). Additionally, an employer can be subject to a penalty under Code section 4980H(b) to the extent it fails to provide "affordable" coverage that provides "minimum value" to an employee with an annual modified adjusted gross income (measured across the household and with certain specific adjustments by Code) ("MAGHI") of or between 100% and 400% of the federal poverty level (i.e., an individual who is otherwise eligible for an employee premium tax credit under Code section 36B).
MINIMUM ESSENTIAL COVERAGE		An employer that seeks to satisfy its employer shared responsibility by offering qualifying coverage generally must provide "minimum essential coverage" to all full-time employees and their dependents. Although Code section 5000A, as amended by the ACA, fails to expressly reference self-funded group coverage in its definition of "minimum essential coverage," the regulators have indicated that they anticipate issuing guidance to make clear that self-funded group coverage will indeed qualify as such. Note: "Minimum essential coverage" is to be distinguished from "essential health benefits." The latter represents a category of benefits that must be included as part of any individual or small group

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
MINIMUM ESSENTIAL COVERAGE (CONT'D)	Generally effective for months beginning on or after January 1, 2014	insurance policy. There is no requirement at present mandating that self-funded or large group plans provide coverage for all essential health benefits. Significantly, however, to the extent such plans provide coverage for any given "essential health benefit," they are subject to the restrictions on the use of annual and lifetime dollar limits (see above for further discussion).
MINIMUM VALUE		As noted above, an applicable large employer can be subject to a penalty tax under the Code to the extent it fails to provide "minimum essential coverage" to all full-time employees. To the extent an employer provides such coverage, it can nonetheless be subject to a separate penalty, which is very generally equal to $3,000 per full-time employee if the "minimum essential coverage" so provided is not affordable or does not provide minimum value, but only if the employee has a MAGHI (see above) of or between 100% and 400% of the federal poverty level. No formal regulations have been issued regarding what constitutes "minimum value." However, in recent IRS Notice 2012-31, the IRS stated that it plans to issue proposed regulations that would define minimum value based on the typical self-funded plan. The Notice identified three potential approaches that could be used to determine whether a plan provides minimum value: (i) an actuarial value calculator; (ii) safe-harbor checklists; and (iii) a certification by a certified actuary. Many have wondered whether "minimum value" would be defined solely by reference to a large group or self-funded plan's benefits, i.e., to the extent a plan reimburses any given essential health benefit at a rate of 60%, it would be deemed to provide minimum value. Because of concerns that certain small employers would seek to self-fund and/or that employers would seek to provide less than comprehensive coverage via self-insurance to avoid the penalties under Code section 4980H, the regulators seem poised to adopt an external benchmark for purposes of defining "minimum value." If so, this is likely to decrease the incentive to self-fund under the ACA for employers that might not otherwise choose to do so. A host of interesting issues remain.
AFFORDABLE COVERAGE		As noted above, an applicable large employer can be subject to a penalty tax under the Code to the extent it fails to provide "minimum essential coverage" to all full-time employees. To the extent an employer provides such coverage, it can nonetheless be subject to a separate penalty, which is very generally equal to $3,000 per full-time employee if the "minimum essential coverage" so provided is not affordable or does not provide minimum value, but only if the employee has a MAGHI (see above) of or between 100% and 400% of the federal poverty level. Generally, coverage is unaffordable if the premium exceeds 9.5% of the employee's MAGHI. Thus, cost-sharing (such as copayments and deductibles) are not taken into account for purposes of this

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ACA PROVISION	EFFECTIVE DATE	COMMENTS/CONSIDERATIONS
AFFORDABLE COVERAGE (CONT'D)	Generally effective for months beginning on or after January 1, 2014	determination. Thus, employers may be able to increase such cost-sharing to make coverage affordable (rather than by merely increasing the employer subsidy or reducing coverage to the extent permissible under federal law, i.e., see minimum value requirement above). Please note, however, as discussed above, it appears likely that certain cost-sharing limits will apply to self-funded and large group coverage beginning in 2014 that would limit employer discretion in this regard.
AUTOMATIC ENROLLMENT		The Act requires employers with more than 200 full-time employees to automatically enroll such employees into group coverage (to the extent the employer sponsors group coverage). Many questions were initially raised regarding its effective date. The regulators have indicated that the provision likely will not take effect until 2014 or thereafter. Interesting questions are likely to arise for employers in terms of compliance with this new rule, including with respect to coordination with permissible waiting periods, and the administration of revocation periods and dis-enrollment (and the related tax issues associated with undoing already-paid-for pre-tax coverage).
RESTRICTIONS ON WAITING PERIODS		Employers will be limited to using waiting periods that are no longer than 90 days. Many questions remain regarding how these rules will be applied in operation, including with respect to automatic enrollment and compliance with the "pay or play" mandates.
NOTICE REQUIREMENTS		The Act imposes a host of new notice requirements on employers as plan sponsors and on issuers of group coverage. Very generally, Code section 6055 requires issuers and plan sponsors that provide "minimum essential coverage" to file an annual return with the IRS and distribute annual communications to given individuals to communicate that such individuals are covered by "minimum essential coverage." Where the group coverage is insured, joint and several liability appears to attach to the plan sponsor and issuer alike. However, recent IRS Notice 2012-32 contemplates that the issuer will be made responsible for complying with this notice requirement. Very generally, Code section 6056 applies to applicable large employers that are subject to the Act's employer shared responsibility provisions of Code section 4980H. The provision generally requires the employer to file a return with the IRS each year and to issue a statement no later than January 31st of each subsequent year to plan participants that indicates whether an employer may be liable for a "pay or play" penalty and whether an individual may be eligible for federally-subsidized coverage through a state Exchange.

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FEES AND ASSESSMENTS	See below for individual effective dates	The Act imposes a host of new fees and assessments on issuers, ASOs, and/or plan sponsors. In addition to the PCORI Fee addressed above, two new fees and assessments take effect in 2014, as discussed below.
REINSURANCE ASSESSMENT ("RA")	Applicable for plan years beginning in the three-year period beginning January 1, 2014	The RA requires all health insurance issuers and third-party administrators "on behalf of" self-insured group health plans to make contributions to support a transitional reinsurance program. The contributions will be collected on a quarterly basis beginning in January 2014. Aggregate contributions to be collected for and/or by all states (although states may collect more) are: $10 billion in 2014; $6 billion in 2015; and $4 billion in 2016. Contributions with respect to self-funded plans will be collected by HHS. An additional amount equal, on a national basis, to $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 will be collected for deposit into the general fund of the U.S. Treasury. Final regulations make clear that the RA will be assessed as a per capita fee based on all "covered enrollees." Although the RA will need to be collected and paid by a self-funded plan's third-party administrator, it appears that ultimate liability for the fee remains with the plan sponsor of the self-funded plan. For sponsors of insured coverage, it should be expected that some issuers may seek to pass on the cost of the RA in the form of increased premiums. Significantly, the RA does not count against an issuer for purposes of the MLR calculations (but would presumably be counted for purposes of rate review).
ANNUAL HEALTH INSURER FEE	Calendar years beginning on or after January 1, 2014	This new annual fee will apply to insured individual and group "health insurance" only and is borne by the issuer of such coverage. The fee is levied based on market share and is intended to generate substantial revenue to help pay for the ACA. The aggregate annual fee is $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018. After 2018, the fee is indexed to the rate of premium growth. The statute defines subject coverage by reference to what is <u>not</u> "health insurance." Accordingly, many questions remain regarding the application of this fee. For sponsors of insured coverage, it should be expected that some issuers may seek to pass on the cost of the fee in the form of increased premiums. Significantly, the fee does not count against an issuer for purposes of the MLR calculations (but would presumably be counted for rate review).

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ACA PROVISION	**EFFECTIVE DATE**	**COMMENTS/CONSIDERATIONS**
EXCHANGE IMPLEMENTATION	January 1, 2014	No later than January 1, 2014, states are required to establish health insurance Exchanges through which individuals and small businesses may purchase insurance. These Exchanges will include a Small Business Health Options Program through which a small employer (up to 100 employees, although a state may limit the number of employees to 50 until 2016) may obtain coverage and a subsidy for such coverage. (Large employers may not purchase coverage through an Exchange.) As part of its decision to "pay or play" with respect to the employer shared responsibility requirements discussed above, a small business will have to decide whether to offer health coverage through or outside of an Exchange. A small business may be eligible for a subsidy if it offers coverage through an Exchange. However, small businesses should be mindful that, pursuant to regulations, minimum participation requirements may apply to coverage obtained through an Exchange. Notably, unlike current minimum participation requirements, which generally apply with respect to a given plan, i.e., where a certain number of employees of a small business may need to participate in a plan with a given insurer, it appears that such minimum participation requirements would apply at the Exchange level (not at the issuer level). In other words, a certain number of employees with respect to a given employer would need to obtain coverage from any insurer under the Exchange in order for issuers to guarantee availability to a small business. It is not clear whether minimum participation requirements may apply to coverage obtained by a small business outside of an Exchange, although it would seem likely that such minimum participation requirements may apply (since the rationale for such requirements in the Exchange applies equally outside of the exchange, i.e., that healthy individuals could be incented to purchase individual insurance because of premium banding versus the one-size-fits-all premium that will apply for small group coverage).

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