Employee Benefits Series

ACA by Year & Company Size

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Special Note: This summary provides an overview of key provisions under federal law and is subject to change. Your company or group health plan may be exempt from certain requirements and/or subject to more stringent requirements under state law. **If you have any questions regarding your obligations, please consult with a knowledgeable employment law attorney or your state insurance department.**

Certain requirements under Health Care Reform apply on a plan year basis, meaning that the changes will take effect when a group health plan begins a new plan year. As a result, ***compliance deadlines may vary****.*

AT LEAST 2 EMPLOYEES*	
Effective as of 2014	
90-Day Limitation on Waiting Periods	Prohibits a group health plan from using a waiting period (the time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective) that exceeds 90 days
Coverage of Essential Health Benefits+	Requires non-grandfathered plans offered in the small group market (both inside and outside of Health Insurance Exchanges) to cover a core package of items and services known as "essential health benefits"
Dependent Coverage to Age 26	Requires both grandfathered and non-grandfathered group health plans that offer dependent coverage to make coverage available until a child reaches age 26, regardless of other coverage options
Elimination of Annual Limits	Prohibits annual dollar limits on coverage of "essential health benefits"
Guaranteed Availability+	Requires issuers offering non-grandfathered group plans to accept every employer that applies for coverage, with certain exceptions
Limits on Cost-Sharing+	Requires non-grandfathered group plans to ensure that out-of-pocket maximums under the plan for coverage of "essential health benefits" provided in-network do not exceed certain annual limitations
No Preexisting Condition Exclusions	Prohibits group health plans from excluding individuals from coverage or limiting or denying benefits on the basis of preexisting medical conditions (the provision became effective in 2010 for children under 19 years of age)
Nondiscrimination for Wellness Programs	Revises the nondiscrimination rules under HIPAA (the Health Insurance Portability and Accountability Act) for health-contingent wellness programs, which require an individual to satisfy a standard related to a health factor to obtain a reward

* *Group health plans that do not cover at least two participants who are current employees (such as plans in which only retirees participate) are generally exempt from the Affordable Care Act's market reform requirements.*

+ If allowed by a particular state and insurer, a small business may be able to renew its current group coverage that does not comply with certain rules under Health Care Reform (including the requirements related to essential health benefits, guaranteed availability, limits on cost-sharing and fair premiums), through policy years beginning on or before October 1, 2018, so long as the policy ends by December 31, 2018. Eligible businesses will receive notice from their carriers for each policy year.

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AT LEAST 2 EMPLOYEES*	
Effective as of 2014, *Continued*	
Restrictions on Premium Variations+	Requires issuers that offer non-grandfathered health insurance coverage in the small group market to limit any variation in premiums with regard to a particular plan or coverage to age and tobacco use (within limits), family size, and geography
Transitional Reinsurance Program	Requires employers sponsoring certain self-insured plans and issuers of insured health plans to make contributions to support payments to individual market issuers that cover high-cost individuals **Note:** For 2015 and 2016, certain self-insured, self-administered group health plans do not have to pay the fee
Effective as of 2013	
Additional Medicare Tax for High Earners	Requires employers to withhold Additional Medicare Tax (at a rate of 0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year
Employer-Provided Notice Regarding Exchange-Marketplaces	Requires employers to provide written notice about a Health Insurance Exchange (Marketplace) to each new employee at the time of hiring, within 14 days of the employee's start date—there is one model notice for employers that offer a health plan, and another model notice for those that do not offer a plan
Health FSA Contribution Limits	Limits the amount of salary reduction contributions to health flexible spending accounts (FSAs) to $2,500 annually, adjusted for inflation (for tax year 2016, the limit is $2,550; for tax year 2017, the limit is $2,600)
Effective as of 2012	
Expanded Coverage of Preventive Services for Women	Requires non-grandfathered group health plans to cover additional women's preventive services such as well-woman visits, breastfeeding support, domestic violence screening, and contraception without cost-sharing **Note:** The requirement to provide contraceptive coverage without cost-sharing is subject to certain exemptions for religious employers and accommodations for non-profit religious organizations and certain closely held for-profit entities that meet specific eligibility criteria.
Medical Loss Ratio (MLR) Rebates	Makes employers responsible for distributing rebates, received as a result of insurance companies not meeting specific standards related to how premium dollars are spent, to eligible plan enrollees where appropriate (starting with the 2014 MLR reporting year, an issuer must provide any rebate owed by September 30th)

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AT LEAST 2 EMPLOYEES*	
Effective as of 2012, *Continued*	
PCORI Fees for Employers Sponsoring Self-Insured Plans	For plan years ending on or after October 1, 2012, and before October 1, 2019, requires employers that sponsor certain self-insured plans—including health reimbursement arrangements (HRAs) that do not satisfy the requirements to be treated as excepted benefits—to pay fees to fund the Patient-Centered Outcomes Research Institute (fees are due no later than July 31st of the year following the last day of the plan year)
Summary of Benefits and Coverage (SBC)	Requires group health plans and health insurance issuers to provide a summary of benefits and coverage (SBC) to participants and beneficiaries at several points during the enrollment process and upon request
Effective as of 2011	
Reimbursements for Over-the-Counter Medicines and Drugs	Distributions from HRAs and health FSAs are allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription, except insulin (a similar rule applies for HSAs and Archer MSAs)
Effective as of 2010	
Break Time for Nursing Mothers	Requires employers to provide reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth, as well as a place to do so (other than a bathroom) that is shielded from view and free from intrusion from coworkers and the public
Coverage of Preventive Services	Requires non-grandfathered group health plans to cover certain preventive services delivered by in-network providers without cost-sharing
Reviewing Claims Decisions	Established new procedures that non-grandfathered group health plans must follow regarding decisions to deny payment for treatment or services
Prohibition on Rescission of Coverage	Prohibits insurance companies from rescinding coverage except in cases of fraud or intentional misrepresentation
Effective Date Delayed	
Nondiscrimination Rules for Insured Group Health Plans	Insured group health plans are not required to comply with certain rules prohibiting discrimination in favor of highly compensated individuals, currently applicable to self-insured plans, until after the issuance of regulations or other administrative guidance (cafeteria plan health benefits remain subject to the nondiscrimination requirements of IRC Section 125)
Cadillac Tax on High Cost Employer-Provided Coverage ***Effective Beginning in 2020***	Effective for taxable years beginning after December 31, 2019, an excise tax will be imposed on high cost employer-sponsored health coverage (the cost of plan benefits generally cannot exceed the threshold of $10,200 for self-only coverage and $27,500 for family coverage, with exceptions for certain types of coverage)

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50+ EMPLOYEES ALSO NEED TO COMPLY WITH:	
Effective as of 2015	
"Pay or Play" (Employer Shared Responsibility)	Requires applicable large employers (ALEs) to offer affordable health insurance that provides a minimum level of coverage to full-time employees and their dependents or pay a penalty tax if any full-time employee is certified to receive a premium tax credit for purchasing coverage on an Exchange **Note:** The transition relief which delayed compliance with the "pay or play" requirements until 2016 for ALEs with 50 to 99 full-time employees (including FTEs) is now expired for ALEs with calendar year plans. For ALEs with non-calendar year health plans, this transition relief, along with the transition relief for dependent coverage, continued to apply for any calendar month during the 2015 plan year that fell in calendar year 2016 (information from the 2016 calendar year is reported in early 2017).
ALE Information Reporting on Health Insurance Coverage	Requires ALEs subject to "pay or play" to report certain information to the IRS and to their employees regarding compliance with the employer shared responsibility provisions and the health care coverage they have offered **Note:** Self-insured employers (**regardless of size**) providing minimum essential health coverage are subject to a separate set of requirements, but employers subject to **both** reporting provisions (generally ALEs with self-insured plans) will satisfy their reporting obligations on a single form.
250+ EMPLOYEES ALSO NEED TO COMPLY WITH:	
Effective as of 2012	
Form W-2 Reporting of Employer-Sponsored Health Coverage	Requires employers who must file 250 or more Forms W-2 for the preceding calendar year and who sponsor a group health plan to report the cost of coverage provided to each employee annually on the Form W-2 (provided to employees in January), with certain exceptions

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OTHER PROVISIONS AFFECTING SMALL EMPLOYERS:	
Effective as of 2016 & 2017	
New ACA Section 1557 Nondiscrimination Requirements	Entities administering any health program or activity that receives federal financial assistance (such as hospitals that accept Medicare or doctors who accept Medicaid) must comply with the final rule implementing section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. Changes to health benefit plan design must be made on the first day of the first plan year beginning on or after January 1, 2017. In addition, as of October 2016 such entities must inform individuals of their civil rights under section 1557. For more on this notice requirement, click here (see "Procedural Requirements").
Effective as of 2014	
Small Business Health Options Program (SHOP)	Exchanges are required to operate a SHOP as an option for qualified small employers to purchase employee health coverage. For 2016, the federally-facilitated SHOP is open to employers with 50 or fewer full-time equivalent employees. However, states operating their own SHOP Marketplaces may make them available to businesses with up to 100 employees. Employers with more than 50 employees are advised to contact their state insurance department or the SHOP Call Center (800-706-7893) to learn more about application and enrollment.
Effective as of 2010	
Small Business Health Care Tax Credit	Eligible small businesses (generally those with **fewer than 25 full-time equivalent employees** that meet certain other requirements) that pay at least half of employee health insurance premiums may receive a tax credit For up to two years starting in 2014, the maximum credit increases to 50% of premiums paid by eligible small businesses; however, the credit is generally only available if coverage is obtained through a SHOP Exchange (Marketplace).

Notes:

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