Newtek®
"The Small Business Authority®"

Health Care Reform by Year & Company Size

AT LEAST 1 EMPLOYEE*

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 (Without Exception)

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.

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.

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 2015, the limit is $2,550).

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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.

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).

PCORI Fees for Employers Sponsoring Self-Insured Plans

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) and health FSAs 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.

Dependent Coverage to Age 26

Requires group health plans that cover dependents to continue to make the coverage available until a child reaches the age of 26 (until 2014, there was a temporary exception which allowed grandfathered group health plans to exclude adult children who were eligible to enroll in an employer-sponsored health plan other than the group health plan of the parent).

Prohibition on Rescission of Coverage

Prohibits insurance companies from rescinding coverage except in cases of fraud or intentional misrepresentation.

Reviewing Claims Decisions

Establishes new procedures that non-grandfathered group health plans must follow regarding decisions to deny payment for treatment or services.

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).

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50+ EMPLOYEES ALSO NEED TO COMPLY WITH:

Effective Beginning in 2015

"Pay or Play" (Employer Shared Responsibility)

Requires large employers 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.

Employer Information Reporting on Health Insurance Coverage

Requires employers 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, also referred to as "section 6056 reporting. "Self-insured employers and other parties that provide minimum essential health coverage are subject to a separate set of requirements (referred to as "section 6055 reporting,") but employers that are subject to both reporting provisions (generally large employers that sponsor self-insured group health plans) may satisfy their reporting obligations on a single return form.

Information reporting under Internal Revenue Code sections 6055 and 6056 is voluntary for calendar year 2014. Therefore, the first section 6055 and 6056 returns required to be filed are for the 2015 calendar year and must be filed no later than February 29, 2016 (or March 31, 2016, if filed electronically).

201+ EMPLOYEES ALSO NEED TO COMPLY WITH:

Effective Date Delayed

Automatic Enrollment

Employers are not required to comply with the law's automatic enrollment provisions until final regulations are issued and become applicable (these provisions require employers to automatically enroll new full-time employees in one of the employer's health plans, subject to any waiting period authorized by law, and continue the enrollment of current employees in a health benefits plan offered through the employer)

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

OTHER PROVISIONS AFFECTING SMALL EMPLOYERS:

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. Although businesses with up to 100 employees will generally be eligible to participate in SHOPs, states may limit participation to businesses with up to 50 employees until 2016. The federal government operates the program in states that did not elect to establish an Exchange. (For 2015, the federally-facilitated SHOP is open to employers with 50 or fewer full-time equivalent employees. Employers located in a state operating its own SHOP must follow that state's application and enrollment process.)

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Effective as of 2010

Small Business Health Care Tax Credit

Eligible small businesses (generally those with f**ewer than 25 full-time equivalent employees** with average annual wages that do not exceed $50,800 for tax year 2014 or $51,600 for tax year 2015, and adjusted for inflation in future tax years) that pay at least half of employee health insurance premiums may receive a tax credit.

For tax years 2010–2013, the maximum credit is 35% of premiums paid by eligible small businesses. **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).**