Health Care Reform by Year & Company Size

This summary provides an overview of key provisions under federal law. The information is subject to change based on new government requirements or amendments to the law. Your company or group health plan may be exempt from certain requirements and/or subject to more stringent requirements under your state's laws. **If you have any questions regarding your obligations with respect to Health Care Reform, please consult with a knowledgeable employment law attorney or your state insurance department.**

Note: 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 Note: Consistent with prior guidance, final regulations provide that a requirement to successfully complete a reasonable and bona fide employment-based orientation period is permissible as a condition for eligibility for coverage under a group health plan, if the orientation period does not exceed one month and the maximum 90-day waiting period begins on the first day after the orientation period. The rules also address the relationship between the 90-day limit and the "pay or play" provisions.
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" Note: According to a letter from the U.S. Department of Health and Human Services, this requirement **will not apply** to individual or group health insurance issuers in the U.S. territories (i.e., Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands). The agency intends to issue regulations, and issuers in the territories will not be subject to this requirement pending their completion.
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 Note: Final rules clarify that for purposes of the employer shared responsibility ("pay or play") provisions under Health Care Reform, a child is a dependent for the entire calendar month during which he or she attains age 26.

Elimination of Annual Limits	Prohibits annual dollar limits on coverage of "essential health benefits" Note: Employer payment plans (arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or uses its funds to directly pay the premium for an individual policy) fail to satisfy this requirement; transition relief was provided to small employers through June 30, 2015.
Guaranteed Availability+	Requires issuers offering non-grandfathered group plans to accept every employer that applies for coverage, with certain exceptions Note: According to a letter from the U.S. Department of Health and Human Services, this requirement **will not apply** to individual or group health insurance issuers in the U.S. territories (i.e., Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands). The agency intends to issue regulations, and issuers in the territories will not be subject to this requirement pending their completion.
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 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 years 2015 and 2016, the limit is $2,550)
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)
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
	Requires non-grandfathered group health plans to cover certain preventive services delivered by in-network providers without cost-sharing

Coverage of Preventive Services	Note: Employer payment plans (arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, or uses its funds to directly pay the premium for an individual policy) fail to satisfy this requirement; transition relief was provided to small employers through June 30, 2015.
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)
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:** As a reminder, transition relief delayed compliance with the "pay or play" requirements until 2016 for ALEs with **50 to 99 full-time employees** (including FTEs) that certified that they met certain eligibility criteria related to workforce size, maintenance of workforce and aggregate hours of service, and maintenance of previously offered health coverage. **For ALEs with non-calendar year health plans, this transition relief continues to apply for any calendar month during the 2015 plan year that falls in 2016.**
	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, also referred to as "section 6056 reporting." Self-insured employers and other parties that provide minimum essential health coverage (**regardless of size**) are subject to a separate set of requirements (referred to as "section 6055 reporting"), but employers that are subject to **both** reporting provisions (generally ALEs that sponsor self-insured group health plans) may satisfy their reporting obligations on a single return form.

ALE Information Reporting on Health Insurance Coverage	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 May 31, 2016** (or June 30, 2016, if filed electronically).
	
	Note: Two sets of questions and answers from the Internal Revenue Service (IRS) provide guidance on the information reporting requirements under Health Care Reform. One set of Q&As relates to section 6055 reporting, and the other set of Q&As relates to section 6056 reporting. The following forms and instructions are also available:
	
	• **Large Employer Reporting (Section 6056)**
	  ◦ Form 1094-C
	  ◦ Form 1095-C
	  ◦ Instructions
	
	• **Minimum Essential Coverage (MEC) Reporting (Section 6055)**
	  ◦ Form 1094-B
	  ◦ Form 1095-B
	  ◦ Instructions
	
	Click here for more information on the reporting requirements.

201+ EMPLOYEES ALSO NEED TO COMPLY WITH:	
Effective Date Delayed	
Automatic Enrollment	**Special Update: Automatic Enrollment Provisions Repealed** Federal legislation has repealed the ACA's automatic enrollment provisions. (Previously released FAQs provided that employers were not required to comply with these provisions until regulations were issued.) The provisions required employers with more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health plans (subject to any waiting period authorized by law), and to 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. 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** with average annual wages that do not exceed $51,600 for tax year 2015 or $51,800 for tax year 2016, 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).**

*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, 2017, so long as the policy ends by December 31, 2017. Businesses that are eligible to continue existing coverage will receive a notice from their insurance companies for each policy year.