

Employee Benefits Series



Health Care Reform Rules for Small Business (FEWER THAN 50 EMPLOYEES)

Benefits Requirements, Notices, Financial Provisions



Health Care Reform & Small Business (< 50 Employees)

Businesses of all sizes are affected by the Affordable Care Act. While the law does not penalize small employers that do not offer health insurance, those that do provide coverage must ensure that the benefits offered comply with a number of requirements. Small employers may also be eligible for a special tax credit and other advantages under the law. The following guide highlights the key benefits requirements, notices, and financial provisions that may affect **employers with fewer than 50 employees**.

BENEFITS REQUIREMENTS		
Requirement	Employer Action Items	Notes/Tips
<u>90-Day Limitation on Waiting Periods</u>	Ensure that any waiting period does not exceed 90 days (a waiting period is the time that must pass before coverage for an individual who is otherwise eligible to enroll can become effective)	Eligibility conditions that are not based solely on the lapse of a time period (e.g., meeting certain sales goals or successfully completing a reasonable and bona-fide employment-based orientation period) are generally allowed.
<u>Break Time for Nursing Mothers</u>	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	An employer with fewer than 50 employees is not subject to the requirement if it can demonstrate that compliance with the provision would impose an undue hardship.
<u>Coverage of Preventive Services</u>	For non-grandfathered plans, continue to monitor guidelines for preventive services (which are regularly updated to reflect new medical advances) to ensure coverage of such services is provided without cost-sharing	As new services are approved, non-grandfathered group plans will be required to cover them with no cost-sharing for plan years beginning one year later. 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; <u>transition relief</u> is available for small employers until 6/30/15.
<u>Dependent Coverage to Age 26 (Without Exception)</u>	If the group plan covers dependents, confirm that coverage is made available until a child reaches age 26 , regardless of other coverage options	A temporary exception allowed <u>grandfathered plans</u> to exclude adult children who were eligible to enroll in employer-based coverage other than the group health plan of a parent until plan years beginning in 2014.
<u>Essential Health Benefits</u>	For non-grandfathered plans, confirm the plan covers a core package of items and services known as "essential health benefits" (not applicable for self-insured plans)	If allowed by a particular state and insurer, a small business may be able to <u>renew its current group coverage</u> that does not comply with the requirement to cover essential health benefits, through policy years beginning on or before October 1, 2016.
<u>Guaranteed Availability and Restrictions on Premium Variations</u>	For non-grandfathered plans, determine impact (if any) of the requirements that issuers generally accept every employer that applies for coverage and limit any variation in premiums to age and tobacco use, family size, and geography	If allowed by a particular state and insurer, a small business may be able to <u>renew its current group coverage</u> that does not comply with the requirements related to guaranteed availability and fair premiums, through policy years beginning on or before October 1, 2016.

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BENEFITS REQUIREMENTS (cont'd)		
<i>Requirement</i>	<i>Employer Action Items</i>	<i>Notes/Tips</i>
<u>No Preexisting Condition Exclusions</u>	Ensure that preexisting condition exclusions have been eliminated for individuals of all ages	The prohibition on exclusions of children under 19 years of age on the basis of pre-existing conditions became effective in 2010.
<u>Nondiscrimination for Wellness Programs</u>	For employers sponsoring a wellness program that requires an individual to satisfy a standard related to a health factor in order to obtain a reward, confirm the program complies with revised nondiscrimination rules	Under the revised rules, an employer is permitted to increase the maximum permissible reward (up to 30% of the cost of coverage, or 50% for programs designed to prevent or reduce tobacco use).
NOTICES		
<i>Notice</i>	<i>Employer Action Items</i>	<i>Notes/Tips</i>
<u>Exchange Notice (Notice of Coverage Options)</u>	Provide written notice about the Health Insurance Exchange (Marketplace) to each new full- and part-time employee at the time of hiring, within 14 days of the employee's start date	Two model notices are available to help employers comply with this requirement— one <u>notice</u> for those that offer a health plan, and another <u>notice</u> for those that do not.
<u>Summary of Benefits and Coverage (SBC)</u>	Confirm contractual arrangements with the carrier or third party administrator to prepare and provide the SBC (if the carrier or TPA does not assume responsibility, the employer should provide this notice, without charge, to employees and beneficiaries at specified times during the enrollment process and upon request)	An <u>updated SBC template</u> is available which includes language indicating whether the plan provides " <u>minimum essential coverage</u> ," and whether the plan meets the ACA's " <u>minimum value</u> " standard. Until further guidance is issued, the previously authorized template <u>may be used</u> without penalty, provided the SBC is furnished with a cover letter or similar disclosure that includes the additional language. <u>Proposed rules</u> have been issued to revise the templates and would place additional obligations on plans that contract with issuers to provide the SBC. The rules are generally expected to be finalized and <u>applied</u> in connection with coverage beginning on or after January 1, 2016 .
<u>Updated COBRA Election Notice</u>	Update the plan's election notice, to be distributed to employees, spouses (including <u>legally married same-sex spouses</u>) and dependents who are eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), to include additional information regarding coverage alternatives available through the Health Insurance Exchange (Marketplace)	<u>COBRA</u> applies generally to group health plans sponsored by employers with at least 20 employees on more than 50% of their typical business days in the previous calendar year.

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FINANCIAL PROVISIONS		
Provision	Employer Action Items	Notes/Tips
<u>Additional Medicare Tax for High Earners</u>	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	Additional Medicare Tax first became effective in 2013.
<u>Elimination of Annual Limits</u>	Confirm that no annual dollar limits apply to coverage of "essential health benefits"	Health plans may continue to limit the number of visits to health providers and days of treatment, so long as the visit or day limit does not amount to a dollar limit. 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; <u>transition relief</u> is available for small employers until 6/30/15.
<u>Limits on Cost-Sharing</u>	For non-grandfathered plans, ensure that out-of-pocket maximums under the plan for coverage of "essential health benefits" provided in-network do not exceed certain annual limitations	If allowed by a particular state and insurer, a small business may be able to <u>renew its current group coverage</u> that does not comply with the limits on cost-sharing, through policy years beginning on or before October 1, 2016.
<u>Medical Loss Ratio (MLR) Rebates</u>	Distribute any rebates , received as a result of insurers not meeting specific standards related to how premium dollars are spent, to eligible plan enrollees as appropriate (not applicable for self-insured plans)	Rebates are due to employer-policyholders by September 30th.
<u>PCORI Fees</u>	For employers sponsoring certain self-insured health plans (including HRAs and FSAs not treated as excepted benefits), report and pay applicable fees to fund the Patient-Centered Outcomes Research Institute (PCORI)	For plan years ending on or after October 1, 2012, and before October 1, 2019, IRS <u>Form 720</u> must be filed annually to report and pay the fees no later than July 31st of the year following the last day of the plan year to which the fee applies.

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FINANCIAL PROVISIONS (cont'd)		
<i>Provision</i>	<i>Employer Action Items</i>	<i>Notes/Tips</i>
<u>Requirements for Tax-Favored Arrangements</u>	<p>Ensure that health reimbursement arrangements (HRAs), health flexible spending arrangements (FSAs), and cafeteria plans comply with several ACA requirements that took effect in 2013 and 2014:</p> <ul style="list-style-type: none"> • HRAs generally must be "integrated" with other group health plan coverage and cannot be used to reimburse an employee's individual insurance policy premiums • A health FSA must qualify as excepted benefits and must be offered through a cafeteria plan (a plan which meets specific requirements to allow employees to receive certain benefits on a pre-tax basis) • Except for SHOP coverage, an employer may not provide a qualified health plan offered through the Health Insurance Exchange (Marketplace) as a cafeteria plan benefit 	<p>Employers sponsoring health FSAs also need to limit the amount of salary reduction contributions to <u>\$2,500</u> (for tax year 2015, the limit is \$2,550)</p> <p>Effective as of 2011, 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).</p>
<u>SHOP (Small Business Health Options Program)</u>	<p>Consult with agent or broker to review and compare price, coverage, quality, and other important features of plans offered inside and outside the SHOP Exchange (Marketplace) and for help with applying for plan coverage and enrolling employees</p>	<p>Employers located in a <u>state operating its own SHOP</u> must follow the state's application and enrollment process.</p>
<u>Small Business Health Care Tax Credit</u>	<p>Determine if your company qualifies for the small business health care tax credit</p>	<p>Small businesses (generally those with fewer 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 annually thereafter for inflation), that pay at least half of employee health insurance premiums for coverage obtained through SHOP, may be eligible to claim the credit for two consecutive taxable years starting in 2014.</p>

This summary is for general reference purposes only and is not all-inclusive. The information is subject to change and your group plan may be exempt from certain requirements and/or subject to more stringent requirements under state law. If you have questions regarding your obligations, please consult a knowledgeable employment law attorney or your state insurance department.

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