Affordable Care Act Mandates: 2015 and Beyond

HealthSmart is pleased to provide its customers and partners with the following summary of upcoming Affordable Care Act (ACA) mandates for 2015 and beyond. The effective date for compliance with most of the ACA mandates will depend on the renewal date of the plan year (i.e., calendar year plans and fiscal year plans). This document is for informational purposes only. Your health plan may be subject to additional plan amendments or other ACA mandates not listed below.

Shared Responsibility for Employers (the "Pay-or-Play" Penalty Tax)	Beginning January 1, 2015, employers with 50 or more full-time employees (including full-time equivalents) must pay a penalty tax for: ▶ Failing to offer minimum essential health care coverage for all full-time employees and their dependents for any month or; ▶ Offering eligible employer-sponsored coverage that is not "affordable" (exceeds a percentage of the employee's household income) or does not offer "minimum value" (the plan's share of the total allowed cost of benefits is not at least 60%) and; ▶ Any full-time employee certifies to their employer as having purchased a qualifying health plan where a premium tax credit or cost-sharing reduction is allowed. Applies to plan years beginning after December 31, 2014. Non-calendar year plans that meet certain conditions have until the first day of the 2015 plan year to comply.
Cost-Sharing Limits	For plan years beginning on or after January 1, 2014*, there is an overall limit on cost-sharing (deductibles, coinsurance, copayments, or similar charges) with respect to essential health benefits covered under a group health plan. Grandfathered health plans are not required to comply. FAQ guidance provided for a one-year safe harbor to the cost-sharing rules for plans that utilize multiple service providers to administer benefits (for example, a third party administrator to administer major medical coverage and a separate pharmacy benefit manager to administer prescription drug coverage). Under the safe harbor, these plans would be in compliance with the cost-sharing rules if the plan complied with the overall cost-sharing limit both with respect to major medical coverage and (separately) non-major medical coverage. For plan years beginning on or after January 1, 2015, all non-grandfathered group health plans must comply with the cost-sharing limitations regardless of whether the plan uses more than one service provider to administer benefits. The 2015 out-of-pocket expense limits are $6,600 for self-only coverage and $13,200 for other than self-only coverage. The 2015 limits for HDHPs are $6,450 for self-only HDHP coverage and $12,900 for family HDHP coverage.

Code 6055 Information Reporting (Health Insurance Issuers, Self-Insuring Employers, Government Agencies, and Health Coverage Providers)

The ACA requires any person who provides minimum essential coverage to an individual during a calendar year to report certain health insurance coverage information to the IRS using Form 6055. Information reported in Form 6055 includes:

- Name, address, and the taxpayer identification number for each person covered under the plan policy;
- The dates each person was covered under minimum essential coverage during a calendar year;
- Whether coverage is a qualified health plan offered through an Affordable Insurance Exchange and;
- Amount of advanced premium tax credit or cost-sharing reduction for each covered person.

A written statement to each individual listed on the return must also be provided.

Reporting requirements for health insurance issued through an employer's group health plan includes:

- Name, address, and employer identification number; and
- Portion of premium to be paid by employer.

Minimum essential coverage includes any eligible employer-sponsored plan. An eligible employer-sponsored plan means any group health plan or group health insurance coverage offered by an employer to an employee that is (i) a governmental plan, or (ii) any other plan or coverage offered in a state's small or large group market.

The regulations require the name, address, and TIN (or Social Security number) for all covered individuals (including spouses and dependents). Reporting entities are required to make reasonable efforts to obtain TINs. Under the rules, the steps for making reasonable efforts to obtain the TIN include:

- If the reporting entity does not already have the TIN, it must ask for it at the time the relationship with the individual is established.
- If the TIN is not provided when the relationship is established, the reporting entity must make an attempt to obtain the TIN by December 31st of the year in which the relationship begins (January 31st of the following year if the relationship begins in December).
- If the TIN is still not provided, the reporting entity must ask again by December 31st of the following year.

If a TIN cannot be obtained after these reasonable efforts, the final regulations allow reporting of a birth date.

Reporting is required beginning in early 2016 for coverage provided in 2015.The first information return is due January 31, 2016.

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Code 6056 Information Reporting (Large Employers)	The ACA requires employers to report annually to the IRS whether they offer full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. This requirement includes providing a written statement to full-time employees. The information to be furnished to the IRS is as follows: ▶ Name, date, and employer identification number; ▶ Certification stating the employer offers its full time employees and their dependents minimum essential coverage; ▶ Length of waiting period for the coverage; ▶ Months coverage was available during the calendar year; ▶ Lowest cost monthly premium offered; ▶ Employer's share of the total costs; ▶ Total number of full time employees during the calendar year; and ▶ Name, address, and Social Security Number of each full time employee during the calendar year. Reporting is required beginning in early 2016 for coverage provided in 2015. The first information return is due January 31, 2016
Reinsurance Contributions	Contributing entities are required to make contributions toward state transitional reinsurance programs to help stabilize premiums for individual market coverage from 2014 through 2016. A contributing entity is defined as an insurer or third-party administrator on behalf of a self-insured group health plan. However, the health plan is ultimately liable for the contribution. Health plans must report their enrollment counts to HHS by November 15th of each year beginning in 2014. HHS will provide health plans with the assessable contribution by December 15th of each respective year. Payment must be made to HHS no later than thirty days after the health plan receives its assessment and can be made in two installments, the first being by January (invoiced in December) and the second payment in the fourth quarter. Additionally, pay.gov allows the contributing entity to: ▶ Register; ▶ Submit the annual enrollment count and; ▶ Make contribution payments.

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PCORI Fees	The ACA established the Patient-Centered Outcomes Research Institute (PCORI) to explore the effectiveness, risks, and benefits of medical treatments. The program is effective for policy and plan years ending after October 1 2012 and before October 1, 2019; for calendar-year policies/plans years, it is effective 2012 through 2018. Plan sponsors of self-insured health plans must report (using IRS Form 720) and pay the PCORI fees no later than July 31st of the year following the last day of the plan year.
Health Plan Identifier Delay	The Department of Health and Human Services (HHS) announced on October 31 it will delay enforcement of regulations related to obtaining the Health Plan Identifier (HPID) and using the HPID in Health Insurance Portability & Accountability Act (HIPAA) transactions that were adopted in the HPID final rule. It applies to all HIPAA covered entities, including healthcare providers, fully insured and self-funded health plans, and healthcare clearinghouses. Insured plans and self-funded health plans that have not already obtained an HPID do not need to do so until further notice. This delay comes on the heels of a recommendation by the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS. The NCVHS asked HHS to review the HPID requirement and recommended that HPIDs not be used in HIPAA transactions. NCVHS's primary opposing argument to implementation of the HPID standard was that the healthcare industry has already adopted a "standardized national payer identifier based on the National Association of Insurance Commissioners (NAIC) identifier." *Other Reasons for the Change* ▶ Lack of clear business need and purpose for the HPID ▶ Confusion about how the HPID would be used in administrative transactions ▶ Challenges faced by health plans defining controlling health plan (CHP) and subhealth plan (SHP) ▶ Cost to health plans, clearinghouses, and providers if software has to be modified to account for the HPID Whether HHS will adopt the recommendations of the NCVHS on a permanent basis remains to be seen, but for the time being, plan administrators may discontinue the HPID application process and should stay tuned for further announcements from HHS.

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2015 FSA and Commuter Benefits Update	On Thursday, October 30th, for tax year 2015, the Internal Revenue Service announced new annual inflation adjustments for 2015, including the following: **Flexible Spending Accounts** The annual dollar limit on employee contributions to employer-sponsored health care FSAs rises to $2,550 in 2015, up from $2,500 in 2014. The annual limit for dependent care FSAs or dependent care assistance plans (DCAPs) will remain at $5,000 for qualifying individuals and those who are married and file a joint return, and will remain at $2,500 for those who are married and file separate returns. REMINDER—Beginning in 2014 but expected to be more widely adopted in 2015, the U.S. Treasury Department and the IRS altered the long-standing "use it or lose it" rule, allowing employers to offer a carryover of up to $500 in unused health FSA funds to the following year or to continue a grace period option giving employees a two-and-a-half month extension to spend remaining FSA funds. FSAs cannot have both a carryover and a grace period option, and employers are not obligated to offer either extension. **Transit Benefits** The monthly limit for qualified transportation benefits are unchanged for 2015 ($130/month for transit passes and $250/month for qualified parking), assuming no year-end action by Congress. These are the applicable numbers for the tax year 2015 and are effective January 1, 2015 for Plan Years beginning in 2015.
Transitional Reinsurance Program Enrollment Extended to December 5, 2014	The transitional reinsurance program annual enrollment and contribution form filing has been extended to December 5, 2014. The Department of Health and Human Services has received numerous requests for an extension. The January 15, 2015 and November 15, 2015 payment deadlines remain the same. For more information, please visit: www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html