Current Healthcare Reform Hot Topics

There have been numerous changes and challenges in the healthcare landscape over the past few years, many driven by Healthcare Reform. With so many moving parts, many employers are struggling to understand the new requirements, figure out how to comply with them, and devise strategies to keep up with the changing rules.

Hot topics include the measurement of full-time employees under the employer mandate, the need to obtain a Health Plan ID and certify the plan's compliance with certain HIPAA rules, the fees associated with the Transitional Reinsurance program, and required IRS reporting are the provisions most employers are focusing on today.

Employer Mandate Measurement Period

Under the employer mandate (also referred to as the employer shared responsibility provision, play or pay mandate, or Free Rider Penalty), large employers must offer employees who work 30 or more hours per week (and their dependent children) adequate and affordable healthcare coverage or potentially pay a penalty (if at least one employee enrolls in public Exchange coverage and qualifies for a premium tax credit). Full-time status is based on "hours of service," which includes all work time and non-work time for which pay is due. For employees paid a salary or per diem, employers must either credit hours based on actual service records or use a days or weeks worked equivalency. For employees paid on an hourly basis, an employer will count actual hours of service from records of hours worked. Note that a contractual arrangement to work a set number of hours does not, in and of itself, create a service record.

To credit hours of service worked by employees, the employer may either use a monthly or look-back measurement period. Many organizations are planning to use the look-back measurement period method. Using this method, the employer determines whether an employee has averaged a full-time schedule over a three to 12 month measurement period. If an employee is considered full-time during the measurement period, the employee must be treated as a full-time employee for benefits purposes for a subsequent "stability period" regardless of the employee's number of hours worked during the stability period, so long as the individual remains an employee.

Because the employer mandate generally becomes effective for plan years beginning on or after January 1, 2015, (for employers with 100+ full-time equivalent employees), employers who use the look-back measurement period method need to be measuring hours of service for their workforce now. While generally an employer using a 12-month measurement period must also have a 12-month measurement period, a transition rule allows employers to use a six-month measurement period beginning in 2014, so long as the measurement period starts no later than July 1, 2014. (Note that some employers with non-calendar year plan years may not qualify for the transition rule that offers an option to avoid penalties before the start of the 2015 plan year, such as employers who changed their plan years after December

27, 2012. Those employers could start incurring penalties beginning January 1, 2015 regardless of their plan years.)

The bottom line is that most employers who plan to use the look-back measurement period are already into their first measurement periods. Therefore, they should already have procedures in place to track hours worked and calculate who will be considered full-time under the law and be prepared with a "play or play" strategy.

Health Plan Identifier and Certification of Compliance with HIPAA Transaction Rules

The Department of Health and Human Services (HHS) requires health plans to obtain a health plan identifier (HPID) by November 5, 2014 (small health plans with annual receipts of $5 million or less have until November 5, 2015 to comply). Employers that sponsor self-funded health plans will need to register for this ID; insurance companies will perform this task on behalf of employers that sponsor fully-insured plans. An employer may register for and obtain the HPID from the HHS website. Once a health plan has received their HPID, any covered entity or business associate that identifies the health plan must utilize the assigned HPID number when conducting electronic, standard business transactions, so it will be important to share the HPID with applicable entities.

The second part of this new HIPAA requirement is to get assurance from plan administrators and vendors who process standard transactions for the plan that the vendor has gone through a required testing process and has received the necessary certification from HHS. Both large and small health plans must submit certification of their compliance with certain standard transaction rules by December 31, 2015. Note that this process can reportedly take six months or more, so health plans should start working on the certification process as soon as they receive their HPIDs.

For now, the first step is to register for the HPID on the HHS website. Detailed instructions are also available on the site.

Transitional Reinsurance Fee

For three years beginning in 2014, insurers of fully-insured plans and plan sponsors of self-funded plans must pay reinsurance fees to the HHS. The purpose of the fee is to help stabilize premiums for coverage in the individual market during the first three years of Public Exchange operation. Plan sponsors and issuers must submit covered life information by November 15, 2014, HHS will send invoices based on this information by December 15, 2014, and issuers and plan sponsors must pay the fees within 30 days.

Preliminary HHS estimates are that the fee for 2014 could be as much as $63 times the average number of covered lives in the plan. Proposed regulations allow for a portion of the fee to be paid in January of the year following the applicable fee with the remaining portion to be due later in the fourth quarter of the

year in which the fee is applicable. $52.50 of the 2014 fee estimate of $63.00 will be paid in January 2015 and the remaining $10.50 will be payable late in the fourth quarter of 2015. The estimate for the 2015 calendar year is $44 broken into two parts of $33 payable in January 2016 and $11 late in the fourth quarter of 2016.

The presence of these fees requires both self-funded and fully-insured plans to consider these costs in the budgeting process. Self-funded plans will also have the burden of paying these fees directly to the Federal government. HHS is expected to provide more information on how to report the required information and pay the fee.

Code Section 6055 and 6056 Reporting

Certain employers will be required to report information about their employees and their health coverage to both employees and the IRS each year. Internal Revenue Code (Code) Section 6055 requires every entity that provides Minimum Essential Coverage (MEC) to file an annual return reporting specific information for each individual. The 6055 reporting is applicable to insurers of insured major medical plans and plan sponsors of self-funded major medical plans. Employers of any size that sponsor Minimum Essential Coverage must submit this report. As a general matter, only major medical coverage is considered Minimum Essential Coverage.

Under Code Section 6056, every employer that employed on average at least 50 full-time equivalent employees on business days during the preceding calendar year (“large employers”) must file a return that reports the terms and conditions of the healthcare coverage provided to the employer's full-time employees during the year. In addition, the report is required to include and certify detailed and specific information on the employer's full-time employees, including those who received the coverage and when they received it.

Large employers are responsible for the Section 6056 reporting regardless of whether the health coverage is fully insured or self-funded. All employers in a controlled or affiliated service group are combined for purposes of deciding if the employer is “large,” but each employer in the group must file the Section 6056 report separately.

Under both 6055 and 6056, the first reporting will be for calendar year 2015 (regardless of plan year) and will be due in 2016. They are due to covered individuals by January 31 and to the IRS by February 28 or March 31, if filed electronically. Large employers that sponsor self-funded plans are required to report the information required under both Section 6055 and 6056 on a single combined form using Form 1095-C. Simplified reporting is also available in certain circumstances. Final regulations and draft forms have been published, but the forms are not yet final and instructions are not yet available.

Employers should begin reviewing the forms to determine available sources for collecting the information that must be reported. Note that employers may not currently have access to all information

required to be reported. For example, employers must report a tax identification number (TIN, e.g., Social Security Number) for all individuals (employees and dependents) who were enrolled in health coverage. Certain exceptions are available; for example, date of birth may be used instead if the individual does not have a TIN or the employer made "reasonable efforts" to obtain the TIN (which means the employer made at least one initial solicitation, then two qualifying follow-up attempts) but was unable to do so. In any event, employers should plan ahead to ensure they are prepared to collect all of the information that must be reported.

Conclusion

American Fidelity Administrative Services provides a variety of services designed to assist employers in understanding the changing laws and developing compliance strategies. Learn more at www.americanfidelityconsulting.com, or contact us at 877-302-5073.

Caution:

This is only a brief summary that reflects our current understanding of select provisions of the law, often in the absence of regulations. All of the interpretations contained herein are subject to change as the appropriate agencies publish additional guidance.