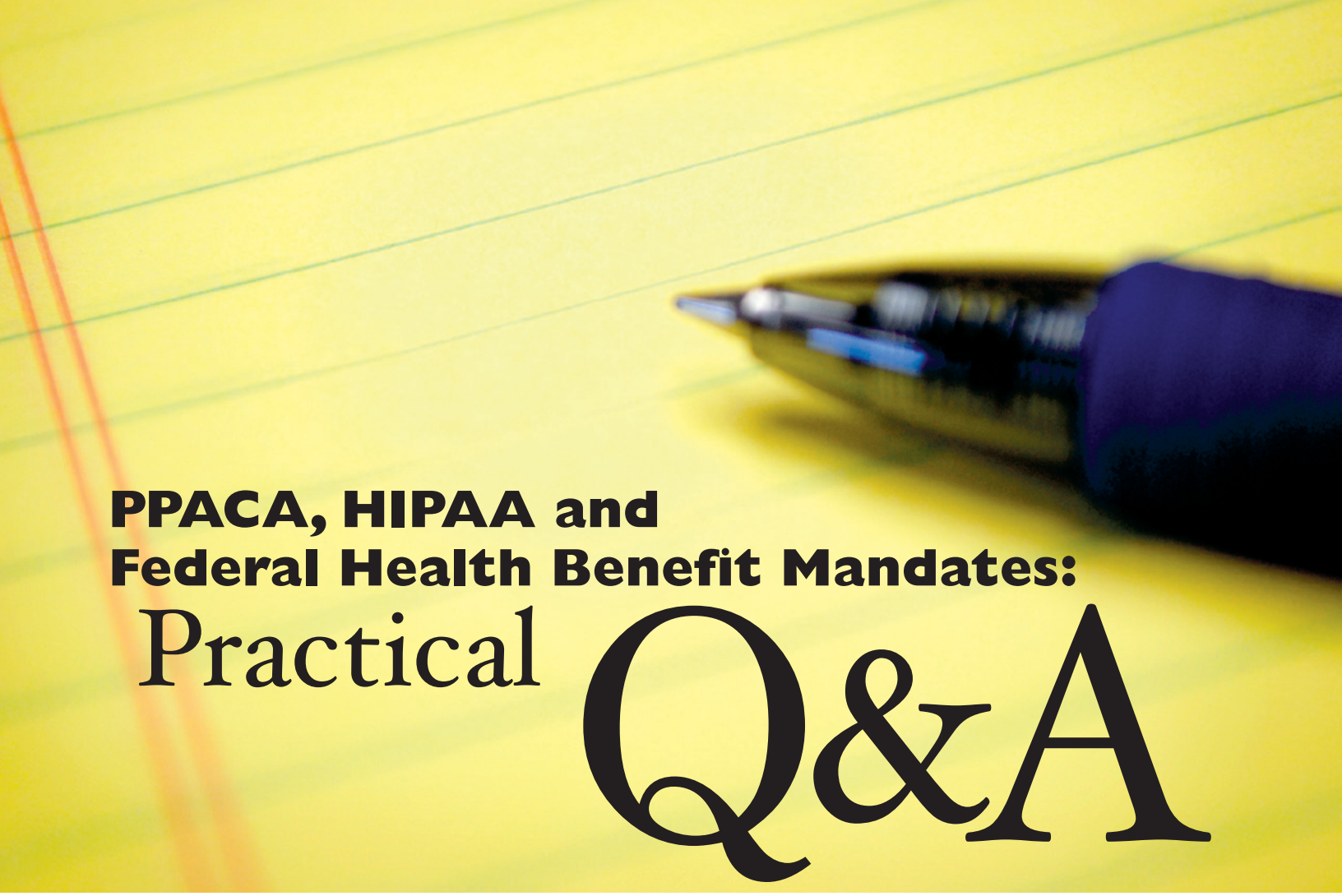

PPACA, HIPAA and Federal Health Benefit Mandates: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

2014 Health Plan Sponsor Year End Checklist

As 2014 draws to a close, we thought it would be helpful to provide a high level recap of the year's guidance and plan sponsor compliance requirements. Many of the issues discussed herein have been addressed in more detail in prior articles throughout the year.

Indefinite Delay for Health Plan Identifier Number and HIPPA EDI Compliance Certification

Health plans with annual receipts of more than $5 million were required to obtain a health plan identifier number ("HPID") by November 5, 2014. Health plans with annual receipts of less than $5 million have until November 5, 2015 to obtain an HPID. HPIDs for fully-insured plans will be obtained by the insurer, and HPIDs for self-insured plans must be obtained by the sponsor. Based on informal agency FAQ guidance, an HPID is not required for many health reimbursement accounts ("HRAs") and healthcare flexible spending accounts ("FSAs"). Once an HPID is obtained, large plans are required to certify their HIPAA compliance to HHS by December 31, 2015 and small plans are required to certify within a year of obtaining their HPID.

On October 31st, CMS announced that it is suspending enforcement of the HIPAA HPID requirement until further notice. The following statement is on the

CMS website at www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.

Register for and Pay Transitional Reinsurance Fees

Self-insured health group plan sponsors as well as health insurance issuers are responsible for paying this annual fee. Registration was initially required by November 17th (first weekday after November 15th). On November 14th CMS announced a delay until December 5th for reinsurance fee registration. www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html The first installment of the fee, which is $52.50 per covered life, is still due no later than January 15, 2015 and the second installment is due by November 15, 2015. Sponsors and issuers may also choose to pay the entire $63 fee per covered life by the January 15th deadline if desired.

Pay PCORI Fee

Although the Patient-Centered Outcomes Research Institute Trust Fund fee ("PCORI" fee) is not a new requirement, the applicable dollar amount was recently announced as being $2.08 per covered life for plan years ending after September 30, 2014 and before October 1, 2015. Payment of the fee was due July 31, 2014 and is again due on July 31, 2015.

Cafeteria Plan Amendment Deadlines

The following changes to cafeteria plans are permitted, but amendments are required as noted below:

Mid-year Election Changes to Allow Group Health Coverage and Exchange Elections

Under IRS Notice 2014-55 cafeteria plans are allowed, but not required, to permit plan participants to revoke their group health plan coverage and elect other minimum essential (MEC) coverage in the following situations:

1. An employee who was expected to average 30 hours of service or more per month experiences an employment status change such that the employee is no longer expected to average 30 hours or more each month but does not otherwise lose eligibility under a group health plan that provides minimum essential coverage.
2. An employee is eligible to enroll in a Qualified Health Plan offered in the Marketplace (i.e., "Exchange") during the Marketplace's special or annual election period.

Plans who wish to permit these election changes must amend their plan by December 31, 2015, or if later, the end of the plan year in which the changes are allowed. Employers who permit these election changes must notify participants of the new election change provision in order for the amendment to be effective.

Healthcare FSA Contribution Limits

An employee's annual salary reduction contributions made to a health FSA are capped at $2,500 by the ACA. While this requirement has been in place for plan years commencing on or after January 1, 2013, some plans may not have yet been amended to reflect this. The amendment must be adopted by December 31, 2014. Also, the cost of living adjustment for health FSAs has increased the limit to $2550 for plan years commencing on or after January 1, 2015. See IRS Rev. Proc 2014-61.

Healthcare FSA carryovers

Cafeteria plans are allowed, but not required, to provide for a carryover of upCto $500 in unused healthcare FSA contributions to be applied to reimburse health expenses in subsequent plan years. This represents a change from the previous rule, which required that all unused contributions as of the end of the plan year be forfeited. This amendment cannot be adopted if the cafeteria plan provides a grace period allowing employees to use their FSA funds to cover eligible expenses incurred during a two and a half month period following the last day of the plan year. In order to allow the carryover the plan must be amended to terminate the grace period. If an eligible cafeteria plan wishes to adopt the amendment, it must do so by the last day of the plan year from which amounts can be carried over.

Employer Responsibility Requirement (aka "Employer Mandate" or "Pay or Play" Requirement)

Beginning January 1, 2015, most employers with at least 100 full-time employees (or full-time equivalent employees) will be subject to an excise tax penalty under Section

4980H of the Code if they fail to 1) offer coverage to 70% (95% after 2015) of their full-time employees and their dependent children, or 2) offer coverage that is both affordable and provides minimum value (i.e., generally provides "bronze level" type or 60% coverage). Final regulations were issued in February of 2014 and employers will need to check their eligibility and coverage requirements to ensure compliance.

Transition Rule Exceptions

Employers with between 50 to 99 full-time and full-time equivalent employees in 2014 may not be subject to this requirement until 2016 if certain conditions are met. Additionally, employers that have maintained a non-calendar year plan as of December 27, 2012 may have until the first day of their 2015 plan year to comply if certain requirements are met.

Prepare for New Reporting Requirements

Code Sections 6055 and 6056 include two sets of new health care coverage reporting requirements regarding minimum essential coverage and applicable large employers. While the first reports are not due until January 2016, employers will want to prepare now so that the required information will be tracked throughout 2015 and available to be reported. One important action item for 2014 will be the collection of taxpayer identification numbers from employees and their covered dependents, discussed below.

Minimal essential coverage reporting (found in 6055) requires both issuers and sponsors of health plans to file information returns with the IRS and provide statements to covered individuals. Large employer reporting (found in 6056) requires employers subject to the employer coverage mandate to file information returns with the IRS and provide statements to their full-time employees. If large employers offer self-insured minimum essential coverage, they may provide a combined report.

Both reports require taxpayer identification numbers ("TINs"). To comply with large employer reporting, the TIN of each full-time employee must be provided. To comply with the minimal essential coverage reporting, the TIN of every covered individual must be provided. This may prove difficult if you have not previously collected the Social Security numbers for covered spouses or dependent children. The IRS will allow plans to report the date of birth of those covered individuals if they are not able to procure a TIN after reasonable efforts. The IRS will consider the

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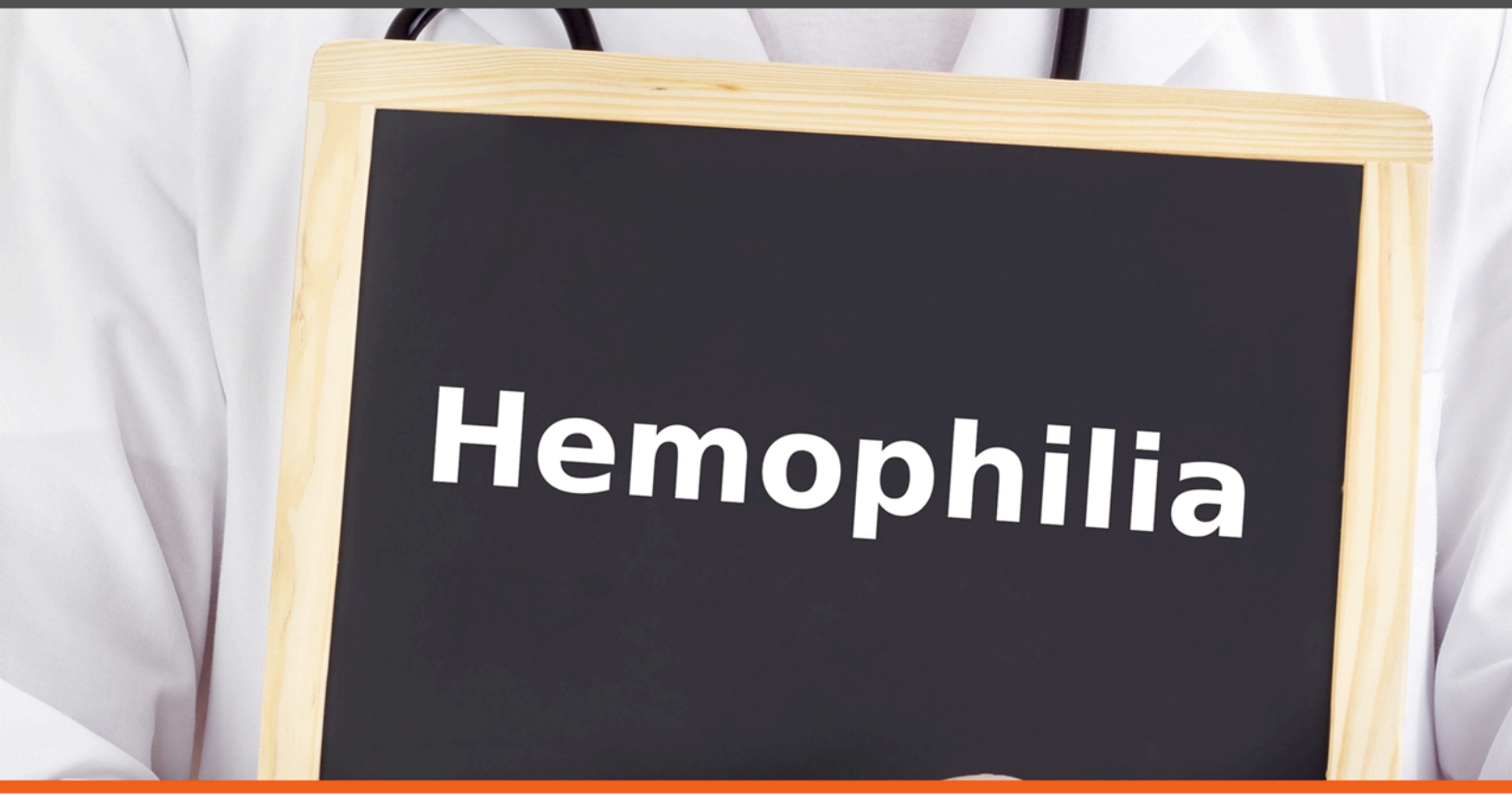

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following as a reasonable effort: 1) plans should request the TIN by December 31, 2014, and, if the TIN is not provided at that time, they must 2) make a second request by December 31, 2015. If the second request is unsuccessful, plans may use the date of birth in place of the TIN for the individual in question.

Existing Notice Requirements

As a reminder, employers are required to distribute certain notices to new employees within 14 days of hire (the Marketplace notice), and enrollment notices prior to or once coverage begins (COBRA, HIPAA Privacy, and Special Enrollment Rights notices, as well as the Summary of Benefits and Coverage). They must also provide participants and beneficiaries with certain annual notices (Women's Health and Cancer Rights Act, Medicare Part D, and CHIP Premium Assistance notices).

Communicate Any Plan Changes

Any plan changes should be timely communicated to eligible employees via either a Summary of Material Modifications ("SMM") or an updated Summary Plan Description ("SPD"). Furthermore, the ACA requires that a revised Summary of Benefits and Coverage ("SBC") be issued at least 60 days before a material modification to an SBC becomes effective. ■

Attorneys John R. Hickman, Ashley Gillihan, Johann Lee, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Johann Lee are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by email to Mr. Hickman at john.hickman@alston.com.