Compliance Recap

February 2015

Regulatory agencies were busy during the month of February, providing information on a variety of topics including: (1) reporting, (2) premium payment arrangements, (3) single benefit products and excepted benefits, (4) and benefit parameters. More information was also released on the “Cadillac tax” and on the definition of “spouse” as it relates to the Family Medical Leave Act (FMLA).

Open enrollment in the Patient Protection and Affordable Care Act’s (PPACA) health insurance Marketplace (or Exchanges) ended on February 15, 2015, however taxpayers will have an opportunity to enroll during a recently announced special enrollment period from March 15 to April 30, 2015. This period is only for individuals who discover (in the process of filing their taxes) that they owe a fee for not purchasing coverage for 2014. The special enrollment period will not affect penalties assessed for 2014, but will allow those who take advantage of it to avoid being assessed the penalty again for this year. It applies only to people who live in the states that use the federally-facilitated Marketplace, though several states with their own Marketplaces are similarly extending enrollment periods.

Reporting Forms

The IRS published final versions of forms and instructions for required reporting by employers and insurers under PPACA’s Sections 6055 and 6056. The forms, which are labeled as 2014 forms, are voluntary. The benefits industry anticipates that the 2015 forms will be similar. An employer with fewer than 50 full-time and full-time equivalent employees in its controlled group that sponsors a fully insured medical plan will not have reporting requirements under Sections 6055 and 6056. All other employers will be responsible for some level of reporting, including employers with 50 to 99 employees for 2015.

Read more about the reporting forms and requirements.

IRS Notice 2015-17

The IRS issued a Notice addressing employer payment or reimbursement of individual premiums in light of PPACA requirements, and preventing employers from reimbursing or paying premiums for individual coverage on a pre-tax or after-tax basis. The IRS introduced a grace period for small employers, who will

not be subject to penalties for 2014 or from January 1 through June 30 of 2015. The Notice also addressed reimbursement for Medicare premiums, TRICARE premiums, and premiums of 2-percent shareholders.

Read more about the premium reimbursement restrictions and grace period.

Single Benefit Products and Excepted Benefits

The IRS also issued Frequently Asked Questions (FAQ) on whether supplemental health insurance coverage that provides additional categories of benefits may qualify as excepted health benefits. The IRS has determined that, in addition to the existing criteria for determining if supplemental coverage is excepted, the agency will propose regulations that would classify supplemental coverage as being excepted only if it does not provide coverage of an essential health benefit (EHB) in the state where it is marketed.

Read more about the requirements to be a single product excepted benefit.

Benefit and Payment Parameters

On February 20, the Centers for Medicare and Medicaid Services and the Department of Health and Human Services issued a Final Rule with standards for insurers and Marketplaces in 2016, covering topics such as transparency in health insurance rate increases, formulary drug lists, drug mail order opt out provisions, determination of minimum value, and benefits discrimination. Open enrollment for the 2016 benefit year will begin on November 1, 2015, and end on January 31, 2016.

The Final Rule reminds issuers that benefits are not EHBs if the benefit design, or implementation of a benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. The agencies became aware of benefit designs that would discourage enrollment by older individuals or those with health conditions, which it noted were a violation of discrimination prohibitions. Three noted examples of potentially discriminatory practices include labeling a medically necessary benefit as a "pediatric service," refusing to cover a single-table drug regimen or extended release regimen that is as effective as a multi-tablet regimen, without appropriate reason for the refusal, and placing most or all drugs that treat specific conditions on the highest cost tiers.

Both fully insured and self-funded plans must pay a transitional reinsurance fee (TRF) for 2014 through 2016. For 2016, the annual contribution for the transitional reinsurance program is $27 per enrollee. The contribution was $44 per enrollee for 2015, and funds reinsurance to the individual market. The contribution is assessed to health insurers and self-insured group health plans providing major medical coverage, although some exceptions exist.

The maximum annual limit on cost-sharing for 2016 has been set. The limit will be $6,850 for self-only coverage and $13,700 for coverage that is not self-only.

Definition of "Spouse" Updated for FMLA

The Department of Labor has issued an updated definition for "spouse" under the Family and Medical Leave Act (FMLA) to make compliance with FMLA easier for both employers and employees. The new regulations will be effective on March 27, 2015, and will define "spouse" as a husband or wife, which refers to a person "with whom an individual entered into marriage as defined or recognized under state

law." The governing state law is that of the "celebration state" or where the marriage took place. Residency of the employee or the state of the employer will no longer have any bearing on the definition of "spouse" for purposes of FMLA. This change means that the same criteria for determining whether an employee is legally married will apply to both benefits and FMLA eligibility determinations.

The updated regulations will allow an employee in a same-sex or common-law marriage to take FMLA leave to care for a child of his or her spouse, or take care of a parent's same-sex or common-law spouse. For individuals married outside of the United States, the regulations will also apply to any marriages that were legal in the country in which they were performed, as long as the marriage could be legally entered into in at least one state.

Employers may request "reasonable" documentation of a family relationship, but the request cannot interfere with an employee's rights, and the employer cannot dictate what documentation must be presented. A simple statement by the employee may be sufficient, although the employer may request that a statement be put in writing.

Cadillac Tax

Beginning in 2018, plans that provide coverage that exceeds a threshold will owe an excise tax that is frequently referred to as the "Cadillac tax." The threshold generally will be $10,200 for single benefits and $27,500 for benefits provided to an employee, retiree, or member of a bargaining unit and dependents. The tax is 40% of the value of coverage provided over that threshold level.

The IRS is beginning the process of writing regulations that will provide details on how this tax will operate. On February 23, 2015, the IRS issued Notice 2015-16, which provides some information on the types of benefits that will count toward the tax. It has requested input on how best to value some of these benefits. It also said in the Notice that as part of the process it plans to finally provide guidance on how Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums should be calculated.

Generally, coverage that will count toward the tax includes health flexible spending arrangements (FSAs), health savings accounts (HSAs), governmental plans, retiree coverage, and certain on-site medical clinics. Excluded coverage will include long-term care, stand-alone dental and vision programs, and fixed indemnity coverage. Dollar limits will apply depending on whether the employee has self-only coverage, or other-than-self-only coverage.

Read more about the Cadillac tax proposal.

Question of the Month

Q: When must plan participants be notified of a change to the summary of benefits and coverage?

A: If a group health plan or insurer makes a material change to the terms of a summary of benefits and coverage (SBC) during the year, an updated SBC (or other notice of the change) must be provided at least 60 days in advance of the date that the modification will become effective. If, however, the change occurs as part of the renewal process, the updated SBC can simply be provided as part of the open enrollment materials, even if that is very close to the effective date.

A material reduction that is not addressed in the SBC, such as an eligibility change, must be communicated through a summary of material modification within 60 days after the effective date of the change. Changes that do not require more immediate notifications, because they do not affect the SBC and are not a material reduction in benefits, must be communicated through a summary of material modifications or an updated summary plan description within 210 days after the end of the plan year.

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