Compliance Recap

May 2015

After a few quiet months, regulatory agencies have picked up steam, leaving employers with a significant amount of new information to digest and work through. The Internal Revenue Service (IRS) was busy updating FAQs relating to reporting under the Patient Protection and Affordable Care Act (PPACA) and setting the 2016 high deductible health plan (HDHP) limits. The Department of Labor (DOL) updated all of its model forms and notices relating to FMLA, and issued FAQs on a variety of topics. The Center for Consumer Information & Insurance Oversight (CCIIO) also released a technical guidance to assist with medical loss ratio rebates and calculations.

High Deductible Health Plan Limits

The IRS has announced that for calendar year 2016 the annual limitation on contributions for individual self-only coverage with an HDHP is $3,350. The annual limit on contributions for an individual with family coverage under an HDHP is $6,750. For 2016 a health plan with an annual deductible cannot be less than $1,300 for self-only coverage, or $2,600 for family coverage and the annual out-of-pocket expenses cannot exceed $6,550 for self-only coverage or $13,100 for family coverage.

Preventive Services FAQ

On May 11, 2015, the Department of Labor (DOL), along with other federal agencies, issued an FAQ regarding the implementation of the Patient Protection and Affordable Care Act (PPACA) that focused on coverage of preventive services. Non-grandfathered group health plans and health insurance offered in the individual or group markets must provide certain listed benefits with no cost-sharing to the beneficiary. The FAQ provided information on some commonly confusing or ambiguous requirements including BRCA testing, contraception coverage, and colonoscopy related anesthesia charges.

Read more about the DOL's Preventive Services FAQ.

Cost-Sharing Limits and Provider Discrimination FAQ

On May 26, 2015, federal agencies including the DOL issued a short, five-question FAQ on two PPACA-related issues: limitations on cost-sharing and provider discrimination. The FAQ further confirmed the self-only maximum annual limitation on cost sharing applies to each individual, regardless of the type of coverage they are enrolled in

(self only, family, high deductible, etc.). The FAQ also confirmed that enforcement of PPACA's provider non-discrimination requirements are delayed, assuming plans use a good faith interpretation of the statute as it stands.

Read more about the FAQ on cost-sharing limits and provider discrimination.

IRS FAQs and Webinars

On May 20, 2015, the IRS updated all of its FAQs relating to reporting under PPACA sections 6055 and 6056. These FAQs provided more information on reporting COBRA coverage and offers, qualifying offers, when employees must be provided with forms, how governmental units should report, reporting on terminated employees, and third-party reporting.

The IRS also held a webinar on reporting, going over key points on counting employees and properly reporting coverage that is offered.

Read more about the FAQs and IRS webinar.

Technical Guidance on Medical Loss Ratio (MLR) Rebates

The Center for Consumer Information & Insurance Oversight (CCIIO) issued a technical guidance covering two topics: (1) limited circumstances in which a health insurance issuer may exclude agent and broker fees or commissions from earned premium; and (2) premium rebate applicability for policy holders who use a premium tax credit.

The MLR requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, and requires them to issue rebates to enrollees if the percentage does not meet minimum standards. The regulations state that a premium means "all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan" including reporting "agents and brokers fees and commissions" as non-claims costs. The Centers for Medicare & Medicaid Services (CMS) has become aware of issuers seeking ways to exclude agent and broker fees from premium. Recognizing there are some instances where a policyholder retains an agent or broker and pays the agent or broker's fee or commission, CMS set the following seven conditions that must all be met in order to exclude agent or broker fees and commissions from premium:

1. The law of the state in which the policy is issued does not deem the agent or broker to be a representative of the issuer;
2. The policyholder is not required to utilize an agent or broker to purchase insurance and may purchase a policy directly from the issuer;
3. The policyholder selects, retains, and contracts with the agent or broker on his or her own accord;
4. The policyholder negotiates and is responsible for the fee or commission separate and apart from premium;
5. The issuer does not include these agent or broker commissions and fees in rate filings submitted to the applicable regulatory agency;
6. The policyholder voluntarily chooses to pass the fee or commission through the issuer and is not required to do so, or the policyholder pays the fees or commission directly to the agent or broker; and,
7. The policyholder issues the 1099 to the agent or broker, if a 1099 is required.
8. The guidance also confirmed that in regard to the MLR rebate, when a policyholder is owed an MLR rebate and a portion or all of the premium was paid the premium tax credit, the issuer must provide the rebate to the policyholder.

UBA Guidance

UBA also issued guidance on a variety of topics, including the importance of tracking full-time employees and an overview of mid-size employer obligations under transition relief rules and upcoming community rating changes.

Question of the Month

Q. How is PPACA's "rate of pay safe harbor" calculated?

A. Under PPACA, coverage is considered affordable if it costs less than 9.5 percent of an employee's household income. Because employers are often unaware of an employee's household income, there are three safe harbors that an employer can use to determine affordability. One is the "rate of pay safe harbor" and under it coverage is affordable for an hourly employee if the hourly employee's contribution for self-only coverage is less than 9.5 percent of his rate of pay at the start of the coverage period, or if less, 9.5 percent of the employee's rate of pay during the calendar month, times an assumed 130 hours worked during a month, regardless of how many hours the employee actually worked. To calculate the rate of pay method for a salaried employee, the monthly salary at the beginning of the coverage period is used.

This method cannot be used for salaried employees whose salary is reduced during the year, even if the reduction is due to a reduction of hours worked. For salaried employees that are not paid monthly, a reasonable method to convert the payroll period to a monthly salary may be used.

The rate of pay method excludes tips and overtime and disregards pay increases, but does not require an adjustment for unpaid leave.

Employers may use different safe harbors for different employee groups, so long as the employee groups are based on reasonable classifications such as hourly or salaried employees, geographic location, and job category.

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