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IRS REMINDS EMPLOYERS OF STIFF PENALTIES FOR REIMBURSEMENT OF INDIVIDUAL INSURANCE PREMIUMS

The Internal Revenue Service (IRS) released guidance reiterating previously established rules from IRS Notice 2013-54 that prohibit employers from reimbursing employees for individual insurance policy premiums on a pretax basis. Highlights of the Questions & Answers (Q&A) guidance can be found below.

Under the Affordable Care Act (ACA), employer payment plans (group health plans that reimburse employees for payments made towards their individual insurance policy premiums) cannot be integrated with individual insurance policies without violating the ACA prohibition on annual dollar limits for Essential Health Benefits (EHB) and the requirement to cover preventive care services without cost-sharing. The Q&A reminds employers of the possible excise tax penalty of $100 per day, per employee affected, for noncompliance. Other consequences and penalties could result from the Departments of Labor (DOL) and Health and Human Services (HHS) as well.

No Action Required

Employers who have historically reimbursed employees tax-free for their individual insurance policy premiums should have already stopped doing so. If an employer has continued doing so, they must file IRS Form 8928 to report and pay the excise tax, quarterly, for their violation.

For complete details, see the IRS Q&A at:

http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements

OREGON AND PENNSYLVANIA TO ALLOW SAME-SEX MARRIAGE

Following two federal district court decisions that a statewide ban on same-sex marriage is unconstitutional, two more states, Oregon and Pennsylvania will soon permit same-sex couples to marry thereby becoming the 18th and 19th states, respectively, to allow same-sex marriage (other states permitting same-sex marriage include: California, Connecticut, Iowa, Massachusetts, New Jersey, New Mexico, Delaware, Hawaii, Illinois, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Maine, Maryland, Washington, and the District of Columbia).

Same-sex marriage bans in Arkansas and Idaho have similarly been held as unconstitutional; however, these rulings take effect awaiting the result of the appeal from that decision. Additionally, in Ohio, a federal court ruled that the state must recognize same-sex marriages performed in other states. The Ohio ruling is also only effective awaiting the appeal.

Action Required

Employers with employees in Oregon and Pennsylvania should ensure equal treatment of same-sex spouses as opposite-sex spouses. Any employee benefits provided to same-sex spouses in those states will not be taxable if not taxable to opposite-sex spouses.

For complete details, see:

Pennsylvania Ruling: http://www.pamd.uscourts.gov/sites/default/files/opinions/13-1861.pdf

Oregon Ruling: http://www.plainsite.org/dockets/uiu6gqlq/oregon-district-court/geiger-et-al-v-kitzhaber-et-al/

FINAL REGULATIONS AND FAQ ISSUED ON ACA MARKET REFORM AND EXCHANGE PROVISIONS

On May 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released a set of Frequently Asked Questions (FAQ) addressing certain health insurance market reforms and Exchange provisions under the Affordable Care Act (ACA). Specifically, guidance addresses the implementation of the Essential Health Benefits (EHB) package, Actuarial Value (AV), guaranteed availability, Minimum Essential Coverage (MEC) and transitional policy extensions. The following week, on May 27, 2014, the Department of Health and Human Services (HHS) released final regulations on the ACA Exchange and Insurance Market Standards for 2015 and beyond. The final regulations largely finalized the previously released proposed regulations on these provisions (released March 21, 2014). Highlights are on the following page.

Final Regulations and FAQ Issued on ACA Market Reform and Exchange Provisions (Continued)

Essential Health Benefits

Q1. For plans that must provide coverage of the Essential Health Benefit (EHB) package under section 1302(a) of the Affordable Care Act (ACA), if a health insurance issuer imposes a waiting period before an enrollee can access a covered benefit, is that a violation of 45 Code of Federal Regulations (CFR) 156.125?

A1. 45 CFR 156.125 states that a health insurance issuer does not provide an EHB package if its benefit design, or the implementation of its 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 condition. We are concerned that waiting periods for specific benefits discourage enrollment of or discriminate against individuals with significant health needs or present or predicted disability. For example, a plan that includes a waiting period for any type of transplant would discriminate against those whose conditions make it likely that they would need a transplant (e.g., those with kidney disease, heart conditions, or similarly critical and life-threatening ailments). In addition, imposing a waiting period on an EHB could mean the health insurance issuer is not offering coverage that provides an EHB as required by 45 CFR 156.115, which would be a violation of Section 2707(a) of the Public Health Service Act (PHS Act) and its implementing regulations. ***Therefore, with respect to plans that must provide coverage of the EHB package, health insurance issuers may not impose benefit-specific waiting periods, except in covering pediatric orthodontia, in which case any waiting periods must be reasonable pursuant to §156.125 and providing EHBs.***

Any health insurance issuer that currently has a waiting period in its plan policy for an EHB needs to amend the policy to remove the waiting period within a reasonable timeframe of the release of this FAQ. This clarification refers to a waiting period that is applied uniformly to a specific benefit within the plan design and not reasonable medical management.

Guaranteed Availability of Coverage

Under section 2702 of the PHS Act, as added by the ACA, health insurance issuers are generally required to guarantee the availability of coverage to every employer or individual in the State that applies for coverage. Section 2702(b)(1), however, states that health insurance issuers may restrict enrollment to open or special enrollment periods. ***The guaranteed availability regulation at 45 CFR 147.104(b) requires health insurance issuers in the individual market to provide special and limited open enrollment periods in certain circumstances, including for individuals who lose MEC and for individuals enrolled in non-calendar year individual health insurance policies when their policy year ends in 2014.***

Final regulations address a related provision, guaranteed-renewability rules. Under this rule, health insurance issuers must renew coverage at the option of the policyholder, subject to permitted modifications of coverage applied uniformly to all in the individual and small group markets. Increasing or decreasing premiums by more than 2% would be considered offering a new product and not a uniform modification of coverage. The policyholder has a guaranteed right to renew a modified policy but if the product is discontinued, the policyholder has a right to purchase any other health coverage offered by the same health insurance issuer in that market on a guaranteed availability basis.

Minimum Essential Coverage

Q6. Are conversion policies, offered to individuals losing group health insurance coverage, considered to be MEC under section 5000A(f) of the Internal Revenue Code (IRC)?

A6. Yes, as long as the conversion coverage is offered by a health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act) and is an individual market policy subject to the consumer protections that apply to such coverage (notwithstanding that under section 2741(e)(2) of the PHS Act, the issuer is not deemed to be a health insurance issuer offering individual health insurance coverage solely because such health insurance issuer offers a conversion policy).

Transitional Policy Extensions

Q8. Is a large group employer who employs 51-100 employees required to remain with the same insurer between 2013 and 2016 in order to be eligible for transitional relief in 2016?

A8. No. A large group employer is not required to remain with the health insurance issuer from which it had coverage in 2013 in order to be eligible for the extended transitional relief in 2016. Therefore, they may shop for alternative coverage with a different health insurance issuer. The key is that the extended transitional relief for eligible large group plans applies to the large employer plan that the employer has in place at the time of the renewal that occurs on or after January 1, 2016 and on or before October 1, 2016. Meaning, on January 1, 2016, if an employer employs between 51-100 employees, they will be redefined as a small employer and will be covered by the non-enforcement provisions, outlined in the March 5, 2014 bulletin, through October 1, 2016 if their large employer policy does not conform to small employer rules and it is permitted by their State and offered by the health insurance issuer.

Final Regulations and FAQ Issued on ACA Market Reform and Exchange Provisions (Continued)

Transitional Policy Extensions (Continued)

Q11. Does the large employer transitional policy starting in 2016 apply to large employers with 51-100 employees who did not have health insurance coverage at the time the transitional policy extension bulletin was issued (March 5, 2014), but who purchase a large employer policy after March 5, 2014 but before January 1, 2016?

A11. Yes. The extended transitional policy in 2016 applies to large employers with 51-100 employees that purchase health insurance coverage any time before January 1, 2016.

Q12. Are transitional policies considered MEC?

A12. Yes. Since transitional policies are offered in the individual and small group markets, they are considered to be MEC, and individuals enrolled in these plans would satisfy the individual shared responsibility requirement.

Special Enrollment Periods

The final regulations provide that Exchange Special Enrollment Periods (SEP) for loss of MEC allow affected individuals up to 60 days to enroll in Exchange coverage.

No Action Required

Employers should be aware of these rules that may affect their plans and/or employees; however, this information will primarily affect insurance carriers in the individual and small group markets.

For the complete FAQ, go to: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf

For final regulations on the Exchange and insurance market standards for 2015, go to: http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf

CALIFORNIA EXPANDS PAID FAMILY LEAVE

Beginning July 1, 2014, Senate Bill 770 will expand the definition of family members for which Paid Family Leave (PFL) may be used. Eligible California workers will be able to take PFL to care for a seriously ill parent-in-law, grandparent, grandchild or sibling.

Currently, PFL provides up to six weeks of wage replacement benefits for individuals who must take time off of work to care for a seriously ill child, spouse, parent, or registered domestic partner, or to bond with a new child. The PFL wage replacement program is administered by the State Disability Insurance (SDI) Program and provides disability compensation to cover individuals who take time off of work to care for a sick family member or to bond with a new baby.

Action Required

Employers with employees in California should ensure their leave policies are updated to include this new expanded list of family members for whom PFL may be taken.

For the complete details, see:

Senate Bill 770: http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0751-0800/sb_770_bill_20130924_chaptered.pdf

PFL Fact Sheet: http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0751-0800/sb_770_bill_20130924_chaptered.pdf

SDI FAQs: http://www.edd.ca.gov/disability/FAQs.htm

COMPLIANCE REMINDERS...

The Affordable Care Act (ACA) implemented a Patient-Centered Outcomes Research (PCOR) Fee on health plans intended to fund clinical effectiveness research for chronic illnesses. The PCOR fee began for plan years ending on/after October 1, 2012 and will expire October 1, 2019. The fee is due annually by July 31 of the calendar year following the end of the plan year.

PCOR Fee due July 31, 2014

Remit Fee using Form 720 Quarterly Federal Excise Tax Return

- *Plan sponsors of self-funded plans and fully-insured plan carriers are subject to the fee*
- *Plans exempt from the fee include stand-alone dental and vision plans, Employee Assistance Programs (EAP), wellness programs, Health Savings Accounts (HSA), some Health Reimbursement Arrangements (HRA)and Flexible Spending Accounts (FSA)*

Fee amount due in 2014 is $1 per covered life for plans ending January through September 2013 and $2 per covered life for plans ending in October, November or December 2013

- *Contact your Barney & Barney Representative for more details on PCOR fees due next month for any self-funded plans, including special rules for FSAs and HRAs*

For more information, see: http://www.irs.gov/uac/Application-of-the-Patient-Centered-Outcomes-Research-Trust-Fund-Fee-to-Common-Types-of-Health-Coverage-or-Arrangements; and, http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

QUESTION OF THE MONTH

Q1: What actions are health insurance issuers required to take to ensure that Qualified Health Plans (QHPs) intended for the individual market Exchange Marketplace meet the guaranteed availability standards, consistent with the May 16, 2014 Centers for Medicare & Medicaid Services (CMS) FAQs on QHP and the Affordable Care Act's Guaranteed Availability Standards?

A1: "As we [CMS] explained in our FAQ of May 16, 2014, all non-grandfathered individual market health insurance products must be guaranteed available to all individuals, unless an exception applies. Health insurance issuers may direct consumers who wish to enroll in a QHP to the Marketplace for enrollment, and are not required to market any QHP for sale outside of the Marketplace. Health insurance issuers who intend a QHP to be primarily for sale in the Marketplace are not required to create a designated pathway for off-Marketplace enrollment, and will satisfy the guaranteed availability standard if they enroll consumers who wish to enroll outside of the Marketplace using a process employed entirely on an ad hoc basis."

Source: CMS FAQ: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq_on_qhps_and_guaranteed_availability_6314.pdf