Benefit Beat

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SUSPENSION OF HPID REQUIREMENT

The Center for Medicare and Medicaid Services (CMS) announced on October 31, 2014 that they have suspended, until further notice, the use of the health plan identifier (HPID). The HPID and other unique identifier requirements were imposed by the HIPAA for the purpose of streamlining electronic claim processing and other health plan matters. Due to questions raised about the efficacy of the use of these unique identifiers by **CMS' advisory board**, CMS has announced that they have been suspended. A collective sigh of relief can be taken.

Source: See *Statement of Enforcement Discretion regarding 45 CFR 162 Subpart E - Standard Unique Health Identifier for Health Plans*, as posted on the CMS' Health Plan Identifier webpage.

Background Benefit Beat articles:

- *HPID Compliance Assistance Tools* (10/8/14)
- *Attention Self-funded Health Plan Sponsors: The HPID Obligation Looms Large* (8/20/14)
- *Health Plan Identifier -- Attention: Self-funded plans. Apply or Wait? That is the Question* (6/9/14)

HONEYWELL'S WELLNESS STRATEGY MAY BE NOT SO SWEET

For the third month in a row, we are reporting on challenges to employer-sponsored wellness programs [see *Another Wellness Program Challenged by EEOC*, (10/8/14) and *EEOC Challenges Wellness Program Standards* (9/9/14)].

On October 27, 2014, the Chicago office of the Equal Employment Opportunity Commission (EEOC) filed a petition seeking a preliminary injunction against the Honeywell wellness program (*EEOC v. Honeywell Int'l Inc.*, No. 14-cv-04517-ADM-TNL (D. Minn.).

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According to the EEOC petition, the Honeywell's health benefit plan, as part of its wellness program strategy, requires employees and their participating spouses, to undergo biometric testing. The testing would include blood pressure screening, a blood draw for testing cholesterol and glucose levels, a BMI testing (height, weight and waist circumference), and testing for nicotine or cotinine. Penalties for failure to undergo the biometric test by the employee and his/her spouse could result in loss of the company's contribution toward the employee's health savings account, a $500 surcharge applied to his/her medical plan cost, and a $1,000 tobacco surcharge even if the employees chooses not to undergo a biometric testing for reasons other than smoking; plus another $1000 "tobacco surcharge" if his/ her spouse does not undergo testing, even if the spouse declines to participate for reasons other than smoking.

A wellness program must run the gauntlet of many laws, certain of which have a clearer path of compliance than others. Both the HIPAA and Affordable Care Act's nondiscrimination based on health status rules have relatively clear guidelines (for a summary of the ACA's wellness program rules, see the CBIZ Health Reform Bulletin, *Final Rules Issued: Incentives for Nondiscriminatory Wellness Programs in Group Health Plans*, 6/3/13).

In addition, wellness programs must comply with the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Compliance with both of these laws is less straight forward.

The ADA requires that any collection of medical information be voluntary unless the collection is used in conjunction with a bona fide medical plan. In a class action lawsuit a few years ago (see *Update: Wellness Program – ADA Class Action Case, Benefit Beat*, 5/12/11) the court determined that the collection of medical information in that situation was accomplished, in fact, in conjunction with a bona fide health plan and was not used as a subterfuge or a way to avoid the protections of the ADA. The Honeywell matter seems to be questioning the "voluntariness" of the biometric testing.

In addition, GINA requires that family medical history not be used for underwriting purposes. The requirement that a spouse must undergo biometric testing which could result in obtaining medical history is, according to the EEOC, a violation to this requirement.

After hearing arguments on November 3, 2014, the EEOC's request for preliminary injunction has been denied by the Court. Thus, Honeywell is able to maintain its wellness program during the pendency of the proceedings.

While these challenges leave employer wellness strategies in a state of flux, whether these challenges will succeed on their merits is clearly uncertain at this point. The good news is that, hopefully, clearer guidance will derive from these challenges.

ADDITIONAL STATE RECOGNITION OF SAME-SEX MARRIAGE

Since last month's *Benefit Beat* article, twelve more states sanction same-sex marriage. This issue continues to change and evolve. Below is the latest tally as it stands at the time of this writing:

States with Same-Sex Marriage Laws		
Alaska	Iowa	Oklahoma
Arizona	Maine	Oregon
California	Maryland	Pennsylvania
Colorado	Massachusetts	Rhode Island
Connecticut	Minnesota	Utah
Delaware	Nevada	Vermont
District of Columbia	New Hampshire	Virginia
Hawaii	New Jersey	Washington
Idaho	New Mexico	West Virginia
Illinois	New York	Wisconsin
Indiana	North Carolina	Wyoming

UPDATES: SAN FRANCISCO'S HEALTH CARE SECURITY ORDINANCE

2015 Salary Exemption Limit

Along with adjusting an employer's health care expenditure amounts for 2015 (see *San Francisco HCSO Expenditure Rates for 2015*, *Benefit Beat*, 7/8/14) for purposes of the San Francisco's Health Care Security Ordinance (HCSO), the Office of Labor Standards Enforcement (OLSE) has adjusted the salary exemption figure. An employee who is a manager, supervisor, or confidential employee, and who earns at or above an annual salary of $90,745 (or, $43.63 hourly) in 2015 is exempt from coverage under the HCSO. In 2014, the annual salaried figure was $88,212 or $42.41 hourly.

Clarification Guidance relating to Expenditures

The Office of Labor Standards Enforcement have recently updated and released several pieces of guidance relating to the Health Care Security Ordinance (HCSO):

- ***Revocable and Irrevocable Health Care Expenditures***
- ***The HCSO and the Affordable Care Act***
- ***Expenditures and Enforcement for 2014***

Of particular note is the guidance relating to revocable and irrevocable health care expenditures. *Irrevocable expenditures* refer to monies that cannot be retained or returned to the employer, even in the event of termination of employment or cessation of business. Examples of these types of expenditures include payments for medical, dental, or vision insurance premiums, contributions to the City Option, or contributions to reimbursements accounts such as a health savings account or medical savings account.

A *revocable expenditure* is one that the employer allocates for or on behalf of an employee which could revert back to the employer.

According to this guidance, an employer can provide a portion of its obligation in the form of a revocable contribution; however, over the next few years, the portion that can be revocable will be phased out. In 2015, forty percent of the employer contribution can be revocable; the revocable percentage decreases to 20% in 2016. Beginning in 2017, all employer contributions must be irrevocable.

There are four criteria for determining a revocable expenditure; they are:

1. The expenditure is reasonably calculated to benefit the employee;
2. No portion of the expenditure can be returned to the employer prior to a specified amount of time;
3. The employee receives notification within 15 days of the employer's expenditure; and
4. The employee separating from employment receives notification within 3 days of termination explaining that any unused portions of the revocable expenditure will continue to be available for a minimum of 90 days following termination, how remaining amounts can be used, the current account balance, restrictions for using the revocable expenditure, and the date of when the account monies will no longer be available.

The minimum length of time a revocable expenditure must remain available prior to when an employer can reclaim any unused funds occurs on the earliest of:

- 24 months from the expenditure date;
- 90 days following an employee's separation from employment; or
- Where revocable expenditures are made prior to January 1, 2014, the date an employee waives, in writing, the unused portion.

2015 Benefit Plan Limits

In ***Revenue Procedure 2014-61***, the IRS released 2015 inflationary or cost of living adjustments relating to several types of benefits, as follows.

Small Business Tax Credit. The small business tax credit (SBTC) phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $25,800 in the 2015 tax year (the phase-out wage limit for 2014 was $25,400). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the SBTC, and only for a 2-consecutive year period.

FSA Cap. The amount that can be contributed to a health flexible spending account (FSA) through voluntary salary reductions in 2015 is increased to $2,550, up from $2,500 in 2014.

Qualified Transportation Fringe Benefits
In 2015, the transportation expenses reimbursed by an employer and excludable from the employee's income under a qualified transportation program remain unchanged from the 2014 limits:

	2014	2015
Commuter Highway Vehicle (van pooling) and Any Transit Pass	$130	$130
Qualified Parking	$250	$250

As a reminder, employees who use their bicycles for traveling between home and their place of employment are entitled to receive a reimbursement of up to $20 per month ($240 annually) for qualified bicycle expenses. This limit is not indexed nor tied to a cost of living adjustment.

Qualified Adoption Assistance Reimbursement Program (IRC §137)
An employer-provided adoption assistance program that meets the qualifications of IRC §137, allows participants to recover expenses relating to adoption, such as reasonable adoption fees, court costs, attorney's fees and traveling expenses. Below are the exclusion limits and AGI phase-out limits for 2014 and 2015:

	2014	2015
Exclusion Limit	$13,190	$13,400
AGI Phase-out Limits	Between $197,880 and $237,880	Between $201,010 and $241,040

Health Savings Accounts. Please note that the 2015 annual limits applicable to health savings accounts were released earlier this year (see ***IRS issues 2015 HSA Limits and Other Cost-Sharing Matters***, *Benefit Beat*, 5/8/14).

Archer Medical Savings Accounts. The Archer MSA pilot project ended on December 31, 2007; therefore, no new MSAs could be established after that date. For existing MSAs, the annual deductible limit of a HDHP and out-of-pocket expense limit in an Archer medical savings account for 2015 are slightly increased:

	2015	
	Single	*Family*
HDHP Annual Deductible	Between $2,200 and $3,300	Between $4,450 and $6,650
Out-of-Pocket Expenses	$4,450	$8,150

Long-Term Care Premiums. The IRS limitations relating to eligible long-term care premiums includible as medical care, as defined by IRC §213(d) are:

Age at End of Tax Year	2015 Premium Limit
<40	$380
>40 but <50	$710
>50 but <60	$1,430
>60 but <70	$3,800
>70	$4,750

Premium Tax Credit for Coverage under a Qualified Health Plan

Individuals who buy coverage through the marketplace and meet certain income criteria may be eligible for an advance credit payment wherein a portion of the premium is made directly to the insurer to cover the cost of coverage. The amount of an individual's premium tax credit is reduced by the amount of any advance credit payments made during the year. If the advance credit payment for a taxable year exceeds the premium tax credit limit, the individual would owe the excess as additional tax, subject to certain inflationary limits.

For tax years beginning in 2015, the limitation on tax imposed for excess advance credit payments is determined using the following table:

Household Income *(as percent of poverty line)*	**Limitation amount for unmarried individuals** *(other than surviving spouse and head of household)*	**Limitation amount for all other taxpayers**
Under 200%	$300	$600
Between 200% and 300%	$750	$1,500
Between 300% and 400%	$1,250	$2,500

2015 Social Security Cost-of-Living Adjustment

The 2015 cost of living adjustment to the Social Security wage base is increased from $117,000 to $118,500. The Medicare tax is generally assessed on all wages. The combined tax rate remains at 7.65% - the Social Security portion is 6.2% on wages up to the applicable maximum taxable amount; the Medicare portion is 1.45% on all wages. Additional adjustments are included in the SSA's Fact Sheet: ***2015 Social Security Cost-of-Living Adjustments***.

2015 Pension and Retirement Plan Limits

The 2015 plan limits, applicable to defined benefit and defined contribution plans, have been issued by the IRS (highlights below).

	2014	2015
Defined benefit plan annual limit	$210,000	$210,000
Defined contribution plan annual limit	$52,000	$53,000
Elective deferral limit for purposes of cash or deferred arrangements (401(k) plans) and tax-sheltered annuities (403(b) plans)	$17,500	$18,000
Maximum deferral limit for 457 plans	$17,500	$18,000
>Age 50 Catch-up Contribution Limit to 401(k), 403(b) or 457(b) Plans	$5,500	$6,000
Maximum deferral limit for SIMPLE plans	$12,000	$12,500
>Age 50 Catch-up Contribution Limit to SIMPLE Plans	$2,500	$3,000
Minimum compensation considered in determining eligibility for a SEP	$550	$600
Threshold for Highly compensated employee (HCE)	$115,000	$120,000
Key Employee Compensation Limit for Top Heavy Plan Purposes	$170,000	$170,000
Annual compensation limit	$260,000	$265,000

Sources:

- ***IRS News Release***
- ***IRS COLA Table*** (includes 2013-2015 limits)

2015 Medicare Parts A and B: Premium and Deductible Rates

The Centers for Medicare and Medicaid Services has released the applicable Medicare Part A and Part B premium and deductible rates for 2015.

2015	Part A
Premium	❒ No monthly Part A premium for those with 40+ quarters of Medicare-covered employment. ❒ $407 per month for people who are not otherwise eligible for premium-free hospital insurance and <30 quarters of Medicare-covered employment.
Deductible	❒ $1,260 for first 60 days of inpatient care; ❒ Additional $315 per day for days 61 through 90; ❒ Additional $630 per day beyond the 90th day.

Part B Premium and Deductible

The standard Medicare Part B monthly premium ($104.90) the Part B deductible ($147) for 2015 remains unchanged from 2014.

Source: ***Medicare 2014 & 2015 costs at a glance***

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