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About Us

ICMS is a full service employee benefits consulting firm, utilizing creative and innovative solutions to assist clients in achieving greater value by increasing efficiencies, reducing cost, and enhancing employee productivity consistent with each client's unique culture.

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Innovative Cost Management Services, Inc.

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Health Care Reform:

At ICMS, one of our main priorities is to keep you as up-to-date and informed as possible on the ever-evolving world of health benefits and Obama's Affordable Care Act. We will be sending out a monthly compliance recap to cover these changing laws, and if an update comes out that is of a more urgent nature, you can rest assured that you will get the news as soon as we do!

Monthly Compliance Recap

During the month of October, there were developments in the courts and new information from the regulatory agencies that may affect sponsors of group health plans.

Requirement to Obtain a Health Plan Identifier (HPID) Delayed

On Friday October 31, 2014 the Department of Health and Human Services (HHS) quietly updated its Health Plan Identifier information page to delay the requirement that insurance carriers and self-funded health plans obtain a health plan identifier (HPID). The delay is in effect until further notice.

Plans that have already obtained their HPID do not need to take any action. Those that do not yet have the number do not need to complete the process.

This delay does not affect the Transitional Reinsurance Fee (TRF) filing - that submission remains due November 15, 2014.

Transitional Reinsurance Program Filing

The transitional reinsurance fee (TRF) applies to fully insured and self-funded major medical plans for 2014, 2015, and 2016. Insurers are responsible for reporting and paying the fee on the policies they issue, although the fee will generally be passed on to the employer. Plan sponsors of self-funded plans (or their representatives) must report and pay the fee to the federal government at www.pay.gov.

All plans that provide primary major medical coverage to employees or retirees owe this fee. Major medical coverage includes medical plans that provide minimum value (that is, have an actuarial value of 60% or more) and all medical policies provided through the Marketplace.

The annual fee is $63.00 per covered life for 2014. This year's TRF filing is due by November 15, 2014, although the fee itself is not due until 2015.

Read a summary of the TRF requirements.

Read a line-by-line description of how to complete the submission.

2015 Cost-of-Living Adjustments

The IRS has issued the cost-of-living adjusted figures for qualified plans and for several fringe benefits for 2015. Of particular interest to many employers are:

- An increase in the maximum employee contribution to a health flexible spending account (HFSA) to $2,550
- An increase in the 401(k) and 403(b) contribution limit to $18,000
- An increase in the 401(k) and 403(b) catch-up limit to $6,000

Download a summary of key annual limits.

This relatively late notice of the 2015 HFSA limit may create issues for employers that have completed open enrollment. Employers that wish to increase the limit in their plan should read their plan document. Some plans are written to set the HFSA limit at whatever the indexed amount is, in which case no plan amendment will be needed (and the employer will need to allow elections of $2,550). If the plan states that the limit is a flat $2,500, a plan amendment will be needed before the start of the 2015 plan year if the employer wishes to increase the HFSA maximum contribution. Employers that have completed open enrollment, but who want to allow the increased contribution limit, may allow an amended election. Under IRS rules the amended election may be accepted up to the first day of the 2015 plan year, although for administrative reasons employers may wish to use a deadline prior to that date.

Another EEOC Challenge to a Wellness Program

The Equal Employment Opportunity Commission (EEOC) has filed another lawsuit against an employer that has built significant penalties into its wellness program. Under the Honeywell wellness program, employees and their spouses are required to participate in biometric screenings, including a blood draw to obtain cholesterol and glucose levels. Employees and their spouses were only asked to get the screenings; they did not need to achieve a particular result. An employee and spouse who declined to participate in the screening would lose a company contribution to the employee's health savings account of up to $1,500, incur a $500 surcharge on medical plan costs, and owe tobacco surcharges of up to $1,000.

The EEOC's position is that the program violates the Americans with Disabilities Act's (ADA) protection against involuntary medical inquiries. In the view of the EEOC, the incentives are large enough that as a practical matter they are involuntary, effectively forcing employees to participate in the biometric screenings.

The EEOC also claims that the program violated the Genetic Information Nondiscrimination Act's (GINA) prohibition against providing inducements to employees to obtain the family medical history of the employees. According to the EEOC, by imposing a penalty on the employee if the employee's spouse does not participate in the program's biometric screening, Honeywell's program is providing a financial inducement to obtain family medical information.

It remains to be seen whether the courts will agree with the EEOC's interpretation of these laws, but employers that sponsor wellness programs need to be aware that simply complying with the PPACA wellness requirements may not be enough to avoid legal issues.

Reference-Based Pricing and Cost-Sharing Limits

The Department of Labor (DOL), the IRS, and the Department of Health and Human Services (HHS) have jointly issued a FAQ that addresses how "reference-based pricing" works with the Patient Protection and Affordable Care Act's (PPACA) restrictions on out-of-pocket maximums. PPACA limits the out-of-pocket maximum a non-grandfathered plan may impose, and generally requires that co-pays, coinsurance, and deductibles be counted toward this limit. However, premiums, balance billed amounts for non-network providers, and non-covered services do not need to be applied to the out-of-pocket limit. (For 2015, the limits are $6,600 per individual or $13,200 per family.) The new FAQ explains how the out-of-pocket limit applies to plans that use reference-based pricing-i.e., a design under which the plan pays a fixed amount for a particular procedure (such as a knee replacement), which certain providers have agreed to accept as full payment.

The FAQ states that the agencies will permit the reference price to be treated as the in-network price, as long as the plan uses a reasonable method to provide adequate access to quality providers who are willing to accept the reference price. The agencies will determine whether a plan that uses reference-based pricing (or a similar network design) is using a reasonable method to ensure adequate access to quality providers based on:

- The Type of Service. Plans may treat providers that accept the reference price as the sole network providers only for those services for which consumers have enough time to make an informed choice of provider. For example, this design is not appropriate for emergency services.
- Reasonable Access. Plans should ensure the availability of an adequate number of providers that accept the reference price. Considerations include network adequacy approaches developed by the states, geographic distance measures, and patient wait times.
- Quality Standards. Plans should ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.
- Exceptions Process. Plans should offer an easily accessible exceptions process when access to a provider that accepts the reference price is unavailable or would compromise the quality of services for a particular individual because, for example, of the patient's other medical issues.
- Disclosure. Plans should provide, automatically and free of charge, information about the pricing structure, including the services to which it applies and the exceptions process. In addition, the plan should provide specified information, such as provider lists, upon request.

Same-Sex Marriage

With the decision of the U. S. Supreme Court not to hear appeals of several cases that overturned same-sex marriage bans, more employers are located in states that recognize same-sex marriage. This area continues to change rapidly, and state and local laws can have a significant impact on an employer's options and obligations.

Read a summary of the issues plan sponsors need to consider when covering - or excluding - same-sex spouses.

Question of the Month

Q: Must a plan still provide notices of creditable coverage to terminating participants?

A: Plans must still provide notices of creditable coverage until December 31, 2014. This is because pre-existing condition limitations will not be totally eliminated for non-calendar year plans until the start of their 2014 plan year.