Understanding Self-Funded Concepts In Light of Health Care Reform
Agenda

• Overview
• Differences between self-funded and fully insured plans under the ACA
• Out-of-Pocket Limit Transition Relief
• Essential Health Benefits
• HRAs under ACA
• Nondiscrimination Rules
Overview

• Considerations when contemplating self-funding:
  – Cash flow
  – Appetite for risk
  – Administrative costs
Overview

- Benefits of self-funding:
  - No premium taxes (except on stop-loss insurance), but need an administrator
  - Self-funded ERISA plans do not need to comply with state mandated benefit laws, which leads to:
    - consistency in benefit design when operating in multiple states;
    - greater freedom to determine eligibility;
    - greater freedom to determine covered benefits; and
    - greater flexibility to exclude or limit coverage for certain types of claims
  - Potential for better coordination with wellness programs
Overview

- Other considerations:
  - Greater responsibility for claims decisions
  - Ability to tailor plan documentation
  - HIPAA compliance
Self-Funded Group Health Plans Under ACA

- Most of the ACA’s group health plan mandates apply equally to self-funded and fully insured group health plans, including:
  - Coverage of preventive health services
  - Extension of coverage to adult children (age 26)
  - Prohibitions on lifetime dollar limits, rescissions
  - Elimination of preexisting condition exclusions
  - Patient Protections (PCP designations, ER parity)
Self-Funded Group Health Plans Under ACA

- Some mandates apply only to fully insured plans:
  - Deductible limits (2014)
    - Small group deductibles cannot exceed $2,000/$4,000
    - Exception for plans that cannot meet stated actuarial value
  - Modified community rating rules (2014)
    - Applicable to non-grandfathered individual and small group plans
    - Carriers may vary premiums based only on age (3:1), tobacco use (1.5:1), family size, and geography
  - Should small employers consider renewing by December 2013?
Self-Funded Group Health Plans Under ACA

- Some mandates apply only to fully insured plans:
  - Medical loss ratio rebates
  - Nondiscrimination rules (unknown effective date)
    - Already apply to self-funded plans
  - Health insurance industry tax (2014)
    - Could lead to more plans self-funding
    - Applies to medical, dental and vision
  - Guaranteed issue and renewability (2014)
    - Could ease transition back into fully insured market
    - Could lead to adverse selection in insured market
Self-Funded Group Health Plans Under ACA

- PCORI and Transitional Reinsurance Fees apply to self-funded and fully insured group health plans
  - $1/$2 PCORI fee applies to HRAs
    - Fee applies on a per-covered employee basis for HRAs
    - Applies on a per-member basis for major medical
Out-of-Pocket Limits – 2014 Transition Relief

- Out-of-Pocket Limits – Applicable to all non-grandfathered plans
  - 2014 OOP limits for in-network care: $6,350 single / $12,700 family
  - Deductibles, coinsurance and copayments apply toward the limit
  - Additional regulatory guidance may be forthcoming; existing regulations apply only to Exchange plans

- Transition Relief for Plans that use Multiple Service Providers
  - Released as part of the DOL FAQ series in February 2013
  - Applies only to the first plan year beginning in 2014
  - Generally applicable to self-funded plans that use a PBM
  - Departments will consider a plan to have satisfied the OOP limits if:
    1. Plan complies with OOP limit for major medical coverage; and
    2. To the extent the plan includes an OOP limit on the other coverage (e.g., there is a separate OOP limit for Rx), it complies with the limit)
Essential Health Benefits

- Plans **not required** to cover Essential Health Benefits
  - Self-insured plans
  - Insured large group plans
  - Grandfathered plans
  - If these plans cover EHBs, they cannot impose annual or lifetime limits on the dollar value of EHBs

- Plans **required** to cover Essential Health Benefits
  - Non-grandfathered health insurance plans in the individual and small group markets both inside and outside of the Exchanges
  - Medicaid benchmark and benchmark-equivalent and Basic Health Programs
Essential Health Benefits

- **Essential Health Benefits** include:
  1. Ambulatory patient services (doctor’s visits);
  2. Emergency services;
  3. Hospitalization;
  4. Maternity and newborn care;
  5. Mental health and substance use disorder services, including behavioral health treatment;
  6. Prescription drugs;
  7. Rehabilitative and habilitative services and devices;
  8. Laboratory services;
  9. Preventive and wellness services and chronic disease management; and
  10. Pediatric services, including oral and vision care.
Essential Health Benefits

- Employers that sponsor self-insured plans should identify which benefits are EHB’s
- Under current guidance, a self-funded plan can adopt any HHS-approved EHB package for purposes of determining which benefits offered under the self-funded plan are EHBs
- Employers should consider how the election of a particular EHB package as a benchmark should be documented (e.g., plan document, SPD, administrative policy)
Essential Health Benefits – Pediatric Dental

- In 2014, plans offered in the individual and insured small group market must either include pediatric dental benefits, or provide them under a stand alone plan.
- Exchange plans may exclude pediatric dental from their EHB package if it is available as a stand alone benefit on the Exchange.
  - No requirement to purchase, even if children in family.
- Non-Exchange plans may exclude pediatric dental if carriers are reasonably assured that participants are otherwise covered.
- Self-funded and large group plans do not have to offer the pediatric dental benefit.
Small Group Health Insurance Plans

- **Small group health plans** are generally subject to all the same insurance mandates and market reforms as large group and self-insured group health plans, PLUS
  - Required to cover Essential Health Benefits
  - Deductibles cannot exceed $2,000/$4,000 single/family
  - Subject to Modified Community Rating (Fair Health Insurance Premiums)

- “**Small**” for Insurance/Exchange purposes: 100 or fewer employees on business days during preceding calendar year (states may reduce limit to 50 or fewer until 2016)
- “**Small**” for Play or Pay purposes: Less than 50 FTEs
HRAs under ACA

• Use of HRAs To Reimburse Premiums In the Individual Market
  – IRS: Free Standing HRAs that reimburse premiums for individual policies do not meet ACA requirements regarding annual limits
    – Such arrangements are not “integrated”

• What is the fate of Premium Reimbursement Arrangements and HRAs that are “106(c)(2) FSAs”
  – Can they still reimburse premiums for individual policies?
Nondiscrimination under Code Section 105(h)

- Nondiscrimination rules for insured plans under ACA originally intended to apply the later of (i) first plan year beginning on or after September 23, 2010 or (ii) when plan loses its grandfathered status
- These requirements have been indefinitely delayed until further regulatory guidance is released
- Already apply to self-funded plans
- For insured plans, however, the penalty is $100/day with respect to each individual to whom the failure relates, not taxation of benefit payment
Nondiscrimination under Code Section 105(h)

- Under Code §105(h) a plan cannot discriminate in favor of highly compensated individuals (HCEs) as to eligibility to participate or the benefits provided under the plan.
- HCEs include:
  - The five highest paid officers.
  - A shareholder who owns more than 10 percent of the employer’s stock.
  - The highest paid 25 percent of all employees (other than excludable employees).
  - HCEs assessed on a Controlled Group Basis.
  - Look for subsidiaries, brother-sister controlled group, affiliated service groups—separate EIN meaningless.
Nondiscrimination under Code Section 105(h)

- **ELIGIBILITY TEST**
  - Three alternative tests:
    - the 70% test;
    - the 70%/80% test; or
    - a nondiscriminatory reasonable classification test
  - Excludable employees include those who:
    - Have less than three years of service;
    - Are under age 25;
    - Belong to a union or who are nonresident aliens; or
    - Are “part-time” or “seasonal employees”
      - Part-time for this purpose is less than 35 hours
Nondiscrimination under Code Section 105(h)

- ELIGIBILITY TEST
- The 70% test:
  - The plan benefits 70% or more of all employees – e.g., 100 employees, at least 70 must be covered
- The 70%/80% test:
  - The plan “benefits” 80% or more of all employees who are eligible to benefit under the plan and 70% or more of all employees are eligible to benefit under the plan – e.g., 100 employees, at least 70 must be eligible for coverage and at least 80% of those employees (56) are covered
Nondiscrimination under Code Section 105(h)

- ELIGIBILITY TEST
- Reasonable Classification test:
  - The plan benefits a classification of employees set up by the employer which is found by the Internal Revenue Service not to be discriminatory in favor of HCEs
  - Based upon the facts and circumstances of each case
Nondiscrimination under Code Section 105(h)

• Example of Eligibility Test
  • Employer sponsors a self-insured plan in which its rank and file participate
  • Employer establishes a fully insured plan in which only the executives of the Company may participate
  • There are 100 employees; only 10 executives are eligible to participate
    • Result: once executive plan loses its grandfathered status, this arrangement will fail the Eligibility Test, as only 10% of the workforce is eligible to participate.
    • $100 per affected employee per day penalty for discriminatory insured plans under ACA (delayed)
Nondiscrimination under Code Section 105(h)

- **BENEFITS TEST**
  - All benefits provided to any one HCE are provided to all other participants on the same basis; and
  - The plan must also not discriminate in favor of HCEs in actual operation
  - Essentially, if any benefit is provided to an HCE that any other participants do not receive, the plan will fail the benefits test
  - Note: Benefits are not only those benefits included in the plan—IRS has ruled that benefits include any premium contribution that is greater for HCEs, shorter waiting periods, longer COBRA, etc.
Nondiscrimination under Code Section 105(h)

- Example of Benefits Test
- If an employer pays a greater percentage of premium for any of its HCEs than for all of its non-HCEs, the plan will fail the Benefits Test.
- Similarly, if an employer extends the post-termination COBRA or other coverage for an HCE and does not provide the same extension to all non-HCEs, the plan will fail this test.
Nondiscrimination under Code Section 105(h)

- Observations
- Are executive insurance products dead?
- Under 50 exclusion from penalty
- Potential work arounds for other practices
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