April 26, 2018

Compliance Issues Related to Emerging Employee Benefit Strategies

Presented by Benefit Comply

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- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.

- You will be able to submit questions during the webinar by using the “Questions” or “Chat” box located on your webinar control panel.

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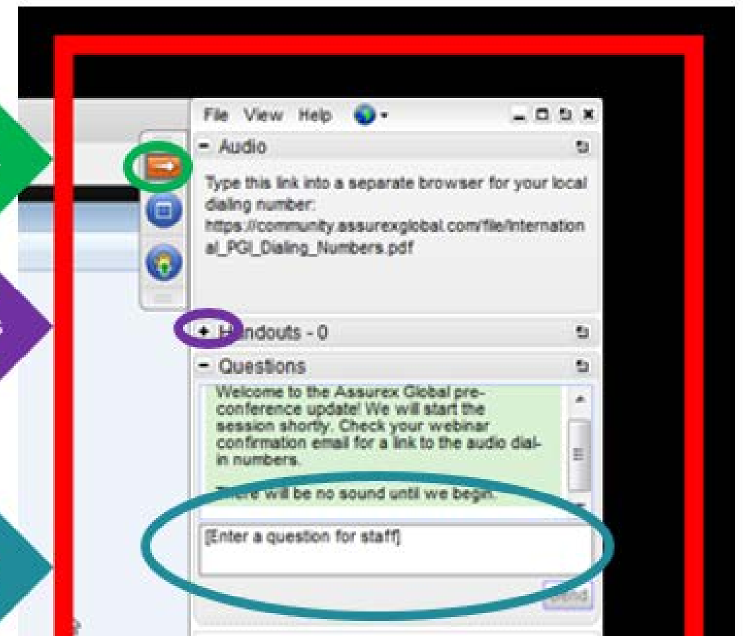

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Agenda

- Onsite Clinics
- New Health Care Delivery Models and Direct Primary Care
- Spousal Carve-outs and Surcharges
- Reference Based Pricing
- Self-Insuring Small Employers
- Waiver Incentives
- Dealing With Health Plan Affordability

On-site Medical Clinics

Onsite Clinics

Issues arise for both employer sponsored onsite clinics and medical providers who offer free or reduced cost medical services to employees

- ERISA
  - If clinic provides services for more than "the treatment of minor injuries or illnesses or rendering first aid then likely considered group health plan subject to ERISA
    - Benefits should be articulated in plan document and SPD
      - Most common approach is to include clinic benefits in the wrap documents with other ERISA benefits
    - Employee participation should be counted for 5500 purposes
- ACA
  - An on-site clinic will likely meet the HIPAA definition of an excepted benefit:
    - Does not need to comply with ACA group health plan rules (e.g. max OOP, no lifetime or annual max, etc.)
    - Does not need to be integrated with group health plan, so it can be offered to employees who are not enrolled in the employer's health plan

Onsite Clinics

- HIPAA Privacy and Security
  - The clinic must comply with HIPAA Privacy and Security as a medical provider
  - As an employer sponsored plan, HIPAA includes an exemption from Privacy and Security rules for excepted benefits - but HIPAA rules should be followed by employer when offered as part of the employer sponsored health plan
- HSA Eligibility
  - Access to benefits through an onsite clinic may interfere with HSA eligibility if the services provided are:
    - considered significant benefits in the nature of medical care other than allowed preventive care
    - are provided at reduced or no cast (i.e., below fair market value) before an individual satisfies their HDHP deductible
  - Added complexity: there is no clear definition of “fair market value”

On-site Clinics

- HSA Eligibility (continued)
  - IRS Notice 2008-59 includes example of insignificant medical benefits
    - Not significant benefits - HSA eligibility preserved
      - A manufacturing plant operates an on-site clinic that provides the following free health care for employees: (1) physicals and immunizations; (2) allergy injections; (3) aspirin and other nonprescription pain relievers; and (4) treatment for injuries at the plant.
    - Significant benefits - covered individuals not HSA eligible
      - A hospital permits its employees to receive care at its facilities for broad range of medical needs. For employees who have health insurance, the hospital waives all deductibles and co-pays

On-site Clinics

- COBRA
  - As an employer sponsored group health plan, clinic access must be offered to COBRA qualified beneficiaries
  - Offer combined with health plan or separate?
    - Employers have some flexibility because COBRA regulations give little guidance on combined or separate offers – should be based on “the instruments governing the plan”
    - If clinic access is provided to employees who are not enrolled in employer’s group health plan, COBRA for just clinic access must be offered
  - COBRA Rate
    - Calculate cost based on prior years’ total employer costs to provide clinic access to all eligible participants - example:
      - $100,000 annual employer cost / 1000 eligible participants = $100 per participant per year
      - $100/12 month = $8.33/mo
      - Employer plan has an average of 3 participants per family
      - COBRA Rate - S = $8.50 mo. Family = $25.50/mo.

New Health Care Delivery Models

- Telemedicine, Clinic Concierge Arrangements
  - Key questions to ask
    - What medical services are being provided - i.e. preventive only, access only, significant medical services?
    - Is employer sponsoring the plan, or does the offer meet the DOL voluntary benefit safe harbor (no employer payment, no employee pre-tax contributions, no employer involvement in plan administration)?
  - Assuming the arrangement is employer sponsored and is providing medical care, issues similar to onsite medical clinics arise under ERISA and COBRA

New Health Care Delivery Models

- Telemedicine, Clinic Concierge Arrangements (continued)
  - HSA eligibility
    - If more than preventive care is provided at less than fair market value, these arrangements can make individuals ineligible for HSA contributions
  - Health FSA, HRA, and HSA reimbursements
    - Concierge "access fees" are generally not reimbursable through Health FSA, HRA, or HSA
  - ACA
    - Most programs won't meet the requirements for an excepted benefit
    - Under current ACA rules, employer sponsored plans may not be offered on a stand-alone basis and should be integrated with the employer medical plan
      - ACA integration means only employees covered by employer group health plans should be offered these benefits

Direct Primary Care

- Background
  - Most arrangements involve a flat fee paid to a provider for a broad range of primary care service – typically includes more than preventive care
  - Many states are considering legislation to exclude these arrangements from state insurance laws
- Even if excluded from state insurance law, they may still be an employer sponsored plan
  - Is employer sponsoring the plan, or does the offer meet the DOL voluntary benefit safe harbor (no employer payment, no employee pre-tax contributions, no employer involvement in plan administration)?
  - Assuming the arrangement is employer sponsored, similar compliance issues arise
    - ERISA
    - COBRA
    - HSA eligibility
    - ACA integration

Spousal Carveouts and Surcharges

Spousal Carve-outs, Incentives, and Surcharges

- Background
  - As health care costs continue to rise, there has been an increasing number of employers considering the implementation of a spousal carve-out or spousal surcharge as a strategy to reduce costs
- ACA Considerations
  - Applicable Large Employers must offer coverage to full-time employees and children to avoid §4980H penalties – no requirement to offer coverage to spouses
  - Spouses who are not eligible for the employer plan could qualify for subsidies when purchasing individual coverage on a public Exchange

Types of Programs

- Complete Spousal Carve-Out
  - Spouses are ineligible to participate if they are eligible for other employer sponsored coverage
    - Will eligibility for any type of other coverage make spouse ineligible?
      - What if the spouse is only eligible for an employer sponsored “mini-med” plan or other limited plan coverage?
    - Is the cost of the other coverage a factor in determining eligibility?
- Spousal Surcharge
  - Charging an employee contribution surcharge for spouses who are eligible for other employer sponsored coverage
  - Provides an incentive for spouses to enroll in the other group coverage, but still allows eligibility in the employer’s plan for those who need it
- Eligibility restricted to when other coverage is also elected
  - Some employers define eligibility so that if a spouse has other coverage available, they must enroll in that coverage to be eligible for the plan
  - Allowing spouses to enroll in the plan only if they also enroll in other available coverage makes the employer plan the secondary payer for claims purposes

Documentation Issues

- Employee Affidavits
  - Common approach - require a signed affidavit from the employee which certifies that the spouse is not eligible for other employer sponsored coverage
- Eligibility Audits
- Certification from Spouse's Employer
  - Some employers require the spouse to obtain a signed form or certification from their employer
    - Spouse's employer is not legally required to provide information
    - Spouse's employer may be prohibited from providing plan enrollment information directly to another employer due to HIPAA privacy rules

Other Issues

- Healthcare Reform and Grandfathered Plan Status
  - A spousal surcharge could affect a plan's grandfathered status
    - To retain grandfathered status, employer may not reduce the percentage of premium paid by the employer by more than 5% for any tier of coverage, compared to employer contribution 03/23/2010
      - Example, if employer paid 75% of the family premium for a plan on 03/23/2010, it must continue to pay at least 70% of family premiums to retain grandfathered status
- HIPAA Special Enrollment Rules
  - Employers should consider how their rules will impact the spouse's ability to enroll in their own employer's plan
    - Loss of coverage triggers a HIPAA special enrollment, so a loss of eligibility due to a spousal carve-out would require the spouse's plan to allow a mid-year enrollment
    - Implementation of a surcharge is not a HIPAA special enrollment

Other Issues

- COBRA
  - Loss of eligibility due to a plan change is not a COBRA qualifying event for the spouse
    - Employers may be tempted to offer COBRA in this situation, but an insurance carrier or stop-loss provider may not provide coverage since it is not an actual COBRA event
- Section 125 Cafeteria Plan Issues
  - The ability for the spouse to make election changes in their employer sponsored plan will depend on that plan's definition of allowable status change events
    - As described above, health plans are required to allow mid-year election changes in the case of HIPAA special enrollment events, however, other Section 125 status changes (e.g. cost or coverage change) are optional and can vary from plan to plan

Reference Based Pricing

Reference Based Pricing

- Reference Based Pricing Background
  - Health plan design where payment for specific services are pegged to a "reference price" (e.g. 125% of Medicare reimbursement amount)
    - Patient may be liable for balance billing if provider refuses to accept reference price for services provided
- ACA Out-of-Pocket (OOP) Maximums Background
  - ACA limits the OOP maximum in a health plan
  - 2018 OOP limits are $7,350 for self-only coverage and $14,700 for family coverage
    - These are different than HDHP OOP maximums

Reference Based Pricing and OOP Maximums

- Regulatory agencies (DOL,HHS, IRS) issued FAQ guidance on how cost-sharing limits apply to plans that use reference-based pricing
  - Participants should have reasonable access to providers willing to accept the reference price
  - If a plan sets reference pricing so that few providers would be willing to accept as payment in full, the plan must count a participant's out-of-pocket payments toward the plan's overall cost-sharing limit
- Agencies will determine whether a plan that uses reference-based pricing is reasonable based on factors including:
  - Type of Service - Plans should only include services where participants have enough time to make an informed choice of provider. For example – reference-based pricing should not be used for emergency services
  - Reasonable Access - Plans should ensure the availability of an adequate number of providers who meet reasonable quality standards accept the reference price
  - 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

Reference Based Pricing and OOP Maximums

- Disclosure
  - Plans should provide information about the pricing structure, including the services to which it applies and the exceptions process. In addition, plans should provide the following specified information upon request:
    - a list of providers that will accept the reference price for each service;
    - a list of providers that will accept a negotiated price above the reference price for each service; and
    - information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards

Self-Insuring Small Employers

Self-Insuring Small Employers

- Background
  - Insurance industry has introduced new “hybrid” products (e.g. level funded plans) to smaller employers that are considered self-insured plans under state insurance law
    - Uses a very low stop-loss arrangement to limit small employer risk
  - Fully-insured small group market subject to community rating rules
    - Self-insured plan rates can be more closely tied to prior claims experience than in the insured small group market
- COBRA and State Continuation
  - Background
    - COBRA applies to fully-insured or self-insured plans sponsored by employers with at least 20 employees
    - State health plan continuation laws often apply to employers with less than 20 employee, but applies only to fully-insured plans
  - When an employer with less than 20 employees sponsors a self-insured plan, participants will not have COBRA or state continuation rights

Waiver Incentives

Waiver Incentives

- Description
  - Providing cash or other incentives to those who are eligible, but waive coverage under the group health plan
  - Also referred to as an “Opt-Out Credit” or “Cash-in-Lieu of Benefits”

Waiver Incentives

- While allowed, there are several design considerations:
  - Some carriers have underwriting and policy restrictions around such practices (e.g. in order to maintain participation)
  - Additional cash should be treated as additional taxable compensation
  - Should part of the cafeteria plan to avoid issues of constructive receipt (which may have additional tax consequences)
  - Cash opt-out credits may affect affordability calculation under §4980H(b) (more later)
  - Safest to offer the incentive to all who waive, or limit it to those who show proof of other <u>group health coverage</u>
    - Current guidance prohibits employers from reimbursing employees for individual health insurance
    - Employers are generally prohibited from incenting high claimant/high risk individuals to not enroll in the group coverage
    - For those enrolled in governmental coverage (e.g. Medicare, Medicaid or TRICARE), rules prohibit employers from incenting individuals not to enroll in the group health plan

Waiver Incentives

- Affordability Considerations
  - For opt-outs put in place after December 16, 2015, amounts considered to be an unconditional opt-out increase the employee contribution for purposes of affordability
  - Example 1 – Unconditional Opt-Out (available to all who waive)
    - Eligible employees may enroll in the employer's medical plan by contributing $150/mo. or waive and receive $75/month in taxable cash
      - For affordability purposes, $225 ($150+$75) is the monthly employee contribution
  - Example 2 – Conditional Opt-Out (available to those with other group coverage)
    - Eligible employees may enroll in the employer's medical plan by contributing $150/mo., or waive and receive $75/mo. in taxable cash upon proof of other group health coverage
      - For affordability purposes, $150 is the monthly employee contribution

§4980H Affordability

§4980H(b) Affordability

- §4980H(b) Requirements and Background
  - Employer must offer minimum value, affordable (as defined by the ACA) coverage to all full-time employees
  - Penalty for failure to do so is $290/mo. ($3480/yr) in 2018 for each full-time employee who purchases subsidized coverage through a public Exchange
  - Affordability is based on the employee cost for single coverage on the employer's lowest cost minimum value plan
  - Employer must only offer affordable coverage to avoid (b) penalty – it does not matter is employee elects the coverage
  - An offer of affordable MV coverage makes the employee and their dependents ineligible for a subsidy if purchasing individual health insurance through a public Exchange/Marketplace

§4980H(b) Affordability

- Definition of "Affordable" for Employer Purposes
  - Employer is protected from any potential penalties under §4980H(b) so long as the coverage is affordable based on the employee's household income, or under 1 of 3 safe harbors:
    - Federal poverty level (FPL) safe harbor;
    - Rate of pay safe harbor; or
    - Form W-2 safe harbor
  - Affordability percentages

2015	2016	2017	2018
9.56%	9.66%	9.69%	9.56%

§4980H(b) Affordability

- Setting Employer Contributions
  - Nothing under §4980H rules requires a uniform contribution rate across all categories of employees; rather, affordability is considered on an employee-by-employee basis
  - Employers may contribute differently to different categories of employees, or even on a per-employee basis (e.g. a percentage of salary) subject to nondiscrimination rules, which generally prohibit providing benefits in a way that favors the highly compensated individuals
  - Sometimes it is better financially to take on some risk of penalty under §4980H(b) than to make the coverage affordable for all full-time employees

§4980H(b) Affordability

- Example
  - Employer has full-time employees making as little as $9/hour (lowest Box 1 wages expected to be $18,000) and lowest cost minimum value option is $400/mo. in 2018
  - Required employer contribution to meet different safe harbors:
    - FPL safe harbor – employee contribution of $96/mo. or less is affordable
      - Employer contribution would be $304/mo.
    - Rate of pay safe harbor - employee contribution of $111/mo. or less is affordable
      - ($9 X 130 X 9.56%) - Employer contribution would be $289/mo.
    - Form W-2 safe harbor - employee contribution of $143/mo. or less is affordable
      - ($18,000 X 9.56% ÷ 12) - Employer contribution would be $257/mo.

§4980H(b) Affordability

- Other Considerations
  - If the employer is contributing more than $290/month for coverage, the employer is paying more than the employer would pay as a penalty under §4980H(b)
    - Note: $290 penalty is not tax deductible
  - Even when a safe harbor does not apply, coverage is not necessarily unaffordable. Household income, which in many cases will also include income from other dependents, may be higher
  - Employer could choose to set the employee contributions at $136/mo., making it affordable to those that make $11/hr or more ($11 X 130 X 9.56%)
    - There would be some penalty risk ($290/mo.) for those full-time employees making less than $11/hr, but only if they waive the coverage and instead enroll through a public Exchange and qualify for a tax subsidy

§4980H(b) Strategies

- Case Study
  - Employer with approximately 500 full-time employees
    - Employer contribution toward single coverage was already over $400 per month
  - Estimated the plan was unaffordable for approximately 25 low wage full-time employees
    - Very few of these employees currently participated in the plan
  - Employer was considering two strategies
    1. Raising employer contribution for single coverage $30 per month on all employees
    2. Setting a 2-tier employer contribution rate that was higher for lower wage employees
       - Employer was afraid that by doing this it would create significant new enrollments among this subgroup of employees
  - Employer elected to not change the contribution and take small risk of some of the 25 employees purchasing subsidized individual coverage through a public Exchange

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