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2017 Employee Benefits Webinar Series

Self-Insurance in a Post-ACA World

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Agenda

- Overview of Self-Insured Plans
- Differences between self-insured and fully insured plans under ACA
- Essential Health Benefits
- HRAs under the ACA
- Nondiscrimination Rules
- ACA Reporting for Self-Insured Plans

Overview of Self-Insurance

- Considerations when contemplating self-funding/self-insurance:
  - Cash flow
  - Appetite for risk
  - Administrative costs

Self-Insuring Group Health Plans

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- Benefits of self-funding:
  - No premium taxes (except on stop-loss insurance), but need an administrator
  - Potential for better coordination with wellness programs
  - Self-insured 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

Self-Insuring Group Health Plans

- Other considerations:
  - Greater responsibility for claims decisions
  - Ability to tailor plan documentation
  - HIPAA compliance

Self-Insuring GHPs under the ACA

- Most of the ACA's group health plan mandates apply equally to self-insured 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-Insuring GHPs under the ACA

- Some mandates apply only to fully insured plans:
  - Deductible limits (REPEALED)
  - Modified community rating rules
    - 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

Self-Insuring GHPs under the ACA

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- Some mandates apply only to fully insured plans:
  - Medical loss ratio rebates
  - Nondiscrimination rules (DELAYED)
    - Already apply to Self-Insured plans
  - Health insurance industry tax
    - Could lead to more plans self-funding
    - Applies to medical, dental and vision
  - Guaranteed availability and renewability
    - Could ease transition back into fully insured market
    - Could lead to adverse selection in insured market

Self-Insuring GHPs under the ACA

- PCORI fee applies to self-insured and fully insured plans
  - Fee is $2.26 fee per member per year for plan years ending on or after October 1, 2016, and before October 1, 2017
  - Paid by insurers if insured plan, by plan sponsor if self-insured (Form 720)
  - Fee supposed to sunset after 2019
- Applies on a per-member basis for major medical
- Applies on a per-covered employee basis for HRAs
- Examples of due dates:
  - 07/01/15 – 06/30/16 – due by 7/31/17
  - 01/01/17 – 12/31/17 – due by 7/31/18
  - 07/01/17 – 06/30/18 – due by 7/31/19

Self-Insuring GHPs under the ACA

- Transitional Reinsurance Fee (2014-2016 calendar years)
  - Intended to stabilize premiums in the individual markets
- Assessment on carriers and self-insured plans
- Fee was $27 PMPY ($2.25 PMPM) for 2016
- Generally applies to all group health plans – no exceptions for non-ERISA plans (e.g., governmental or church plans)
- Does not apply to HIPAA-excepted benefits, expatriate plans, post-65 retiree plans, “integrated” HRAs and non-minimum value plans
  - For 2015 & 2016: Does not apply to self-insured, self-administered plan
- Pay via Pay.Gov

Self-Insuring GHPs under the ACA

- Cadillac Tax effective in 2020 (delayed two years under the PATH Act)
  - 40% tax on excess over threshold
  - $10,200 Single, $27,500 Family
  - Based on total cost of coverage (employer plus employee), plus any contributions to HRA/FSA/HSA
- Tax is paid by insurer or administrator, not by participant
  - PATH Act made payment of the Cadillac Tax a deductible business expense
  - Proposed FY2017 Federal Budget modifies the threshold to equal the average premium for a gold Exchange plan in each State
- Increased by $1,650 Single, $3,450 Family:
  - For retirees age 55 or older and not eligible for Medicare, or
  - If majority of employees covered by the plan are engaged in a high-risk profession (listed in statute)

Self-Insuring GHPs under the ACA

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- Cadillac Tax (cont.)
  - Only people who love taxes like this tax
  - The Congressional Budget Office estimates this tax will generate $149 billion in revenue between 2018 – 2025 (later revised down to $80 billion)
  - Only ¼ of the revenue is estimated to come from the tax
  - ¾ of the revenue will come from employers who shift compensation from an employer sponsored plan to taxable wages
  - Big Union, Big Business, the Teachers, States, Municipalities, Not-for-Profits—everyone dislikes this tax
  - It's on most everyone's repeal wish list—but can they afford to repeal it?

Self-Insuring GHPs under the ACA

- Cadillac Tax (cont.)
- What can be done to prepare?
  - Reduce richness of plan design
  - Higher out-of-pocket costs
  - Eliminate or implement private exchange options for pre- and post-65 retirees
  - Private exchanges for active employees (?)
  - Eliminate spousal coverage
  - Narrow provider networks
  - Reference pricing
  - Eliminate pre-tax benefits programs
  - Increase use of wellness incentives

Essential Health Benefits

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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

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- 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
- 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

Essential Health Benefits

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- Employers that sponsor self-insured plans should identify which benefits are EHB's
- Under current guidance, a self-insured plan can adopt any HHS-approved EHB package for purposes of determining which benefits offered under the self-insured 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)

Out-of-Pocket Limits

- All non-grandfathered group health plans must embed an individual out-of-pocket (OOP) limit within the family limit
  - 2018 OOP limits: $7,350 / $14,700
  - 2017 OOP limits: $7,150 / $14,300
    - Example: Employee has family coverage with a $14,300 OOP limit (2017)
      - Spouse has $10,000 in cost-sharing and the employee has $3,000
      - With an embedded OOP limit, the spouse's cost sharing is capped at $7,150, with the remaining $2,850 being covered by the plan
- Was effective for plan years beginning in 2016
- Limits apply to in-network essential health benefits
  - Includes annual deductibles, in-network coinsurance and other types of in-network cost sharing, including prescription drug copayments

Reference Pricing under the ACA

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- Plan has a reference-based pricing structure for a particular procedure (e.g., a knee replacement)
- Some providers accept the reference price as payment in full; others will not
- As long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers, it may treat providers as out-of-network if they do not accept the reference price as payment in full
- ACA's OOP limit rules do not apply to out-of-network providers
  - However, if the plan does not ensure that there is access to providers that will accept the reference price, it may need to count participants' OOP expenses incurred at out-of-network providers toward the OOP limit

HRAs under the ACA

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- Use of HRAs To Reimburse Premiums In the Individual Market – Strictly Prohibited
- IRS & DOL: Free Standing HRAs (or whatever name they're given) that reimburse premiums for individual policies do not meet ACA requirements regarding annual limits
- Such arrangements are not "integrated"
- Guidance even prohibits reimbursement of premiums for individual market coverage on a post-tax basis
- Exception for Certain Small Employers
  - Cures Act: Starting in 2017, small employers (under 50 FTEs) who do not offer any group health plan may pay for employees' individual market policies up to $4,950 (single) / $10,000 (family) per year
  - Eligibility and contribution requirements apply – generally must offer to all full-time employees and comply with notice requirements

Alternatives to Coverage

- Can we identify high cost claimants and encourage them to move on to an exchange plan or Medicare?
- No – that practice can violate ERISA, HIPAA, ADA, the Code and the Medicare Secondary Payer Rules

Opt-Out Benefits

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- Employers may still provide cash incentive to employees who opt-out of group health plan coverage
  - Unconditional opt-outs are counted as employee contribution for “affordability” purposes under the ACA’s employer mandate
  - Opt-out payments conditioned upon proof of other group health plan coverage are not considered to be required employee contributions for “affordability” purposes
  - Transition relief for opt-out arrangements in effect prior to 12/16/2015
    - May treat opt-out as employer contribution for plan years beginning before 1/1/17
- Cafeteria plan flex-credits that can only be used to pay for medical care (e.g., FSA contribution) or the employer’s health premiums are treated as an employer contribution

Code Section 105(h) Nondiscrimination

- These rules currently apply to self-insured plans
- Nondiscrimination rules for insured plans under ACA originally intended to apply in 2011 (or when a plan loses grandfathered status)
  - The ACA’s requirements have been indefinitely delayed until further regulatory guidance is released
  - For insured plans, the penalty is $100/day with respect to each individual to whom the failure relates
- For self-insured plans, the penalty is taxation of the discriminatory benefit

Code Section 105(h) Nondiscrimination

- Under Code § 105(h) a self-insured 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 highest paid 25% of employees
    - Also includes the five highest paid officers and any shareholder who owns more than 10% of the employer's stock
  - HCEs assessed on a Controlled Group Basis
  - Look for subsidiaries, brother-sister controlled group, affiliated service groups—separate EIN meaningless

Code Section 105(h) Nondiscrimination

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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 if other employees performing similar work have substantially more hours

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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

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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

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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.

ACA Employer Reporting Requirements

- Code Sections 6055 (insurers and self-insured plans) & 6056 (applicable large employers)
- Complex reporting requirements
- Employers that self-insure have a reporting obligation under Section 6055 as well as 6056
- Will generally use C-Series Forms 1094/1095 when reporting
- ACA reporting penalties up to $260 per return ($520 for willful failures)

Section 6055 – Reporting for HRAs

- No reporting for HRA coverage is required when an employee is covered under the HRA in connection with coverage under that employer's fully insured major medical plan
- However, if an employer offers HRAs to employees who are enrolled in their spouse's plan, the employer must report on employees covered under their HRA

Indexing Pay-or-Play Penalties

- Annual pay-or-play penalties are indexed to increase each calendar year after 2014
  - 2015: $2,080 / $3,120
  - 2016: $2,160 / $3,240
  - 2017: $2,260 / $3,390

Other ACA Reporting News

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- IRS intended to begin sending employer mandate penalty notices for 2015 “early in 2017”
  - Funding cuts have slowed efforts to get assessments out
    - As of October 2016, IRS processed 439,201 Forms 1094-C and ~110 million Forms 1095-C
  - IRS unable to process paper filings timely and accurately
    - As of October 2016, IRS estimated that ~16,000 paper Forms 1094-C and 1.4 million paper Forms 1095-C had not been processed
- IRS has begun sending “applicable large employer” notices to employers (requests for Forms 1094-C / 1095-C)
- Individual Mandate: IRS will not systematically reject “silent returns” that don’t indicate whether the taxpayer maintained health insurance coverage

IRS Guidance on Self-Insured Indemnity

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- IRS Office of Chief Counsel Memo 201703013
- Provides Guidance on Fixed Indemnity Plans
  - Addresses potentially abusive arrangements using hybrid self-insured indemnity plan and wellness program
- Programs that claim they can be implemented at no cost to the employer and without impact to an employee's net take-home pay and will result in:
  - Employers saving an average of $1,000 in FICA taxes per employee per year;
  - Employees receiving an average of $2,000 per year in additional benefits
- Memo provides that payments under a fixed-indemnity plan are taxable when premiums are paid pre-tax
  - Memo is drafted broadly, although appears to target self-insured fixed indemnity plans

Questions?

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HR Professional Credits

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