



EXECUTIVE MEDICAL REIMBURSEMENT PLANS

Why Offering Carve-Out Coverage Remains a Viable Option — Third Edition

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INCREASED COMPETITION FOR TALENT



With low unemployment rates and a scarcity of qualified candidates on the market, **companies continually struggle to find ways to recruit and retain** C-suite and top-level management candidates.

In today's competitive business environment, it has become increasingly challenging for successful companies to attract top talent. With low unemployment rates and a scarcity of qualified candidates on the market, companies continually struggle to find ways to recruit and retain high-performing C-suite and top-level leadership candidates. In fact, with baby boomers reaching retirement age, the leadership talent pool dwindled by 30% between 2009 and 2015¹ and certain industries such as healthcare are forecasted to have huge shortfalls for roles like nurses, physicians and even CEOs.²

A recent Willis Towers Watson global talent management and reward study that surveyed 2,000 companies with a collective workforce of 21 million employees found that well over half of employers are experiencing problems attracting top performers and high-potential employees.³ The same study concluded that between the increased hiring activity and gaps in employer understanding of retention drivers, 58% of senior executives are at risk of leaving. Additionally, 2/3 of employees say they would consider a job offer from a recruiter even if they were not thinking of a career or job change.⁴ Many more statistics support the same reality: the talent market is simply tight.

Replacing a key employee is costly and the more senior and highly compensated, the worse both direct and indirect costs will be, not to mention the disruption factor to the organization. So what can companies do to boost retention of their leaders and other key talent? One of the important ways is to ensure you offer a compelling benefit package as 4 out of 5 employees stay or leave based on the quality of benefits,⁵ and in a survey of 900 executives, 61% of respondents said that such incentives motivate them to remain at their current company.⁶ But improving health benefits in an era of rising healthcare costs can be a challenge to say the least. This is where carve-out supplemental expense reimbursed insurance plans can play a critical role.

One program that was historically popular, particularly with key leaders, was so-called "executive medical reimbursement plans". These plans typically fund the cost-sharing obligations under the primary plan (deductibles and co-pays), as well as provide additional benefits and contracted services not covered or offered by the primary plan—such as vision; dental and elective top-to-toe physical exams. While many companies have had much success in leveraging these enhanced health benefits to attract, retain and reward executives and other key talent over the past decades, there is a great deal of confusion and misinformation about whether they remain viable after the passage of the Affordable Care Act (ACA) in March 2010 and the incorporated non-discrimination provisions.

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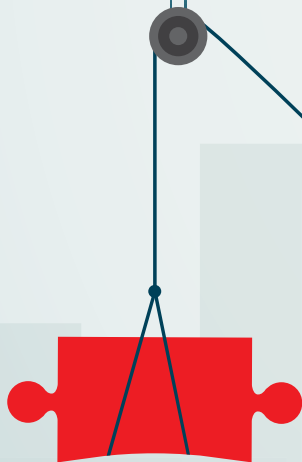
THE ACA

While the landscape has changed, offering enhanced health benefits to a select group of employees does not have to be a thing of the past... **The key is to ensure that the plan is properly structured** to meet current federal laws and regulations.

The ACA made sweeping and complex changes to the healthcare system. The older executive medical reimbursement plans that were structured as modified primary health plans could not meet requirements of the ACA such as prohibition on annual benefit limits, and many issuers of these products elected to discontinue these plans, rather than restructure them to either comply with the ACA or to fall within an exception from the ACA.

The ACA also added a provision to the Public Health Services Act (Section 2716) that extends 105(h) like nondiscrimination rules to insured “group health plans”. This caused many advisers and authors of articles on the ACA to interpret nondiscrimination to apply to all insured health benefits. However, what was generally overlooked is that “group health plan” has a distinct definition in the Public Health Services Act, a definition that is separate and apart from other insured group health plans that are considered excepted benefits. This distinction is meaningful when it comes to the viability of offering supplemental health benefits to just select groups of employees, as we will discuss later in this paper.

Unfortunately, the decision of some plans to exit the market, coupled with the misunderstanding of new nondiscrimination rules, created the impression that you can no longer boost benefits selectively. However, while the landscape has changed, strong supplemental insurance plans geared toward leadership and other key talent do not have to be a thing of the past. You can still attract and retain “the best and the brightest” employees by selectively enhancing their benefit program with a medical reimbursement plan that is not restricted by all of the complex regulatory requirements set forth by ACA. The key is to ensure that the plan is properly structured to meet current federal laws and regulations.



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KEY REQUIREMENTS

First, the fundamental requirement—that your plan must be fully insured—still applies. Section 105(h) of the tax code states that reimbursements cannot favor highly compensated employees over the rest of the workforce, unless those reimbursements are provided under a contract of insurance. Importantly, this does not mean that just having an approved insurance policy is sufficient to qualify, because “insurance” generally refers to a carrier funding and taking risk on claims.⁷ In other words, a plan that is largely self-funded by the employer, even if administered independently, likely will run afoul of these regulations. You will want to be cautious with descriptions of “pay as you go” or “claims premium”, which really is just another way of saying “cost-plus”, given the employer is funding the claim and paying an administration fee before anything is paid to the employee.

Second, certain categories of health benefits, referred to as “excepted benefits,” are exempt from compliance with many of the federal laws that regulate primary health plans. This is not a new concept. Excepted benefits were first defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are described in the Public Health Services Act Section 2791(c). Note that they only include insured products, so if you fail the first hurdle, you also cannot qualify as an excepted benefit. Examples of excepted benefits are critical illness and hospital indemnity insurance plans.

Historically, excepted benefits have been exempt from the provisions of the tax code, the Employee Retirement Income Security Act (ERISA) and HIPAA, which set minimum standards for most voluntarily established pension and health plans in private industry. The ACA takes that same approach and exempts excepted benefits from most of its requirements, including the new nondiscrimination provisions.

In order to be an “excepted benefit,” the benefit must fall within one or more of four categories. Each category is separately defined and has different requirements. Multiple categories can be “bundled” and offered in a single contract of insurance.⁸ However, the requirements for a specific category continue to apply to that category alone, not all.⁸ Thus, it is important when evaluating an insurance policy that includes multiple categories of excepted benefits to apply the right standards to the right benefits.



The four categories of “excepted benefits” are:

- ▶ Incidental health benefits that are included in other forms of insurance, like auto insurance.
- ▶ Benefits that are limited in scope, such as vision, dental or long-term care.
- ▶ Benefits that cover only a specific disease or that provide fixed indemnity.
- ▶ Benefits that supplement Medicare or TRICARE, or that provide similar supplemental coverage to an employer-sponsored primary plan.

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UNDERSTANDING SIMILAR SUPPLEMENTAL COVERAGE

The category of excepted benefits that has caused the most marketplace confusion is “similar supplemental coverage.” The term “similar” is a comparison to the additional coverage that Medicare supplemental policies provide to an individual’s Medicare coverage. Statutory law does not identify the features of a benefit plan that make it “similar” to Medicare supplemental coverage.

However, federal regulations issued by the Departments of the Treasury, Labor, and HHS in 2004 describe similar supplemental coverage as coverage that is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. In addition, the Departments have issued subsequent guidance that further describes the features of this category of excepted benefits, including permitting coverage beyond just deductibles and co-pays for expenses like acupuncture or hearing aids that are not considered essential health benefits in most states.⁹

In issuing its guidance, the Departments noted that their goal was to prevent issuers from avoiding compliance with healthcare reform by “issuing multiple insurance contracts in connection with a plan....”¹⁰ To that end, the guidance describes the features of genuinely supplemental (and excepted) coverage, as opposed to coverage which, though labeled supplemental, actually “is designed to provide a major portion of the medical benefits to the participants of the primary group health plan....”¹¹

The Departments identified four safe harbor criteria which, if met, will automatically qualify a similar supplemental health insurance product as an excepted benefit in the view of the Departments. Note that the safe harbor criteria are not requirements or mandates. Thus, if a product does not meet each of the safe harbor criteria, it is not automatically disqualified as an excepted benefit. Rather, the Departments may require additional analysis of the product to make sure that it is supplemental in nature and designed to fill gaps in primary coverage.

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SAFE HARBOR CRITERIA

The four safe harbor criteria established by the Departments are:

1 The policy cannot be issued by the same insurer that issues the primary plan.

2 The policy must be designed to fill gaps in primary coverage with no coordination of benefits. The Departments have recognized that coverage “gaps” include both cost sharing obligations imposed by the primary plan *and* additional benefits not included in the primary plan as long as those additional benefits are not considered essential health benefits in the state of issuance.

3 The value of the supplemental coverage cannot exceed 15% of the cost of the primary coverage. The HHS Memo describes this calculation as an evaluation of whether “the proportion of total benefits that is charged to a policyholder as cost-sharing [is] similar to the proportion of total Medicare benefits that is charged to beneficiaries *as cost-sharing*.” [Emphasis added.] The HHS Memo notes that the Departments will consider “any reasonable method” for calculating the relative value of coverage.

Note that in a policy that bundles different categories of excepted benefits and also incorporates non-insurance services, the 15% criterion only applies to the components of coverage that relate to the applicable supplemental benefits, not the entire premium, as excepted benefit requirements do not cross-pollinate between categories.

4 The policy cannot use health factors to differentiate between individuals in terms of benefits, eligibility or premiums.

To the extent that a supplemental medical reimbursement plan qualifies as an excepted benefit, it would be exempt from the provisions of Part 7 of ERISA, chapter 100 of the tax code, and Title XXVII of the Public Health Service Act, including certain relevant provisions added by the ACA such as the new non-discrimination provision. A plan provider should be able to specifically address how the plan meets each of the four requirements of the safe harbor guidelines, including the 15% cost calculation.



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KEY REGULATORY EXCERPTS

On bundling excepted benefits: under HIPAA, “the term ‘excepted benefits’ means benefits under **one or more (or any combination thereof)** of” four categories of benefits. [42 USC §300gg-91(c)]. [Emphasis added.]

On the purpose for the DOL Field Assistance Bulletin: *In order to prevent issuers from avoiding compliance with ERISA’s health reform provisions by issuing multiple insurance contracts in connection with a plan*, this bulletin establishes an enforcement **safe harbor** under which supplemental health insurance will be considered excepted benefits for purposes of Part 7 of ERISA. Similar supplemental coverage that does not meet the standards for this safe harbor may be subject to enforcement actions by the Department. [Emphasis added.]

On the guidelines not being a “pass/fail” test: The section immediately below (SAFE HARBOR STANDARDS) provides that if the standards in that section are satisfied, the supplemental health insurance will be considered to satisfy the conditions for being excepted benefits for purposes of chapter 100. Supplemental health insurance not satisfying the conditions for the safe harbor **is subject to further examination** for a determination whether it is not “similar supplemental coverage to coverage under a group health plan” and thus is subject to all the requirements of chapter 100. [Emphasis added.]

On the 15% value of coverage: *The proportion of total benefits that is charged to a policyholder as cost-sharing* should be similar to the proportion of total Medicare benefits that is charged to beneficiaries as cost-sharing. **According to CMS actuaries, this proportion is currently around 15 percent.** We will consider **any reasonable method** for calculating the value of the total coverage. [Emphasis added.]

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SUMMARY

In summation, with proper guidance and knowledge of the right structure, it is still possible to offer enhanced health benefits to a select group of employees whether they are executives, partners, other key leaders or hard-to-retain and recruit employees like nurses, system developers and even skilled labor. Excepted benefits programs are not restricted by the ACA and new nondiscrimination provisions. The supplemental plan should be fully insured (not a “claims plus” arrangement) as outlined by Section 105(h) of the tax code and to qualify as excepted benefits (which must be insurance). It should also meet the specific excepted benefit guidelines for that or those excepted benefit categories that are included in the coverage. Finally, we believe it should deliver all the other key ingredients such as hassle-free service, assistance with travel-related emergencies and specialty care guidance that will allow you to attract and retain the strategic leaders and other talent your company needs.

A Note on ArmadaCare’s Targeted Benefit Boosting Solutions

ArmadaCare offers a full complement of supplemental insured products that allow companies to boost coverage selectively to reduce turnover costs and get a competitive edge in their retention and recruitment efforts. Our expense reimbursed insured plans can work as stand-alone or in conjunction with one another to help achieve both cost containment and talent management objectives. Our premier product, Ultimate Health, is a leadership-oriented program that provides plan options of \$100,000 in annual coverage for the vast majority of out-of-pocket healthcare expenses. This market-leading, employer-paid executive benefit program combines a robust healthcare reimbursement insurance plan with tailored non-insurance health and wellness support services designed to keep a company’s top performers healthy, productive and focused on the business.

Our contemporary policy filing, which has gained recent approvals in over 40 states, allows us to extend our plan selections to meet the needs of other employee constituencies as well. Our product consultants will be happy to give you ideas and insights into how to apply our solutions to your specific needs, be it just Ultimate Health or the full solutions suite. Contact us at 1-800-481-3380 or solutions@armadacare.com today or visit us on the web at ArmadaCare.com.

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CONTACT US

Contact our experts today to get more in-depth information on the regulatory framework for certain excepted benefit plans.

1-800-481-3380

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ArmadaCare's insurance policies are underwritten by Sirius America Insurance Company, Transamerica Financial Life Insurance Company and Transamerica Premier Life Insurance Company. Insurance plans and coverages vary by state. Please contact us to confirm state availability.

In the state of New York (where New York is only policy situs option), this solution is available for groups that are defined as large group (101 or more employees) and who have a primary plan that is self-insured.



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