

EXECUTIVE MEDICAL REIMBURSEMENT PLANS

Why Offering Executive Medical Reimbursement Remains a Viable Option

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ULTIMATE HEALTH
by ArmadaCare®

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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 management candidates.

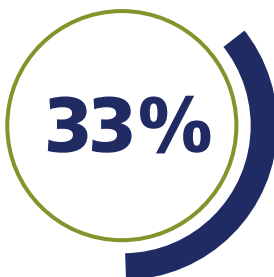
A recent Towers Watson talent management survey found that nearly **two-thirds of employers are experiencing problems attracting top performers and high-potential employees**, while more than half report difficulty retaining top employees.¹ Additionally, ExecuNet reports that only **one out of three executives expect to stay at their organization for another year**, compared to almost two out of four two years ago.²

A VITAL RESOURCE

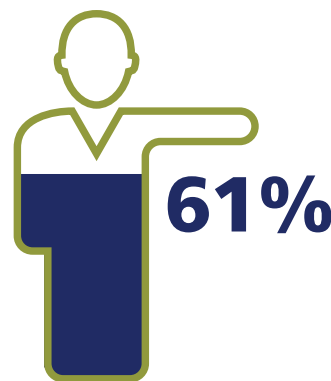
Traditionally, employers sought to retain these mission-critical individuals by offering long-term incentives, such as an attractive health benefits package. In a recent global survey of more than 900 executives, conducted by the Association of Executive Search Consultants, **61% of respondents said that such long-term incentives motivate them to remain at their current company**, and about half of those who receive them said the incentives motivate them to higher levels of performance.³ One program that historically has been popular with key leaders are so-called "executive medical reimbursement plans" or "executive health plans."



Employers experiencing problems attracting top performers and high-potential employees



Executives that expect to stay at their organization for another year



Executives who said long-term incentives motivate them to remain with their current company

“ These plans typically fund the executive’s co-insurance obligations under the primary plan...”

These plans typically fund the executive’s co-insurance obligations under the primary plan, as well as provide additional benefits and contracted services not covered or offered by the primary plan—such as vision; dental; comprehensive physical exams; timely, personalized clinical support to address illnesses; and evacuation or travel service in the event of an emergency.

While many companies have had much success in leveraging these enhanced health benefits to attract, retain and reward executives, some benefit consultants have questioned whether they remain viable after the passage of the Affordable Care Act (ACA) in March 2010.

THE ACA

The ACA made sweeping and complex changes to the healthcare system. Executive medical reimbursement plans that were structured as healthcare products did not meet the requirements of the ACA 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 to full ACA compliance.

The decision of some plans to exit the market has created the impression that executive medical reimbursement plans are no longer viable. That, however, is not the case. **While the landscape has changed, executive health benefits are not a thing of the past.** You can still attract and retain “the best and the brightest” employees by offering an executive benefit program with a medical reimbursement

“ While the landscape has changed, executive health benefits are not a thing of the past.”

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.

KEY REQUIREMENTS

First, the fundamental requirement—that your plan must be fully insured—still applies. Insurance typically means that the insurance carrier is responsible for funding and taking risk on claims. Section 105(h) of the IRS tax code states that reimbursements cannot favor highly compensated employees over the rest of the workforce, unless provided under a contract of insurance. Thus, a plan that is largely self-funded, even if administered independently, likely will run afoul of these regulations.



Your Executive Medical Plan Must Be Fully Insured

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).



Your Executive Medical Plan Must Offer Only “Excepted Benefits”

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.

Excepted Benefits Are Excepted From:



HIPAA



ACA



ERISA



TAX CODE

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. However, the requirements for a specific category continue to apply to that category alone, not all. 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 a private primary plan.

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 guidance that further describes the features of this category of excepted benefits.



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...”⁴ 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...”⁵

As part of their guidance, the Departments identified four safe harbor criteria which, if met, will automatically qualify a supplemental health insurance product as an excepted benefit in

the view of the Departments. The safe harbor criteria are not requirements or mandates. If a product does not meet each of the safe harbor criteria, a product is not 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.

SAFE HARBOR CRITERIA

The four safe harbor criteria established by the Departments are:

- The policy cannot be issued by the same insurer that issued the primary plan.
- 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.
- The value of the supplemental coverage cannot exceed 15% of the cost of the primary coverage. 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 value of total coverage.
- The policy cannot use health factors to differentiate between individuals in terms of benefits, eligibility or premiums.

Safe Harbor



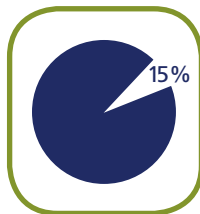
Separate Entity



Fill Gaps



No Health Questions



Value of Coverage

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 IRS tax code, and Title XXVII of the Public Health Service Act, including certain relevant provisions added by the ACA. 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.

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)).

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.* [Emphasis added]

We will consider *any reasonable method* for calculating the value of the total coverage.

SUMMARY

In summation, with proper guidance and knowledge of the right choice of group insurance plans, it is still possible to offer an executive excepted benefits program that is not restricted by ACA, that meets the specific excepted benefit guidelines, and delivers all the key ingredients that will allow you to attract and retain the strategic executives your company needs.

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

Contact Us

1-800-481-3380

EMAIL US

A NOTE ON ULTIMATE HEALTH

Ultimate Health, is a limited benefit and supplemental insurance plan that combines four advantages into one solution:

- Robust reimbursement coverage for medical, dental, vision, prescriptions, flex-type expenses and more.
- TopDoc Connect for guidance and access to leading specialty physicians.
- Coverage toward Executive Physicals.
- Take Me Home Emergency Travel program.

This policy, can be carved out by employee class and added on to any primary qualified health plan that has in-network, out-of-network and prescription coverage. These flexible features enable you to create a robust benefit package that will keep your top performers happy, healthy and productive.

A registered mark of UnitedHealthcare Global, Take Me Home is provided by UnitedHealthcare Global and subject to their terms, conditions, limitations and exclusions. TopDoc Connect is facilitated by ArmadaHealth and subject to their terms and conditions; ArmadaHealth is not a provider of healthcare or medical treatment or advice.

Insurance plans and coverage may vary by state. Detailed coverage and exclusions and limitations are listed in the Certificate of Insurance.

SOURCES

- ¹ “2014 Global Talent Management and Rewards Study – Making the Most of the Employment Deal,” Towers Watson, August 2014.
- ² “Retention is Waning as More Executives are on the Move,” William Flamme, ExecuNet, <http://www.execunet.com/retention-waning-executives-move/>
- ³ “Executives report pay increases, say incentives are good retention tool,” By Neil Amato January 14 2015, CGMA Magazine, <http://www.cgma.org/magazine/news/pages/201511633.aspx>
- ⁴ Field Assistance Bulletin 2007-04. <http://www.dol.gov/ebsa/regs/fab2007-4.html>; IRS Notice 2008-23 http://www.irs.gov/irb/2008-07_IRB/ar09.html; CMS Program Memorandum, Transmittal No. 08-01
- ⁵ “Circumstances Under Which Supplemental Health Insurance Coverage Satisfies the Requirements for Excepted Benefits Under Section 2791(c) of the Public Health Service Act,” Insurance Standards Bulletin 08-01, Department of Health and Human Services, May 2008.

ArmadaCare
230 Schilling Circle, Suite 140
Hunt Valley, MD 21031
1-800-481-3380

AT#1327019

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