A Compliance Checklist:

Understanding Executive Medical Reimbursement

ArmadaCare®

The key is that reimbursement must be done inside a contract of insurance

CONTENTS

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Leadership talent is vital to any company's success, especially in these disrupted and unprecedented times. Because leadership and business continuity are intertwined, savvy employers and their advisers should be proactive about keeping leaders happy and productive so they can stay focused on their important stewardship role.

59% *Organizations fear losing their hard-won talent.* *(Source: Payscale, 2018)*

2X **base salary** *True cost of replacing employees* *(Source: Entrepreneur, 2018)*

When it comes to benefits, it is important to realize these executives and key leaders often have unique benefit needs and wants, and primary healthcare coverage and wellness programs often fail to fully meet them. With healthcare plan costs having risen so dramatically, though, it can be difficult to meet these needs by enriching the primary plan without exceeding budgetary constraints.

INTRODUCTION

SHIFTING HEALTHCARE REGULATIONS

Supplemental executive medical reimbursement plans have long been popular as the go-to solution. These plans usually fund the cost-sharing obligations of the primary plan, such as co-pays and deductibles. They also provide additional benefits and services, including vision, dental and elective executive physicals or massage therapy, and may include timesaving services such as medical specialist matching.

With the passage of the Affordable Care Act (ACA) in March 2010, the healthcare regulatory landscape shifted. The law included new non-discrimination provisions and changes that have caused confusion about compliance and the current standing of executive medical reimbursement plans.

These plans still provide a viable way to meet executives' healthcare needs while helping employers manage health plan costs and realize tax advantages—as long as they are compliant with existing regulatory guidance.

The regulatory landscape is continually evolving. In addition, new products frequently enter the market, which adds to the complexity of evaluating the right robust and compliant solutions for executive medical reimbursement plans.

With a compliant insurance plan, businesses can:

- Offer enhanced benefits only to highly compensated employees
- Deduct plan premiums as a business expense

For employees, reimbursements do not become taxable as ordinary income.

Given these significant benefits to the business, here are the key details that advisers need to know when determining if a plan is compliant.

INTRODUCTION

TAX-ADVANTAGES AND DISCRIMINATION

Executive medical reimbursement plans have been subject to IRS Section 105(h)[1] rules since their inception. To be compliant, a plan must qualify as insurance. Only then can both the employer and employee realize the tax-advantaged benefits:*

- Employers can deduct healthcare premiums as an ordinary business expense.
- Reimbursements do not become taxable income for individual plan participants.

The key is that reimbursement must be done inside a contract of insurance as mentioned above. This unfortunately, is not as simple as policy equals insurance. The United States Supreme Court and various tax courts[2] have defined insurance as more: a plan must demonstrate adequate risk transfer to an insurance carrier and there should be risk distribution among many participants. This is why advisers and employers should avoid plans that claim to be insurance but are really structured as claims plus administrative fees.[3] In short, who funds the claims matters. If it really is the employer, there may not be adequate risk transfer to qualify as insurance.*

**This is not local, state or federal tax advice as each person and each company is unique. It is recommended that you seek the independent counsel of a professional tax adviser.*

INTRODUCTION

DISCRIMINATION VS. NON-DISCRIMINATION

When employers offer reimbursement benefits specifically to highly compensated people, such as executives or key leaders, they are doing so on a "discriminatory" basis. Section 105(h) prohibits discrimination in favor of highly compensated individuals if the plan is self-insured, which is one of the reasons the question of insurance is so important.

Further—and as many of you are aware—the ACA introduced additional "105(h)-like"[4] non-discrimination rules. As we will discuss later, it is now also important to evaluate what type of insurance it is and whether or not it is an excepted benefit plan exempt from most of the market reforms.

WHAT'S AT STAKE?

Violation of non-discrimination rules can come at a high cost.

As explained above, compliant plans provide benefits to both employers and executives. Plans that are not in compliance introduce significant financial and regulatory risk.

NON-COMPLIANCE

If the selected plan does not qualify as insurance under Section 105(h) and the employer offers benefits to highly compensated employees while deriving tax-preferred treatment, it risks:*

- Violation of non-discrimination rules, which can lead to fines
- DOL and IRS audits, which may lead to back taxes, fees and more—for businesses and individuals as the benefit becomes ordinary income for individuals

Plans that do not qualify as excepted benefits may result in fines at a rate of up to $100 per day[4] per individual discriminated against (i.e. everyone who does NOT have the plan) as well as the plan being subject to ACA mandates—which include prohibition on annual benefit limits, a non-starter for executive medical reimbursement plans.

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THE IMPORTANCE OF EXCEPTED BENEFITS

As mentioned above, excepted benefits also play an important role in a post ACA world. You can no longer simply evaluate if a plan is insurance; you must also consider the type of insurance that it is. This is because ACA discrimination and other mandates do not apply to insurance that consists of excepted benefits. Excepted benefits have been in place since the late 1990s. There are four categories, all defined in the Public Health Services Act Section 2791(c).[5] They are:

NON-HEALTH INSURANCE

- Worker's comp insurance
- Services not in the nature of insurance

LIMITED BENEFIT PLANS

- Limited-scope dental and vision plans
- Long-term care insurance

NON-COORDINATED BENEFITS

- Critical illness insurance
- Fixed indemnity plans

SUPPLEMENTAL BENEFITS

- Medicare supplemental plans
- Similar supplemental plans

These benefits are treated as excepted across the interconnected laws of:

- HIPAA
- ERISA
- The Revenue Code
- ACA

DEFINING SIMILAR SUPPLEMENTAL PLANS

The category of excepted benefits that most often comes into play for executive medical reimbursement plans is similar supplemental plans. These plans function similarly to a Medicare Supplemental plan, but they instead supplement an employer-sponsored plan. According to statute, a similar supplemental plan must be designed to be supplemental by covering the cost sharing obligations of the primary health plan. The similar supplemental plan is also allowed to provide coverage for treatments and services on a non-cost-sharing basis ("first dollar") as long as that coverage is not for Essential Health Benefits (EHBs) in the state of issuance.[6]

WHAT'S AN EXAMPLE OF AN EHB?

Hearing aids are considered EHBs in some states but not in others. In states where they are EHBs, the supplemental plan would pay on a cost-sharing basis after the primary plan has paid.

A SIMILAR SUPPLEMENTAL PLAN IS NOT:

- A primary plan trying to masquerade as a supplemental plan
- Designed to provide the majority of an employee's healthcare coverage
- A gap or worksite voluntary plan, which typically fall under other excepted benefit categories

A SIMILAR SUPPLEMENTAL PLAN IS INTENDED TO:

- Fill gaps in coverage
- Include coverage for the participant's cost-sharing obligations, like co-pays and deductibles
- Provide coverage for additional services not covered under the primary plan
- Function similarly to Medicare and Tricare Supplemental plans

Look for a policy with a base requirement that there is a qualified, compliant primary plan in place to ensure that the executive medical reimbursement plan under evaluation will be considered supplemental insurance.

UNDERSTANDING SAFE HARBOR GUIDELINES AND THE FOUR PILLARS

Plans that qualify as excepted benefits are still subject to regulation. Each of the four categories has its own unique requirements, and they do not cross over.

A Safe Harbor Guideline was issued specifically only for the similar supplemental category, originally in 2007 and affirmed by DOL, IRS, and HHS on October 31, 2016. It contains four key pillars that can be used to ensure similar supplemental plans are in "safe harbor" as an excepted benefit.[7] These are:

INDEPENDENT OF PRIMARY COVERAGE	The supplemental plan must be issued by a separate entity from the primary plan. This ensures that primary coverage remains primary and that supplemental plans complement the primary plan.
SUPPLEMENTAL FOR GAPS IN PRIMARY COVERAGE	The supplemental plan must be designed to fill gaps in primary coverage and must not be supplemental only as a result of coordination of benefits. The supplemental plan does not provide primary coverage.
SIMILAR TO MEDICARE SUPPLEMENTAL	The supplemental plan cannot use health factors to differentiate between individuals in benefits, eligibility or premiums, similar to how Medicare Supplemental plans function.
SUPPLEMENTAL IN VALUE OF COVERAGE	The value of the cost-sharing coverage of the supplemental plan in relation to the primary plan must not exceed 15%.

Again, these guidelines are to provide a safe harbor standard and are not a "pass-fail" test in terms of a plan's viability as an excepted benefit. It is important that anyone offering an executive medical reimbursement plan can specifically demonstrate HOW their plan meets these guidelines rather than merely reiterating or sharing what the regulations are.

YOUR COMPLIANCE CHECKLIST

It can be tricky to navigate the complexities of compliance when it comes to executive medical reimbursement. The following checklist is designed to provide a step-by-step evaluation to keep you and your clients on firm compliance ground:

DOES THE POLICY QUALIFY AS A POLICY OF ACCIDENT AND HEALTH INSURANCE?

The policy should be approved as such for the state(s) in which you operate and have a principal business location.

IS THE POLICY ISSUED BY A LICENSED INSURANCE COMPANY?

Look for underwriting by highly rated insurance carriers in a majority of states where the policy is offered. Beware of plans that may only have A-rated carriers in a few states and use small B-rated carriers in the majority.

DOES THE POLICY SHIFT SUFFICIENT RISK TO THE INSURANCE COMPANY BASED ON AVAILABLE OBJECTIVE DATA?

There should be full risk transfer. A plan that is set up with a structure in which the claim is billed back to the employer with an administrative fee for employer funding prior to the participant being reimbursed is at higher risk of failing the insurance test. Beware of proposals that present the full available benefit in comparison with the maximum employer exposure, as the likelihood is that expected claims are nowhere near this number. For instance, if the full benefit for three executives is $150,000, and the stop-loss is $100,000, do you really think each executive will incur over $30,000 in claims when your typical executive family incurs about $10,000 or less? Claims of three times the normal is what would be needed for risk transfer to take place.

YOUR COMPLIANCE CHECKLIST

WHAT TYPE OF CLAIMS FUNDING STRUCTURE IS USED?

Be sure to understand the claims funding structure of the plan under your evaluation as it is a major hint to its compliance. Is the plan a fully insured model or a "stop-loss" where policyholders pay a fixed annual premium and the actual cost of claims plus an administrative fee? The law specifically calls out "claims plus" arrangements as being considered self-insured. Even if there is a stop-loss (the employer's maximum exposure), it is typically set significantly above expected claims and thus makes it unlikely that there will be transfer of excess claims risk to the insurance carrier.

IS THE PLAN FILED AND APPROVED AS A "SIMILAR SUPPLEMENTAL (AND/OR LIMITED BENEFIT) EXCEPTED BENEFIT" POLICY?

To minimize compliance risk, the policy should be filed with the particular state insurance department under the "Type of Insurance" (TOI) that the insurer is claiming it to be. For instance, a policy claiming to be filed as a similar supplemental insurance plan should be filed, reviewed and approved as such a policy by that insurance department. If the policy is filed under a different TOI, it may not have been reviewed and approved against the appropriate insurance regulations.

DOES THE POLICY ADDRESS NOT BEING ABLE TO PAY FIRST DOLLAR ON ESSENTIAL HEALTH BENEFITS (EHBS)?

The plan's policy should include language addressing the inability to pay first dollar on Essential Health Benefits, specifically to align coverage with a particular state's EHBs. Such language ensures the plan is in full compliance with this excepted benefit requirement.

HOW DOES THE POLICY ADDRESS "VALUE OF COVERAGE" REGULATIONS?

Carriers should be able to explain not only that they comply but also how they comply. They should be able to provide a Safe Harbor calculation upon request. More robust solutions may have multiple pathways to ensure the 15% rule can be met.

ULTIMATE HEALTH BY ARMADACARE

A COMPLIANT EXECUTIVE MEDICAL REIMBURSEMENT PLAN

Protect your key leadership and meet their healthcare coverage needs with Ultimate Health. Our premier fully insured product combines robust supplemental coverage with a strategic health and wellness program to keep top performers healthy, productive and focused on their work.

Ultimate Health is a bundled similar supplemental and limited benefit excepted benefit plan that sits outside ACA non-discrimination and other mandates and complies with Section 105(h) insurance standards. It includes $50,000 or $100,000 aggregated family coverage for eligible medical, dental, prescription and vision expenses as well as items not typically covered under primary plans, like LASIK and massage therapy. It also includes valuable services, including specialty matching service TopDoc Connect, Get Me Home emergency travel support, and coverage toward elective executive physicals.

Ultimate Health is one of many ArmadaCare add-on insurance solutions structured to align with current excepted benefit regulations, including the latest regulations for similar supplemental coverage. Ultimate Health now also offers an HSA-compatible, indemnity-based version for clients with primary plans that are HDHP/HSAs.

The Ultimate Health excepted benefit plan offered by ArmadaCare is:

- Approved by state regulators
- Designed as “similar supplemental and limited benefit coverage”
- Filed and approved in 44 states and DC
- Boasts two A-rated carriers
- Requires presence of an ACA compliant primary plan for issuance
- Has a fully insured model with full risk transfer to the carrier
- Addresses prohibition on paying first dollar on EHBs
- Offers multiple pathways to meet Safe Harbor “value of coverage” regulation (15% rule)

SOURCES

SOURCES

1. (Section 1.105-11 (b)(1) of the tax code
2. See also Supreme Court Cases Spring Canyon Coal Co. v. Commissioner, 43 F2d 78 (10th Cir. 1930) and Helvering v. LeGierse, 312 US 531 (1943).
3. (Section 1.105-11 (b)(ii) of the tax code
4. "Section 2716 of the Public Health Services Act." https://www.irs.gov/pub/irs-drop/n-11-01.pdf
5. Parallel provisions defining the categories of excepted benefits can be located at Section 2791 of the Public Health Service Act, Sections 732 and 733 of the Employee Retirement Income Security Act (ERISA), and Sections 9831 and 9832 of the Internal Revenue Code of 1986.
6. "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance." Federal Register. https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-shortterm-limited-duration-insurance
7. Field Assistance Bulletin 2007-04. https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2007-04; 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. https://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf

ABOUT ARMADACARE

A leading insurance program manager, ArmadaCare delivers uncommon health insurance solutions designed to enhance ordinary health benefits. With the steadfast belief that health insurance should be better, ArmadaCare's plans fill voids in coverage for routine and unexpected healthcare expenses, offer valuable health and productivity support services and invite usage with modern conveniences, education touchpoints and people-first service. The result gives our clients the edge they need to retain, recruit and reward talent at any level.

LEARN MORE

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