MARSH & McLENNAN AGENCY


# 2020 Employee Benefits Webinar Series

## Compliance Considerations when Self-Insuring

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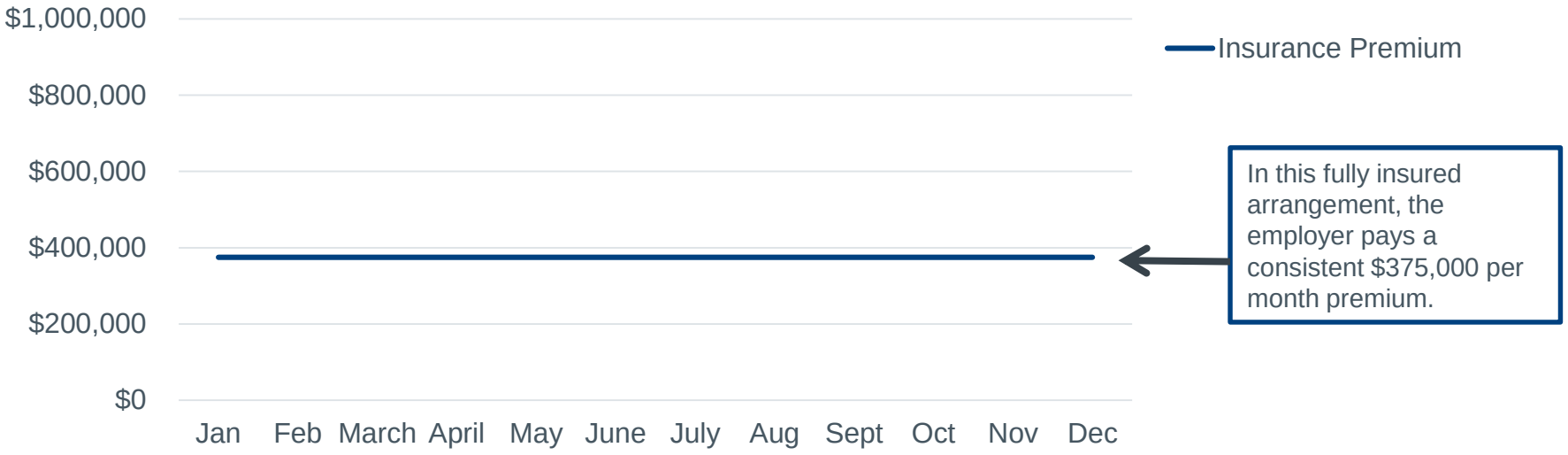
WORLD CLASS. LOCAL TOUCH.

# Agenda

- Financial Overview
- Plan Design, Fiduciary Duties, and the Administrative Services Agreement
- Plan Documents, Reporting & Disclosure Requirements, and Fees & Taxes
- Certain Tax Code Nondiscrimination Requirements
- HIPAA Privacy & Security Rules
- Questions?

# Financial Overview

# The Fully-Insured Model

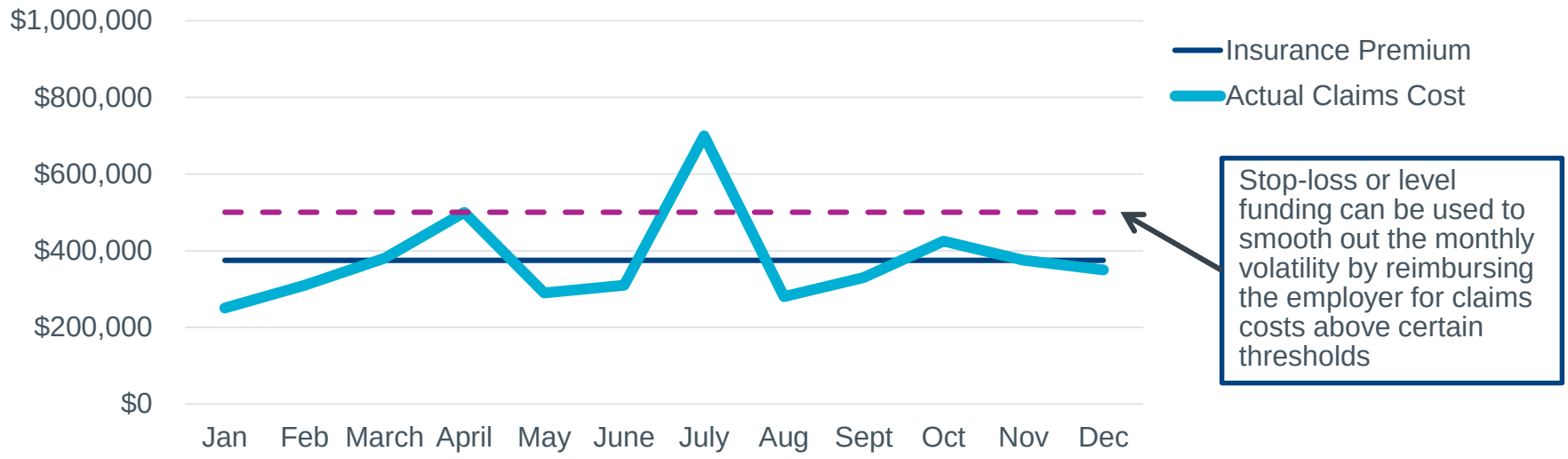



The employer pays a level premium each month and can budget with certainty. The premium includes the carrier's "profit margin" (typically 6% - 8%) and other amounts, such as taxes, surcharges, etc.

# The Self-Insured Model


The employer is responsible for estimating the plan's costs for the year, and employer's costs fluctuate with the plan's claims experience each month. The costs include hiring third parties to assist in the administration of the plan, but coverage excludes the carrier's premium profit margin and premium taxes. The employer charges participants a "premium equivalent" as their contribution.

# Self-Insured Model with Stop-Loss (Level Funding)




The employer is splitting the difference with this type of design. The employer still estimates its annual costs for the year, and monthly costs fluctuate up to an upper limit. The employer pays premiums for excess risk coverage that pays for or reimburses claims that exceed the upper limit. This premium does include some profit, premium taxes, etc.

# Plan Design, Fiduciary Duties, and the Administrative Services Agreement

# Plan Design

- An employer (as the plan sponsor) has greater control over the design and administration of a self-insured plan
  - Fully-insured plans are often “pre-set” designs purchased from an insurance carrier and do not offer the same degree of flexibility
- An employer has the freedom to carve-out coverage and administration to third parties
- Most Affordable Care Act (ACA) mandates apply to self-insured group health plans
  - Self-insured (and large group insured plans) are not required to cover all essential health benefits (EHB) mandated by a state’s EHB package
  - The plan will still have to establish a reasonable definition for EHBs for dollar and cost-sharing limits such as selecting a benchmark plan
  - Some mandates may be avoided by a grandfathered plan or a plan that fits with certain exceptions

# Plan Design

- Many self-insured group health plans qualify for ERISA preemption and are not subject to state or local insurance mandates and related regulatory requirements
  - Some states or local mandates are really obligations on an employer and not the employer's plan, and ERISA does not preempt these
- Some self-insured group health plans do not qualify for ERISA preemption including:
  - Church plans
  - Governmental plans (including Indian tribal governments)
  - Benefits that qualify as payroll practices (many short-term disability plans)
  - Plans maintained solely to comply with worker's compensation or disability insurance laws
- But, greater flexibility in design and administration comes with greater fiduciary responsibility…

# Fiduciary Duties

## Two Types of Fiduciaries Under ERISA

1. “Named fiduciary”
    - ERISA plans are required to name one or more fiduciaries responsible for the administration of the plan
        - There are frequently similar requirements for non-ERISA plans under other federal or state law
    - Plan administrator
        - Single employer plans → This will generally be the responsibility of the employer
        - Multiemployer plans → This will be the responsibility of the board of trustees or other designated entity
    - Trustees of plan assets

# Fiduciary Duties

## Two Types of Fiduciaries Under ERISA

2. “Functional fiduciary” (or fiduciary in fact)
   - Entities that may exercise discretionary authority or control over the administration of the plan or plan assets are also fiduciaries
   - Discretionary authority or control generally means final and binding decisions may be made without the plan sponsor or plan administrator’s input

# Fiduciary Duties

## Following Plan Rules Versus Discretionary Authority

- A third party does not exercise discretion if it is merely following the plan's terms or plan's procedures
  - Applying plan rules to determine who is eligible and administering enrollment
  - Processing claims based on plan rules
  - Preparing employee communication materials
  - Answering questions about whether certain benefits are covered
- But contrast with…
  - An entity with the authority to determine whether an employee is in an eligible class of employees
  - An entity with authority to make final benefit determinations
  - An entity with the authority to pursue subrogation

# Fiduciary Duties

## Delegation of Fiduciary Powers

- Authority and liability can be delegated
  - An employer will want contractual protection that the third party will follow applicable law
  - A third party that actually exercises discretionary authority over plan administration or assets is a fiduciary whether or not authority has been formally delegated
- And it can be inadvertently taken back…
  - Applying influence or pressure to a third party can negate the delegation
- A delegation does not mean the plan administrator has no liability
  - The plan administrator can't get rid of certain statutory responsibilities
  - Instead, the plan administrator can seek contractual damages (indemnification) from third parties that agree to delegation but fail to perform

# Fiduciary Duties

## Certain Fiduciary Responsibilities Under ERISA

1. Exclusive benefit rule
   - Plan fiduciaries must administer plan solely to provide benefits to participants and beneficiaries
   - Plan assets and self-dealing
2. Prudent person standard
   - Plan fiduciaries must administer plan using the care, skill, prudence, and diligence of a prudent person acting in a similar situation (this includes selecting third party vendors)
3. Follow the terms of the plan
   - Plan exceptions…
4. Prohibited transaction rules
   - Plan assets and self-dealing

# Administrative Services Agreements (ASA)

## Overview

- An employer will usually engage one or more third parties ( “third party administrators” or “TPAs”) to assist with plan administration
  - Common examples include maintaining a network of providers and claims processing
  - Insurance carriers often act as TPAs for self-insured plans
- The ASA (or ASO) is a contract specifying the parties’ rights and responsibilities toward each other including:
  - The services the TPA will perform
  - The parties’ liabilities to each other (remember, a TPA’s actions may still make it a fiduciary)
  - The fees for those services
  - The duration of the contact
  - How the contract can be amended or terminated

# Administrative Services Agreements (ASA)

## Overview

- When reviewing the ASA, watch out for:
  - Limitations on the employer's ability to access and use data; TPAs often attempt to restrict clients to a "company store" model
  - Severe limitations on the TPA's liability, including:
    - "Gross negligence" and "willful misconduct" standards
    - A dollar cap limitation well below the plan's possible financial exposure for a TPA's error
  - Whether the ASA allows for a no-fault termination by the employer (i.e. without cause) and how long the contract must run before it can be exercised
- The TPA's ASA will usually indicate the laws of the state where the ASA is incorporated control in the event of a dispute
  - Larger employers have more leverage to change this

# Plan Documents, Reporting & Disclosure Requirements, and Fees & Taxes

# Plan Documents

## ERISA

- ERISA plans must be established and maintained through a plan document that addresses:
  - Identifying the plan's named fiduciaries (e.g. plan administrator, trustee(s))
  - Plan administration and how authority may be delegated
  - How payments to and from the plan are made and claims and appeals procedures
  - Group health plans must include a variety of disclosures (e.g. COBRA, HIPAA Privacy and Security, etc.)
  - How to amend or terminate the plan
  - If funded through a trust, the plan's funding policy
- This plan document requirement applies whether the plan is fully insured or self-insured

# Plan Documents

## ERISA

- It's not unusual for an employer to take the position that the summary plan description (SPD) also serves as the plan document:
  - A standard SPD, including insurance booklets or policies an employer is using as an SPD, usually will not include all of the required plan document provisions
  - SPDs are subject to ERISA provisions that do not apply to plan documents
    - SPDs are subject to automatic delivery to participants while delivery of plan documents is only required upon request
    - The inclusion of complex plan document language in the SPD may make it harder for the SPD to satisfy ERISA's "readability" requirement, which doesn't apply to plan documents
- The consequences for a defective plan document are usually:
  - Coverage for a participant and/or claim that could have been avoided
  - Potential monetary penalties for missing provisions (e.g. required HIPAA language)

# Plan Documents

## ERISA

- A single plan document can include multiple health and welfare benefits (i.e., “wrap” plan).
- Advantages of wrap plans:
  - Can satisfy ERISA’s written plan document requirement for each incorporated benefit
  - Can act as a compliance safety net for the incorporated benefits by addressing language that may be “missing” in the separate documentation for each of the benefits
  - Permits the filing of a single Form 5500 for the incorporated benefits
  - Can permit the use of plan assets (e.g. commissions) attributable to one incorporated benefit for other incorporated benefits
- Non-ERISA benefits can be included, but the plan document should specify which benefits are not subject to ERISA and which provisions in the plan will not apply to them

# Plan Documents

## Tax Code

- Tax Code Section 125 cafeteria plans enable employees to pay for a variety of health and welfare benefits on a pre-tax basis
- Cafeteria plans are also subject to a written document requirement that must address a number of provisions
- The cafeteria plan requirements apply whether the benefits paid for on a pre-tax basis are fully insured or self-insured

# Reporting and Disclosure

## SPDs, SBCs, and Form 5500 Filings

- SPDs are intended to summarize the benefits, rights, and obligations under a plan
  - If the benefit is subject to ERISA, there is a long list of required SPD provisions
- An insurance carrier or TPA may provide a benefits booklet or policy, but compliance belongs to the employer as plan administrator…even for a fully insured plan
  - It is common for the benefits booklet or policy to be used as an SPD by an employer, but these frequently do not contain all of the “bells and whistles” by themselves

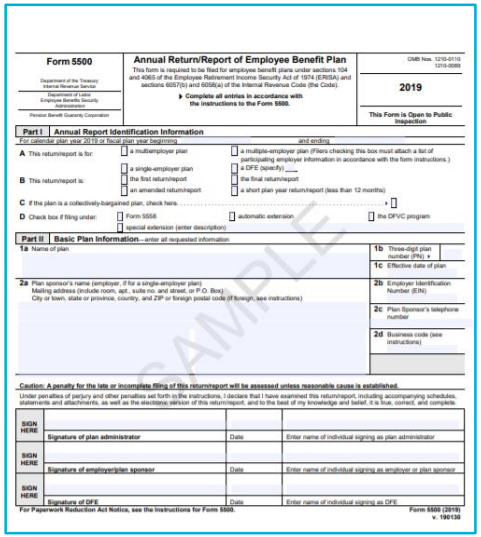
    **Note:** The services contract will usually indicate that the carrier/TPA is not obligated to provide a compliant SPD to its client. The booklet also often says it isn’t an SPD.
  - The benefits booklet or insurance policy will address most benefits and claims-related issues
  - The consequences for a defective SPD are usually coverage for a participant and/or claim that could have been avoided

# Reporting and Disclosure

## SPDs, SBCs, and Form 5500 Filings

- SBCs are essentially “diet SPDs” required for certain benefits under the ACA
  - Self-insured → The compliance and delivery requirements belong to the plan administrator
  - Fully-insured → The responsibility is actually shared by both the plan administrator and insurance carrier who will allocate responsibility in the services agreement
- Form 5500 filings
  - Self-insured benefits are not subject to Schedule A
  - Self-insured benefits funded through a trust or other funded arrangement may be subject to Schedules C, and H or I

**Note:** Stop-loss is subject to Schedule A if the premiums are included in the participant’s plan contribution rates.



Form 5500

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110
1210-0089

2019

This Form is Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Part I** Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning and ending

A This return/report is for: a multiemployer plan; a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.); a single-employer plan; a DFE (specify) ____

B This return/report is: the first return/report; the final return/report; an amended return/report; a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. ▶

D Check box if filing under: Form 5558; automatic extension; the DFVC program; special extension (enter description)

**Part II** Basic Plan Information—enter all requested information

1a Name of plan

1b Three-digit plan number (PN) ▶

1c Effective date of plan

2a Plan sponsor’s name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

2b Employer Identification Number (EIN)

2c Plan Sponsor’s telephone number

2d Business code (see instructions)

SAMPLE

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

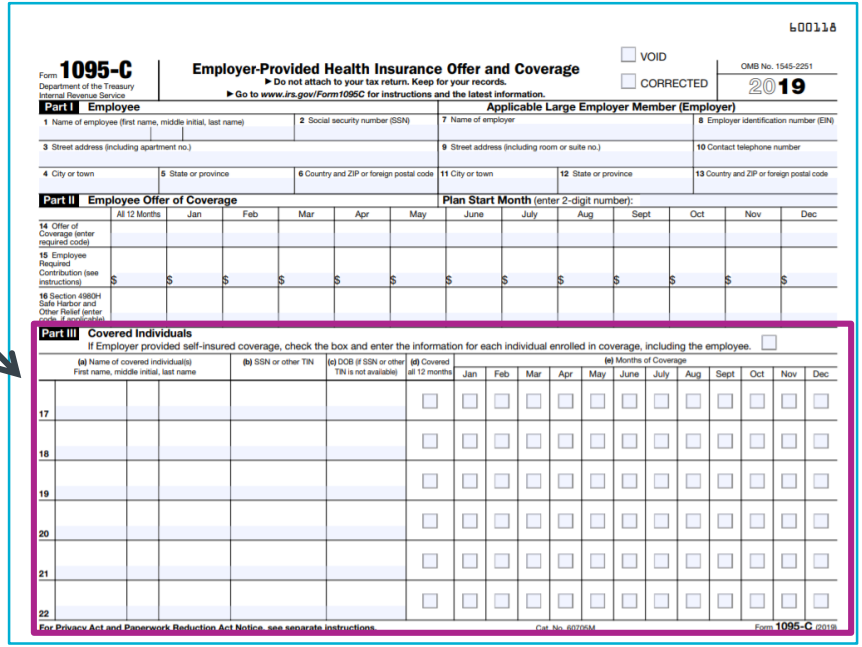
| | | | |
|---|---|---|---|
| SIGN HERE | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | Signature of DFE | Date | Enter name of individual signing as DFE |

For Paperwork Reduction Act Notice, see the instructions for Form 5500. Form 5500 (2019) v. 190130

# Reporting and Disclosure

## Employer Shared Responsibility Reporting

- Form 1095-C
  - Large employers with self-insured coverage are required to complete Part III of Form 1095-C to show the months of coverage for employees and dependents
  - Part III is left blank when the coverage is fully-insured, and the insurance carrier reports this information on Form 1095-B
  - Small employers (<50 FTEs) with self-insured coverage are required to report using Form 1095-B instead



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Form **1095-C** — Department of the Treasury, Internal Revenue Service

**Employer-Provided Health Insurance Offer and Coverage**

▶ Do not attach to your tax return. Keep for your records.

▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID ☐ CORRECTED

OMB No. 1545-2251

2019

**Part I** Employee

1 Name of employee (first name, middle initial, last name) | 2 Social security number (SSN)

3 Street address (including apartment no.)

4 City or town | 5 State or province | 6 Country and ZIP or foreign postal code

**Applicable Large Employer Member (Employer)**

7 Name of employer | 8 Employer identification number (EIN)

9 Street address (including room or suite no.) | 10 Contact telephone number

11 City or town | 12 State or province | 13 Country and ZIP or foreign postal code

**Part II** Employee Offer of Coverage

**Plan Start Month** (enter 2-digit number):

| | All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 Offer of Coverage (enter required code) | | | | | | | | | | | | | |
| 15 Employee Required Contribution (see instructions) | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ | $ |
| 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) | | | | | | | | | | | | | |

**Part III** Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

| | (a) Name of covered individual(s) First name, middle initial, last name | (b) SSN or other TIN | (c) DOB (if SSN or other TIN is not available) | (d) Covered all 12 months | (e) Months of Coverage Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 17 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22 | | | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2019)

# COVID Outbreak Period

*Outbreak Period* = Period during which deadlines are suspended

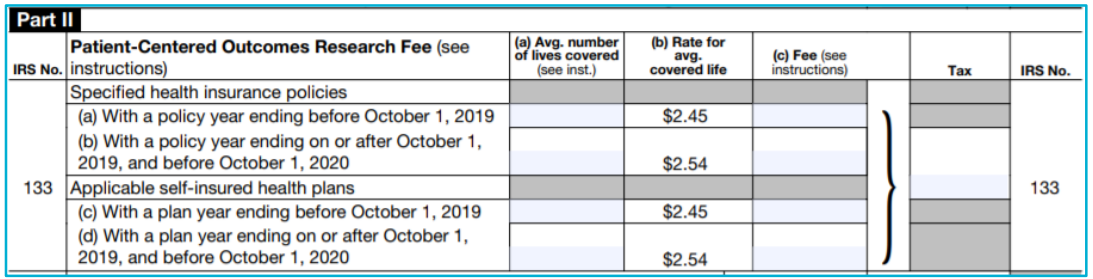
- Began March 1, 2020, the date National Emergency was declared
- Ends 60 days after the end of the National Emergency (or such other date announced by agencies, which could potentially be different for different areas of the country)


- There is temporary relief for most disclosure and notice requirements and many plan administration requirements during the Outbreak Period
- This was addressed in alerts and a separate webinar available from MMA

# Fees and Taxes

## PCORI

- The PCORI Fee is an excise tax applicable to many forms of group health coverage and is assessed based on covered lives
  - Self-insured coverage → Reported and paid by plan sponsors
  - Fully insured coverage → Reported and paid by insurance carriers
- The PCORI Fee is reported on IRS Form 720, Part II and paid annually by July 31st
  - Originally set to sunset in 2020, but Congress extended it through 2030
- PCORI reporting and payment cannot be delegated to a third party



| Part II | | | | | | |
|---|---|---|---|---|---|---|
| IRS No. | **Patient-Centered Outcomes Research Fee** (see instructions) | (a) Avg. number of lives covered (see inst.) | (b) Rate for avg. covered life | (c) Fee (see instructions) | Tax | IRS No. |
| | Specified health insurance policies | | | | | |
| | (a) With a policy year ending before October 1, 2019 | | $2.45 | | | |
| | (b) With a policy year ending on or after October 1, 2019, and before October 1, 2020 | | $2.54 | | | |
| 133 | Applicable self-insured health plans | | | | | 133 |
| | (c) With a plan year ending before October 1, 2019 | | $2.45 | | | |
| | (d) With a plan year ending on or after October 1, 2019, and before October 1, 2020 | | $2.54 | | | |

# Fees and Taxes

## Excise Tax and HIT

- The Excise Tax on High Cost Coverage (“Cadillac Tax”)
  - A 40% deductible excise tax on the cost of employer-provided group health coverage that exceeds certain statutory thresholds
  - “Cadillac Tax” was delayed twice and permanently repealed in the fiscal year 2020 spending bill (“Spending Bill”)
- ACA Health Insurance Provider Fee (HIP/HIT)
  - This annual fee applies to fully insured health plans and is responsible for a 2.5% - 3% increase in premiums for the years in which it is effective
  - The Spending Bill permanently repeals the HIT effective January 1, 2021

# Fees and Taxes

## Medical Loss Ratio

- ACA Medical Loss Ratios (MLR)
  - Insurance companies must spend a certain percentage of premiums received toward the payment of claims and the improvement of health care quality
    - 80% MLR target for small / individual market (<100)
    - 85% MLR target for large group market (>100)
  - The MLR requirement does not apply to self-insured coverage
- Certain states and localities maintain reporting and fee/tax requirements related to health coverage
  - Examples include New York's Public Goods Pool, Massachusetts' EMAC/HIRD, and San Francisco's Health Care Security Ordinance
  - Reporting responsibility and the ability to delegate varies

# Tax Code Nondiscrimination Requirements

# Health & Welfare Nondiscrimination Testing

## Some Basics

- The Tax Code generally divides your employee population into separate groups, which unfortunately are not uniformly determined across all of the various tests:
  - The “haves” which can include employees based on compensation levels, officer status or ownership and are generally referred to as highly compensated employees (or HCEs) or key employees.
  - The “have nots” which is your remaining employee population and are generally referred to as non-highly compensated employees (or NHCEs)
- There are different testing requirements applicable to certain benefits, but all generally test:
  - Eligibility → Did enough have nots participate relative to the number of haves?
  - Benefits → Did the have nots get to participate in the same benefits or receive enough benefits relative to the benefits received by the haves?

# Section 105(h) MERP Nondiscrimination Rules

## Tax Code Section 105 and Treasury Reg. §1.105-11

- Section 105(h) prohibits self-insured medical reimbursement plans from discriminating in favor of certain HCEs, shareholders or owners
  - The term “medical reimbursement plan” is fairly broad and includes self-insured medical, prescription drug, dental, and vision plans, health FSAs and HRAs
  - Health care reform extends portions of Section 105(h) to certain non-grandfathered, fully insured medical reimbursement plans but this has been delayed
- What happens if the plan fails?
  - HCEs are taxed on a pro-rata portion of benefits received under the plan (eligibility failure) or taxed on the value of the discriminatory benefit (benefits failure)
  - Under health care reform, the apparent sole consequence of failure for a fully insured plan is an excise tax on the employer (No negative tax effect on the covered HCEs)

# Section 125 Cafeteria Plan Nondiscrimination Rules

## Tax Code Section 125 and Proposed Treasury Reg. §1.125-7

- Section 125 cafeteria plans enable employees to pay for a variety of health and welfare benefits on a pre-tax basis
- Section 125 prohibits cafeteria plans from discriminating in favor of certain highly compensated and key employees
- Section 125 applies whether the benefits paid for on a pre-tax basis are fully-insured or self-insured
- What happens if the plan fails?
  - Highly compensated and/or key employees are taxed on the pre-tax amounts contributed for the year, cash-out incentives (e.g. PTO that could be converted to cash), and should probably be taxed on employer HSA contributions (if made through the cafeteria plan)

# HIPAA Privacy & Security Rules

# HIPAA Privacy & Security Rules

## Overview

- HIPAA's Privacy & Security rules apply to *Covered Entities,* which include employer-sponsored health plans (and the employees that perform work on behalf of those health plans)
- A health plan is any plan that provides for or pays the cost of the medical care, including:
  - Medical/prescription drug
  - Dental and Vision
  - EAP benefits
  - Health care flexible spending accounts (FSAs) and
  - Health reimbursement arrangements (HRAs)
- HIPAA also applies to *Business Associates,* which are third parties that create, receive, maintain or transmit PHI on behalf of the health plan

# HIPAA Privacy & Security Rules

## Overview

- HIPAA's privacy and security rules protect the health information created or received by an employer's health plan(s) by:
  - Creating individual rights regarding "protected health information" or "PHI"
  - Limiting or restricting the use and disclosure of PHI
- HIPAA requires employers to:
  - Adopt and implement policies and procedures on behalf of the health plan(s) that comply with the HIPAA rules; and
  - Provide HIPAA training to the employees who perform work on behalf of the plan(s)

# HIPAA Privacy & Security Rules

## Fully-Insured vs. Self-Insured Group Health Plans

- If fully-insured, and the only PHI received by the health plan from an insurance carrier is summary health information or enrollment information, the health plan's HIPAA compliance obligations are limited to:
  - A non-intimidation / non-retaliation requirement
  - A non-waiver of rights requirement
- In other words, the insurance carrier is really the *Covered Entity* for HIPAA compliance purposes when a plan is fully-insured and HIPAA compliance isn't the employer's problem
- The employer is on the hook for HIPAA compliance for its self-insured plans
- Other data privacy laws may also apply

# Questions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