Ogletree Deakins

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SUMMARY CHECKLIST OF HEALTH PLAN DESIGN OPTIONS

The following checklist provides a useful framework when considering health plan options for your company. It is not intended to be an exhaustive list of all health plan options and legal considerations for health plans but summarizes the key issues to consider as you make health plan design decisions regarding your employer-sponsored health plan. This checklist provides general information and should not be relied upon as legal advice for your particular health plan.

FUNDING CONSIDERATIONS

❒ Determine the funding type for major medical coverage.

- **Fully insured**. Fully insured health plans help employers manage the risks of health care costs and the administration of health care claims. The insurance company bears the risk of health care costs exceeding the premiums paid by the company and its employees who participate in the health plan. Correspondingly, because insurance companies bear more risk with these plans, employers have less control over plan design and administration. Fully insured plans must be approved by the state in which the policy is issued and are subject to state laws. With limited exceptions (for church and governmental employers), these plans are also subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Insurance companies will typically satisfy most of the reporting obligations, including preparing and distributing the Summary Annual Report, filing the ACA required reports (1094/1095-C), and providing plan documents (Summary Plan Description, etc.).
- **Self-insured.** Self-insured plans allow employers the most flexibility in plan design and administration, but also shifts more of the risks of high dollar claims and administration to the employer. Most employers, therefore, purchase stop-loss insurance to limits its exposure to the financial risk of claims exceeding the

amount of premiums collected. Employers also typically engage a third-party administrator to manage the claims and other administrative aspects of the health plan. Most self-insured plans are subject to ERISA but exempt from most state insurance laws. Reporting and plan document requirements typically are the responsibility of the employer with some assistance from the third-party administrator.

❒ Consider any Consumer Directed Health Plan options as health plan funding arrangements.

- **Health Flexible Spending Account (Health FSA).** A Health FSA is an employer-sponsored pre-tax benefit account employees can use to pay for eligible medical, dental, and vision care expenses that are not covered by the employee's health insurance plan. Employees with a Health FSA may elect at the beginning of the year to set aside up to $2,700 (indexed annually) from their pay on a pre-tax basis to be used for eligible medical, dental and vision care expenses for themselves, their spouse and dependents. Employers may, but are not required to, contribute to an employee's Health FSA. Most employers engage the services of a third party to manage and administer the Health FSA. A key characteristic of the Health FSA is that the funds in the account must be used by a certain date or the funds are no longer available to the participant ("use it or lose it rule"). Health FSAs are considered group health plans and are therefore subject to many of the same laws applicable to group health plans, including ERISA and the Privacy and Security Rule requirements under the Health Insurance Portability and Accountability Act (HIPAA). Health FSAs may be offered as a standalone benefit or in conjunction with most other group health plans. However, the Health FSA can only be offered in a limited form (limited use Health FSA) when offered in addition to a Health Savings Account (HAS). Other limitations and restrictions also apply when the Health FSA is offered in conjunction with other Consumer Directed health plan options. See chart below.
- **Health Savings Account (HSA).** An HSA is an individually-owned account that allows the individual to deposit funds on a pre-tax basis for eligible medical expenses. Individuals may contribute up to $3,500 if they have single health plan coverage or up to $7,000 if they have family health plan coverage. Eligible individuals must participate in a high-deductible health plan and with limited

exceptions must not participate in any other health plan that is not a high-deductible health plan. Most employers offering a Health Savings Account allow its employees to contribute to their HSA on a pre-tax basis through payroll deduction. Employers may also contribute employer dollars to their employee's HSA. HSAs generally are not employer-sponsored group health plans and therefore are not subject to employee benefit laws such as ERISA. The account are owned by the individual and are taken with the individual if they leave the company. The account balances in the HSA also roll over from year to year. The HSA may be offered with other group health plans and/or Consumer Directed health plan options.

- **Health Reimbursement Arrangement (HRA).** An HRA is an employer-owned account into which only employer dollars can be set aside on a tax-favored basis for employees to pay for eligible healthcare costs. Currently, HRAs must be offered to employees in connection with an employer-sponsored major medical group health plan. An HRA may be offered on a standalone basis (i.e., not connected to any employer-sponsored group health plan) to retirees only. However under proposed regulations, an HRA may be offered to employees on a standalone basis so long as the employee obtains an individual health insurance policy. There is no limit on the amount of funds and employer may contribute to an HRA. Additionally, HRA funds may roll over from year to year. However because the employer owns the account, employees are not able to take HRA funds with them if they leave the company. HRAs may be offered in conjunction with other group health plans including Consumer Directed health plan options.

PLAN STRUCTURE OPTIONS

- **Preferred Provider Organization (PPO).** A type of health plan structure under which the insurance company or third-party administrator contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
- **Health Maintenance Organization (HMO).** A type of health plan structure under which coverage is usually limited to care from health providers who work for or contract with

the HMO. Coverage out-of-network is generally not available except in an emergency. An HMO may require plan participants to live or work in its service area to be eligible for coverage.

- ❒ **Point of Service (POS).** A type of plan structure under which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.
- ❒ **High Deductible Health Plan (HDHP).** A type of health plan structure under which there is a deductible of at least $1,350 for an individual or $2,700 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than $6,750 for an individual and $13,500 for a family. These amounts are for 2019 and are indexed annually.

PLAN DESIGN CONSIDERATIONS

- ❒ **Eligible.** Who will be eligible to participate in the health plan and when can participating begin?
  - **Employer Shared Responsibility.** The Employer Shared Responsibility provisions of the Affordable Care Act provide that large employers that fail to provide a certain level of health insurance coverage to its full-time employees and their dependents may be subject to a penalty. Accordingly, under the ACA, large employers (employers with at least 50 full-time equivalent employees on average) must offer health coverage to its full-time employees and their dependents. Full-time is defined as employees who average working 30 or more hours per week.
  - **Waiting period.** Any waiting period under the plan generally cannot exceed 90 days.
  - **Spouse/Domestic Partner.** Coverage for spouses and/or domestic partners generally is not required (subject to some state law requirements). Determine if, and to what extent, coverage will be offered to spouses and domestic partners.
  - **Children.** Coverage of dependent children generally is not required (subject to state law requirements and potential penalties for large employers under the Affordable Care Act). However if dependent children coverage is offered, the

Affordable Care Act requires that such coverage be granted to children up to age 26.

- **Any state-law mandates.** ERISA generally preempts any state law requirements for health plans. However, some plans (governmental and church plans) are not subject to ERISA and state law mandates would apply. Additionally, fully-insured plans may be obligated to comply with applicable state laws. For example, in some states (e.g. Florida) dependent children may be required to be covered up to age 30.

❒ **Covered Benefits.** Which benefits are required to be covered under the health plan?

- **Affordable Care Act required coverage (e.g. minimum value, preventive care, essential health benefits, etc.).** Ensure that the Affordable Care Act required coverage provisions are addressed in the group health plan (e.g., the plan must provide minimum value, preventive care services covered at 100%, and fully-insured plans must offer all essential health benefits, etc.).
- **State mandated benefits (e.g. autism, infertility, etc.).** For plans governed by ERISA, state-mandated benefits are generally preempted. However for all other plans, state-mandated benefits must be included in the group health plans coverage (e.g., autism, infertility benefits, etc.). Many group health plans choose to cover state-mandated benefits even though they are not required to do so.

❒ **Other Legal Requirements**. Most group health plans must comply with other state and federal laws that impact plan design and coverage. Below are several common laws impacting benefits available under the group health plan.

- Health Insurance Portability and Accountability Act privacy and security
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Under MHPAEA, group health plans offering mental health and substance use disorder benefits must do so in a manner that does not place limitations on such benefits that are less favorable than the limits placed on medical/surgical benefits under the plan.
- Affordable Care Act. In addition to the covered benefits noted above, the ACA also provides certain patient protections, including the prohibition on annual and

lifetime dollar limits on essential health benefits, ensuring coverage for people with pre-existing conditions, and the right to choose a primary care doctor.

OTHER COMMON HEALTH PLAN DESIGN CONSIDERATIONS

- ❒ **On-Site Clinics.** On-Site clinics generally come in 3 variations: (1) Outsourced services where a third party completely runs the on-site clinic; (2) Insourced services where the company hires a healthcare professional to provide clinic services; and (3) A hybrid of versions 1 and 2 in which the employer may provide the facilities and all of the supplies but contracts with a healthcare provider (typically Nurse Practitioner) to administer services. On-Site clinics are all typically a group health plan with some exceptions for clinics that only provide first aid care and care for workplace injuries, and on-site clinics that do not provide significant health care services. Many on-site clinics are integrated with the employer's major medical group health plan, but may also serve as a standalone group health plan offered to all employees regardless of whether they participate on the major medical group health plan or not. Because on-site clinics are not high-deductible health plans, individuals utilizing the on-site clinic are not eligible to participate in a Health Savings Account unless the services from the on-site clinic fall within the definition of preventive care under HSA guidance. On-Site clinics may be offered in conjunction with other Consumer Directed health plan options, such as a Health FSA and Health Reimbursement Arrangement. As a group health plan, the on-site clinics are generally subject to COBRA.

- ❒ **Association Health Plans.** An Association Health Plan is a group health plan sponsored by a group or an association of employers with sufficient ties to one another to be considered a single employer for group health plan purposes. The AHP operates as a large group health plan allowing its members to take advantage of large group health plan pricing and benefits which can be provided to member employees. AHPs are multiple employer welfare arrangements and subject to both ERISA and state insurance laws.
- ❒ **Telehealth.** The Department of Health and Human Services defines Telehealth (or "Telemedicine") as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical healthcare, patient and professional health-related education, public health and health administration".

Telehealth services are considered a group health plan subject to ERISA. Telehealth services also are typically subject to the Affordable Care Act requirements if it is offered outside of a group health plan. However a telehealth services program that qualifies as an "excepted benefit" is not subject to the ACA requirements. Excepted benefits are benefits considered limited or ancillary to comprehensive group health coverage. Typically, excepted benefits do not provide significant benefits in the nature of medical care, are not coordinated with another group health plan, are provided to participants at no cost, and do not impose cost sharing. Unless the telehealth services are considered an excepted benefit, participants using telehealth services generally are not eligible to participate in an HSA. Employers must also consider whether telehealth services are approved under applicable state healthcare provider laws.

- ❒ **Wellness programs.** Wellness programs come in many shapes and sizes. Workplace wellness programs include any initiative designed to improve the health and wellbeing of a company's employees. Many of these initiatives are in and of themselves a group health plan (e.g. a Nurse Practitioner providing flu shots and biometric screening and treatment for preventive care services) or are connected to a health plan (e.g. healthcare premium discount for achieving a certain BMI score). Wellness programs that in and of themselves are group health plans are subject to all applicable laws like any other group health plan. Many wellness programs are tied to the company's group health plan. Such employers must determine if the wellness program should be specifically described in the health plan document to satisfy ERISA requirements.

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BEST PRACTICES

- ❒ Establish a resource team, including Human Resources, insurance brokers, and ERISA attorneys to help navigate plan design and legal issues.
- ❒ Determine which benefits are most important to the Company's employees.
- ❒ Determine the most cost-effective plan funding option.
- ❒ Identify the plan structure with the flexibility best suited for your Company employees, keeping in mind that the more flexible and open plan structures are generally more expensive.
- ❒ Ensure compliance with applicable laws based on benefit plan design options selected
- ❒ Prepare the applicable plan documents and establish a plan reporting and compliance calendar.

If you have any questions about this form, please contact: Ruth Anne Collins Michels | Atlanta, GA | Telephone: 404-870-1725 | E-mail: ruth.michels@ogletree.com or Daniel Sulton | Greenville, SC | Telephone: 864-240-8263 | E-mail: daniel.sulton@ogletree.com