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Alternative Plan Options & Legislative Update
March 27, 2025

Today's Speakers

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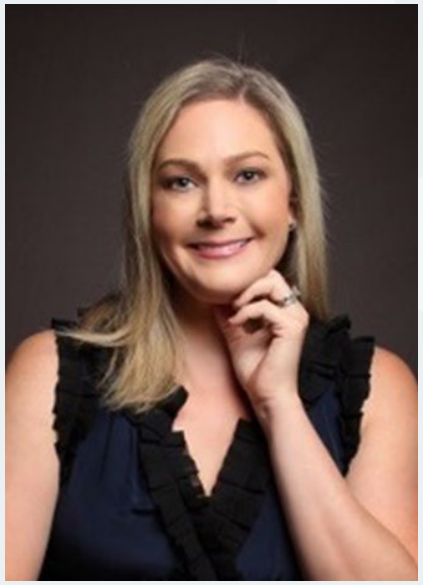

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Agenda

- History of Employer-Provided Health Care
- Current Employer Concerns with Traditional Group health plans
- HRAs as an alternative to group health insurance
- Legislative Update

History of Relationship Between Employer and Employee Benefits

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How It All Started…

- 1920s -Employer-provided health coverage gains traction
  - Baylor University Hospital and Dallas public school employees cited as first Blue Cross plan
  - Choice of employee group as foundation of private health insurance was key element in managing the risk pool and avoiding disproportionate participation by higher-risk individuals
- After World War II - War Labor Board imposed wage and price controls, but ruled contributions to insurance and pension funds did not count as employee wages.
- In 1954 -Tax Code clarified that employer contributions for health benefit plans were tax deductible as business expense and excluded from employee's taxable income
- In 1974 –ERISA boosted employer discretion and involvement in the management of health benefits.

How It Expanded…

- In 1985-COBRA required employers to continue offering health coverage to former employees and their dependents for 18 or 36 months
- In 2010 – ACA imposed insurer spend obligations, eliminated out-of-pocket costs for preventive services, expanded drug coverage requirements, requires coverage of ‘essential health benefits’, prevents denial of coverage due to pre-existing conditions
- ACA requires employers with >50 employees to offer minimum essential coverage that affordable and provides minimum value to at lest 95% of full-time employees
- Even if not required, employees consider health insurance the most important benefit offered by their employer

Employer Concerns with Traditional Health Plans

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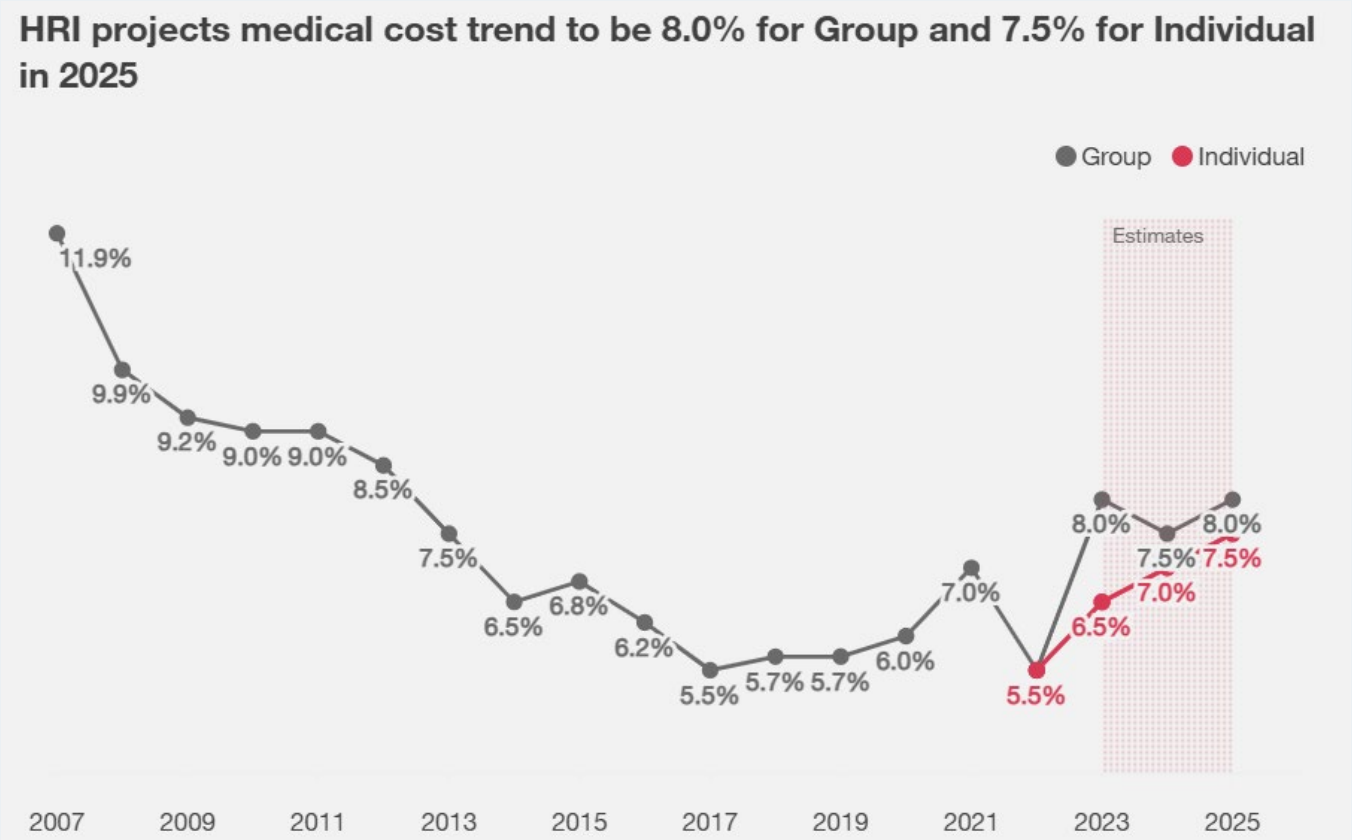
How It Is Going...



Traditional Group Health Plans

- Group Health Plans – offer comprehensive coverage for employees and dependents under single policy sponsored by employer
- Employers select the plan offerings and handle plan administration
- For insured plans, carrier assumes risk, but premium cost is set by insurance carrier
  - Average cost of employer-sponsored health care coverage expected to increase by 9% - surpassing $16,000 per employee in 2025
- For self-funded arrangements, employer assumes risk for paying health care costs that can be unpredictable
  - GLP-1 Drugs
  - Gene editing therapies
  - Increase utilization in 2022 and 2023 due to COVID delaying care
- Average employer subsidizes 81% of plan costs

Common Ways to Reduce Traditional Health Insurance Costs

- Plan Design & Cost-sharing
  - Consider High Deductible Health Plans and Health Savings Accounts (HSAs) to lower premiums
  - Consider self-funded for more control over covered benefits/prescription drugs
  - Implement tiered co-pays / co-insurance
- Implement Wellness programs
  - Incentivize employees to participate in preventive care
  - Promote healthy lifestyle choices (e.g. healthy eating, stress management)
- Employee Education
  - Help employees understand their health plan
- Encourage telehealth
- Healthcare Assistance Programs to help navigate healthcare system

HRAs as Alternative to Group Health Insurance

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Health Reimbursement Accounts

- Account-based group health plan funded solely by employer contributions (no employee contributions)
- HRA funds used to reimburse qualified medical expenses (IRC Section 213(d)) that are incurred by employees (or former employees)
- Third-party administrator often used to substantiate claims, provide participant communications, customer support and enable use of debit cards
- Unspent HRA dollars can rollover to following plan year, but cannot be cashed out
- Considered self-funded group health plan - subject to ERISA, HIPAA, COBRA, ACA and other group health plan mandates
- ACA imposed new requirement that HRA must be integrated with major medical health coverage (or qualify for an exception)
  - Can reimburse expenses of spouses, tax dependents and children under age 27, if they are enrolled in employer's non-HRA plan.

QSEHRA

- Qualified Small Employer HRA to help employees purchase individual coverage & qualified medical expenses
- Permissible stand-alone HRA that is not considered a “group health plan” and exempt from GHP requirements of ERISA, COBRA, and IRC
- Available for employers with fewer than 50 full-time employees
- Defined contribution model: employers select the amount of money to contribute up to the annual contribution limits set by the IRS
  - $6,350 for individuals and $12,800 for families in 2025
- LIMITATIONS:
  - Employer can’t offer any other group health plan within controlled group
  - Only funded by employer contributions (no employee contributions permitted)
  - Self-funded plan nondiscrimination rules apply (IRC 105(h))

ICHRA

- Individual Coverage HRA - Applicable for plan years on and after January 1, 2020
  - Intention to increase utilization of HRAs
- Monthly tax-free allowance to buy individual health coverage and out of pocket medical expenses
- Available to employers of any size (with at least 1 non-owner/spouse employee)
- Non-integrated HRA, but considered to be integrated with qualifying individual health coverage or Medicare
- Employers can decide how much to contribute to the ICHRA each year – there is no minimum or maximum contribution requirements
  - Set amount for employee-only and optional to set different amount for employees' dependents
- To participate, employees must be enrolled in an individual, nonexcepted benefit coverage that complies with prohibition on lifetime and annual dollar limits and proves preventive services or Medicare
- Can reimburse employees for qualifying medical expenses, including premiums for individual coverage or Medicare

ICHRA – PROs

- Available to employers of any size
- Cost Control - Employer sets contribution amount vs. unpredictable like self-funded GHPs
- No imposed annual contribution limit
- Takes employer out of insurance market - Employees can choose benefits that fit their needs
- Employer can decide whether to give employees that become covered midyear the full annual benefit available or a prorated amount
- Self-funded Nondiscrimination rules (105(h)) do not apply to ICHRAs that reimburse only insurance premiums (and not other qualified medical expenses)

ICHRA – CONs

- Must be offered on the same terms and conditions to all employees within a class
  - Can be increased based on age (up to 3x the maximum dollar amount available to the youngest participant) or family size (number of dependents)
- Employee must maintain individual, non-excepted benefit coverage to be reimbursed for any qualified medical expenses
- Employer must establish procedures for substantiating coverage on a monthly basis
- Not exempt from ERISA, COBRA and ACA
- Funds cannot be used towards other group coverage (spousal group plans) or TRICARE
- Individual coverage typically not as good as is group health insurance
- As premium rates increase, the set amount of employer contributions will cover less of the premium payment obligation
- Employee is not eligible for any premium tax credit on the Marketplace
- May be problematic to offer different benefits to different classes due to 105(h) nondiscrimination rules

What About Association Health Plans (AHPs)?

- A type of multiple employer welfare arrangement (MEWA); has existed for decades
- History of fraud and insolvencies made regulators wary of these arrangements
  - between 1988 and 1991, multiple employer entities left 400,000 people with medical bills exceeding $123 million (1992 GAO report)
  - between 2000 and 2002, 144 entities left 200,000 policyholders with $252 million in unpaid medical bills
  - In 2017, NY Times reported major fraud cases in TX, NJ, FL, SC and LA
- 2009 ACA enhanced regulatory oversight of AHPs
  - AHPs that enrolled individuals or small groups subject to ACA individual and small-group market rules, required to offer essential health benefits (EHB)
  - AHP covering small employers could be considered a single large-group health plan under ERISA if:
    - Employers were bound together by a common interest beyond health coverage and effectively operated as one employer controlling the association
    - Employers had to share a common trade, business, or profession; shared geographic location (e.g., a chamber of commerce) was not enough.

AHPs During First Trump Administration

- 2018 DOL greatly expanded circumstances under which an aggregation of small groups could be considered a large group. Criteria were:
  - Association served at least one substantial business purpose other than providing health coverage, even though its primary purpose was offering health coverage
  - Member employers were either in the same trade or business or in the same geographic area, which could span several states, and
  - Employer members in some sense controlled the AHP and health plan.
- Other features:
  - AHPs could cover individual "working owners," even though the working owners had no employees other than themselves.
  - AHPs prohibited from discriminating against enrollees on the basis of health status but allowed to exclude or charge higher premiums to employers on the basis of age, gender, occupation, or other factors.
- 2019 rules struck down in federal court as violating ERISA; Administration appealed
- 2024 Biden Administration rescinded Trump Administration rule

Legislative Update

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Telehealth and HDHPs

- Bipartisan CR agreed to in January before Trump/Musk feedback included extension of COVID-era telehealth exception to HDHP/HRA rules. CR as approved in January did not include extension
  - Expired March 14, 2025
- CR signed into law on March 15 did not include extension of ability to provide first-dollar coverage of telehealth under a HDHP/HRA
  - Expires September 30, 2025
- Telehealth Expansion Act reintroduced in House and Senate on February 27, 2025
  - HDHP safe harbor for absence of deductible for telehealth
  - Effective for plan years beginning after 12/31/24
  - No sunset date
- Stakeholder letter to Congressional leaders– 300 signatories

PBM Discussions

- Pharmacy Benefit Manager legislation remains a bipartisan priority for Congress
- Future legislation could mirror Bipartisan Continuing Resolution negotiated in December 2024
  - PBMs for large fully insured or self-insured plans to pass 100% of rebates or other discounts directly to the employer plan sponsor
  - New reporting requirements
  - Additional limits imposed by Medicare & Medicaid (ban spread pricing, require NADAC + dispensing fee, prohibit tying compensation to size of discount negotiated)
- Current Legislation:
  - The Patients Before Monopolies Act (S.5503, H.R. 10362)
  - The Pharmacists Fight Back Act (H.R. 9096)
  - The Lower Costs, More Transparency Act (H.R. 5378)
- States still testing the fences
  - NAIC is looking at a new recommendation for each state to require PBMs to obtain a license and also considering the creation of market conduct exams for PBMs

Arkansas Rule 128

- Enacted to make sure reimbursement rates paid by PBMs to pharmacies in Arkansas are “fair and reasonable”
  - NADAQ +dispensing fee
- Enforcement authority given to AID
- Bulletin 18-2024 requires data from:
  - fully-insured group health plans issued in Arkansas
  - fully-insured group health plans issued outside of Arkansas that cover Arkansas residents
  - self-funded group health plans (including government plans) that provide benefits to Arkansas residents

Arkansas Rule 128

Confusing language and potential ERISA issue

- Rule 128 (Section III) carves out:

  "federally regulated heath benefit plans restricted from state regulation under federal law or those health benefit plans which are exempted from state regulation under state law."

- The Bulletin expressly states that the Rule applies to self-funded employer health plans and self-funded government health plans
  - Potentially in conflict with ERISA
- Employers should consult their own counsel re: impact of compliance

Florida Data Call

- 2023 Florida passed SB 1550
- January 2025, Florida Agency for Health Care Administration requested PBMs turn over detailed prescription data, including patients' names, birthdates, medications, prescribing providers and dispensing pharmacies
- Sought data from self-funded ERISA plans
- American Benefits Council asked FL to withdraw request that “violates the health privacy and security of millions of Floridians”
- Employers should consult their own counsel re: impact of compliance

California Infertility Coverage Mandate

- Effective 7/1/25
  - Unless legislation enacted to delay
- Require fully insured large group health plans in California to cover infertility diagnosis and treatment
  - Up to 3 IVF cycles
- Requires carriers for small group plans to offer option to employer of covering infertility diagnosis and treatment
- Covers unmarried partners, same-sex partners, individuals
  - Anyone unable to reproduce, either by themselves or with their partner, without medical intervention
- Without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation

How It May Be in the Future…

- Smaller DOL?
  - Trump Administration's focus to eliminate 'unnecessary administrative expenses' and reduce size of federal workforce
  - Fewer resources for employer plan audits
- Imposed regulatory freeze that prevents all new federal rules from going into effect until current Administration can review
  - HIPAA Security Rule to Strengthen Cybersecurity for ePHI
  - MHPAEA – NQTL updates scheduled to go into effect 1/1/2026 are paused
- Long-standing preferential tax treatment of employer-provided insurance (going back to 1954) is at risk of being used to offset congressional intent to make the cuts within the Tax Cut and Jobs Act permanent ($5T price tag)

Cadillac Tax 2.0?

- March 20, 2024, Republican Study Committee's Budget and Spending Task Force released budget proposal which included a limit on tax treatment for health care expenditures, including amounts paid by both an employer and an employee.
- What if tax exclusion for ESI was capped at 75% of average in 2026 and indexed for inflation using chained CPI-U? ($11,200 individual/$27,600 family)
- By 2032 , this policy would limit the tax exclusion to the 50th percentile of premiums ($8,900 individual/$21,600 family in 2026 dollars)
  - 2.8 million fewer people would have coverage through employment by 2035
  - Move toward less robust coverage to stay under the cap
- Other long-run annual impacts:
  - $40 billion less GDP
  - 240,000 fewer jobs
  - $280 billion less after-tax employee compensation

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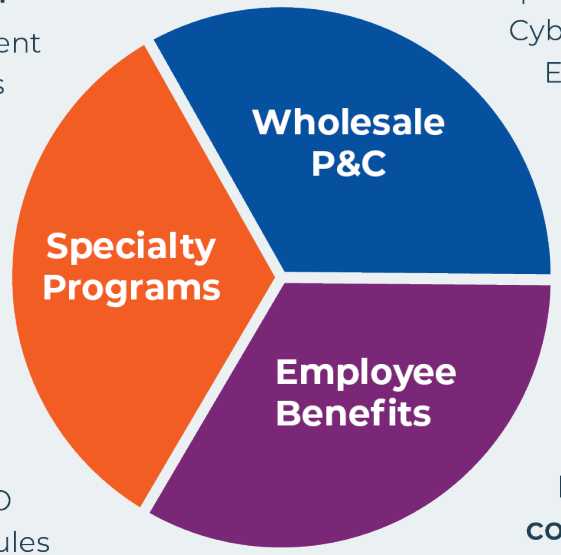

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