Compliance Guide for Self-Funded Plans

Overview

Sponsors of self-insured plans may experience more flexibility and cost advantages compared to their fully insured counterparts. With a self-insured model, employers fund covered health expenses directly, as the plan incurs claims. A third-party administrator (TPA) will typically be engaged to adjudicate and process claims, contract with and coordinate provider networks, arrange for stop-loss coverage, and more. Level-funded plans are considered self-insured plans.

Self-insured and fully insured group health plans are governed by somewhat different rules. For example, state insurance laws generally do not apply to self-insured, ERISA-covered plans. The intention as stated in the Employee Retirement Income Security Act (ERISA) is "to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States." This contrasts with a fully insured plan, which is subject to regulation by the state and state insurance mandates. Self-insured plans still may be exempt from ERISA if they are considered a church plan or a governmental plan. The following summarizes federal rules that apply to self-insured plans.

Affordable Care Act Reforms

- ACA Reporting: Required regardless of an employer's size for self-insured plans
- For an employer with fewer than 50 full-time equivalent (FTE) employees, Forms 1094-B and 1095-B; for applicable large employers (ALEs), Forms 1094-C and 1095-C
- Employer shared responsibility provisions: If the employer has 50 or more full-time or full-time equivalent employees
- Elimination of pre-existing condition limitations
- Dependent child coverage to age 26
- Coverage of preventive health services without cost-sharing
- Lifetime and annual dollar limit prohibitions on essential health benefits

- Participants' maximum out-of-pocket expenses for covered essential health benefits (EHBs) cannot exceed specified amounts (grandfathered plans are exempt). To determine which benefits are considered EHBs, a self-insured group health plan may choose any state benchmark plan that was approved by the Department of Health and Human Services (HHS).
- No rescissions of coverage except for fraud or intentional misrepresentation of material fact
- No waiting periods exceeding 90 days
- Summary of Benefits and Coverage required, unless the plan is a certain excepted benefit or retiree-only plan
- Patient Centered Outcomes Research Institute (PCORI) Fee: Annual filing of Form 720 (due July 31) and payment of fee
- Notice regarding the exchanges
- W-2 reporting of health care coverage costs (this only applies if the employer provided 250 or more W-2s for the prior calendar year)
- Wellness program rules

Affordable Care Act reforms that do not apply to self-insured plans

- EHB package requirement, which states that non-grandfathered insurance plans in the individual and small group markets must offer a comprehensive package of items and services
- Medical loss ratio (MLR) rules, which require health insurance issuers to spend 80% to 85% of their premium dollars on medical care and health care quality improvement, rather than administrative costs
- Small employer tax credit, which is only available for the purchase of health care through a Small Business Health Options Program exchange
- Review process for unreasonable increases in premiums for health insurance coverage
- Annual insurance fee required by the ACA's revenue-raising provisions
- Variety of insurance market reforms, including guaranteed issue and renewability and insurance premium restrictions

Required Plan Documents

- Cafeteria plan document, if contributions are run through a cafeteria plan
- Summary of Material Modification, if the plan is subject to ERISA
- Summary Annual Report, if the plan is subject to ERISA and required to file a Form 5500

- Summary of Benefits and Coverage, if the plan is subject to ERISA
- Plan document and Summary Plan Description (SPD), or combination plan document/SPD or wrap plan document, if the plan is subject to ERISA
- Stop loss policies (if purchasing through a stop-loss provider)

Plan Notices, as applicable

- Medicare Part D creditable coverage notice
- Women's Health and Cancer Rights Act notice
- Newborns' and Mothers' Health Protection Act notice (or opt out notice)
- Premium Assistance under Medicaid and CHIP notice
- Wellness Program Notice of Reasonable Alternatives
- Wellness Program Disclosure, if the plan is subject to ERISA
- Wellness Program voluntary notice if the plan is subject to the Americans with Disabilities Act (ADA)
- Notice Regarding Wellness Program
- Grandfathered Plan Notice
- Patient Protection Notice, applicable to all non-grandfathered group health plans
- HIPAA Notice of Privacy Practices
- Notice to Enrollees regarding Opt-Out (mental health parity exemption no longer available for renewal)
- HIPAA Notice of Special Enrollment Rights
- COBRA notices, if the plan is subject to COBRA
- National Medical Support Notice
- Michelle's Law Enrollment Notice
- Mental Health Parity and Addiction Equity Act (MHPAEA) notices
- Advance notice of material modifications to Summary of Benefits and Coverage Notice
- Internal Claims and Appeals and External Review Notices, applicable to all non-grandfathered group health plans

- External Review Process Disclosure, applicable to all non-grandfathered health plans, only if no state process applies and is binding
- Employer Notice to Employees of Coverage Options available through the Exchange, applicable to all employers subject to the Fair Labor Standards Act
- Advance notice to each participant who will be affected by a rescission of coverage
- U.S. Department of Labor (DOL) claims procedure notices
- Consolidated Appropriations Act Surprise Billing notice

Government Filings

- Form 5500, if subject to ERISA, unless an exemption applies
- W-2 reporting of health care coverage costs, if the employer provided 250 or more W-2s for the prior calendar year
- ACA employer reporting to the IRS on coverage
- Form 720 to report and pay the PCORI fee, which applies from 2012 to 2029
- Medicare Part D Creditable Coverage Disclosure
- Section 111 Medicare Secondary Payer Mandatory Reporting (plan administrator)
- Annual gag clause attestation
- Annual Prescription Drug Data Collection reporting (RxDC reporting)
- Annual Air Ambulance Reporting

Consolidated Appropriations Act Provisions

Most, but not all CAA, 2021 provisions are in effect; however, some have been delayed pending regulatory guidance.

- Prohibition on Gag Clauses and Attestation
- Mental Health Parity Comparative Analysis
- Primary Care Provider Designation
- Preventing Surprise Medical Bills (No Surprises Act)
- Ending Surprise Air Ambulance Bills (No Surprises Act)

Continuity of Care

- Medical ID Card Cost-Sharing
- Machine-readable in-network rates and out-of-network allowed amounts on public website
- Annual Reporting on Pharmacy Benefits and Drug Costs
- Price Comparison Tool for Shoppable Items/Services
- Advance Explanation of Benefits
- CAA Surprise Billing Notice

COBRA Equivalent Premium

The IRS provides two methods for determining COBRA premiums for self-funded health plans. The plan administrator determines the COBRA premium based on a reasonable actuarial estimate method or a past-cost method.

Other Considerations

- Section 125 nondiscrimination testing if contributions are run through a cafeteria plan
- Section 105(h) nondiscrimination testing applies only to self-insured plans
- HIPAA Privacy and Security Rules apply to self-insured plans (fully insured plans have fewer HIPAA obligations)
- In some states, employers report state individual mandated coverage using Form 1095-C
- ERISA fiduciary obligations