Compliance Guide for Group Health 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 while also potentially being subject to ERISA. Both insured and self-insured plans 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 and fully insured plans. Plan sponsors should note that grandfathered plans are exempt from many ACA reforms.

Affordable Care Act Reforms for Self-Funded Plans

- ACA reporting: Required regardless of an employer's size
- 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

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- 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. 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 for Fully Insured Plans

- Employer reporting to the IRS on coverage. Insurer will file Form 1094-B with the IRS if there are fewer than 50 FTEs. If there are 50 or more FTEs, insurer will file Form 1094-B (with copies of all Forms 1095-B) with the IRS; employer will file Form 1094-C (with copies of all Forms 1095-C) with the IRS.
- Employer shared responsibility provisions if employer has 50 or more full-time or full-time equivalent employees (50 FTEs)
- Elimination of pre-existing condition limitations
- EHB package requirement: 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 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
- Dependent child coverage to age 26

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- Coverage of preventive health services without cost-sharing
- Lifetime and annual dollar limit prohibitions on essential health benefits
- No rescissions of coverage except for fraud or intentional misrepresentation of material fact
- No waiting periods exceeding 90 days (first day of fourth month after date of hire with administrative period)
- Summary of Benefits and Coverage, unless the plan is a certain excepted benefit or retiree-only plan
- 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
- Employer reporting to the IRS on coverage
- Review process for unreasonable increases in premiums for health insurance coverage
- Variety of insurance market reforms, including guaranteed issue and renewability and insurance premium restrictions

Required Plan Documents for Self-Funded Plans

- 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)

Required Plan Documents for Fully Insured Plans

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- Summary Annual Report, if the plan is subject to ERISA and required to file a Form 5500
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Plan Notices for Self-Insured Plans, as applicable

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- 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 Children's Health Insurance Program (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 (CAA) Surprise Billing notice
- Primary Care Provider Designation

Plan Notices for Fully Insured Plans, as applicable

- Medicare Part D creditable coverage notice

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- Women's Health and Cancer Rights Act notice
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- Premium Assistance under Medicaid and CHIP notice
- Wellness Program Notice of Reasonable Alternatives
- Wellness Program Disclosure, if the plan is subject to ERISA
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- 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
- DOL claims procedure notices
- CAA Surprise Billing Notice (for fully insured plans, the insurance carrier is directly responsible for posting the notice on its public website)
- Primary Care Provider Designation
- Notice of rebate for failure to meet medical loss ratio (MLR) standards

Government Filings for Self-Funded Plans

- Form 5500, if subject to ERISA, unless an exemption applies

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- W-2 reporting of health care coverage costs, if the employer provided 250 or more W-2s for the prior calendar year
- 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
- 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 (also applies to grandfathered plans)

Government Filings for Fully Insured Plans

- 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)
- Employer reporting to the IRS on coverage. Insurer will file Form 1094-B with the IRS if there are fewer than 50 FTEs. If there are 50 or more FTEs, insurer will file Form 1094-B (with copies of all Forms 1095-B) with the IRS; employer will file Form 1094-C (with copies of all Forms 1095-C) with the IRS.
- Form 720 to report and pay the PCORI fee, which applies from 2012 to 2029 (paid by the insurance provider; the fee is typically built in to the plan's premiums)
- Medicare Part D Creditable Coverage Disclosure
- Annual gag clause attestation (submitted by insurance provider)
- Annual RxDC reporting (submitted by insurance provider)
- Annual Air Ambulance Reporting (also applies to grandfathered plans) (fully insured plans may enter into a written agreement to have another party submit this reporting, such as a third-party administrator or insurance provider)

Consolidated Appropriations Act, 2021 (CAA) Provisions for Both Self-Funded and Fully Insured Plans

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

- Prohibition on Gag Clauses and Attestation
- Mental Health Parity Comparative Analysis

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- Primary Care Provider Designation
- 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 (posted on public website)

COBRA Equivalent Premium for Self-Funded Plans

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 for Self-Funded Plans

- 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

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- HIPAA Privacy and Security Rules (fully insured plans have fewer HIPAA obligations)
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