April 2019 Employee Benefits Compliance

Transitioning to Self-Funding

Introduction

Employers that choose to sponsor group health plans have both plan design and funding options to consider. Plan funding is generally categorized as either fully-insured or self-funded/self-insured.[1] Most medical plans start out fully insured but as employers grow many consider self-funding. In its simplest form self-funding entails paying claims from an employer's general assets as opposed insuring risk. Although some employers fund benefits through a trust, a trust is not required[2] and can complicate compliance. The move to self-funding is most commonly driven by projected financial savings and a desire to avoid numerous and sometimes onerous state insurance code mandates. Administrative, financial and compliance considerations that come with a transition to self-funding are addressed below.

Administrative Issues with Self-Funding

Maintaining a group health plan, and providing major medical coverage in particular, requires coordinating several plan functions. The core components of most plans include:

- Provider Network – negotiated discounts with contracted providers for services
- Claims Administration – process and pay claims, manage appeals, track deductibles and out-of-pocket maximums, and issue payments to providers
- Pharmacy Benefits Manager – develops formulary list, negotiates pricing, and issues payments to providers

In a typical fully-insured arrangement, the insurance carrier manages the network and claims administration in exchange for a fixed premium. Importantly, the carrier also is financially responsible for all covered claims. In a self-funded arrangement, the employer/plan sponsor can decide whether to bundle most plan functions with a single third party administrator (TPA) or carve out certain aspects of the plan for separate administration, like pharmacy benefits. The employer/plan sponsor is financially responsible for all covered claims and is essentially betting that actual claims and administrative costs will be less that the premium they would have paid a carrier. Finding and contracting with a competent TPA and ensuring an adequate network are generally the most important decisions an employer/plan sponsor will make.

Even where self-funded plan administration is largely consolidated with a single TPA, it is important to make sure that every third party involved with the plan understands the plan's design and administration. It is important to carefully review all contracts for consistency.

Financial Responsibility and Reinsurance

Employers may initially shy away from self-funding because of the unknown nature of claims risk. Although actuaries should be able to project claims and estimate required reserves under general accounting standards, many employers that self-fund purchase re-insurance to protect against unusually costly years or members.[3] Reinsurance or "stop-loss" coverage generally includes a specific annual deductible and an aggregate annual deductible or attachment point. The specific deductible is the amount the employer will be responsible for paying for a given employee's claims in a single year before being reimbursed by the stop-loss carrier (i.e. the employer/plan will have to pay the first $100,000 worth

[1] For an in depth discussion of hybrid funding, sometimes called level funding or partial self-funding, See our Alliant Insight, Partial Self-Funding (Level-Funding, Flex-Funding, Balance-Funding, Minimum Premium Plans, etc.).

[2] A Trust is required to meet Davis Bacon or Service Contract Act contribution requirements.

[3] It is important to note that stop-loss insurers are not "health insurance issuers offering group health insurance coverage." Stop-loss insurers are not subject to HIPAA, ERISA, or health care reform requirements.

of claims for a given member each year and anything above that will be covered 100% by re-insurance). The aggregate deductible is the maximum amount of claims the employer will have to pay for all of its covered employees' claims in a given year (i.e. the employer must pay the first $3 million in claims each year and anything above that will be covered 100% by re-insurance).

Importantly, reinsurance agreements can be drafted based on required plan disclosures to exclude specific claims or members (referred to as exclusions and lasers). A stop-loss policy may also have a cap or a maximum claim level after which the risk reverts back to the employer/plan sponsor. Lastly, terms of eligibility in the stop-loss contract must match those from the third party administrator's contract or plan document and any variation from stated eligibility or eligibility exception needs to be reviewed and approved by the stop loss carrier. Without that review and approval the employer/plan sponsor will lose the financial protection provided by reinsurance and may find itself inadvertently assuming excessive financial liability.

Compliance Responsibilities with Self-Funding

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), group health plans sponsored by employers with more than 20 employees must offer individuals that lose medical coverage as a result of a qualifying event the option to continue coverage for 18 months (36 months in some instances). COBRA provides that plan sponsors can charge individuals who elect to continue coverage up to 102% of the applicable cost of coverage. For fully-insured plans the cost of coverage is the full premium charged by the carrier. In a self-funded environment, a plan sponsor with the aid of an actuary develops its expected costs and creates "premium equivalent rates." The premium equivalent rates plus 2% is then the COBRA rate. It is important to make sure that items that may be budgeted in to expected costs that are not part of the group health plan or subject to COBRA, like employer HSA funding, are not included in the COBRA rate for self-funded plans.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) protects individually identifiable health information (PHI) and requires certain policies and procedures to protect that information. A fully-insured group health plan sponsor will generally have limited access to PHI, as all claims and records are handled by the insurance carrier. As a result, the carrier is responsible for HIPAA compliance. This responsibility shifts to the employer/plan sponsor when they self-fund any HIPAA covered benefit. This requires adopting and implementing detailed privacy and security policies and procedures. Although most employers already have data privacy and security rules in place (for reasons other than HIPAA compliance) that largely meet HIPAA requirements, some additional steps are usually required. The core of HIPAA privacy and security compliance are:

- Appoint a Privacy Officer and a Security Officer;
- Create policies and procedures securing PHI and preventing access by anyone other than the group health plan;
- Create and follow notification procedures following a potential PHI data breach;
- Distribute a notice of privacy practices;
- Execute Business Associate Agreements with all business associates; and,
- Train the plan's workforce regarding the privacy and security rules and their requirements.

Employers should work with their advisers to develop HIPAA privacy and security policies and procedures before self-funding. Business Associate Agreements should also be executed with all third parties that

will assist with plan operations in advance.[4] For more information on HIPAA privacy and security compliance see Alliant's HIPAA Compliance Toolkit.

Health Plan Taxes & Fees

The Patient Protection and Affordable Care Act (ACA) included several fees that were burdensome for self-funded plans, specifically the Transitional Reinsurance Fee and, to a lesser extent, the Patient Centered Outcomes Research Institute Fee (PCORI). The Reinsurance Fee is no longer in effect. Although the PCORI fee was scheduled to sunset with plan years ending after September 30, 2019, it was extended to plan or policy years beginning through October 1, 2028 (ending after 9/30/29). The other remaining ACA fee, the Federal Health Insurance Industry Fee, only applies to fully insured plans and can account for ~2-3% of a group's total premium. As a result, for the first time since the ACA's enactment it is more beneficial to self-fund.

ACA Reporting

Under the ACA, all Applicable Large Employers (ALEs) that employ more than 50 full-time equivalent employees must report detailed information on their offers of coverage and its affordability to both full-time employees and the IRS. A fully-insured group will satisfy ALE reporting by completing a Form 1095-C (Parts I & II) for each full-time employee. Those 1095-C Forms are provided to each individual and sent to IRS with a Form 1094-C transmittal form.

Additionally, all issuers of Minimum Essential Coverage (MEC), generally insurance carriers and self-funded plan sponsors, must also report on the months any covered individual and their dependents were covered during the year. This is done by completing an additional section on Form 1095-Cs (Part III). One challenge is that each covered dependent must be listed by name and their social security number must be provided. After three requests for a social security number a date of birth may be used instead. For more information, refer to the Alliant Employer Reporting Guide.

Non-Discrimination

Another requirement that comes with self-funding is the addition of non-discrimination requirements under section 105(h) of the Internal Revenue Code. Under section 105(h), a self-insured health plan cannot discriminate in favor of highly-compensated individuals (HCIs) as to eligibility to participate in the plan and cannot favor HCIs as to the actual benefits provided under the plan. Fairly intensive testing is required that looks at both the availability of benefits and whether enough non-HCI participants enroll in coverage relative to HCI participation. These two tests are called the "Eligibility Test" and the "Benefits Test." Although there is little or no active enforcement by IRS of 105(h) rules, employer/plan sponsors should understand these rules and plans should be designed to be non-discriminatory. For more information on 105(h) see our Alliant Insight, Summary of IRC § 105(h) Non-Discrimination Rules.

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[4] Any organization with access to PHI that provides legal, financial, actuarial, consulting, administration or appeal services will be a business associate of the plan.

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