Differences in Compliance Requirements with Respect to Insured and Self-Funded Health and Welfare Plans

When there is an insurance policy to pay plan benefits, there is an insured plan. A self-funded plan is simply a plan that does not purchase insurance to pay benefits. The purchase of stop-loss insurance does not make the plan an insured plan.

This summary points out some of the differences in legal responsibilities for an insured plan v. a self-funded plan.

Issue	Distinction
Discrimination	Self-funded health plans are subject to Code Sec. 105(h) which prohibits discrimination in favor of highly compensated individuals (generally, the top 25% paid) as to eligibility and benefits. Failure can result in adverse tax consequences to highly compensated individuals. Per health care reform, insured, non-grandfathered medical plans will be subject to similar rules when guidance indicates. A discriminatory insured plan may be subject to an excise tax of $100 per day with respect to each individual to whom such failure relates.
HIPAA Privacy Rule	Self-funded, self-administered health plans with fewer than 50 participants do not have to comply with the HIPAA Privacy Rule. Otherwise, self-funded health plans must distribute a Notice of Privacy Practices automatically to participants at the time of enrollment and within 60 days of a material revision. Every 3 years, participants should be notified of the availability of the notice and how to obtain it. For health benefits provided through an insurance contract with a health insurance issuer or HMO, the plan must merely maintain a notice and provide such notice upon request. Health plans, other than insured health plans that do not create or receive PHI, must write and implement privacy policies and procedures.
State Law	State insurance code provisions that mandate that certain benefits (e.g., oral chemotherapy) or certain eligible classes (e.g., domestic partners) be included in a plan do not apply to self-funded plans. State insurance code provisions may require coverage through the end of the month of notification to the carrier that the employee is no longer eligible. Insured plans (and not self-funded plans) are subject to state premium tax. Insured health plans (and not self-funded plans) may be subject to state continuation requirements either following COBRA or where COBRA does not apply.[1] Generally, ERISA preempts any state law that relates to benefits (not including insurance laws which apply to carriers). There are, however, various exceptions.[2]
Plan Documents	For an insured plan, the document that communicates benefits to participants is generally called a “certificate of insurance” or “certificate of coverage.” A carrier

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	drafts this document. Employers have little flexibility with respect to changing plan provisions. For a self-funded plan, the document that communicates benefits to participants is generally called a "booklet" or "summary plan description." For a self-funded plan, generally, the third party administrator ("TPA") will provide a draft summary plan description, for the employer's review. There is flexibility as to drafting plan provisions such as those setting forth eligibility terms. Employers with either insured or self-funded plans should ensure that the summary plan description content requirements are met with respect to the applicable document in order to comply with ERISA.
Contracts	The contract that sets forth the terms of the relationship between the carrier and the employer for an insured plan is generally called the insurance policy. There is generally little or no flexibility with respect to its terms. The contract that sets forth the terms of the relationship between the TPA and the employer for a self-funded plan is generally called the administrative services agreement. There is generally flexibility with respect to its terms. Self-funded plans usually have stop loss contracts that cover claims over a specified amount. Stop loss contracts require carefully review as they often contain exceptions as to what the carrier will cover (e.g., lasers, exclusion of experimental procedures – more restrictive definition than is in the SPD).
Claims Procedures	With respect to insured plans, the carrier is the ERISA claims fiduciary. With respect to self-funded plans, the employer is generally the claims fiduciary, but can contract with the TPA to shift the responsibility to it.
Exceptions	There is generally little or no flexibility in making exceptions as to covered claims under an insured plan. For a self-funded plan, there is generally flexibility when the TPA is not the claims fiduciary. Any exceptions should be approved by the stop loss carrier. Making exceptions gives other employees the argument that they are entitled to the same treatment. Under ERISA, there is a fiduciary duty to follow plan terms.
COBRA[1] Applicable Premium	For insured plans, the applicable premium for COBRA purposes is the premium charged by the carrier. For self-funded plans, the applicable premium is either: • a reasonable estimate of the cost of providing coverage, determined on an actuarial basis; or • the cost to the plan for the preceding determination period (with a cost-of-living adjustment) if coverage under the plan has not significantly changed from the preceding determination period to the current determination period.
Summary Annual Report (SAR)	An SAR should generally be distributed automatically to participants within 9 months after end of plan year or 2 months after due date for filing Form 5500 (with approved extension). An SAR is not required to be furnished for a plan for which Form 5500 is not required or a plan under which benefits are paid solely from the general assets of the employer.
PCOR Fee	Per health care reform, there is a new fee on health plans to fund a Patient-Centered Outcome Research program which was established to fund research of the clinical effectiveness of medical treatments, procedures, and drugs. For insured plans, insurance carriers will pay a fee that equals $1 in the first year ($2 in the next year, then indexed) multiplied by the average number of lives

	insured under a group health plan policy. For self-funded plans, the employer will pay a fee that equals $1 in the first year ($2 in the next year, then indexed) multiplied by the average number of lives covered by the group health plan.
Health Insurer Fee	Covered entities engaged in the "business of providing health insurance" will be subject to new fees. This provision generally applies to fully insured arrangement and excludes self-insured plans of an employer. The fee will not apply to stop-loss coverage until such time and only to the extent that future guidance addresses the issue of whether, and if so under what circumstances, stop-loss coverage constitutes health insurance. The fees are imposed industry wide on annual basis as follows: • 2014 – $8 billion; 2015-16 - $11.3 billion; 2017 – $0; 2018 – $14.3 billion; and after 2018, the fee will be increased by the rate of premium growth. Certain exceptions and limitations apply. Includes dental/vision.
6055/6056 Annual Reporting	Large employers[1] must complete Forms 1095-C and 1094-C annually, regardless of whether they maintain a medical plan. However, large employers with self-funded plans must complete Part III of Forms 1095-C which contains coverage information while insured plans leave Part III blank. Instead, for insured plans, the carrier provides Forms 1095-B which contains coverage information. In addition, small employers with self-funded plans must complete Forms 1095-B and 1094-B.
Summary of Benefits and Coverage ("SBC")	Health care reform requires a 4-page SBC and uniform glossary to be provided to plan participants in connection with open enrollment. This is prepared by the carrier for a fully insured plan and the employer for a self-funded plan. It is generally distributed by the employer for both types of plans.
Medical loss ratio ("MLR")	Insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan, it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to enrollees. This does not apply to self-funded plans.
Trusts	If a plan accepts participant or beneficiary contributions, it will be deemed to have plan assets. Plan assets must be held in trust. However, the DOL has a nonenforcement policy with respect to participant contributions received under a cafeteria plan. This includes after-tax contributions (e.g., COBRA or retiree contributions) as long as there is a cafeteria plan. Even though this is technically not an exception, most employers treat it as such. For an insured plan, the premiums must be paid directly to the insurance carrier by the employer from its general assets or partly from its general assets and partly from contributions by its employees within 3 months of receipt for the nonenforcement policy to apply. For a self-funded plan, benefit payments must be made from the employer's general assets and participant contributions (including COBRA premiums) must

[1] Large employers employed an average of at least 50 on business days during the preceding calendar year.

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	not be segregated from the employer's general assets. Holding the money in a separate account could subject the assets to the trust requirement, irrespective of the nonenforcement policy. Giving the TPA checkwriting authority over the employer's general checking account or having a separate checking account in the employer's name (rather than the plan's name) avoids this problem. The nonenforcement policy is not an exception to the exclusive benefit rule – that contributions must be applied only to the payment of benefits and reasonable administrative expenses of the plan. If there is a trust or separate account in the plan's name, the exclusive benefit rule applies to the entire amount (i.e., amounts can't revert to the employer). If not, it only applies to participant contributions (i.e., employer amounts can revert to the employer). Violation of the exclusive benefit rule can result in a participant lawsuit such as one for breach of fiduciary duty which can result in personal liability and/or prohibited transaction which can result in civil penalties. The DOL could also enforce this rule, but this is less likely. A voluntary employees' beneficiary association (VEBA) uses a trust and is exempt from tax to provide of life, sick, accident or other benefits to employees, spouses, and dependents. Although exempt status originally meant that VEBAs could accumulate funds tax-free, there is now a limit on the amount of funds that can be accumulated tax-free as well as a tax on the unrelated business taxable income of the fund. In addition there are statutory nondiscrimination rules that apply to VEBAs.

[1] COBRA does not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year.

[2] State tax laws should be consulted with respect to taxation of benefits. Employers with employees in Hawaii, San Francisco, or Massachusetts may be subject to special rules. California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico provide compulsory temporary disability insurance for workers with non work-related injuries.