ACA COMPLIANCE OVERVIEW

Self-insured Plans Under the ACA

The Affordable Care Act (ACA) includes numerous reforms affecting the health coverage that employers provide to their employees. Many of these reforms apply to all group health plans, regardless of their method of funding. Plans that have grandfathered status under the ACA, however, are not required to comply with select ACA requirements. In addition, self-insured plans are exempt from certain ACA requirements.

A self-insured plan is a health plan where the employer assumes the financial risk of providing health care benefits to its employees. Employers may decide to self-insure their health plans for a number of reasons, such as avoiding state insurance taxes and state benefit mandates, retaining more control over plan design and controlling reserves. There may also be disadvantages associated with self-insuring, such as a greater assumption of risk and increased administrative obligations.

This ACA Overview highlights how select ACA requirements apply to self-insured plans.

LINKS AND RESOURCES

- DOL Report on Self-Insured Health Benefit Plans for 2018
- IRS Health Care Tax Tip 2015-42: Employers Providing Self-Insured Health Coverage Must Report on Information Returns
- IRS webpage on Information Reporting by Providers of Minimum Essential Coverage

Highlights

Self-insured Plans

- The employer assumes the financial risk of providing health care benefits and paying claims.
- Benefits are not provided through an insurance policy.
- The employer may obtain stop-loss insurance to protect against large claims.
- An insurance carrier or third-party administrator may provide administrative services.

Self-insuring Pros and Cons

- Self-insured plans are not subject to state insurance laws and are exempt from some ACA rules.
- An employer may assume greater risk when self-insuring benefits and may have more administrative obligations.

ACA Reforms that Apply to Self-insured Plans

Many ACA reforms affect all group health plans, regardless of whether they are fully insured or self-insured. For example, among many other reforms, self-insured and fully insured plans must comply with the following ACA provisions:

- Dependent coverage for adult children up to age 26;
- Coverage of preventive health services without cost-sharing (grandfathered plans are exempt);
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact;
- No lifetime or annual dollar limits on essential health benefits (EHBs);
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt);
- No waiting periods exceeding 90 days;
- No pre-existing condition exclusions for any enrollees;
- No discrimination against participants who participate in clinical trials (grandfathered plans are exempt); and
- Participants' maximum out-of-pocket expenses for covered EHBs cannot exceed specified amounts (grandfathered plans are exempt). To determine which benefits are EHB, a self-insured group health plan may choose any state benchmark plan that was approved by the Department of Health and Human Services (HHS).

Both self-insured and fully insured plans are subject to the ACA's requirement to provide participants and beneficiaries with the uniform **summary of benefits and coverage** (SBC). Sponsors of self-insured and fully insured plans alike must also comply with the ACA's requirement to report the aggregate cost of employer-sponsored group health plan coverage on their employees' **Forms W-2**.

In addition, sponsors of self-insured plans and issuers of fully insured plans are required to pay **Patient-Centered Outcomes Research Institute (PCORI) fees** under the ACA for plan years ending on or after Oct. 1, 2012. These fees were extended to apply for an additional 10 years, through 2029.

Employer Penalty Rules and Coverage Reporting Requirements

Applicable large employers (ALEs) must comply with the ACA's **employer shared responsibility rules and related reporting requirements**. Under the employer shared responsibility rules, an ALE may be subject to a penalty if it does not offer health coverage to substantially all of its full-time employees (and their dependents), or if it offers health coverage that is unaffordable or does not provide minimum value.

ALEs are employers with 50 or more full-time employees, including full-time equivalent employees (FTEs). The employer shared responsibility rules apply to all ALEs, regardless of whether they offer health coverage on a fully-insured or self-insured basis, or offer health coverage at all.

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage. The IRS will use this information to verify employer-sponsored coverage and administer the employer shared

responsibility provisions. This reporting requirement is found in Internal Revenue Code (Code) **Section 6056**. All ALEs with full-time employees must report under Section 6056, starting in 2015.

All sponsors of self-insured health plans must file an annual return with the IRS reporting information for each individual who is provided with coverage. Related statements must also be provided to individuals. This reporting requirement is found in **Code Section 6055**. To simplify the reporting process, the IRS allows ALEs with self-insured plans to use a single combined form for reporting the information required under both Section 6055 and Section 6056.

TYPE OF REPORTING	AFFECTED EMPLOYERS
Code § 6056—Applicable large employer health coverage reporting	Applicable large employers (those with at least 50 full-time employees, including FTEs)
Code § 6055—Reporting of health coverage by issuers and sponsors of self-insured plans	Employers with self-insured health plans

Reinsurance Fees and Exemption—Expired

The ACA includes reforms related to the allocation of insurance risk through reinsurance, risk corridors and risk adjustment. The purpose of these reforms, which took effect in 2014, is to protect against risk selection and market uncertainty as insurance changes and the Exchanges are implemented. Self-insured plans are not subject to some of these provisions. However, the ACA required each state to have a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014-2016). Administrators of self-insured plans were required to contribute to the transitional reinsurance program; **however, this program has expired and reinsurance fees are no longer due**.

In addition, HHS exempted certain self-insured, self-administered plans from the reinsurance fees for 2015 and 2016. For the 2015 and 2016 benefit years, HHS excluded from the requirement to make reinsurance contributions those self-insured plans that **do not use a third party administrator** for their the core administrative functions of claims processing or adjudication (including management of appeals) or plan enrollment.

For this purpose, a self-insured plan will not lose self-administered status because it uses an unrelated third party to obtain provider network and related claim repricing services. Also, a self-insured plan will not lose self-administered status because it outsources:

- Core administrative functions (claims processing, claims adjudication and enrollment services) to an unrelated third party, such as a pharmacy benefits manager (PBM), provided that the underlying benefits are pharmacy benefits or excepted benefits; or
- A small amount (up to 5%) of core administrative services for benefits other than excepted benefits or pharmacy benefits to an unrelated third party. The five percent limit is measured based on either the number of transactions processed by the third party or the volume of claims processing and adjudication and plan enrollment services provided by the third party.

ACA Reforms that Do Not Apply to Self-insured Plans

Essential Health Benefits (EHB) Package

Beginning in 2014, non-grandfathered insurance plans in the individual and small group markets must offer a comprehensive package of items and services, known as EHBs. This requirement applies to plans offered inside and outside of the Exchanges. The ACA identified in broad terms 10 benefit categories that must be included as EHBs. Within these broad categories, the individual states have flexibility to select their own benchmarks for defining EHBs.

Self-insured group health plans, health insurance coverage offered in the large group market and grandfathered plans are not required to cover EHBs.

Medical Loss Ratio (MLR) Rules

The MLR rules took effect on Jan. 1, 2011. These rules require health insurance issuers to spend 80 to 85 percent of their premium dollars on medical care and health care quality improvement, rather than administrative costs. Issuers that do not meet these requirements must provide rebates to consumers. The MLR rules do not apply to self-insured plans.

Small Employer Tax Credit

Beginning with 2010 tax years, the ACA created a tax credit for eligible small employers that provide health care coverage to their employees. In order to be eligible for the health care tax credit, an employer must:

- Have fewer than 25 full-time equivalent employees (FTEs);
- Pay average annual wages of less than $50,000 per FTE; and
- Pay at least half of employee health insurance premiums (based on single coverage) for a qualified health plan (QHP) offered through an Exchange's Small Business Health Options Program (SHOP).

Beginning in 2014, the maximum tax credit is 50 percent of premiums for small business employers and 35 percent of premiums for small tax-exempt employers. In addition, beginning in 2014, it may only be claimed for two consecutive tax years.

The tax credit is only available for the purchase of health insurance coverage through a SHOP Exchange, and so it does not apply to self-insured coverage.

Review of Premium Increases

The ACA required HHS to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage. Effective Sept. 1, 2011, issuers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets must publicly disclose the proposed increases, along with justification for the increases. Starting Sept. 1, 2012, the 10 percent threshold may be replaced with a state-specific threshold to reflect insurance and health care cost trends particular to that state. The increases will be reviewed by either state or federal experts to determine whether they are unreasonable.

This review process for rate increases applies to issuers in the small group and individual markets. However, it does not apply to grandfathered health plan coverage, excepted benefits (such as liability insurance, workers' compensation insurance, limited scope dental or vision benefits, long-term care or nursing home benefits and hospital indemnity insurance) or to self-insured plans.

Annual Insurance Fee

The ACA's revenue raising provisions require certain health insurance providers to pay an annual fee, beginning in 2014. Issuers with net premiums in a calendar year of $25 million or less are exempt from the fee. Employers that self-insure their employees' health coverage are also exempt from the fee.

Insurance Market Reforms

Effective for 2014, health insurance issuers must comply with a new set of market reforms. Market reforms that are inapplicable to self-insured arrangements include:

- *Guaranteed Issue and Renewability*—Health insurance issuers offering coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual.
- *Insurance Premium Restrictions*—Health insurance issuers in the individual and small group markets cannot charge higher rates due to heath status, gender or other factors. Premiums may vary based only on age (no more than 3:1), geography, family size and tobacco use.