Brought to you by National Insurance Services, Inc.

Self-insured Plans under Health Care Reform

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 health care reform 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 Legislative Brief summarizes how the health care reform law applies to self-insured plans.

REFORMS THAT APPLY TO SELF-INSURED PLANS

As noted above, many of the ACA's 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 dollar limits on essential health benefits and annual dollar limits are restricted until 2014 (in 2014, all annual dollar limits on essential health benefits are prohibited);
- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt); and
- Effective for 2014, no waiting periods exceeding 90 days.

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. 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.

Beginning in 2014, the ACA requires certain health plans to comply with cost-sharing limits with respect to their coverage of essential health benefits. The cost-sharing limits include both an overall annual limit, or an out-of-pocket maximum, and an annual deductible limit. The ACA's annual deductible limit is $2,000 for self-only coverage and $4,000 for family coverage. It only applies to insured plans in the small group market. However, the out-of-pocket

maximum applies to all non-grandfathered plans, including self-insured plans. For plan years beginning in 2014, the ACA's out-of-pocket maximum is $6,350 for self-only coverage and $12,700 for family coverage.

REINSURANCE FEES AND EXEMPTION

The ACA includes reforms related to the allocation of insurance risk through reinsurance, risk corridors and risk adjustment. The purpose of these reforms, which are effective 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, under the ACA, each state must 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 are required to contribute to this program.

On March 11, 2014, the Department of Health and Human Services (HHS) published its 2015 Notice of Benefit and Payment Parameters Final Rule, which exempts certain self-insured, self-administered plans from the reinsurance fees for 2015 and 2016. For the 2015 and 2016 benefit years, the final rule excludes from the requirement to make reinsurance contributions those self-insured plans that **do not use a third party administrator** for their core administrative processing functions:

- Claims processing or adjudication (including the management of appeals); and
- Plan enrollment.

The final rule clarifies that 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 percent) 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.

REFORMS THAT DO NOT APPLY TO SELF-INSURED PLANS

Essential Health Benefits 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 essential health benefits. This requirement applies to plans offered inside and outside of the state insurance exchanges (Exchanges). The ACA identified in broad terms 10 benefit categories that must be included as essential health benefits. Within these broad categories, the individual states have flexibility to select their own benchmarks for defining essential health benefits.

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

Medical Loss Ratio Rules

The medical loss ratio (MLR) rules became effective 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 beginning in 2012. The MLR rules do not apply to self-insured plans.

7/12, EM 3/14

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 tax years 2010 through 2013, the maximum health care tax credit is 35 percent of premiums for small business employers and 25 percent of premiums for small tax-exempt employers. An enhanced version of the credit will be effective in 2014.

The tax credit is only available for the purchase of health insurance coverage, 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.

HHS's process provides that 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 or to excepted benefits (for example, liability insurance, workers' compensation insurance, limited scope dental or vision benefits, long-term care or nursing home benefits and hospital indemnity insurance). It also does not apply 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.

Methods to Allocate Insurance Risk

As mentioned above, the ACA includes three risk-spreading mechanisms to mitigate the potential impact of adverse selection and stabilize premiums as insurance reforms and the Exchanges are implemented, starting in 2014. Administrators of self-insured plans will be required to contribute to the ACA's transitional reinsurance program. (A proposed rule would exempt certain self-insured, self-administered plans from the reinsurance fees for 2015 and 2016.) However, self-insured plans are not included in the ACA's risk corridor and risk adjustment programs.

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:

7/12, EM 3/14

- *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 will not be permitted to charge higher rates due to heath status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use.

Annual Deductible Limit

Effective for plan years beginning in 2014, the annual deductible for an insured health plan in the small group market may not exceed $2,000 for self-only coverage and $4,000 for family coverage. Self-insured plans are not subject to this cost-sharing limit. However, as noted above, self-insured plans are subject to the ACA's out-of-pocket maximum, effective for 2014 plan years.

7/12, EM 3/14