Best Practices for Level-Funded Plan Compliance

Stacey Stewart, JD
Senior Vice President, Employee Benefits Compliance Officer | National Specialty Practices

Question: We are considering moving from a fully-insured to a level-funded group health plan. What should we be thinking about from a compliance perspective?

Summary:

Often considered a hybrid approach, level-funded plans provide the stability of fixed premiums (similar to fully-insured plans) along with the ability to share in a degree of cost savings (a feature of self-funded plans). However, it is essential to understand that level-funded plans are generally considered self-funded plans for compliance purposes, including under the Employee Retirement Income Security Act ("ERISA"), Health Insurance Portability and Accountability Act ("HIPAA") and the Affordable Care Act ("ACA"). This means that employers who sponsor level-funded plans generally take on more robust compliance responsibilities than they previously had when fully-insured.

Many compliance obligations stem from the mere fact that you have a group health plan and vary depending on whether you are subject to ERISA, the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), etc. However, the degree and financial impact of missteps increases with the use of a self-funded or level-funded approach to funding plan benefits.

Detail:

1. Background

Let's start at the beginning. When you decide to offer group health benefits to your employees you do so by adopting a group health plan. The plan is a separate entity (capable of filing suit and being sued)[1] governed by the terms of a plan document that is a contractual agreement whereby you, the employer, promise to provide certain benefits to your employees.

This an important point to understand as people often discuss how they have a self-funded or fully-insured plan or are considering a level-funded plan. Keep in mind that we are really just referring to the funding mechanism for providing benefits promised under your plan. Many compliance obligations stem from the mere fact that you have a group health plan and vary depending on whether you are subject to ERISA, the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), etc. However, the degree and financial impact of missteps increases with the use a self-funded or level-funded approach to funding plan benefits.

Now that we understand the distinction between a group health plan and its funding mechanism, let's review how the level-funding approach to funding plan benefits works. Level-funding is sometimes referred to as partially self-funding or self-funding with training wheels. In each case, the reference indicates how the approach appears to fall between fully-insuring and self-funding benefits on the spectrum of funding arrangements.

With level-funding, employers generally pay a carrier a set monthly amount equal to the maximum amount of expected claims based on underwriting projections. This amount also generally includes the cost of administrative services, stop-loss insurance and other fees. While including these amounts in one monthly payment can make the approach seem simpler and easier to understand from the employer's perspective, it can also have significant compliance concerns depending on how things are structured.

The chosen carrier then generally handles claims throughout the year. At year end, if payments exceed claims, there is a surplus which may result in a refund or credit to use in the following year. On the other hand, if claims exceed payments then the idea is that stop-loss will cover the overage. Hence, level-funding strives to provide stability and predictability similar to fully-insuring benefits, but allows the employer the ability under a self-funded approach to share in cost-savings, have greater flexibility in plan design and access useful claims data.

2. Key Compliance Considerations

Level-funded plans are generally considered self-funded for most employee benefit compliance purposes. This means that when employers move to this funding arrangement, they take on additional compliance obligations that apply in the self-funded plan context. Below we will summarize some of the key additional compliance considerations under the ACA, ERISA and HIPAA. This is not intended as a comprehensive list – more of a list of top best practice compliance considerations that may be easily overlooked. Additional items may apply depending on the funding structure, facts and circumstances surrounding the employer, its plan and the participant population.

a. **ACA –** A plan's funding status can affect the manner of compliance with ACA rules. For example, small employers will have ACA reporting obligations that they previously did not have with a fully-insured plan. In using the term 'small employer' we refer to an employer that is not considered an applicable large employer ("ALE") under ACA rules (i.e., an employer who averages less than fifty full-time employees including full-time equivalents in the prior calendar year is not an ALE for the current calendar year).[2]

   When a non-ALE switches to a level-funded plan, it becomes responsible for filing the Form 1094/5-B series to report minimum essential coverage.[3] This requires filing information reporting forms with the IRS and providing forms to applicable employees. These employers may not be familiar with ACA reporting rules as the carrier in the fully-insured employer plan context generally has the responsibility for handling the Form 1094/5-B series.[4] Employers that are ALEs will continue to report on the Form 1094/4-C series but will need to include additional information.[5]

   The level and depth of ACA reporting obligations are important to understand on the front-end. Employers need to ensure they will have the necessary access to information needed to complete the forms. They also need to determine who will handle completing and transmitting forms - will the carrier assist or should they hire a vendor?

   Switching gears, the ACA also requires sponsors of self-funded group health plans to pay certain fees to support the Patient-Centered Outcomes Research Institute ("PCORI") created under the ACA.[6] These fees are referred to, surprisingly enough, as PCORI fees, and the amount due is based on the average number of lives covered under the plan.[7] The requirement to pay PCORI fees initially only applied for plan years ending after October 1, 2012, and before October 1, 2019.[8] However, just as it looked like the fees would fade into history, Congress passed legislation in December 2019 extending the PCORI fee requirement through plan years ending before October 1, 2029.[9] Hence, this is still an important compliance obligation and one frequently missed in the move to level-funding.

One of the largest traps for the unwary employer using a level-funded arrangement lies in the handling of any surplus at year-end. Employers commonly assume that those funds can and should be 'refunded' to them. However, the ability to do so depends on whether the funds are considered plan assets under ERISA.

b. **ERISA –** One of the largest traps for the unwary employer using a level-funded arrangement lies in the handling of any surplus at year-end. Employers commonly assume that those funds can and should be 'refunded' to them. However, the ability to do so depends on whether the funds are considered plan assets under ERISA. Generally speaking, any portion of the plan premiums paid with participant contributions (including COBRA premiums) would be considered plan assets.[10]

ERISA requires plan assets be used for the exclusive benefit of plan participants[11] which generally means the employer cannot take the full refund amount to use in its discretion. So depending on how the arrangement is structured it may be that a portion of the refunded amount must be returned to plan participants (similar to how medical loss rebates are typically handled). Or, once again depending on how the arrangement is structured, it could be that all amounts become plan assets because, for example, they are (or should be) held in trust.

Once a plan is considered "funded" ERISA generally requires plan assets be held in trust.[12] To keep the waters muddy, a plan is considered "funded" when it has plan assets (such as participant contributions), so the term actually has nothing to do with the funding mechanism (i.e., fully-insured or self-funded). Clear as mud, right? Luckily there is some non-enforcement relief for certain insured plans and for self-funded arrangements where participant contributions are run through a cafeteria plan.[13]

There is also an exemption from the trust requirement for plan assets held by an insurance company.[14] This can be particularly helpful for level-funded arrangements as the exemption may apply even when the carrier is acting in role of third-party administrator under an administrative services only contract.[15] In the end, caution is key and employers should always take steps to confirm if and how the trust exemption applies under their particular set of facts.

While we are on the topic of funded plans, there can be other implications under ERISA. Bear with us on the terminology here…if a level-funded plan is considered funded, then ERISA may require a Form 5500 regardless of the size of the plan.[16] A plan that has always satisfied the small welfare plan exemption (e.g., insured plan under 100 participants as of the first day of the plan year)[17] may no longer do so upon moving to a level-funding arrangement. Keep in mind that many of these considerations, such as determining whether the trust exemption discussed above applies and whether

and when a plan is considered funded, can be fact specific and complex. Employers should ensure they ask the right questions and enlist help as needed to understand the full impact of their plan funding choice.

c. **HIPAA** - We previously mentioned how group health plans have certain compliance responsibilities by virtue of their status as a group health plan and that these obligations may increase depending on funding mechanism. The HIPAA privacy and security arena presents a good example. Most group health plans, with the exception of certain small self-administered plans (which are pretty rare), are subject to HIPAA privacy and security rules.[18] Often employers who take the fully-insured funding route will limit the amount of protected health information ("PHI") to which the plan has access.

When an employer limits the PHI its fully-insured group health plan creates or receives from the carrier to enrollment information, summary health information and information released pursuant to a HIPAA authorization, most HIPAA compliance obligations fall on the carrier versus the group health plan.[19] That is not an option for a self-funded group health plan. Instead, it must comply with the full gambit of HIPAA privacy and security obligations, including, among other things, to provide a HIPAA privacy notice and workforce training, and implement more robust privacy and security procedures.

d. **Other –** The above discussion focuses on key ACA, ERISA and HIPAA implications of adopting a level-funded arrangement, but there a host of other compliance considerations. To touch on the Internal

Revenue Code for example, since a level-funded group health plan is considered self-funded, the nondiscrimination requirements under its Section 105(h) apply.[20] These rules are designed to ensure the plan does not discriminate in favor of the highly compensated employees and require annual testing to ensure compliance.

While employers who maintain cafeteria plans (to permit employees to pay certain premiums pre-tax) may be familiar with cafeteria plan nondiscrimination testing, this adds an additional, different layer of testing. Plus the implications of failed testing in the 105(h) context can be much more severe than in the cafeteria plan testing realm – in some cases requiring the highly compensated include the value of benefits provided (e.g., the cost of heart surgery as opposed to the value of health plan premiums paid) in gross income.[21] This means employers moving to level-funding should consider their plan design in light of these rules and determine what, if any, adjustments may be needed to address testing concerns.

Other tax issues can develop as well. For example, an employer may lose the tax deduction for surplus amounts returned after-year end (assuming the refund is proper which may not always be the case). This is just one more item to add to the list of considerations in determining how to handle surplus amounts at year-end.

Finally, employers moving from a fully-insured arrangement may not have paid careful attention to plan, provider and vendor agreements but it is vitally important to do so in the self-funded context. For example, how will they obtain the information needed for ACA reporting purposes? What happens with reserves after run-out if they return to fully-insured coverage or switch carriers? Did the ASO carrier agree to assume ERISA fiduciary duties regarding claims administration? Have they confirmed consistency/coordination between plan document and stop-loss contract/coverage? How are the proceeds of stop-loss handled? Is the stop-loss contract held by the plan or the employer? This is just a sample of the questions employers must answer to ensure their ability to meet compliance responsibilities.

Conclusion:

Level-funding can present a great group health plan funding option. It can provide the stability and predictability similar to fully-insuring benefits, while offering the cost-savings, greater flexibility in plan design and access useful claims data available under a self-funded approach. Just keep in mind that there are significant additional compliance considerations and responsibilities. Enjoy the benefits of the level-funding approach but do your due diligence and don't be caught in one of the many traps for the unwary!

References

1 - ERISA §502(d)(1).
2 - IRC § 4980H(c)(2)(A).
3 - IRC § 6055.
4 - Treas. Reg. § 1.6055-1(c)(1)(i).
5 - See 2021 Instructions for Forms 1094-C and 1095-C, p. 13 (as visited April 12, 2022). See also Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C, Q/A-10 (as visited April 12, 2021).
6 - IRC § 4376(b).
7 - IRC § 4376(a) as adjusted pursuant to subsection (d) thereof.
8 - IRC § 4376(e) as it read before the change made by P.L. 116-94, Sec. 104(c)DivN, which was enacted 12/20/2019 and changed "2019" to "2029".
9 - IRC § 4376(e).
10 - DOL Reg. §2510.3-102.
11 - ERISA §403(c).
12 - ERISA §403(a).
13 - ERISA Tech. Rel. 92-01, 57 Fed. Reg. 23272 (June 2, 1992).
14 - ERISA §403(b)(2).
15 - See Question and Answer at May 1995 meeting of the American Bar Association Joint Committee on Employee Benefits and certain Department of Labor representatives (as summarized by the ABA Committee in Q&A #12).
16 - DOL Reg. §2510.3-102.
17 - 5500 filing note
18 - 45 CFR §160.103.
19 - 45 CFR §164.530(k).
20 - IRC § 105(h).
21 - IRC § 105(h)(1).

McGriff

McGriff.com