Becoming a Self-Funded Plan

Switching from a fully insured group health plan to a self-funded, or self-insured, plan shifts several compliance responsibilities and risks — along with other legal and operational implications — to the employer.

This paper outlines some key compliance considerations for self-funded plans, including level-funded plans. If you have additional questions on any of the topics outlined below, please reach out to your Alera Group consultant.

ERISA Requirements

Almost all employers with group health plans must comply with Employee Retirement Income Security Act (ERISA) requirements, with exceptions for church or government plans. All employer health plans that do not fall into an ERISA exception need to have an ERISA wrap document and/or other ERISA-governing documents for their group health plans. Additional ERISA requirements include providing Summary Plan Descriptions (SPDs) and updating Summary of Material Modifications (SMMs) for plan changes. Plan documents should be reviewed regularly to capture any revisions necessitated by changing a plan from fully insured to self-funded.

Other ERISA requirements, such as Form 5500 filings and other fiduciary duties, do not change when a plan goes from fully insured to self-funded. Employers should ensure that they continue to meet these standards as they move from fully insured to self-funded.

Employee Contributions as Plan Assets

If a self-funded plan accepts employee contributions, those employee contributions will always be considered ERISA plan assets, even if those funds are never separated from the employer's general assets.

ERISA fiduciaries are required to use plan assets in ways permitted under ERISA, which include paying for participant benefits and reasonable plan expenses. If there is a surplus of plan assets built up overtime, it must be used to offset costs to the employee benefit plans or plan enhancements. These funds cannot be used to benefit the employer.

ACA Compliance

Employer Mandate

All applicable large employers (ALEs) with 50 or more full-time employees measured in the prior calendar year need to comply with the employer mandate to offer affordable, minimum value coverage for all full-time employees working 30 or more hours a week. Self-funded plans must still comply with the ACA's employer mandate, ensuring that coverage meets minimum value and affordability standards.

Benefits Requirements

ACA requirements such as coverage of preventive care, coverage of dependents up to age 26 and prohibitions on annual or lifetime limits on essential health benefits apply to both fully insured and self-funded plans.

ACA Reporting Requirements

All employers subject to the employer mandate need to comply with the annual ACA reporting requirements filing Forms 1094-C and 1095-C.

All self-funded plans under 50 full-time employees still have reporting obligations of annually filing Forms 1094-B and 1095-B. This applies based on calendar year, meaning that if a non-ALE switches from a fully insured plan to a self-funded plan for a partial calendar year, it will have reporting requirements due in the next calendar year. For example, if an employer moves from a fully insured plan to a level-funded plan in October 2024, it will have ACA reporting due in February and March of 2025 for the months of October through December of 2024.

Additional Self-Funded Requirements and Reporting

Patient-Centered Outcomes Research Institute (PCORI) Fees

Self-funded plans are responsible for paying their own PCORI fees, which are generally handled by insurers in a fully insured arrangement. PCORI fees are due by July 31 of the calendar year following the end of the plan year. For example, if an employer moves from a fully insured plan to a level-funded plan in October 2024, and the plan year ends in September of 2025, the employer will be responsible for paying the PCORI fee in July 2026.

HIPAA and Privacy Rules

- Privacy and Security Compliance: Self-funded plans must ensure compliance with HIPAA privacy and security rules, often requiring updated policies and procedures around data privacy, breach notification and employee training. You cannot make hiring or firing decisions based on someone's health status.
- Business Associate Agreements: Employers often need to enter into Business Associate Agreements (BAAs) with third-party administrators (TPAs) and any vendors handling protected health information (PHI).

Consolidated Appropriations Act (CAA)

- Gag Clause Attestations: The CAA requires group health plans and health insurance carriers to attest annually to the government that they have no gag clauses in their contracts. Self-Insured plans should confirm responsibilities and consider including this provision in future requests for services.
- Machine Readable Files: Non-grandfathered plans must publicly disclose cost-sharing information in three separate machine-readable files (MRFs), updated monthly. Employers should enter into a written agreement (contract) with the TPA or other parties to provide and maintain the MRFs. A contract may include indemnification to the employer, should the contracted party fail to perform. Plans seeking indemnification must provide on their own website a public-facing link where data may be retrieved.
- RxDC (Prescription Drug Data Collection): All group health plans — including self-funded plans — and insurers offering major medical coverage must submit RxDC data. Self-funded employers often rely on third-party administrators or pharmacy benefit managers (PBMs) for support with data collection and submission. Any employer whose carrier or TPA is not filing on their behalf, or whose carrier or TPA is asking the employer to complete certain sections of the filing needs to review the CMS instruction manual and complete the reporting by the deadline.

Mental Health Parity and Addiction Equity Act (MHPAEA)

All employers with more than 50 employees sponsoring group health plans must comply with the MHPAEA and perform annual comparative analyses of non-quantitative treatment limitations (NQTLs) to ensure that financial requirements (such as co-pays) and treatment limitations for mental health/substance use services are no more restrictive than those applied to medical/surgical benefits. Fully insured plans likely have their insurance carriers completing these analyses for them. Self-funded plans will need to hire a vendor to complete these analyses for them.

Nondiscrimination Testing

Self-funded plans must adhere to nondiscrimination rules under IRS Code Section 105(h), which prevents favoring highly compensated employees in terms of plan benefits. This requires additional annual nondiscrimination testing.

Stop-Loss Insurance Considerations

Many employers moving to self-funding purchase stop-loss insurance to protect against catastrophic claims. However, stop-loss policies are not technically health insurance, so employers must understand policy terms, claim limits and their regulatory obligations regarding stop-loss coverage.

Employer Responsibility for Claims

As the employer is ultimately responsible for paying claims in a self-funded plan, adequate financial reserves and careful claims management are critical. Plan design, including cost-sharing and benefit limits, can help manage financial risk.

Accounting and Operational Considerations

Switching to a self-funded health plan involves significant accounting and operational changes for employers, as they take on more financial risk and administrative responsibility.

State Regulatory Compliance

Self-funded plans are typically governed by federal ERISA standards rather than state insurance regulations, which can simplify some compliance aspects. However, employers must still monitor state-mandated requirements, especially for stop-loss insurance, as states have varying rules on stop-loss policy thresholds and requirements.