UBA
Compliance Advisor

What every HR leader should know about compliance

Federal Requirements for Fully Insured and Self-Funded Plans

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A plan sponsor's requirements under federal law will vary depending on factors such as group health plan design, size, grandfathered status, and whether the plan is fully insured or self-funded.

The lists below highlight the main federal requirements that apply when a plan is fully insured and when a plan is self-funded.

Plan Documents

Fully Insured Plans	Self-Funded Plans
• Cafeteria plan document if contributions are run through a cafeteria plan • Summary of Material Modification, if the plan is subject to ERISA • Summary Annual Report, if the plan is subject to ERISA and required to file a Form 5500 • Summary of Benefits and Coverage, if the plan is subject to ERISA • Plan document and Summary Plan Description (SPD) (or combination plan document/SPD or wrap plan document), if the plan is subject to ERISA	• Cafeteria plan document if contributions are run through a cafeteria plan • Summary of Material Modification, if the plan is subject to ERISA • Summary Annual Report, if the plan is subject to ERISA and required to file a Form 5500 • Summary of Benefits and Coverage, if the plan is subject to ERISA • Plan document and Summary Plan Description (SPD) (or combination plan document/SPD or wrap plan document), if the plan is subject to ERISA

Affordable Care Act

Fully Insured Plans	Self-Funded Plans
• Employer shared responsibility provisions if employer has 50 or more full-time or full-time equivalent employees (50 FTEs) • Elimination of pre-existing condition limitations	• Employer shared responsibility provisions if employer has 50 or more full-time or full-time equivalent employees (50 FTEs) • Elimination of pre-existing condition limitations

Affordable Care Act (continued)

Fully Insured Plans	Self-Funded Plans
• Dependent child coverage to age 26 • Lifetime and annual dollar limit prohibitions on essential health benefits • No rescissions of coverage except for fraud or intentional misrepresentation of material fact • Eligibility waiting period limits • Summary of Benefits and Coverage, unless the plan is a certain excepted benefit or retiree-only plan • Notice regarding the exchanges • W-2 reporting of health care coverage costs (this only applies if the employer provided 250 or more W-2s for the prior calendar year) • Wellness program rules • Employer reporting to the IRS on coverage • Automatic enrollment (applies only to employers with more than 200 full-time employees; requirement has been delayed indefinitely)	• Dependent child coverage to age 26 • Lifetime and annual dollar limit prohibitions on essential health benefits • No rescissions of coverage except for fraud or intentional misrepresentation of material fact • Eligibility waiting period limits • Summary of Benefits and Coverage, unless the plan is a certain excepted benefit or retiree-only plan • PCORI Fee: The fee applies from 2012 to 2029, based on plan/policy years ending on or after October 1, 2012. Plan sponsor pays the fee. • Notice regarding the exchanges • W-2 reporting of health care coverage costs (this only applies if the employer provided 250 or more W-2s for the prior calendar year) • Wellness program rules • Employer reporting to the IRS on coverage • Automatic enrollment (applies only to employers with more than 200 full-time employees; requirement has been delayed indefinitely)
The following do not apply to grandfathered plans: • Coverage of preventive care without employee cost-sharing, including contraception for women • Limitations on out-of-pocket maximums • Essential health benefits (these apply to insured small group plans) • Modified community rating (applies to insured small group plans) • Guaranteed issue and renewal (applies to insured plans) • Nondiscrimination rules for fully insured group health plans (requirement has been delayed indefinitely) • Expanded claims and appeal requirements	The following do not apply to grandfathered plans: • Coverage of preventive care without employee cost-sharing, including contraception for women • Limitations on out-of-pocket maximums • Expanded claims and appeal requirements • Additional patient protections (right to choose a primary care provider designation, OB/GYN access without a referral, and coverage for out-of-network emergency department services) • Coverage of routine costs associated with clinical trials • Reporting to the Department of Health and Human Services (HHS) on quality of care (requirement has been delayed indefinitely)

Affordable Care Act (continued)

Fully Insured Plans	Self-Funded Plans
• Additional patient protections (right to choose a primary care provider designation, OB/GYN access without a referral, and coverage for out-of-network emergency department services) • Coverage of routine costs associated with clinical trials • Reporting to the Department of Health and Human Services (HHS) on quality of care (requirement has been delayed indefinitely) • Prohibition of discrimination based on health-status related factors • Transparency in coverage reporting and cost-sharing disclosure requirements (transparency in coverage reporting requirement for group health plans has been delayed indefinitely) • Nondiscrimination in health care providers requirement	• Prohibition of discrimination based on health-status related factors • Transparency in coverage reporting and cost-sharing disclosure requirements (transparency in coverage reporting requirement for group health plans has been delayed indefinitely) • Nondiscrimination in health care providers requirement

Plan Notices

Fully Insured Plans	Self-Funded Plans
• Medicare Part D creditable coverage notice • Women's Health and Cancer Rights Act notice • Newborns' and Mothers' Health Protection Act notice • Premium Assistance under Medicaid and CHIP notice • Wellness Program Notice of Reasonable Alternatives • Wellness Program Disclosure, if the plan is subject to ERISA • Wellness Program voluntary notice if the plan is subject to the ADA • Notice Regarding Wellness Program • Grandfathered Plan Notice • Patient Protection Notice, applicable to all non-grandfathered group health plans • HIPAA Notice of Privacy Practices • HIPAA Notice of Special Enrollment Rights • COBRA notices, if the plan is subject to COBRA	• Medicare Part D creditable coverage notice • Women's Health and Cancer Rights Act notice • Newborns' and Mothers' Health Protection Act notice (or opt out notice) • Premium Assistance under Medicaid and CHIP notice • Wellness Program Notice of Reasonable Alternatives • Wellness Program Disclosure, if the plan is subject to ERISA • Wellness Program voluntary notice if the plan is subject to the ADA • Notice Regarding Wellness Program • Grandfathered Plan Notice • Patient Protection Notice, applicable to all non-grandfathered group health plans • HIPAA Notice of Privacy Practices • Notice to Enrollees regarding Opt-Out • HIPAA Notice of Special Enrollment Rights

Plan Notices (continued)

Fully Insured Plans	Self-Funded Plans
• National Medical Support Notice • Michelle's Law Enrollment Notice • Mental Health Parity and Addiction Equity Act (MHPAEA) notices, • Advance notice of material modifications to Summary of Benefits and Coverage • Internal Claims and Appeals and External Review Notices, applicable to all non-grandfathered group health plans • External Review Process Disclosure, applicable to all non-grandfathered health plans, only if no state process applies and is binding • Employer Notice to Employees of Coverage Options available through the Exchange, applicable to all employers subject to the Fair Labor Standards Act • Advance notice to each participant who will be affected by a rescission of coverage • DOL claims procedure notices • Notice of rebate for failure to meet medical loss ratio (MLR) standards	• COBRA notices, if the plan is subject to COBRA • National Medical Support Notice • Michelle's Law Enrollment Notice, • Mental Health Parity and Addiction Equity Act (MHPAEA) notices, • Advance notice of material modifications to Summary of Benefits and Coverage Notice • Internal Claims and Appeals and External Review Notices, applicable to all non-grandfathered group health plans • External Review Process Disclosure, applicable to all non-grandfathered health plans, only if no state process applies and is binding • Employer Notice to Employees of Coverage Options available through the Exchange, applicable to all employers subject to the Fair Labor Standards Act • Advance notice to each participant who will be affected by a rescission of coverage • DOL claims procedure notices

Government Filings

Fully Insured Plans	Self-Funded Plans
• Form 5500, if subject to ERISA, unless an exemption applies • Employer reporting to the IRS on coverage (insurer will file Form 1094-B with the IRS if there are fewer than 50 FTEs; if there are 50 or more FTEs, insurer will file Form 1094-B (with copies of all Forms 1095-B) with the IRS; employer will file Form 1094-C (with copies of all Forms 1095-C) with the IRS)	• Form 5500, if subject to ERISA, unless an exemption applies • Employer reporting to the IRS on coverage (plan sponsor (generally the employer) will file Form 1094-B (with copies of all Forms 1095-B) with the IRS if there are fewer than 50 FTEs; if there are 50 or more FTEs, plan sponsor (generally the employer) will file Form 1094-C (with copies of all Forms 1095-C) with the IRS)

Government Filings (continued)

Fully Insured Plans	Self-Funded Plans
• W-2 reporting of health care coverage costs (if the employer provided 250 or more W-2s for the prior calendar year) • Medicare Part D Creditable Coverage Disclosure	• W-2 reporting of health care coverage costs (if the employer provided 250 or more W-2s for the prior calendar year) • Form 720 to report and pay the PCORI fee which applies from 2012 to 2029, based on plan/policy years ending on or after October 1, 2012. • Medicare Part D Creditable Coverage Disclosure • Section 111 Medicare Secondary Payer Mandatory Reporting (plan administrator)

Other

Fully Insured Plans	Self-Funded Plans
• Section 125 nondiscrimination testing if contributions are run through a cafeteria plan • Wellness program rules • HIPAA privacy policy and security policy • Business Associate Agreements	• Section 125 nondiscrimination testing if contributions are run through a cafeteria plan • Section 105(h) nondiscrimination testing • Wellness program rules • HIPAA privacy policy and security policy • Business Associate Agreements

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