

EPSTEINBECKERGREEN

**THE IMPACT OF THE PATIENT
PROTECTION AND AFFORDABLE CARE ACT
ON SELF-INSURED ERISA HEALTH AND
WELFARE BENEFIT PLANS:
*A GUIDE FOR ADMINISTRATORS
OF SELF-INSURED PLANS***

Daly D. E. Temchine, Esq.

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I. Introduction

There has been an ongoing trend for large employer benefit plan sponsors, particularly those operating in multiple states, to move away from insured health and welfare benefit plans (“H&W Plans”) and to create self-insured plans. A rationale¹ for this transition is that self-insured plans offer greater flexibility in benefit design because, by virtue of ERISA’s² first preemption clause, 29 U.S.C. § 1144, they are not subject to state insurance benefit mandates or other forms of insurance regulation. In contrast, insurance companies’ health care coverage products are subject to state regulation and must include state-mandated benefits. Consequently, ERISA plans that fund their benefits through insurance must cover these mandated benefits. In effect, insured employee health benefit plans can be indirectly subject to the varying individual legislative and regulatory preferences of 50 different state legislatures and insurance departments.

Unlike the pension plan provisions of the statute, ERISA has limited requirements with respect to the substantive benefits that must be offered by H&W Plans. Consequently, employers and other plan sponsors that self-insure the H&W Plans they sponsor have very broad discretion with respect to the scope and design of the benefits covered by their H&W Plans.

As this **White Paper** will reveal, this is no longer the case. PPACA³ imposes a significant number of requirements regarding both the eligibility for plan membership and the scope of the benefits that self-insured plans must provide. Nonetheless, self-insured plans are not nearly as comprehensively regulated by PPACA as insured plans are.

II. The Definitional Provisions of PPACA Differentiate Between Self-Funded and Insured Plans

PPACA includes a variety of plan classifications and imposes varying rights and obligations on each. As noted, the purpose of this **White Paper** is to identify the distinctions between the treatment under PPACA of self-funded plans and other forms of plans, insured plans in particular. The goals of this comparison are to enable (i) plan administrators to understand the variations in

¹ Other considerations include the elimination of the cost of the following: (i) premium taxes; (ii) the risk elements insurers factor into the premiums they develop; and (iii) the portion of the profit margins that also are built into premiums attributable to the risk component, as distinguished from the administrative component of the carrier’s charges.

² “ERISA” is the acronym for the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1974). This is the key legislation that regulates all employee benefit plans, such as pensions and health benefit plans.

³ “PPACA” is the acronym for the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 (2010).

plan administration requirements established by PPACA, and (ii) employers to make informed decisions regarding a choice between self-funded and insured plans.

PPACA uses the following terms and categories:

- **Applicable Self-Insured Health Plan** – This term means any plan for providing accident or health coverage if “*any* portion of such coverage is provided other than through an insurance policy” (emphasis added).

NOTE: Under this definition, a self-insured H&W Plan does not have to self-insure all of the benefits it covers. It is sufficient for only a portion of the benefits provided by a plan to be self-insured for the plan to be classified as a self-insured plan. Consequently, H&W Plans that have limited “first dollar” payment liability on their benefit claim risk and purchase stop-loss insurance to cover the balance of that risk should be treated as self-insured plans. Self-insured H&W Plans, unlike insured plans, should not be subject to either direct or indirect state regulation under ERISA’s “Deemer Clause.”⁴ (But see the definition and accompanying Note regarding the term “Health Plan.”)

- **Entities in General**⁵ – A self-insured H&W Plan is not an “Entity” under PPACA. Its Plan Sponsor and Plan Administrator, however, are each classified as an “Entity.” This means that, if the Plan Sponsor and Plan Administrator achieve “covered entity” status (see next definition), they will be subject to the obligations imposed by the statute. PPACA differs from ERISA in this important respect because plan sponsor status under ERISA, by itself, does not impose statutory obligations on employers with respect to plan administration.

NOTE: With exceptions, such as jointly trusted H&W Plans, employers usually are the Plan Sponsors of ERISA H&W Plans. As made clear by the next statutory definition, employer sponsors of self-insured plans are not covered entities under PPACA. This remains true even if the employer also is the Plan Administrator of the self-insured plan that it sponsors.

- **Covered Entity**⁶ – This term means an entity that provides health insurance for any United States health risk.

⁴ ERISA, 29 U.S.C. § 1144(b)(2)(B); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). As a hypothetical matter, the states may seek to achieve some indirect regulation of self-insured plans with stop-loss insurance through regulation of the stop-loss insurance policies. Should the courts support the states’ position in this regard, it may be possible to limit to a single state the states’ ability to indirectly regulate a multi-state employer’s self-insured H&W plan through the stop-loss policy.

⁵ PPACA § 1001, adding § 2715 to the Public Health Service Act (“PHSA”).

⁶ PPACA § 9010(d).

NOTE: Under this definition, an employer sponsor of a self-insured plan is not a covered entity. Similarly, carriers and third-party administrators (“TPAs”) whose sole function for a self-insured plan is to adjudicate claims are not a covered entity because their relationship to a self-insured plan does not involve the provision of insured coverage. Also, the typical Administrative Services Only (“ASO”) contract between carriers and self-insured plans specifies that the carrier’s obligations are limited to claims adjudication functions, and that they are not the Plan Administrator. Carriers and TPAs also are not a “Plan Sponsor” unless, of course, their employees participate in the plan that they administer.

- **Health Plan**⁷ – This category *expressly excludes* “group health plans” to “the extent they are not subject to state insurance regulation under Section 514 of ERISA.” As noted, self-insured health plans are not subject to state insurance regulation.

NOTE: The limitation implicit in the phrase “to the extent they are not subject to state insurance regulation” brings up a question previously raised in connection with the term “Applicable Self-Insured Health Plan” but in a different context. Is an H&W Plan that has both self-insured and insured benefits a “Health Plan” to the extent of its insured benefits but not a “Health Plan” with respect to its self-insured benefits? Or does the definition of “Applicable Self-Insured Health Plan,” which posits that plans having any self-insured benefits are self-insured plans under PPACA, make the “Health Plan” category wholly inapplicable to them? The answer is important because “Health Plans” are subject to obligations under PPACA that do not apply to self-insured plans. However, if the answer is that self-insured plans can be placed in both categories, will they then be subject to dual regulation under both state and federal law? The answer to that question must await either the promulgation of regulations or a definitive judicial precedent.

- **Group Health Plan**⁸ – This definitional category includes self-insured plans. The definition appears in Section 2791(a) of the PHSA, which states as follows:

The term “group health plan” means an employee welfare benefit plan . . . to the extent that the plan provides medical care (. . . including items and services paid for as medical care) to employees or their dependents . . . directly or through insurance, reimbursement, or *otherwise*” (emphasis added).

- **Qualified Health Plan**⁹ – This term “means a health plan that has in effect a certification . . . that such plan meets the criteria for certification described in section 1311(c) issued or recognized by *each Exchange through which such plan is offered*” (emphasis added).

⁷ PPACA § 1301(b)(1).

⁸ PPACA § 1301(b)(3).

⁹ PPACA § 1301(a).

NOTE: Self-insured health plans cannot be offered through Exchanges that are limited to insured products. Therefore, such plans cannot be a qualified health plan.

- **Low Actuarial Risk Plan¹⁰** – Self-insured plans are expressly excluded from this category.

NOTE: Self-insured plans are thus exempt from the charges the states can assess against this plan category.

- **High Actuarial Risk Plan¹¹** – Self-insured plans also are excluded from this category.

NOTE: As a consequence, self-insured plans are not eligible for payments the states are required to make to this category of plans under PPACA.

- **Employment Based Plan¹²** – This refers to a group health benefits plan maintained by one or more current or former employers (including any state or local government or political subdivision), employee organization, a voluntary employees’ beneficiary association, or a committee or board of individuals appointed to administer such plan, or a multiemployer plan (as defined in Section 3(37) of ERISA) that provides health benefits to early retirees.

NOTE: This category appears to include self-insured H&W Plans, as it makes no reference to the manner in which the covered benefits are funded.

III. PPACA Provisions that Impose Obligations on or Affect Self-Insured Plans

Unlike ERISA, Congress, through PPACA, has imposed a variety of detailed obligations on self-insured plans such as, by way of example, automatic enrollment, coverage of defined “preventive health services,” and the obligation to pay fees to fund certain types of research. In comparison to insured H&W Plans, however, far fewer obligations are imposed on self-insured plans than are imposed on insured plans.

The following are obligations imposed on self-insured plans:

- **Automatic Enrollment: Employees of Large Employers¹³** – This provision amends the Fair Labor Standards Act as follows:

¹⁰ PPACA § 1343(a)(1).

¹¹ PPACA § 1343(a)(2).

¹² PPACA § 1102(a)(2)(B).

¹³ PPACA § 1511.

[A]n employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans *shall automatically enroll new fulltime employees* in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. . . . Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll *except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section* (emphasis added).

- **Notification of Modifications¹⁴** – Group health plans, which, as previously discussed, include self-insured plans, must provide notice to plan members of any “material” modifications to the terms or coverage of the plan that are not disclosed in the plan’s Summary Plan Description. The disclosure must be made at least 60 days before the effective date of the modification.
- **Fees to Finance Patient-Centered Outcomes Research Fund¹⁵** – In a revision to Chapter 34 of the U.S. Internal Revenue Code, self-insured funds with plan years that end after September 30, 2012, are subject to a \$1.00 fee multiplied by the average number of members in the fund during that year. For those funds with a plan year that ends after September 30, 2013, the fee is \$2.00 and is annually adjusted, beginning September 30, 2014, by the percentage increase in National Health Expenditures.
- **Coverage of Emergency Services¹⁶** – This provision says that group health plans, *if* such plans cover any emergency services, must conform to the requirements of subpart (2)(B) of Section 2719A, which concerns emergency services. The plans are not required to cover emergency services but, if they do, the text provides that they will do so “without the need for any prior authorization determination; whether the health care provider furnishing such services is” or is not a participating provider . . .

in a manner so that, if such services are provided . . . by a nonparticipating health care provider with or without prior authorization; . . . such services will be provided without imposing any requirement . . . for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

¹⁴ PPACA § 1001, adding § 2715 to the PHSA.

¹⁵ PPACA § 6301.

¹⁶ PPACA § 1001, as modified by § 10101, adding § 2719A to the PHSA.

If such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network, without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

- **Lifetime or Annual Limits**¹⁷ – PPACA has two provisions with respect to benefit limits. One provision addresses **annual** limits on “essential health benefits,” and allows those benefits to be limited as permitted by federal or state law until 2014. That law states as follows:

ANNUAL LIMITS PRIOR TO 2014.—With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are *essential health benefits* under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.¹⁸

The other provision concerning *non-essential benefits* is not time-limited and addresses both **annual** and **lifetime** benefit limits. It also only allows limits that are permitted under federal and state laws, and says the following:

PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.¹⁹

NOTE: The reference to state law presumably is attributable to the circumstance that the preceding provisions concerning lifetime and annual limits are applicable to insured ERISA H&W Plans. Unlike self-insured plans, insured ERISA H&W Plans

¹⁷ PPACA § 1001, as amended by § 10101 and § 2301 of the Health Care and Education Reconciliation Act of 2010, adding § 2711 to the PHSA.

¹⁸ PPACA § 1001, as amended by § 10101 and § 2301 of the Health Care and Education Reconciliation Act of 2010, adding § 2711(a)(2) to the PHSA.

¹⁹ PPACA § 1001, as amended by § 10101 and § 2301 of the Health Care and Education Reconciliation Act of 2010, adding § 2711(b) to the PHSA.

are subject to indirect regulation under state law. The proposition that state law limits are applicable to self-funded plans would give rise to ERISA preemption issues.

- **Prohibition on Rescission²⁰** – Self-insured plans, as a group health plan, may not rescind an enrollee’s coverage once the enrollee is covered. The only exception is when an enrollee has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. Rescission requires prior notice to the enrollee, and must conform to the provisions of Section 2702(c) or 2742(b) of PPACA.
- **Preventive Health Services²¹** – PPACA says the following with regard to coverage of preventive health services:

A group health plan [i.e., a self-insured plan] . . . shall, at a minimum, provide coverage for and shall not impose any cost sharing requirements for–

(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph;

(5) for the purposes of this Act, and for the purposes of any other provision of law, the current recommendations of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

- **Non-Discrimination Against Providers in Health Care²²** – A group health plan (i.e., a self-insured plan) may not discriminate “against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” This section does not require that a group health plan contract with any health care provider willing to abide by the terms and conditions for participation

²⁰ PPACA § 1001, as modified by § 2301 of the Health Care and Education Reconciliation Act of 2010, adding § 2712 to the PHSA.

²¹ PPACA § 1001, as modified by § 10101, adding § 2713 to the PHSA.

²² PPACA § 1201, adding § 2706 to the PHSA.

established by the plan. “Nothing in this section shall be construed as preventing a group health plan or the Secretary from establishing varying reimbursement rates based on quality or performance measures.”

- **Right to Maintain Existing Coverage**²³ – This is a “grandfathering” provision that exempts group plans in existence – i.e., with actual membership – on the date PPACA was enacted, March 23, 2010.²⁴
- **Allowance for Family Members to Join Current Coverage**²⁵ – This provision enables “family members” of “enrolled” individuals – i.e., plan members – in grandfathered plans to enroll in the plan if its provisions allow such enrollment without jeopardizing the plan’s “grandfathered” status.
- **Allowance for New Employees to Join Current Plan**²⁶ – This provision allows new employees of an employer with a “grandfathered” plan to join the plan without affecting the plan’s status. The text reads as follows:

A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

- **Rating Reforms Must Apply Uniformly to Both Health Insurance Issuers and Group Health Plans**²⁷ – This provision requires that any standard or requirement adopted by a state pursuant to Title I of PPACA be applied uniformly. However, the author of this **White Paper** is unaware of any standard or requirement that would be adopted by a state pursuant to Title I that would be applicable to a self-funded plan. For instance, states may create standards relating to what is a qualified health plan, but, as discussed previously, self-funded plans cannot become qualified health plans so the standards would be inapplicable. The provision can apply only to insured plans as any other interpretation would require the assumption that Congress silently repealed ERISA’s Deemer Clause.²⁸ There is no basis for any such assumption.
- **Access to Pediatric Care**²⁹ – PPACA says the following:

²³ PPACA § 1251.

²⁴ “CONTINUATION OF COVERAGE. With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.”

²⁵ PPACA § 1251(b).

²⁶ PPACA § 1251(c).

²⁷ PPACA § 1252.

²⁸ ERISA § 514(b)(2)(B).

²⁹ PPACA § 1001, as modified by § 10101, adding § 2719A(c) to the PHSA.

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, . . . if the plan . . . requires or provides for the designation of a participating primary care provider for the child, the plan . . . shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.

NOTE: PPACA does not require plans to offer pediatric service coverage. This allows parents to freely select their children’s health care provider within the plans’ network of participating providers.

- **Patient Access to Obstetrical and Gynecological Care³⁰** – PPACA requires both insured and self-insured plans to allow women to obtain gynecologic and obstetrical services from a provider of their choice without requiring that they first obtain a referral from a primary care physician. As is the case with pediatric services, this provision does not require plans to alter the scope of the benefits they cover. In addition, the physician chosen by a female plan member can be required to report to the primary physician the course of treatment that will be pursued.
- **Coverage for Individuals Participating in Approved Clinical Trials³¹** – PPACA states the following:

If a group health plan . . . offering group or individual health coverage . . . provides coverage to a qualified individual, then such plan –

- (A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);
- (B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
- (C) may not discriminate against the individual on the basis of the individual’s participation in such trial.

- **Extension of Dependent Coverage³²** – PPACA says the following: “A group health plan . . . that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age.”
- **Uniform Explanation of Coverage Documents and Standardized Definitions³³** – This section requires the Secretary of Labor to develop standardized summaries of

³⁰ PPACA § 1001, as modified by § 10101, adding § 2719A(d) to the PHSA.

³¹ PPACA § 1201, as modified by § 10103, adding § 2709 to the PHSA.

³² PPACA § 1001, as modified by § 2301 of the Health Care and Education Reconciliation Act of 2010.

³³ PPACA § 1001, as modified by § 10101, adding § 2715 to the PHSA.

benefits and coverage that will accurately describe the latter to enrollees in consultation with various groups.

NOTE: Self-insured plans that fail to utilize the standardized information elements can be subjected to heavy penalties of up to \$1,000.00 for each offense. Each failure to provide conforming documents to a plan member constitutes a separate offense.

- **Ensuring the Quality of Care Reporting**³⁴ – The Secretary of Labor is required to develop reporting criteria concerning plan or benefit coverage to the Secretary and plan enrollees. Self-insured plans’ reports must apply these criteria.
- **Internal Due Process Appeals**³⁵ – Self-insured plans have always been required by ERISA to provide an internal appeal procedure to plan enrollees who have complaints concerning benefits.

NOTE: Certain components of the appeal process specified in PPACA should be inapplicable to self-insured plans. For example, the requirement that enrollees must be informed of the availability of assistance from insurance commissioners and state “Ombudsmen” (discussed later) is not relevant as both entities have jurisdiction only with respect to insurance products.

- **External Review**³⁶ – Self-insured plans are required to comply with external review standards to be promulgated by the Secretary of Health and Human Services (“Secretary”). They are not required to comply with state criteria.
- **Reinsurance for Early Retirees**³⁷ – This provision requires the Secretary to establish a temporary reinsurance program to provide reimbursement to “participating employment-based plans.” The purpose is to reimburse such plans for a portion of their cost of providing “health insurance coverage.” Regulations for this provision have been issued and explicitly allow for self-funded plan participation.³⁸
- **Prohibition of Discrimination Based on Preexisting Condition or Other Discrimination**³⁹ – Self-insured plans may not discriminate on these grounds.
- **Discrimination Based on Health Status**⁴⁰ – Self-insured plans are “group health plans” and, therefore, may not have eligibility criteria based on the following factors:

³⁴ PPACA § 1001, as modified by § 10101, adding § 2717 to the PHS.A.

³⁵ PPACA § 1001, as modified by § 10101, adding § 2715 to the PHS.A.

³⁶ PPACA § 1001, as modified by § 10101, adding § 2719(b) to the PHS.A.

³⁷ PPACA § 1102.

³⁸ 75 Fed. Reg. 24450. The statutory text was somewhat ambiguous as to whether the self-funded coverages of a self-funded plan could participate.

³⁹ PPACA § 1201, as modified by § 10103, adding § 2704 to the PHS.A.

- (i) health status;
- (ii) medical conditions (either physical or mental);
- (iii) claims experience;
- (iv) receipt of health care;
- (v) medical history;
- (vi) genetic information;
- (vii) evidence of insurability (including those involving domestic violence);
- (viii) disability; and
- (ix) “any other health status-related factor.”

NOTE: Sections 2704 and 2705 and similar provisions of PPACA refer to both “group health plans” and “health insurance issuers” as offering “insurance coverage.” These provisions reflect the perspective of plan participants and beneficiaries for whom the plans appear to operate in the same manner. Indeed, many employers who sponsor self-funded plans enter into ASO arrangements with carriers to administer the claims operations of those plans. This would certainly be the perspective of plan participants and their beneficiaries. The functional similarities between self-insured and insured plans have been noted in a few court decisions.

- **Limitations on Cost-Sharing**⁴¹ – Self-insured plans are *seemingly* subject to the limitations on cost-sharing set out in paragraphs (1) and (2) of Section 1302(c) of PPACA because Section 2707(b) states that “group health plans” are subject to those provisions, and, as noted, self-funded plans are group health plans.

IV. Self-Insured Plans Are Favorably Treated Under PPACA

The following review of some of the burdens and obligations imposed on *insured* ERISA H&W Plans, multiple employer welfare arrangements (“MEWAs”), and voluntary employees’ beneficiary associations (“VEBAs”) demonstrates that self-insured plans have been spared many of the obligations imposed by PPACA. No opinion is intended to be expressed concerning whether Congress purposefully structured PPACA to encourage the growth of self-insured plans. That result, however, is consistent with a goal to achieve greater federal control and uniformity over the content of ERISA H&W Plans than would otherwise be feasible without effecting a substantial change to the principle that the states have the exclusive authority to regulate the business of insurance.

PPACA imposes the following burdens and obligations:

⁴⁰ PPACA § 1201, adding § 2705 to the PHSA.

⁴¹ PPACA § 1201, adding § 2707(b) to the PHSA.

- **Comprehensive Coverage for Health Benefits Package⁴²** – Self-insured plans are *not* required to offer the package of benefits specified in Section 1302 of PPACA. This is required of insured plans only.
- **Essential Health Benefits Requirements⁴³** – This provision of PPACA is applicable to “Health Plans” and, thus, *does not apply* to self-funded plans.
- **Prohibition of Discrimination Based on Salary⁴⁴** – Self-insured plans are expressly relieved of the obligation to comply with this requirement.
- **Annual Limitation on Deductibles for Employer Sponsored Plans⁴⁵** – This limitation does not apply to self-insured plans.
- **Guaranteed Issue of Coverage⁴⁶** – This does not apply to self-insured plans.
- **Exemption from the Requirements of Sections 2716 and 2718 of the PHSA⁴⁷** – These provisions involve (i) the prohibition of discrimination in favor of highly compensated individuals, (ii) the protection of Second Amendment gun ownership rights and the prohibition of the collection of information on gun ownership, (iii) the prohibition of considering gun ownership as a factor in the calculation of premiums, and (iv) the requirement for the submission of annual reports providing detailed financial information concerning the provision of covered benefits.
- **Self-Insured Plans Are Not Subject to the Jurisdiction of State Ombudsmen⁴⁸** – PPACA provides for the creation of a state-level office for an “Ombudsman.” The function of the Ombudsman is to address complaints concerning violations by plans or plan officials of both state and federal laws. Section 2793 clearly provides that the Ombudsman’s jurisdiction is limited to insured plans. As a result of this exclusion of self-insured plans from the Ombudsmen’s jurisdiction, some complex ERISA preemption issues have been avoided.
- **Prohibition on the Making of False Statements and Representations⁴⁹** – This provision is applicable only to MEWAs.

⁴² PPACA § 1201, adding §2707(a) to the PHSA.

⁴³ PPACA § 1302.

⁴⁴ PPACA § 1001, as modified by § 10101, adding § 2716 to the PHSA.

⁴⁵ PPACA § 1302(c)(2).

⁴⁶ PPACA § 2702.

⁴⁷ PPACA § 1562, adding § 715 to ERISA.

⁴⁸ PPACA § 1002, adding § 2793 to the PHSA.

⁴⁹ PPACA § 6601.

- **Application of State Law to Combat Fraud and Abuse**⁵⁰ – This provision also applies only to MEWAs.
- **Imposition of Cease and Desist Orders**⁵¹ – This applies only to MEWAs.
- **Ensuring that Consumers Get Value for Their Dollars**⁵² – This provision empowers the Secretary to investigate the reasonability of premiums and to publicize findings and conclusions. The Secretary is to be assisted in this endeavor by state insurance commissioners. Employees of employers that sponsor self-insured ERISA H&W Plans typically are required to make contributions as a condition of plan participation. The statute does not authorize the Secretary to investigate the value or reasonability of the level of contribution required. As state insurance commissioners have no jurisdiction over such plans, self-insured plans do not have to bear the costs and administrative burdens attendant to investigations and scrutiny by regulatory agencies. Employee participants of self-insured plans have a body of remedies made available to them by Congress in Section 502 of ERISA.
- **Administrative Simplification**⁵³ – Pursuant to this provision, the Secretary is required to develop a “single set of operating rules” governing the administration of various functions and transactions that are common to all H&W Plans. The entities subject to these rules will have to file documented reports of compliance with the Secretary, and are subject to penalties if they make misrepresentations in those reports. The entities subject to these obligations are “Health Plans,” a category that excludes self-insured plans.
- **Guaranteed Renewability of Coverage**⁵⁴ – This requirement applies only to insurers.

V. Conclusion

The intent of this **White Paper** is to help Plan Administrators distinguish the particular effects PPACA has on self-insured, or self-funded, H&W Plans. Under PPACA, self-insured plans are not subject to all of the limitations and requirements applicable to insured plans. In that sense, they can be viewed as easier to administer. Because, however, Plan Sponsors have greater flexibility in the design of self-insured plans than is the case with insured plans, Plan Administrators may be confronted with plan-specific variables.

The greater flexibility of self-funded plans may offer an opportunity for Plan Administrators to develop and propose to both Plan Sponsors and plan fiduciaries benefit design structures that may

⁵⁰ PPACA § 6604.

⁵¹ PPACA § 6605.

⁵² PPACA § 1003, as modified by § 10101, adding § 2794 to the PHSA.

⁵³ PPACA § 1104.

⁵⁴ PPACA § 1201, adding § 2703 to the PHSA.

not be feasible in the insured benefit setting. This opportunity could also allow Plan Administrators to create economically efficient and affordable structures that do not have adverse impacts on the quality of the health care provided to self-funded plan members. This flexibility, together with the protected status of self-insured plans under ERISA, allows the creation of lawful and prudent structures that would enable smaller employers to take advantage of the flexibility available to self-insured plans and provide them with the opportunity to consider benefit designs not available in insured products.

The choice to self-insure health benefits plans need not be limited to very large employers with thousands of employees. There are legal structures through which smaller employers can implement self-insured benefit plan structures and limit their risk exposure. In this fashion, they can achieve the same flexibility available to very large employers in selecting the benefits they can afford to offer to their employees. As demonstrated, more flexibility is available to employers that sponsor self-funded benefit plans than to those that choose to sponsor insured benefit plans.

If you wish to discuss this subject further, please contact the author:

[Daly D. E. Temchine](#)

Epstein Becker & Green, P.C.

1227 25th Street, NW

Washington D.C. 20037

202.861.1837

dtemchine@ebglaw.com