Benefits
BULLETIN

Checklist for Self-Insured Group Health Plans

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Group health plans are subject to changing regulations surrounding compliance and notice obligations. Many requirements apply equally to insured and self-insured arrangements, though the insurance carrier in insured plans often ensures compliance with certain items. This Benefits Bulletin provides an overview of the obligations of self-insured (including level-funded) group health plans.

- ✓ **Plan Document.** Plans that are subject to ERISA must be established and maintained pursuant to a written plan document. The plan (and any amendments) must be properly adopted by the plan sponsor and signed by an authorized individual. The plan document is not required to be distributed, but a copy must be furnished to participants upon written request.

- ✓ **Summary Plan Description (SPD).** Plans subject to ERISA are required to provide and maintain an SPD and distribute it to participants. Note that third-party administrators (including insurers acting as third-party administrators) of self-insured plans frequently do not provide the employer with an SPD, so the employer may need to prepare one themselves or engage another party to prepare it. Employers should follow the ERISA delivery requirements for SPDs and other required benefit notices. During a DOL audit, an employer may need to prove its delivery methods and procedures were appropriate.

- ✓ **Summary of Material Modifications (SMM).** Participants must be informed of any material changes to the plan or its operation within prescribed time limits. These changes can be communicated by distributing an updated SPD or an SMM. Employers should communicate plan changes to participants as soon as reasonably possible to help avoid benefit disputes. Plan changes may take effect at the beginning of the upcoming plan year, and employers may decide to include an SMM in their open enrollment materials.

- ✓ **HIPAA Privacy & Security.** Self-insured health plans typically have greater responsibility for complying with the HIPAA privacy and security rules than fully insured plans because, for fully insured plans, much of the responsibility for complying with HIPAA falls on the insurance carrier. Ensuring compliance with the HIPAA privacy and security rules will require, among other things, appointing privacy and security officers, establishing written policies and procedures, conducting a security risk assessment, developing breach notification procedures, entering into Business Associate Agreements, training the workforce, and distributing a Notice of Privacy Practices.

- ✓ **Medicare Part D Notice of Creditable (or Non-Creditable) Coverage.** Employers with group health plans that provide prescription drug coverage must determine whether their drug benefits are "creditable" or "non-creditable" (as compared to coverage under Medicare Part D). They also must notify Medicare-eligible individuals and the Centers for Medicare and Medicaid Services (by online filing) annually of the plan's creditable or non-creditable status.

- ✓ **COBRA.** Employers must prepare and distribute various COBRA notices to certain individuals at prescribed times. They also must administer COBRA continuation coverage, although most employers elect to hire a third-party COBRA administrator rather than handling it themselves.

- ✓ **Other Employee Notices.** Other required employee notifications include SBCs, HIPAA special enrollment rights, CHIP, NMHPA, WHCRA, MHPAEA, GINA, ACA patient protections, grandfathered plan status, ERISA claims/appeals and external review. For more information, read our 2025 Open Enrollment Checklist. (Note that some notices may not apply to certain self-insured plans.)

- ✓ **Form 5500.** Plans subject to ERISA must file a Form 5500 annually if they have 100 or more participants at the beginning of the plan year. A Form 5500 is required for plans of any size if they hold "plan assets." In addition, insured and self-insured plans with "plan assets" must distribute a summary annual report (SAR) summarizing the Form 5500 to participants annually.

- ✓ **PCORI Fee.** Self-insured group health plan sponsors must calculate, report, and pay an annual fee to fund the Patient Centered Outcomes Research Institute (PCORI) using IRS Form 720. The fee is due July 31 each year through 2029. Note that HRAs offered in conjunction with fully insured group medical plans are subject to the fee.

- ✓ **Nondiscrimination Rules – Section 105(h).** The Internal Revenue Code imposes nondiscrimination requirements on self-insured group health plans. These rules are

designed to ensure that self-insured plans do not impermissibly favor highly compensated individuals in terms of eligibility or benefits. It is generally recommended that self-insured plans test at least annually, although more frequent testing may be needed in some circumstances.

- ✓ **Code 213(d) Medical Expense Exclusion.** While some employers self-insure their health benefits to give them more flexibility over plan design, they should nonetheless be reminded that only medical expenses under Code Section 213(d) may be paid or reimbursed on a tax-free basis. Plan sponsors should monitor claims administrators to ensure that the plan pays only claims for qualifying medical expenses.

- ✓ **ACA Reporting (Forms 1094 and 1095).** Code Section 6055 requires employers with self-insured health plans to provide a Form 1095 to plan enrollees each year and to file a Form 1094 with the IRS (along with copies of the 1095s). Self-insured plan sponsors that are not "applicable large employers" (ALEs) use IRS Forms 1094- and 1095-B to meet these reporting obligations; ALEs that sponsor self-insured health plans use IRS Forms 1094- and 1095-C.

- ✓ **Public Disclosure of Machine Readable Files (MRFs).** Group health plans must disclose detailed pricing information about in-network rates, out-of-network spending, and prescription drug costs by posting MRFs on a public website. Self-insured health plans should rely upon TPAs or ASOs to create and regularly update the MRFs. Still, employer-sponsors will be responsible for posting a link to the MRFs on their public website unless they have entered into a specific agreement with the TPA or ASO that delegates the responsibility for the public posting to them. Enforcement began on July 1, 2022.

- ✓ **Prescription Drug Reporting.** Under the Consolidated Appropriations Act, group health plans must submit an annual report to the DOL, IRS, and HHS that includes information regarding costs associated with prescription drug benefits; HHS will then publicly post de-identified aggregated reports on its website on drug pricing trends. The reporting is due annually by June 1st.

- ✓ **Price Comparison Tool.** To promote transparency in coverage, group health plans must make an internet-based self-service price comparison tool available that discloses personalized price and cost-sharing liability information (the same information must also be made available over the telephone upon request). For plan years that began on or after January 1, 2023, the tool must include information for the 500 most common "shoppable" expenses; for plan years beginning on or after January 1, 2024, information must be available for all covered expenses.

- ✓ **Surprise Billing Notice.** As part of the consumer protections against surprise billing, group health plans must provide a notice to participants that includes information on surprise billing, details of any applicable state rules, and lists of who to contact to file a complaint. This notice must also be provided with any EOB for an item or service to which the protections apply.

- ✓ **Provider Directory.** Group health plans must maintain participating provider directories on a public website, regularly update the directory information, and respond to requests for information about participating providers. If inaccurate information is provided, a covered individual cannot be required to pay more than in-network cost sharing.

- ✓ **Gag Clause Attestation.** Group health plans and insurers are prohibited from entering into contracts with health care providers, third-party administrators (TPAs), or other service providers that contain gag clauses. Health plans and issuers must submit an attestation of their compliance with the gag clause prohibition annually by December 31st.