COMPLIANCE ALERT

Guide to Compliance Considerations for Level-Funded Plans

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Quick Facts

- The vast majority of level-funded plans are self-insured plans where the employer pays a fixed monthly amount to cover costs of administration, claims and stop-loss premiums.
- Level-funded plans are often designed to look and feel like fully insured plans.
- Plan sponsors of level-funded plans must adhere to the compliance guidelines of other self-funded plan sponsors.

Background

The vast majority of level-funded plans are self-insured plans where the employer pays a fixed monthly amount to cover costs of administration, claims, and stop-loss premiums. They are often designed to mimic fully insured plans and are most often provided by small groups (fewer than 50 employees). The monthly payment is typically based on maximum exposure or worst-case claims scenario. It is common for a plan to be issued a refund at the end of the year if the total claims incurred are less than the maximum exposure.

One of the most common sources of compliance errors for level-funded plans is that the employer forgets the plan is self-insured. This is not surprising given that level-funded plans are often designed to look and feel like fully insured plans. Thus, it's important when implementing a level-funded plan to remember that:

- The plan is self-insured
- It may not always operate as a fully insured plan
- Compliance alerts that apply to self-funded plans also apply to level-funded plans

PCORI Fees

A level-funded plan sponsor is required to pay the Patient Centered Outcomes Research Institute (PCORI) fee each year. Occasionally, the level-funded plan vendor may include the PCORI fee in the monthly payment amount and submit the payment to the Internal Revenue Service (IRS) on the employer's behalf. Wrapping the PCORI fee into the monthly payment amounts, which may be paid in part by employee contributions, can be problematic. Accordingly, in most cases, the level-funded plan sponsor is responsible for reporting and paying the PCORI fee each year.

ACA Reporting

Because it is self-insured, an employer who sponsors a level-funded plan is required to complete Affordable Care Act (ACA) reporting under Internal Revenue Code (IRC) §6055 for all individuals enrolled in self-insured coverage. An employer who is also an applicable large employer (ALE) will complete this reporting on Part III of Form 1095-C. An employer who is not an ALE will complete the

reporting using Form 1095-B. Occasionally the level-funded plan vendor will do this reporting on the employer's behalf, but ultimately the employer is responsible for completing this reporting.

ERISA Preemption

Self-funded plans are not subject to state insurance mandates because of Employee Retirement Income Security Act (ERISA) preemption. Since a level-funded plan is self-funded, it is does not have to comply with state insurance mandates. This may allow the level-funded plan to:

- Avoid covering certain procedures mandated by state law (e.g., cochlear implants, applied behavioral analysis (ABA) therapy for autism spectrum disorder)
- Avoid compliance with state minimum employer contribution rules
- Disregard state continuation rules (see below)

However, many level-funded plans are intentionally designed to mimic fully insured products. It is possible the vendor may include certain coverage mandated by state insurance laws in its level-funded products even though it is not required to do so. Employers should not assume that coverage required by state law is included in their level-funded plan, nor should they assume it is not. Rather, they should carefully review the plan documents if there is any question whether or not a particular state insurance requirement is included in their level-funded plan.

COBRA

COBRA and State Continuation

As a self-funded plan, a level-funded plan is not subject to state continuation rules unless the vendor has deliberately incorporated those rules into the plan document. Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage does not apply to employers with fewer than 20 employees on a typical business day in the preceding calendar year. For small employers with level-funded plans, there are often no continuation rights available to participants, and employers must be careful not to offer continuation that does not actually exist. Note that level-funded plans offered by employers with more than 20 employees will still be subject to federal COBRA even though state continuation does not apply.

COBRA Premiums

Assuming federal COBRA applies, the rules for determining the COBRA premium are different for self-funded plans compared to fully insured plans. For a self-funded plan, the COBRA premium is either:

- A reasonable estimate of the cost of providing coverage, determined on an actuarial basis, for the current plan year
- Or the cost to the plan of providing coverage in the preceding plan year, provided the plan design has not significantly changed in the current plan year

Of particular relevance to a level-funded plan, the fixed monthly cost the employer pays the vendor is typically calculated based on the plan's maximum liability, not its expected liability. That means in most cases, the employer cannot simply use the monthly fixed payment as the basis for the COBRA premiums. Rather, they must set the COBRA premiums based on expected claims (if provided by the vendor) or the previous year's total costs, taking into account any refund the employer received at year end based on plan performance.

Year End Refunds as Plan Assets

Under ERISA, employee contributions and any funds that can be traced to those contributions are plan assets that must be used for the exclusive benefit of plan participants and cannot simply be retained by the employer. Thus, to the extent that employees contributed towards the cost of the level-funded plan, the employer must consider whether any portion of the year-end refund is attributable to those employee contributions. If so, the portion of the refund attributable to the employee contributions are plan assets that must be used for the exclusive benefit of plan participants.

If the plan document contains language specifically addressing ownership of the year-end refunds or describes a method or formula for allocation of the refund between employer and employees, then that language will control the plan document. In the absence of such language, it is reasonable to rely on the Medical Loss Ratio (MLR) rebate guidance to allocate the refund between employer and employee contributions. For example:

- If over the course of the year employee contributions amounted to 25% of the fixed monthly payments and the employer paid the remaining 75% of those payments
- And the employer received a year-end refund based on plan performance of $10,000
- $7,500 of that refund would belong to the employer and the remaining $2,500 would be plan assets that must be used exclusively for the benefit of plan participants

Options for using the employee portion of the refund include returning the funds to employees as taxable wages, giving a premium holiday on upcoming employee contributions, or using the funds to upgrade the plan to provide better coverage, e.g., by implementing a wellness program. Employers are not required to go back and identify the specific employees enrolled on the plan during the year which generated the refund or allocate the employee share in direct proportion to the amount contributed by each individual employee. Rather, the Department of Labor (DOL) has indicated employers can use the funds for the benefit of current plan participants and divide it equally among them or use any other fair and equitable apportionment method.

Nondiscrimination Testing

Self-funded plans, including level-funded plans, are subject to IRC §105(h) nondiscrimination testing, which prohibits the plan from discriminating in favor of highly compensated individuals (HCIs). HCIs for this purpose include the highest-paid 25% of all employees, so every employer will have HCIs.

While the details of §105(h) nondiscrimination testing are beyond the scope of this alert, plan designs that may raise red flags include owners and executives who are provided coverage at no charge while other employees must contribute. This may also include eligibility rules that deny coverage to significant numbers of lower-paid employees or different waiting periods for managers vs. line employees. If a plan fails one of the nondiscrimination tests, the highly compensated employees will lose the tax-favored benefit of the plan and must be taxed on some or all of the value of the plan.

Note that it is often difficult to locate vendors willing to perform the nondiscrimination tests on small self-funded plans if the third-party administrator (TPA) does not offer the service.

Prescription Drug Data Collection Reporting

The sponsors of self-funded plans, including level-funded plans, are responsible for ensuring their plans complete the prescription drug reporting (RxDC) required by the transparency in coverage provisions of the ACA and Consolidated Appropriations Act (CAA) of 2021. The first reports are due

December 27, 2022, for the calendar years 2020 and 2021, and then in June of each subsequent year for the preceding calendar year.

As a practical matter, the plan's TPA and/or pharmacy benefit manager (PBM) will have to prepare the substantive portions of the reports, but every TPA and PBM is handling the filing differently. Some TPAs will file everything on behalf of the plan. Others require the employer to file a portion of the reports themselves, namely the so-called P2 and D1 files, while they file the substantive files. Others will merely provide the employer with the necessary data and leave it up to the employer to do the actual filing. Employers with level-funded plans need to check with their TPA what their responsibility will be with respect to the reporting.

Compliance Checklist

- ❑ Level-funded plans are self-insured
- ❑ PCORI Fees
- ❑ ACA (§6055) Reporting
- ❑ ERISA preemption – state insurance mandates do not apply
- ❑ State continuation does not apply – COBRA will not apply for small (<20 employees) employers
- ❑ COBRA premium generally cannot be based on monthly payment amount
- ❑ A portion of the year-end refund may be plan assets
- ❑ §105(h) nondiscrimination testing
- ❑ Complete RxDC Reporting

EPIC Employee Benefits Compliance Services

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