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Health Care Reform
Creates Self-funding Advantages

No Deductible Limits for Small Groups
Self-funded plans are exempt from the deductible limits on small groups. Non-grandfathered groups of fewer than 50 lives and fully insured will have to limit deductibles. The limits are $2,000 for individuals and $4,000 for family coverage, and they will be increased for plan years beginning after 2014 by the premium adjustment percentage, as announced by the federal government.

Not Subject to Essential Health Benefits
Self-funded plans are not subject to essential health benefits. Essential health benefits cover 10 federally defined benefit categories that include: ambulatory patient services, emergency services, hospitalization, prescription drugs, mental health and substance use disorder services (including behavioral health treatment), rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, maternity and newborn care, and pediatric services, including oral and vision care.

Exchanges
Self-funded plans are not required to participate in either the federal or state health insurance exchanges. This includes providing essential health benefits, limiting cost-sharing and providing bronze, silver, gold or platinum-level coverage as it relates to the full actuarial benefits under the plan. They may, however, participate or create their own private exchanges, which may allow for more customization and flexibility of plan designs.

Guaranteed Issue of Coverage and Renewability of Coverage Exemptions
Self-funded plans are exempt from guaranteed issue of coverage and renewability of coverage.

No Health Insurance Tax (HIT)
The HIT is a permanent annual fee on health insurers. Self-funded plans are not subject to the HIT.

No Medical Loss Ratio (MLR)
There is no MLR for self-funded plans. Fully insured plans are required to use 80 percent or 85 percent of premiums on medical claims. Any excess premiums must be refunded to group health plans, and the plans are required to determine how to use the rebates or refund them to plan participants.

Minimum Essential Coverage (MEC)
MEC is any employer-sponsored coverage, including coverage under a self-funded group health plan, as confirmed in final regulations issued by the IRS on Aug. 30, 2013. This is the coverage individuals need beginning Jan. 1, 2014, to avoid paying the individual mandate penalty. In other words, self-funded coverage will ensure your employees are not penalized as long as they enroll in the plan you offer.

Modified Community Rating Does Not Apply
The modified community rating system is not applicable to self-funded groups. Insurers in the individual and small group markets must use the modified community rating system and can only vary premiums based on a few criteria, such as coverage category (individual vs. family), tobacco use, age and rating area (as established by the states).

Premium Change Approval Not Required
Self-funded groups are not required to obtain approval to make changes to the premiums.

About Benefits Partners

We do more than help companies get by. We elevate them through the power of collaboration and innovation. A division of NFP, Benefits Partners is a national corporate benefits organization of more than 185 offices across the country — bringing together leading-edge thinking, preferred carrier relationships, best-of-breed products, advanced benchmarking and analysis tools, and comprehensive decision and implementation support services that help keep companies ahead of the curve.

More than a leading national corporate benefits producer group, Benefits Partners is a movement that strives to bring all companies — regardless of their size — the greatest, most comprehensive and cutting-edge benefit offerings and resources in the market.

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