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IDENTIFYING SELF-INSURED HEALTH PLANS USING REGULATORY DATA SOURCES

June 15, 2012

This document is one of the three reports constituting the *Final Data Review Report* pursuant to Subtask 8 of Task Order DOLB109330993 (Self-Insured Group Health Plans Report), as modified, under Contract DOLJ089327415.

Contents

INTRODUCTION

This report compiles research on federal and state-level agency regulatory filing requirements for group health plan sponsors. In particular, this report highlights agency filing requirements that could be used as self-insured group health plan data sources. The filing requirements of a single municipal government, San Francisco, are included for illustrative purposes.

This report identifies federal government reporting requirements across multiple agencies and formats including annual tax filings, informational statements to employees, and self-reporting on health plan operations and financials. Each of the 50 states was researched to identify state-level group health plan reporting requirements. This document includes six states with relevant reporting requirements, and half of those states have multiple relevant reporting requirements. No pertinent regulatory filing requirements were found in the remaining 44 states. Many state agencies deferred to the regulatory reporting requirements set forth by the Employee Retirement Income Security Act (ERISA) and the U.S. Department of Labor (DOL).

In addition to providing background information on the purpose and requirements of a particular filing, this report highlights instances where, by nature of submission, or based on questions contained in a form or filing, information about self-insured group health plans may be gathered. For example, a form may ask an employer to identify itself as the sponsor of a self-insured group health plan, or the form itself may be an application to self-insure.

FEDERAL REGULATORY DATA SOURCES

This section compiles select federal government reporting requirements that may identify self-insured group health plans. These reporting requirements span several federal agencies including the DOL, the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS), the Internal Revenue Service (IRS), and the Social Security Administration (SSA).

Form 5500 Annual Return/ Report of Employee Benefit Plan (Form 5500)

Overview	
Recipient:	DOL
Filer:	Plan sponsors
Frequency:	Annually, by the last day of the 7th calendar month after the end of the plan year (2½-month extension available)
Mode of Delivery:	Electronic
Reporting Threshold:	All welfare benefit plans unless they meet a stated exception
Public Access:	Available from the DOL website: http://www.efast.dol.gov/portal/app/disseminate?execution=e1s1

Funding Mechanism Information:

A plan indicates its funding arrangement(s) on Line 9(a) of Form 5500 by selecting one or more of the following: insurance, trust, code section 412(e)(3) insurance contracts, general assets of the plan sponsor.[1]

Highlights:

- Page 17 of the 2010 Instructions for Form 5500 Annual Return/Report of Employee Benefit Plan indicates "General assets of the sponsor" means either the plan had no assets or some assets were commingled with the general assets of the plan sponsor prior to the time the plan actually provided the benefits promised. As a result, it is difficult to identify self-insured health plans since other plans (e.g., plans with a flexible spending account) may select this option.

[1] See *Self-Insured Health Benefit Plans 2012* (forthcoming) for a discussion of how the Form 5500 can be used to identify the funding status of health plans. This analysis indicates that the information on Line 9(a) (and Line 9(b)) applies to all benefit plans reported and may be insufficient to derive the funding status of the health benefits component. It is also noted that the information on Line 9(a) is not always consistent with Schedules A – Insurance Information (Schedule A) or Schedule H – Financial Information (Schedule H)/Schedule I – Financial Information – Small Plan (Schedule I).

Additional Information:

ERISA requires any administrator or sponsor of an employee benefit plan subject to ERISA to report details on such plans annually, unless they are exempt from filing. The Form 5500 was developed to satisfy this ERISA filing requirement. The Form 5500 Instructions list the following exceptions:

- A welfare benefit plan that covered fewer than 100 participants as of the beginning of the plan year and is unfunded, fully insured, or both;
- A plan maintained outside of the U.S. primarily for nonresident aliens;
- A governmental plan;
- An unfunded or insured welfare benefit plan maintained for a select group of management or highly compensated employees meeting the requirements of 29 CFR 2520;
- An employee benefit plan maintained only to comply with workers' compensation, unemployment compensation, or disability insurance laws;
- A welfare benefit plan that participates in a group insurance arrangement that files a Form 5500 on behalf of the welfare benefit plan as specified in 29 CFR 2520;
- An apprenticeship or training plan meeting all of the conditions specified in 29 CFR 2520;
- An unfunded dues financed welfare benefit plan exempted by 29 CFR 2520;
- A church plan under ERISA Section 3(33);
- A welfare benefit plan maintained solely for one individual or an individual and his or her spouse, who wholly own a trade or business or (2) partners or the partners and the partners' spouses in a partnership.

Form 5500 consists of the main Form 5500 and various Schedules and various Attachments. The main Form 5500 collects general plan information, such as the name of the sponsoring company, the type of benefits provided to participants, funding and benefit arrangements, and the number of plan participants. Fully insured plans must file a Schedule A for each insurance (or similar organization) contract providing benefits under the plan. Additionally, if the Form 5500 Line 9a(1), 9a(2), 9b(1), or 9b(2) is checked indicating that the plan funding arrangement or plan benefit arrangement includes an account, policy, or contract with an insurance company, at least one Schedule A is required (i.e., a self-insured plan whose stop-loss insurance policy is an asset of the plan).

References:

- Form 5500 Instructions (http://www.dol.gov/ebsa/5500main.html)
- DOL Technical Release No. 92-01 (http://www.dol.gov/ebsa/newsroom/tr92-01.html)

Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs) (Form M-1)

Overview	
Recipient:	DOL
Filer:	Multiple Employer Welfare Arrangements
Frequency:	Annually, or within 90 days of origination (60-day extension available for both annual and origination filing)
Mode of Delivery:	Electronic & U.S. Mail
Reporting Threshold:	MEWAs
Public Access:	Directly from DOL

Funding Mechanism Information:

A welfare benefit plan's funding mechanism has no bearing on whether or not a Form M-1 filing requirement exists, but Form M-1 does ask fully insured plans to identify themselves.

Highlights:

- Form M-1, Part III, Question 5d asks if the MEWA is fully insured.

Additional Information:

In general, any employee welfare benefit plan, or any other arrangement, established or maintained for the purpose of offering or providing welfare benefits to the employees of two or more employers, must file a Form M-1 unless it is an ECE and thus entitled to take advantage of an available exception.[2]

The Form M-1 must be filed at the time a MEWA is originated and then annually. The Form M-1 describes compliance with federal health legislation, including the Health Insurance Portability and Accountability Act (HIPAA), Women's Health and Cancer Rights Act, Mental Health Parity Act, and Newborns' and Mothers' Health Protection Act.

References:

- FAQs on the Form M-1 (http://www.dol.gov/ebsa/faqs/faq-FormM1.html)
- 2011 Form M-1 and Instructions (http://www.dol.gov/ebsa/pdf/2011M1Package.pdf)

[2] A plan may be excepted from the filing requirement if it is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, and claims it is not a MEWA because the plan or other arrangement claims the exception relating to plans established or maintained pursuant to one or more collective bargaining agreements. The administrator of an ECE must file this report each year for the first three years after the ECE is "originated."

Form CMS-10198 Disclosure to CMS (Form CMS)

Overview	
Recipient:	CMS
Filer:	Plan sponsors
Frequency:	Annually, completed no later than 60 days from the beginning of a plan year, within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status
Mode of Delivery:	Electronic
Reporting Threshold:	Any employer whose policies include prescription drug coverage for Medicare Part D eligible individuals
Public Access:	Not available

Funding Mechanism Information:

A group health plan's funding mechanism has no bearing on whether or not a plan sponsor has a Form CMS filing requirement.

Highlights:

- All types of plans that include prescription drug coverage must file Form CMS. Employer-sponsored group health plans are identified.
- Form CMS asks entity/plan sponsor to provide entity name, Federal Employer Identification Number (FEIN), address, coverage type, number of prescription drug options offered under coverage, and whether options offered are creditable, non-creditable, or both. Form CMS also asks for an estimated number of individuals expected to be covered under the plan and under a group retiree health plan. It also requires plan sponsors to indicate when they distributed the required disclosure to Part D eligible individuals of creditable or non-creditable coverage. If a plan sponsor has a change in creditable coverage status of previously disclosed information to CMS it must indicate this in the Form CMS.

Additional Information:

Beginning in 2006, entities that provide prescription drug coverage to Medicare Part D eligible individuals must disclose whether the coverage is "creditable prescription drug coverage." This disclosure is required whether the entity's coverage is primary or secondary to Medicare. Form CMS is used to report the creditable coverage status of a plan sponsor's prescription drug plan. Form CMS should be completed annually no later than 60 days from the beginning of a plan year, within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status. Form CMS is completed online and cannot be appended. If an entity does not have access to the Internet, then a hard copy can be faxed to CMS.

Reference:

- CMS website (https://www.cms.gov/CreditableCoverage/ArchivesCC/list.asp#TopOfPage)

Form 8928 Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code (Form 8928)

Overview	
Recipient:	IRS
Filer:	Group health plan or employer
Frequency:	Annually, as needed
Mode of Delivery:	U.S. Mail
Reporting Threshold:	Group health plans reporting certain failures by the plan or employer
Public Access:	Not available

Funding Mechanism Information:

A group health plan's funding mechanism has no bearing on whether or not an employer or group health plan must file Form 8928.

Highlights:

- Name of filer, and name and address of plan sponsor are indicated.

Additional Information:

Effective January 1, 2010, group health plans may be subject to excise taxes for failure to comply with certain requirements related to administration of health benefits, including COBRA and HIPAA portability and nondiscrimination, as well as other federal group health plan mandates. Group health plans must self-report compliance failures and pay related excise taxes. The amount of the tax is generally $100 per individual for each day of noncompliance.

References:

- 2011 Instructions for Form 8928 (http://www.irs.gov/pub/irs-pdf/i8928.pdf)
- Form 8928 (http://www.irs.gov/pub/irs-pdf/f8928.pdf)

Form W-2, Wage and Tax Statement (Form W-2)

Overview	
Recipient:	SSA
Filer:	Plan sponsors
Frequency:	Annually, by January 31 to employees, by February 28 to SSA (extension to March 31 if e-filing)
Mode of Delivery:	Electronic, U.S. Mail
Reporting Threshold:	All employer-sponsored group health plans
Public Access:	Not available

Funding Mechanism Information:

The reporting requirement applies to all employers that provide applicable employer-sponsored healthcare coverage.

Highlights:

- Internal Revenue Code Section 6051(a)(14) provides that employers report to employees the group health plan coverage costs that are excludable from employee gross income.
- Pursuant to IRS Notice 2010-69 an employer does not have to report this information for Forms W-2 issued for 2011. Reporting requirement begins with the 2012 calendar year.

Additional Information:

As part of the Patient Protection and Affordable Care Act of 2010 (ACA), the aggregate cost of applicable employer-sponsored coverage must be reported on Form W-2. Applicable employer-sponsored coverage means, with respect to any employee, coverage under any group health plan made available to the employee by an employer that is excludable from the employee's gross income, or would be so excludable if it were employer-provided coverage.[3] Reporting to employees is for information only, to inform them of the cost of healthcare coverage. IRS Notice 2012-9, providing interim guidance on information reporting to employees of the cost of their employer-sponsored group health plan coverage, will be published in Internal Revenue Bulletin 2012-4.

References:

- IRS Notice 2012-9 (http://www.irs.gov/pub/irs-drop/n-12-09.pdf)
- IRS Notice 2010-69 (http://www.irs.gov/pub/irs-drop/n-2010-69.pdf)

[3] Applicable employer-sponsored coverage does not include any coverage for long-term care, any coverage described in IRC Section 9832(c)(1) other than coverage for on-site medical clinics, any coverage under a separate policy providing benefits mainly for the treatment of the mouth or for treatment of the eye, and any coverage described in IRC Section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction is not allowable.

Form 990 Return of Organization Exempt from Income Tax (Form 990)

Overview	
Recipient:	IRS
Filer:	Plan administrator
Frequency:	Annually, by 15th day of the 5th month following the end of the organization's taxable year
Mode of Delivery:	Electronic, U.S. Mail
Reporting Threshold:	Funded welfare benefit plans (Voluntary Employee Beneficiary Association) (VEBA Trust)
Public Access:	Three most recent years Forms 990 must be made available to public

Funding Mechanism Information:

All VEBA Trusts funded by the employer, with a few small exceptions, are required to file Form 990.[4]

Highlights:

- Name and form of organization, amount of contributions from employer or sponsoring organization are indicated.

Additional Information:

A VEBA Trust is a vehicle through which an employer may fund self-insured welfare benefits provided to employees and their beneficiaries. In order to reduce or eliminate income taxes at the trust level, such plans typically apply for tax-exempt status. The IRS requires such VEBA Trusts to submit Form 990 as a tax-exempt trust to provide the IRS with information about the VEBA Trust's income, contributions, and expenses.

References:

- 2011 Instructions for Form 990 (http://www.irs.gov/pub/irs-pdf/i990.pdf)

[4] A Form 990 must generally be filed for organizations that are exempt from income tax under IRC Section 501(2) if they have either gross receipts greater than or equal to $200,000 or total assets greater than or equal to $500,000 at the end of the tax year. Other organizations may be eligible to file a Form 990-EZ or Form 990-N. Certain organizations such as churches, certain government organizations, and political organizations may be exempt from filing. See the instructions to the Form 990 for more detail.

Early Retiree Reinsurance Program (ERRP) Application

Overview	
Recipient:	CMS
Filer:	Plan sponsors
Frequency:	One time, any time between June 29, 2010 and May 5, 2011
Mode of Delivery:	U.S. Mail
Reporting Threshold:	All employer-sponsored group health plans
Public Access:	Not available

Funding Mechanism Information:

Plans are identified on the application as self-insured, externally insured, or both.

Highlights:

- Question Part II, section 1c) identifies self-insured plans.
- Plan information including name, benefit options, and administrator is indicated.
- Attachment for unique/additional benefit options also identifying those option types as self-funded.

Additional Information:

As of June 29, 2010 employers with self-insured and externally insured plans can apply for ERRP. ERRP provides reimbursement to employer and union sponsors of participating employment-based healthcare plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses, and dependents. The ACA provides $5 billion for this temporary program, reimbursing for medical claims dating back to June 1, 2010.

CMS ceased accepting ERRP applications on May 5, 2011. Currently, ERRP has received requests for reimbursement exceeding the $5 billion in funding. Those requests that exceed the funding allotment are being held in order of receipt, pending availability of the funds. For each plan year a reimbursement is made, a plan sponsor must submit a full-replacement Claim List and an associated reimbursement request by March 30, 2012. CMS will initiate action to recoup funds for failure to meet these filing requirements, to be used to pay those claims currently being held.

References:

- ERRP.gov (http://www.errp.gov/)
- CMS ERRP website (http://cciio.cms.gov/programs/errp/index.html)
- Regulations & Guidance (http://cciio.cms.gov/resources/regulations/index.html#errp)

STATE REGULATORY DATA SOURCES

This section compiles state government reporting requirements that may identify self-insured group health plans. A review of all 50 states' reporting requirements revealed 6 states with reporting requirements that may identify self-insured health plans: Hawaii, Idaho, Massachusetts, Michigan, New York, and Virginia.

Hawaii—Form HC-61 Health Care Application for Self-Insurance Authorization (Form HC-61)

Overview	
Recipient:	Director of the Department of Labor and Industrial Relations (DLIR)
Filer:	Employer
Frequency:	One time, at time employer is seeking approval as self-insurer
Mode of Delivery:	U.S. Mail, in person
Reporting Threshold:	Any employer seeking to provide self-insured health coverage
Public Access:	Not available

Funding Mechanism Information:

An employer can be identified as a self-insured plan sponsor by virtue of filing this form.

Highlights:

- A copy of the applicant's self-insured healthcare plan should be attached.
- General information including the applicant's name and business information, and the plan administrator name and function are provided.
- The total number of employees in Hawaii to be covered under the healthcare plan is indicated.
- A copy of the stop-loss insurance policy should be attached, as applicable.

Additional Information:

As a self-insurer, an employer must show proof of financial solvency and ability to pay benefits by providing the DLIR a copy of the most recent audited financial statements along with the Form HC-61. Upon approval, audited financial statements must be filed annually for continued approval of the self-insured plans.

The employer must agree to make monthly deposits of at least $150 per member to a medical expense reimbursement account.

References:

- Form HC-61 (http://hawaii.gov/labor/forms/DCD-HC-61_herman.pdf)
- DLIR Prepaid Healthcare FAQ's (Section III) (http://hawaii.gov/labor/dcd/dcd-links/frequently-asked-questions)

Hawaii—Form HC-4 Health Care Coverage Questionnaire Form (Form HC-4)

Overview	
Recipient:	DLIR, Disability Compensation Division
Filer:	Employer
Frequency:	One time, at time employer is seeking approval as self-insurer
Mode of Delivery:	U.S. Mail, in person
Reporting Threshold:	Any employer seeking to provide self-insured health coverage
Public Access:	Not available

Funding Mechanism Information:

The form asks employers to identify what type of plan they are sponsoring, including if coverage is provided by an insurance company or through self-insurance.

Highlights:

- Indicates type(s) of plan(s) already in place, including information about plan administrator, plan name, group number, effective date, class and number of employees covered.
- If a plan is self-insured, a copy of the plan and employer's audited financial statements must be attached to the Form HC-4.

Additional Information:

Form HC-4 should be filed in conjunction with Form HC-61 for initial approval to adopt a self-insured healthcare plan.

References:

- Form HC-4 Health Care Coverage Questionnaire (http://hawaii.gov/labor/forms/DCD-HC-4_herman.pdf)
- DLIR Prepaid Healthcare FAQ's (Section III) (http://hawaii.gov/labor/dcd/dcd-links/frequently-asked-questions)

Idaho—Information Statement for Self-Funded Employee Health Care Plan

Overview	
Recipient:	Idaho Department of Insurance (ID DOI)
Filer:	Employer
Frequency:	One time, at time employer is seeking approval as a self-insurer
Mode of Delivery:	U.S. Mail
Reporting Threshold:	Any employer seeking to provide self-insured health coverage
Public Access:	Not available

Funding Mechanism Information:

By virtue of submission of the statement, an employer can be identified as a self-insured plan sponsor.

Highlights:

- Name and physical address of self-insured plan and plan administrator.

Additional Information:

The Information Statement is filed in conjunction with the Application for Registration of Self-Funded Employee Health Care Plan by any employer seeking to operate a self-funded healthcare plan on behalf of employees in the state of Idaho.

References:

- Information Statement (http://www.doi.idaho.gov/Company/selffund_information.pdf)
- Self-Funded Health Care Plans Statement of Back Taxes Due (http://www.doi.idaho.gov/company/tbsfhp.pdf)
- Self-Funded Employee Health Care Plans Registration Requirements (http://www.doi.idaho.gov/company/selffund_req.aspx)

Idaho—Application for Registration of Self-Funded Employee Health Care Plan

Overview	
Recipient:	Director of Insurance, ID DOI
Filer:	Employer
Frequency:	One time, at time employer is seeking approval as a self-insurer
Mode of Delivery:	U.S. Mail
Reporting Threshold:	Any employer seeking to provide self-insured health coverage
Public Access:	Not available

Funding Mechanism Information:

By virtue of submission of the application, an employer can be identified as a self-insured plan sponsor.

Highlights:

- Employer name and description of the plan are provided.
- Question 21 asks if an employer asserts that the plan's program of coverage is qualified under ERISA (copy of qualification notice from DOL required if covered).
- Completed chart highlighting benefits provided, by whom contributions are made (employer or employee), and approximate number of beneficiaries covered.
- An Information Statement, a copy of written statement of benefits, trust agreement, proof of bond, audited financial statements, and a copy of any study made of the proposed self-funded plan by a consultant for the information of the employer or employees attached.

Additional Information:

Any employer seeking approval to operate a self-funded healthcare plan on behalf of employees must submit this registration form in conjunction with a series of other forms and documentation for review and approval by the ID DOI. This filing is made only once at plan initiation. Subsequently, employers are required to provide annual audited financial statements, along with any other documentation requested to verify that they are financially sound for purposes of benefits payments.

Reference:

- Application for Registration of Self-Funded Employee Health Care Plan (http://www.doi.idaho.gov/Company/selffund_app.pdf)

Massachusetts—Form MA 1099-HC Commissioner's Report (Form MA 1099-HC)

Overview	
Recipient:	Massachusetts Department of Revenue (MA DOR)
Filer:	Plan sponsors with 11+ full-time equivalent (FTE) employees residing in Massachusetts
Frequency:	Annually, by the last day of February following the close of the calendar year
Mode of Delivery:	Electronic
Reporting Threshold:	All employer-sponsored group health plans
Public Access:	Not available

Funding Mechanism Information:

If the MA DOR receives a report directly from an employer, such employers can typically be identified as sponsors of self-insured health plans.

Highlights:

- Name of the insurance company providing coverage and the name of the plan administrator, as applicable.
- Subscriber information, including all employees issued Form MA 1099-HC.

Additional Information:

Beginning in 2009, all types of group health plans are required by the Commissioner at the MA DOR to provide Form MA 1099-HC to eligible employees and file a report of consolidated information with the MA DOR. Typically, the plan administrator will issue the forms and report on behalf of fully insured plans and self-insured plans that have a third party administrator. If the employer is self-insured and prepares and distributes Form MA 1099-HC to employees, the employer must also file the Commissioner's Report.

The Form 1099-HC is provided by all employers with Massachusetts resident employees to all health plan participants to verify they received minimum creditable coverage.

References:

- Form MA 1099-HC (http://www.mass.gov/dor/docs/dor/health-care/2009/1099-hc-09.pdf)
- Health Care: Frequently Asked Questions for Employers (http://www.mass.gov/dor/businesses/current-tax-info/health-care-frequently-asked-questions-for.html)

Massachusetts—Health Insurance Responsibility Disclosure (HIRD)

Overview	
Recipient:	Massachusetts Division of Health Care Finance and Policy (DHCFP)
Filer:	Employers with 11+ FTE employees residing in Massachusetts
Frequency:	Quarterly, by the 15th day of February, May, August, and November
Mode of Delivery:	Electronic
Reporting Threshold:	All plans
Public Access:	Not available

Funding Mechanism Information:

Neither the filing of the HIRD nor information included on the form indicates how a plan is funded.

Highlights:

- Benefit design and coverage trend information for employer-sponsored health insurance coverage in Massachusetts, including costs of health insurance premiums, waiting periods, benefit design, dollar amount of the employee-paid portion of the monthly premium, and employer's group health plan contribution percentage.

Additional Information:

Effective on July 1, 2007, employers are now required to submit the HIRD in conjunction with the Fair Share Contribution Report. The HIRD collects information about employer compliance with the state requirement to adopt and maintain a Section 125 Cafeteria Plan.

FTEs are determined by payroll hours. One FTE is equal to 2,000 payroll hours. Since part-time employees are also counted, an employer may reach 11 FTEs without having 11 full-time employees.

References:

- Health Insurance Responsibility Disclosure (HIRD): Employer HIRD Information (http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/employer-info/health-insurance-responsibility-disclosure-hird.html)
- Employee Health Insurance Responsibility Disclosure Form (http://www.mass.gov/eohhs/docs/dhcfp/g/hcr/employee-hird.pdf)

Massachusetts—Fair Share Contribution (FSC) Report

Overview	
Recipient:	DHCFP
Filer:	Employers with 11+ FTE employees residing in Massachusetts
Frequency:	Quarterly, by the 15th day of February, May, August, and November
Mode of Delivery:	Electronic
Reporting Threshold:	All employer-sponsored health plans
Public Access:	Not available

Funding Mechanism Information:

Neither the filing of the FSC Report nor information included on the FSC Report indicates how a plan is funded.

Additional Information:

The FSC Report is filed so that the DHCFP can determine if an employer has a liability for payment of a per-employee FSC. Employers that do not meet contribution thresholds for their employee health insurance must make payments to the Commonwealth Care Fund through the Department of Unemployment Assistance.

References:

- Fair Share Contributions FAQ (https://fsc.detma.org/Help/Help.aspx)
- Filing Instructions (https://fsc.detma.org/Help/FileInstructions.htm)

Massachusetts—Student Health Program (SHP) Benefit Survey

Overview	
Recipient:	DHCFP
Filer:	Massachusetts higher education institutions
Frequency:	Annually, by November 1
Mode of Delivery:	Electronic
Reporting Threshold:	All school-sponsored health plans
Public Access:	Student Health Program Annual Report published by DHCFP

Funding Mechanism Information:

The survey requires schools to indicate if they are self-insured, but the filing requirement is not limited to self-insured plans.

Highlights:

- Evidence of coverage or a description of the benefits, benefit levels, exclusions, limitations, and other important terms and conditions of their school's SHP.

Additional Information:

Since 1989, Massachusetts law has required every full-time and part-time student enrolled in an institution of higher learning in Massachusetts to participate in a student health program or a health benefit plan with comparable coverage. Institutions are required to submit a benefits survey each year. Along with the survey, schools are also required to submit information each year regarding fall enrollment and performance metrics.

Based on information submitted by schools on the surveys, the DHCFP publishes an annual report summarizing information collected through the SHP Benefit Survey. This report indicates which Massachusetts schools had insurance carriers underwrite their health plan and which schools self-insured their student health programs.

References:

- Student Health Insurance Filing Information (http://www.mass.gov/eohhs/consumer/basic-needs/essentials/insurance/student-health-insurance.html#Filing_Information)
- Student Health Program Academic Year 2009-2010 Annual Report (http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/shp-2009-2010-report.pdf)

Michigan—Form 4926, Electronic Funds Transfer Application – Health Insurance Claims Assessment (Form 4926)

Overview	
Recipient:	Michigan Department of Treasury (MI DOT)
Filer:	Insurer, third party administrator (TPA), employer
Frequency:	Quarterly, by April 30, July 30, October 30, and January 30
Mode of Delivery:	Electronic
Reporting Threshold:	Any employer sponsoring a group health plan
Public Access:	Not available

Funding Mechanism Information:

Form 4926 does not provide information related to how a plan is funded. However, if a payment is submitted directly by an employer, then the plan is more likely to be a self-insured health plan. All other payments are submitted by insurers or TPAs.

Highlights:

- Beginning January 1, 2012, certain TPAs, carriers, and self-insured entities are required to pay an assessment on certain paid healthcare claims for Michigan residents for health-related services performed in Michigan.
- Beginning in 2013, Form 4931, Annual Return for Health Insurance Claims Assessment (HICA) will be due to MI DOT annually.

Additional Information:

The “paid claims” tax will be collected directly from insurers, sponsors, and TPAs.

Group health plans required to pay HICA must register with the MI DOT by completing and submitting Form 4926.

References:

- Michigan Department of Treasury website (http://www.michigan.gov/taxes/0,4676,7-238-43519-264498--,00.html)
- Health Insurance Claims Assessment (HICA) overview (http://www.michigan.gov/documents/taxes/HICA_Info_Seminars_370417_7.ppt)

Michigan—Form 4930, Quarterly Worksheet for Health Insurance Claims Assessment (Form 4930)

Overview	
Recipient:	Retained by preparer; file copy subject to audit by the MI DOT
Filer:	Prepared by insurer, TPA, employer
Frequency:	Quarterly, by April 30, July 30, October 30, and January 30
Mode of Delivery:	N/A
Reporting Threshold:	Any organization sponsoring a group health plan
Public Access:	Not available

Funding Mechanism Information:

Form 4930 does not provide information related to how a plan is funded. However, if it is prepared and retained by an employer, then the plan is more likely to be a self-insured health plan.

Highlights:

- Form 4930 identifies organization type as TPA or carrier, gross paid claims during assessment period, and net health insurance claims paid subject to assessment.[5]

Additional Information:

Form 4930 is used by TPAs and carriers to calculate the claims assessment on certain paid healthcare claims. The worksheet should be retained for four years after the HICA due date.

References:

- 2011 Form 4930 (http://www.michigan.gov/documents/taxes/4930_372265_7.pdf)

[5] Michigan's definition of carrier includes an employer that established or maintains a group health plan, including entities that self-insure for healthcare.

Michigan—Form 4931, Annual Return for Health Insurance Claims Assessment (Form 4931)

Overview	
Recipient:	MI DOT
Filer:	Prepared by insurer, TPA, employer
Frequency:	Annually, by February 28
Mode of Delivery:	Electronic
Reporting Threshold:	Any organization sponsoring a group health plan
Public Access:	Not available

Funding Mechanism Information:

This form does not provide information related to how a plan is funded. However, if it is prepared and submitted by an employer, then the plan is more likely to be a self-insured health plan.

Highlights:

- First Form 4931 due February 28, 2013.
- Form 4931 to be released on MI DOT website in 2012.

Additional Information:

The Form 4931 will generally follow the format of the HICA quarterly worksheet. This return is a year-end reconciliation of the quarterly payments as documented on Form 4926.

References:

- MI DOT website business tax page (http://www.michigan.gov/taxes/0,4676,7-238-43519-264498--,00.html)

New York—New Hire Reporting Requirement

Overview	
Recipient:	New York State Department of Taxation and Finance (Department of Taxation)
Filer:	All employers
Frequency:	Within 20 days of new hire date; if submitting electronically, 2 monthly reports are due between 12 and 16 days apart
Mode of Delivery:	Electronic or U.S. Mail
Reporting Threshold:	All plans
Public Access:	Not available

Funding Mechanism Information:

The group health plan funding mechanism has no bearing on whether or not an employer has a filing requirement.

Additional Information:

Effective July 15, 2011, pursuant to the Low Income Support Obligation and Performance Improvement Act, any employer with employees working in New York (not just New York domiciled companies) must report certain dependent health coverage information to the state on a quarterly basis, as well as when an employee is hired or rehired.

Employers must report the employee's name, address, Social Security number, the availability of dependent health insurance, and the date the employee is eligible for the dependent health insurance. Employers must report this information within 20 calendar days after the employee's hire date, which is the first date worked.

This new information must be reported on Form IT-2104 (Employee's Withholding Allowance Certificate) or Form IT-2104-E (Certificate of Exemption From Withholding), or by submitting the information electronically at www.nynewhire.com.

In addition, as part of the Form NYS-45, Quarterly Combined Withholding, Wage Reporting, And Unemployment Insurance Return, the employer must now disclose whether or not such employer made dependent health insurance coverage available to employees through the employer-sponsored health plan.

References

- New Hire Reporting Requirement (http://www.tax.ny.gov/bus/wt/newhire.htm)

Virginia—Form 216-H Self-Insured Plan Opt-In to Virginia External Review Process (Form 216-H)

Overview	
Recipient:	State Corporation Commission Bureau of Insurance
Filer:	Employer
Frequency:	As needed, to opt-in to the Virginia external review process for health insurance claims
Mode of Delivery:	Facsimile
Reporting Threshold:	Any self-insured plan seeking to opt-in to Virginia external review process
Public Access:	Not available

Funding Mechanism Information:

By virtue of submission of Form 216-H, an employer can be identified as a self-insured plan sponsor.

Highlights:

- Form 216-H is only applicable to self-insured group health plans.
- Name and address of plan, administrator, and TPA (as applicable) identified.

Additional Information:

Self-insured plans may opt into the Virginia External Review Process of adverse claims determinations by completing Form 216-H. This opt-in must be complete before any requests for external review are submitted. If an adverse determination for healthcare services that is a covered benefit has been reviewed by the designated review entity and determined not to meet the requirements for coverage, then a covered participant may request review by an external independent review board. The self-insured plan must submit the Opt-in Form along with requested documentation related to the adverse determination.

References:

- Independent External Review information (http://www.scc.virginia.gov/boi/omb/ext_review.aspx)
- Form 216-H (http://www.scc.virginia.gov/boi/omb/files/216h.pdf)

MUNICIPAL REGULATORY DATA SOURCE (SAMPLE)

Although California did not have any relevant state-level reporting requirements, San Francisco's Health Care Security Ordinance Annual Reporting Form demonstrates a relevant municipal-level regulatory data source.

San Francisco—Health Care Security Ordinance (HCSO) Annual Reporting Form

Overview	
Recipient:	Office of Labor Standards Enforcement (OLSE)
Filer:	Employer
Frequency:	Annually, by April 30
Mode of Delivery:	Electronic
Reporting Threshold:	All employers engaging in business in San Francisco with 20+ employees
Public Access:	Analysis of the San Francisco Health Care Security Ordinance (HCSO) Annual Reporting Forms is available on the OLSE website (http://sfgsa.org/index.aspx?page=391)

Funding Mechanism Information:

Neither the filing of the HCSO Annual Reporting Form nor information included on the HCSO Annual Reporting Form indicates how a plan is funded.

Highlights:

- Part C of the HCSO Annual Reporting Form asks employers providing fully funded and self-insured group health benefits to identify total number of employees for which health insurance premiums were paid and dollar amount per quarter.
- Exception for employers providing self-insured group health benefits: if average expenditures under that plan per covered employee for the preceding year equal or exceed the employer's healthcare expenditure rate for the current year, then the employer is deemed to satisfy the healthcare expenditure requirement and is not required to make quarterly expenditures to satisfy the HCSO.

Additional Information:

Effective January 9, 2008, HCSO requires covered employers to make a minimum healthcare expenditure based on the number of covered employees. The amount of the minimum healthcare expenditure is published annually. Employers may satisfy this obligation by making payments on behalf of their covered employees to the city's healthcare services program, Healthy San Francisco. Alternatively, employers may purchase health insurance coverage for their covered employees, or provide self-insured health benefits. Required healthcare expenditures must be made regularly, no later than 30 days after the end of the preceding quarter, subject to exception for certain self-insured coverage (see above). Covered employers must provide information to the city regarding the employer's healthcare expenditures on an annual basis. Effective January 1, 2012, businesses with 20 or more employees must post a notice indicating the minimum amounts that employers are required to spend.

References:

- Healthy San Francisco Health Access Program (http://www.healthysanfrancisco.org/employers/city_option/)
- Health Care Security Ordinance (http://sfgsa.org/index.aspx?page=418)
- 2010 Annual Reporting Form (https://etaxstatement.sfgov.org/arf2010.pdf)
- Analysis of the Health Care Security Ordinance 2010 Annual Reporting Forms (http://sfgsa.org/modules/ShowDocument.aspx?documentid=7894)

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