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# Employee Benefits Compliance Checklist for Small Employers

Federal law imposes numerous requirements on the group health coverage that employers decide to provide to their employees. Many federal compliance laws apply to all group health plans, regardless of the size of the sponsoring employer. However, there are some compliance exceptions for group health coverage provided by small employers. For this purpose, a small employer is one with **50 or fewer employees**.

This Legislative Brief provides a compliance checklist for employee benefit laws applicable to small employers, and also indicates when a compliance law does not apply to a small employer's health coverage.

**COMPLIANCE CHECKLIST**

☐ ***Health Care Reform – Health Coverage Changes***

*Applicability* – The health care reform law applies to health plans and health insurance issuers, with narrow exceptions for certain types of plans (for example, retiree medical plans). **There is not an exception for small employers.**

*Summary* - The health care reform law makes many changes to health coverage requirements, such as extending coverage for young adults up to age 26, prohibiting rescissions of health coverage (except in cases of fraud or intentional misrepresentation), eliminating preexisting condition exclusions for children under the age of 19 (applicable to adults in 2014), prohibiting lifetime limits on essential health benefits and restricting annual limits, and requiring coverage for preventive care without cost sharing. The law has staggered effective dates. Many of its changes are effective now, and others will become effective in future years.

*Notices/Disclosure* – The health care reform law created a number of notice and disclosure obligations for group health plans, such as:

- Statement of Grandfathered Status – Plan administrator or issuer was required to provide the first statement before the first plan year beginning on or after Sept. 23, 2010. The statement must continue to be provided on a periodic basis with participant materials describing plan benefits. This requirement only applies to grandfathered plans.
- Notice of Rescission – Plan administrator or issuer must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.
- Notice of Patient Protections and Selection of Providers – Plan administrator or issuer must provide a notice of patient protections/selection of providers whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. These provisions relate to the choice of a health care professional and benefits for emergency services. The first notice should have been provided no later than the first day of the plan year beginning on or after Sept. 23, 2010. This requirement does not apply to grandfathered plans.
- Uniform Summary of Benefits and Coverage – Plan administrator or issuer must provide the uniform summary of benefits and coverage to participants and beneficiaries at certain times, including upon application for coverage and at renewal. Plan administrators and issuers must also provide a 60-day advance notice of material changes to the summary that take place mid-plan year. Plans and issuers must begin providing the summary to participants and beneficiaries who enroll or re-enroll in plan

coverage during an open enrollment period beginning with the first open enrollment period that starts on or after Sept. 23, 2012. For participants and beneficiaries who enroll in plan coverage other than through an open enrollment period, the summary must be provided beginning with the first plan year that starts on or after Sept. 23, 2012.

- Waiver of Annual Limit Requirement – Plans must provide an annual notice to eligible participants regarding the plan's annual limit waiver as part of any plan or policy documents regarding coverage that are provided to enrollees, such as the SPD. This requirement only applies to plans that have received an annual limit waiver.

More information on the health care reform law, including model notices, is available from the Department of Health and Human Services (HHS) at http://cciio.cms.gov/index.html.

☐ ***Health Care Reform – W-2 Reporting***

*Applicability* – The Form W-2 reporting obligation applies to employers sponsoring group health plans. **Small employers (those that file fewer than 250 W-2 Forms) are exempt until further guidance is provided.** Other employers must comply with this reporting requirement beginning with the 2012 tax year (for W-2 Forms that are issued in January 2013).

*Summary* – Employers must disclose the aggregate cost of employer-sponsored coverage provided to employees on the employees' W-2 Forms. The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. The reporting does not mean that the cost of the coverage is taxable to employees.

*Notices/Disclosure* – Form W-2

☐ ***Health Care Reform – Employer Penalties***

*Applicability:* Effective in 2014, the health care reform law imposes penalties on employers with **at least 50 full-time equivalent employees** if they do not offer health coverage to their employees or if they offer health coverage to their employees that is not "affordable" or does not provide "minimum value" and certain other requirements are met.

*Summary:* Beginning in 2014, large employers (those with at least 50 full-time equivalent employees) that do not offer health coverage will be subject to a penalty if any of their full-time employees receives a premium credit toward a health plan offered through a state-based insurance exchange. In 2014, the monthly penalty will be equal to the number of full-time employees (minus 30), multiplied by 1/12 of $2,000 for any applicable month.

Large employers that do offer coverage may be subject to penalties if the coverage is not "affordable" or does not provide "minimum value" and at least one full-time employee obtains a premium credit in an insurance exchange. In 2014, the monthly penalty for each full-time employee who receives an exchange credit will be 1/12 of $3,000 for any applicable month. However, the total penalty for an employer would be limited to the total number of full-time employees (minus 30), multiplied by 1/12 of $2,000 for any applicable month.

*Notices/Disclosure* – None specified at this time

☐ ***Health Care Reform – Employee Notice of Exchange***

*Applicability* – The employee notice of Exchange requirement applies to all employers who are subject to the Fair Labor Standards Act (FLSA).

*Summary* – Employers will be required to provide all new hires and current employees with a written notice about the health care reform law's health insurance exchanges (Exchanges). The health care reform law required employers to provide the Exchange notice by March 1, 2013, but the Department of Labor (DOL)

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delayed this deadline. On May 8, 2013, the DOL set a compliance deadline for providing the Exchange notices that matches up with the start of the first open enrollment period under the Exchanges, as follows:

- New Hires – Employers must provide the notice to each new employee at the time of hiring beginning **Oct. 1, 2013**. For 2014, the DOL will consider a notice to be provided at the time of hiring if the notice is provided within **14 days** of an employee's start date.
- Current Employees – With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice no later than **Oct. 1, 2013**.

In general, the notice must:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- Explain how employees may be eligible for a premium tax credit or a cost-sharing reduction if the employer's plan does not meet certain requirements;
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes; and
- Include contact information for the Exchange and an explanation of appeal rights.

*Notices/Disclosure* - The DOL provided the following model Exchange notices:

- A model Exchange notice for employers who do not offer a health plan; and
- A model Exchange notice for employers who offer a health plan to some or all employees.

Employers may use one of these models, as applicable, or a modified version, provided the notice meets the content requirements described above. The notice may be provided by first-class mail, or may be provided electronically if the requirements of the DOL's electronic disclosure safe harbor are met. Federal agencies plan to issue more specific guidance on this notice requirement.

☐ ***COBRA***

*Applicability* – COBRA applies to employers that had **20 or more employees** on more than 50 percent of the typical business days during the previous calendar year.

*Summary* - COBRA requires employers to provide eligible employees and their dependents who would otherwise lose group health coverage as a result of a qualifying event with an opportunity to continue group health coverage.

*Notices/Disclosure* – There are a number of notice/disclosure requirements under COBRA, such as the following:

- Initial/General COBRA Notice – Plan administrator must generally provide an explanation of COBRA coverage and rights within 90 days of when group health plan coverage begins.
- Notice to Plan Administrator – Employer must notify the plan administrator of certain qualifying events, such as an employee's termination or reduction in hours, an employee's death, an employee's Medicare entitlement and the employer's bankruptcy. The notice must be provided within 30 days of the qualifying event or the date coverage would be lost as a result of the qualifying event, whichever is later.
- COBRA Election Notice – Plan administrator must generally provide the COBRA election notice within 14 days after being notified of the qualifying event (or 44 days after the qualifying event if the employer is the plan administrator).

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- Notice of Unavailability of COBRA – If an individual is not eligible for COBRA, the plan administrator must generally provide a notice of COBRA unavailability within 14 days after being notified of the qualifying event (or 44 days after the qualifying event if the employer is the plan administrator).
- Notice of Early Termination of COBRA – Plan administrator must provide an early termination notice as soon as practicable following the determination that COBRA coverage will terminate earlier than the end of the maximum coverage period.
- Notice of Insufficient Payment – Plan administrator must notify a qualified beneficiary that the COBRA payment was not significantly less than the correct amount before coverage is terminated for nonpayment.
- Premium Change Notice – Plan administrator should provide a notice of premium increase at least one month prior to the effective date.

Model COBRA notices are available from the Department of Labor (DOL) at: www.dol.gov/ebsa/COBRA.html.

☐ ***ERISA – General Requirements***

*Applicability* – ERISA applies to employee welfare benefit plans, including group health plans, unless specifically exempted. Church and government plans are not subject to ERISA. **There is not an exception for small employers**.

*Summary* – ERISA imposes a variety of compliance obligations on the sponsors and administrators of group health plans. For example, ERISA establishes strict fiduciary duty standards for individuals that operate and manage employee benefit plans and requires that plans create and follow claims and appeals procedures.

*Notices/Disclosures* – ERISA requires plan administrators to provide the following notices/disclosures:

- SPD – Plan administrator must automatically provide an SPD to participants within 90 days of becoming covered by the plan. An updated SPD must be provided at least every five years if changes have been made to the information contained in the SPD. Otherwise, an updated SPD must be provided at least every 10 years.
- Summary of Material Modifications (SMM) – Plan administrator must provide an SMM automatically to participants within 210 days after the end of the plan year in which the change was adopted. If benefits or services are materially reduced, participants generally must be provided with the SMM within 60 days from adoption.
- Plan Documents – Plan administrator must provide copies of plan documents no later than 30 days after a written request.

☐ ***ERISA – Form 5500 Requirements***

*Applicability* – The Form 5500 requirement applies to plan administrators of ERISA plans, unless an exception applies. **Small health plans (those with fewer than 100 participants) that are fully insured, unfunded, or a combination of fully insured and unfunded, are exempt from the Form 5500 filing requirement.**

*Summary* – The Form 5500 is used to ensure that employee benefit plans are operated and managed according to ERISA's requirements. The filing requirements vary according to the type of ERISA plan. Unless an extension applies, the Form 5500 must be filed by the last day of the seventh month following the end of the plan year (that is, July 31 of the following year for calendar year plans).

*Notices/Disclosure* – Form 5500

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☐ ***ERISA – Summary Annual Report (SAR)***

*Applicability* – Plan administrators of ERISA plans are subject to the SAR requirement, unless an exception applies. **Plans that are exempt from the annual Form 5500 filing requirement are not required to provide the SAR.** Large, completely unfunded health plans are also exempt from the SAR requirement. However, large insured health plans must provide the SAR.

*Summary* – The SAR is a narrative summary of the Form 5500 and includes a statement of the right to receive a copy of the plan's annual report. The SAR must generally be provided within nine months after the end of the plan year. If the deadline for filing the Form 5500 was extended, the SAR must be provided within two months after the end of the extension period.

*Notices/Disclosure* - SAR

☐ ***Family and Medical Leave Act (FMLA)***

*Applicability* - The FMLA applies to private sector employers **with 50 or more employees in 20 or more workweeks in the current or preceding calendar year**, as well as all public agencies and all public and private elementary and secondary schools.

*Summary* - The FMLA provides eligible employees with job-protected leave for certain family and medical reasons. An employer must maintain group health coverage during the FMLA leave at the level and under the conditions that coverage would have been provided if the employee had not taken leave.

*Notices/Disclosure* – The FMLA requires employers to provide the following notices/disclosures:

- General Notice – Covered employers must prominently post a general FMLA notice where it can be readily seen by employees and applicants for employment. If the employer has any FMLA-eligible employees, it must also include the general notice in the employee handbook or other written employee guidance or distribute a copy of the notice to each employee upon hiring.
- Eligibility/Rights and Responsibilities Notice – Written guidance must be provided to an employee when he or she notifies the employer of the need for FMLA leave. The employer must detail the specific expectations and obligations of the employee, and explain the consequences for failing to meet these obligations.
- Designation Notice – After the employer has sufficient information, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave.

Model forms from the DOL are available at: www.dol.gov/whd/fmla/index.htm.

☐ ***Genetic Information Nondiscrimination Act (GINA)***

*Applicability* – GINA applies to group health plans and health insurance issuers. **There is not an exception for small employers.**

*Summary* - GINA prohibits health plans and health insurance issuers from discriminating based on genetic information. GINA generally prohibits group health plans and health insurance issuers from: (1) adjusting group premium or contribution amounts on the basis of genetic information; (2) requesting or requiring an individual or an individual's family members to undergo a genetic test; and (3) collecting genetic information, either for underwriting purposes or prior to or in connection with enrollment.

*Notices/Disclosure* – No general notice/disclosure requirements

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1/12; BK 5/13

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☐ ***HIPAA Portability***

*Applicability* – HIPAA's portability rules apply to group health plans and health insurance issuers, unless an exception applies. Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers**.

*Summary* – HIPAA's Portability rules are designed to help individuals transition from one source of health coverage to another. HIPAA's portability provisions limit exclusions for preexisting conditions, prohibit discrimination based on health status and provide for special enrollment opportunities. Effective for plan years beginning on or after Jan. 1, 2014, the health care reform law prohibits group health plans and issuers from imposing preexisting condition exclusions on any enrollees.

*Notices/Disclosures* – The HIPAA Portability rules require the following notices/disclosures:

- Certificate of Creditable Coverage – Plans and issuers must provide a certificate of creditable coverage when covered individuals lose group health coverage or become eligible for COBRA coverage and when COBRA coverage ends. Plans and issuers should plan on providing HIPAA certificates through the end of 2014.
- General Notice of Preexisting Condition Exclusions – Plans and issuers must provide the general notice of preexisting condition exclusions as part of any written application materials distributed for enrollment. If the plan or issuer does not distribute these materials, the general notice must be provided by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.
- Individual Notice of Period of Preexisting Condition Exclusion – Plans and issuers must provide the individual notice as soon as possible following the determination of creditable coverage.
- Notice of Special Enrollment Rights – Plans and issuers must provide the special enrollment rights notice at or before the time an employee is initially offered the opportunity to enroll in the plan.

☐ ***HIPAA Privacy and Security***

*Applicability* – The HIPAA Privacy and Security Rules apply to health plans, health care clearinghouses and health care providers that transmit health information electronically (covered entities), unless an exception exists. The rules also apply to business associates (service providers to covered entities) that use protected health information (PHI). **A self-funded health plan with fewer than 50 participants that is administered by the employer that established and maintains the plan is exempt.**

*Summary* – The HIPAA Privacy Rule governs the use and disclosure of an individual's PHI. The HIPAA Security Rule creates standards with respect to the protection of electronic PHI.

*Notices/Disclosures* – The HIPAA Privacy and Security Rules require the following notices/disclosures:

- Notice of Privacy Practices - Plans and issuers must provide a Notice of Privacy Practices when a participant enrolls, upon request and within 60 days of a material revision. At least once every three years, participants must be notified about the notice's availability.
- Notice of Breach of Unsecured PHI – Covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of the breach.

☐ ***CHIPRA***

*Applicability* – The CHIPRA requirements apply to employers that maintain group health plans in states that provide premium assistance subsidies under a Medicaid plan or the Children's Health Insurance Program (CHIP). **There is not an exception for small employers.**

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1/12; BK 5/13

*Summary* – States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in the state.

*Notices/Disclosure* – Annual Employer CHIP Notice. A model notice is available from the DOL at www.dol.gov/ebsa/pdf/chipmodelnotice.pdf.

☐ ***Medicare Part D***

*Applicability* – The Medicare Part D requirements apply to group health plan sponsors that provide prescription drug coverage to individuals who are eligible for Medicare Part D coverage. **There is not an exception for small employers.**

*Summary* – Employer-sponsored health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with requirements on disclosure of creditable coverage and coordination of benefits.

*Notices/Disclosure* – Medicare Part D requires the following notices/disclosures:

- Disclosure Notices for Creditable or Non-Creditable Coverage – A disclosure notice must be provided to Medicare Part D eligible individuals who are covered by, or apply for, prescription drug coverage under the employer's health plan. The purpose of the notice is to disclose the status (creditable or non-creditable) of the group health plan's prescription drug coverage. It must be provided at certain times, including before the Medicare Part D Annual Coordinated Election Period (October 15 through December 7 of each year).
- Disclosure to CMS – On an annual basis (within 60 days after the beginning of the plan year) and upon any change that affects the plan's creditable coverage status, employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the plan's coverage is creditable.

Model forms are available from CMS at: www.cms.gov/CreditableCoverage.

☐ ***Mental Health Parity and Addiction Equity Act (MHPAEA)***

*Applicability* – The MHPAEA applies to group health plans offering mental health and substance use disorder benefits. There is an exception for health plans that can demonstrate a certain cost increase and an exception for small health plans with fewer than two participants who are current employees (for example, retiree health plans). **There is also an exception for employers with 50 or fewer employees during the preceding calendar year.**

*The final rule implementing the health care reform law's essential health benefits requirement directs non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services as well as to comply with the federal parity law requirements beginning in 2014.*

*Summary* – The MHPAEA imposes parity requirements on group health plans that provide benefits for mental health or substance use disorder benefits. For example, plans must offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits.

*Notices/Disclosure* – No general requirements

☐ ***Michelle's Law***

*Applicability* – Michelle's Law applies to employer-sponsored group health plans. Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers.**

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*Summary* – Michelle's law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. (Note: The health care reform law expanded coverage requirements for dependents by requiring plans to provide coverage up to age 26, regardless of student status.)

*Notices/Disclosure* – Plan administrators and issuers must include a Notice of Michelle's Law with any notice regarding a requirement for certification of student status.

☐ ***Newborns' and Mothers' Health Protection Act (NMHPA)***

*Applicability* – The NMHPA applies to group health plans that provide maternity or newborn infant coverage. **There is not an exception for small employers.**

*Summary* - Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.

*Notices/Disclosures* – The plan's SPD must include a statement describing the NMHPA's protections for mothers and newborns.

☐ ***Women's Health and Cancer Rights Act (WHCRA)***

*Applicability* – The WHCRA applies to group health plans that provide coverage for mastectomy benefits. Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers.**

*Summary* – The WHCRA requires health plans that provide medical and surgical benefits for a mastectomy to also cover: (1) all stages of reconstruction of the breast on which a mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas.

*Notices/Disclosure* – Plans must provide a notice describing rights under WHCRA upon enrollment and on an annual basis after enrollment.

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