PROFESSIONAL GROUP PLANS
Specializing in Employee Benefits

Your Guide to Benefits Compliance

Contact Us With Any Questions

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BENEFITS COMPLIANCE GUIDE

The goal of this guide is to equip you with information to help you better understand how to administer a health plan correctly.

Offering a health plan subjects an employer to several regulatory compliance rules and responsibilities. Any employer or organization offering a health plan to its employees is considered a plan sponsor.

WHERE DO THESE COMPLIANCE RULES COME FROM?

Plan sponsors are required to comply with several rules and regulations . These rules and regulations come from three main sources:

1 **Federal Laws:** The federal laws that apply to health insurance plan sponsors are the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act (ACA). This guide will assist you with compliance in each of these areas.

2 **State Laws:** There are some state laws that may also apply to a health plan. However, these are very limited in scope and generally do not contain reporting or disclosure requirements.

3 **Contract With The Carrier:** The employer is entereing into a contract with the carrier when offering a health plan (Oxford, UnitedHealthcare, Empire BCBS, etc.). It is important to know what is written in the contract and to comply with those provisios. The contract will usually contain contractual obligations, such as a minimum amount the company must contribute to the health plan (often 50% of employee-only coverage) and a definition of which employees are eligible to participate in the health plan. It also most likely contains a minimum participation requirement, meaning that a certain minimum percentage (generally between 50% - 75%) of the employees must enroll in the plan for the carrier to continue it.

FULLY-FUNDED VS. SELF-INSURED HEALTH PLANS

It's important to know if a health plan is "fully-funded" or "self-insured." A "fully-funded" health plan is one in which the employer pays the premiums and bears no responsibility for claims.

A self-insured group health plan is one in which the employer assumes all or some of the financial risk for providing health care benefits to its employees. Self-insured employers either pay for each claim or have an administrator who does so for them. So instead of only being responsible for paying a fixed premium to a health insurance carrier, a self-insured health plan bears all responsibility for claims. Self-insured plan sponsors have more responsibilities than fully-funded plan sponsors do, so it is important to know the difference. This guide will assist you with compliance in each of these areas.

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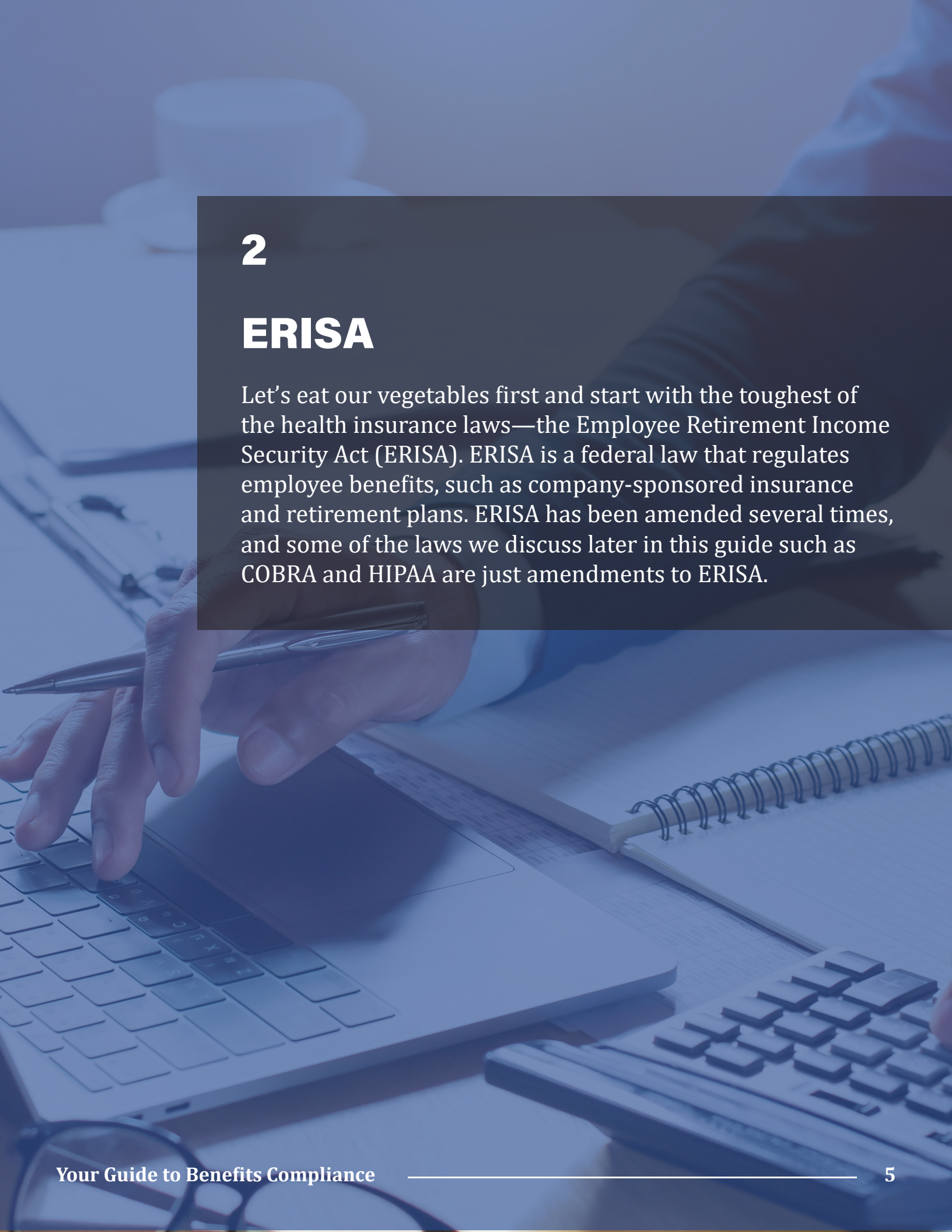

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ERISA

Let's eat our vegetables first and start with the toughest of the health insurance laws—the Employee Retirement Income Security Act (ERISA). ERISA is a federal law that regulates employee benefits, such as company-sponsored insurance and retirement plans. ERISA has been amended several times, and some of the laws we discuss later in this guide such as COBRA and HIPAA are just amendments to ERISA.

THE PURPOSE OF ERISA

ERISA was established to protect employees and their family members who participate in company-sponsored insurance and retirement plans. These employer-sponsored plans cover about **143** million U.S. workers and their dependents and include assets of over **$8.7** trillion.2 Due to these large numbers, ERISA was enacted on Labor Day in **1974** to ensure the integrity of these private employer benefit plans.

The U.S. Department of Labor conducts an average of 3000 audits per year. They estimate that around 70% of audits find some type of ERISA violation.[3] But to give you some peace of mind, the majority of errors have to do with the management of 401(k) plans, such as failing to get the employee's contribution into the 401(k) plan in a timely manner or failing to include certain pay categories (such as bonuses and severance payments) in eligible compensation for 401(k) contributions. However, some of these errors deal with health insurance plan sponsors failing to maintain the required plan documents (such as the SPD) or failing to follow all of the guidelines in their plan documents (such as adhering to the plan's employee eligibility requirements).

SUMMARY OF MAJOR PROVISIONS

ERISA sets minimum standards for companies that sponsor health plans. The intent of these standards is to protect the employee plan participants and to offer them transparency regarding the plan. So basically, ERISA requires that the plan sponsor provide participants with certain information and disclosures regarding the plan. It also requires that the plan sponsor meet certain codes of conduct (including non-discrimination in the administration of the plan). Finally, ERISA requires that some plan sponsors report on the plan to the federal government.

REQUIRED FILINGS

FORM 5500

Filing Name:
Form 5500

Who Must File:
Plan sponsor of any fully-funded health plan covering 100 or more employees at the beginning of the plan year & plan sponsors of all self-insured health plans

Filing Method:
Electronic filing required through Department of Labor's EFAST2 system

Filing Frequency:
Annual

Due Date:
The last day of the seventh month after the plan year ends (July 31 for a calendar-year plan)

Description:
The Form 5500 is an annual report that contains information about a plan's financial conditions, investments, and operations. The purpose of the Form 5500 is to provide the Internal Revenue Service (IRS) and DOL with information about the plan's operation and compliance with government regulations.

CREDITABLE COVERAGE DISCLOSURE TO CMS

Filing Name:
Creditable Coverage Disclosure

Who Must File:
Plan sponsor of any health plan offering a prescription coverage benefit

Filing Method:
Electronic filing required at CMS.gov

Filing Frequency:
Annual

Due Date:
60 Days after the beginning date of the plan year; 30 days after the termination of the prescription drug plan; and 30 days after a change in the plan's creditable vs. non-creditable status

Description:
This disclosure let's CMS know if a plan's prescription drug coverage is creditable or non-creditable. Creditable coverage is coverage that is expected to pay on average as much as the standard Medicare prescription drug coverage. Non-creditable coverage does not.

REQUIRED NOTICES

ERISA has lots of required notices.
Some of these are the employer's responsibility, some are the carrier's responsibility and some are shared.

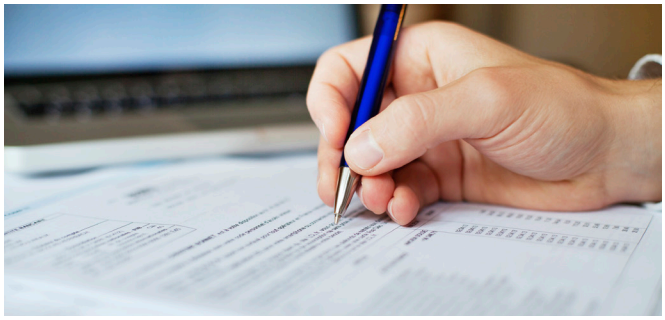
EMPLOYER'S RESPONSIBILITY

Summary Plan Description (SPD)
An SPD offers a complete summary of a health plan. **Unfortunately, the carrier does not provide an SPD.** What the carrier does provide is a Certificate of Coverage. Most small employers combine the Certificate of Coverage with some additional Wrap language, which is the information that is needed to make the document ERISA compliant as well as create a fully-compliant SPD. The SPD must be distributed to all employees and former employees enrolled in the plan, but it need not be provided separately to dependents of employees (unless it is requested). The SPD must be provided to participants within 90 days after they become covered, whether they request it or not. When a new plan is secured, the SPD must be distributed within 120 days after the plan is established. An updated SPD must be furnished to all covered employees and covered former employees on COBRA every five years. If nothing in the plan has changed, this time frame can be extended to every ten years.

Official Plan Document
ERISA requires that employers have a formal written document that describes exactly how the plan is administered. This is often known as the Official Plan Document. In practice, small to mid-sized employers that sponsor a fully-funded health plan generally use the SPD as their official plan document. There is some debate as to whether this fully meets ERISA's requirements. The Official Plan Document only needs to be provided to employees upon request.

Summary Annual Report (SAR)
The SAR is a summary of the Form 5500 filing. So, this notice only applies to those plan sponsors who are required to file a Form 5500. The SAR must be automatically distributed to participants within nine months after end of plan year.

Notice of Creditable/Non-Creditable Prescription Drug Coverage
If a health plan offers prescription coverage and it has any participants who are eligible for Medicare who are covered on the health plan, you are required to provide them with a notice describing whether the prescription drug plan covers at least as much as Medicare's plan (i.e. is "credible coverage"). This notice must be distributed to all Medicare-eligible individuals on the health plan prior to October 15th each year and to all Medicare-eligible individuals when they first join the plan. The information in this notice is essential to a participant's decision whether or not to enroll in a Medicare Part D prescription drug plan. Often, the carrier sends these notices on the employer's behalf, but the ultimate responsibility for these notices falls on the employer.



EMPLOYER'S RESPONSIBILITY (CONT'D)

Children's Health Insurance Program (CHIP) Notice
The CHIP notice is only required in 37 states. Your state will be specifically listed on the notice if it's required in your state. Basically, employers that provide health coverage in states with premium assistance through Medicaid or CHIP must inform employees of potential opportunities for assistance in obtaining health coverage. If you have employees in these states, you must provide the notice annually before the start of each plan year. It should be provided to all new employees with their initial enrollment materials and annually at open enrollment.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice
This verbiage is usually included in the SPD.

Notice of Patient Protections
This verbiage is usually included in the SPD.

Summary of Material Modifications (SMM)
When a change is made to the plan, that change must be communicated to employees in writing. The organization has two methods to communicate plan changes. It may either simply change the SPD and redistribute it, or it may send out a Summary of Material Modifications. When a change is made, either the new SPD or the Summary of Material Modifications must be provided to all participants within 210 days of the end of the plan year in which the change was adopted.

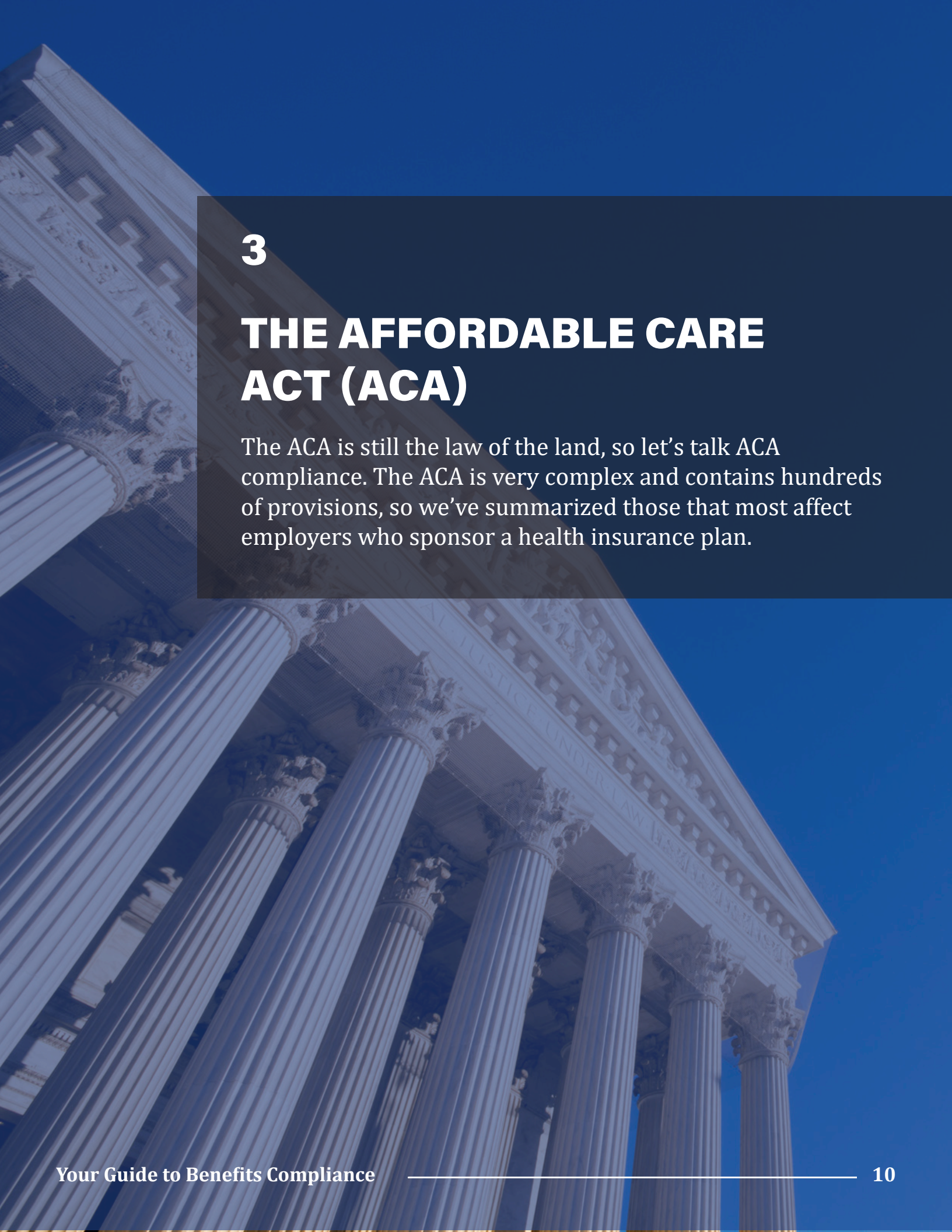
Summary of Material Reduction in Covered Services or Benefits
This notice is required if a plan change results in the loss of covered services or benefits. It must be furnished within 60 days of adoption of the material reduction in group health plan services or benefits.

Women's Health and Cancer Rights Act (WHCRA) Notice
Although responsibility for this notice is shared between the employer and the carrier, the carrier generally mails this notice to each participant's home address.

CARRIER'S RESPONSIBILITY
(Unless self-insured)

Explanation of Benefits (EOB)
An EOB is provided by the health insurance carrier in response to each claim filed.

Mental Health Parity and Addiction Equity Act (MHPAEA) Notice
The carrier typically mails this notice to each participant. annually.



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THE AFFORDABLE CARE ACT (ACA)

The ACA is still the law of the land, so let's talk ACA compliance. The ACA is very complex and contains hundreds of provisions, so we've summarized those that most affect employers who sponsor a health insurance plan.

SUMMARY OF MAJOR PROVISIONS

1 **ACA's Waiting Period**
Regardless of a company's size, if a company offers a health plan, the waiting period for new full-time employees may not exceed 90 calendar days. (Traditionally, the most common waiting period used by employers was "the first of the month following 90 days of employment." Based on the ACA's 90-calendar day waiting period maximum, the first of the month following 90 days of employment is no longer a permissible waiting period.)

2 **Employer Mandate**
While employers are not technically required to provide employees with health insurance, those averaging 50 or more full time equivalent employees in the previous calendar year may be subject to penalties for not providing employee health coverage or for providing coverage considered too expensive. It is important to note that the penalty only applies if any full-time employee receives a government subsidy for health coverage.

3 **Small Business Health Care Tax Credit**
Many small employers are missing out on a potential tax credit. Employers with 25 or fewer full-time employees averaging $50,000 or less in average annual wages may be eligible for a tax credit of up to 50% of the employer's premium costs of providing employee health coverage. But to be eligible for this small business health insurance tax credit, the company has to contribute at least 50% of the employee-only premium cost and the company must purchase its health plan in its state health insurance exchange. This tax credit is provided on a sliding scale, so the closer you get to 25 employees or average annual wages of $50,000, the lower the tax credit available.

4 **Employer Reimbursements for Individual Health Plans**
Employers that sponsor a group health plan are not permitted to offer employees stipends or reimbursements for individual health plans. For example, if an employee tells you that they have a great Marketplace health plan that they would like to keep and asks if you can simply provide them with a monthly allowance to help them pay for that plan, the employer has to say "no deal." Per IRS Notice 2013-54 and Notice 2015-17, employers may not reimburse employees for Individual or Marketplace plans.

REQUIRED FILINGS

1094/1095

Applicable large employers (ALEs)—those that had an average of 50 or more full-time employees or full-time equivalents during the previous calendar year must report whether they offered eligible employees affordable health coverage that provides minimum essential coverage and meets the minimum value threshold using Form 1095-C.

Small employers with fewer than 50 full-time employees are exempt from most ACA reporting requirements. However, self-insured small employers must comply with this reporting requirement using Forms 1095-B and 1094-B.

SECTION 6056 FILING (1094-Cs AND 1095-Cs)

Filing Name:
Section 6056 Filing (1094-C and 1095-Cs)

Who Must File:
Companies averaging 50+ full-time equivalent employees in the previous calendar year

Filing Method:
Paper filing permitted if filing fewer than 250 1095-C forms; otherwise, electronic filing required

Filing Frequency:
Annual

Due Date:
1095-C forms are due to employees by January 31st; federal filing is due February 28th for paper filers and March 31st for electronic filers

SECTION 6055 FILING (1094-BS AND 1095-BS)

(Self-insured employers only)

Filing Name:
Section 6055 Filing (1094-B and either 1095-Bs or 1095-Cs with Parts I-III completed)

Who Must File:
Insurance carrier or employer with a self-insured health plan

Filing Method:
Paper filing permitted if filing less than 250 1095-B forms; otherwise, electronic filing required

Filing Frequency:
Annual

Due Date:
1095-B forms to plan participants by January 31st; federal filing due February 28th for paper filers and March 31st for electronic filers

REQUIRED NOTICES

Notice of Exchanges and Subsidies (Exchange Notice)
Virtually all employers (regardless of size) are required to distribute a Notice of Exchanges and Subsidies to each new employee (whether part-time, full-time or health plan enrollment status) within 14 days of the employee's start date. The US Department of Labor has issued two model notices, one for employers who offer a company-sponsored health plan to some or all employees, and one for employers who do not offer a health insurance plan. The purpose of these Notice of Exchanges and Subsidies is to inform new employees of their health insurance options through their new employer, the existence of Health Insurance Exchanges (also called Health Insurance Marketplaces), and potential federal subsidies available to them.

Summary of Benefits and Coverage (SBC)
Your health insurance carrier is required to make this notice for every plan it offers, but the employer is required to distribute this notice to all employees as they become eligible for health insurance and each year at open enrollment. Keep in mind that if you offer more than one health insurance plan option, you must distribute an SBC for each plan that you offer. If you don't know where these are, ask your broker or carrier for copies. The purpose of the SBC is to create an "apples to apples" approach to comparing and contrasting health insurance plans. Similar to food nutritional labels, this document requires the carrier to use a standard format to disclose items such as the annual deductible, out of pocket maximum, co-payments, co-insurance and the like so employees can more easily compare health plan options.

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SECTION 125

Section 125 simply refers to the section of the IRS tax code that allows employers to offer insurance on a pre-tax basis. A pre-tax benefit saves both the employer and the employee a bit of money in payroll taxes.

SUMMARY OF MAJOR PROVISIONS

1 To enjoy favorable tax treatment, a written cafeteria plan must be in place. There are two types of cafeteria plans, a Premium-Only Plan (POP) or a Flexible Spending Account (FSA).

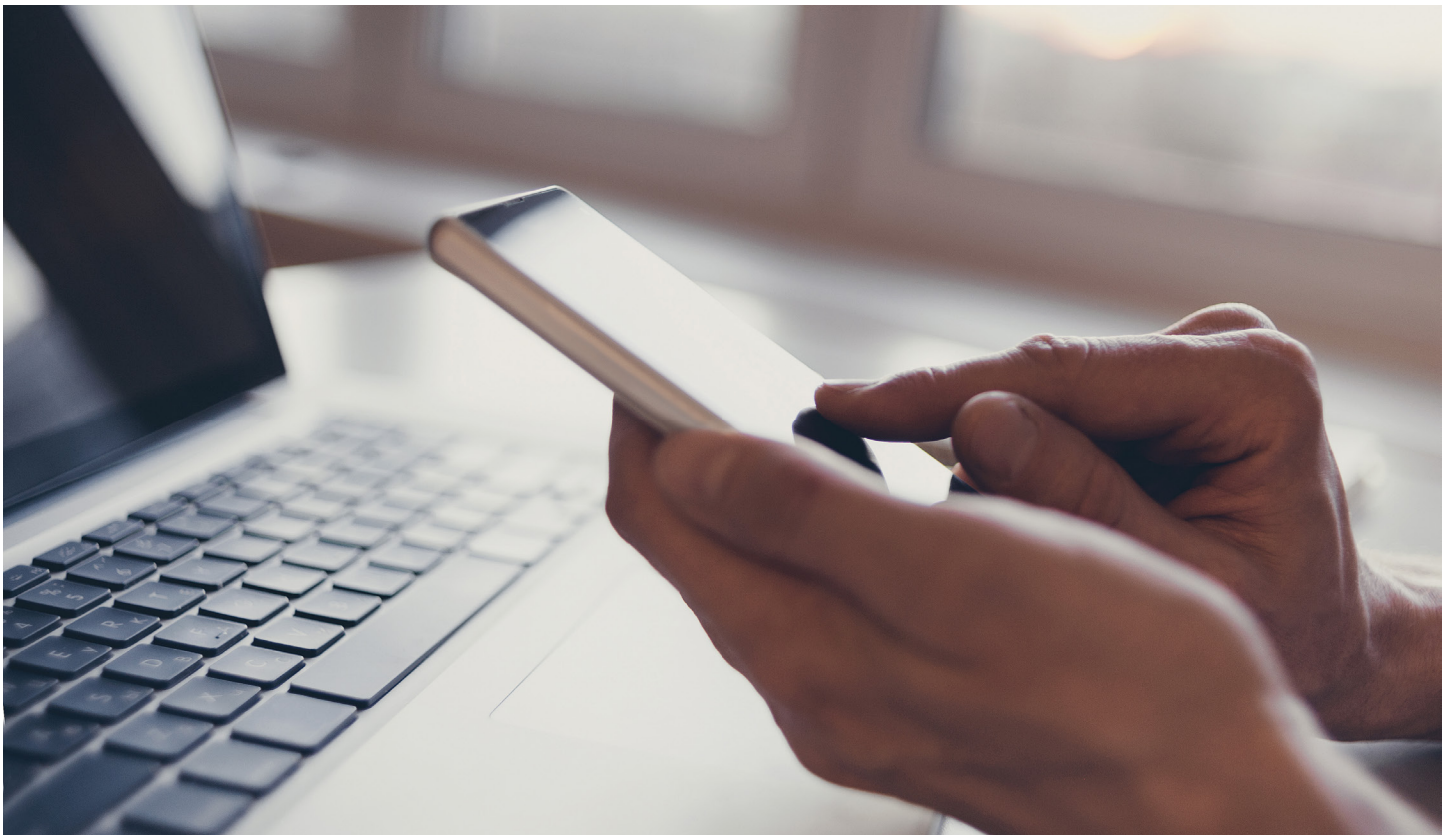
2 The tradeoff for favorable tax treatment is that the IRS limits when plan changes may be made during the year. Employees may only add or discontinue coverage in the middle of the plan year if they experience a qualifying event or the company offers a special enrollment period.

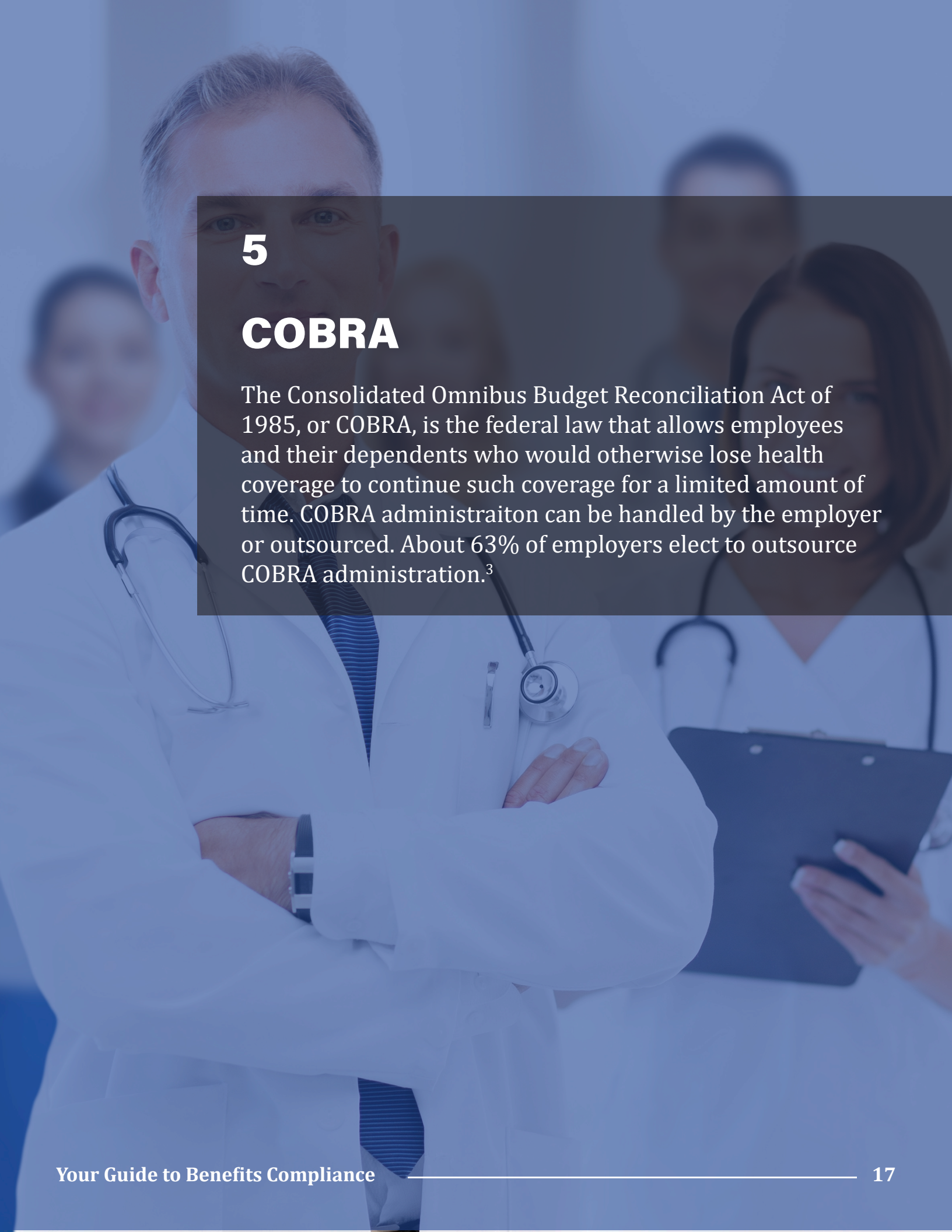
3 Section 125 requires the company to have an open enrollment period on an annual basis. Open enrollment is a time when employees can make changes to their health plan without having a qualifying event. Employees can add dependents, drop dependents, switch plans, drop all coverage, add a plan, etc. during open enrollment.

REQUIRED NOTICES

Section 125 Plan Document
The employer must create and adopt a Section 125 Plan Document (often called a Cafeteria Plan Document) if it would like employees to enjoy pre-tax deductions. This document includes items such as which plans are eligible for Section 125 favorable tax treatment, participation rules, election procedures, and the plan year. This document need not be distributed to employees or filed with the federal government. But it must be on file should the company ever be audited. In addition, it must be provided to employees upon request.

Salary Redirection Agreement
This form is not required under federal law; however, we consider it a best practice. This is the form that employees sign when they elect to participate in the group health plan. On the form, the employee elects whether they would like their deductions taken out of their payroll check on a pre-tax or post-tax basis. This form often contains some important disclosures about the implications of electing pre-tax deductions. This form also serves as the employee's written consent for the deduction, which is required in some states. We recommend including one in the annual open enrollment kit.





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COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, is the federal law that allows employees and their dependents who would otherwise lose health coverage to continue such coverage for a limited amount of time. COBRA administraiton can be handled by the employer or outsourced. About 63% of employers elect to outsource COBRA administration.[3]

SUMMARY OF MAJOR PROVISIONS

1 Federal COBRA applies to employers with 20+ employees. However, almost all states have mini-COBRA laws that apply to companies with 2-19 employees. So if you have fewer than 20 employees, make sure to check your state COBRA requirements.

2 COBRA allows employees and family members losing coverage to continue coverage by paying the full amount of the premium to the employer.

3 The most common circumstance under which employers must offer COBRA is when an employee separates from the company. But there are many circumstances under which an employee or dependent may lose coverage, such as:

SEPARATION OF EMPLOYMENT (UP TO 18 MONTHS OF COBRA)

TRANSFER FROM A FULL-TIME TO PART-TIME ROLE (UP TO 18 MONTHS OF COBRA)

DIVORCE (UP TO 36 MONTHS OF COBRA)

DEATH OF EMPLOYEE (UP TO 36 MONTHS OF COBRA)

ENTITLEMENT TO MEDICARE (GENERALLY UP TO 36 MONTHS OF COBRA)

If a family member is disabled and meets certain requirements, all of the members of that family who are eligible for COBRA are entitled to an 11-month extension of the maximum period of continuation coverage.

REQUIRED NOTICES

Initial COBRA Notice
This notice must be provided within 90 days of an employee enrolling in a group health plan. It simply lets the employee know that the plan is covered by COBRA and summarizes their rights under COBRA to continue coverage when they leave the plan. The company can satisfy this requirement by including the Initial COBRA Notice verbiage in the plan's SPD and giving the SPD to the employee within 90 days of plan enrollment. Or the COBRA notice can be a stand-alone document.

COBRA Notice & Election Form
The COBRA Notice and Election Form must be mailed to employees and former employees when they are about to lose coverage. It explains their rights to continue coverage under COBRA and gives them essential information about COBRA, such as how much COBRA will cost each month, where to remit payment for COBRA, and when COBRA premiums are due.

Other Notices Based on Circumstances
At times, other notices may be required. For example, if a former employee will be removed from COBRA before they have exhausted their 18, 29, or 36-month entitlement, a Notice of Early Termination of COBRA must be provided. Also, when the company makes the decision to deny a request for COBRA or deny an extension of COBRA, the company must give the individual a Notice of Unavailability of Continuation Coverage.

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HIPAA

HIPAA is an amendment to ERISA and covers a variety of subjects, such as when Section 125 qualifying events occur, how anti-discrimination provisions are applied to health plans, how wellness programs and incentives are provided, and how certain requirements pertain to privacy of medical information.

SUMMARY OF MAJOR PROVISIONS

1 **HIPAA** provides employees and their family members with special enrollment rights to jump on the health plan outside of the annual open enrollment period when specific events occur (such as the birth of a child or a substantial change in employer contribution).

2 Employers may not discriminate in terms of plan offerings and plan prices based on medical conditions.

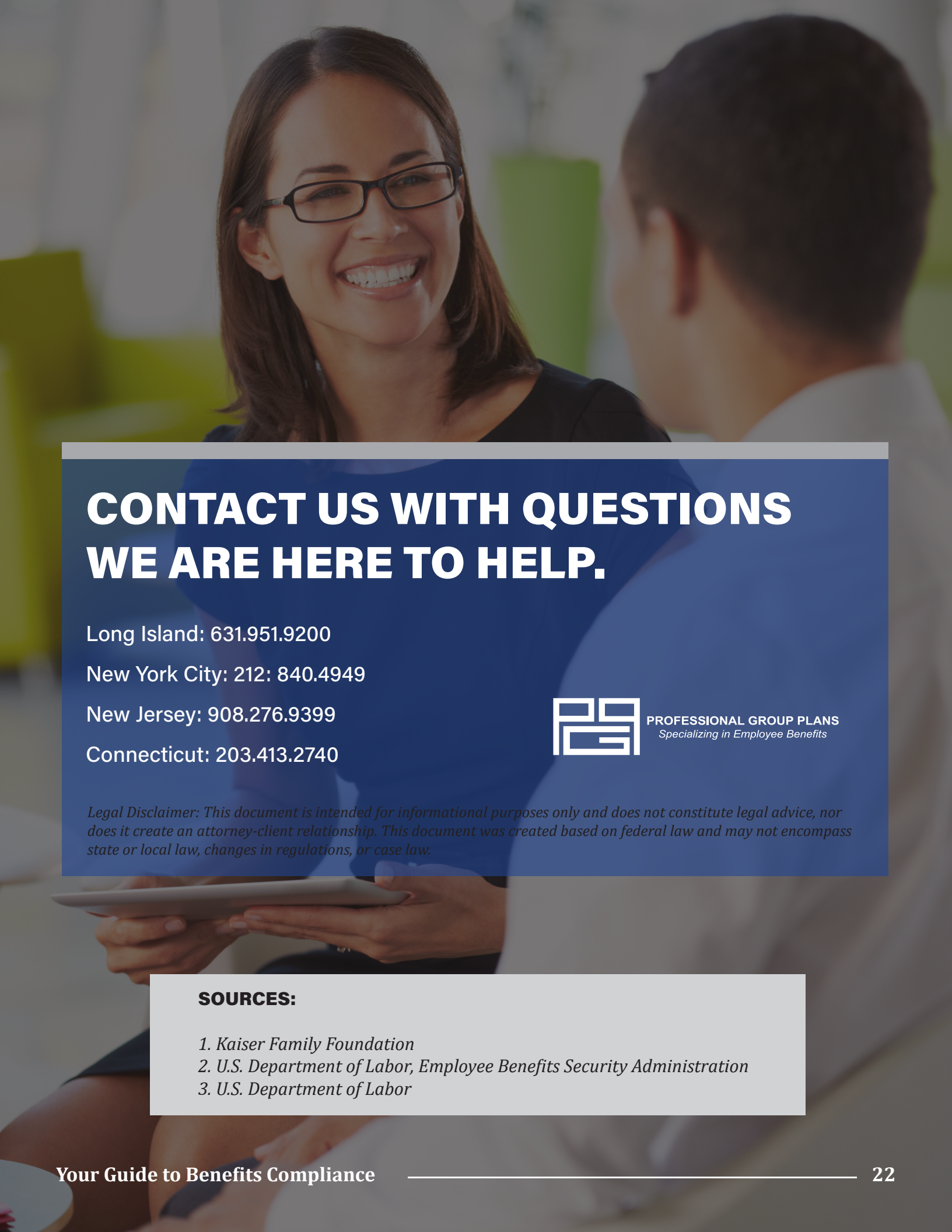
3 The company-sponsored insurance plans are covered by HIPAA's Privacy Rule; however, this fact alone does not make the employer a HIPAA covered entity required to comply with the Privacy Rule. Assuming you are not in the medical industry or deal with Protected Health Information in the course of your company's business, you are not a HIPAA covered employer for the purpose of the Privacy Rule simply because you sponsor a group health plan for your employees.

4 It is a best practice that you do not disclose any medical information you know about employees to others unless there is a strict need to know. It's also a best practice to refrain from collecting or retaining health information from your employees. For example, if your carrier requires all employees to complete a health questionnaire so that you can get a quote for insurance, we recommend having employees return their completed questionnaire directly to your health insurance broker without you ever touching it.

REQUIRED NOTICES

Special Enrollment Rights Notice
Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan. This can be included in the SPD, but only if the SPD is provided immediately when the employee becomes eligible for the plan. Most employers do not provide an SPD right when an employee becomes eligible for health plan enrollment, so they use a separate notice to meet this requirement. It is generally included in the initial enrollment package and with all annual open enrollment materials.

HIPAA Notice of Privacy Practices
The insurance carrier must provide the Notice of Privacy Practices, not the employer. However, if you have a self-insured plan, this requirement may fall on you depending on the structure of your plan. This notice must be provided when a participant enrolls, upon request, and within 60 days of a material revision to the notice. At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.



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SOURCES:

1. Kaiser Family Foundation
2. U.S. Department of Labor, Employee Benefits Security Administration
3. U.S. Department of Labor