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BENEFITS REDEFINED

Employee Benefits Compliance
for Small Employers (Less than 50)

An easy-to-understand guide featuring key employee benefit laws

COMPLIANCE & LEGAL

Benefit Advisors
NETWORK

Federal law imposes numerous requirements on the group health coverage that employers provide to their employees. Many federal compliance laws apply to all group health plans, regardless of the size of the sponsoring employer. This document has been created to address those small employer compliance requirements. However, there are some compliance exceptions for group health coverage provided by small employers. For this purpose, a small employer is one with fewer than 50 employees. Small employers should also review their State laws and regulations as they may have additional compliance requirements.

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AFFORDABLE CARE ACT (ACA)

The following checklist provides a high-level overview of key ACA market reforms:

- ✓ Must provide **comprehensive health coverage** consisting of the essential health benefits (EHB) package — Applies to all non-grandfathered insured health plans in the small group market.
- ✓ **No annual or lifetime dollar limits on EHB** — Applies to all health plans.
- ✓ **Out-of-pocket maximums** on EHB cannot exceed certain limits — Applies to all non-grandfathered health plans.

Out-of-pocket Maximum Limits

Plan Year	Self-only Coverage	Family Coverage
2019	$7,900	$15,800
2020	$8,150	$16,300

- ✓ Cannot impose a **waiting period that exceeds 90 days** — Applies to all health plans.
- ✓ No **pre-existing condition exclusions** on any covered individual — Applies to all health plans.
- ✓ Cannot discriminate against plan participants who participate in **clinical trials** — Applies to all non-grandfathered health plans.
- ✓ Must cover specific **preventive care services without imposing cost-sharing requirements** — Applies to all non-grandfathered health plans.
- ✓ Health plans that provide dependent coverage for children must make coverage available for **adult children up to age 26** — Applies to all health plans.
- ✓ Cannot **rescind coverage** for covered individuals, except in cases of fraud or intentional misrepresentation of material fact — Applies to all health plans.

AFFORDABLE CARE ACT (ACA)

Notice	Provide To	When Due
Forms 1094-B (Transmittal) and 1095-B (Health Coverage) (Click on the links above for the forms) Note: For self-insured employers only.	Responsible individuals enrolled in self-insured coverage (may be the primary insured, employee, former employee, or other related person named on the application)	Form 1095-B must generally be furnished to covered individuals by January 31 Forms 1094-B and 1095-B must generally be filed with the IRS by February 28 (or March 31, if filing electronically)
Health Insurance Exchange Notice (There is one model notice for employers who offer a health plan to some or all employees, and another model notice for employers who do not offer a plan—click on the link above to access)	All new employees	Within 14 days of an employee's start date
Summary of Benefits and Coverage (SBC) & Uniform Glossary (Click on the link above for a list of all available templates and related documents)	Group health plan participants & beneficiaries	Must be provided at specified times during the enrollment process and upon a participant or beneficiary's request, generally as follows: • Prior to initial enrollment in the plan; • Upon renewal of plan coverage; • Within 90 days of special enrollment; and • Within 7 business days following receipt of a request (The SBC may be provided together with other summary materials such as an SPD, if the SBC information is intact and prominently displayed at the beginning of the materials and in accordance with the timing requirements for providing an SBC.)
Notice of Modification (Model notice unavailable)	Group health plan participants & beneficiaries	No later than 60 days prior to the effective date of a material plan or coverage change that would affect the content of the SBC and that occurs other than in connection with a renewal or reissuance of coverage Note: A complete & timely notice may also satisfy the requirement to provide an SMM.

AFFORDABLE CARE ACT (ACA) CONTINUED

Notice	Provide To	When Due
Disclosure of Grandfathered Status (Click on the link above for model notice)	Group health plan participants & beneficiaries	In any plan materials for a grandfathered group health plan provided to a participant or beneficiary describing the benefits provided under the plan
Notice of Patient Protections (Click on the link above for model notice)	Group health plan participants	Whenever a participant in a non-grandfathered group health plan that requires or provides for the designation of a participating primary care provider is furnished an SPD or other similar description of benefits under the plan
Patient-Centered Outcomes Research Institute (PCORI) Fees	Filed with the Internal Revenue Service	IRS Form 720 must be filed annually by plan sponsors of certain self-insured health plans, no later than July 31st of the calendar year immediately following the last day of the plan year to which a fee applies
ACA Section 1557 Nondiscrimination Notice & Taglines (Click on the link above for sample notices and taglines in a variety of languages)	Beneficiaries, enrollees, applicants, and members of the public that participate (or may participate) in certain health programs or activities that receive federal financial assistance	Notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services are generally required to be posted in: (1) significant publications and communications targeted to beneficiaries, enrollees, applicants, and members of the public; (2) conspicuous physical locations where an entity interacts with the public; and (3) a conspicuous location on the entity's website, accessible from the homepage of such site. Note: The content requirements are modified for small-sized significant communications (such as postcards).

AMERICANS WITH DISABILITIES ACT (ADA) NOTICE REGARDING WELLNESS PROGRAMS

The ADA only applies to wellness programs if such programs make disability-related inquiries or conduct or request medical examinations. The EEOC defines a "disability-related inquiry" to mean a question (or series of questions) that is likely to elicit information about a disability. A disability-related inquiry includes obvious questions, such as asking an employee whether he or she has (or ever had) a disability or how he or she became disabled. However, a disability-related inquiry also includes asking questions relating to an employee's genetic information (including the employee's family medical history), asking whether the employee is currently taking any prescription drugs or medications, and asking broadly worded questions about an employee's impairments that are likely to elicit information about a disability. On the other hand, general questions regarding an employee's well-being, whether the employee has been drinking, the employee's current illegal use of drugs, or a request for contact information for the employee in the case of a medical emergency are not disability-related inquiries. The EEOC defines a "medical examination" as a procedure or test that seeks information about an individual's physical or mental impairments or health. Whether a particular test or procedure is a medical examination will be determined based on several factors, but the EEOC has determined that certain tests, including blood pressure screenings and cholesterol tests, are medical examinations for purposes of the ADA.

The broad range of questions and tests covered under the EEOC's definitions of "disability-related inquiry" and "medical examinations" makes it very unlikely that a health risk assessment (provided as part of a wellness program) would not be subject to the ADA's requirements concerning these restrictions. An example of a program that would not be considered to ask any disability-related questions or conduct any medical examinations is a smoking cessation program that is available to any employee who smokes and only asks employees to disclose how much they smoke. EEOC Final Rule On May 17, 2016, the EEOC released final regulations to provide guidance on designing wellness programs that would comply with the ADA.

The new notice requirement and incentive rules apply for plan years starting on and after January 1, 2017. The EEOC states that all other provisions, such as the confidentiality requirements, are clarifications of existing obligations; so those provisions were effective immediately. The final regulations apply to all workplace wellness programs, including those offered to employees or their family members that do not require participation in a particular health plan.

Notice	Provide To	When Due
ADA Notice Regarding Wellness Program (Click on the link above for sample notice)	All employees offered participation in a wellness program that collects employee health information	Must be provided before the employee provides any health information, with enough time for the employee to decide whether to participate in the program

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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.

Notice	Provide To	When Due
Children's Health Insurance Program (CHIP) Notice (Click on the link above for model notice)	All employees in states with group health plan premium assistance	Annually before the start of each plan year (may be provided with enrollment packets, open season materials, or the SPD).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)*

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. 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 insurance. COBRA includes a number of notice/disclosure requirements:

Notice	Provide To	When Due
General Notice of COBRA Rights (Click on the link above for model notice)	Covered employees & their spouses	Within the first 90 days of coverage Note: This requirement can be satisfied by including the general notice in a plan's SPD and giving the SPD to the employee and spouse within the first 90 days of coverage.
Notice of COBRA Qualifying Event (Model notice unavailable)	Plan administrator	The employer must provide notice within 30 days of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than for gross misconduct), reduction in hours, or entitlement to Medicare Note: The employee or one of the qualified beneficiaries is responsible for notifying the plan if the qualifying event is divorce, legal separation, or loss of dependent status under the plan (the employee or qualified beneficiary has at least 60 days from the date of the event to give notice).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)* CONTINUED

Notice	Provide To	When Due
COBRA Election Notice (Click on the link above for model notice)	Covered employees, spouses, & dependent children who are qualified beneficiaries	Generally within 14 days after receiving notice of a qualifying event Note: If the employer is also the plan administrator, the notice must be provided not later than 44 days after the date the qualifying event occurred or the date of loss of coverage due to the qualifying event (if the plan provides that COBRA coverage starts on the date of lossof coverage).
Notice of Unavailability of COBRA Coverage (No model notice provided by the federal government. Sample notice available byclicking on the link above for general reference purposes only.)	Individuals who have submitted a Notice of Qualifying Event who are determined ineligible for COBRA	Generally within 14 days after receiving notice of a qualifying event, unless the employer is also the plan administrator (see above note)
Notice of Underpayment of COBRA Premium (No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)	Qualified beneficiary who makes timely payment in an amount not significantly less than the amount due for a period of COBRA coverage	A plan must provide notice and grant a reasonable period of time (no less than 30 days) for payment of a deficiency, where the incorrect amount is not significantly less than the amount due, before taking action to terminate coverage
Notice of Early Termination of COBRA Coverage (No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage	As soon as practicable following the plan administrator's determination that COBRA coverage will terminate

*COBRA generally applies to group health plans sponsored by employers with 20 or more employees, including both full- and part-time employees. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full-time. Companies that are part of a controlled group or which have common ownership interests should contact a knowledgeable attorney for issues related to headcount.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

ERISA applies to employee welfare benefit plans, including group health plans, unless specifically exempted. Church and government plans are not subject to ERISA.

ERISA imposes a variety of compliance obligations on the sponsors and administrator 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. ERISA requires plan administrators to provide the following notices/disclosures:

Notice	Provide To	When Due
Summary Plan Description (SPD) (Model notice unavailable)	Group health plan participants	Within 90 days after the employee becomes a participant in the plan An updated SPD must be furnished every 5 years if changes are made to SPD information or the plan is amended (otherwise, it must be furnished every 10 years)
Summary of Material Modifications (SMM) and Summary of Material Reduction in Covered Services or Benefits (Click on the SMM link above for model notices)	Group health plan participants	No later than 210 days after the end of the plan year in which the change is adopted, for material changes to the plan that do not result in a material reduction in covered services or benefits Within 60 days of adoption of a material reduction in covered services or benefits (alternatively, notice may be provided with plan information that is furnished at regular intervals of not more than 90 days, if certain conditions are met) Note: Timely distribution of a "Notice of Modification" (below) may satisfy these requirements.
Plan Documents (e.g., SPD, any SMMs, and other documents under which the plan is established or operated) (Model notice unavailable — plan documents are specific to each plan)	Group health plan participants & beneficiaries	Copies must be furnished within 30 days of a written request, and the plan administrator must make copies available for examination at its principal office (the DOL can also request any documents relating to the plan)

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

GINA applies to group health plans and health insurance issuers. 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.

Notice	Provide To	When Due
Genetic Information Nondiscrimination Act (GINA) Disclosures (The link above contains model "warning" language from the federal government as well as a sample general disclosure, which may be used for general reference purposes only.)	Entities from whom requests for health-related information are made	Whenever an applicant or employee is sent for a medical examination by an employer with 15 or more employees An additional "warning" is required when requests for health-related information are made by employers with 15 or more employees (e.g., to support an employee's request for reasonable accommodation or a request for sick leave), but only if the request for medical documentation is made in a way that is likely to result in receipt of genetic information

HIPAA PORTABILITY

HIPAA's portability rules apply to group health plans and health insurance issuers, unless an exception applies.

HIPAA's portability rules are designed to help individuals transition from one source of health insurance to another. HIPAA's portability provisions limit exclusions for pre-existing conditions, prohibit discrimination based on health status and provide for special enrollment opportunities. HIPAA's portability rules require the following notice/disclosure:

Notice	Provide To	When Due
Notice of Special Enrollment Rights (Click on the link above for model notice)	Employees eligible to enroll in the employer's group health plan	At or before the time an employee is initially offered the opportunity to enroll in the plan
Wellness Program Disclosure (Click on the link above for model notice)	Group health plan participants & beneficiaries eligible to participate in a health-contingent wellness program	In all plan materials that describe the terms of a health-contingent wellness program (both activity-only and outcome-based wellness programs). For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard. If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.
Notice of Privacy Practices (Click on the link above to download model notices in 4 different formats) Note: Fully insured group health plans that do not create or receive protected health information (PHI)—other than summary health and enrollment information—are not required to develop this notice.	Individuals enrolled in the plan	Fully insured group plans that create or receive PHI in addition to summary health information and enrollment information must maintain a notice and provide it to any person upon request. Other health plans must provide the notice as follows: To new enrollees: At the time of enrollment To individuals covered by the plan: Within 60 days of a material revision to the policy (special rules apply for website notice postings) A health plan also must notify individuals covered by the plan of the availability of, and how to obtain, the notice at least once every 3 years, and make it available to any person who asks for it.

MEDICARE PART D CREDITABLE COVERAGE

The Medicare Part D requirements apply to group health plans sponsors that provide prescription drug coverage to individuals who are eligible for Medicare Part D coverage. Employer sponsored health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with the following disclosure requirements:

Notice	Provide To	When Due
Medicare Part D Creditable Coverage Disclosure Notice or Non-Creditable Coverage Disclosure Notice (Click on the links above for model notices. Word versions unavailable.)	Medicare-eligible individuals (including certain dependents) who are offered prescription drug coverage under the employer's group health plan	Annually prior to October 15th, upon request, and at various other times as required under the law An online disclosure to the Centers for Medicare & Medicaid Services (CMS) is also required annually, no later than 60 days from the beginning of a plan year, and at certain other times

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT (MHPAEA)

Group health plans of employers with 50 or fewer employees are exempt from the MHPAEA requirements under the small employer exemption, regardless of any State insurance law definition of small employer. For nonfederal governmental plans, the PHS Act was amended by the Affordable Care Act to define a small employer as one that has 100 or fewer employees.

MICHELLE'S LAW

Effective for the first plan year following October 9, 2009, all group health plans that cover dependents must extend coverage for dependent college students who take medically necessary leaves of absence. The coverage is available for up to one year or, if earlier, until the date on which the coverage would otherwise end under the plan. The extended coverage must provide the same benefits as if the child was not on a medically necessary leave of absence. Written certification must be provided by the child's treating physician stating the child is suffering from a serious illness or injury, and the leave (or change of enrollment) is medically necessary. The plan must include a description of the terms for continued coverage when sending any notice describing the plan's student certification requirements for coverage.

Under the Patient Protection and Affordable Care Act of 2010 ("PPACA"), all group health plans that offer coverage to dependents must offer coverage to children of covered employees, up to the age of 26. As such, for the most part Michelle's Law will become irrelevant in most cases. However, Michelle's Law will remain applicable to those plans that offer coverage to dependents beyond the age of 26 who remain in college.

Notice	Provide To	When Due
Michelle's Law Notice (No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)	Group health plan participants	With any notice regarding a requirement for certification of student status under a plan that bases eligibility for coverage on student status (and that provides dependent coverage beyond age 26)

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The NMHPA applies to group health plans that provide maternity or newborn infant coverage. 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. The plan's SPD must include a statement describing the NMHPA's protections for mothers and newborns.

Notice	Provide To	When Due
Newborns' and Mothers' Health Protection Act Notice (Click on the link above for model notice)	Group health plan participants	Must be included in the SPD for a plan providing maternity or newborn infant coverage

QUALIFIED SMALL EMPLOYER HRA (QSEHRA)

On December 7, 2016, the Senate passed the 21st Century Cures Act ("Cures Act"), an omnibus measure that includes the Small Business Healthcare Relief Act ("Relief Act"), which significantly expands small employers' options for providing health coverage. The law is effective for plan years beginning on or after January 1, 2017. The HRA Relief Act allows small employers—defined as those who are not applicable large employers ("ALEs")—to establish a qualified health reimbursement arrangement ("HRA") that reimburses eligible employees and their family members for medical expenses, including individual health insurance premiums, up to a specified annual limit. In general, an employer is an ALE if it employed at least 50 full time equivalent employees on average in the prior calendar year.

Notice	Provide To	When Due
Qualified Small Employer HRA (QSEHRA) Notice Sample notice available by clicking on the link above. Additional QSEHRA information and model notice language available on Q&A#38.	Eligible employees of employers with fewer than 50 full-time employees in the preceding calendar year that do not offer a group health plan and that fund a QSEHRA	Generally no later than 90 days before the beginning of the year in which the QSEHRA is funded. In the case of a newly eligible employee, the initial written notice must be furnished on or before the first day the employee becomes eligible to participate in the QSEHRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) applies to all employers and protects an employee's job status, promotion and benefits while the employee is on qualified leave. A group health plan must offer up to 24 months of continuation coverage for current health benefits to the employee (and his or her covered dependents) while the employee is serving in the "uniformed services." Service in the "uniformed services" includes active or reserve duty, whether voluntary or involuntary, and time off for training or instruction. Under USERRA, a group health plan is any insurance policy or contract or other arrangement under which health services are provided. This broad definition of group health plan includes not only plans providing medical, dental, vision and prescription drug coverage, but also includes health flexible spending accounts and health reimbursement arrangements (HRAs). USERRA requires employers to develop reasonable procedures for employees to use in electing continuation coverage, but the statute does not require any particular election procedure. Nor does the statute specify the time within which the election must be made, whether the election must be in writing or who may make an election on behalf of a covered employee. If the period of coverage is less than 31 days, the plan may not require the employee to pay more than his or her regular premium payment. If the period of coverage is 31 days or more, the plan may charge the employee up to 102% of the applicable premium for this coverage. USERRA does not provide any time period within which premiums must be paid. Employers must provide employees entitled to rights and benefits under USERRA a notice of their rights, benefits and obligations under USERRA by posting a notice provided by the DOL. The notice must be posted where the employer usually posts employee notices. The poster may be found on the DOL website at: U.S. Department of Labor — Veterans' Employment and Training Service (VETS) — Understanding Your Rights Under USERRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) CONTINUED

Notice	Provide To	When Due
Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice (Click on the link above for model notice)	All employees	May be posted where employers customarily place notices for employees

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The WHCRA applies to group health plans that provide coverage for mastectomy benefits. Plans with fewer than two participants, who are current employees, are exempt.

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.

Plans must provide a notice describing rights under WHCRA upon enrollment and on an annual basis after enrollment.

Notice	Provide To	When Due
Women's Health & Cancer Rights Act (WHCRA) Notices (Click on the link above for model notices)	Group health plan participants & beneficiaries	Upon enrollment in a plan that provides coverage for medical and surgical benefits related to a mastectomy, and annually thereafter