Health and Welfare Compliance Guide Checklist

2021

COMPLIANCE & LEGAL

Benefit Advisors NETWORK

ABOUT THE HEALTH AND WELFARE COMPLIANCE GUIDE CHECKLIST

Updated: March 1, 2021

The enclosed Compliance Checklist is designed to assist employers with compliance regulations as it relates to company Health and Welfare benefit plans.

This Checklist is to be used in conjunction with the Health and Welfare Compliance Guide as prepared by our legal counsel, Marathas Barrow Weatherhead Lent LLP. It is not intended to be all-inclusive, but is designed to provide highlights with respect to Health and Welfare compliance.

As you review the Checklist, please refer to the appropriate section of the *Compliance Guide* for more information and assistance.

Refer to the applicable section in the Compliance Guide for more details

	Affordable Care Act (ACA) and Grandfathered Plans	Section 2
☐	If the plan is "grandfathered" under the ACA, has the grandfathered plan notice been distributed to participants on all plan materials relating to benefits?	Section 2
☐	If the plan is "grandfathered" under the ACA, has the plan complied with all mandates applicable to grandfathered plans (e.g., no lifetime or annual dollar limits on essential health benefits, coverage of adult children to age 26, no preexisting condition exclusions or limitations, no coverage waiting periods of more than 90 days)?	Sections 2, 12.10, 12.11, 12.12, 12.14, 12.27
☐	If the plan is "non-grandfathered" under the ACA, does the plan comply with all mandates applicable to non-grandfathered plans?	Section 3.9
	Plan Documents / Summary Plan Descriptions (SPD) / Summary of Benefits and Coverage	**Section 3**
☐	Does the company have written Plan Documents for every employee benefit plan subject to ERISA (i.e., all employer-sponsored plans, except churches and governments)?	Section 3.1
☐	Are SPDs being given to participants and beneficiaries*: • Within 30 days after a request for a copy? • Within 90 days after becoming a participant in the plan (or 120 days after the newly created plan becomes subject to ERISA)? • Every 5 years if a plan is amended (or every 10 years if no intervening amendments)? • With a foreign language notice (if applicable)?	Section 3.2
☐	Are Summaries of Material Modifications (SMMs) (or updated SPDs) being provided no later than 210 days after the end of the plan year in which a material change is made to the plan*?	Section 3.3

☐	Are Summaries of Benefits and Coverage (SBCs) being provided in accordance with the distribution rules and timeframes established under the ACA: • As part of enrollment materials to newly eligible individuals? • Within 90 days of enrollment for special enrollees? • By beginning of open enrollment periods? • Upon request (as soon as practicable, but not later than 7 business days after receipt of request by participants or beneficiaries)? • With a foreign language notice (if applicable)?	Section 3.5
☐	Does the company provide at least 60 days advance notice prior to making any mid-year plan design changes that affect the content of the most recent SBC?	Section 3.5
☐	Has the company updated its SBCs to reflect the new template and Uniform Glossary for use beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 (see here)?	Section 3.5
☐	Does the SPD include the Claims and Appeal Process? If the plan provides for disability benefits, has the SPD been reviewed to determine what changes, if any, need to be made under final regulations for disability claims filed under the plan after April 1, 2018*?	Section 3.7
☐	Has the company advised individuals that certain deadlines included in the SPDs or other plan materials have been extended due to COVID 19 until the earlier of (1) one year from the date on or after March 1, 2020 that an individual was first eligible for relief, or (2) 60 days after the end of the COVID-19 National Emergency or such other date as announced by the IRS and DOL or otherwise declared by the federal government as a result of the COVID-19 national emergency?	COVID-19 Addendum
Electronic Disclosure of Notifications		**Section 3**
☐	Are documents (e.g., SPDs, HIPAA, SARs, EOBs) being provided electronically? • Are notices being provided to each recipient each time a document is distributed electronically? • Has benefits counsel approved the company's electronic distribution procedure?	Section 3.10
Document Retention		**Section 3**
☐	Does the company retain all benefit plan documents and ERISA documents for at least 6 years (best practice is at least 8 years)?	Section 3.11

	COBRA (20+ Employees)	Section 4
☐	Does the company offer COBRA continuation coverage to those losing coverage due to a "qualifying event"?	Section 4.1
☐	Is the company satisfying all applicable COBRA notice obligations? • Initial Notice – to each covered employee and employee's spouse (if covered under the plan) within 90 days of becoming covered under the plan. (Notice should be mailed to employee's home and address to employee and spouse, if married.) • Qualifying Event Notice and Election Form – to former participants and covered dependents within 14 days (or if employer is plan administrator, 44 days)* • Other Administrative Notices (including Notice of Unavailability (Denial) of Coverage, Termination Notice, and Insufficient Payment Notices).	Section 4.3
☐	Has the company reviewed its Initial (General) COBRA Notice and its Qualifying Event Notice and procedures recently?*	Section 4.3
☐	Has the company established and maintained a COBRA recordkeeping process that includes all COBRA Notifications with dates sent and detailed records of COBRA rejection or acceptance?	Section 4.4
☐	Does the company follow state-specific Mini-COBRA laws, if applicable?	Section 4.5
☐	Did the company communicate the COVID-19-related extensions to qualified beneficiaries? (Individuals have an extension to elect COBRA, notify the plan of a qualifying event or disability determination, or pay premiums from March 1, 2020 until the earlier of (i) 60 days after announced end of the national emergency, or (ii) 1 year from the date of the applicable deadline for that individual).	COVID-19 Addendum
	Health Insurance Portability and Accountability Act (HIPAA) – Portability	**Section 5**
☐	Does the company distribute the Notice of Special Enrollment Rights when employees are first eligible for coverage (can be in SPD)?	Section 5.1
☐	Did the company abide by the COVID-19 related extensions for individuals to request a special enrollment? (Individuals have an extension to notify the plan of a special enrollment right/request a special enrollment from March 1, 2020 until the earlier of (i) 60 days after announced end of the national emergency, or (ii) 1 year from the date of the applicable deadline for that individual)	COVID-19 Addendum
☐	Does the company distribute the CHIP Notice to employees annually?	Section 5.2

	Health Insurance Portability and Accountability Act (HIPAA) – Privacy	Section 5
☐	Does the company maintain written HIPAA privacy policies and procedures for complying with HIPAA privacy regulations which impose rules for the use and disclosure of protected health information (PHI)? • Has the policy been revised to conform with the treatment of genetic information as PHI, as required under the Genetic Information Nondiscrimination Act (GINA)? • Does the company send the HIPAA Privacy Notice automatically at time of enrollment and to others upon request and within 60 days of a material revision to notice? • Does the company send a notice of availability of HIPAA privacy notice every 3 years?	Sections 5.3 and 12.9
☐	Does the company obtain signed Authorization to Release Information forms from employees in order to receive PHI for purposes other than treatment, payment or health care operations?	Section 5.3
☐	Does the company have a Business Associate Agreement in place with all vendors that have access to PHI for a health plan? (e.g., TPAs, attorneys, accountants, consultants, and insurance agent/brokers)?	Section 5.3
☐	Has the company reviewed and updated its HIPAA privacy policies and procedures in accordance with the omnibus HIPAA privacy rule?	Section 5.4
	Health Insurance Portability and Accountability Act (HIPAA) – Security	**Section 5**
☐	If the company electronically maintains or transmits PHI, has a formal policy been established and procedures implemented to adhere to the requirements of the security standards? (Includes notification requirement for breach of unsecured PHI under the HITECH Act – Section 5.4)	Section 5.6
	Wellness Programs	**Section 6**
☐	If the company offers a Wellness Program, has it been reviewed by benefits counsel for compliance with all applicable federal laws and DOL requirements? Has the company considered the tax consequences of wellness incentives, if offered? (Section 6.2)	Section 6.1
☐	If the company offers a wellness incentive that requires satisfaction of a standard related to a health factor, does it comply with all DOL requirements relating to the amount of the reward, and the availability of a reasonable alternative standard?	Section 6.2
☐	If the company provides a Health Risk Assessment in conjunction with its group health plan, has it been reviewed by benefits counsel for compliance with applicable federal laws (e.g., ADA, GINA)?	Sections 6.4 and 6.5
☐	Has the company considered the AARP v. EEOC case and the impact of the court vacating the EEOC's 30% incentive limits beginning in 2019?	Section 6.5
☐	Has the company considered the impact of its wellness program on the "affordability" of employee premium contributions under the ACA?	Section 6.6

	Military Leave – Uniformed Services Employment and Reemployment Rights Act (USERRA)	**Section 8**
☐	Has the company developed reasonable procedures for employees on qualified military leave to use in electing continuation coverage?	Section 8
☐	Does the company post a DOL notice of rights, benefits, and obligations under USERRA?	Section 8
☐	Does the company abide by all requirements and obligations under USERRA which protects an employee's job status, promotion, and benefit continuation while on leave?	Section 8.1
	Code Section 105(h) Non-Discrimination Rules	**Section 9**
☐	For self-insured* plans, if the company has different benefit eligibility requirements and different premium contributions for different levels of employees, is it operating on a nondiscriminatory basis under Section 105(h) of the Internal Revenue Code with respect to eligibility and benefits? *Under the ACA, the nondiscrimination rules will apply to non-grandfathered fully insured plans once additional regulatory guidance is provided. These rules do not apply to fully insured plans at this time.	Sections 9.1, 9.3, 9.4 and 18.1
	Family and Medical Leave Act (FMLA) (>50 employees)	**Section 10**
☐	Does the company comply with FMLA, which grants an eligible employee up to a total of 12 workweeks of unpaid leave in a 12-month period for qualified leaves of absence?	Section 10
☐	Has the company established an administrative process which includes, among other things, timely providing all required notices (i.e. Eligibility Notice and Rights and Responsibilities Notice and applicable Certification form, Designation Notice) within 5 business days after employee gives notice of need for FMLA leave?	Sections 10 and 10.1
☐	Has the company considered relevant state family and medical leave regulations?	Section 10.2
	Medicare Part D – Medicare Modernization Act (MMA)	**Section 11**
☐	Does the company annually file a report electronically with the Centers for Medicare and Medicaid Services (CMS) as to whether the prescription drug coverage under the plan is creditable? (Notification is to be provided within 60 days after the beginning of each plan year and/or within 30 days of the termination of a prescription drug coverage/change in the creditable coverage status.)	Sections 11 and 11.1

☐	Is the Medicare Part D Notice of Creditable Coverage provided at the following times? • Annually to all employees and covered dependents before the Medicare Part D Enrollment Period (October 15th)? • Upon request? • When prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable? Note: If this notice is distributed to all covered individuals (rather than just Medicare Part D eligible individuals) by October 15, the plan is relieved of the requirement to also distribute the notice to covered individuals who first become eligible for Medicare coverage during the year (i.e., new hires).	Sections 11 and 11.2
Other Laws and Requirements		**Section 12**
☐	Do the company's group health plans (covering >50 employees) comply with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA)?	Sections 12.1 and 12.2
☐	Has the company performed and documented a comparative analysis of the design and application of nonquantitative treatment limits per the Consolidated Appropriations Act, 2021?	Section 12.2
☐	Do the company's group health plans comply with the Newborns' and Mothers' Health Protection Act (Newborns' Act) (including the required statement in the SPD)?	Section 12.3
☐	Do the company's group health plans provide coverage for mastectomies, is the plan compliant with the Women's Health and Cancer Rights Act (WHCRA)? Does the company notify participants about the availability of this coverage at the time of enrollment in the health plan and then annually thereafter?	Section 12.4
☐	Do the company's group health plans comply with the Qualified Medical Child Support Order (QMCSO) requirements? Does the company maintain written procedures to determine if a medical child support order is qualified under ERISA?	Section 12.6
☐	Does the company respond in a timely fashion to the Centers for Medicaid and Medicare Services (CMS) data match request for the Medicare Secondary Payer (MSP) information?	Section 12.8
☐	Do the company's group health plans comply with the applicable ACA mandates including, but not limited to, the prohibition on annual and lifetime dollar limits on essential benefits, coverage of adult children to age 26, prohibitions on preexisting conditions and rescissions, choice of health care professional and emergency room cost-sharing parity?	Sections 12.1 – 12.28
☐	Is the company reporting the cost of employer-sponsored health coverage on each employee's IRS Form W-2 (Box 12, Code DD) Note: This is voluntary if the company filed fewer than 250 W-2s for the prior calendar year.	Section 12.20
☐	If the plan is self-insured, has it paid the PCORI fees (i.e., for calendar year plans, fees apply for plan years 2012 through 2028) and the Transitional Reinsurance Program fee (applied on a calendar year basis from 2014-2016)?	Sections 12.21 and 12.30

☐	Does the company comply with the Notice of Exchange requirement under the ACA, which requires notification to all new employees (within 14 days of their start date)?	Section 12.24
☐	Has the company considered the impact of the ACA's 90-day limit on waiting periods and its requirements for bona fide employment-based orientation periods?	Section 12.27
☐	Do the company's group health plans comply with the ACA's out-of-pocket limits, including the embedded out-of-pocket limits?	Section 12.28
☐	Has the company evaluated whether it is a covered entity under Section 1557 of the ACA prohibiting discrimination on the bases of, among other grounds, sex (including gender identity) in certain health programs and activities? If so, has it taken the steps to comply with the requirements of that section?	Section 12.31
Health Savings Accounts (HSA)		**Section 13**
☐	If the company offers a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), is the company complying with the rules governing HDHP/HSA plans including contributions?	Section 13
Health Reimbursement Arrangements (HRA)		**Section 14**
☐	If the company offers a Health Reimbursement Arrangement (HRA), does it comply with the rules governing HRAs including COBRA, employer and employee contribution rules and "integration" with group coverage?	Section 14
☐	If a small employer (i.e., cannot be an "applicable large employer" for ACA purposes) offers a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), does it comply with all applicable rules?	Section 14
☐	If the company offers an Excepted Benefit HRA, does it comply with all applicable rules	Section 14
☐	If the company offers an Individual Coverage HRA (ICHRA), does it comply with all applicable rules	Section 14
Flexible Spending Accounts (FSAs) – Health Care		**Section 15**
☐	If the company offers a Health Care Flexible Spending Account (with or without a debit card option), does it comply with the rules governing such arrangements including claim substantiation?	Sections 15 and 15.1
☐	If the company offers a Health Care Flexible Spending Account, does it qualify as an "excepted benefit"?	Section 15.1

☐	If the company offers a Health Care Flexible Spending Account with a carryover feature, does it comply with all applicable rules?	Section 15.3
☐	If the company offers a Health Care Flexible Spending Account, if it intends to adopt one or more of the following, is it prepared to amend the plan by December 31, 2021 and/or December 31, 2022 and to operate the plan in accordance with the amendment between now and the date the amendment is adopted: • If the plan does not have a grace period, then it may allow participants to carry over all unused health FSA contributions or benefits remaining at the end of the 2020 and/or 2021 plan years to the 2021 and/or 2022 plan years, respectively • If the plan does not offer a carryover, then it may extend a grace period for using any benefits or contributions remaining at the end of a plan year ending in 2020 or 2021 to 12 months after the end of the applicable plan year • Allow participants who cease participation during the 2020 or 2021 plan year to continue to be reimbursed from any unused benefits through the end of the plan year (and applicable grace period) in which participation ceased. This is often referred to as a "spend down" provision when included in a traditional DCAP • Allow employees to, on a prospective basis, (i) make a new election, (ii) revoke an existing election, and/or (iii) increase or decrease their election (subject to annual limitations) to their contributions for the plan year ending in 2021 without experiencing a change in status event.	Section 15.3
Flexible Spending Accounts (FSAs) – Dependent Care		**Section 16**
☐	If the company offers a Dependent Care Flexible Spending Account, does it comply with the rules governing such arrangements including eligible expenses, eligible dependents and allowable changes in status?	Sections 16 and 16.1
☐	If the company offers a Dependent Care Flexible Spending Account, if it intends to adopt one or more of the following, is it prepared to amend the plan by December 31, 2021 and/or December 31, 2022 and to operate the plan in accordance with the amendment between now and the date the amendment is adopted: • If the plan does not have a grace period, allow participants to carry over all unused DCAP contributions or benefits remaining at the end of the 2020 and/or 2021 plan years to the 2021 and/or 2022 plan years, as applicable. • If the plan does not allow the carryover above, it can adopt (or extend) a grace period for using any benefits or contributions remaining at the end of a plan year ending in 2020 or 2021 to 12 months after the end of the applicable plan year (the plan may have a carryover or grace period, but not both). • Reimburse employees for dependent care expenses for children who turned 13 during the pandemic. The relief applies to plan years with open enrollments that ended on or before January 31, 2020 (e.g., calendar year 2020 plans). It also applies for the subsequent plan year (e.g., calendar year 2021 plans) to the extent the employee has a balance at the end of the 2020 plan year after any relief adopted by the employer, such as an extended grace period or carry over. The relief allows the employer to substitute "age 14" for "age 13" for purposes of determining eligibility for reimbursement of a child's expenses. In general, DCAP eligibility ends at age 13, except in cases of mental or physical incapacity. • Allow employees to, on a prospective basis, (i) make a new election, (ii) revoke an existing election, and/or (iii) increase or decrease their election (subject to annual limitations) to their contributions for the plan year ending in 2021 without experiencing a change in status event.	

	Filing Requirements – Form 5500	Section 17
☐	Are IRS Form 5500s being filed electronically for all welfare benefits that have over 100 participating employees (or that pay benefits from a trust) by the last day of the 7th month after the end of the plan year? (for a calendar year plan year, the filing date is July 31st)	Sections 17.1 and 17.6
☐	If filing a single Form 5500 for all benefits, does the company have a wrap document explaining that for ERISA purposes all of the company's health and welfare plans are combined into one consolidated benefit plan?	Section 17.1
☐	If the plan is a multiple employer welfare arrangement (MEWA), is the Form M-1 required to be filed?	Sections 17.1 and 17.7
☐	Is a Summary Annual Report (SAR) distributed to employees in 100+ groups (or plans with trusts) by the last day of the 9th month after the end of the plan year?	Section 3.6
	Filing Requirements – W-2 (Wage and Tax Statement)	**Section 17**
☐	In addition to reporting wages on IRS Form W-2, is the company including taxable benefits such as group legal services contributions or benefits, premiums for group term life insurance above $50,000, employer contributions towards certain domestic partners, and employer payments under adoption assistance plans?	Section 17.5
	Fiduciary Obligations	**Section 18**
☐	To the extent required, does the company have an updated fidelity bond in place equal to at least 10% of any health and welfare and retirement funds to a maximum of $500,000? Is this bond reviewed and updated annually?	Section 18
	Employer Shared Responsibility (a/k/a the "Play or Pay" Mandate)	**Section 22**
☐	Is the company an "applicable large employer" subject to the Play or Pay Mandate?	Section 22.3
☐	Has the company identified who are "full-time employees" for purposes of the mandate?	Section 22.4
☐	Has the company satisfied the coverage test and affordability test?	Section 22.5
☐	Has the employer filed information returns identifying full-time employees and describing the coverage offered?	Appendix A
	Miscellaneous	
☐	If a plan covers non-tax dependent domestic partners, is the value of the coverage (minus any post-tax contributions) included in the employee's gross income?	Not in Guide
☐	If there are multiple companies/subsidiaries covered under a single, self-funded health plan, be sure they are a controlled group under ERISA to avoid creating a MEWA (Multiple Employer Welfare Arrangement).	Not in Guide
☐	Does the company have retirees or other people not on the payroll covered under the benefits plan?	Not in Guide

☐	Does the company have any type of special situations in place that would need to be signed off by an insurance carrier?	Not in Guide
☐	Does the company have liability insurance in place for Human Resource errors for ERISA fiduciary liability?	Not in Guide
☐	Does the company have employees who work (not reside) in any of the following states that require mandatory state short-term disability insurance: CA, HI, NJ, NY, RI, or Puerto Rico?	Not in Guide
☐	Does the company have employees who reside in any of the following states that require mandatory health insurance coverage: MA, NJ (2019), DC (2019), VT (2020), CA (2020), RI(2020)?	Not in Guide
☐	Can the company confirm that the owners of an S-Corp, LLC, LLP or Sole Proprietorship are not included in the pre-tax Section 125 plan and do not participate in FSAs?	Not in Guide
☐	If any plan with over 100 participants has a trust, is the trust being audited annually?	Not in Guide

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