Employee Benefits: Compliance Review – Non-ERISA Checklist

Client Name:

✓	?	!	−	Review for Church and Government Plans	Notes
				Has the employer received an official legal opinion from outside legal counsel that they fall under the ERISA safe harbor as a church or governmental plan?	
				This is of particular importance for any church-based employer or an employer of a quasi-governmental agency such as a school, fire department, etc.	
				Is the legal opinion re-reviewed by counsel following any important Supreme Court decisions relating to ERISA safe harbors?	
				Has the employer confirmed that none of the language in the documentation "borrows" language or terminology from ERISA, including but not limited to claims and appeals language or the term "Summary Plan Description".	

✓	?	!	−	Plan Documents	Notes
				Does the employer have adequate documentation of the health and welfare benefit plans offered to employees, including documents from insurance carriers, so when questions or concerns arise, they can be answered by the documentation?	
				If employer offers a retiree plan, is it properly documented, separately from the active employee plan?	

✓	?	!	−	Notices to Employees	Notes
				Please describe the process for providing notices and disclosures for participants.	
				Does the employer comply with the Notice of Exchange requirement under the ACA, which requires notification to all new employees (within 14 days of their start date)?	
				Do the employer's group health plans comply with the Newborns' and Mothers' Health Protection Act (Newborns' Act)?	
				Do the employer's group health plans provide coverage for mastectomies, and otherwise comply with the Women's Health and Cancer Rights Act (WHCRA)? Does the employer notify participants about the availability of this coverage at the time of enrollment in the health plan and then annually thereafter? **Note:** WCHRA does not apply to self-insured church plans.	
				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?	
				Does the employer disclose to CMS whether the coverage is "creditable prescription drug coverage". This disclosure is required whether the entity's coverage is primary or secondary to Medicare.	
				Does the employer distribute the HIPAA Notice of Special Enrollment Rights when employees are first eligible for coverage?	
				Does the employer distribute the CHIP Notice to employees annually?	
				Does the employer send the HIPAA Privacy Notice to employees automatically at time of enrollment, to others upon request, and within 60 days of a material revision to the notice?	
				Does the employer send a notice of availability of HIPAA privacy notice every 3 years?	
				If the plan is "grandfathered" under the ACA, has the grandfathered plan notice been distributed to participants on all plan materials relating to benefits? If the plan is grandfathered, has it eliminated or substantially eliminated a benefit since March 23, 2010, increased cost sharing percentages, increased copay, raised fixed cost sharing other than copayments, lowered the employer contribution rate by more than 5%, or added or reduced an annual limit?	
				Has the employer distributed the Surprise Billing Notice, effective January 1, 2022 and every year thereafter?	
				Does the plan require designation of a primary care provider? If so, does the employer provide the Notice of Patient Protections?	

✓	?	!	−	Eligibility	Notes
				What is the employer's waiting period, and is it the same for all employees/ new hires?	
				Does employer differentiate new hires that are variable hour, seasonal, etc.? If so does the ALE use the measurement-lookback or the monthly method?	
				Does the employer cover domestic partners? **See domestic partner section for more questions.*	
				Does the employer cover independent contractors, board members, etc.?	

✓	?	!	−	Domestic Partners	Notes
				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?	
				If the domestic partner is not a tax dependent, is the employer aware that employees are unable to spend money from account-based plans (i.e. FSA, HRA, HSA) on a domestic partner's medical expenses?	
				Is the employer aware, the domestic partner does not have any independent COBRA election rights? If the employer is providing COBRA-like coverage independently to a domestic partner, do their plan documents (and stop-loss provider if self-insured) allow for such coverage?	

✓	?	!	−	Summary of Benefits and Coverage	Notes
				Are Summaries of Benefits and Coverage (SBCs) being provided in accordance with the distribution rules and time frames 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 no later than 7 business days after receipt of request by participants or beneficiaries)?	
				• In a culturally and linguistically appropriate manner (i.e. foreign language) if applicable?	
				Does the employer 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 125 and Nondescrimination Testing	Notes
				List the pre-tax benefits.	
				If premiums or benefits are paid on a pre-tax basis, is the section 125 plan or plans formally adopted and documented? Documentation includes: written documents describing the available benefits, participation rules, election procedures, contribution limits and processes, applicable grace period provisions, election forms, salary reduction agreements, reimbursement request forms, mid-year election change forms, claims denial forms, COBRA forms, and HIPAA disclosures.	
				Are non-employees eligible for pre-tax benefits? Can the employer confirm that more than 2% owners of an S-Corp, LLC, LLP partners or Sole Proprietorship are not included in the pre-tax Section 125 plan and do not participate in FSAs or HRAs?	
				Has the employer performed nondiscrimination testing on all pre-tax benefits?	
				Has the employer identified in its plan documents which of the available qualifying events it recognizes, communicated these to the employees, and provided a time frame in which employees must notify the employer of a qualifying event (30, 35, 45, or 60 days).	
				Are employees allowed to change their HSA contribution at least once a month?	
				For self-insured plans, has the employer performed 105(h) testing?	

✓	?	!	−	Imputed Income	Notes
				In addition to reporting wages on IRS Form W-2, is the employer 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/or employer payments under adoption assistance plans?	
				Are incentives recieved through wellness programs imputed as income?	
				Are domestic partner's benefits treated as imputed income?	
				Are employer provided COBRA subsities imputed as income?	

				Affordable Care Act (ACA) Employer Mandate	Notes

				Which method does the Employer use to identify employees who are "full-time" for purposes of the employer mandate?
				• Monthly Measurement Method
				• Lookback Measurement Method
				  • What are the dates of the standard measurement period, administration period & stability period? What are the initial measurement stability period time frames for variable hour new hires?
				  • Does the Section 125 Plan Document allow an employee who is locked in a stability period to change their medical election if the employee is working part-time hours?	

				Does the Employer offer coverage to the full-time employees and their dependents?	
				Upon which affordability safe harbor is the Employer relying: • W-2 • Rate of Pay • Federal Poverty Level? Did employer properly calculate the impact of any wellness program differential's in this calculation?	
				What is the employee's cost for the EE-O tier MV "base" plan? Plan Years Beginning in 2021: 9.83% Plan Years Beginning in 2022: 9.61%	
				Does the employer file information returns (Forms 1094/1095) identifying full-time employees and describing the coverage offered?	
				Does the employer furnish hard-copy Forms 1095 to employees, using electronic distribution only if employees "opt-in" and consent to receiving the Forms electronically? **1095-C Due to Participants**: March 2, 2022 **1094-C & 1095-Cs Due to IRS (Filing on paper)**: February 28, 2022 **1094-C & 1095-Cs Due to IRS (Filing electronically)**: March 31, 2022 **Failure to File / Failure to Furnish Penalties** 2022: $280 per failure 2023: $290 per failure	
				Does the employer live in a state with an individual mandate? (CA, RI, DC, MA, NJ, VT, HI).	

				Health Savings Accounts (HSAs)	Notes
				If the employer offers a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), is the employer complying with the rules governing HDHP/HSA plans, including contributions?	

Health Savings Accounts (HSAs)	2021	2022
HSA contribution limit (employer + employee)	Self-only: $3,600 Family: $7,200	Self-only: $3,650 Family: $7,300
HSA catch-up contributions (age 55 or older)	Self-only: $1,000 Family: $1,000	Self-only: $1,000 Family: $1,000
HDHP minimum deductibles	Self-only: $1,400 Family: $2,800	Self-only: $1,400 Family: $2,800
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	Self-only: $7,000 Family: $14,000	Self-only: $7,050 Family: $14,100

				Is the HDHP structured to preserve HSA eligibility? Examples impacting eligibility includes:
				• Allowing first dollar coverage HRA or FSA funds
				  • Structure a limited-purpose or post-statutory deductible FSA/HRA
				  • Allow employees to forfeit carryovers from the prior year when enrolling in the HDHP
				• On-site clinics providing more than first aid benefits
				• No-cost or low-cost telemedicine visits prior to satisfying the statutory deductible
				• No-cost or reduced costs at a hospital or clinic (including hospitals or clinics owned by the employer)
				• Regulated in a state with a drug accumulator program applicable to HDHPs
				• Entitled to Medicare	

				Does the Section 125 Plan Document allow an employee to change their HSA election once per month without a Qualifying Life Event?	

				Health Reimbursement Arrangements (HRA)	Notes
				Does the employer offer only certain individuals an HRA?	
				Does the employer file the PCORI for the HRA?	

				Flexible Spending Accounts (FSAs)	Notes
				If the employer 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?	
				If the employer offers a health care FSA, does it qualify as an "excepted benefit"?	
				Does the employer offer a carryover feature or grace period?	
				If the employer offers both a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), and a plan with a health care FSA, is it ensuring that participants who move between plans during open enrollment are not locked out of HSA eligibility in the upcoming plan year?	

Flexible Spending Accounts (FSAs)	2021	2022
20% Caryover Allowed	$2,750	$2,850

Health Care FSA Plan Design	Impact on HSA Eligibility
Grace Period and • Participant has a health FSA balance on the last day of the plan year[1].	Participant is not eligible to contribute to an HSA, or receive contributions from employer until the first of the month after the end of the grace period (e.g. April 1st if calendar year plan with 2 ½ month grace period).
Grace Period and • Participant does not have a health FSA balance on the last day of the plan year. (e.g. full amount elected reimbursed and the bank account shows $0.00).	Participant is eligible to participate in an HSA on the first day of the next plan year. HSA eligibility in not impacted.
Carryover/Rollover and • Participant has a health FSA balance on the last day of the plan year[1, 2].	Participant is not eligible to contribute to an HSA, or receive contributions from employer for the entire subsequent plan year, even after the carryover is exhausted and even if the employee does not make or receive new health FSA contributions for that plan year.
Carryover/Rollover and • Participant does not have a health FSA balance on the last day of the plan year. (e.g. full amount elected reimbursed and the bank account shows $0.00).	Participant is eligible to participate in an HSA on the first day of the next plan year. HSA eligibility in not impacted.

[1]unless the plan is designed to permit participants to opt-out or waive the grace period or carryover prior to the beginning of the following year.

[2]unless the plan is designed so a minimum threshold amount is required to create a new annual election and their balance is less than to the limited purpose FSA for employees who elect an HDHP.

				Dependent Care Assistance Program (DCAP / DCFSA)	Notes
				If the employer offers a Dependent Care Flexible Spending Account (also known as a dependent care assistance program DCAP), does it comply with the rules governing such arrangements including eligible expenses, gainful employment rule, eligible dependents and allowable changes in status?	
				Does it perform nondiscrimination testing at least once a year?	

✓	?	!	−	Consolidated Omnibus Budget Reconciliation Act (COBRA)	Notes
				Does the employer offer COBRA continuation coverage to those losing coverage due to a "qualifying event"?	
				Is the employer satisfying all applicable COBRA notice obligations? This should be overseen and varified routinely. Has the employer established and maintained a COBRA record keeping process that includes all COBRA notifications with dates sent and detailed records of COBRA rejection or acceptance?	
				Does the employer follow state-specific continuation laws e.g. Mini-COBRA laws, if applicable?	
				Does the employer offer COBRA-like coverage for domestic partners?	
Note: Church plans are not subject to COBRA.					

✓	?	!	−	Leave	Notes
				Does the employer comply with Family Medical Leave of Absence (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? If it has multiple locations has it determined which locations are applicable?	
				Does the employer comunicate in advance how premiums are paid when a employee is on leave?	
				Are employees required to maintain all coverage when on leave?	
				At what point in time is an emloyee no longer active while on leave?	
				Has the employer developed reasonable procedures for employees on qualified military leave (Uniformed Services Employment and Reemployment Rights Act - USERRA) to use in electing continuation coverage?	
				Does the employer post a DOL notice of rights, benefits, and obligations under USERRA?	

				Wellness Programs	Notes
				Does the employer differentiate between smokers or vaccinated employees?	
				If the employer offers a Wellness Program, has it been reviewed by benefits counsel for compliance with all applicable federal laws and DOL requirements? Has the employer provided the ADA, GINA, and/or RAS notice?	
				Has the employer considered the tax consequences of wellness incentives, if offered? Are spouses, domestic partners, and dependants eligible for incentives?	
				If the employer 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? This notice should be included anywhere contributions are described.	
				If the employer 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)?	
				Has the employer considered the impact of its wellness program on the "affordability" of employee premium contributions under the ACA?	

				Medicare	Notes
				Does the employer 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).	
				Does the employer provide an annual notice to all Medicare eligible individuals covered under their prescription drug plan?	
				Does the employer incentivize Medicare eligible individuals to take Medicare over the group health plan?	

				State Specific	Notes
				Does the employer have employees who work (not reside) in any of the following states that require mandatory state short-term disability insurance: CA, DC, HI, NJ, NY, RI, WA or Puerto Rico?	
				Does the employer have employees who reside in any of the following states that require health insurance coverage: CA, DC, MA, NJ, RI, VT?	
				Do any employees reside in Illinois?	
				Has the employer considered relevant state family and medical leave regulations?	

✓	?	!	−	Self-Funded Plans	Notes
				Has the employer paid the PCORI fee?	
				Does the employer have any type of special situations in place that would need to be signed off by an insurance carrier or stop loss provider (e.g. benefits continue during unprotected leave of absence)?	
				Are benefits paid from the general assets of the employer?	
				Has the employer performed a risk assessment?	
				Does the employer 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)?	
				Does the employer obtain signed Authorization to Release Information forms from employees in order to receive PHI for purposes other than treatment, payment or health care operations?	
				Does the employer 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)?	
				If the employer electronically maintains or transmits PHI, has it established a formal policy and implemented procedures to adhere to the requirements of the security standards (including the notification requirement for breach of unsecured PHI under the HITECH Act)?	
				Has the employer evaluated whether it is a covered entity under Section 1557 (e.g., because it's principally engaged in providing health care services and receives federal funding), or sponsors a plan that is under Section 1557 (e.g. the employer is not principally engaged in providing health care services but receives money from HHS for its health plan) of the ACA prohibiting discrimination in certain health programs and activities on the basis of, among other grounds, sex? If so, has it taken the steps to comply with the requirements of that section?	
				Have you performed NQTL analysis under the MHPAEA?	

				Transparency	Notes

				• In Oct. 2020, CMS released final rules (the "TiC Final Rules") requiring plans and TPAs to make available personalized out-of-pocket cost information for all covered health care items and services, as well as publish the in-network negotiated rates with their network providers.
				• Under these rules, most self-insured plans and insurance carriers must disclose price and cost-sharing information to participants.
				  • Participants are entitled to personalized out-of-pocket cost information for covered health care items and services.
				  • Participants will have access to in-network negotiated rates, historical payments of allowed amounts to out-of-network providers, and historical net prices for covered prescription drugs.
				  • Plans must prepare 3 separate machine-readable files (MRFs) by July 1, 2022.
				• TiC Final Rules to be phased in between 2022-2024.	

				Beginning in 2022, plans and carriers to make price comparison information available to participants through an internet-based self-service tool.	
				Beginning December 2022, plans must report detailed information to the agencies regarding the cost of prescription drugs (e.g., the 50 most-dispensed brand drugs, number of paid claims for each of the 50 most-dispensed brand drugs, 50 costliest drugs in terms of annual spend, and 50 drugs with the greatest increase in cost) and every June thereafter.	
				Beginning January 2022, new provider directory standards require plans and carriers to establish a process for updating and verifying the accuracy of information in their provider directories and responding to telephone calls and electronic communications from participants about a provider's network participation status.	
				• The law bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers. • It also bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared under HIPAA with business associate for plan administration and quality improvement purposes. Effective plan year beginning in 2022.	

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