Checklist of Key 2020 Requirements for Health & Welfare Benefit Plan Sponsors

Complying with the many rules that govern health and welfare benefits can be a challenge for benefits administrators. EPIC has prepared this compliance checklist to help administrators manage their 2020 benefits compliance efforts.

Please note that this checklist may not cover every requirement applicable to a specific employee benefit plan. This list focuses on key federal requirements affecting most health and welfare plans and is subject to legislative or regulatory changes. Additional requirements or exceptions may apply under state insurance laws which vary from state to state. Administrators should also remember that the Affordable Care Act (ACA) remains in effect despite certain recent legislative and regulatory changes as well as legal challenges.

Mark Yes, No, N/A or insert applicable comment in space provided.

AFFORDABLE CARE ACT (ACA) REQUIREMENTS				
Employer Shared Responsibility ("Play or Pay") Mandate				
Are you prepared to comply with the ACA's "Play or Pay" mandate?	**Yes**	**No**		**N/A**
"Applicable large employers" (ALEs) that do not offer "minimum essential coverage" that is affordable and meets minimum value requirements to their full-time employees and dependent children are subject to penalties if a full-time employee receives a subsidy for health coverage through a Marketplace (Exchange). These requirements are known as the "employer shared responsibility" or "play or pay" provisions. An ALE is an entity that employed 50 or more full-time and full-time-equivalent (FTE) employees in the prior calendar year.				
Determine your ALE status for 2020 by calculating the number of full-time and FTE employees on business days for each calendar month in 2019 and dividing that number by 12.				
Full-time employees are common law employees who average 30 or more hours of service per week, or 130 or more hours of service in a month. Hours of service include all hours for which an employee is paid or entitled to payment. Employers must track hours of service for all employees (full-time, part-time, and seasonal) to determine whether they meet the full-time employee definition.				
Regulations provide guidance on how to determine ALE status, how to define full-time employees, how to measure a plan's affordability, and how to determine minimum value.				
Are you aware of the applicable penalties?	**Yes**	**No**		**N/A**
An ALE will satisfy the requirement to offer minimum essential coverage to "substantially all" of its full-time employees and their dependents if it offers coverage to **at least 95%** – or fails to offer coverage to no more than 5% (or, if greater, five) – of its full-time employees (and dependents)				

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AFFORDABLE CARE ACT (ACA) REQUIREMENTS

Employer Shared Responsibility ("Play or Pay") Mandate

The 4980H(a) Penalty: The monthly penalty assessed on ALE's that do not offer coverage to substantially all full-time employees and their dependents is equal to the ALE's number of full-time employees (minus 30) x 1/12 of the annual 4980H(a) penalty for any applicable month. (The 2020 penalty has not yet been announced.)

The 4980H(b) Penalty: ALEs that do offer coverage to substantially all full-time employees (and dependents) may still be subject to a penalty if such coverage is either unaffordable or does not meet minimum value and at least one full-time employee obtains a subsidy through the Marketplace. The monthly penalty assessed for each full-time employee who receives a subsidy is 1/12 of the annual 4980H(b) penalty for any applicable month. (The 2020 penalty has not yet been announced.)

However, the 4980H(b) Penalty B cannot exceed the amount an employer could be assessed under 4980H(a).

Is your health coverage affordable and does it provide minimum value?	**Yes**	**No**		**N/A**

Under the ACA, an ALE's health coverage is considered *affordable* if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year (as adjusted each year). The 2020 adjusted percentage is 9.78%.

A plan is considered to provide *"minimum value"* (MV) if it covers certain types of medical expenses and is designed to pay at least 60% of employees' health care costs. An employer can determine if the plan meets MV by using one of the four available methods.

Annual Information Reporting of Health Plan Coverage

Are you prepared to comply with the health plan coverage reporting requirement for 2019?	**Yes**	**No**		**N/A**

Health insurance issuers and sponsors of self-insured plans that provide "minimum essential coverage" (MEC) are required to report certain health coverage enrollment and other information on Forms 1095-B or Form 1095-C, respectively, to the IRS and covered individuals.

- ALEs are required to report offers of coverage to full-time employees and their dependents and certain health plan information on Form 1095-C.
- Form 1094-C is used to transmit Forms 1095-C to the IRS, which includes certain employer data.

The 2019 forms are due to individuals by January 31, 2020. Paper filing is due to the IRS by February 28, 2020, and electronic filing is due by March 31, 2020.

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Plan Design Changes				
Do you know the grandfathered status of your health plan?	**Yes**	**No**		**N/A**
A grandfathered plan is a health plan that was in existence when the ACA was enacted on March 23, 2010, and that has continuously adhered to certain guidelines. If plan changes go beyond those guidelines, the plan is no longer grandfathered. Grandfathered plans are exempt from some (but not all) of the ACA's requirements.				
If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2020 plan year. A grandfathered plan's status will affect its compliance obligations.				
If you move to a non-grandfathered plan at any time, confirm that the plan immediately complies with all additional patient rights and benefit provisions required by the ACA (Examples: coverage of in-network preventive care at 100%; limits on out-of-pocket maximums).				
Limits on Cost-sharing				
Does your plan comply with ACA limits on cost-sharing or out-of-pocket maximums?	**Yes**	**No**		**N/A**
Non-grandfathered health plans are subject to limits on cost-sharing or out-of-pocket (OOP) maximums. For 2020, the OOP maximums generally are limited to $8,150 per covered person (whether enrolled for self-only or family coverage) and $16,300 for all covered family members combined, with respect to coverage for essential health benefits.				
If you have a health savings account (HSA)-compatible high-deductible health plan (HDHP), your plan's OOP maximum cannot exceed IRS limits. For 2020, the IRS limits on HDHP OOP maximums are $6,900 for self-only coverage or $13,800 for family coverage. If the HDHP also is a non-grandfathered plan, it is subject to both the ACA limits and IRS limits.				
Ongoing ACA requirements				
Is your plan in compliance with the following ACA requirements?	**Yes**	**No**		**N/A**
No Pre-existing Condition Exclusions: Group health plans may not impose pre-existing condition exclusions.				
Child Coverage to Age 26: Group health plans that cover children of employees must extend coverage to children through the end of the month during which they turn 26.				
Limited Waiting Periods: Group health plans may not impose a waiting period that exceeds 90 calendar days. Many waiting periods have been shortened to "first of the month following 60 days" to ensure that health plan coverage will start within the maximum allowable 90-day waiting period.				

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Is your plan in compliance with the following ACA requirements?	Yes	No		N/A
Essential Health Benefits (EHBs): Non-grandfathered small group plans must cover each of the EHBs categories listed under the ACA. This requirement does not apply to grandfathered plans, self-funded plans or insured plans in the large group market. However, any plan that covers EHBs must conform to applicable ACA provisions such as prohibitions against lifetime and annual dollar limits and, for non-grandfathered plans, limits on cost-sharing.				
Clinical Trial Participants: Non-grandfathered health plans cannot terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny benefits to that individual for routine care that would otherwise be covered.				
Summary of Benefits and Coverage (SBC): Provide at enrollment and upon request in accordance with applicable distribution rules.				
Marketplace (Exchange) Notice: Provide Marketplace Notice to new employees within 14 days of hire in accordance with applicable distribution rules. Be prepared to assist employees with information if requested by the Marketplace to help determine an employee's eligibility for premium subsidies.				
Grandfathered Plan Notice: If you have a grandfathered plan, provide disclosure with all materials describing the plan's benefits (e.g., enrollment materials and Summary Plan Description (SPD).				
Patient Protection Notice (aka Physician Designation Notice): If you have a non-grandfathered plan, provide this notice at enrollment and include it in the SPD.				
W-2 Reporting of Health Coverage: Report aggregate cost of health coverage on Forms W-2 (Employers that filed fewer than 250 W-2s for the prior year are exempt from this requirement for the current year).				
Patient Centered Research Institute Fee (PCORI): The final PCORI fee for plan years ending from January 1, 2019, to September 30, 2019, will be due by July 31, 2020. Report and pay PCORI fee to IRS using Form 720. The IRS set the amount used to calculate the fee at $2.45 per employee covered by plan years ending October 1, 2018, through September 30, 2019. PCORI ends in 2019, and fees will not apply for plan years ending after September 30, 2019. Insurers file forms and make payments for insured plans; employers file and pay for self-funded plans.				
Medical Loss Ratio Rebates: Provide notice to affected plan participants if rebates are received from insurers. Handle rebates in accordance with the ERISA plan document provisions applicable to the medical plan, if subject to ERISA, or DOL Technical Release 2011-4, for further guidance.				

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OTHER BENEFITS REGULATIONS AND REQUIREMENTS

Wellness Programs

Do you sponsor a wellness program that offers health benefits (including biometric screening or health coaching)? If so, does the program comply with the Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), and Genetic Information Nondiscrimination Act (GINA) wellness rules?	**Yes**	**No**		**N/A**

Incentives for employee participation or meeting certain health standards must be designed to comply with HIPAA and the ADA. Alternative standards must be offered to employees for whom it is unreasonably difficult or inadvisable to meet the standard. Notice to participants about the program's alternative standards is required.

GINA's wellness rules apply to all wellness programs that request, require or purchase genetic information about employees or their family members. Genetic information includes a family member's medical history or health information. GINA restricts an employer from offering incentives to an employee in exchange for genetic information, which is defined by GINA to include family medical history.

Employers that offer wellness programs that collect employee health information must notify plan participants about the medical information that will be collected, how it will be used, who will have access to it, and how it will be kept confidential.

Mental Health Parity and Addiction Equity Act

Does your plan comply with the Mental Health Parity and Addiction Equity Act (MHPAEA)?	**Yes**	**No**		**N/A**

The MHPAEA is a federal law that generally prevents health plans that provide mental health – as well as substance use disorder benefits – from imposing less favorable benefit limitations on those benefits than those imposed on medical and surgical benefits. State laws may require additional standards with respect to mental health and/or substance use disorder benefits.

Health FSA Requirements

Does your health flexible spending account (Health FSA) limit employee pre-tax contributions to the annual federal limit?	**Yes**	**No**		**N/A**

An employee's annual pre-tax salary reduction contributions to a Health FSA cannot exceed $2,500 per year (as adjusted for inflation). The 2019 Health FSA maximum contribution limit is $2,700. The maximum 2020 Health FSA employee contribution limit has not yet been announced.

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Ongoing General Requirements				
Do you have the following documents, plan provisions, and processes in place?	**Yes**	**No**		**N/A**
Is your ERISA plan document up to date and available to participants and beneficiaries and U.S. Department of Labor (DOL) upon request?				
Has it been formally adopted?				
Is your SPD up to date, automatically provided to participants, and available to participants and beneficiaries (and DOL) upon request?				
Do you provide SPDs in accordance with DOL's distribution rules?				
Is your cafeteria plan document up to date and has it been formally adopted?				
Does your cafeteria plan include specific provisions applicable to your benefits plans? For example:				
▪ "Cash in lieu" provisions (if applicable)				
▪ Carry-over or grace period provisions (if adopted)				
▪ Health FSA contribution limit changes to match the federal limit (if adopted)				
▪ Health Savings Account (HSA) (if applicable)				
Do you provide up-to-date health plan notices, the Children's Health Insurance Program (CHIP) notice, Medicare Part D notice(s) and SBCs at enrollment or when otherwise required?				
Are notices distributed in accordance with applicable distribution rules?				
Is the annual Form 5500 filed in a timely manner? (if applicable)				
Are Summary Annual Reports (SARs) distributed as required? (if applicable)				
Are all required COBRA notices provided to plan participants? (if applicable) The initial COBRA notice should be mailed to employees' homes to ensure delivery to spouses. If you have a COBRA third party administrator (TPA), confirm that the TPA is issuing the required COBRA notices to plan participants (including the initial COBRA notice).				
Do you conduct regular testing on tax-favored benefits to ensure the plans do not discriminate, as required under the IRC? Non-discrimination rules apply to cafeteria plans, self-funded health plans (including health FSAs and HRAs), group term life, and dependent care assistance plans. Non-discrimination testing must also be conducted on HSAs, if part of the cafeteria plan. Additional non-discrimination rules for insured health plans are not currently enforced.				

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