Plan Administration Checklist

This checklist identifies the ongoing administration requirements that HR should be managing with respect to their health and welfare benefit offerings.

I. NOTICE & DISCLOSURE REQUIREMENTS

Upon hire		
	Notice of Coverage Options	▪ Must be provided to all newly hired employees (regardless of benefit eligibility) ▪ May be provided in hand, by mail or electronically[1]. **USI's Important Legal Notices Package: *Included***
	Employee Handbook	▪ May include important information related to benefits (e.g., eligibility terms, continuation of coverage policies, etc.) ▪ Many states and cities have leave (paid and unpaid) requirements that are disclosed in the handbook.
	Electronic Disclosure Request	▪ Employers that want to issue Form W-2 and/or Form 1095-C electronically to employees must obtain a separate signed electronic disclosure for *each* Form. ▪ Without the signed disclosure, the Form must be provided in paper form.
	FMLA Notice	▪ Employers subject to FMLA must provide a notice of Employee and Employer Rights to FMLA eligible employees. ▪ Notice may be distributed in: ¬ Employee Handbook; ¬ Other written guidance to employees concerning employee benefits or leave rights; ¬ By distributing a copy of the general notice to each new employee upon hire (distribution may be electronic).
Prior to, or in connection with, initial enrollment Unless otherwise noted, all of these notices may be provided to the plan participant (the eligible employee) in hand, by mail or electronically and are included in ***USI's Important Legal Notices Packet*** unless otherwise noted.		
	Summary of Benefits and Coverage (SBC)	▪ Summary of the medical plan's benefits and coverage (including any HRA). ▪ Document must meet certain government requirements and is produced by the carrier (or TPA in a self-funded arrangement)[2]. ▪ Must be provided in a non-English language with additional assistance available if employee resides in a county where at least 10% of the population is literate in the same non-English language. ▪ New model notices should be used for plan years that begin on or after April 1, 2017. ***Not included in USI's Important Legal Notices Packet***
	Notice of Special Enrollment Rights	▪ All group medical plans must provide a notice of special enrollment rights describing the opportunity to enroll in health plan coverage upon loss of other health plan coverage, loss of Medicaid coverage, eligibility for Medicaid/CHIP assistance, marriage, birth, adoption or placement for adoption.

[1] Unless otherwise noted, "electronically" means in accordance with the DOL Electronic Delivery Safe Harbor rules.
[2] Unlike carriers of insured health plans who are required by law to generate this document, the TPA in a self-funded arrangement may create this document by request and for a fee. Ultimately the plan sponsor is responsible for content and delivery of this document.

	WHCRA Notice	▪ Required if group health plan provides mastectomy benefits and reconstructive surgery.
	Medicare Part D *Participant* Creditable (non-Creditable) Coverage Notice	▪ Notice disclosing the Creditable (or non-Creditable) status of prescription drug coverage under the group health plan. ▪ Best practice is to provide to all plan participants and their spouses (even though the employer is only required to provide to Medicare eligible individuals). ¬ If providing by e-mail, include a statement that the employee-recipient must deliver this information to *any* Medicare eligible individual in the household.
	CHIPRA Notice	▪ Group health plan in a state with a CHIP or Medicaid premium assistance program for group health plan coverage. ▪ Must provide a notice to all employees to inform them of possible opportunities in the state in which they reside.
	HIPAA Notice of Privacy Practices	▪ Self-insured health plans (medical, dental, vision, health FSA, HRA) must provide to participants. ▪ Special rules apply for electronic delivery
	HIPAA Wellness Program Disclosure	▪ Health-contingent wellness programs must include a notice describing the availability of alternatives to achieve any reward. ▪ Consider including the notice next to any information that explains the program.
	ADA Wellness Notice	▪ If the employer incentivizes medical exams and/or disability related inquiries (e.g., physicals, risk assessments, biometric screening); the ADA notice must be provided.
	Grandfathered Plan Notice	▪ Required if the group health plan is grandfathered.
	Patient Protections Notice	▪ Non-grandfathered plan that requests or requires designation of a PCP (e.g., HMOs).
	Michelle's Law Notice	▪ **Not Common**. ▪ If a health plan extends eligibility for children *beyond* age 25 with student status, materials describing eligibility terms should include reference to continuation of coverage in the event the child takes a medically-related leave of absence from school.
Within 90 days of initial enrollment		
	Summary Plan Description (SPD)	▪ All **ERISA** plans must provide SPDs to participants. ▪ Booklets from the carriers typically do not contain required ERISA information; a WRAP SPD can be used to supplement the booklet and create a complete SPD. ▪ The WRAP SPD may also be used (in conjunction with a WRAP Plan Document) to pull multiple ERISA-covered benefits under a single ERISA plan. ▪ SPD should outline eligibility terms for each ERISA benefit offered by the employer. ▪ An SPD for a medical plan should include: ¬ Qualified Medical Child Support Order (QMCSO) procedures or a statement of where to obtain procedures, ¬ the Newborn's and Mother's Health Protection Act (NMHPA) notice, and ¬ COBRA reasonable procedures describing how to an individual notifies the plan of certain COBRA events.
	COBRA Initial General Notice	▪ Must be provided to covered participants and covered spouses. Delivery by first class mail is recommended.
Prior to, or in connection with, annual enrollment		
	See Initial Enrollment Notices	▪ Annually, eligible individuals should receive the following notices (as applicable): ¬ SBC ¬ Notice of special enrollment rights

		¬ WHCRA notice ¬ Medicare Part D *Participant* notice of creditable (or non-creditable) coverage ¬ HIPAA notice of privacy practices ¬ CHIPRA notice ¬ Wellness program disclosure ¬ Grandfathered status notice ¬ Patient protection notice ¬ Michelle's law notice **USI's Important Legal Notices Package: *Included***
Annual notices and reporting The following are provided annually; generally outside of the open enrollment window.		
	Form 5500	▪ For **ERISA** plans with at least 100 participants on the first day of the plan year (and insured and/or unfunded), the Form 5500 is due to the DOL no later than 7 months from the close of the applicable plan year. ▪ Must be filed electronically using the EFAST system. ▪ Funded plans, regardless of size, must file a Form 5500. ▪ If filing a single Form 5500 with multiple benefits included, there should be a WRAP plan document and SPD reflecting the single ERISA plan. ▪ For recordkeeping purposes, keep a copy of the DOL Acknowledgement Code verifying that the filing was received.
	Summary Annual Report (SAR)	▪ Due to plan participants (including COBRA participants) no later than 9 months following the close of the plan year to which the filing relates. ▪ Required if there is a 5500 filing (unless the plan is self-funded and unfunded). ¬ If there are insured and self-insured benefits under a single ERISA plan, the SAR is required, reflecting the insured benefits.
	Medicare Part D *CMS* Notice	▪ The plan sponsor must notify CMS no later than 60 days from the first day of the applicable plan year, of the creditable (or non-creditable) status of any prescription drug program. ▪ This is done through an online system.
	Medicare Part D *Participant* Creditable (non-Creditable) Coverage Notice	▪ If the plan sponsor does not provide the Notice to participants within the same 12 month period each year, then the plan sponsor must provide this notice annually by October 15 each year.
	Forms 1095-C to Full-Time Employees	▪ Applicable large employers (generally at least 50 employees in the preceding calendar year) must provide each ACA Full-time Employee (at least 30 hours of service on average a week determined under the applicable measurement method) with a Form 1095-C. ▪ Due no later than January 31 of the year following the calendar year to which the report relates.
	Form 1094-C and all Forms 1095-C to the IRS	▪ Applicable large employers must submit a Form 1094-C and all applicable 1095-Cs to the IRS. ▪ If filing electronically (required if there are at least 250 Forms), due by March 31 of the year following the calendar year to which the filing relates. ▪ If filing by paper, then February 28.
	MEC Reporting	▪ Self-insured plans, regardless of size, must report any coverage an individual has through a self-insured employer sponsored plan under the same time requirements that apply to the Forms 1095-C/1094-C described above. ▪ Applicable Large Employers satisfy this requirement by

		completing all parts of Form 1095-C. ▪ Small employers that self-insure will need to use the Forms 1094-B/1095-B to satisfy this requirement.
	Form W-2 with certain health care related information	▪ Due no later than January 31 of the year following the calendar year to which the report relates. ▪ Employers with 250+ employees must file the Form electronically and must include the value of health insurance coverage in Box 12 (using Code DD). ▪ Employer HSA contributions, Dependent Care FSA elections and the value of Group Term Life Insurance above $50,000 must be reported on the W2, regardless of the number of Forms filed with the IRS.
	Form M-1	▪ **Not Common**. ▪ An M-1 must be filed electronically each year by March 1 if the arrangement is a Multiple Employer Welfare Arrangement (MEWA).
Event notices The following are provided upon the occurrence of certain events. An employer's particular circumstances will determine when the following notices are provided.		
	Plan Documents	▪ All **ERISA** plans must have a written plan document. ▪ This includes the latest SPD, Plan Document or Wrap Plan, Cafeteria Plan Document, Form 5500, trust agreement, insurance contracts, other plan policies, procedures, ASO or TPA contracts and stop loss contracts. ▪ Must be provided to a participant, beneficiary, assignee or the Department of Labor within 30 days of a written request (and made available at the employer's principal business office).
	SPD Updates	▪ Should be updated and provided every 5 years if there are plan amendments (or every 10 years if there are no amendments.)
	Summary of Material Modification (SMM)	▪ SMM substitutes an amendment not otherwise included in the SPD. ▪ Any changes made to the ERISA plan and not included in the most recent SPD must be provided to participants within 210 days following the end of the plan year. ▪ Best practice is to provide as soon as possible.
	Summary of Material Reduction in Covered Services or Benefits (SMR)	▪ Health plan changes that result in a reduction of benefits or contributions require notice within 60 days of adoption of the change. ▪ Best practice is to provide as soon as possible.
	SBC and Uniform Glossary must be provided upon request	▪ Beginning 2017, the SBC will have a link to the Uniform Glossary – no separate document required.
	SBC changes outside of renewal	▪ Any change that affects the SBC and is made outside of renewal requires 60 days advance notice. ▪ Such notice satisfies any SMM or SMR notification requirement. ▪ *See* earlier comments regarding language assistance.
	QMCSO	▪ Employers with group health plans should follow QMCSO policies and procedures and ensure notifications are provided accordingly. ▪ **QMCSO Participant Notice.** Must provide notice regarding receipt and any qualification determination on a QMCSO. ▪ **National Medical Support Notice.** Must respond to a notice issued by a state agency responsible for enforcing a QMCSO.

	Federal COBRA Notices	▪ Applies to employers with at least 20 employees. ▪ COBRA vendor may be providing the Notices. ▪ **Applicable to**: Employers with at least 20 employees and any group health plan benefits (e.g., medical, dental, vision, underspent health FSA, onsite clinics, EAPs, HRAs, Teledoc). ▪ **Election Notice.** Provide notice to qualified beneficiaries[3] no later than 14 days after the plan administrator receives notice of a qualifying event[4] (such notice required within 30 days of the event). ▪ **Early Termination Notice.** Provide notice to qualified beneficiaries if COBRA ends before the entire COBRA period is exhausted (best practice within 14 days). ▪ **Unavailability of Coverage Notice.** Provide notice to qualified beneficiaries if COBRA is not available (best practice within 14 days). ▪ **Conversion Notice.** If applicable, notice required to QBs describing conversion options within 180 days. ▪ **State "mini-COBRA" laws.** To the extent state law requires "COBRA-like" continuation for insured contracts written in a particular state (e.g., CA, CT, and NY) discuss with carriers and vendors regarding any notification requirements.
	USERRA Notices	▪ Notice requirements apply to leave due to uniformed services, including a posted notice.
	Mental Health Parity and Addiction Equity (MHPAEA) Notices	▪ Applies to employers with at least 51 employees offering MH/SUD benefits and non-grandfathered insured plans in the small group market. ▪ **Medical necessity determination.** Participants and contracting health providers are entitled to receive criteria for medical necessity determinations upon request. ▪ **Cost exemption.** Notice is required to participants, beneficiaries and government agencies if an employer claims a cost exemption (**not common**).
	Notice of a Subsidy from the Marketplace	▪ Employers may receive notice from the Marketplace on any employee who receives a subsidy. ▪ Appeals process available.
	Medicare-related Notices	▪ **CMS Data Match Letters.** Employers may receive a data match request from CMS used to identify situations where Medicare incorrectly paid primary and seeks reimbursement from the plan. ▪ **Medicare Part D *Participant* Creditable (Non-Creditable) Coverage Notice.** Any time the creditable status of coverage changes and by request. ▪ **Medicare Part D *Participant* Creditable (Non-Creditable) Coverage Notice.** Notify CMS within 30 days of a change in the creditable status of the coverage or the termination of the prescription drug coverage. ▪ **Responsible Reporting Entities Reporting Requirement. Not common.** Self-administered, self-insured plans must report information regarding Medicare eligibles and soon-to-be Medicare eligibles. Only applies to a self-administered HRA if the annual benefit is more than $5,000.

[3] Employee, spouse or child who was covered by the group health plan on the day before the qualifying event.
[4] Certain events (termination, reduction in hours, divorce, death, child aging of coverage), when coupled with a loss of group health plan coverage, trigger a COBRA continuation of coverage right.

	FMLA	▪ Employees requesting leave under FMLA must receive certain notices, including: Rights and Responsibilities, Certification Form, and Designation Notice. ▪ Notice of non-payment of premium must be provided if premium payment is more than 30 days late and employer intends to drop coverage.
	Advance Notice of Rescissions	▪ Notice is required at least 30 calendar days prior to retroactive cancellation of coverage. ▪ Coverage may only be rescinded in limited circumstances (e.g. fraud).
	Conversion of Benefits	▪ Determine whether the carrier or the employer has the responsibly to notify an employee about conversion rights, if any. ▪ These rights may be included in life insurance, disability insurance and/or medical insurance policies. ▪ Conversion means that upon termination of employment the employee may be allowed to convert the group policy into an individual policy and continue existing coverage (e.g., convert a group term life insurance policy into an individual term life insurance policy). There are usually notice and timing rules that must be followed.

II. ADMINISTRATIVE REQUIREMENTS

General requirements	
Cafeteria Plan	▪ Written cafeteria plan (plan document) must be in place to allow pre-tax salary reductions to pay for qualified benefits. ▪ Only employees may participate in a cafeteria plan (not "self-employed" (e.g., partners, 2% shareholders in S-Corp, members of LLC)). ▪ Pre-tax elections are generally not revocable during the plan year except upon the occurrence of certain events.
Discrimination Testing	▪ A cafeteria plan and a self-insured health plan (e.g. major medical, health FSA) cannot discriminate in favor of highly compensated employees or highly compensated individuals[5]. ▪ Cafeteria plan testing should be performed at least once a year with year-end data (however, earlier testing is also recommended so corrections can be made). ▪ Employers may have discrimination issues under 105(h) if COBRA premiums are paid by the employer to former highly compensated employees.
Wrap Plan Document and SPDs	▪ All ERISA plans must have a written plan document and provide SPDs to participants. ▪ Wrap documents may be used to (1) ensure all appropriate ERISA language is contained in the plan documents and SPD and/or (2) to treat multiple benefits as a single plan. ▪ **Foreign Language Requirements:** SPD must contain a notice for assistance in a non-English language when (1) there are fewer than 100 participants and 25% are only literate in the same non-English language; or (2) there are at least 100 participants and the lesser of 500 or 10% are only literate in the same non-English language.
Eligibility Terms	▪ Eligibility terms should be spelled out in the SPD. ▪ **Spouse.** Coverage for spouses should be provided to both same and opposite sex spouses. ▪ **Non-tax dependents.** Benefits provided to non-tax dependents must be imputed as income unless paid for by the employee on an after tax basis. ▪ **Multiple employers under a single ERISA plan.** There must be sufficient common ownership for an ERISA plan to provide benefits to the employees of multiple employers (generally 80% common ownership is needed). ▪ **Non-employees**. Covering non-employee independent contractors or board members may not be allowed under the terms of the underlying contracts. Such coverage may also result in the creation of a MEWA which may not be allowed in certain states. ▪ **Medicare and Medicaid eligible individuals.** Status as eligible/entitled to Medicare may not be taken into account and benefits generally must be provided on the same basis as any other active employee.
Taxation	▪ **Tax free coverage.** Employer contributions (including employee pre-tax contributions) to the cost of accident or health insurance on behalf of an employee and the employee's spouse, child until the tax year he/she turns age 27 and tax dependents are non-taxable. ¬ Benefits are "tax-free" (except in a discriminatory self-insured plan).

[5] Highly compensated employee definition is applicable to cafeteria plans and highly compensated individuals definition is applicable to self-insured plans. The definitions are different and so the employer must be careful when designating employees in each category.

	▪ **Non-tax dependents.** The cost for coverage of a non-tax dependent (e.g., domestic partner) is based on the fair market value (FMV) less any after-tax payments. ¬ Imputed income calculations should be performed. ▪ **State tax rules.** State tax rules may differ from federal tax requirements in certain jurisdictions. ¬ This may include treatment of domestic partners, adult-aged children and HSA contributions. ▪ **Group term life insurance.** The value of group term life insurance in excess of $50,000 is subject to imputed income rules under Code section 79. ¬ The determination of the value is based on IRS Table 1 rates. ▪ **Disability insurance.** If LTD (or STD) is paid on a pre-tax basis, or employer paid, then the value of the benefit is taxable as income to the employee and subject to FICA tax. Determine whether the carrier/TPA pays the employer share of the FICA tax. ¬ If the LTD (or STD) is paid on an after-tax basis, then the benefit is tax free. ¬ If there is a combination of premium payments that are pre-tax and post-tax, then during the disability year, the benefits are taxable but at a pro-rated basis.
Records Retention	▪ Benefit plan records should be retained 8 years from the close of a plan year. ▪ Grandfathered plans must retain records supporting the status for as long as the status is claimed.
Participant Contributions & Plan Assets	▪ Participant contributions are plan assets and must be held in trust unless an exception applies (Technical Release 92-01). ▪ **Exception**: participant contributions made through a cafeteria plan and held in general assets of the employer are not required to be held in trust if they are used to pay claims or insurance premiums in a timely manner. ▪ Plan assets may only be used to pay plan expenses (e.g., claims) and reasonable administrative services.
ERISA Fiduciary Responsibilities	▪ ERISA fiduciaries must: ¬ Act solely in the best interest of plan participants and beneficiaries; ¬ Use plan assets for the exclusive purpose of paying plan benefits and reasonable administrative expenses; ¬ Act with the care, skill, prudence and diligence that a prudent person in a similar circumstance would use; ¬ Diversify plan investments (not usually applicable to health and welfare plans); and ¬ Act in accordance with the governing plan documents. ▪ Fiduciaries have personal liability for losses caused to the plan and a civil penalty may be assessed by the DOL for breaches of fiduciary duty. ▪ Fiduciaries of the plan should consider fiduciary liability insurance which protects the fiduciary. The bond does not cover fiduciaries.
HIPAA Privacy, Security & Breach	▪ Insured health plans that have access to PHI and self-insured health plan must establish HIPAA privacy and security policies and procedures. ¬ Assign a privacy officer and a security officer ¬ Conduct a risk analysis ¬ Implement procedures regarding the use and disclosure of PHI ¬ Self-insured plans should provide a HIPAA notice of privacy practices; insured plans with PHI should retain a notice on file and provide upon request.

	¬ Implement business associate agreements with third parties who have access to PHI ¬ Have appropriate safeguards in place to protect against breach ¬ Self-insured group health plans should have TPAs capable of complying with EDI requirements (including EFT remittance to providers) ¬ Annual HIPAA training of internal policies and procedures and specific requirements
Employer Shared Responsibility	▪ Applicable Large Employers may face penalties if health insurance coverage is not offered to substantially all full-time employees and their children to age 26, or coverage is offered but it is not affordable or minimum value.[6] ▪ **Applicable Large Employer ("ALE") Status.** ALE status is determined by counting full-time employees (and full-time equivalent employees) to determine whether the employer had at least 50 full-time employees in the previous year. ¬ All employees under a controlled group are counted. ▪ **Identify ACA Full Time Employees ("FTEs").** Employees who have on average at least 130 hours of service per month determined under the monthly or look-back measurement method. ¬ Employers should have a look-back measurement policy in place. ¬ Employers should maintain records of analysis performed and notifications, if any, issued to the employee. ▪ **Identify whether there is an offer of coverage to at least 95% of ACA FTEs and children to age 26.** To avoid the "A" penalty, at least 95% of all ACA FTEs (and their dependents) should receive an offer of minimum essential coverage ("MEC"). ▪ **Identify whether the coverage offered is minimum value.** To avoid the "B" penalty, health insurance must cover at least 60% of total benefits and cannot exclude hospitalization or physician services. ▪ **Identify whether minimum value coverage is *affordable* under a safe harbor.** To avoid the "B" penalty, the coverage must be affordable, determined under an IRS safe harbor when MV coverage is offered.[7] ▪ Perform affordability analysis once a year, prior to the beginning of the plan year. Consider specific rules: ¬ Flex Credit – an employer flex credit that is used only for medical care will decrease the affordability calculation. ¬ Opt-out Waiver – an opt-out waiver will increase the affordability calculation. ¬ Wellness premium differential – has no effect on affordability unless the premium differential is for a smoking/tobacco cessation program. If the premium differential is for a smoking/tobacco cessation program, then the premium

[6] For 2016 (increases for inflation each year).
"A" penalty. This penalty applies when an ALE does not offer at least **95%** of FTEs and their dependent children a group health plan (i.e., minimum essential coverage) and at least one FTE receives a subsidy in the Marketplace to purchase qualified health plan coverage. The penalty is $180/month (or $2,160/year) multiplied by the total number of FTEs – **30**.
"B" penalty. This penalty applies when an ALE offers at least **95%** of FTEs and their dependent children a group health plan (i.e., minimum essential coverage) but the coverage is not *affordable*, does not provide *minimum value* or excludes **5%** or fewer FTEs and one (or more) of those FTEs receive a subsidy in the Marketplace. In this case, the penalty is the lesser of:
- $270/month (or $3,240 annually) multiplied by each FTE who receives a subsidy in the Marketplace to purchase health insurance coverage; or
- the "A" penalty.

[7] **Safe harbors.** An employer will not be subject to a penalty with respect to an FTE if that employee's required contribution for the employer's lowest cost self-only coverage that provides minimum value does not exceed:
- 9.66% of W-2 wages (Box 1 on Form W-2); or
- 9.66% of the employees rate of pay (either $/hour multiplied by 130 hours or monthly salary); or
- $95.63/month (9.66% of 2016 FPL for 48 continuous states).

	differential will decrease the affordability calculation. ▪ Provide annual shared responsibility reporting (see annual notices and reporting).
Annual Dollar Limit Verification	▪ Certain employee benefit limits may increase each year (e.g. Health FSA, OOPM, Transportation, etc.). ▪ An employer should review plan documents (e.g. cafeteria plan documents, open enrollment materials, etc.) to ensure the annual limit has been updated accordingly (through a Plan Amendment). ▪ Otherwise, an employee would be limited to contribute the annual limit in the plan document or open enrollment materials, creating discrepancies. ▪ If the benefit is administered by a third party vendor, the vendor should be contacted to review necessary steps.
Secondary Payer Rules	▪ Generally, a group health plan will be the primary payer to Medicare. ▪ The employer cannot "take into account" an active employee's (or their family member's) Medicare status (e.g., cannot exclude Medicare eligible from the health plan or incentivize the Medicare eligible to drop group health plan coverage. ▪ The same is true with TRICARE. ▪ ERISA prohibits group health plans from taking into account Medicaid eligibility of participants.
Wellness Programs	▪ Carefully review rewards for compliance with HIPAA, GINA and ADA. ▪ Usually rewards that are less than 30% of the total cost of self-only coverage are permissible. ▪ Any reward that is above this 30% threshold should be reviewed for compliance.
PCORI Fee	▪ Self-insured health plans and HRAs must pay this fee. ▪ For 2015/2016, the amounts are $2.08 in the third year, $2.17 in the fourth year (depending on plan year start date) multiplied by the number of covered lives. ▪ This includes covered employees, spouses, domestic partners, children, COBRA qualified beneficiaries and certain retirees. ▪ Paid via Form 720 by July 31 of the calendar year following the last day of the applicable plan year.
Reinsurance Fee	▪ Self-insured health plans must pay this fee. ▪ 2016 is the last benefit year at $27/covered life. ▪ Enrollment counts due to HHS via pay.gov by November 15, 2016 and payment due January 15, 2017 (and November 15, 2017 if paying in two installments).
Medicare Tax Adjustment for High Paid	▪ Employers paying wages of more than $200,000 must withhold and additional 0.9% on the Medicare portion of FICA taxes. Not paid on the employer's portion of the FICA tax.

III. STATE SPECIFIC REQUIREMENTS

State/City Health Care Requirements	
Hawaii (Prepaid Health Care Act (PHCA))	▪ Mandates that employers provide health benefits to employees working at least 20 hours per week after one month of service, pay the total premium amount except for *1.5% of a participant's wages*, and cover various benefits (whether or not the plan is self-funded). ▪ Generally, the employer must purchase an insured approved health plan to comply with this requirement. ▪ A self-insured health plan would need approval by the Advisory Council before it will be deemed acceptable coverage for Hawaii residents. ▪ For more information visit http://labor.hawaii.gov/dcd/about-phc/.
Massachusetts	▪ Most of the state requirements affecting employers with employees residing in MA have been streamlined to coordinate with federal health care reform. ▪ However, employees who reside in MA must have Minimum Creditable Coverage (MCC) to avoid an individual state penalty tax.[8] ▪ To meet MCC, the plan must cover certain benefits. ▪ Employers outside of MA with MA employees will want to determine whether the health plan is MCC. ▪ At year end, a 1099-HC is issued to the MA residents to demonstrate MCC. ▪ Ensure your carrier/TPA can comply with this requirement, including submitting information to the MA Department of Revenue. ▪ For more information on MCC, visit http://www.mass.gov/courts/docs/lawlib/900-999cmr/956cmr5.pdf.
San Francisco (Health Care Security Ordinance)	▪ Employer with at least 20 employees must make a health care expenditure to an employee who performs at least 8 hours of work per week within the City or County of San Francisco. ▪ In most cases, if the employer offers the employee health insurance coverage, that offer is usually sufficient to meet this requirement. ▪ Issues arise if the employer has employees in San Francisco that are not offered health insurance coverage (e.g., part-time employees). ▪ There is an annual report that must be filed with the City. ▪ For more information visit http://www.sfgov.org/olse/health-care-security-ordinance-hcso.
Vermont	▪ Employers are required to pay Health Care Contributions for employees that are without coverage on their state quarterly Wage & Contribution Report. ▪ For more information visit http://labor.vermont.gov/wordpress/wp-content/uploads//HC-3-Info-for-completing-HC-1.pdf
Mandatory State Disability	
California	▪ Mandatory unless the employer has a government-approved voluntary plan. ▪ For more information visit: http://www.edd.ca.gov/Disability/.

[8] Under the Massachusetts Health Care Reform Law, employers and plan sponsors are not required to provide coverage that meets the Health Connector Board's MCC standards. However, employers, plan sponsors and carriers are required to provide a written statement, known as a 1099-HC, annually to each subscriber or covered individual residing in the Commonwealth to whom they have provided minimum creditable coverage in the previous calendar year. Therefore, carriers, employers, and plan sponsors will need to determine if their health benefit plans satisfy the MCC standards. In addition, carriers are required to disclose the MCC status of their fully insured health benefit plans sold in the Commonwealth of Massachusetts.

Hawaii (Hawaii Temporary Disability Insurance (TDI))	▪ Requires employers to provide partial wage replacement insurance coverage to their eligible employees for non-work-related sickness or injury (including pregnancy).[9] ▪ For more information visit http://labor.hawaii.gov/dcd/home/about-tdi/.
New Jersey (Temporary Disability Benefits Law (TDBL))	▪ Applicable to Employers with employees in New Jersey. ▪ Benefits are payable when a New Jersey employee cannot work because of sickness or injury that is not work-related. ▪ Both the employer and the employee contribute to the cost of temporary disability insurance. ▪ An employer is automatically covered under the State Plan unless workers are covered under an approved private plan for temporary disability insurance.[10]
New York (New York Disability Benefit Law (DBL))	▪ Requires employers to provide disability benefits coverage to employees for a non-work-related injury or illness. ▪ State mandated disability coverage can be obtained by an employer through: ¬ an approved disability benefits insurance carrier who is authorized to write this coverage, or ¬ an authorized and approved self-insured program of an employer. ▪ For more information, visit http://www.wcb.ny.gov/content/main/DisabilityBenefits/Employer/introToLaw.jsp.
Rhode Island (Rhode Island Temporary Disability Insurance (TDI))	▪ Provides income support to individuals who are out of work because of non-work-related illness or injury. ▪ The program is financed by employee payroll deductions. ▪ Most individuals who work in Rhode Island, regardless of place of residence, are covered by TDI. ▪ For more information, visit http://www.dlt.ri.gov/tdi/.
Puerto Rico	▪ The Commonwealth of Puerto Rico also has a government-run disability program. ▪ Employers may be able to offer a private plan, subject to approval. ▪ Contact information is available at 787-754-5353.
State Income Tax	
States With An Income Tax	▪ All states have a state income tax, except: Alaska, Florida, New Hampshire, Nevada, South Dakota, Tennessee, Texas, Washington and Wyoming. ▪ State taxation of certain benefits may differ from federal tax treatment (e.g., treatment of domestic partner benefits, coverage provided to children, treatment of HSA contributions). ▪ California, Alabama and New Jersey tax HSA contributions and interest.

[9] Employers may adopt one of the following programs to comply with this requirement:
- Purchase an insured plan from an authorized insurance carrier (list available at http://labor.hawaii.gov/dcd/files/2013/01/TDI-Carriers.pdf).
- Provide a self-insured plan, called a "sick leave policy". Such a program must receive approval from the state before it can be put into effect and must demonstrate financial solvency and ability to pay benefits.
- Provide a program pursuant to a collective bargaining agreement that contains sick leave benefits at least as favorable as what is required by the law.

[10] The TDBL allows employers the option establishing a private plan (insured or self-insured) for the payment of temporary disability benefits in place of the State Plan. Such private plans may be:
- contracts of insurance issued by authorized carriers,
- offered by employers as self-insurers after application is approved or
- agreements between unions and employers.

Marriage and Domestic Partners	
Marriage	▪ States are required to perform and recognize marriages for same-sex couples on the same basis as opposite-sex couples. ▪ Employers should consult with counsel if benefits are not offered equally to same and opposite sex married couples. ▪ Under federal law, a civil union or registered domestic partnership is *not* considered marriage. ▪ Valid common-law marriages are also recognized under federal law. ▪ The following states have common-law marriages: ¬ Alabama, Colorado, District of Columbia, Georgia (only if common-law marriage began before 01/01/1997), ¬ Idaho (only if common-law marriage began before 01/01/1996), ¬ Iowa, Kansas, Montana, Ohio (only if common-law marriage began before 10/10/1991), ¬ Oklahoma (only if common-law marriage began before 11/01/1998), ¬ Pennsylvania (only if common-law marriage began before 01/01/2005), ¬ Rhode Island, South Carolina, Texas and Utah.
Domestic Partners	▪ Some states to have state registries for domestic partners providing equal rights under the law as a spouse (e.g., WA, only where one partner is at least age 62). ▪ Some cities also have registries. ▪ Other states and/or employers may continue to mandate/offer domestic partner coverage.
Equal Benefits Ordinances	▪ Employers that contract with cities, counties or states may be required to demonstrate compliance with certain equal benefits or other ordinances in order to secure contracts.
State Fees on Self-Insured Plans	
Surcharges	▪ Self-insured plans may see surcharges applied to their benefit programs with respect to certain state assessments (e.g., 1% tax on claims paid in Michigan, New York public goods pool for claims incurred in New York).
Immunization Fees	▪ Idaho and New Mexico, New Hampshire, Alaska, Colorado and Rhode Island have mandatory annual vaccine assessments.
Claims Reporting Database	▪ Many states have claims databases where health plans/TPAs are required to submit claim information under state law. ▪ Self-insured ERISA plans cannot be required to comply with these requirements as the Supreme Court found a state law mandating reporting of claims data is preempted under ERISA.
State Insurance Mandates	
Insured Plans	▪ Insured plans are required to comply with specific state insurance laws that may require additional benefits, eligibility terms or processing requirements. ▪ Carriers can clarify how any state mandate affects the employer's plan. ▪ Example of these mandates includes coverage for certain types of providers, extension of coverage to children older than 25, extension of COBRA beyond 18-months.

State Leave Laws, Including Paid Leave	
Employers Should Review Leave Laws in Applicable States	▪ Most states have leave laws that either mirror or improve upon federal leave protections (FMLA). ▪ Additionally, many cities and some states have enacted paid leave. ▪ Review policies in the cities and states where you operate business. ▪ A discussion of these various requirements is beyond the scope of this summary.

IV. ACCOUNT BASED PLANS

Health FSA	▪ Part of the written cafeteria plan. ▪ Subject to discrimination testing, irrevocable elections, $2,550 annual limit and may affect HSA eligibility unless limited. ▪ Subject to COBRA if underspent. ▪ May have a grace period or carryover. ▪ Carryover is available during COBRA continuation period (at no additional cost). ▪ Employers may not seed the health FSA with more than $500 except in a dollar-for-dollar matching arrangement (uncommon)
Dependent Care FSA (DCAP)	▪ Tax favored reimbursement account included under the cafeteria plan that provides reimbursement of otherwise unreimbursed expenses for care of eligible individuals (e.g., children under age 13) while parents are working or looking for work. ▪ Subject to annual discrimination testing and $5,000 calendar year maximum.
Health Reimbursement Arrangement (HRA)	▪ Employer funded reimbursement account that must be integrated with a group medical plan. ▪ Disqualifying for purposes of HSA unless limited.
Health Savings Account (HSA)	▪ Must have qualified HDHP coverage and no disqualifying coverage to contribute to a HSA. ▪ Specific rules apply if an employer has a Health FSA and an HSA and an employee has a qualifying event permitting change of plan option. Generally, an employee is permitted to enroll in the HDHP, but cannot contribute to an HSA. ▪ An individual cannot contribute to a HSA if enrolled in Medicare.
Qualified Transportation Fringe	▪ Tax free reimbursement or payment for these types of benefits (parking, vanpool, transit and bicycle). ▪ May be required by certain States and/or Cities, including NYC, San Francisco, and Washington D.C.