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December 2020

2021 Compliance Checklist

As we near the end of the year, group health plan sponsors should be aware of the numerous compliance requirements and filings to be completed for the year ahead. For plan years beginning on or after Jan. 1, 2021 there are many changes to understand and adopt to. Employers should review their plan documents to confirm that they include these required changes.

In addition, any changes to a health plan's benefits for the 2021 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, when applicable—for example, the summary of benefits and coverage (SBC). To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

Although no checklist is one-size-fit-all, the following items may need to be considered based on your group size, funding type, Grandfathered status, plan type (HDHP-HSA or not), etc.

Plan Design

Out-of-Pocket Maximum

Non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). The annual limit on total enrollee cost sharing for EHB for plan years beginning on or after Jan. 1, 2021, is **$8,550** for self-only coverage and **$17,100** for family coverage.

- ☑ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2021 plan year ($8,550 for self-only coverage and $17,100 for family coverage).
- ☑ If you have a high deductible health plan (HDHP) that is compatible with a health savings account (HSA), keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2021 plan years, the out-of-pocket maximum limit for HDHPs is $7,000 for self-only coverage and $14,000 for family coverage.
- ☑ If your plan uses multiple service providers to administer benefits, confirm that the plan coordinates all claims for EHB across the plan's service providers or divides the

out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2021.

Preventive Care Benefits

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (that is, deductibles, copayments or coinsurance) for the services. Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. If you have a non-grandfathered plan, you should confirm that your plan covers the latest recommended preventive care services without imposing any cost sharing.

Be cognizant of Task Force recommendations that may happen throughout the year, especially related to COVID-19 testing, treatment and vaccinations.
More information on the recommended preventive care services is available through the U.S. Preventive Services Task Force and www.HealthCare.gov.

Wellness Plan Design—ADA Compliance

The Americans with Disabilities Act (ADA) applies to employer-sponsored wellness plans that ask for health information or include medical exams (for example, biometric testing). In May 2016, the Equal Employment Opportunity Commission (EEOC) issued final rules addressing the ADA's requirements for employer-sponsored wellness programs. The final rules included a 30% limit for wellness incentives. A federal court vacated this incentive limit, effective Jan. 1, 2019. Consistent with this court ruling, the EEOC removed the incentive limit from its final wellness rules.

Due to the lack of guidance from the EEOC, it is currently unclear what level of incentive, if any, is permissible under the ADA for employer-sponsored wellness plans that ask for health information or include medical exams. If you sponsor a wellness program that asks for health information or includes medical exams, you should carefully review any incentive associated with the program (due to the lack of guidance from the EEOC).

Watch for any developments related to the EEOC's wellness rules.
If the EEOC issues proposed wellness rules before the start of the 2021 plan year, review your wellness incentives and consider whether to make any adjustments.

Health FSA Contributions

The ACA imposes a dollar limit on employees' salary reduction contributions to a health flexible spending account (FSA) offered under a cafeteria plan. An employer may impose

its own dollar limit on employees' salary reduction contributions to a health FSA, as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year.

The ACA set the health FSA contribution limit at $2,500. For years after 2013, the dollar limit is indexed for cost-of-living adjustments. For 2020 plan years, the health FSA limit is $2,750. The IRS has announced the health FSA limit for 2021 plan years will remain at $2,750.

HDHP and HSA Limits for 2021

If you offer an HDHP to your employees that is compatible with an HSA, you should confirm that the HDHP's minimum deductible and out-of-pocket maximum comply with the 2021 limits. The IRS limits for HSA contributions and HDHP maximum out-of-pocket limit increase for 2021. The HSA contribution limits will increase effective Jan. 1, 2021, while the HDHP out-of-pocket limit will increase effective for plan years beginning on or after Jan. 1, 2021.

Check whether your HDHP's cost-sharing limits need to be adjusted for the 2021 limits. The table on the next page contains the HDHP and HSA limits for 2021 as compared to 2020. It also includes the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2020	2021	Change
HSA Contribution Limit	Self-only	$3,550	$3,600	**Up $50**
	Family	$7,100	$7,200	**Up $100**
HSA Catch-up Contributions *(not subject to adjustment for inflation)*	Age 55 or older	$1,000	$1,000	No change
HDHP Minimum Deductible	Self-only	$1,400	$1,400	No change
	Family	$2,800	$2,800	No change
HDHP Maximum Out-of-pocket Expense Limit *(deductibles, copayments and other amounts, but not premiums)*	Self-only	$6,900	$7,000	**Up $100**
	Family	$13,800	$14,000	**Up $200**

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ACA DISCLOSURE REQUIREMENTS

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees to help them understand their coverage and make coverage decisions. Plans and issuers must provide the SBC to participants and beneficiaries who enroll or re-enroll during an open enrollment period. The SBC also must be provided to participants and beneficiaries who enroll other than through an open enrollment period (including those who are newly eligible for coverage and special enrollees).

On Nov. 8, 2019, the Departments of Labor (DOL) and Health and Human Services (HHS) issued an updated template and related materials for the SBC. These materials are required to be used for plan years beginning on or after Jan. 1, 2021. **This means that the updated template must be used for the 2021 plan year's open enrollment period**.

- ☑ In connection with a plan's 2021 open enrollment period, prepare to use the new SBC template and related materials. The SBC should be included with the plan's application materials. If coverage automatically renews for current participants, the SBC must generally be provided no later than 30 days before the beginning of the new plan year.
- ☑ For self-funded plans, the plan administrator is responsible for providing the SBC. For insured plans, both the plan and the issuer are obligated to provide the SBC, although this obligation is satisfied for both parties if either one provides the SBC. Thus, if you have an insured plan, you should confirm that your health insurance issuer will assume responsibility for providing the SBCs.

Grandfathered Plan Notice

If you have a grandfathered plan, make sure to include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. Model language is available from the DOL.

Notice of Patient Protections

Under the ACA, non-grandfathered group health plans and issuers that **require** designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Also, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If your plan is subject to this notice requirement, you should confirm that it is included in the plan's open enrollment materials. Model language is available from the DOL.

Other Notices and Documents

Initial COBRA Notice

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees that sponsor group health plans. Group health plan administrators must provide an initial COBRA notice to new participants and certain dependents within 90 days after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. A model initial COBRA notice is available from the DOL.

Notice of HIPAA Special Enrollment Rights

At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). This notice may be included in the plan's SPD.

Summary Plan Description

Plan administrators must provide an SPD to new participants within 90 days after plan coverage begins. Any changes that are made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or if the plan is amended. Otherwise, a new SPD must be provided every 10 years.

HIPAA Privacy Notice

The HIPAA Privacy Rule requires covered entities (including group health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who is the subject of protected health information (PHI). Health plans are required to send the Privacy Notice at certain times, including to **new enrollees at the time of enrollment**. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans are required to maintain and provide their own Privacy Notices. Special rules, however, apply for fully insured plans. Under these rules, the health

insurance issuer, and not the health plan itself, is primarily responsible for the Privacy Notice.

> ***Special Rules for Fully Insured Plans:*** The plan sponsor of a fully insured health plan has limited responsibilities with respect to the Privacy Notice.
>
> - If the sponsor of a fully insured plan has access to PHI for plan administrative functions, it is required to maintain a Privacy Notice and to provide the notice upon request.
> - If the sponsor of a fully insured plan does not have access to PHI for plan administrative functions, it is not required to maintain or provide a Privacy Notice.
>
> A plan sponsor's access to enrollment information, summary health information and PHI that is released pursuant to a HIPAA authorization does not qualify as having access to PHI for plan administration purposes.

Model Privacy Notices are available through HHS.

HIPAA Special Enrollment Notice

At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under HIPAA. This notice should be included with the plan's enrollment materials. It is often included in the health plan's SPD or insurance booklet. Model language is available in the DOL's compliance assistance guide.

Annual CHIPRA Notice

Group health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual notice about the available assistance to all employees residing in that state. The DOL has provided a model notice.

WHCRA Notice

Plans and issuers must provide notice of participants' rights to mastectomy-related benefits under the Women's Health and Cancer Rights Act (WHCRA) at the time of enrollment and on an annual basis. Model language for this disclosure is available on the DOL's website.

Medicare Part D Notices

Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D-eligible individuals who are covered by, or

who apply for, prescription drug coverage under the health plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage. The notice generally must be provided at various times, including when an individual enrolls in the plan and each year before **Oct. 15** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' website.

Summary Annual Report

Plan administrators who are required to file a Form 5500 must provide participants with a narrative summary of the information in the Form 5500, called a summary annual report (SAR). A model notice is available from the DOL.

Group health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file the Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period.

Michelle's Law Notice

Group health plans that condition dependent eligibility on a child's full-time student status must provide a notice of the requirements of Michelle's Law in any materials describing a requirement for certifying student status for plan coverage. Under Michelle's Law, a plan cannot terminate a child's coverage for loss of full-time student status if the change in status is due to a medically necessary leave of absence. Due to the ACA's age 26 mandate for dependent coverage, most health plans no longer condition dependent eligibility on full-time student status and, thus, are not subject to Michelle's Law.

HIPAA Opt-out for Self-funded, Nonfederal Governmental Plans

Sponsors of self-funded, nonfederal governmental plans may opt out of certain federal mandates, such as the mental health parity requirements and the WHCRA coverage requirements. Under an opt-out election, the plan must provide a notice to enrollees regarding the election. The notice must be provided annually and at the time of enrollment. Model language for this notice is available for sponsors to use.

Wellness Program Notices

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be

provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations.

HIPAA Wellness Program Notice—HIPAA imposes a notice requirement on health-contingent wellness programs that are offered under group health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (for example, not smoking) in order to obtain rewards. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program. The DOL's compliance assistance guide includes a model notice that can be used to satisfy this requirement.

ADA Wellness Program Notice—Employers with 15 or more employees are subject to the ADA. Wellness programs that include health-related questions or medical exams must comply with the ADA's requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure and the way information will be kept confidential. The EEOC has provided a sample notice to help employers comply with this ADA requirement.

Summary of Material Modifications (SMM)/Plan Amendment

Self-funded plan sponsors are responsible for distributing a SMM to members when any modification to the Summary Plan Description (SPD) is made. If the change is "significant", then the SMM must be distributed no later than 210 days after the effective date. IF the change is pertaining to a "reduction" in benefits, then the distribution must be no later than 60 days.

Summary Plan Document (SPD)

An SPD must be provided to new health plan participants within 90 days of the date their plan coverage begins. Employers may include the SPD in their open enrollment materials to make sure employees who newly enroll receive the SPD on a timely basis. Also, an employer should include the SPD with its enrollment materials if it includes notices that are required to be provided at the time of enrollment, such as the WHCRA notice.

In addition, an updated SPD must be provided to participants at least every five years, if material modifications have been made during that period. If no material modifications have been made, an updated SPD must be provided at least every 10 years.

ACA Affordability

Under the ACA's employer shared responsibility rules, applicable large employers (ALEs) are required to offer affordable, minimum value health coverage to their full-time employees (and dependent children) or risk paying a penalty. These employer shared responsibility requirements are also known as the "employer mandate" or "pay or play" rules.

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 adjusted percentage is 9.78% for 2020.

For plan years that begin on or after Jan. 1, 2021, the affordability percentage is 9.83%. This means that employer-sponsored coverage for the 2021 plan year will be considered affordable under the employer shared responsibility rules if the employee's required contribution for self-only coverage does not exceed 9.83% of the employee's household income for the tax year.

- ☑ If you are an ALE, confirm that at least one of the health plans offered to full-time employees (and their dependent children) satisfies the ACA's affordability standard (9.83% for 2021 plan years). Because the affordability percentage increased from 2020 when it was 9.78%, employers may have additional flexibility in setting their employee contributions for 2021 to avoid a penalty under the pay or play rules.

ACA Reporting and Disclosure

The ACA requires ALEs to report information to the IRS and to their full-time employees regarding the employer-sponsored health coverage they offer. The IRS will use the information that ALEs report to verify employer-sponsored coverage and administer the employer shared responsibility provisions. This reporting requirement is found in **Code Section 6056**.

The ACA also requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides MEC to file an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements

must also be provided to individuals. This reporting requirement is found in **Code Section 6055**.

> The IRS has provided **relief from the penalty for failing to furnish a statement to individuals as required under Section 6055 for 2019 and 2020** in certain cases. Specifically, the penalty for failing to furnish a Form 1095-B to responsible individuals will not apply in cases where the reporting entity:
>
> - Prominently posts a notice on its website stating that responsible individuals may receive a copy of their 2019 or 2020 Form 1095-B, as applicable, upon request; and
> - Furnishes a 2019 or 2020 Form 1095-B, as applicable, to any responsible individual upon request within 30 days of the date the request is received.

The individual mandate penalty has been reduced to zero, beginning in 2019. As a result, an individual does not need the information on Form 1095-B in order to calculate his or her federal tax liability or file a federal income tax return. However, reporting entities required to furnish Form 1095-B to individuals must continue to expend resources to do so.

Both of these reporting requirements took effect in 2015. **Returns are due in early 2021 for health plan coverage offered or provided in 2020.**

Returns generally must be filed with the IRS by **Feb. 28** (or **March 31**, if filed electronically) of the year after the calendar year to which the returns relate. For the 2020 calendar year, returns must be filed by **March 1, 2021** (since Feb. 28 is a Sunday), or **March 31, 2021**, if filed electronically.

Written statements generally must be provided to employees no later than **Jan. 31** of the year following the calendar year in which coverage was provided. For the 2020 calendar year, the deadline to furnish individual statements was set to be Feb. 1, 2021 (since Jan. 31 is a Sunday). However, the IRS has provided an **additional 30 days** for furnishing the 2020 Form 1095-B and Form 1095-C, extending the due date to **March 2, 2021**.

ALEs with self-funded plans are required to comply with both reporting obligations, while ALEs with insured plans will only need to comply with Section 6056. To simplify the reporting process, the IRS allows ALEs with self-insured plans to use a single combined form for reporting the information required under both Section 6055 and 6056.

ALEs that sponsor self-insured plans	ALEs that sponsor insured plans	Non-ALEs that sponsor self-insured plans	Non-ALEs that sponsor insured plans
Must report: 1. Information under Section 6055 about MEC provided; and 2. Information under Section 6056 about offers of health coverage.	Must report information under Section 6056. These employers are not required to report under Section 6055.	Must report information under Section 6055. These employers are not required to report under Section 6056.	These employers are not required to report under either Section 6055 or Section 6056.

Forms Used for Reporting

Under both Sections 6055 and 6056, each reporting entity must file all of the following with the IRS:

A separate **statement** for each individual; and

A single **transmittal form** for all of the returns filed for a given calendar year.

Under Section 6055, reporting entities will generally file Forms 1094-B (a transmittal) and 1095-B (an information return). Under Section 6056, entities will file Forms 1094-C (a transmittal) and 1095-C (an information return) for each full-time employee for any month. Entities that are reporting under both Sections 6055 and 6056 will file using a combined reporting method, on **Form 1094-C** and **Form 1095-C**.

Requirement	File with the IRS:	Furnish to each individual:
Section 6055	One Form 1094-B; and A separate Form 1095-B for each responsible individual	A copy of his or her Form 1095-B*
Section 6056	One Form 1094-C; and A separate Form 1095-C for each full-time employee	A copy of his or her Form 1095-C
Both Sections 6055 & 6056	One Form 1094-C; and A separate Form 1095-C for each full-time employee and each responsible individual	A copy of his or her Form 1095-C

**Note, though, that penalty relief is available for 2019 and 2020 calendar year reporting under certain circumstances for reporting entities that furnish Forms 1095-B to responsible individuals only upon request.*

Electronic Reporting

Any reporting entity that is required to file at least 250 returns under Section 6055 or Section 6056 must file electronically. The 250-or-more requirement applies separately to each type of return and separately to each type of corrected return. Entities filing fewer than 250 returns during the calendar year may choose to file in paper form but are permitted (and encouraged) to file electronically. Electronic filing will be done using the ACA Information Returns (AIR) Program. More information on the AIR Program is available on the IRS website.

Individual statements may also be furnished electronically if certain notice, consent and hardware and software requirements are met (similar to the process currently in place for the electronic furnishing of employees' Forms W-2).

Penalties

A reporting entity that fails to comply with the Section 6055 or Section 6056 reporting requirements may be subject to the general reporting penalties for failure to file correct information returns (under Code Section 6721) and failure to furnish correct payee statements (under Code Section 6722).

Penalties may be waived if the failure is due to reasonable cause and not to willful neglect or may be reduced if the failure is corrected within a certain period of time. Also, lower annual maximums apply for reporting entities that have average annual gross receipts of up to $5 million for the three most recent taxable years. **The penalty amounts for failures related to returns and statements required to be filed or furnished in 2021 have not been released at this time.** The penalty amounts for returns and statements required to be filed or furnished in 2020 are as follows:

Penalty Type	Per Violation	Annual Maximum	Annual Maximum for Employers with ≤$5 Million in Gross Receipts
General	$270	$3,339,000	$1,113,000
Corrected within 30 days	$50	$556,500	$194,500
Corrected after 30 days, but before Aug. 1	$110	$1,669,500	$556,500
Intentional disregard	$550*	None	N/A

**For failures due to intentional disregard, the penalty is equal to the greater of either the listed penalty amount or 10% of the aggregate amount of the items required to be reported correctly.*

Misc

Medicare Part D Disclosure to CMS

Group health plan sponsors that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether prescription drug coverage is creditable or not. In general, a plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of the Medicare Part D prescription drug coverage. Disclosure is due:

- ☑ Within 60 days after the beginning of each plan year;
- ☑ Within 30 days after the termination of a plan's prescription drug coverage; and
- ☑ Within 30 days after any change in the plan's creditable coverage status.

Plan sponsors must use the online disclosure form on the CMS Creditable Coverage webpage.

PCORI Fee

Deadline for filing IRS Form 720 and paying Patient-Centered Outcomes Research Institute (PCORI) fees for the previous year. **For insured health plans**, the issuer of the health insurance policy is responsible for the PCORI fee payment. **For self-insured plans**, the PCORI fee is paid by the plan sponsor.

The PCORI fees were scheduled to expire for policy or plan years ending on or after Oct. 1, 2019. However, a spending bill enacted at the end of 2019 extended the PCORI fees for an additional 10 years. These fees will continue to apply for the 2020-2029 fiscal years.

As a result, the Internal Revenue Service (IRS) issued Notice 2020-84 to increase the PCORI fee amount for plan years ending on or after Oct. 1, 2020, and before Oct. 1, 2021, to **$2.66** multiplied by the average number of lives covered under the plan.

Form 5500

Plan administrators of ERISA employee benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year, unless an extension has been granted. Form 5500 reports information on a plan's financial condition, investments and operations. Form 5558 is used to apply for an extension of two and one-half months to file Form 5500.

Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded, are generally exempt from the Form 5500 filing requirement.

The Department of Labor's (DOL) website and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.

Medical Loss Ratio (MLR) Rebates

The deadline for issuers to pay medical loss ratio (MLR) rebates for the 2014 reporting year and beyond is Sept. 30. The ACA requires health insurance issuers to spend at least 80 to 85 percent of their premiums on health care claims and health care quality improvement activities. Issuers that do not meet the applicable MLR percentage must pay rebates to consumers.

Also, if the rebate is a "plan asset" under ERISA, the rebate should, as a general rule, be used within **three months** of when it is received by the plan sponsor. Thus, employers who decide to distribute the rebate to participants should make the distributions within this three-month time limit.

General Reminders

- Update your COBRA rates for the new plan year. Along with notifying your administrator, be sure that current COBRA participants are properly notified of any changes.
- If you integrate a Health Reimbursement Arrangement (HRA) with your group medical plan, then you need to properly include and establish "rates" for the HRA under COBRA.
- Do you have an ERISA "Wrap" document? If so, then there may need to be updates to the document for the new plan year. It's also a good time to consider creating a Wrap document if there is not one in place.
- Plan sponsors are required to the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug benefits coverage is "creditable". The Disclosure must be made on the CMS web site:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm

It should be completed:

- Within 60 days after the beginning date of the Plan Year for which the entity is providing the Disclosure to CMS Form;
- Within 30 days after the termination of a plan's prescription drug coverage; and
- Within 30 days following any change in the plan's creditable coverage status.