HEALTH CARE PLANNING AND COMPLIANCE FOR SMALL EMPLOYERS

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I. PERMITTED HEALTH CARE FINANCING OPTIONS FOR SMALL EMPLOYERS

A. Small Business Health Care Tax Credit benefits employers that:

- Have fewer than 25 full-time equivalent employees
- Pay average wages of less than $50,000 a year per full-time equivalent (indexed annually for inflation beginning in 2014).
    - For tax year 2018, the inflation-adjusted amount is $53,400
- Offer a qualified health plan to its full-time employees through a Small Business Health Options Program; and
- Pay at least 50 percent of the cost of employee-only – not family or dependent – health care coverage for each employee

What is the Employer Credit?

The maximum credit is:

- 50 percent of premiums paid for small business employers; and
- 35 percent of premiums paid for small tax-exempt employers.
- The credit is available to eligible employers for two consecutive taxable years

The amount of the credit employers receive is on a sliding scale. The smaller the employer, the bigger the credit. So if you have more than 10 full-time equivalent employees or if the average wage is more than

$25,000 (as adjusted for inflation), the amount of the credit received is less.

Even if no tax is owed during the year, employers can carry the credit back or forward to other tax years. Also, since the amount of the health insurance premium payments is more than the total credit, eligible small businesses can still claim a business expense deduction for the premiums in excess of the credit. That's both a credit and a deduction for employee premium payments.

The credit is refundable, so if the employer is tax-exempt entity, the employer may be eligible to receive the credit as a refund so long as it does not exceed its income tax withholding and Medicare tax liability.

For information about State-based SHOPs participating in the direct enrollment process, such as the one adopted by federally-facilitated SHOP Marketplaces, see the Centers for Medicare & Medicaid Services (CMS) FAQs about flexibilities for State-based SHOP direct enrollment. The requirement to purchase insurance through the SHOP Marketplace did not apply to tax years prior to 2014.

Determining FTEs for the health care tax credit

In general, you consider all employees who perform services for the small employer during the tax year when determining the number of full-time equivalent employees, as well as average annual wages and premiums paid.

However, in your FTE calculation, do not include the wages and hours worked for the types of employees mentioned below. You also don't include the premiums paid on behalf of these employees to determine the amount of the health care tax credit:

- Owner of a sole proprietorship
- Partner in a partnership
- Shareholder of S Corporation owning more than 2 percent
- Owner of more than 5 percent of the business or other businesses
- Family members of the above

For purposes of the health care tax credit, one FTE generally equals 2,080 hours per year. This is different from other provisions of the Affordable Care Act that count 30 hours per week as one FTE. Any number of part-time employees that work a combined number of hours equal to that of a full-time employee equals one FTE. For example, two half-time employees count as one FTE; 20 half-time employees is equivalent to 10 FTEs. Exclude from the calculation the hours that exceed 2,080. Also exclude seasonal employees who work 120 or fewer days per year from the calculation of the number of FTEs and average annual wages; however, the health insurance premiums paid by the employer on behalf of these employees may be counted in determining the amount of the credit.

Calculating average annual wages

If you pay total annual wages of $200,000 to your 10 FTEs, you divide $200,000 by 10 — the number of FTEs — to determine your average annual wage. In this example, the average annual wage would be $20,000.

Claiming the health care tax credit

You must use Form 8941, Credit for Small Employer Health Insurance Premiums, to calculate the credit.

If you're a small business, include the amount as part of the general business credit on your income tax return.

If you're a tax-exempt organization, include the amount on line 44f of the Form 990-T, *Exempt Organization Business Income Tax Return*. You must file the Form 990-T in order to claim the credit, even if you don't ordinarily do so.

If you are a small business employer, you may be able to carry the credit back or forward. And if you are a small tax-exempt employer, you may be eligible for a refundable credit

What Years Can I Claim Employer Tax Credits for HealthCare?

- Eligible small employers (defined below) use Form 8941 to figure the credit for small employer health insurance premiums for tax years beginning in 2010.
- Starting in 2014, the employer tax credit is only offered for a 2 consecutive tax year credit period.
- Tax Credits are retroactive for tax years 2010 – 2012, meaning you can file for those tax credits if you haven't already.
- So a company who qualified since 2010 can claim 2010-2015, but not beyond. You also can't claim in 2014 and 2016, as the years must be consecutive.

Example of Tax Credit Calculations

Assumptions: Taxable employer. S Corporation with 1 owner. 12 full-time employees (excluding the owner). 4 part-time employees that each work 15 hours per week. Full-time employees each earn $16 per hour and work 40 hours per week. The employer pays $700 per month towards the health insurance for each of the 12 employees.

In this example the employer is eligible for a tax credit for the year of $30,870.

The government health care tax credit estimator can be found at:

https://www.healthcare.gov/shop-calculators-taxcredit/

B. Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

To avoid violating health care reform's prohibition on annual and lifetime limits and its preventive health services mandate, health reimbursement accounts for active employees generally must be integrated with other compliant group health coverage or be limited to providing excepted benefits (e.g., vision or dental expense reimbursements). Also, HRAs cannot be used to reimburse premiums for individual major medical coverage.

For years beginning after 2016, Congress has changed the rules for certain small employer HRAs as part of the 21st Century Cures Act ("Cures Act"). The Cures Act includes a provision that allows eligible small employers to help employees purchase individual market major medical coverage and pay for certain other medical expenses using a type of stand-alone HRA called a qualified small employer health reimbursement arrangement (QSEHRA) that is exempt from many of the group health plan requirements under the Code, ERISA, and the PHSA.

<u>Who is eligible to offer a QSEHRA</u>?

To offer a QSEHRA, employers may not be an Applicable Large Employer (ALE). This means they employ less than 50 full-time or full-time equivalent employees and are not subject to ACA coverage

requirements. These eligible employers also do not offer group health insurance to any of their employees.

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Who can contribute to QSEHRAs?

Like a regular health reimbursement arrangement (HRA), only employers can contribute to them. Employees cannot contribute. Contributions are tax-deductible to the employer.

What health expenses can QSEHRAs cover?

Employers can reimburse workers with individual coverage up to $5,050 in health costs in 2018, and those with family coverage up to $10,250. Those reimbursements are tax-free to employees, as long as they maintain minimum essential health insurance coverage (MEC) while they are receiving QSEHRA payments.

What's the advantage of a QSEHRA over a regular HRA?

Health reimbursement arrangements (HRAs) have been popular among small companies because they provide employers a tax break for reimbursing employees' health care costs and can help control overall health care spending. However, the ACA limited the use of those plans. It made "standalone" HRAs — those that reimburse costs for employees who are not covered by a group health plan — unlawful and assessed them an excise tax of $100 a day per employee.

The QSEHRA was created to allow small businesses with less than 50 employees to offer a standalone HRA again — reimbursing employees' health care costs on the individual market. Large companies are not eligible.

Do all employees have to be included in the QSEHRA?

Regular, full-time employees are eligible for a QSEHRA. Employers are allowed to, but not required to, exclude certain types of employees, including part-time and seasonal employees, those with less than 90 days of service, those under age 25, union employees and nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States.

Can owners who are considered “self-employed” participate?

No. Owners who are “self-employed individuals” within the meaning of Code §401(c) are not considered employees for this purpose and may not participate in an HRA on a tax-favored basis. Ineligible owners include partners, sole proprietors, and more-than-2% shareholders in a Subchapter S corporation. The ownership attribution rules in Code § 318 apply when determining who is a more-than-2% shareholder of a Subchapter S corporation.

What kind of notification requirements must employers follow?

When offering a new QSEHRA, employers must notify their employees at least 90 days in advance of the start of the year, or the start of a new employee's eligibility. It must also tell each employee:

- What the amount of the employee's annual benefit is;
- That the employee must report their QSEHRA benefit to the marketplace where they apply for premium tax credits (PTC); and
- That they will have to pay taxes on the benefit for any month that they fail to maintain health coverage.

Do I need A Plan Document and Summary Plan Description?

Yes. A QSEHRA is considered a health plan subject to ERISA, even though it is excluded from the definition of a group health plan. Plan document and SPDs are required.

What Expenses Can a QSEHRA Reimburse?

QSEHRAs can reimburse employees for medical care as defined under Code §213(d) that are incurred during the QSEHRA period of coverage. Thus, reimbursement of individual major medical health insurance premiums, as well as other Code §213(d) expenses incurred during the QSEHRA coverage period, is permitted. A QSEHRA can even reimburse premium payments for coverage of a spouse or other eligible family member, including expenses paid through another employer's plan. Although expenses incurred before or after the QSEHRA coverage period are not eligible, a QSEHRA can have a run-out period for submission of claims incurred during the coverage period. However, cash-outs of unused QSEHRA amounts (or other payments that are made irrespective of whether medical expenses are incurred) are not permitted (even on a taxable basis) and will disqualify a QSEHRA, causing all payments to all eligible employees to be taxable.

"Proof of Coverage" Requirement

QSEHRAs may only pay or reimburse medical expenses "after the employee provides proof of coverage." While the statute does not define the term "coverage" for this purpose, IRS guidance provides that each individual (including dependents) whose expenses will be reimbursed must have minimum essential coverage (MEC), either through the QSEHRA or another plan for the month in which the expense is incurred.

Funding

A QSEHRA must be funded solely by the sponsoring employer; no salary reduction contributions are permitted. Thus, QSEHRA funds must be an addition to salary, not a salary substitute. If salary reductions are used to fund benefits, the arrangement will cease to be a QSEHRA and would become a group health plan that fails the health care reform requirements prohibiting stand-alone, non-integrated HRAs and the use of HRAs or other account-based plans to reimburse premiums for individual market coverage.

Nondiscrimination and Uniformity

In general, a QSEHRA must provide for the payment or reimbursement of eligible medical expenses "on the same terms to all eligible employees" of the eligible employer and all other members of its controlled group. (This is called the "uniformity requirement.") Thus, an employer may choose to limit its QSEHRA benefit maximum (e.g., to a flat dollar amount or percentage of the current or prior year's QSEHRA maximum), but with the exception of carryovers of unused benefit amounts, the employer generally cannot vary the benefit level among eligible employees. IRS guidance clarifies that uniformity is determined on the basis of the amount made available for

reimbursement and not the amount actually reimbursed. Furthermore, when additional amounts are available for additional family members, the amount of permitted benefit for additional family members that have MEC must be available regardless of whether the additional family members are covered under a single policy or multiple policies, and regardless of whether each family member is also an employee. For this purpose, an "eligible employee" is any employee of the employer or other controlled group member. Thus, a QSEHRA will not meet the uniformity requirement if it is only available to the eligible employees of one eligible employer in a controlled group; instead, each employer in the group must offer a QSEHRA to its eligible employees and each QSEHRA must be provided on the same terms.

While a QSEHRA must generally provide uniform benefits, the employer can vary the amount of reimbursements available under the arrangement based on the eligible employee's age (and the family members' ages, if the arrangement covers family members), how many of an employee's family members are covered under the arrangement, or both factors.

The age and family size determinations can be made as of the first day of the QSEHRA plan year and need not provide for a change in permitted benefits if the employee's circumstances change during the year (e.g., the employee marries or divorces). Furthermore, employers can utilize rounding in increments of $50 to the nearest whole dollar (so long as the applicable statutory dollar limit is not exceeded). Any such variations must be made in accordance with the variations in price of an insurance policy in the relevant individual health insurance market that provides MEC and is available for purchase by at least one employee. For this purpose, any variations must be determined by reference to the same insurance policy with respect to all eligible employees.

Given the relatively low maximum QSEHRA limits and the difficulty of administering different benefit levels based on individual premium costs, many employers may choose not to vary the benefit maximum for their QSEHRAs.

An employee in one of the above excludable categories must be offered the QSEHRA no later than the day after the date on which the employee ceases to fall within any the excludable categories. If employees in any of the excludable categories are allowed to participate, they must receive the full QSEHRA benefit. An employer cannot provide a different QSEHRA benefit to otherwise excludable employees (even though it could, by plan design, exclude such employees completely). Furthermore, an employer that provides a group health plan to current employees in an excludable category is not an eligible employer.

Employees cannot waive participation in a QSEHRA (e.g., to preserve HSA eligibility) because a QSEHRA must be "provided" (not "offered") to all eligible employees. In addition, an employer cannot allow employees to select between different permitted benefit options (e.g., premium reimbursement or medical expense reimbursement) without running afoul of the uniformity requirement. These rules could cause individuals who would like to make HSA contributions to be ineligible for an HSA if the employer provides a QSEHRA that reimburses more than medical coverage premiums (e.g., it reimburses out-of-pocket medical expenses).

C. Health Reimbursement Arrangements

In general, a health reimbursement arrangement must meet the requirements of a group health plan including the annual dollar limit prohibition and the preventive services requirements. Most employers would not take on such liability.

Integrated HRA - Health reimbursement arrangements can be integrated with the employer's group health plan in order to meet the annual dollar limit prohibition and the preventive services requirements. An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if:

1. the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits;

2. the employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage);

3. the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse);

4. the HRA is limited to reimbursement of one or more of the following-co-payments, co-insurance, deductibles, and premiums under the non- HRA group coverage, as well as medical care (as defined under Code Sec. 213(d)) that does not constitute essential health benefits; and

5. under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon

termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code Sec. 5000A and will thus preclude the individual from claiming a Code Sec. 36B premium tax credit.

Who can participate in an HRA?

Tax-free benefits under an HRA can be provided only to current and former employees (including retirees), and their spouses, covered tax dependents, and children who have not attained age 27 by the end of the tax year.

Can owners who are considered "self-employed" participate?

No. Owners who are "self-employed individuals" within the meaning of Code §401(c) are not considered employees for this purpose and may not participate in an HRA on a tax-favored basis. Ineligible owners include partners, sole proprietors, and more-than-2% shareholders in a Subchapter S corporation.

The ownership attribution rules in Code § 318 apply when determining who is a more-than-2% shareholder of a Subchapter S corporation, so any employee who is the spouse, child, parent, or grandparent of a more-than-2% shareholder of a Subchapter S corporation would also be unable to participate in the S corporation's HRA

Anything special for businesses with just a single owner

Yes. Standalone Section 105 medical reimbursement plans (including Health Reimbursement Arrangements (HRAs) are consider group health plans under the Affordable Care Act. Because these plans

impose an annual dollar limit up to an amount established by the employer, the plan violates the “no annual dollar limits” requirement of the ACA. Similarly, because these plans do not provide preventive services without cost-sharing in all instances like a normal health care plan, they violate the preventive services requirements of the ACA.

There are some exceptions to these ACA requirements. Specific exemptions from the ACA market reforms are provided for plans with fewer than two participants who are current employees.

Plans that provide only ancillary benefits are also excluded from this prohibition, including:

Accident-only coverage

Disability income

Certain limited-scope dental and vision benefits

Certain long-term care benefits

Benefits under an employee assistance program, if the program does not provide significant benefits in the nature of medical care or treatment

Medicare Supplement Benefits

Because of the above exceptions, HRAs reimbursing only dental or vision expenses, for example, are still allowed. Furthermore, a sole proprietor with a single employee can continue to offer an HRA to that employee without also providing a group health care plan. Add another employee to the plan and the plan becomes noncompliant.

IRS Notice 2015-17 clarified that if an employee is covered under a reimbursement arrangement with his spouse or dependent (who are

also employees), this arrangement will be considered to cover only one employee. As such, a small family business with no other employees may continue to reimburse for a family plan and fall under the "fewer than two participants who are current employees" exception to the market reforms.

Can an HRA Provide Reimbursement for Individual Health Coverage or Medicare Part B, Part D, or Medigap for Active Employees?

Employer payment or reimbursement of Medicare Part B or D premiums for active employees will be considered a non-compliant group health plan, subject to the $100 per employee per day penalties, **unless** the employer payment plan is integrated with a group health plan. A reimbursement program will be considered integrated if:

The employer offered a group health plan to the employee that offers minimum value (a plan with at least 60% actuarial value that covers physician and hospital care), even if the Medicare-eligible employee declined it;

The employee who receives premium payments is actually enrolled in Medicare Parts A and B;

The program provides that premium payments are only available to employees who are enrolled in Medicare Part A and either Part B or D; and

Premium payment or reimbursement is only for Medicare Part B or D premiums and excepted benefits, including Medigap premiums.

This rule applies to employers of all sizes. Employers need to remember that Medicare Secondary Payer rules prohibit an employer with 20 or more employees from in any way incentivizing an active

employee to elect Medicare instead of the group health plan. Reimbursing premiums is generally considered an impermissible inducement, and therefore it is unlikely that as a practical matter employers with 20 or more employees are able to reimburse an active employee for Medicare or Medigap premiums.

A retiree-only plan is not subject to these PPACA requirements, and therefore reimbursing Medicare premiums for retirees generally is allowed.

Special rules for Reimbursing Premiums for 2% Shareholders. Questions have been raised about how the employer payment plan rules apply to 2-percent shareholders in S corporations. S corporation shareholders have specific requirements for deducting insurance premiums, under which the reimbursed premium is included in the 2-percent shareholder's income, but is deductible by the shareholder.

IRS Notice 2015-17 provides that, until further notice and at least through 2015, an S corporation may pay for, or reimburse, individual premiums for employees who are 2-percent shareholders without causing the employer to be treated as a sponsor of a non-compliant group health plan to which the $100 per employee per day penalty applies. However, an S corporation cannot use a premium payment arrangement of this type for employees who are not 2-percent shareholders.

The Notice also clarifies that when determining if a plan covers more than one employee (which is what brings the PPACA requirements into play), if only one person is covered as the employee (and the employee's spouse is covered as a dependent spouse and not as an employee), the plan is considered to cover only one employee. However, if an employer has multiple premium payment arrangements, it will be considered to have a single plan with multiple

participants, even though one arrangement covers a 2-percent shareholder and the other covers a non-shareholder

Plan Document and SPD Requirements – A plan document is required under the Internal Revenue Code and ERISA. Also, the ERISA requires that a summary plan description must be provided to the eligible employees.

Plan documentation. An employer establishes an HRA by adopting a formal plan and distributing a Summary Plan Description (SPD) to all eligible employees. The SPD describes among other things, the amount of money available to each employee's personal health account for the coverage. As eligible expenses are submitted, the employee's account is reduced and paid to them on a non-taxable basis. At the end of the HRA plan year, the employee's account is increased to the level of reimbursement applicable to the new year. Any funds left over from the prior year can either be forfeited or credited to the participant's bookkeeping account for the subsequent year, as determined by the employer in the initial design of the plan. Stand-alone HRAs are not permitted for health care expenses other than dental and vision unless the employer also maintains an ACA compliant group health plan.

II. UPCOMING FORM 5500 CHANGES - 2019-

On July 16, 2016, the DOL, IRS, and PBGC jointly issued proposed major changes to the 2019 Form 5500 that would affect retirement, health, and other welfare plans. The guidance and related materials totaled almost 1,000 pages.

Some of the notable proposed modifications include:

- Individual changes to schedules that include the addition of a new Schedule J for group health plans with questions specific to the Public

Health Service Act. Small group health plans that have been previously exempt from filing will now need to report coverage on Form 5500. This will increase the number of plan sponsors filing Form 5500 for health plan coverage. Schedule E for ESOP plans will be reinstated (this schedule was previously removed) and Schedule I for small plans will be eliminated and replaced by Schedule H with an audit report exemption.

- Schedule H will be expanded to incorporate information on alternative investments, hard-to-value assets and investments through collective investment vehicles through the inclusion of new categories, such as derivatives, foreign investments, limited partnerships, venture capital, private equity, hedge funds, self-directed brokerage accounts and tangible personal property. Plan sponsors will need to report the number and type of investment funds offered, including the default investment for the plan. Plan fees will be classified in greater detail including salaries, audit and recordkeeping fees. Additional changes will include reporting information currently on the Schedule H, Line 4i – Schedule of Assets (Held at End of Year) and Schedule H, Line 4j – Schedule of Reportable Transactions attachments directly onto the body of the Schedule H in order to present this information within the filing in a data compliance format necessary for the electronic filing requirements.

- Schedule C will include more information regarding fee disclosure requirements for small plan filers and a separate Schedule C for each service provider.

- New questions throughout that focus on plan participation and compliance, including reporting of any enhanced contribution details, monitoring uncashed checks for plan distributions, confirming whether 401(k) plan participants were provided required fee disclosures, whether required minimum distributions were made to 5 percent owners and if any

hardship distributions were made during the year. Additionally, plan coding descriptions will be replaced with “yes” and “no” responses.

- Audit requirements may be affected due to changing the audit count threshold on participants with actual account balances (rather than including in the count employees who are eligible to participate, but do not have an account balance).

- There are new required disclosures related to the plan auditor:

- Disclosure of the audit engagement partner and audit matters

- The auditor’s communications with those charged with plan governance

- The audit firm’s peer review information

- Inclusion of the plan’s limited audit scope certification (for plans for which a limited scope audit was performed)

- Increased Group Health Plan Filing Obligations. The proposal would require Form 5500 reporting by all ERISA group health plans (including those now covered by the filing exemption for small unfunded, insured, or combination unfunded/insured welfare plans), including a comprehensive new Schedule J (Group Health Plan Information).

- Schedule J would indicate the types of health benefits offered and the funding method, including information about participant and employer contributions, and whether the plan is insured, uses a trust, or pays benefits from the employer’s general assets. It would also require information about COBRA coverage and insurer refunds, and would ask whether the plan claims grandfathered status under health care reform or is a high deductible health plan, HRA, or health FSA. In addition, most filings (except those for small fully insured plans) would have to provide financial and claims information, and list TPAs, stop-loss carriers, and other plan service providers such as mental health or substance abuse

benefit managers. These filers must also answer questions about compliance with HIPAA, GINA, the mental health parity rules, health care reform, and other mandates, including specific questions about SPD and SBC compliance.

- Retirement Plan Changes That Would Apply to 401(k) Plans. The main body of the Form 5500 would request additional data about participant accounts, contributions, and distributions. Filers would have to indicate whether their plans use safe harbor or SIMPLE designs, or include Roth, investment education, or investment advice features. Information would also be requested about offset and 414(x) plans, default investments, rollovers used for business start-ups (ROBS), leased employees, and pre-approved plans. A separate Schedule E would be reinstated for ESOP reporting. Schedule R would include new questions about participation rates, matching contributions, and nondiscrimination.

- Proposals for All Types of Plans. A separate Schedule C would be filed for each service provider, and revisions would more closely align the schedule with the service provider fee disclosure rules. Also, the Schedule C filing requirement would be extended to some small plans currently exempt from filing it. Schedule H would be expanded to include questions on fee disclosures, leveraged asset acquisitions, annual fair market valuations, designated investment alternatives, investment managers, plan terminations, asset transfers, administrative expenses, uncashed participant checks, SPDs, and other topics. It would also distinguish between assets held for investment and those that were sold during the year. Schedule I would be eliminated; small plans that currently file Schedule I would generally need to file Schedule H instead. And plans that invest through a direct filing entity (DFE) would no longer be required to file Schedule D; DFEs would still file Schedule D.

- The changes are generally targeted to take effect with 2019 plan year filings. Similar changes are proposed for Form 5500-SF, which would no longer be available to group health plans.

HOW WILL THESE CHANGES IMPACT PLAN AUDIT REQUIREMENTS?

For smaller defined contribution plans, this proposal may ease audit requirements. Under the current rules, a plan with 100 or more participants at the beginning of the plan year must have an audit performed by an independent qualified public accountant. Under the revised rules, the plan will require an audit only if 100 or more participants have *account balances* at the beginning of the year.

III. HEALTH AND WELFARE PLAN DOCUMENTS

A. Plan Documents – ERISA requires that employer sponsored group health plans must be in writing. Without any other documentation, the "plan document" for an insured health plan will be the underlying insurance contract.

1. Eligibility – Many employers use a different eligibility requirement than what is stated in the underlying insurance contract. For example, the insurance contract may provide that employees that work 30 or more hours per week may participate in the plan on the first day of the month following 60 days or employment. In reality, we have seen many companies that require an employee to work 40 hours per week in order to be eligible for participation in the company health insurance plan.

2. Problem - Since these companies do not have a separate plan document and rely solely on the health insurance documentation, employees who work at least 30 hours per week in the above example have a right to participate in the

health insurance coverage. Such employees may also have an ERISA cause of action against the employer for retroactive coverage during the period they were not allowed to participate in the plan.

B. Summary Plan Description – ERISA requires that every health and welfare plan have a summary plan description. While some insurance companies may provide a summary of the benefits provided, many times such documents fail to satisfy the summary plan description regulations issued by the U.S. Department of Labor.

The summary plan description must describe all of the important plan rules and the benefits available under the plan, as well as key information about the plan, including:

- The plan name.
- The employer's name, address and employer identification number (also known as a federal tax identification number).
- The name, address and telephone number of the plan administrator.
- A name and address of the plan's agent for service of legal process.
- The plan number for annual reporting purposes.
- The plan year.
- The source of plan contributions.
- Information about plan trustees.
- A claims procedure.

- Information about eligibility for plan participation.

- A statement of ERISA rights.

Many of the insurance company booklets do not provide this required information. In addition, plan sponsors are required to distribute various annual notices to the participants. In many cases the insurance companies do not provide the employer or the participants the required notices.

Although you may find an insurance company that provides the employer with a satisfactory summary plan description, employers need to be mindful that the requirements apply to all health and welfare plans. A summary plan description prepared by a health insurer for the company health insurance plan will not help the employer meet the requirements for its dental plan, group life and disability plans, vision plans and other ERISA welfare benefit plans. Also, the SPD prepared by the insurance company will not include the service requirements the employer actually requires.

C. Certain benefits are referred to as "excepted benefits," The excepted benefits are:

1. limited scope dental or vision benefits;

2. benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;

3. other similar, limited benefits as specified in the regulations.

Also, benefits provided under a health flexible spending arrangement are excepted benefits if they meet certain requirements. Under this exception, the maximum benefit payable to any participant in the class for a year cannot exceed

two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

4. Excepted benefits are generally excluded from the Code's group health plan requirements, if either of the two following exceptions apply:

   a. They are provided under a separate policy, certificate, or contract of insurance; or

   b. They are otherwise not an "integral part of the plan."

   Prior to the issuance of guidance on December 24, 2013, to the extent the dental or vision benefits were provided on a self-insured basis, employees must have had the right not to receive coverage, and an employee that elected coverage was required to pay an additional premium (even a nominal amount) for such benefit.

   Proposed Regulations were issued on December 24, 2013 which modified the requirements for excepted benefits. Under the Proposed Regulations, benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if participants have the right to elect not to receive coverage for the benefits.