

Gap Analysis Report

Every employer sponsored health plan has risks, but with the right information and the right partners, you can minimize those risks. Below you will find the results of our analysis. Focusing on the action items and highlighted sections are great next steps to address any compliance issues discovered.



Plan year:
01/01/2025

EIN:
20-9209209

Medical Plan:
Self-Insured

ERISA Plan:
Yes

Controlled Group:
No

Full-time Employees:
123

New Hire Waiting Period:
1st of the month following 30 days

Coverages:

- ✓ **Group Medical**
- ✓ **Dental**
- ✓ **Voluntary Supplemental Life for Spouse/Dependents**
- ✓ **HRA**
- ✓ **Long-Term Disability**

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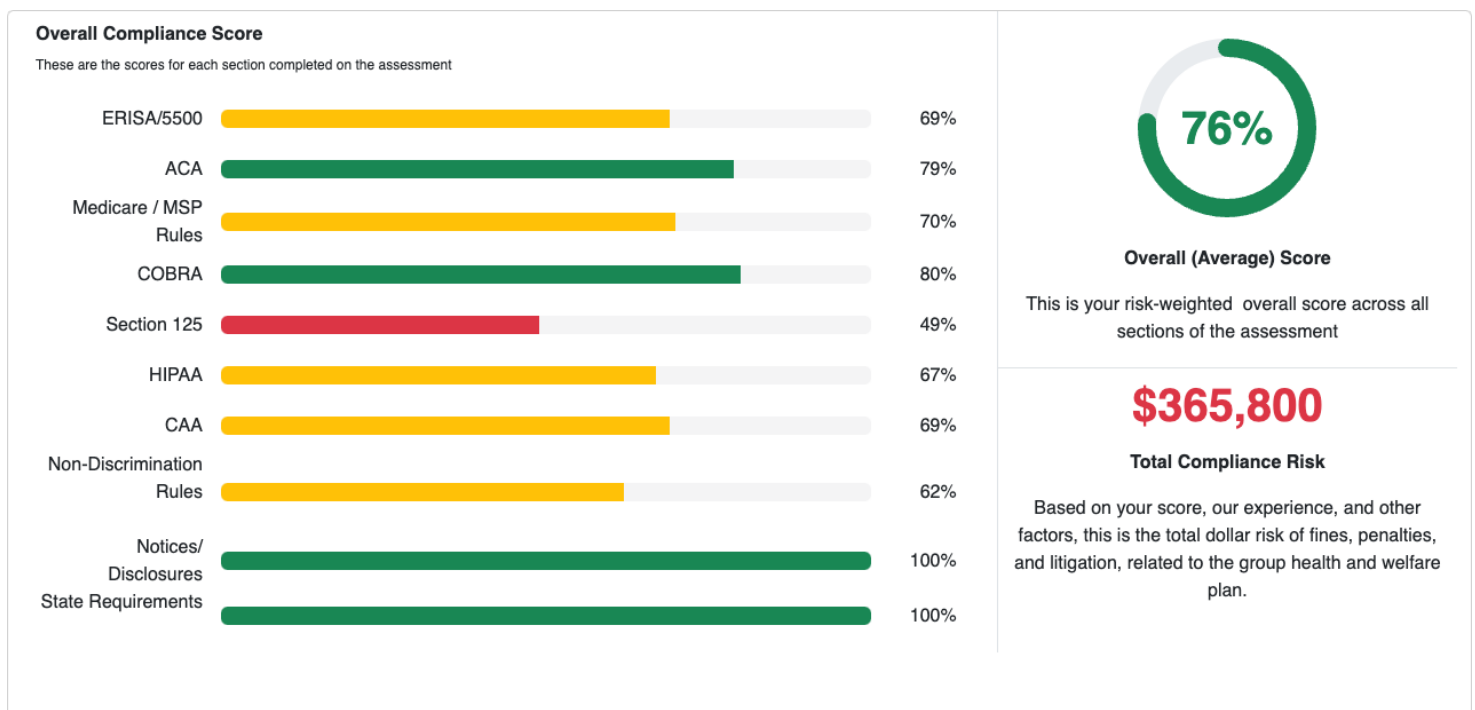
Executive Summary & Your Overall Scores

Executive Summary

Your overall compliance risk score is 76%, which is a weighted average across all sections of the assessment. Listed below in the executive summary, you will find a list of action items that you and your team can take in order to mitigate risk areas and avoid potentially expensive and stressful problems from happening in the near future.

If left unaddressed, this score translates to approximately \$365,800 in possible fines and penalties. This, of course, doesn't include the many hours spent by company leadership and staff trying to correct errors and locate records, sometimes months and years after the fact. A significant increase in the last 2 years in enforcement by the DOL and HHS, along with the increased transparency rules of the CAA, should be considered when developing a plan of action.

Your Overall Scores





Action Items

(14) Action Items

Below is a list of highlighted items for the employer to address. If available, you can add reminders for some of these items directly to the employer's calendar, or export into a printer-friendly list



#1 – ERISA "wrap" document required

Due:

Ensure ERISA "wrap" plan document/Summary Plan Description is adopted. If "wrap" is already in place, make sure it is amended for any appropriate changes (e.g., carrier, eligibility, plan coverage, etc.,) || Due date = last day of plan year for plan year indicated (ex. 1/1/xx plan year, last day is 12/31/xx)

Notes:

Responsible Party:



#2 – Check for carrier/TPA coverage booklets

Due:

Ensure copies of carrier or TPA Coverage Booklets (AKA Certs/COCs/SPDs/Plan Booklets) are received or in place for all lines of coverage. || Due date = last day of plan year for plan year indicated (ex. 1/1/xx plan year, last day is 12/31/xx)

Notes:

Responsible Party:



✓ **#3 – Summary Annual Report (SAR) distribution** Due: **September 30, 2025**

Make sure the Summary Annual Report (SAR) is distributed to plan participants within 9 months of the end of the plan year, or within 2 months of filing the Form 5500 (if 5500 was filed on extension)

Notes:

Responsible Party:

✓ **#4 – Properly use the look-back measurement period** Due:

Make sure to track variable-hour employees in a look-back measurement period to determine health plan eligibility

Notes:

Responsible Party:

✓ **#5 – Update major medical waiting period** Due:

Make sure medical plan waiting periods are less than 90 days

Notes:

Responsible Party:



#6 – MSP rules – no exclusion of Medicare-eligible individuals

Due:

Employers with more than 20 total employees are prohibited from excluding Medicare-eligible individuals from the group health plan

Notes:

Responsible Party:



#7 – Distribute the COBRA election notice

Due:

The COBRA election notice is provided upon a COBRA qualifying event to all qualified beneficiaries by first class mail

Notes:

Responsible Party:



#8 – Cafeteria Plan Document requirements

Due:

Make sure employer adopts a Section 125 Cafeteria Plan Document (AKA Premium Only Plan/POP) document with required contents/language

Notes:

Responsible Party:



✓ **#9 – Cafeteria plan participation prohibited for owners** Due:

Make sure self-employed owners (e.g. sole proprietors, partners, more than 2% shareholders in an S-corp) are not participating in cafeteria plan, including health FSA

Notes:

Responsible Party:

✓ **#10 – HIPAA policies & procedures** Due:

Employer must have written policies and procedures for the handling of PHI, regardless of fully insured or self-insured

Notes:

Responsible Party:

✓ **#11 – MHPAEA comparative analysis** Due:

Employer must perform Mental Health Parity QTL & NQTL comparative analyses

Notes:

Responsible Party:



#12 – CAA: RxDC reporting

Due:

Employer must ensure that RxDC reporting is submitted to CMS no later than June 1st each year

Notes:

Responsible Party:



#13 – Section 105h non-discrimination testing

Due:

Make sure Section 105h nondiscrimination testing is performed at least annually

Notes:

Responsible Party:



#14 – Add imputed infome for domestic partnership coverage

Due:

Make sure employer is imputing income for portion of the domestic partner coverage cost

Notes:

Responsible Party:

ERISA/5500 Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from ERISA/5500 compliance within the employer's group health plan.

\$155,000

Fiduciary Responsibility & Participant Protection

ERISA/5500 Requirements



ERISA/5500 score: 69%

Missing value for dynamic text component

Originally enacted to address concerns over the mismanagement of private pension funds, the Employee Retirement Income & Securities Act of 1974 (ERISA) was amended over time to include how plan sponsors handle the health care needs of participants. The majority of employers who sponsor a group health plan are subject to ERISA requirements, which include:

- A written plan document
- A Summary Plan Description (SPD) to be distributed to employees
- Summary of Material Modifications (SMM) should plan be distributed
- Form 5500 Filing with the Department of Labor (DOL)
- Summary Annual Report (SAR) to be distributed to participants

The Employee Benefits Security Administration, the IRS, and the Pension Benefit Guaranty corporation all play a role in the enforcement of ERISA through audits, investigations, and other means. As of 2023, some of the penalty amounts are as follows:

- Failure to furnish information to (or maintain records for), an employee: \$33 per employee per failure
- Failure (or refusal) to file a plan's annual report with the DOL. \$2,400 per day, starting on the date of failure (or refusal)
- Failure by multiple employer welfare arrangements (MEWAs) that provide health benefits to file an annual report on time with the DOL: \$1,746.
- Failure to provide plan info, such as a SPD, to the DOL in a timely fashion. \$171 per day (not to exceed \$1,713 per request).
- Willful failure by a group health plan to provide information to a participant and/or beneficiary. \$1,264 per failure..



ERISA/5500

ERISA/5500 Answers

Below you will find your answers provided in the ERISA/5500 portion of the assessment. Any items that need addressing are highlighted below.

Q1: Select all of the documents currently on file for the employer:

Answer: Self-insured medical plan document (provided by the TPA), None

Q2: What is the ERISA plan year listed on the ERISA wrap document?

Answer: No wrap in place yet

Q3: When the wrap was first adopted, was the wrap distributed to plan participants within 120 days?

Answer: Need to put a wrap in place.

Q4: Ongoing: Is the Wrap SPD provided to new plan participants within 90 days of plan enrollment?

Answer: Yes

Q5: Does the employer have 100 or more participants (includes active employees, retirees or COBRA QBs) enrolled on any of their current benefit plans as of the first day of the plan year, including employer-paid life or disability?

Answer: No

Q6: Has the employer filed a Form 5500 with the Department of Labor for the health and welfare benefits 7 months following the end of the plan year (or up to 2.5 months on extension)?

Answer: Yes



Q7: Does the employer distribute the Summary Annual Report (SAR) to all plan participants within 9 months of the end of the plan year or within 2 months of filing Form 5500 on extension?

Answer: No

⚠ Make sure the Summary Annual Report (SAR) is distributed to plan participants within 9 months of the end of the plan year, or within 2 months of filing the Form 5500 (if 5500 was filed on extension)

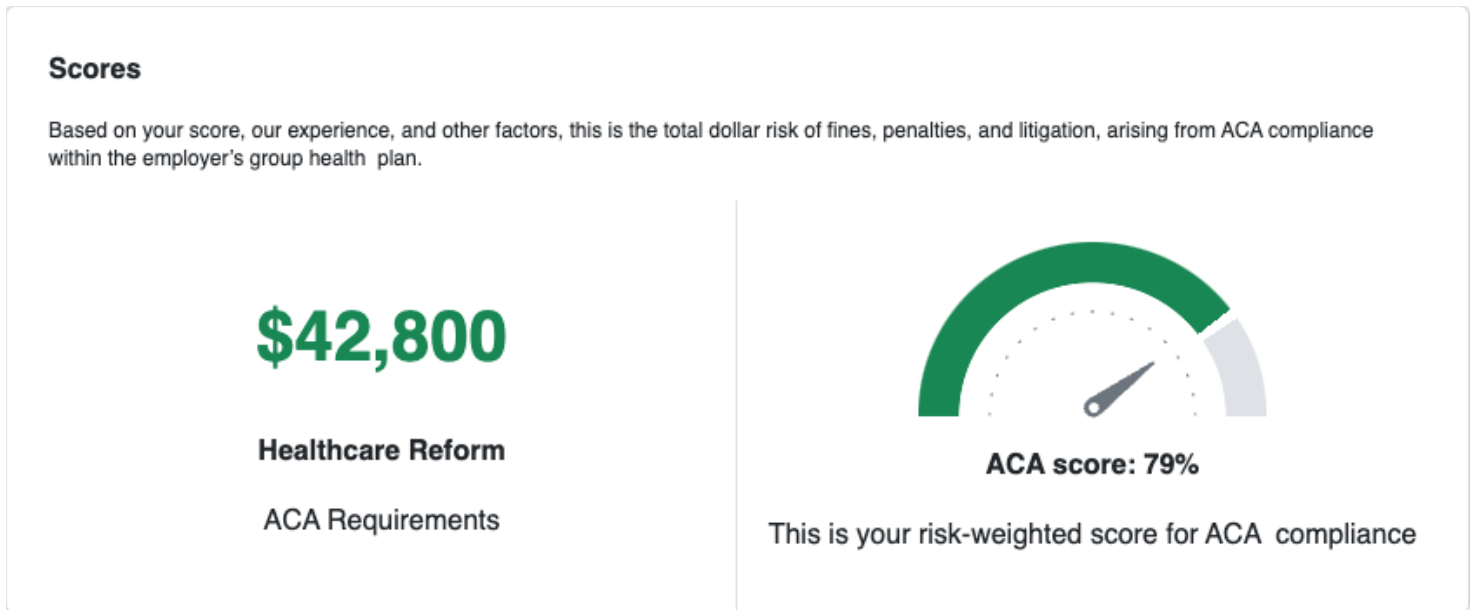
Q8: Are ERISA recordkeeping rules followed, requiring plan sponsors to maintain ERISA documents for not less than 6 years after the filing date of a Form 5500 (or the date it would be filed but for an exemption)?

Answer: Yes

Q9: Is the electronic disclosure safe harbor being met for electronic delivery of ERISA documents and required notices?

Answer: Yes

ACA Scores



The Affordable Care Act is often viewed as the cornerstone of compliance for employer health plans. Upon its passing in 2010, a wave of change necessarily occurred among carriers, employers, and brokers alike, changing how the entire industry perceived compliance. At the core of the law is affordability of healthcare for all Americans, which, for employer sponsored health plans, manifested itself in several key requirements, including:

- 6055 Reporting for Insurers and non-“Applicable Large Employers” (ALEs) with self-insured coverage
 - Includes filing 1095-C & 1094-C forms
- 6056 Reporting for ALEs
 - Includes filing 1095-B & 1094-B forms
- Defined thresholds for “Minimum Value” (MV) and penalties for failure to provide MV coverage for Applicable Large Employers
- Requirements to provide “Minimum Essential Coverage” (MEC) to 95% of FT eligible employees & their dependents for ALEs

To-date, the ACA remains one of the most widely enforced laws pertaining to group benefits, partially because the DOL has good information on employee headcount, premiums from payroll and W-2 data, as well as records on when an employee seeks other, more affordable coverage on the Healthcare marketplace. All of these make it easier for the DOL to find employer violations.

As of 2023, penalties for ACA violation include:

- 4980H(a) Penalty: \$240 or \$2,880 annually, per employee
 - Issued when ALEs fail to offer MEC coverage to 95% of eligible FTEs or
 - One or more employee receives a Premium Tax Credit (PTC) for purchasing coverage through a state or federal healthcare exchange
- 4980H(b) Penalty: \$360 or \$4,280 annually, per employee
 - Issued when an ALE issues coverage that is unaffordable, not Minimum Value, or both AND



- Had one or more employee receive a PTC for purchasing coverage through a state or federal healthcare exchange
- Failure to file penalty: \$290 to \$580 per return
- Failure to furnish penalty: \$290 to \$580 per return



ACA

ACA Answers

Below you will find your answers provided in the ACA portion of the assessment. Any items that need addressing are highlighted below.

Q1: Does the employer sponsor a Grandfathered health plan?

Answer: Yes

Q2: Is the employer considered an "Applicable large Employer" (ALE) under the ACA? (ALE = Generally 50+ FT employees plus FT equivalents in prior calendar year)

Answer: Yes

Q3: Does the ALE track variable hour employees in a look-back measurement period?

Answer: No

⚠ Make sure to track variable-hour employees in a look-back measurement period to determine health plan eligibility

Q4: Does the ALE offer minimum essential coverage (MEC) to at least 95% of all FT eligible employees and their dependents to age 26?

Answer: Yes

Q5: Which of the 3 affordability safe harbors does the ALE use?

Answer: Rate of Pay

Q6: Does the ALE complete Section 6056 ACA reporting (1095/1094-C forms)?

Answer: Yes



Q7: Does the employer remit the PCORI fee each year to the IRS on Form 720 for self-insured plans (including level-funded & HRAs)?

Answer: Yes

Q8: Are the number of actual days an employee has to wait in the waiting period 90 days or less for major medical coverage?

Answer: No

 Make sure medical plan waiting periods are less than 90 days

Medicare / MSP Rules Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from Medicare/MSP Rule compliance within the employer's group health plan.

\$15,100

Benefits for an Aging Employee Population

Medicare/Medicare Secondary Payer Rules



Medicare / MSP Rules score: 70%

This is your risk-weighted score for Medicare/MSP rule compliance

In order to protect the solvency of Medicare as a whole, The Centers for Medicare & Medicare Services (CMS) has put in place a set of rules that prevents Medicare from paying claims when another entity is responsible for paying first. The Medicare Secondary Payer rules create guidelines for the scenarios in which group health insurance is required to pay claims for Medicare participants, and generally for how Medicare & group health insurance interact. Some key requirements include:

- Definition of "primary" payer and "secondary" payer in a variety of Medicare & other coverage scenarios
- Prevention of employer alteration of group health eligibility requirements based on participant's Medicare eligibility

The MSP rules are important particularly because violating them seems an obvious solution to reducing claims costs for an employer, and many less experienced HR professionals and brokers are not aware of the rules. However, the penalties are steep:

- Excise penalty equal to 25% of group health expenses during the calendar year
- Statutory penalty of \$5,000 per incident
- Conditional payments for when Medicare paid but should have been other coverage
- If CMS had to bring legal action to recover damages, CMS entitled to collect twice the reimbursement amount (i.e. double damages)



Medicare / MSP Rules

Medicare / MSP Rules Answers

Below you will find your answers provided in the Medicare / MSP Rules portion of the assessment. Any items that need addressing are highlighted below.

Q1: Is the employer providing Medicare Part D Creditable Coverage Notices to participants annually by 10/15?

Answer: Yes

Q2: Is the employer submitting the online Creditable Coverage Disclosure to CMS 60 days after the start of the plan year?

Answer: Yes

Q3: Does the employer financially incentivize or encourage Medicare-eligible employees, including spouses, to enroll in Medicare (e.g., subsidize/reimburse Medicare or Medicare Supplement premiums for the employee or spouse)?

Answer: No

Q4: Does the employer exclude Medicare-eligible participants, including spouses, from enrolling in the group health plan?

Answer: Yes

⚠ Employers with more than 20 total employees are prohibited from excluding Medicare-eligible individuals from the group health plan

COBRA Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from COBRA compliance within the employer's group health benefits plan.

\$6,100

Ensuring Continuity of Coverage

COBRA



COBRA score: 80%

This is your risk-weighted score for COBRA compliance

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) addressed rising concerns for employees who lost health coverage when they lost their jobs. For almost 30 years, it has provided qualified beneficiaries who lose eligibility (could also be due to illness, reduction in hours, etc.,) an option for continuing group health coverage, regardless of employment status.

COBRA provides guidelines on when COBRA coverage must be offered, what an employer can charge a participant for, who is eligible, how to notify eligible participants of eligibility and loss of coverage, and more. Some key requirements include:

- Who must offer: employers with 20 or more total "employees"
- The definition of "qualifying events" that would trigger the offer of COBRA coverage
- Requirements to provide relevant COBRA notices at specific times

It is worth noting that COBRA timelines have been extended in recent years in response to the Covid-19. As of late 2022, these "extensions" have since been rolled back. In the future, it may be helpful to know that the extension of COBRA timelines may occur in response to adverse economic events in the US.

Penalties for COBRA violations include:

- Up to \$110 excise tax levied by the IRS per beneficiary per day of non-compliance
- Up to \$110 penalty per day (in addition)
- Civil penalties can be severe: if an eligible participant is forced to cover their own claims as a result of negligence in the extension of COBRA coverage, damages and legal fees can be extensive



COBRA

COBRA Answers

Below you will find your answers provided in the COBRA portion of the assessment. Any items that need addressing are highlighted below.

Q1: What coverage continuation rules apply to this employer? States with state continuation laws ("mini-COBRA"): AZ, AR, CA, CO, CT, DE, D.C., FL, GA, HI, IL, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, NE, NV, NG, NJ, NM, NY, NC, ND, OH, OK, IR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY

Answer: COBRA

Q2: How is COBRA administered?

Answer: Third Party COBRA administrator (outsourced)

Q3: Is the COBRA initial general notice provided to participants and enrolled spouses within 90 days of coverage by first class mail?

Answer: Yes

Q4: Is the COBRA election notice provided upon a COBRA qualifying event to all qualified beneficiaries by first class mail?

Answer: No

⚠ The COBRA election notice is provided upon a COBRA qualifying event to all qualified beneficiaries by first class mail

Q5: When an employee takes FMLA or other protected leave, will benefits continue beyond mandatory leave (ie- employer-approved leave policy)?

Answer: Yes, benefits continue beyond FMLA/mandatory leave.

Section 125 Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from Section 125 compliance within the employer's group health plan.

\$5,100

Incentivizing Participants with Tax-Free Benefits

Section 125



Section 125 score: 49%

This is your risk-weighted score for Section 125 compliance

Many parts of the IRS code are written in order to incentivize behaviors the government believes is in the best interest of American citizens. It is one of the strongest tools the government has to change behavior for the broader good. In the case of employee benefits, Section 125 encourages the adoption of health insurance by making certain benefits free of federal and state income tax.

It is important to note, however, that any time the IRS gives a "tax break," strict rules are put in place to ensure that the rules are not abused. With Section 125 (the section of the IRS code dictating this favorable tax status for certain types of employee benefits), these rules include:

- Requirement for a written "Cafeteria Plan" document
- Section 125 plan must be adopted prior to 1st day of plan year
- Mid-year plan changes for participants may only be enacted upon the occurrence of certain pre-defined "life events"
- Plan must not be discriminatory in favor of highly compensated or key employees

Enforced by the DOL's Employee Benefits Security Administration (EBSA), Section 125 plan misuse can lead to tax penalties and fines, including, but not limited to:

- Application of income taxes for participants who were supposed to receive tax-favored treatment on benefits
- Application of employment taxes for employer and participants
- Penalties for failing to report taxes appropriately



Section 125

Section 125 Answers

Below you will find your answers provided in the Section 125 portion of the assessment. Any items that need addressing are highlighted below.

Q1: Which benefits are paid by employees via pre-tax salary reduction? (select all that apply)

Answer: Medical, Dental, Vision

Q2: Has the employer adopted a Section 125 Cafeteria Plan Document Premium Only Plan (POP) with required contents/language?

Answer: No

⚠ Make sure employer adopts a Section 125 Cafeteria Plan Document (AKA Premium Only Plan/POP) document with required contents/language

Q3: Is the employer allowing prospective mid-year plan changes only upon the appropriate qualifying life events?

Answer: Yes

Q4: Are self-employed owners allowed to participate pre-tax through the cafeteria plan, including Health FSA?

Answer: Yes

⚠ Make sure self-employed owners (e.g. sole proprietors, partners, more than 2% shareholders in an S-corp) are not participating in cafeteria plan, including health FSA

HIPAA Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from HIPAA compliance within the employer's group health plan.

\$66,600

Protecting Personal Health Information

Protecting Personal Health Information: HIPAA
Privacy & Security



HIPAA score: 67%

This is your risk-weighted score for HIPAA
compliance

In the late 1990's and early 2000's, as more and more healthcare transactions were beginning to take place electronically, the US Department of Health and Security put into place guidelines for how sensitive health information should be handled by employers, insurance carriers, and other relevant parties.

As with the data it pertains to, the rules of HIPAA privacy & security can get complicated. Luckily, many specialist vendors have entered the marketplace to help with the more technical aspects of handling sensitive Personal Health Information (PHI). Some of the requirements of HIPAA privacy & security rules include:

- How Personal Health Information is encrypted at rest and in transit
- The requirement for an appointed privacy officer
- The requirement for an appointed security officer
- How breaches of Personal Health Information (PHI) are to be handled
- What the participants' rights are in regard to their own PHI

Many employers are not aware they are subject to HIPAA, as they use many third parties in the administration of their health plan. However, it's important to note that any exposure to Personal Health Information, as defined in the HIPAA Privacy & Standard guidelines, makes an employer subject to the requirements of HIPAA.

Penalties for HIPAA Privacy & Security violations include:

- Criminal penalties for knowing violations of up to \$50,000 and up to one year imprisonment
- Minimum fine of \$100 per violation
- Maximum fine of up to \$1000
- Penalties become more severe based on covered entity's knowledge of how PHI should be handled and their immediacy in correcting any known problems



HIPAA

HIPAA Answers

Below you will find your answers provided in the HIPAA portion of the assessment. Any items that need addressing are highlighted below.

Q1: Does the employer have any exposure to Protected Health Information (PHI)?

Answer: Yes – employer is self-insured but hands-off (level-funded with no FSA or HRA and no claims analytics drill-down)

Q2: Does the employer have written documented policies and procedures for the handling of PHI?

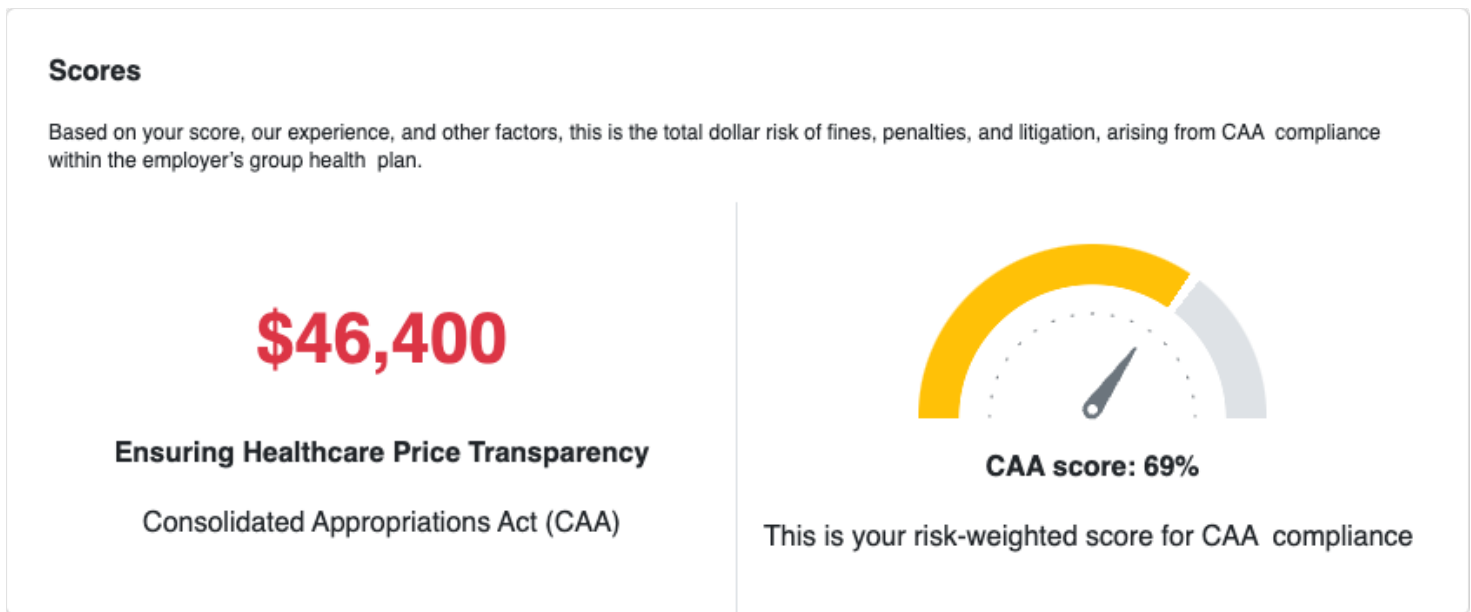
Answer: No

 Employer must have written policies and procedures for the handling of PHI, regardless of fully insured or self-insured

Q3: Is the employer properly distributing the HIPAA privacy notice?

Answer: Yes

CAA Scores



One of the primary complaints about Healthcare in the United States is that no one really knows the cost of care. The lack of pricing transparency causes many issues: it can make it difficult to discern what the best options for care are for participants and employers, make it harder for new healthcare-related service providers to enter the marketplace, and make it easier for large carriers to increase their prices at the expense of those paying premiums.

The Consolidated Appropriations Act of 2021 included several sweeping regulations intended to make healthcare costs available to the market as a whole. Several key requirements include:

- Requirement to provide a comparative analysis to the appropriate parties for medical vs mental health benefits of a group health plan to ensure parity of benefits
- Requirement for non-grandfathered group plans and carriers to provide detailed pricing information in 2 separate Machine-Readable Files
- Certain "Balance Billing" practices are no longer allowed
- The prohibition of gag clauses in contracts between health plans & other parties
- New prescription drug reporting requirements (Section 204 reporting) for carriers & group health plans

The CAA is one of the broadest new pieces of legislation affecting employer sponsored health plans of the last 10 years, and as a result many employers are struggling to get in compliance with all requirements. Penalties include:

- Up to \$100/day per person for failure to provide MRF
- Up to \$100/day per person for Section 204 reporting failures
- Other penalty amounts are pending clarification from CMS & other enforcement agencies as of this writing



CAA

CAA Answers

Below you will find your answers provided in the CAA portion of the assessment. Any items that need addressing are highlighted below.

Q1: If self or level funded, has the employer performed their Mental Health Parity QTL & NQTL comparative analysis?

Answer: No

 Employer must perform Mental Health Parity QTL & NQTL comparative analyses

Q2: If self or level funded, Has the TPA provided 2 separate Machine-Readable Files of required healthcare costs?

Answer: Yes

Q3: If self or level funded, does the employer or their TPA provide an online, self-service, searchable tool that provides information on the cost-share for items and services covered by the health plan?

Answer: Yes

Q4: If self or level funded, has the employer submitted the required Prescription Drug Data Collection (RxDC) reporting to CMS, or are plans in place to complete annually by the June 1st deadline?

Answer: No

 Employer must ensure that RxDC reporting is submitted to CMS no later than June 1st each year

Q5: Does the employer apply the in-network cost share when a participant receives out-of-network emergency services, some non-emergency services at an in-network facility, and/or air ambulance? (i.e.- no balance billing)?

Answer: Yes



Q6: Is the employer providing participants with the No Surprises Act notice as required?

Answer: Yes

Q7: If self or level funded, who will submit the online Gag Clause Prohibition Compliance Attestation (GCPCA) annually by 12/31?

Answer: Medical TPA

Non-Discrimination Rules Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from non-discrimination rule compliance within the employer's group health plan.

\$28,500

Offering Fair Benefits

Non-discrimination Rules



Non-Discrimination Rules score: 62%

This is your risk-weighted score for non-discrimination rule compliance

It's common for employers to want to provide "premium" health benefits to executives, owners, and/or senior managers of the company. However, if an employer offers pre-tax salary reductions for benefits premiums through a cafeteria plan, they are required to make sure the plan is "non-discriminatory," based on the rules outlined in IRS Code Section 125. Intended to ensure "fairness" in benefits across the company, the non-discrimination rules provide direction on who is considered a "Highly Compensated Employee" (HCE), and how to determine if eligibility rules and the costs of the plan are considered discriminatory.

Key requirements include:

- No employee is required to complete more than 3 years of service to participate
- Eligible employees start no later than the first day of the plan year after eligibility requirements are met
- Non-taxable benefits offered to "key employees" must not exceed 25% of the total value of benefits offered under the cafeteria plan

Non-discrimination testing should be performed by an experienced vendor of choice, as it involves much data collection and calculation.

The consequences for failing non-discrimination testing include the taxation of HCEs and "Key Employees" benefits. Failure does not impact non-HCEs or "key employees," and would not jeopardize the favorable tax status of the plan itself.



Non-Discrimination Rules

Non-Discrimination Rules Answers

Below you will find your answers provided in the Non-Discrimination Rules portion of the assessment. Any items that need addressing are highlighted below.

Q1: If the benefits offered are not the same for all employees, is the employer using valid business classifications per the Section 125 rules (e.g., salary vs hourly, managers vs staff, geographic location, division, etc.)?

Answer: Yes

Q2: Is the employer (or a third party) completing the required Section 125 nondiscrimination testing at least annually?

Answer: Yes

Q3: (If Self-Funded or HRA) has the employer (or a third party) completed the required Section 105h nondiscrimination testing?

Answer: No

⚠ Make sure Section 105h nondiscrimination testing is performed at least annually

Q4: Has the employer added the appropriate "imputed income" to employees who receive in excess of \$50,000 of employer-provided group term life?

Answer: Yes

Q5: Has the employer added the appropriate "imputed income" to employees who cover their domestic partners?

Answer: No

⚠ Make sure employer is imputing income for portion of the domestic partner coverage cost

Notices/ Disclosures Scores

Scores

Based on your score, our experience, and other factors, this is the total dollar risk of fines, penalties, and litigation, arising from notice & disclosure requirements compliance within the employer's group health plan.

\$0

Providing the Right Information to Your Employees

Notices & Disclosures



Notices/ Disclosures score: 100%

This is your risk-weighted score for notice & disclosure requirements compliance

Legal notices and disclosures are ubiquitous in the U.S.. Just about every product you buy requires you to acknowledge T&Cs, sign a contract, or otherwise be sent a legal disclosure or notification. As a result, many people have become less aware of the importance of these documents when it comes to protecting themselves. This "shrugging off" often puts people and organizations at great risk.

As an employer, sponsoring a group health plan involves sending participants many different notices and disclosures to help them understand their rights and the rules of the plan. Without these notifications, invalid claims may be paid, laws can be unintentionally broken, and the employer is at much greater risk of legal and civil penalties.

A few of these key notifications & disclosures include:

- Summary of Benefits & Coverage
- HIPAA special enrollments notification
- Medicare Part D Creditable Coverage Notification
- HIPAA Privacy Notice
- COBRA general initial notice
- COBRA election notice
- COBRA early termination/availability notices

It's important to remember that the rules regarding the distribution of these notices include notice timing and delivery mechanism. Not all documents can be delivered electronically, and not all can be sent at any time.

Failure to understand and comply with specific notice requirements most often are tallied on a per participant per failure basis, and can add up quickly, based on the number of employees in question. However, perhaps



more significantly failure to communicate how the plan works appropriately can lead to significant civil penalties, and liability for large claims unpaid by the carrier.



Notices/ Disclosures

Notices/ Disclosures Answers

Below you will find your answers provided in the Notices/ Disclosures portion of the assessment. Any items that need addressing are highlighted below.

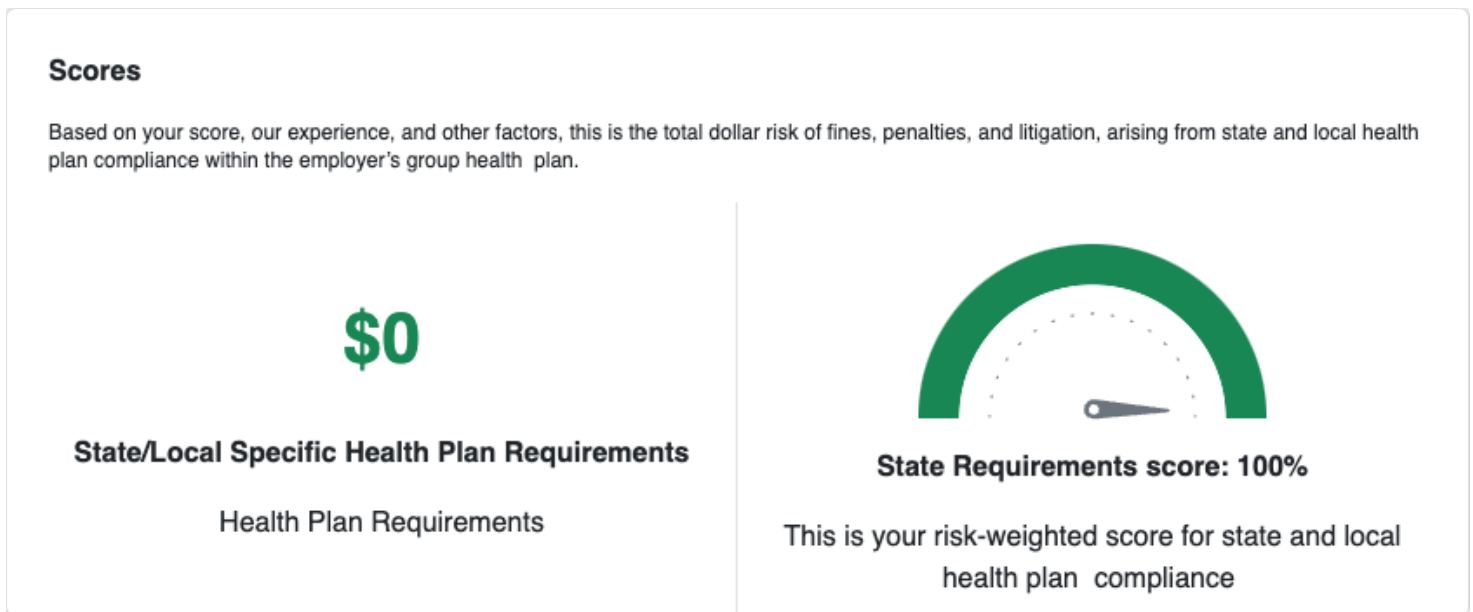
Q1: Is the employer providing the appropriate notices prior to enrollment? Including: •Summary of Benefits & Coverage (SBC) •HIPAA special enrollments • Women's Health and Cancer Rights (WHCRA) annual notice • Medicare Part D Creditable Coverage Notice • Marketplace Exchange Notice • HIPAA Privacy notice • Children's Health Insurance Program (CHIP) notice •Wellness Program HIPAA/EEOC notice? These notices are typically placed either in the enrollment guide or as a separate legal notices packet.

Answer: Yes

Q2: Is the employer including the proper information in their wrap plan document/SPD? (Michelle's law, Internal Appeals and External Review Procedures, WHCRA notice, Mothers & Newborns notice, Patient Protection Act Notice, Notice of Privacy Practice)

Answer: Yes

State Requirements Scores



Federal regulation is not the only thing that employers should be aware of when it comes to the implementation and administration of their group plans. Many states and locales through the US have specific laws that apply. Understanding the complete scope of all state and local laws is outside of the scope of BCS Pro, however we do seek to provide key highlights for employers to be aware of.

Some of these key areas include:

- State continuation of coverage requirements (AKA mini-COBRA/state continuation)
- State specific domestic coverage requirements
- State specific mandatory temporary disability benefits
- State specific health insurance notices
- State or locale-specific commuter benefit requirements
- State or locale-specific leave mandates

Which state or local requirements apply depend on the employer situs, and in many cases, the location of remote workers as well. For further details on what state/local benefits regulation applies to a specific employer's situation, we recommend working with qualified counsel.



State Requirements

State Requirements Answers

Below you will find your answers provided in the State Requirements portion of the assessment. Any items that need addressing are highlighted below.

Q1: Is the employer providing any mandatory temporary disability benefits (CA, HI, NJ, NY, RI)?

Answer: Currently no employees in these states

Q2: Is the employer complying with any state required reporting for health coverage and State Individual Mandates (CA, MA, NJ, RI, VT, DC)?

Answer: Currently no employees in these states

Q3: Does the employer have employees in states with registered domestic partner coverage requirements (CA, DC, ME, NV, OR, WA, WI)?

Answer: Currently no employees in these states

Q4: Is the employer providing any state-specific health insurance notices, including the Illinois EHB comparison for employees residing in IL?

Answer: Currently no employees in these states

Q5: Does the employer provide commuter benefits to employees in certain cities/states? (New York City, Philadelphia, Los Angeles, Berkeley, Richmond CA, SF Bay Area, Seattle, Washington D.C., and State of New Jersey)

Answer: Currently no employees in these states



Q6: Is the employer maintaining the employees coverage for the duration of any applicable state or local leave mandates? RS Resource Tool ; XpertHR Tool

Answer: Currently no employees in these states

Q7: Is the employer complying with specific health care spending requirements (San Francisco Health Care Security Ordinance; Hawaii Prepaid Health Care Act)?

Answer: Currently no employees in these states
