2025

Employee Benefits Compliance Guide for Small Employers

CRC BENEFITS

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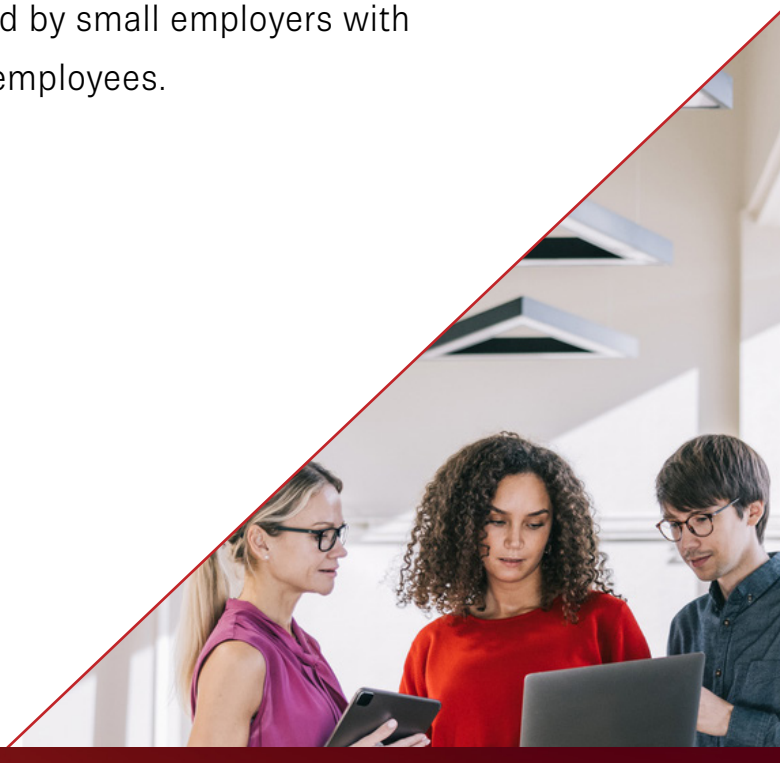
Federal law imposes many requirements on employers when it comes to the group health coverage they provide to employees. A number of these compliance laws apply to all group health plans, regardless of the size of the sponsoring employer, but there are some exceptions for group health coverage provided by small employers with fewer than 50 employees.



Small Group Compliance Check

Small group employers are businesses with 50 and fewer employees. Not all compliance law requirements apply to small employers.

SMALL GROUPS MUST COMPLY WITH:

- Affordable Care Act (ACA) market reforms, such as the essential health benefits package for Small Group plans
- COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage (and/or state continuation laws)
- HIPAA (Health Insurance Portability and Accountability Act) portability rules
- Medicare Part D creditable coverage disclosures

SMALL GROUPS **DO NOT** HAVE TO COMPLY WITH:

- Employer shared responsibility rules for applicable large employers (ALEs)
- Section 6056 reporting (unless level-/self-funded)
- ACA Form W-2 reporting rules
- Family and Medical Leave Act (FMLA) requirements
- Form 5500 filing requirement (if the plan is insured and/or unfunded)

Affordable Care Act (ACA)

The Affordable Care Act brought a number of changes to the way health insurance issuers do business and the way health plans are structured. These reforms apply broadly to health plans and with narrow exceptions for certain types of plans, such as retiree medical plans. **It's important to note that there is not an overall exception for small employers.**

ACA QUICK REFERENCE

Here's a high-level look at some of the key ACA market reforms.

- Employers must provide comprehensive health coverage consisting of the essential health benefits (EHB) package. Applies to all non-grandfathered insured health plans in the Small Group market, which most states define as employers with 50 or fewer employees.

These apply to *all non-grandfathered* insured health plans:

- Out-of-pocket maximums on EHB cannot exceed certain limits.
- No discrimination against plan participants who participate in clinical trials.
- Plans must cover specific preventive care services without imposing cost-sharing requirements.

These apply to *all* health plans:

- Insurance providers cannot impose annual or lifetime dollar limits on EHB.
- Waiting periods cannot exceed 90 days.
- No pre-existing condition exclusions on any covered individuals.
- Health plans that provide dependent coverage for children must make coverage available for adult children up to age 26.
- Coverage for covered individuals cannot be rescinded, except in cases of fraud or intentional misrepresentation of material fact.

NOTICE AND DISCLOSURE OBLIGATIONS

The ACA also created several notice and disclosure obligations for group health plans, including:

- **Statement of Grandfathered Status.** Plan administrator or issuer of a grandfathered plan must provide this statement on a periodic basis with participant materials describing plan benefits, such as the summary plan description (SPD) and open enrollment materials.
- **Notice of Rescission.** Plan administrator or issuer must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.

- **Notice of Patient Protections and Selection of Providers.** Plan administrator or issuer of a non-grandfathered plan must provide a notice of patient protections/selection of providers whenever the SPD or similar description of benefits is provided to a participant. These provisions relate to the choice of a healthcare professional and benefits for emergency services.
- **Uniform Summary of Benefits and Coverage (SBC) and Glossary.** Plan administrator or issuer must provide the uniform SBC and Glossary to participants and beneficiaries at certain times (including upon application for coverage and at renewal), as well as provide a 60-day advance notice of material changes to the summary that take place mid-plan year.
- **Exchange Notice.** Employers must provide new hires a written notice about the ACA Exchanges (see below for details).

ONGOING REQUIREMENTS FOR NOTICES AND REPORTS

- Employers must provide a written notice – called Employer Notice about Health Insurance Exchanges (Marketplaces) – to all full-time and part-time employees, whether or not benefits-eligible, within 14 days of hire.
- The federal notice explains the availability of the Health Insurance Exchanges (Marketplaces) and the circumstances under which employees may be eligible for subsidies to buy coverage through an Exchange.
- This requirement applies to all employers covered by the Fair Labor Standards Act (FLSA), including employers that do not offer health coverage.
- Employers can satisfy the Employer Exchange Notice requirement by using one of the DOL model notices, filling in the blank sections as needed, and distributing the completed notice to all employees within 14 days of hire.
    - There are two versions of the notice:

1 Employers who currently offer health insurance to any or all employees.

and **2** Employers who currently do not offer health insurance to any or all employees.

ACA SMALL EMPLOYER HEALTH REFORM CHECKLIST

Summary of Benefits and Coverage (SBC) and Glossary

Health insurers – and employers with self-funded health plans – must provide an SBC and Glossary for each plan describing its benefits and coverage. The SBC must use a standardized format; the U.S. Department of Labor provides samples and instructions.

ACA regulations require that the SBC be provided in several instances:

- By the first day of open enrollment
- By the first day of coverage if there are any changes
- Upon special enrollment events
- Upon request
- 60 days prior to off-renewal changes

Grandfathered Plan Notice

Employers with a grandfathered plan must review it to confirm that it still qualifies for grandfathered status. If so, materials describing the plan's benefits must include a notice regarding the plan's status as a grandfathered plan. The notice must include contact information for questions or complaints.

Note that plans that lose grandfathered status immediately become subject to the same health reform requirements as non-grandfathered plans.

Patient Protection Notice

Non-grandfathered health plans must include a notice regarding each participant's right to designate a primary care physician and to obtain obstetrical or gynecological care without prior authorization.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The rules established under COBRA apply to employers that had 20 or more employees on more than 50 percent of the typical business days during the previous calendar year. COBRA requires employers to provide eligible employees and their dependents who would otherwise lose group health coverage as a result of a qualifying event with an opportunity to continue group health coverage.

This law encompasses a number of notice/disclosure requirements, including:

- **Initial/General COBRA Notice.** The plan administrator must generally provide an explanation of COBRA coverage and rights within 90 days of when group health plan coverage begins.
- **Notice to Plan Administrator.** The employer must notify the plan administrator of certain qualifying events, such as an employee's termination or reduction in hours; an employee's death; an employee's Medicare entitlement; or the employer's bankruptcy. The notice must be provided within 30 days of the qualifying event or the date coverage would be lost as a result of the qualifying event, whichever is later.
- **COBRA Election Notice.** The plan administrator must generally provide the COBRA election notice within 14 days after being notified of the qualifying event (or 44 days after the qualifying event if the employer is the plan administrator).
- **Notice of Unavailability of COBRA.** If an individual is not eligible for COBRA, the plan administrator must generally provide a notice of COBRA unavailability within 14 days after being notified of the qualifying event (or 44 days after the qualifying event, if the employer is the plan administrator).
- **Notice of Early Termination of COBRA.** Plan administrator must provide an early termination notice as soon as practicable following the determination that COBRA coverage will terminate earlier than the end of the maximum coverage period.
- **Notice of Insufficient Payment.** Plan administrator must notify a qualified beneficiary that the COBRA payment was not significantly less than the correct amount before coverage is terminated for nonpayment.
- **Premium Change Notice.** Plan administrator should provide a notice of premium increase at least one month prior to the effective date.
- Model COBRA notices are available from the U.S. Department of Labor.

Employee Retirement Income Security Act (ERISA)

This law imposes a variety of compliance obligations on group health plan sponsors and administrators. ERISA establishes strict fiduciary duty standards for individuals who operate and manage employee benefits plans and requires that plans create and follow claims and appeals procedures.

ERISA applies to employee welfare benefit plans, including group health plans, unless specifically exempted.

Church and government plans are exempt. **There is not an exception for small employers.**

This law requires plan administrators to provide these notices and disclosures:

- **Summary Plan Description (SPD) or SPD WRAP.** Plan administrator must automatically provide an SPD to participants within 90 days of becoming covered by the plan. An updated SPD must be provided at least every five years if changes have been made to the information contained in the SPD; otherwise, an updated SPD must be provided at least every 10 years.
- **Summary of Material Modifications (SMM).** Plan administrator must provide an SMM automatically to participants within 210 days after the end of the plan year in which the change was adopted. If benefits or services are materially reduced, participants generally must be provided with the SMM within 60 days from adoption. Also, plan administrators and issuers must provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the Summary of Benefits and Coverage (SBC). The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.
- **Plan Documents.** Plan administrator must provide copies of plan documents no later than 30 days after a written request.
- **Summary Annual Report (SAR).** ERISA plan administrators are subject to the SAR requirement, unless an exception applies. Plans that are exempt from the Form 5500 filing requirement are not required to provide the SAR. The SAR is a narrative summary of the Form 5500 and includes a statement of the right to receive a copy of the plan's annual report. The SAR must generally be provided within nine months after the end of the plan year. If the Form 5500 filing deadline was extended, the SAR must be provided within two months after the end of the extension period.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA's portability rules are designed to help individuals transition from one source of health coverage to another. The act limits exclusions for pre-existing conditions, prohibits discrimination based on health status and provides for special enrollment opportunities.

HIPAA applies to group health plans and health insurance issuers, unless an exception applies.

Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers.**

Effective for plan years beginning on or after January 1, 2014, the ACA prohibits group health plans and issuers from imposing pre-existing condition exclusions on any enrollees.

HIPAA requires these notices/disclosures:

- **Notice of Special Enrollment Rights.** Plans and issuers must provide the special enrollment rights notice at or before the time an employee is initially offered the opportunity to enroll in the plan.
- **Notice of Alternative Wellness Program Standard.** Group health plans and issuers that offer health-contingent wellness programs must disclose the availability of an alternative standard to receive a reward under the wellness program. This disclosure must be included in all materials that describe the wellness program.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage.

If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in the state.

There is not an exception for small employers.

A model notice is available from the Department of Labor.

Medicare Part D Creditable Coverage Disclosures

The Medicare Part D requirements apply to group health plan sponsors that provide prescription drug coverage to individuals who are eligible for Medicare Part D coverage. **There is not an exception for small employers.**

Employer-sponsored health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with these disclosure requirements:

- **Disclosure Notices for Creditable or Non-Creditable Coverage.** A disclosure notice must be provided to Medicare Part D eligible individuals who are covered by, or apply for, prescription drug coverage under the employer's health plan. The purpose of the notice is to disclose the status (creditable or non-creditable) of the group health plan's prescription drug coverage. It must be provided at certain times, including before the Medicare Part D Annual Coordinated Election Period (October 15 through December 7 of each year).
- **Disclosure to Centers for Medicare and Medicaid Services (CMS).** On an annual basis (within 60 days after the beginning of the plan year) and upon any change that affects the plan's creditable coverage status, employers must disclose to CMS whether the plan's coverage is creditable.
- Model forms are available from CMS.

Michelle's Law

Michelle's Law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage.

This law applies to employer-sponsored group health plans. Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers.**

If a health plan requires a certification of student status for coverage, plan administrators and issuers must include a description of Michelle's Law with any notice regarding a requirement for certification of student status.

Michelle's Law was enacted before the ACA required group health plans to provide coverage for dependent children up to age 26, regardless of student status. Now that the ACA's coverage expansion for dependents is effective, Michelle's Law has limited applicability. In general, it will only apply if a plan offers coverage for dependents who are not covered by the ACA mandate (for example, dependents who are older than age 26) and conditions eligibility on student status.

Newborns' and Mothers' Health Protection Act (NMHPA)

Under the NMHPA, group health plans may not restrict the benefits of mothers and newborns for hospital stays to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.

The NMHPA applies to group health plans that provide maternity or newborn infant coverage. **There is not an exception for small employers.**

The plan's SPD must include a statement describing the NMHPA's protections for mothers and newborns.

Women's Health and Cancer Rights Act (WHCRA)

The WHCRA applies to group health plans that provide coverage for mastectomy benefits.

Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt. **There is not an exception for small employers.**

The WHCRA requires health plans that provide medical and surgical benefits for a mastectomy to cover:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications of mastectomy, including lymphedemas.

Plans must provide a notice describing rights under WHCRA upon enrollment and on an annual basis after enrollment.

Questions? Contact Misty.Baker@crcgroup.com or Carol.Taylor@crcgroup.com

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