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Welcome

Employee benefit laws change rapidly —
UBA Partner Firms help their clients stay one step ahead
with ongoing expert compliance resources.

Hosted by UBA

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Please remember, employment and benefits law compliance depends on multiple factors – particularly those unique to each employer's circumstances. Numerous laws, regulations, interpretations, administrative rulings, court decisions, and other authorities must be specifically evaluated in applying the topics covered by this webinar. The webinar is intended for general-information purposes only. It is not a comprehensive or all-inclusive explanation of the topics or concepts covered by the webinar.

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ERISA Plan Documents

What Employers Need to Know

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Agenda

1. ERISA Plan Documents
   - Who must have them?
   - What's required?
   - Best practices
2. ERISA Wrap Plans
   - Why you should have them (Pros and Cons)
3. Cafeteria Plans
   - Who's covered?
   - What's required?

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1. ERISA Plan Documents

What Is ERISA?

Employee Retirement Income Security Act of 1974:

Only Title I, called "Protection of Employee Benefit Rights," applies to "employee welfare benefit plans" (as defined in ERISA § 3(1)).

- Title I of ERISA is, in turn, divided into seven Parts
- Only five of those Parts apply to and impose requirements on "employee welfare benefit plans:"
  - Part 1 (ERISA §§ 101-111) - Reporting and Disclosure
  - Part 4 (ERISA §§ 401-414) - Fiduciary Responsibility
  - Part 5 (ERISA §§ 501-515) - Administration and Enforcement
  - Part 6 (ERISA §§ 601-609) - COBRA Continuation Coverage and Additional Standards for Group Health Plans
  - Part 7 (ERISA §§ 701-734) - Group Health Requirements [HIPAA, Newborns' and Mothers' Health Protection Act, Mental Health Parity Act and Women's Health and Cancer Rights Act]

Which Employers Are Covered By ERISA?

- Virtually all private-sector employers
- Nonprofits are covered
- Certain governmental employers and churches are exempt
  - Governmental plan is *"a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing."*
  - Pension Protection Act of 2006 (PPA) clarified that plans of Indian Tribal Governments are included within exemption
  - Many similar rules apply under Internal Revenue Code (IRC) and Public Health Service Act (PHSA)
  - Caution drafting plans – state laws and contract rights

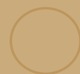
What is a Welfare Benefit Plan?

- A plan, fund or program
- That is established or maintained by an employer
- For the purposes of providing one or more benefits enumerated by ERISA to employees and their beneficiaries
- That is not otherwise excepted from Welfare Benefit Plan status

What is a Welfare Benefit Plan?

- In determining whether there is a “plan, fund or program” within the meaning of the ERISA definition, the courts ask whether from the surrounding circumstances a reasonable person could ascertain:
  - the intended benefits;
  - a class of beneficiaries;
  - the source of financing; and
  - the procedures for receiving benefits
- Plan exists only if there is a commitment to pay benefits systematically, including an ongoing administrative responsibility or scheme to determine eligibility and calculate benefits. *Fort Halifax Packing Co. v. Coyne*

What Benefits are Enumerated by ERISA?



- Medical benefits
- Sickness, accident, death, disability, and unemployment benefits
- Vacation benefits
- Apprenticeship benefits
- On-site and certain other day care benefits
- Scholarship funds
- Prepaid legal services
- Holiday pay
- Severance pay benefits
- Housing assistance benefits

What are the Regulatory Benefit Exceptions?

- Payroll practice exemptions
- Voluntary (Employee Pay All) Plan exceptions
- Other miscellaneous exceptions

What Benefits Qualify for Payroll Practice Exemptions?

- Must be paid from employer's general assets
- Not through trusts or insurance contracts
- Must be paid only to currently employed individuals
- Not to former employees or family of former employees
- Only for certain types of benefits

Types of Benefits Eligible for Payroll Practice Exemptions?

- Wages
- Overtime pay
- Shift premiums
- Holiday pay
- Sick pay
- Vacation pay
- Income replacement benefits
- Jury duty pay

Voluntary Plan Safe Harbor

- Applies to Group or "Group-Type" insurance arrangements
- Employer may not:
  - Contribute towards the cost of the coverage
  - Receive payment for granting insurer access to workplace
  - Endorse the program
  - Require employee participation
  - Perform recordkeeping functions
  - Allow payroll deductions to be made on a pre-tax basis

Voluntary Plan Safe Harbor

The Plan/Employer may:

- Allow employees to fund premium payments through payroll deductions
- Permit insurer to market directly to employees
- Forward employee premium deductions to the carrier

What Benefits Qualify for Misc. Regulatory Exceptions?

- Onsite clinics/EAPs that do not provide significant medical benefits or cover non-employees
- Tuition and education expense reimbursement plans paid out of general assets
- Remembrance funds for deceased employees and their family members

HSAs Under Voluntary Plan Safe Harbor Exemption

- DOL FABs 2004-1 and 2006-02 provide HSAs meeting Voluntary Plan Safe Harbor are Exempt from ERISA
- But - special rules for HSAs that allow certain practices that would otherwise be excessive employer involvement or endorsement such as:
  - limiting the number of HSA providers that market their HSA products in the workplace, even by selecting a single HSA provider to which the employer will forward contributions; and
  - providing employees with general information on the advisability of using an HSA in connection with the employer's HDHP.

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Special HSA Exemption

- HSAs with employer contributions are exempt from ERISA if:
  - HSA is completely voluntary on part of the employee; and
  - Employer does not:
    - limit the ability of eligible individuals to move funds to another HSA;
    - impose conditions on payments from HSA funds beyond those permitted under the Code;
    - influence investment decisions;
    - represent that HSAs are ERISA plans; and
    - receive any payment or compensation in connection with an HSA

What are the Requirements of a Written Plan Document?

- Every ERISA benefit must be described in a written document
- ERISA does not generally dictate:
  - Contents of the plan document (except for certain required provisions)
  - The format of the plan document
- Settlor function to design plan terms
- No specific penalty for failure to have written document

Special Considerations for Written Plan Documents

- DOL broad view of "plan document" may include all instruments under which plan is administered
- Plan document compliance issues for insured plans
- Plan document compliance for "bundled plans"
- Can a single document serve as both plan document and SPD?
- Using "wrap" and "umbrella" documents for compliance

What does ERISA Require?

- Written Plan documents
- Distribution of Summary Plan Description and other participant disclosures (e.g., SMM, SAR, SBC)
- Rules regarding processing of claims for benefits
- Annual Form 5500 reporting
- Plan assets used exclusively for benefit of participants and reasonable expenses (Trust and Exclusive Benefit Requirements)
- Strict fiduciary obligations and bonding requirements

What are the Requirements of a Written Plan Document

ERISA Required Plan Provisions:

- Named Fiduciary
- Procedures for allocation of responsibilities and delegation of duties
- Funding policy
- How payments are made
- Claims procedures
- Amendment procedures

What are the Requirements of a Written Plan Document

ERISA Required Plan Provisions:

- Distribution of assets on plan termination
- Required provisions for group health plans:
  - COBRA & USERRA rules
  - HIPAA Portability, Special enrollment and nondiscrimination rules
  - HIPAA Privacy and Security
  - Minimum hospital stays after childbirth
  - Mental Health/SUD benefit disclosure
  - WHCRA mastectomy provisions
  - QMCSO rules
  - Disclosures regarding remaining Federal Mandates and other Laws

Recommended Provisions

Optional plan provisions regarding fiduciary functions

- Firestone language regarding discretion
  - State laws regarding insurance may prohibit

Other important plan provisions

- Permission to use plan assets to pay plan administrative expense
- Incorporating provisions that appear in SPD
  - eligibility rules and benefits promised
  - exceptions and limitations that can result in the loss or denial of benefits; and
  - how the plan is administered

Recommended Provisions

Other important plan provisions

- General business elements
  - governing state law, subject to preemption by applicable federal law;
  - no contract of employment
  - no guarantee of tax consequences and
  - what happens if the plan sponsor is sold (e.g., successor employer provision)
- Other important plan provisions
  - subrogation and coordination of benefits provisions
  - language regarding exclusion of independent contractors; and
  - whether assignment of benefits is permitted

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2. ERISA Disclosures

ERISA Mandated Participant Disclosures

- Summary Plan Descriptions
- Summaries of Material Modifications
- Summary Annual Report
- Summary of Benefits and Coverage
- Providing copies of documents on written request
- Making documents available at principal office

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Summary Plan Description Requirements

- The most important document under ERISA
- Often enforced over language found in plan document
- Plan Administrator is liable for furnishing
  - Liability can be personal
- No small plan exception

Enforcement of SPD Language

- Employees are allowed to rely on terms of SPD
- If there is no SPD, courts will look to other communications
  - Including oral representations

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SPD Statutory Penalties

- $171 per day for failure to provide within 30 days of written request by participant
- Applies if incomplete SPD is provided or not in compliance with electronic disclosure rules
- Penalty is discretionary with DOL and ultimately with federal judge

Summary Plan Descriptions – Who?

- All participants covered under any ERISA welfare plan
- COBRA Qualified Beneficiaries
- Parent or guardian of child covered under a QMSCO
- Spouse of a deceased retiree

Summary Plan Descriptions – When?

- Within 120 days after new ERISA plan is established
- Within 90 days after beginning of individual’s coverage
- Every 10 years for continuing participants
- Every 5 years if there have been material changes

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Summary Plan Descriptions – How?

- Properly addressed first class mail or hand delivery is always sufficient
- Posting in a conspicuous place is never sufficient
- DOL Rules for Electronic Distribution must be followed
- Participants with work-related access may receive
- Participants without work-related access must affirmatively consent – complex administration to comply

Summary Plan Descriptions – What?

- Must be written to be understandable by average plan participants
  - Avoid legalese
  - English as a Second Language issues
  - Section 1557 Notice and Taglines
- Can be the same document as the Plan Document, but not best practice
- Can be wrapped around insurer's certificate of insurance

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Summary Plan Descriptions – Must Include

- Plan Name
- Form 5500 Plan Number
- Plan Administrator Info
- Agent for Service of Legal Process
- Plan Year
- Eligibility Provisions
- Plan Amendment and Termination Provisions
- Subrogation Provisions
- Plan Funding and Contribution Information
- Claims Procedures
- Statement of ERISA Rights

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Summary Plan Descriptions for GHPs – Must Also Include

- Detailed description of group health plan benefit provisions
- Description of the role of health insurers (i.e., whether a related insurer actually insures plan benefits or merely provides administrative services for the plan)
- Description of circumstances that could lead to loss or denial of benefits
- Description of effect of group health plan provider discounts
- Group health plan provider incentives: disclosure required
- Information regarding COBRA coverage
- Disclosures regarding other federal mandates for GHPs

Plan Updates – SMM Requirements

- A Summary of Material Modification (SMM) describes changes to a plan or to the information required in the SPD
- Notice must be given:
  - Automatically to participants receiving benefits (not later than 210 days after the end of the plan year in which the change is adopted)
  - Upon written request
- 60 days' advance notice is required for changes to medical plans that effect information listed in the Plan's Summary of Benefits and Coverage (ACA required document)

Summary of Benefits and Coverage (SBC)

- Must provide (Subject to up $1,264/failure penalty)
  - At initial or open enrollment (in OE materials or, if none, no later than first day of coverage)
  - Within 7 days upon request
  - Within 90 days of special enrollment
- Typically provided by insurers (self-insured employers may contractually require TPA to provide)
- Material plan changes must be issued in SMM to participants 60 days in advance (except at plan anniversary)

Summary of Benefits and Coverage (SBC)

- DOL has model template
- Content mandated by ACA
- Single form may be used for:
  - Multiple coverage tiers
  - Different deductibles and co-payments
  - Plans with add-on coverages such as HRAs and FSAs
  - Plans with carve-out arrangements such as PBMs

ERISA Mandated

- Annual reporting of plan information for welfare benefit plans
- Each plan is required to file unless exempt
- Small unfunded or insured welfare benefit plans are exempt from filing
  - "Small" plans have less than 100 covered participants at the beginning of the plan year
  - No exemption if "funded" and require audit

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ERISA Mandated Form 5500 Government Reporting

- Penalty for non-compliance is $2,400 per day (indexed annually)
- There is no statute of limitations
- May only be enforced by DOL; not private individuals
- DOL offers a voluntary compliance program
- The DFVC which provides for substantially lower penalties for plans which voluntarily bring delinquent filings to DOL's attention

ERISA Mandated Form 5500 Government Reporting

- Reporting for welfare benefit plans is simplified
- No auditors report is required for most insured plans
- All filing is now done electronically through specialized software – due 7 months after the end of the plan year (automatic extensions are available)

Summary Annual Report

- Summarizes the information on Form 5500
- Plan administrator must furnish SARs to participants and others entitled to receive SPD
- Provided within 9 months of filing From 5500
- Information required to be included in SAR is provided in Model SAR contained in DOL Reg. §2520.104b-10(d)(4)
- Exemption - small welfare plans

Best Practices for Document Retention and Recordkeeping

- Keep Everything!
- ERISA documents that may be requested in an audit include:
  - Plan documents, Insurance policies and Riders
  - SPDs, Benefit Booklets, and/or Wrap Document including any amendments and/or riders showing changes in Plan benefits and entitlement to benefits
  - Plan financial statements, cancelled checks, payroll records
  - Copies of all required notices, including lists and logs of issued notices and a description of procedures for distribution
  - Participant records, provider agreements, and fiduciary bonds
  - Names, home address, phone numbers, email addresses and Social Security Numbers of all Plan Trustees, Plan Administrators and named fiduciaries
- Keep up to date service agreements with Administrators and other providers for a *minimum* of 6 years after the filing date of the Form 5500 that is based on those records (8 years generally recommended)

ERISA Required Items Commonly Missing From Insurance Contracts

- Plan administrator designation
- ERISA named fiduciary designation
- Plan name and Plan number
- Plan year
- Designation of how many plans the Plan Sponsor maintains
- Treatment of insurer refunds
- Eligibility Provisions
  - ACA Eligibility vs. Plan Eligibility
  - Insurance Carrier and Stop Loss Considerations

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ERISA Required Items Commonly Found in Insurance Contracts (but make sure)

- Benefit descriptions
- General employee eligibility provisions, but need supplementation
- Funding mechanism for benefits
- Standard of review for benefit decisions
- Required provisions for group health plans

Additional Provisions Beneficial To Include In Wrap Document

- Employer indemnification of employees who perform plan functions
- Employer’s right to amend or terminate plan
- Plan enrollment processes
- Specific employee and dependent eligibility criteria
- Employer/employee allocations regarding coverage costs
- Subrogation provisions (but harmonize with insurance contract)

Plan Document Considerations: Bundling Pros and Cons

- Plan Sponsor can bundle multiple benefit components under one plan document. Alternatively, separate plan documents can cover separate component benefits
- Bundling reduces the number of Form 5500s
- Unbundling helps smaller employers avoid Form 5500 filing requirements
  - If a benefit that is otherwise exempt from the 5500 requirement is included in a wrap, you may need a Schedule A
- Cafeteria plan generally exempt from ERISA – if wrapped, care must be taken not to cause voluntary or other benefits to be subject to ERISA – (exception for health FSA)

3. Cafeteria Plans

What is a Cafeteria Plan?

- A separate written plan maintained by an employer for employees that meets the specific requirements of and regulations of Section 125 of the Internal Revenue Code
- Provides participants an opportunity to receive certain benefits pre-tax
- Participants must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit (such as pre-tax health insurance premium payments)

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Who is covered?

- Every employer who maintains a Cafeteria Plan must comply with written plan document requirements
- No exemptions!
- No exceptions!

Required Plan Provisions

- A specific description of each benefit available under the plan and the 12-month period of coverage
- The rules governing which employees are eligible to participate in the plan
  - All employees with 1,000 hours in prior year
  - May elect all benefits
  - Some employees may be excluded
- The plan year

Required Plan Provisions

- The procedures for making elections under the plan, including when elections may be made (generally before pay is earned), the rules governing irrevocability of elections and the periods for which elections are effective

- How employer contributions may be made such as by salary reduction agreement between the employer and employee, by non-elective employer contributions, or by both

Required Plan Provisions

- The maximum amount of employer contributions available to any participant
  - To meet this requirement, the plan must describe the maximum amount of elective contributions available to any employee either:
    a) by stating the maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions; or
    b) by stating the method for determining the maximum amount or percentage of elective contributions that an employee may make

Qualified Benefits

- Accident and health benefits (but not Archer medical savings accounts or long-term care insurance) (do not pay long term disability pre-tax)
- Adoption assistance
- Dependent care assistance
- Group-term life insurance coverage (on Employee only)
- Health savings accounts

Non-Qualified Benefits

- scholarships;
- educational assistance programs;
- group term life insurance on the life of anyone other than an employee (e.g., an employee's spouse or dependent);
- transportation and certain other fringe benefits;
- Archer medical savings accounts (Archer MSAs);
- long-term care insurance or services;
- health reimbursement arrangements (HRAs) (although high-deductible health coverage that is coupled with an HRA can be offered under the cafeteria plan, if certain rules are met);
- employer-provided meals and lodging; and
- contributions to a Code Section 403(b) plan.

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Eligible Participants

- Plan may make benefits available to common-law employees, their spouses and dependents (no partners, sole proprietors, self-employed)
- Tax-consequences for Domestic Partners and their dependents (unless meet tax-dependency test of employee)
- Plan may include coverage of former employees, but cannot exist primarily for them
- Non-discrimination rules for eligibility, contributions, or benefits (POP safe harbor)

Flexible Spending Arrangements (FSA)

- FSA is a form of cafeteria plan benefit, funded by salary reduction, that reimburses employees for expenses incurred for certain qualified benefits
- An FSA may be offered for dependent care assistance, adoption assistance, and medical care reimbursements
- Benefits are subject to an annual maximum and an annual "use-or-lose" rule
- Health FSA uniform coverage rule

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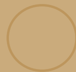
FSA Limits for 2022

- DCAP Limit: *$5,000* annually for a single person or married couple filing a joint income tax return, and *$2,500* annually for each married participant who files a separate income tax return
- Health Plan FSA Limit: *$2,850* annually
  - Carryover (Up to $570)
  - Grace Period
  - Run-out
- Adoption Assistance: *$14,890* annually



Health Savings Account (HSA)

- A HSA is a tax-advantaged medical savings account
- Unlike other types of benefits covered by a Cafeteria Plans (e.g. health FSA, DCAP, self-funded medical), HSAs are covered under general test for nondiscrimination requirements
- However, if an employer chooses not to include HSA under cafeteria plan
  - Employee contributions after-tax and deductible on tax return
  - Employer contributions subject to comparability requirement

Qualified Election Changes

- Plans may allow participants to change elections based on the following changes in status:
- Change in marital status
- Change in the number of dependents
- Change in employment status
- A dependent satisfying or ceasing to satisfy dependent eligibility requirements
- Change in residence
- Commencement or termination of adoption proceedings

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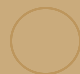
Qualified Election Changes

- Plans may also allow participants to change elections based on the following changes that are not a change in status:
  - Significant cost changes
  - Significant curtailment (or reduction) of coverage
  - Addition or improvement of benefit package option
  - Change in coverage of spouse or dependent under another employer plan
  - Loss of certain other health coverage (e.g., Medicaid)

Qualified Election Changes



- Changes in 401(k) contributions
- HIPAA special enrollment rights
- COBRA qualifying event
- Judgment, decrees, or orders
- Entitlement to Medicare or Medicaid
- Family Medical Leave Act (FMLA) leave
- Reduction of hours (new under the ACA)
- Exchange/Marketplace enrollment (new under the ACA)

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Join Us Again

Employee benefit laws change rapidly —
UBA Partner Firms help their clients stay one step ahead
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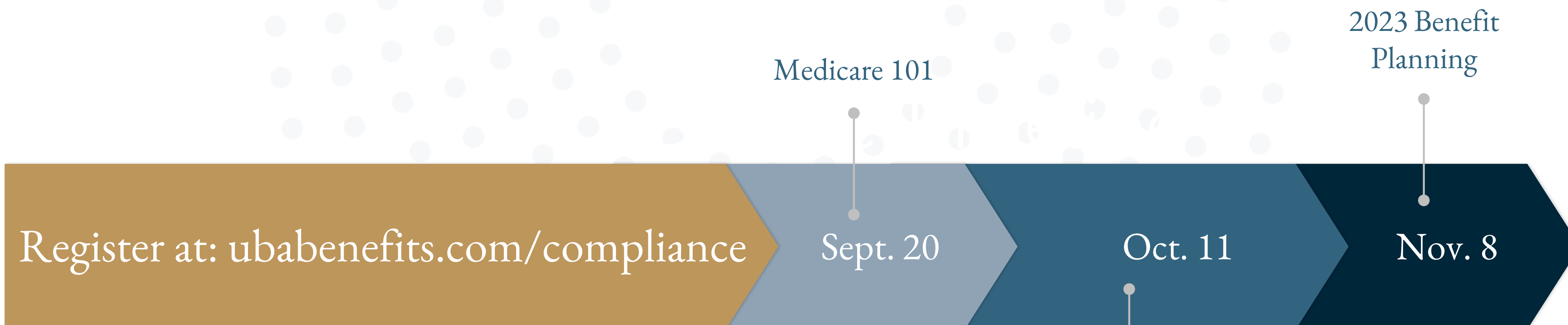

Medicare 101: MSP rules, coordination of coverage, creditable Rx coverage reporting, HSA trap.

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Thank You