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ERISA Benefit Plan Wraps and SPDs: Structuring and Amending Compliant Plan Documents and Notices

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Today's faculty features:

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Wrap It Up!

Using Wrap Plan Documents and SPDs with ERISA Welfare Plans

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Agenda

- When ERISA applies
- ERISA requirements
- The wrap approach
- Ensuring consistency of plan documents
- Summary of benefits and coverage (SBC)

Employee Welfare Benefit Plans

Who is subject to ERISA?

- ERISA applies to private employers
  - Note: ERISA does not have a small employer exception
- ERISA generally does not apply to government employers, Indian tribal governments, or churches
  - Churches can elect to be subject to ERISA

What is subject to ERISA?

- Employee Welfare Benefit Plans or Welfare Plans
- Employee Pension Benefit Plans or Pension Plans

What Parts of ERISA Apply?

- Part 1 of Title I of ERISA (reporting and disclosure requirements)
- Part 4 of Title I of ERISA (fiduciary responsibility provisions)
- Part 5 of Title I of ERISA (administration and enforcement provisions)

Health-related employee welfare benefit plans may also be subject to:

- Part 6 of Title I of ERISA (continuation coverage provisions)
- Part 7 of Title I of ERISA (health care provisions)

Employee Welfare Benefit Plans

"any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefits described in § 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions)"

-ERISA § 3(1)

“any plan, fund, or program”

- intended benefits
- class of beneficiaries
- source of financing
- a procedure to apply for and collect benefits

Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982)

DOL Voluntary Plans Safe Harbor

- A group or group-type insurance program is not subject to ERISA if:
  (1)No employer contributions
  (2)Participation is completely voluntary
  (3)Employer's sole functions are to permit insurer to publicize program, collect premiums, and remit to insurer (and no "endorsement")
  (4)Employer cannot receive consideration (other than reasonable compensation)

DOL Payroll Practices Safe Harbors

- Payment of wages, overtime pay, shift premium, and holiday or weekend premiums does not create an ERISA plan
  - Bonuses generally not subject to ERISA, unless deferred systematically to termination of employment or later
- Payment of sick pay out of general assets does not create an ERISA plan
  - Use of a trust or other separate account to hold assets could create an ERISA plan
  - Must not be paid through insurance
  - Must pay normal compensation (or less)
- Payment for time off out of general assets does not create an ERISA plan

  E.g. vacations/holidays; active military duty; jury duty; training

Other Regulatory Exemptions

- On-premises facilities (e.g. recreation, dining, on-site treatment of minor injuries or illness)
- Holiday gifts (e.g. turkeys, hams)
- Sales to employees or employer articles or commodities (e.g. employee discounts)
- Remembrance funds (e.g. flowers or small gifts)
- Unfunded scholarship or education assistance
- Individual health insurance coverage funded through HRAs
  - If certain conditions are met (similar to voluntary plans safe harbor)
  - Effective plans year beginning on or after 1/1/20

Examples of Welfare Plans

- Accidental Death and Dismemberment Insurance
- Apprenticeship Programs
- Business Travel Accident Policies
- Day-Care Centers
- Dental Plans
- Disability Benefits (some)
- Disease-Management Programs
- Drug and Alcohol Treatment Programs
- Employee Assistance Plans (some)
- Flu-Shot Programs Group Term Life Insurance
- Health Flexible Spending Arrangements (Health FSAs)
- Group Health Insurance Plans
- Health Reimbursement Arrangements (HRAs)
- Prepaid Legal Plans
- Prescription Drug Plans
- Severance Pay Plans (some)
- Smoking Cessation Programs (some)
- Vision Plans
- Weight Loss Programs (some)
- Wellness Programs

Most common types of plans to wrap

- Medical
- Dental
- Vision
- Health care flexible spending account (FSA)
- Short-term disability (if ERISA)
- Long-term disability
- Life and AD&D
- Employee assistance plan (EAP) (if ERISA)

Plan Document Requirement

- "Every employee benefit plan shall be established and maintained pursuant to a written instrument."

  (ERISA § 402(a)(1))

Plan Document Requirement

- Plan Document must:
  - Specify “named fiduciaries” with authority to control and manage operation and administration of plan
  - Describe procedure for establishing and carrying out a funding policy consistent with the plan and Title I of ERISA
  - Describe procedure for allocating responsibilities of plan operation and administration
  - Describe procedure for amending plan and identifying individuals with authority to amend plan

Plan Document Requirement

- Plan Document must:
  - Specify basis on which payments are made to and from the plan
  - Describe procedure for benefit claim denials and “full and fair” review of denials
  - Describe how plan assets will be distributed on plan termination
- Additional provisions for group health plans
  - HIPAA privacy and security provisions

Summary Plan Description Requirement

- Plan administrator responsible, not TPA
- SPD Timeframe
  - 90 days for new participants
  - 120 days for new plans
  - 5 year update if material changes to plan
  - If no material changes, every 10 years

Summary Plan Description Requirement

- SPD must include:
  - Plan-identifying information
    - Plan name
    - Name and address of employer
    - Plan sponsor's EIN
    - Plan number
    - Type of welfare plan (group health plan, disability plan, prepaid legal services, etc.)
    - Type of plan administration (e.g. TPA, self-administered)

Summary Plan Description Requirement

- SPD must include:
  - Plan-identifying information
    - Name, address, and phone number of plan administrator
    - Name and address of agent for service of legal process
    - Plan year
    - Information about plan trustees and collective bargaining agreements (if applicable)

Summary Plan Description Requirement

- SPD must include:
  - Eligibility
  - Benefits
  - Loss of benefits
  - Plan amendment and termination
  - Plan contributions and funding
  - Claims procedures
  - Statement of ERISA rights

DOL Model Statement of ERISA Rights

- Your Rights Under The Employee Retirement Income Security Act (ERISA)
- Continue Group Health Plan Coverage
- Prudent Actions by Plan Fiduciaries
- Enforce Your Rights
- Assistance with Your Questions

Summary Plan Description Requirement

- Additional requirements for group health plans:
  - Detailed description of benefits: cost-sharing, conditions covered, limits, exclusions, etc.
  - COBRA
  - Newborns' and Mothers' Act
  - Often include:
    - HIPAA Privacy Notice
    - CHIPRA Notice
    - Medicare Part D Notice
    - WHCRA Notice

Penalties for Noncompliance

- Participants, beneficiaries, or fiduciaries can sue to enforce ERISA's written plan document requirement (ERISA § 502(a)(3))
- Plan administrator can be charged up to $110 per day per participant for failing to provide copy of written plan document or SPD within 30 days of request (ERISA § 502(c)(1); DOL Reg. § 2575.502c-1)
- Failure to furnish any documents relating to an employee benefit plan requested by DOL under ERISA § 104 - $156 per day. (ERISA § 502(c)(6))

Penalties for Noncompliance

- Failure to provide a participant or beneficiary a Summary of Benefits Coverage – up to $1,156 per failure. (ERISA § 715)
- Any individual or company that *willfully* violates written plan document requirement could be subject to fine of $100,000 or 10 years imprisonment, or both (ERISA § 501)
  - If fine is imposed on a company, it can be increased to $500,000
- Various notice/disclosure/administration violations can lead to excise taxes/penalties
  - e.g., Form 8928 requires self-reporting of excise taxes for certain COBRA, HIPAA, Affordable Care Act violations

DOL Investigations and Lawsuits

- Gaps in plan documentation invite the courts to decide the plan terms for you
  - e.g., employer's authority to construe and interpret the plan terms, discretion to determine benefits and payments
- DOL Investigations
  - Increased audit activity around employee benefit plans, including welfare plans
  - Typical requests
  - Plan document and SPD are at the top of the list
  - Particular focus on compliance with Affordable Care Act provisions

Wrap Plan Documents and SPDs

- Two types: single plan or multiple plan wraps
- Single plan: Document to “wrap around” insurance policy or third party contract
  - Will add necessary ERISA information
- Multiple plan: “Umbrella” wrap document allows plan sponsor to bundle multiple welfare benefits under a single plan
  - This creates single employee welfare benefit plan for ERISA purposes

Advantages of Wrapping

- Fills in gaps of insurance policies or benefits booklets
  - So that combination of insurance policies/benefit booklets and wrap documents comply with ERISA requirements
- Only one Form 5500 required (if umbrella wrap)
- May simplify documentation and administration
  - Lower risk of inconsistencies, for example

References to Other Documents

- Wrap plans are a function of complying with ERISA's plan document requirements
- Insurer's document – Insurance policy, contract, certificate, benefits booklet
- Wrap document – Required ERISA language
- Wrap document + insurance document = ERISA compliant plan document and SPD

References to Other Documents

- Insurer's documents generally lack –
  - Eligibility provisions unique to employer, contributions method, ERISA appeal rights, and updated compliance language
  - Formal name of plan, employer's name and address, plan numbers, plan year (may differ from policy year), plan administrator name and contact information, plan agent for service of legal process, ERISA rights statement
  - Named fiduciary, funding policy, how payments are made to and from the plan, claim procedures, employer's right to amend and terminate the plan, group health mandates (e.g., COBRA and USERRA rights, HIPAA portability and privacy, QMCSO, minimum stay after child birth)

References to Other Documents

- Incorporate insurance document (policy, contract, certificate, benefit booklet) explicitly into the wrap document that contains the required ERISA language
  - Name of the insurance document
  - Policy, contract or certificate number
  - Effective date of the insurance document
  - Period covered by the insurance document

Reference to a Single Insurance Document

References to Multiple Insurance Documents

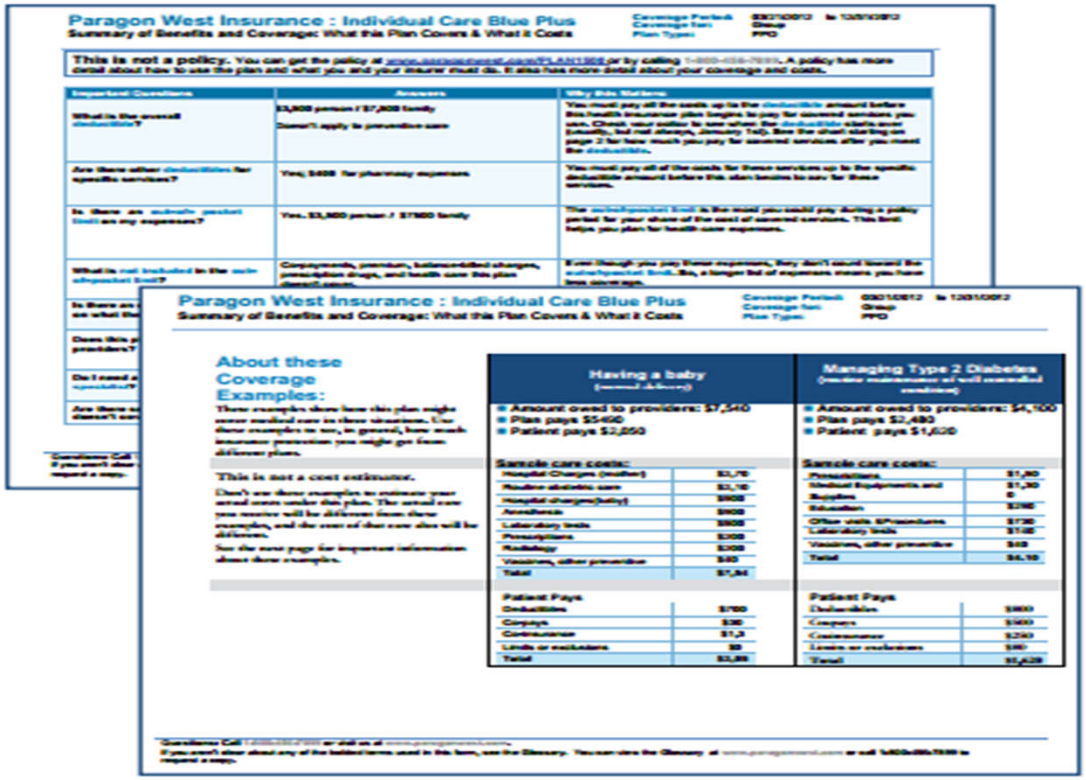
Ensuring Consistency of Plan Documents

- Carefully review underlying benefit program documents
  - Ensure provisions appear properly in base documents (e.g., eligibility)
  - Determine what provisions must be added or supplemented in the wrap document
  - Determine what provisions can be cross-referenced (e.g., claims)
  - Do not (unintentionally) provide additional benefits in the wrap document

Ensuring Consistency of Plan Documents

- Avoid creating conflicts between the documents
  - Be consistent in referencing plan names, numbers, etc.
  - The process may require updates and revisions to be made to the underlying benefit plan or program documents
  - Be careful of “general information” provisions in the base plan or program documents
- Keep the wrap plan and SPD up-to-date
  - Changes in insurers, benefit programs, claims administration, corporate entities, participating employers
  - Changes in the law

Summary of Benefits and Coverage (SBC)



Summary of Benefits and Coverage (SBC)

- Purpose of the Affordable Care Act's SBC Requirements
  - To provide individuals with standard information so they can compare medical plans as they make decisions about which plan to choose
  - SBCs do not replace SPDs; they are in addition to SPDs

- ACA amended the Public Health Service Act (Sec. 2715)
  - Directed DOL, IRS, and HHS to (i) develop standards for insurers in the individual and group markets to provide a summary that "accurately describes the benefits and coverage under the applicable plan or coverage" and (ii) "standards for the definitions of terms used in health insurance coverage"

- Agencies issued SBC regulatory requirements as to content; format; timing of distribution; templates and sample SBCs; Glossary

Summary of Benefits and Coverage (SBC)

- Types of plans covered
  - Individual medical policies
  - Insured and self-funded group medical plans, regardless of grandfathered status
  - Health Reimbursement Arrangements and health Flexible Spending Accounts
- Plans not covered
  - Stand-alone dental and vision plans
  - Health Savings Accounts
  - Retiree-only plans
  - Medicare plans
  - United States issued expatriate plans

Summary of Benefits and Coverage (SBC)

- Format
  - 4 pages (2-sided, 8 pages maximum, 12-point font, in color or grayscale)
  - Can be included in another document, but must be placed prominently at the beginning

- Language requirements
  - If a certain percentage of the population in a county speaks a language other than English, the availability of materials in the non-English language must be communicated by:
    - Including a notice of the availability of language assistance
    - Providing translation upon request (Spanish, Traditional Chinese, Tagalog, Navajo)

Summary of Benefits and Coverage (SBC)

- Templates, samples, and Glossary
  - Promote consistency in communicating description of benefits and coverages
    - www.dol.gov/agencies/ebsa
  - SBC template/MS Word format
  - Sample completed SBC/MS Word format
  - Instructions for completing the SBC (Group plan and individual policies)
  - Glossary (www.healthcare.gov)
  - SBC and Glossary (Chinese, Spanish, Tagalog, Navajo)

Summary of Benefits and Coverage (SBC)

- Templates and samples
  - Must include three coverage scenarios: Having a baby; managing Type 2 diabetes; and emergency room treatment for a simple fracture
  - Estimates are based on national average costs and in-network benefit levels under the plan
  - Must use the common medical and insurance terms and definitions found in the uniform Glossary

Summary of Benefits and Coverage (SBC)

- Templates and samples
  - Must include internet web addresses and phone number to allow online access to policy or group certificate and to obtain additional information
  - Must provide information on whether the plan meets Minimum Essential Coverage and/or Minimum Value Standard requirements
  - Must include a statement that the SBC is a summary only and the plan document or individual insurance policy should be consulted to determine governing provisions

Summary of Benefits and Coverage (SBC)

- Minimum Essential Coverage (MEC)
  - SBC must state whether the group plan or policy provides “Minimum Essential Coverage”
  - Question is part of the template
  - MEC means the health coverage offered by a group plan or policy meets the ACA individual responsibility requirement
    - Includes employer group medical plans, policies offered through the Marketplace, Medicare, Medicaid, CHIP, TRICARE

Summary of Benefits and Coverage (SBC)

- Minimum Value Standard
  - SBC must state whether the group plan or policy meets the "Minimum Value Standard"
  - Question is part of the template
  - Minimum Value Standard is the basic standard used to measure the percent of permitted costs covered by the plan
    - An employer plan must pay for at least 60% of the total allowed costs of benefits to meet the Minimum Value Standard
    - If an employer plan meets the Minimum Value Standard, employees may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace

Summary of Benefits and Coverage (SBC)

- Who is responsible for delivering the SBC?

Type of Plan/Policy	Responsible Party
Individual policy	Insurer
Self-funded group plan	Employer
Insured employer group plan	Insurer and Employer can determine who takes responsibility

Summary of Benefits and Coverage (SBC)

- When must an SBC be provided to an Employee?
  - During each annual open enrollment
    - If must enroll to continue coverage, must be provided when open enrollment materials are distributed
    - If materials not distributed, must be provided by first day employees are eligible to enroll
    - For insured plans, if coverage continues automatically for the next year, must be provided at least 30 days before the beginning of the new plan year
    - Must receive an SBC for the plan in which they are enrolled; SBCs for other available plans must be provided on request
  - Within 90 days after enrollment due to a special enrollment event
  - Within 7 business days when an employee requests an SBC

Summary of Benefits and Coverage (SBC)

- Paper and electronic delivery of SBCs to employees
  - SBCs may be provided in either paper or electronic format
  - Electronic distribution to currently enrolled employees must comply with ERISA rules for electronic delivery
  - Electronic distribution to those not enrolled, either by email or posting on the internet
    - Prominent location; readily accessible; notification to employees as to where they can access the SBC and that a paper copy is available at no cost upon request

Summary of Benefits and Coverage (SBC)

- Notification of “material modifications” made to the group plan during the plan year
  - A notice must be provided at least 60 days before the effective date of any material modification made to a plan during the plan year
  - “Material” change: any change that an average participant would consider to be an important enhancement or reduction in benefits
  - Changes made at annual renewal do not require 60-day advance notice

Summary of Benefits and Coverage (SBC)

- Penalties
  - For 2019, willful failure to provide an SBC results in a penalty of up to $1,156 for each failure
  - A failure with respect to each covered individual constitutes a separate offense
- Who is responsible for paying penalties?
  - Individual medical policies: Insurer
  - Insured group medical plans: Employer and insurer share responsibility
  - Self-funded group medical plans: Employer

Summary of Benefits and Coverage (SBC)

- Attachments
  - Appendix 1: SBC Template
  - Appendix 2: Sample Completed SBC
  - Appendix 3: Uniform Glossary

Questions?

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