UNDERSTANDING ERISA

ERISA, the Employee Retirement Income Security Act of 1974, has a big impact on employers. That's why we've developed this overview of ERISA to help brokers and their clients understand the law and address some frequently asked questions.

What Is ERISA?

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law dealing with minimum standards for most voluntarily established pension and employee benefit plans. ERISA addresses both Qualified Retirement Plans (e.g., pension and profit-sharing plans) as well as Welfare Benefit Plans (e.g., group insurance and other fringe benefit plans).

ERISA requires plans to provide participants with plan information, including important facts about plan features and funding. It sets minimum standards for participation, vesting, benefit accrual, and funding. It also provides fiduciary responsibilities for those who manage and control plan assets and requires plans to establish a claims and appeals process for participants to get benefits from their plans. ERISA gives participants the right to sue for benefits and breaches of fiduciary duty. If a defined benefit plan is terminated, ERISA guarantees payment of certain benefits through a federally chartered corporation, the Pension Benefit Guaranty Corporation (PBGC).

Employee benefit plans may also be regulated by other government agencies, such as the Internal Revenue Service (IRS) and state insurance regulators. An employer's failure to comply with ERISA can result in penalties, enforcement actions, and even employee lawsuits.

What Employers are Subject to ERISA?

Most private-sector corporations, partnerships, and proprietorships, including non-profit corporations, must comply with ERISA regardless of size or the number of employees. While ERISA does not require an employer to establish a retirement or health benefit plan, it does require those who meet certain minimum standards.

Government employers and churches are generally exempt from ERISA Welfare Benefit Plan provisions; however, it's important to carefully review the definition of a government plan" under the law as an exemption can be challenged. This was the case in 2013 in Smith v. Regional Transit Authority, a Louisiana employer.

Why Should an Employer Comply With ERISA?

It's the law! ERISA compliance is required under federal law. Employers can avoid costly penalties if they comply. Compliance may also aid an employer in avoiding litigation and state court penalties, if plan participant or beneficiary brings a claim against a company, its insurers, or the plan administrator for denying benefits.

ERISA trumps state law, although there is a statutory exemption for Hawaii that was enacted in 1974. ERISA applies to self-insured health plans, while both ERISA and state authority apply to insured health plans. Under ERISA, damages are limited to the unpaid benefits. An employer's failure to comply creates potential exposure in state or federal court. In state court, every aspect of a case is subject to a "de novo" review, which includes matters not even in dispute. However, ERISA has a higher standard of review for overturning decisions of a Plan Administrator. In federal court, an Administrator's decision to deny a claim must be deemed "arbitrary and capricious" to be overturned.

Which Benefit Plans are ERISA Plans?

An employee welfare benefit plan under ERISA includes plans providing medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment, as well as vacation benefits, training programs, scholarship funds, prepaid legal, or any benefit described in the Labor Management Relations Act, 1947.

In general, whether a fully insured or self-insured plan, ERISA applies to:

- Medical, Surgical, or Hospital benefit plans (including HMOs and group insurance plans)
- Health Reimbursement Arrangements (HRAs)
- Health Care Flexible Spending Accounts (FSAs)
- Dental Plans
- Vision Plans
- Prescription Drug Plans
- Sickness, Accident, and Disability Insurance Plans
- Group Life and AD&D Insurance
- Employee Assistance Plans (EAPs) if counsel (not just referrals) are provided
- Executive Medical Reimbursement Plans
- Wellness Plans (when medical care is offered)
- Long Term Care Insurance Plans
- Severance Plans
- Unemployment Benefit Plans
- Day Care Centers
- Prepaid Legal Services
- Funded Vacation Benefits
- Holiday Plans
- Scholarship Plans
- Housing Assistance Plans
- Business Travel Accident Plans
- Funded Apprenticeship or other Training Benefits
- 419(a)(f)(6) and 419(e) Welfare Benefit Plans
- Split Dollar Life Insurance Plans
- Single/One Employee Plans

Some self-insured or uninsured plans such as those related to sick pay, short-term disability, overtime, vacation pay, other paid time off, and jury duty may be exempt if benefits are paid:

- as part of a typical payroll practice;
- to individuals who are currently employed (this excludes retirees, COBRA participants, and dependents);
- entirely from the employer's general assets without prefunding or using insurance; **and**
- without employee contributions.

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Which Benefit Plans are ERISA Plans? (cont'd)

Individual insurance plans and voluntary group plans may also be exempt from ERISA, depending on the extent of employer involvement. If participants pay all of the cost and the employer's role is only to withhold premiums through payroll deduction for insurer remittance, an exemption may apply. However, minimal sponsorship or endorsement, like including the employer's name on brochures promoting the product could negate any exemption.

A plan qualifies under the Voluntary Plan Safe Harbor if it is:

- funded by group or group-type insurance;
- totally voluntary;
- not in any way funded by the employer; AND
- not endorsed by the employer.

Which Plans Are Typically Not Subject to ERISA?

ERISA generally does not apply to:

- Cafeteria Plans, Section 125 Plans, Premium Only Plans (POPs), Premium Conversion Plans, or Pre-tax Premium plans
  If the benefits funded by any of these plans are subject to ERISA, these plans should be referenced in the Plan Document and Summary Plan Description (SPD).
- Health Savings Accounts (HSAs) so long as the employer has limited involvement
- Dependent Care FSAs
- Dependent Care Assistance Plans (DCAPs)
- Transit and Parking plans
- Adoption Assistance plans
- Educational Assistance and Tuition Reimbursement plans
- Paid Time Off (PTO) plans
- Medical clinics on-site to provide first aid

What Constitutes an Employer Endorsement?

A Voluntary Plan Safe Harbor may be negated through an implied employer endorsement in any of the following ways:

- selecting the insurer;
- negotiating terms or linking coverage to employee status;
- using the employer's name/associating the plan with other employee plans;
- recommending the plan to employees;
- stating that ERISA applies;
- doing more than permitting employee payroll deductions;
- putting the plan under the employer's Cafeteria Plan; or
- assisting employees with claims or disputes.

What is a Plan Document?

ERISA requires plan documents to describe a plan's terms and conditions related to its operation and administration. Each Welfare Benefit Plan that an employer provides that is subject to ERISA must have a written Plan Document. An ERISA plan can exist without the required written document; however, it will be considered out of compliance.

These documents **do not** constitute a Plan Document or Summary Plan Description as required under ERISA:

- Master contract from an insurance carrier;
- Certificate of Coverage;
- Summary of Benefits Plan.

To be in compliance with ERISA, the Plan Document should contain:

- Plan administrator name;
- designation of named fiduciaries under the claims procedure for deciding benefit appeals (other than the Plan Administrator);
- description of benefits provided and the standard of review for benefits decisions;
- participant eligibility requirements and the effective date of participation;
- information on how the plan is funded (employer and/or employee contributions), if the Plan has assets;
- the amount each Participant must pay toward the cost of coverage;
- details regarding amendment and termination rights and processes for the Plan Sponsor, as well as what happens to any Plan assets if the Plan is terminated;
- rules about the use of Personal Health Information (PHI), if the Plan Sponsor uses such information;
- information regarding COBRA, HIPAA, and other federal mandates such as preexisting conditions exclusions, Women's Health Cancer Rights Act, special enrollment rules, mental health parity, coverage for adopted children, Qualified Medical Support Orders, and minimum hospital stays after childbirth;
- subrogation, coordination of benefits, and offset provisions;
- allocation and designation of Third Party Administrators (TPA) or committee administrative duties;
- the process for allocation of insurer refunds to Participants (e.g., dividends, demutualization).

Any employer sponsoring a health or welfare benefits plan must determine the best way to document benefits (for legal compliance) and effectively communicate them to employees. Employers sponsoring insured benefits are on notice concerning missing ERISA provisions in their insurance documentation. Sometimes using a "wrap document" to bundle benefits into one plan and/or supplement insurance documents is easier for an employer.

Plan Document Compliance for Insured Plans

Insurers typically do not draft contracts with ERISA plan document requirements in mind; as a result, insurance policies often fail to include all of the provisions required for ERISA plan documents and don't always protect the plan sponsor and plan administrator. Many employers may find the best approach is to combine the insurance documents with a "wrap" document.

Plan Document Compliance for Third-Party Contracts

Similar plan document considerations exist where ERISA-impacted plan benefits are provided under a contract with a third party other than an insurer. Benefits under many employee assistance plans (EAPs), for example, are often provided through an agreement with a third-party service provider. The contract may not be designed to serve as the plan document for ERISA purposes and may lack many of the required elements and provisions intended to protect the plan sponsor and plan administrator. A wrap document can supplement existing documentation to include required elements and other optional provisions to protect the plan.

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What is a Plan Document? (cont'd)

Plan Document Compliance for "Bundled" Plans

Some plan sponsors may wish to combine two or more ERISA benefits into one plan for purposes of ERISA compliance. The component plan benefits may be fully insured, self-insured, or a combination of both. The plan document for this kind of bundled plan consists of the insurance policies and/or self-insured plan descriptions combined to make a "mega-wrap" using an umbrella document. A common use of a mega-wrap document is to collect all of the plan sponsor's welfare benefits under a single plan.

What Information Should a Summary Plan Description (SPD) Contain?

The Summary Plan Description (SPD) is the primary document to communicate Plan rights and obligations to Participants and Beneficiaries. It's a summary of the main provisions of the Plan Document. However, for Health and Welfare Benefit Plans, the SPD is typically a combination of the complete description of the Plan's terms and conditions, such as a Certificate of Coverage, and the required ERISA disclosure language.

An SPD must include all of the following:

- Plan name
- Plan sponsor/employer name and address
- Plan sponsor's Employer Identification Number (EIN)
- Plan administrator's name, address, and phone number
- Designation of any named fiduciaries, if other than the plan administrator (e.g., claim fiduciary)
- Designation of whether the Plan is maintained pursuant to one or more collective bargaining agreements and that a copy of the agreement(s) can be provided if requested
- Each trustee must be named along with their title and principal business address If the Plan has a trust
- Plan agent name and address for service of legal process, along with a statement that service may be made on a Plan Trustee or Administrator
- Identity of insurer(s), if any
- Plan type and/or description of benefits
- Plan Year end date (may not be the same as the insurance policy year)
- Plan number for ERISA Form 5500 purposes *(Note: each ERISA Plan should be assigned a unique number)*
- The type of Plan administration – whether it is administered by contract, insurer, or plan sponsor
- Participant eligibility and the effective date of participation
- Process for allocation of insurer refunds to Participants (e.g., dividends, demutualization, and Medical Loss Ratio refunds)
- Details regarding the amendment and termination rights and processes for the Plan Sponsor, as well as what happens to any Plan assets if the Plan is terminated
- Summary of Plan provisions governing the benefits, rights, and obligations of Participants under the Plan on termination, amendment of the Plan, or elimination of benefits
- Summary of Plan provisions regarding the allocation and disbursement of assets upon Plan termination
- Clear identification of the circumstances that may result in loss or denial of benefits (e.g., subrogation, coordination of benefits, and offset provisions)

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What Information Should a Summary Plan Description (SPD) Contain? (cont'd)

- Process and standards for review of benefit decisions
- ERISA model statement of Participants' rights
- Information on how the Plan is funded (employer and/or employee contributions) and the method used to calculate contributions
- Interim SMMs since the SPD was adopted or last restated
- Whether the employer is a participating employer or a member of a controlled group
- Offer of assistance in languages other than English, depending on the number of participants who require assistance in a non-English language

Claims' procedures may be furnished separately in a Certificate of Coverage, if the SPD explains that claims procedures are furnished automatically, without charge, in the separate Certificate of Coverage document and sets time limits for lawsuits, if the Plan imposes them.

Additional requirements for Group Health Plan SPDs include:

- Detailed description of Plan provisions and exclusions – co-pays, deductibles, coinsurance, eligible expenses, network provider provisions, prior authorization and utilization review requirements, dollar limits, day limits, visit limits, and information on coverage related to new drugs, preventive care, and medical tests and devices. *(A link should be provided. Plan limits, exceptions, and restrictions should be conspicuous.)*
- Information regarding COBRA, HIPAA, and other federal mandates like preexisting conditions exclusions, Women's Health Cancer Rights Act, special enrollment rules, mental health parity, coverage for adopted children, Qualified Medical Support Orders, and minimum hospital stays after childbirth.
- Identity and address(es) of insurer(s), if applicable.
- Description of the role of health insurers (e.g., administrative services or other).

Although not required, it is advisable to:

- Provide information on the TPA providing claims payment, benefits administration, and other services (e.g., name, address, phone) for self-insured plans.
- Attach the Summary of Benefits provided by the insurance company (or companies) ensure the language in the Certificate of Coverage is easily understood for insured arrangements.
- Specify which document controls in case of conflict (Plan Document, SPD, or Certificate of Coverage).

How Must SPD Be Provided to Plan Participants?

The Plan Administrator/Employer is responsible for preparing and delivering the SPD to Participants within 90 days of them becoming covered, whether or not they request the SPD.

Plan Administrators of a new Plan must provide the SPD within 120 days after the Plan is established. An updated SPD must be provided to all covered Participants every five years. Even if the SPD has not changed, it must be provided every 10 years.

Fines can be imposed by the DOL for failure to provide the SPD as required and proof can be important in situations of litigation. SPDs can be sent to Participants in a variety of ways, including electronic delivery, first-class mail, and hand delivery.

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How Must SPD Be Provided to Plan Participants? (cont'd)

Participants are defined as:

- Covered employees (not required separately for dependents of covered employees);
- Terminated COBRA Participants;
- Parents/guardians of minors covered under a qualified medical support order;
- Dependents of a deceased retiree under a retiree medical plan.

What Are the Non-Compliance Penalties?

There are Department of Labor penalties for not distributing plan documents to Participants in a timely basis, but just as important is having a compliant ERISA Wrap or Mega-Wrap document to ensure your plan falls under federal regulations and not the state. ERISA is a federal law that trumps state law. Some states allow Participants and Beneficiaries to bring "bad faith' lawsuits against administrators and insurers who have denied benefits.

If you have ERISA language in the Plan Document, you can avoid state lawsuits. There have been many cases where a jury has awarded significant awards through state courts for non-compliance. The ERISA law limits damages to the unpaid benefits and does not allow for jury trials, which often favor the insured over the insurer.

You will never be able to prevent all complaints from Participants who feel they have been wrongly denied benefits; however, an ERISA-compliant Plan Document provides protection to mitigate any penalty potential.

IRS Form 5500 Series

The Department of Labor, Internal Revenue Service, and the Pension Benefit Guaranty Corporation jointly developed the Form 5500 Series so employee benefit plans could utilize the Form 5500 Series forms to satisfy annual reporting requirements under Title I and Title IV of ERISA and under the Internal Revenue Code.

The Form 5500 Series is an important compliance, research, and disclosure tool for the Department of Labor, a disclosure document for plan participants and beneficiaries, and a source of information and data for use by other Federal agencies, Congress, and the private sector in assessing employee benefit, tax, and economic trends and policies. The Form 5500 Series is part of ERISA's overall reporting and disclosure framework, which is intended to assure that employee benefit plans are operated and managed in accordance with certain prescribed standards and that participants and beneficiaries, as well as regulators, are provided or have access to sufficient information to protect the rights and benefits of participants and beneficiaries under employee benefit plans.

There are 3 Form 5500s:

- Form 5500 (100+ participants at beginning of plan year)
- Form 5500-SF (Short Form) (< 100 participants at beginning of plan year & is not exempt from filing)
- Form 5500-EZ -> One Participant (Owner & Spouse) Retirement Plans

Welfare Plans that have 100 or more participants, are generally required to file a Form 5500. Most exemptions apply to welfare benefit plans that have less than 100 participants.

Note: ERISA uses the term "welfare benefit plans" so you will see this term in the Form 5500 instructions. It is used to refer what are commonly known as "health plans."