ERISA Documentation, Disclosures, & Reporting

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Most employee benefit arrangements, group health plans and non-group health plans, are employee welfare benefit plans covered by ERISA and required to comply with documentation, disclosure, and reporting requirements imposed under ERISA. Many employers fail to have compliant or current documentation in place, which puts them at risk in a variety of ways. Below is a summary of which employers and plans are subject to ERISA, as well as general ERISA requirements, but the focus is on plan documentation and Form 5500 reporting.

ERISA Application

Any group plan maintained by an employer *"for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise ... 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 …."* is subject to ERISA.

Examples of ERISA benefits include, but are not limited to, a medical plan, a dental or vision plan, a health flexible spending account (FSA), life insurance, an employee assistance program (EAP), a disease-specific policy, and an onsite medical clinic. Examples of non-ERISA benefits include, but are not limited to, a health savings account (HSA), a dependent care account plan (DCAP), a cafeteria plan, and tuition reimbursement.

Certain employers are exempt from ERISA regardless of what type of benefits they offer. Plans offered by government, tribal, or church employers are NOT subject to ERISA.

In addition, there is a safe harbor for certain voluntary plans. Voluntary plans meeting the following requirements are NOT subject to ERISA:

- No employer contributions;
- Participation must be voluntary; and
- Limited employer involvement (no employer endorsement). Allowing premium payment on a pre-tax basis through the employer's cafeteria plan would be considered "employer involvement."

Plans subject to ERISA will generally not be subject to state laws due to ERISA pre-emption. However, plans not subject to ERISA (e.g. government or church plans) may need to pay more attention to state-specific benefit plan requirements. In addition, fully-insured plans will probably be designed by carriers to comply with state insurance regulations regardless of whether the plan is subject to ERISA.

General ERISA Requirements

ERISA requires plans to name fiduciaries (typically the plan administrator(s)), who are responsible for carrying out certain fiduciary duties in accordance with ERISA. Such duties include, among other things, setting and following plan terms such as benefit inclusions/exclusions, eligibility for coverage, and claims procedures. Fiduciaries are also responsible for the proper handling of funds (plan assets) and for adopting formal plan documents; providing participant disclosures (e.g. summary plan descriptions (SPDs), claims notices, and various group health plan disclosures); and reporting certain information to the government (e.g. Form 5500s). The various requirements are intertwined. For example, failure to adequately communicate plan terms and coverage via a summary plan description (SPD) may be considered a breach of fiduciary duty.

ERISA Plan Documentation

ERISA requires a formal written plan document, a summary plan description (SPD), and a summary of benefits & coverage (SBC). Each of these requirements is discussed in more detail below.

Plan Document

A formal plan document is required for every ERISA plan. ERISA rules require that every plan *"be established and maintained pursuant to a written instrument."* The plan document does not have any specific formatting or structural requirements, but should include the following type of information:

- Plan name, number, and plan year:
    - ERISA plan numbers start at 501 and then continue for each separate ERISA plan maintained by the employer (502, 503, 504, etc.).
    - The ERISA plan year is generally established by the plan document. An ERISA plan year cannot exceed 12 months. It may be necessary to run a short plan year for various business reasons (e.g. going out of business, merger/acquisition, change in plan year), which is permitted. The plan year often matches the insurance contract or policy year, but could be different (e.g. extended rate guarantee).
- Eligibility rules and benefits included/excluded;
    - Eligibility rules should include all participating entities if multiple employers are sharing benefit plans.
    - Differing eligibility rules (including waiting periods) should be clearly outlined for different categories of employees or different benefits bundled into a single ERISA plan via a WRAP document. Eligibility rules should also address any special conditions that may apply due to rehire or leaves of absence.
    - Exclusions or limitations on benefit coverage should be clearly addressed.
- Named fiduciary and allocation of responsibilities;
- Description of funding (e.g. insured or self-insured) and how payments are made;
- Claims procedures;
- Amendment procedures;
- Distribution of assets upon plan termination; and
- For group health plans, COBRA, HIPAA and other federal mandate descriptions (e.g. mental health parity, USERRA, FMLA, QMCSO).

Employers often rely upon carrier and/or TPA documentation, which may be missing content that is required under ERISA and will not always be in the best interest of the employer. Insurer-prepared documentation will represent the insurer's best interests and be drafted to comply with state requirements, not necessarily with ERISA requirements. A WRAP document can be used to add employer-specific terms and to address any missing ERISA-required content not included in a certificate of insurance or coverage. The following items are often missing, incorrect, or not adequately addressed in plan documents:

- Plan name and number;
- Named fiduciary(ies) and allocation of responsibilities;
- Distribution of plan assets upon plan termination;
- Employer-specific processes/procedures;
- Accurate eligibility rules;
- Limitations or requirements for the handling of benefit claims and litigation;
- Inconsistency between documents (e.g. plan document, SPD, employee handbook, insurance contract);
- Up-to-date information (e.g. eligibility rule changes, vendor changes); and
- Language granting the plan sponsor discretionary authority to interpret the plan terms.

A WRAP document can also be used to bundle multiple benefits (e.g. medical, dental, life) into a single ERISA plan; this is sometimes referred to as a mega-WRAP or umbrella document. So, for example, rather than treating the medical, dental, vision, life, disability, and FSA as six separate ERISA plans (501, 502, 503, 504, 505 and 506) requiring a separate plan document for each separate plan, they could be bundled into a single ERISA plan (501) requiring only one plan document with each of the benefits described within the one WRAP document. Bundling benefits into a single ERISA plan can reduce the

amount of documentation required and can also simplify the Form 5500 filing process if applicable (see more later).

There is no delivery requirement for the plan document, but the document must be made available upon request.

Once a plan document is written and formally adopted, we recommend that the content be reviewed annually; but amendments are required only if changes to the language in the plan document are needed.

Having a formal plan document in place is strongly recommended to avoid: (i) liability for additional benefits or coverage arising from unclear eligibility rules or coverage limitations/exclusions; (ii) audit hassle with the Department of Labor (DOL); (iii) claims of breach of fiduciary duty for failure to communicate and follow plan terms: and (iv) litigation risk, including less favorable standards of review by courts and decisions made based on past practices and extrinsic (outside) evidence rather than on specified plan terms. Lack of a formal plan document can also complicate Form 5500 compliance if there are questions about plan year or plan setup (e.g. separate ERISA plans versus a single ERISA plan due to benefits bundled via a WRAP document).

Summary Plan Description (SPD)

An SPD provides a summary of key plan provisions for plan participants. Specific content requirements are set forth in 29 CFR § 2520.102-3. Although the plan document is a separate requirement from the SPD, some employers also use a single document to serve as both the plan document and the SPD. The more conservative approach is to have separate documents, but it may be possible to prepare a single document so long as the document satisfies all requirements for both documents. Similar to the discussion above regarding the plan document, it's possible to use a WRAP document to add missing terms to an insurer/TPA's document or to bundle benefits into a single plan.

Unlike the plan document, an SPD must be distributed to plan participants (employees and former employees, but not spouses or dependents): (i) within 90 days of the effective date of coverage; (ii) within 120 days for new plans; (iii) every 5 years (if material changes have been made); (iv) every 10 years (if no material changes have been made); and (v) upon request. The SPD may be distributed by hand, by mail, or electronically as permitted under the DOL safe harbor (i.e. regular workplace access or consent).

If plan changes are made that either are material or affect the required content of the SPD, a summary of material modification (SMM) must be prepared and distributed to plan participants. Alternatively, the SPD may be amended and re-distributed. Each time the plan is changed as described above, and a new SPD is not created, an SMM must be provided:

- Within 60 days following the adoption of a material reduction in plan benefits; or
- Within 210 days following the close of a plan year when the change is not a material reduction in benefits.

The SMM should be included with the SPD whenever distributed until the SPD is updated with the latest changes.

Failure to distribute compliant SPDs can result in civil penalties for breach of fiduciary duties, and up to a $110/per day penalty for failure to respond to written document requests from plan participants within 30 days. It can also result in the risks discussed above for failure to have a compliant plan document in place.

Summary of Benefits & Coverage (SBC)

The SBC acts as a uniform tool that provides an easier way for eligible individuals to compare medical plan options. The SBC is required for all group health plans, but not for excepted benefits (e.g. stand-alone vision or dental, health FSA) or retiree-only plans. Note that an SBC is generally required for an HRA. A specific template must be used. The template and instructions can be found at

https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits.

The SBC must be distributed to all plan participants, including employees and former employees, and to spouses and dependents; but one notice is adequate for the family unless the employer has reason to know they reside at different addresses. The SBC must be distributed: (i) upon initial enrollment; (ii) upon annual enrollment; (iii) upon special enrollment; and (iv) upon request. It may be distributed by hand delivery, mail, or electronically as follows:

- For covered participants: (i) those who enroll online may receive the SBC electronically with their enrollment; (ii) those who don't enroll online may receive the SBC electronically if the DOL safe harbor is met.
- For those who are eligible but not enrolled, notification (by paper or email) that the SBC is available on the internet.

If plan changes affecting the content of the SBC occur mid-plan year, a notice of modification describing the change(s) must be provided to plan participants 60 days in advance of the effective date of the change.

Failure to distribute compliant SBCs can result in civil penalties of up to $1,156 (indexed annually) per failure in addition to excise taxes of up to $100/day for each affected individual.

Annual Form 5500 Reporting

The Form 5500 is a tool used by the IRS and DOL to collect and share information about employee benefit plans and to oversee enforcement of ERISA and Tax Code rules. Annual filings are in the public record and can be found at https://www.efast.dol.gov/portal/app/disseminate?execution=e1s1.

A Form 5500 is required to be filed annually, no later than 7 months following the end of the plan year (subject to a 2½ month extension, if requested), for the following plans:

1. ERISA welfare plans covering 100 or more participants at the beginning of a plan year;
    - Count employees and former employees, but not spouses or dependents;
    - If there is a WRAP document bundling multiple benefits into a single ERISA plan, the count is based on the number of unique participants across all benefits considered to be part of the same ERISA plan.
2. Funded ERISA benefit plans (plan assets held in a trust or VEBA); and
    - Most plans are unfunded, meaning plan costs are paid out of the employer's general assets.
3. Most multiple employer welfare arrangements (MEWAs).

One of the benefits of bundling multiple benefits into a single ERISA plan via a WRAP document is that it simplifies annual Form 5500 filing requirements, because the requirements apply on a plan basis. So if there is a single ERISA plan, only one Form 5500 is required (listing all included benefits). If filing is required because there are at least 100 unique participants in the plan, all benefits under the plan must be listed regardless of the number of plan participants in each separate benefit. However, if each benefit is a separate ERISA plan, a separate Form 5500 is required for each plan with 100 or more participants.

In some cases, schedules must be filed along with the main Form 5500. A Schedule A is generally required for all fully-insured plans and will often be prepared by the carrier. A Schedule C, used to report information about service providers paid by the plan, is likely to be required only if the plan is "funded" (i.e. assets of the plan are segregated from the general assets of the plan sponsor). NOTE: An unfunded self-funded (self-insured) plan is typically required to file only the main portion of the Form 5500 without any schedules.

MEWAs are formed when unrelated entities share benefit plans. For example, benefits shared by entities without enough common ownership to form a controlled group under §414 (i.e. <80% common ownership), benefits shared by entities within an affiliated service group, or benefit plans covering non-

employees such as independent contractors, owners, or board members. MEWAs are generally required to annually file a Form M-1 and Form 5500 regardless of the number of plan participants. There is an exception to the Form M-1 filing requirement when non-employees make up less than 1% of the covered plan participants or when there is 25% or more common ownership between the entities sharing benefit plans.

Failure to file the Form 5500 as required can result in significant penalties. Although the maximum penalty is $2,194 per day (indexed annually), the standard penalty is $300 per day up to $30,000 per year for non-filers, and $50 per day (with no cap) for late filers. Exposure is increased if there are multiple plans versus a single ERISA plan under which multiple plans are bundled via a WRAP document. There is a delinquent filer voluntary compliance program (DFVCP) that provides for reduced penalties for those who voluntarily report prior to being contacted by the DOL. Penalties are reduced to $10 per day, up to $2,000 per year, and capped at $4,000 per plan when there are multiple years of missed filings. Typically, plan documentation must be adopted and effective on only a prospective basis, so it may not be possible to bundle benefits via a WRAP document retroactively to limit penalty exposure.

Example – Failure to File for 3 Years

Acme Group Health Plan(s)	**Plan #501 (Benefits Bundled via WRAP Doc)**	**Plans #501, #502, #503 (No WRAP Doc)**
Maximum Penalty (no filing)	$800,810 x 3 = **$2,402,430**	$800,810 x 3 x 3 = **$7,207,290**
Standard Penalty (no filing)	$30,000 x 3 = **$90,000**	$30,000 x 3 x 3 = **$270,000**
Standard Penalty (late filing)	$18,250 x 3 = **$54,750**	$18,250 x 3 x 3 = **$164,250**
DFVCP	$2,000 x 3 = $6,000 **Capped at $4,000**	$2,000 x 3 x 3 = $18,000 **Capped at $12,000**

Forms, electronic filing requirements, and other assistance can be found at https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500.

Helpful websites regarding the DFVC program:

- FAQ – https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/dfvcp.pdf
- Penalty calculator and online payment instructions – https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/correction-programs/dfvcp

In addition to the Form 5500 filing, a summary annual report (SAR) may be required to be distributed to plan participants. A SAR is a boiled-down summary of the Form 5500. The SAR is generally required for any plan subject to Form 5500 filing, but there is an exception for self-insured plans without any segregation of assets in a trust or otherwise (unfunded). The SAR, when required, must be distributed annually within 2 months from the date Form 5500 is due, and it can be distributed by hand, by mail, or electronically as permitted under the DOL safe harbor (i.e. with regular workplace access or consent).

A template for the SAR can be found in 29 CFR 2520.104b-10 – https://www.law.cornell.edu/cfr/text/29/2520.104b-10.

Summary

We often run into employers who do not have compliant plan document and distribution processes in place as required under ERISA, thereby risking civil penalties, audit difficulties, incorrect Form 5500 filings, and perhaps most importantly, unintended liability for plan coverage for claimants disputing unclear eligibility or coverage descriptions. With a bit of effort and expense on the front end to put proper documentation, distribution, and reporting processes in place, the employer can greatly reduce the risk of significant hassle and expense in the future.