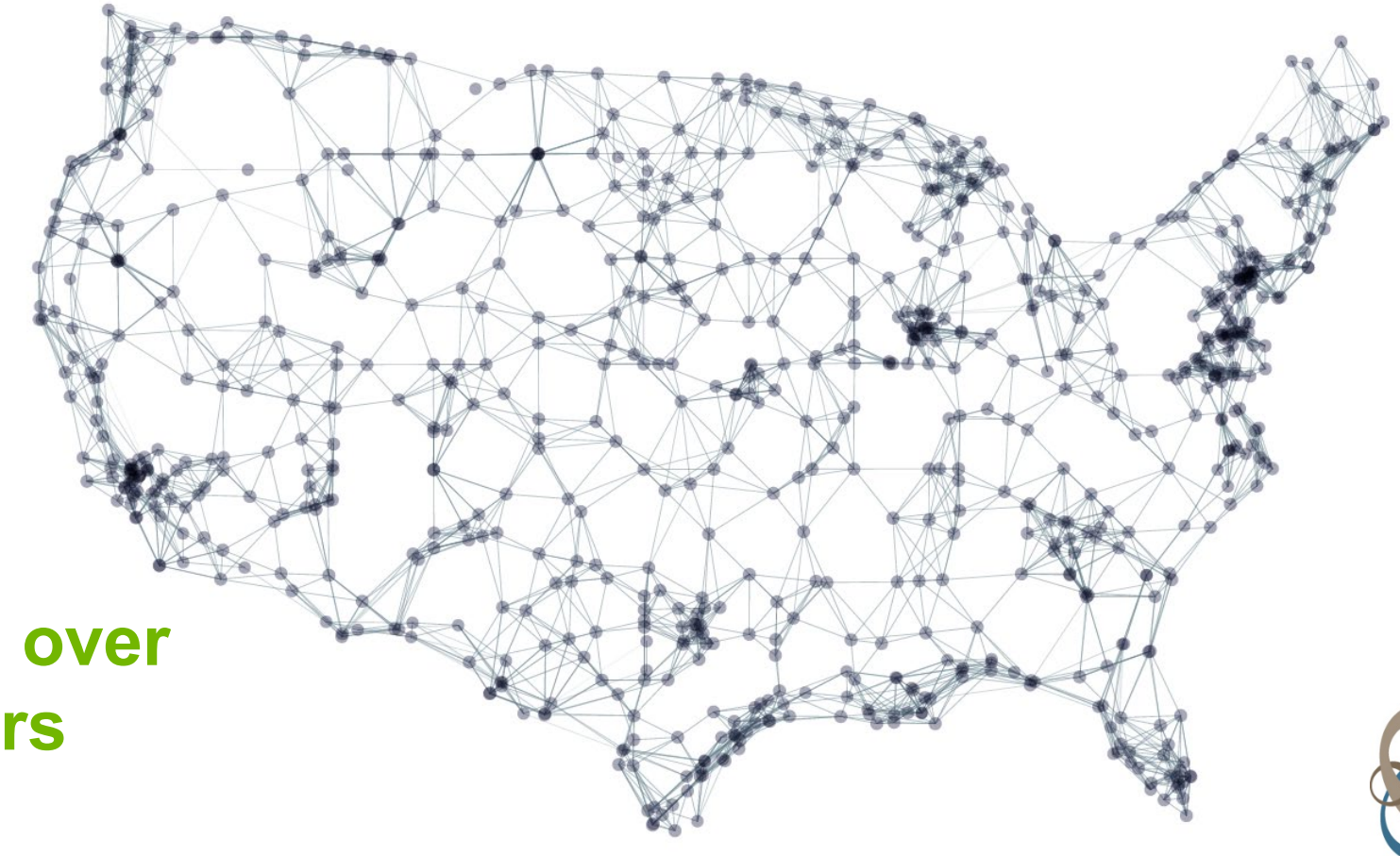
Health and Welfare Compliance Requirements for All Employers

Coast to Coast Administration



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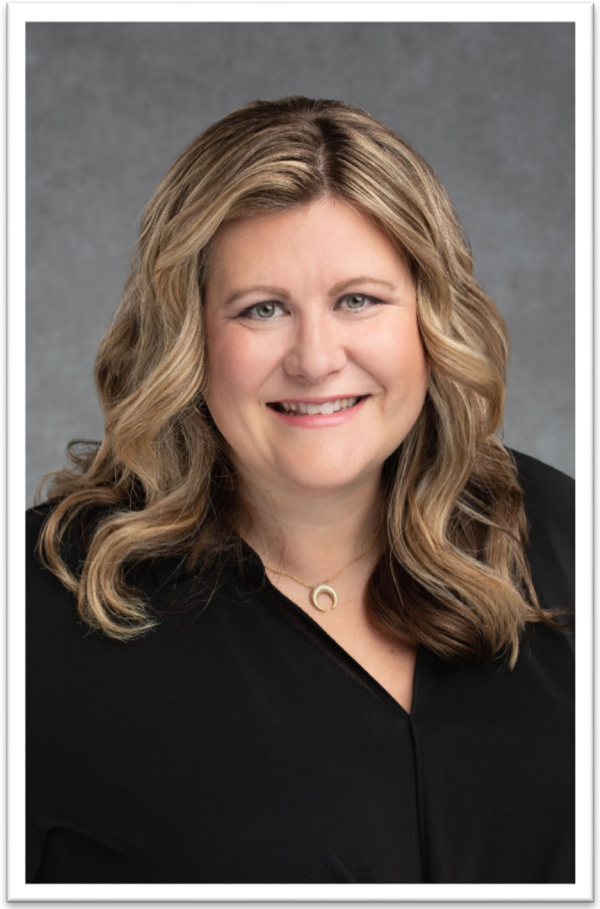

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With over 15 years of experience advising employers, plan sponsors, and third-party administrators on all matters related to benefits administration and general corporate issues, Cat is a regular presenter for BASIC. She focuses her practice on strategic benefit design and technical legal compliance under the Internal Revenue Code, ERISA, COBRA, HIPAA, ACA, LMRA, FMLA, and MHPAEA.

Her operational knowledge and legal expertise deliver great value to clients. She provides the fundamentals and latest news in an understandable way for practical, real-world application.

She holds an L.L.M. from the UIC John Marshall Law School in employee benefits, a J.D. from the DePaul University College of Law, and a B.A. from Aquinas College.

Overview of Topics Discussed

ERISA Fundamentals for Health and Welfare Plans

- What plans are subject to ERISA?
- What are the implications of ERISA?

Other Laws Governing Health and Welfare Plans

- Internal Revenue Code
- Taxability of Benefits
- Cafeteria Plans
- Other Applicable Federal Laws
- Various State Laws

What is ERISA?

- The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for most employer-sponsored plans (pension and welfare)

ERISA Policy Goals

- Primary focus at enactment of ERISA was to protect retirement savings from mismanagement and abuse
- Welfare benefit protection was a secondary purpose; however, the declaration of the policy to protect the interests of participants and beneficiaries applies
  - Requires transparency and accountability
  - Ensures participants have access to information about plans

Application of ERISA

- ERISA applies to most employee benefit plans sponsored by employers
- ERISA does not apply to the following plans:
  - Government plans
  - Church plans
  - Plans that exist solely to comply with workers' compensation, unemployment compensation, or state disability insurance plans

Benefits Subject to ERISA

- Medical, Prescription Drug (Rx), Dental and Vision Benefits (self-funded or fully insured)
- Health Reimbursement Arrangements (HRA) (except some small employer QSEHRAs)
- Employee Assistance Plans (EAP) providing counseling benefits (referral-only EAPs are not subject to ERISA)
- Short-term disability (STD) benefits if provided through a trust or are fully insured
- Long-term disability (LTD) benefits

Benefits Subject to ERISA, Continued

- Group term life insurance
- Accidental death and dismemberment (AD&D)
- Flexible Spending Arrangements (FSA)
  - The medical spending portion of the account is
  - Dependent care and pre-tax premium collection of a 125 cafeteria plan are not
- Most severance benefits (if they do not classify as an on-going administrative scheme)
- On-site medical clinics providing treatment more than for minor injuries and illnesses
- Telemedicine

Benefits Not Subject to ERISA

- Plans sponsored by governments or churches … but be careful with church plans
- Voluntary Plans – Whether or not a plan is voluntary is subject to facts and circumstances
- Many short-term disability plans
- Health Savings Accounts (HSA) generally not subject to ERISA

Voluntary Plan Operation for ERISA Exemption

- NO EMPLOYER CONTRIBUTIONS ALLOWED
- Employer cannot “endorse” the program
- Employee participation must be completely voluntary
- Involvement must be limited to permit the insurer to publicize the program, collect premiums by after-tax payroll deduction, and remit premiums to the insurer

Voluntary Plan Operation for ERISA Exemption

Facts that may lead to a determination that the plan is subject to ERISA:

- The employer's name is used in communications with employees
- The benefit associated with other employer sponsored plans
- The employer selects and recommends the benefit to employees
- Benefit materials include a statement that the program is subject to ERISA
- The employer assists employees with claims or disputes
- The employer allows pre-tax deductions for benefits under a cafeteria plan

ERISA Compliance Requirements

- A written plan document (no prescribed form)
- Disclosure Requirements
  - Summary Plan Document (SPD)
  - Summary of Material Modifications (SMM)
  - 104(b) Requests
  - Summary annual report (SAR) in some circumstances
- Reporting Requirements
  - Form 5500 must be filed unless exception applies

ERISA Compliance Requirements, Continued

- Fiduciary Obligations
  - Must follow the terms of the plan document in a consistent and uniform manner
  - Must exercise prudence in selecting vendors
  - Employer may not mislead plan participants (lie or omit)
  - Bonding requirements (if funded through trust or special account)
  - Prohibited transactions with party in interest (disqualified persons)
  - Prohibition on self-dealing
- Claims and Appeals
- ERISA requirements responsibility of plan administrator, not TPA or insurer

Plan Document Requirements

- Must be written
- May include one benefit or multiple benefits
- Must contain the following information:
  - Named fiduciaries
  - Source of funding
  - Amendment & termination procedures
  - Procedure for allocation of responsibilities for administration of the plan
  - Specification of basis on which payments are made to/from the plan
  - HIPAA privacy (if subject to HIPAA); COBRA rights
- Optional/advisable provisions
  - Discretionary language for review purposes, statute of limitations, and venue identification
  - Identification of benefits for Form 5500 purposes
  - Subrogation and reimbursement language
  - Coordination of benefits

Summary Plan Description (SPD)

- Primary function of SPD is COMMUNICATION
- Explains benefits to participants in an easily understood manner; it is meant to summarize the terms of the written plan document
- Very different feel depending on whether it is meant to be a “wrapped document” of fully insured benefits or includes self-funded benefits

SPD Requirements – Who

Who is entitled to a copy of the SPD?

- Enrolled employees, COBRA beneficiaries, custodial parent under QMSCO, spouses, and enrolled dependents of deceased employees that remain covered under the plan

SPD Requirements – Required Content

What must be included in SPD?

- Plan Name & Number
- Name, address, telephone number, and EIN of employer sponsoring plan/plan administrator
- Names of participating employers
- Type of plan (benefits provided)
- Type of administration (self-funded or insured)
- Plan fiscal year and plan ID number for Form 5500 purposes
- Agent for the service of process (cannot be employer) and a statement that process may be made upon plan administrator or trustee

SPD Required Content, Continued

- Statement of collective bargaining rights, if applicable
- Eligibility and participation rules
- QMSCO procedures – court order providing coverage by non-custodial parent (can be in SPD or separate policy, but SPD should refer to policy and make available free of charge)
- Subrogation/overpayments/reimbursements/coordination of benefits
- Cost-sharing provisions, including deductibles
- Description of plan benefits
- Description of annual, lifetime, or other limits
- Rules regarding provider networks
- Listing of providers must be offered without charge

SPD Required Content, Continued

- Any pre-authorization requirements/utilization review
- Summary of plan exclusions
- Description of the plan's claim and appeals procedures
- Authority of plan sponsor to amend or terminate the plan
- COBRA & HIPAA rules (if required by GHP)
- Source of contributions (employer, employees, trust fund, etc.)
- Identification of insurer
- ERISA rights
- NMHPA rights (mother and newborn inpatient stays in hospital after delivery)

SPD Requirements – When & How

When:

- Within 90 days for new participants; within 120 days of plan establishment/new plan
- Once every five years if material changes; and once every 10 years otherwise (even if no material changes)
- Failure to provide SPD to participants could result in a penalty of $110 per day per participant or beneficiary for each violation

How:

- Method must be reasonably calculated to ensure actual receipt
- Can be distributed via first-class mail or hand-delivery (best), second or third-class mail, or electronically (if requirements are met)
- Plan sponsor should be prepared to document and produce method(s) of distribution & delivery

Other SPD Notes

- Optional Provisions
  - USERRA provisions
  - HIPAA privacy notice
  - Medicare Part D notice of creditable/non-creditable coverage
- Can do combo plan/SPD
  - Eliminates inconsistency
  - Thorough explanations
  - Not really a summary because it is lengthy
  - Evidence of plan amendments – procedures needed
- Booklet from insurer probably not enough
- Wrap document should fill all the gaps – intended to supplement the booklet/certificate with all required information

Summary of Material Modifications (SMM)

SMM is a summary of plan change (amends the SPD)

- Generally, must be provided to each participant within 210 days after the end of the plan year in which a material change is made
- If the change is a material reduction, then within 60 days after the date the plan amendment is adopted
  - Material reduction = elimination or reduction of benefit, increase in deductibles or copays, addition of pre-authorization
- And, if the change affects the information in a summary of benefits and coverage (SBC), then 60 days prior to the effective date of the change

Summary Annual Report (SAR)

SAR is a summary of information that appears in Form 5500

- If exempted from Form 5500, no SAR required
- DOL has model form
- Must be provided to participants annually
- Must be provided within 9 months after the end of the plan year, or 2 months after the extended due date of Form 5500, if later
- Unclear what 5500 changes will do to SAR requirement
- No penalty for failure to send – but if a participant requests one, it must be sent within 30 days of the request (104(b)), or penalty of $110 per day could apply

2020 Disclosure Extensions

EBSA Disaster Relief Notice 2020-01

- Deadlines for furnishing other required notices or disclosures to plan participants, beneficiaries, and other persons so that plan fiduciaries and plan sponsors are extended
  - No ERISA violation for a failure to timely furnish a notice, disclosure, or document that must be furnished between March 1, 2020, and 60 days after the announced end of the COVID-19 National Emergency (one year maximum), if the plan and responsible fiduciary act in good faith and furnish the notice, disclosure, or document as soon as administratively practicable under the circumstances
  - Good faith acts include use of electronic alternative means of communicating with plan participants and beneficiaries who the plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites

Form 5500

What:

- Annual report filed with the federal government for ERISA plans

Who:

- All plans (insured and self-insured through employer's general assets) with 100+ employees and/or retirees enrolled at the beginning of the plan year
- Self-insured funded through a trust; no minimum employee requirement
- Cafeteria plan that includes medical FSAs with 100+ employees enrolled in medical FSA portion at the beginning of the plan year

Form 5500, Continued

How:

- Must be filed for each plan; can file one for all plans if plan document indicates one filing is intended
- Fully insured benefits need a Schedule A for each insurer
- Self-insured benefits need a Schedule C for each service provider paid more than $5,000; however, if the service provider is for an unfunded benefit where employee contributions are paid pre-tax under 125 plan, no Schedule C is needed

Form 5500, Continued

When:

- Last day of the 7th month after the plan year ends
- Plan may file for automatic extension of 2½ months

Penalties:

- $2,233 per day for late filings, per plan, per plan year – no cap
- Reduced if filed under Delinquent Filer Voluntary Compliance Program (DFVCP); for plans with 100+ participants, $10 per day up to maximum of $2,000 per plan per year with a maximum of $4,000 per plan

Form 5500 Filing Deadlines 2020

- IRS Notice 2020-23
  - On April 9, 2020, the IRS announced filing deadline extensions for certain Form 5500s to provide relief from the impact of COVID-19
- This relief only applies to plans with filing deadlines on or after April 1, 2020 and before July 15, 2020
  - There is no need to file extension request to be included in this relief
- The most common Form 5500 filing deadline for calendar year benefit plans is July 31
  - This have not been granted extensions and should plan to file their Form 5500 or extension requests by their filing due date

Wrapping ERISA Benefits

- Insurance documents or third-party contracts (like an EAP provider) may not contain all ERISA required provisions
- Wrapping the underlying policies or documents will fill the ERISA gaps

Mega-Wraps of ERISA Benefits

- The ERISA requirements apply to each plan sponsored by an employer
- If an employer sponsors more than one welfare plan, it may be useful to wrap the benefits together
  - Can limit the number of Form 5500s plan sponsors are required to file
  - Can incorporate all the various insurance policies into one master document – employers can distribute all documents as one packet
  - Fills in the gaps in the insurance and other plan documents

Claims Procedures

- Plan sponsor must adopt claims procedures that comply with DOL regulations
- Group health plans and disability plans have expanded requirements
- Important to follow the claims procedures for litigation purposes for any self-insured benefits
- Clients should familiarize themselves with claims and appeals language in insurer booklets/certificates or ask insurer to verify in writing that their claims and appeals procedures are compliant

2020 Deadline Extension for Claims

- Final Regulations
  - On April 29, 2020, EBSA, DOL, and the IRS issued a joint final regulation extending certain time frames under ERISA and the IRC for group health plans, disability and other welfare plans, and pension plans.
  - HHS "concurs" with the rule and will adopt a similar non-enforcement policy to non-federal governmental group health plans.
  - As of March 1, 2020 and through the end of the Outbreak Period, there are no deadlines to file claims or appeals including the 4-month external review process). Importantly, this includes health FSA and HRA expense reimbursement requests, which are generally a few months after the end of the plan year. For example, if a calendar year FSA plan had a runout period that ended on April 30, 2020, the plan could not require that participants forfeit any remaining balance during the Outbreak Period. Notably, these extensions do not apply to dependent care FSAs.
  - It is important to note that the deadlines under ERISA for plans to adjudicate claims and appeals have not been suspended. Therefore, plans will need to adhere to their current procedures for reviewing claims and appeals in a timely manner.

2020 Deadline Extensions Beyond ERISA

- Suspends the 14-day deadline to provide a COBRA election notice until the end of the Outbreak Period
- HIPAA Special Enrollment Period – The 30-day (in some instances, 60-day) deadline to request enrollment in a group health plan following a special enrollment event (e.g., birth, adoption or placement for adoption of a child, marriage, loss of other health coverage, or eligibility for a state premium assistance subsidy)
- COBRA Qualifying Event and Disability Extension Notices – The 60-day deadline by which qualified beneficiaries must notify the plan of certain qualifying events (e.g., divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the plan) or disability determination
- COBRA Election – The 60-day deadline to elect COBRA continuation coverage
- COBRA Premium Payments – The 45-day (for the initial payment) and 30-day (for subsequent payments) deadlines to timely pay COBRA premiums

Internal Revenue Code

- IRC contains the rules about the tax treatment of employee benefits
- General rule under the IRC is that all income is taxable unless it is specifically permitted as a deduction
- Two sides to tax-favored status: (1) the employer deduction; and (2) the employee deduction
- Besides the inherent positives to offering employees benefits (recruitment, retention, market competitiveness), employers receive tax deduction for most benefits provided to employees

Internal Revenue Code, Continued

Main IRC sections that apply to welfare benefits are:

- §79 - Group-term life insurance
- §104 - Compensation for injuries or sickness funded by employee after-tax contributions
- §105/106 - Amounts received under accident and health plans from employer and employee pre-tax contributions (FSAs, HRAs, medical plan)
- §125 - Cafeteria plans
- §132 - Transportation benefits
- §213 - Qualified medical expenses
- §223 - HSAs

Nondiscrimination Rules - Health Plans 105(h)

Prohibit group health plans from discrimination in favor of HCEs in terms of eligibility and benefits

- Fully-insured group health plans are not subject to any IRC nondiscrimination requirements
- ACA added rules for non-grandfathered fully-insured plans, but are under the Trump freeze
- Self-funded group health plans are subject to the rules

Nondiscrimination Rules – Health Plans 105(h)

- If a self-funded group health plan has different eligibility rules, contribution rates or benefit structures for various groups of employees, there may be a concern
- Can “disaggregate” the plans into sub-plans for testing purposes so that if each sub-plan covers a nondiscriminatory group, the testing may still be satisfied
  - Hourly vs. salary may work if enough non-highly compensated salaried employees
  - Senior management vs. all other employees, probably won’t work
- If plan fails, the value of discriminatory coverage is considered “imputed income” to the HCEs

Nondiscrimination Rules – Non-Health Plans

- Disability plans are not subject to nondiscrimination rules
- Group term life is subject to nondiscrimination rules for coverage under $50,000
- §125 plans are subject to nondiscrimination rules for the plan overall + component parts
  - Health FSA also subject to rules
  - Dependent FSA also subject to rules

Cafeteria Plans

- A cafeteria plan is simply a program that employers can use to help employees pay for certain expenses, like health insurance and dependent care, with pre-tax dollars
- If employees must pay for benefits with pre-tax contributions, then the employer must adopt a cafeteria plan
- Solely governed by the Internal Revenue Code – which is always focused on the taxability of benefits
- Choice is between pre-tax benefits and unreduced salary
- Not subject to any of ERISA's requirements unless there is a health FSA component
- There are completely separate requirements from ERISA, can include requirements in wrap, mega-wrap documents, or in a stand-alone document

Elections

- Under the cafeteria plan, eligible employees will make a prospective (not retroactive) election of benefits and salary reduction amounts, including amount contributed to the health FSA
  - At each annual open enrollment for all eligible employees
  - Within 30 days of hire for new employees
- Generally, elections are **irrevocable** for the coverage period

Mid-year Election Changes Pre-COVID

- Under ordinary circumstances, there are several exceptions to the irrevocable rule that allow participants to make a change their election (Prop. Treas. Reg. § 1.125-4):
  - Change in marital status of the employee
  - Change in number of employee's dependents
  - Change in employment status
  - Change in place of residence

IRS Notice 2020-29; HR 133 & Notice 2021-15 Mid-year Election Changes

- An employer **may** allow employees to make **prospective** election changes during 2020 and 2021
  - An employer may limit the time period during which participants can make election changes
- The following are permitted election changes for both health FSAs (including HSA-compatible) and DCAPs:
  - To make a new election and enroll for the first time, even if the employee is enrolling only to gain use of the carryover or extended claims if the employee initially declined participation
  - To revoke an election
  - To decrease or increase an existing election

IRS Notice 2020-29; HR 133 & Notice 2021-15 Mid-year Election Changes Cont.

- Also apply to prospective elections for contributions for group health plan (including dental or vision for these purposes) under 125 plan
  - Make a new election, if previously declined
  - Revoke an existing election and make a new election to enroll in different health coverage (including from self-only to family)
  - Revoke entirely with attestation of other comprehensive health coverage (not just dental or vision). Notice 2021-15 provides model language:
    - Name: _____ (and other identifying information requested by the employer for administrative purposes). I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan). Signature: _____
- Employers can limit number of times or breadth of changes permitted, no requirement to provide unlimited changes, can think about adverse selection and nondiscrimination impact

Applicable Laws - ACA

Applies to group health plans

- New notice requirements:
  - Grandfathered plan status
  - Summary of Benefits and coverage (SBC)
  - Notice of exchange eligibility – one time notice for new hires
- W-2 reporting of health benefit costs
- Play or pay penalties
- Dependent children covered under end of the month in which they turn 26
- PCORI Fees - Fee for plan years ending after September 30, 2018 and before October 1, 2019 is $2.45+ inflation and is due July 31, 2020
  - Fees were extended in December 2019 for an additional 10 years

Applicable Laws, Continued

Health Insurance Portability and Accountability Act (HIPAA)

- Focus is on portability and privacy
- Office charged with oversight is HHS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Focus is on right to continue benefits after certain events
- Office charged with oversight is EBSA

Applicable Laws, Continued

Family Medical Leave Act (FMLA)

- Focus is providing job rights and benefits for employees who take approved leave
- Office charged with oversight is Wage and Hour Division (WHD) of DOL

Uniformed Services Employment and Reemployment Rights Act (USERRA)

- Focus is on providing job rights and benefits for employees in active military duty
- Office charged with oversight is the Veterans' Employment & Training Service (VETS) of the DOL

Applicable Laws, Continued

Age Discrimination in Employment Act (ADEA)

- Focus is on ensuring nondiscriminatory practices for older employees (at least 40)
- Office charged with oversight is the Equal Employment Opportunity Commission (EEOC)

Americans with Disability Act (ADA)

- Focus is on ensuring nondiscriminatory practices for disabled employees
- Office charged with oversight is the Civil Rights Division of the DOJ

Applicable Laws, Continued

Pregnancy Discrimination Act (PDA)

- Focus is ensuring nondiscriminatory practices for pregnant individuals
- Office charged with oversight is the EEOC

Genetic Information Nondiscrimination Act (GINA)

- Focus is on ensuring nondiscriminatory practices based on genetic information
- Office charged with oversight is the Equal Employment Opportunity Commission (EEOC)

Mental Health Parity and Addiction Equity Act (MHPAEA)

- Focus is on ensuring nondiscriminatory practices for mental health treatment
- Office charged with oversight is the Centers for Medicare & Medicaid (CMS)

Applicable Laws, Continued

Women's Health and Cancer Rights Act (WHCRA)

- Focus is ensuring reconstructive benefits for women after breast cancer
- Office charged with oversight is the EBSA

Newborns' and Mothers' Health Protection Act (NMHPA)

- Focus is on providing minimum stays for mothers and newborns after childbirth
- Office charged with oversight is EBSA

Medicare

- Focus is on providing medical coverage for seniors and disabled Americans
- Office charged with oversight is CMS & Various State Laws

Various State Laws

- Many states have mini-COBRA laws that impose COBRA-like requirements on small employers
- Many states have FMLA-type laws that impose requirements on small employers
- State insurance laws may apply to insurers that provide policies
- No-fault insurance laws can affect coordination of benefits provisions

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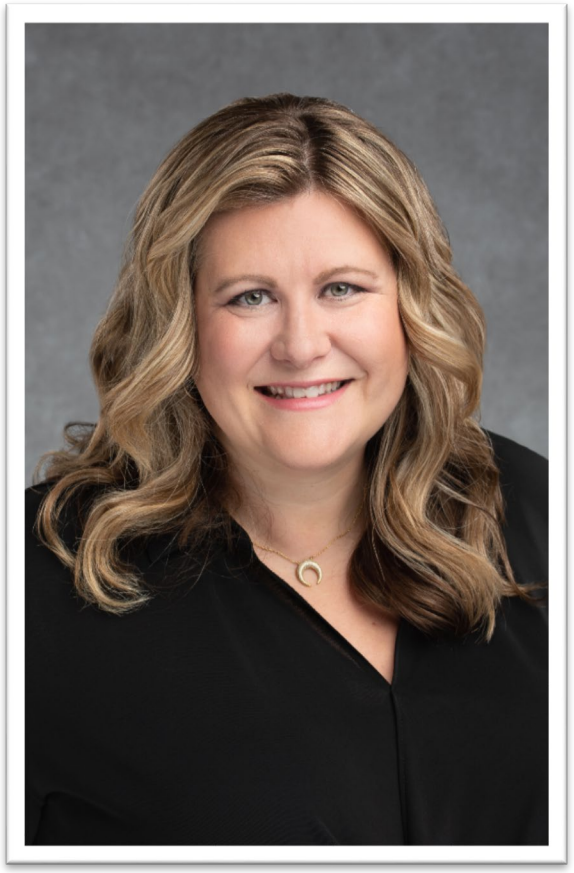

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