



FSA | HRA | HSA | COBRA | FMLA | ERISA



# ERISA Compliance & Health Care Reform



# ERISA

## Employee Retirement Income Security Act



ERISA is governed by the U.S Department of Labor and enforced by the Employee Benefits Security Administration (EBSA).

The EBSA's primary responsibility is to ensure the integrity and compliance of the private employee benefit plan system in the United States.



# Why so many Employers out of Compliance ?

- ✓ Overall Lack of Awareness in Marketplace
- ✓ Carrier Documents thought to be Compliant
- ✓ Confusion due to a Complexity of the Regulations
- ✓ Prior Limited Enforcement
- ***However, Compliance is “Not An Option” — It’s the Law!***



# ERISA Topics

- ERISA Defined
- Employers Subject to ERISA
- Definition of Welfare Benefit Plans
- Benefits Subject to ERISA
- Safe Harbor Exemptions
- Key ERISA Requirements
- Basic ERISA Rules
- Summary Plan Descriptions (SPD)
- Disclosure to Participants and Beneficiaries
- Annual 5500 Reporting



# ERISA Defined

- **Employee Retirement Income Security Act (ERISA)**
  - Federal Law Enacted in 1974
  - Title 1 is part of the labor laws of the US that governs the structure of employee benefit plans
    - Requires detailed disclosure to covered individuals
    - Requires detailed reporting to the Government
    - Imposes strict fiduciary code of conduct on those who sponsor and administer ERISA Plans
    - Imposes federal mechanism for enforcing rights and duties with respect to ERISA Plans and preempts a large body of state laws



# ERISA Defined (cont'd)

- DOL (Department of Labor)
  - Failure to comply with ERISA's requirements can be quite costly
    - Through DOL enforcement actions
      - Government Penalties for Non-Compliance
        - » Recent Case Law:
          - \$86,500** – Failure to File Complete and Accurate Form 5500  
***Airport Hospitality, LTD, King of Prussia, Penn., 2010***
          - \$241,000** – Failure to Provide SPD to Participant  
***Gorini v. AMP Inc., 117 Fed. Appex, 193 (3d Cir. 2004)***
          - \$10,780-** Failure to Provide SPD to Participant  
***Kasireddy v. Bank of America Corp. Benefits Committee, 2010 WL 4168512 (N.D. Ill. Oct. 13, 2010)***



# ERISA Titles

- “Title 1” applies to H&W benefits
- 7 parts- 5 parts apply to H&W benefits
  - Part 1- Reporting & Disclosure
  - Part 4- Fiduciary responsibility
  - Part 5- Administration & Enforcement
  - Part 6- COBRA and additional standards for group health plans
  - Part 7- HIPAA, FMLA, Newborn & Mothers Health Protection, Mental Health Parity Act, Womens Health and Cancer Rights Act (WHCRA)



# Definition of Welfare Benefit Plan

- A Welfare Benefit Plan must be:
  - A Plan, fund or program
  - Established or maintained by an employer
  - Established to provide welfare benefits to Participants and beneficiaries



# Benefits Subject to ERISA

- Health, Dental and/or Vision Insurance or Plans
- Health Flexible Spending Accounts (separate Plans)
- Health Reimbursement Arrangements (separate Plans)
- Accidental Death & Dismemberment Insurance
- Group Term Life Insurance
- Short Term and Long Term Disability
- Severance Insurance Policy
- Wellness and Employee Assistance Programs
- Voluntary Benefits offered as pre-tax benefits under any 125 plan



# Employers Subject to ERISA

- Private-Sector Employers
  - Corporations
  - Partnerships
  - Sole Proprietorships
  - Non-Profit Organizations
    - Unless Exempt under 501a as Governmental entity
      - (listing the following nine factors applied by the courts and the DOL in determining whether the governmental plan exception applies: whether (a) the state or local government exercised control over the plan; (b) the plan provides for only employer or employee contributions or for both; (c) government employees acted as fiduciaries under the plan; (d) the state or local government created the entity; (e) the entity is “administered by individuals who are responsible to public officials or to the general electorate”; (f) the state or local government exercises authority over the entity; (g) the entity performs traditional government functions; (h) the entity's employees are considered government employees under federal and state employment laws; and (i) the entity is funded by state or local government taxes or bonds.



# Safe Harbors of Statutory and Regulatory Exemptions

- Government, Church, and Other
  - Governmental and church plans are exempt from ERISA
  - Programs maintained solely to comply with state-law requirements for
    - Workers compensation
    - Unemployment compensation
    - Disability insurance
    - Plans maintained outside the US for non-aliens



# Safe Harbors of Statutory and Regulatory Exemptions

- Payroll Practice Exemptions
  - Certain payments exempt if made as normal payroll practice
    - Wages, overtime pay, shift premiums
    - Holiday or weekend premiums
    - Sick pay or income replacement benefits
    - Vacation, holiday, jury duty, and similar pay
  - Amounts must be paid out of general assets
  - Pre-funding (VEBA) or use of insurance (Insured STD) can take arrangement outside of the exemption



# Key ERISA Requirements

- Plan document must exist for each Plan
- Plan terms must be followed and strict fiduciary standards adhered to
- Fidelity bond must be purchased to cover every person who handles Plan funds
- Summary Plan Description (SPD) must be furnished automatically to Plan Participants
- Summary of Material Modification (SMM) must be furnished automatically to Plan Participants when a Plan is amended



# Key ERISA Requirements

- Copies of certain Plan documents must be furnished to Participants and beneficiaries on written request and be made available for inspection
- Form 5500 must be filed annually for each Plan (subject to important exemptions, especially for small Plans)
- Summary Annual Report (summarizing Form 5500 information) must be furnished automatically to Plan Participants for a Plan that files a Form 5500 (except totally unfunded welfare Plans)



# Basic ERISA Rules

- Plan Document
  - ERISA benefits must be provided through written document
  - Employer-Sponsor free to design Plan of benefits
  - ERISA Plan can exist without document
    - Will be out of compliance with written document requirement
- Document Type
  - Influenced by nature of Plan benefits
    - Insured Plan document different from self-insured



# Basic ERISA Rules

- Insured Benefits Require “Wrap Document”
  - Insurers may not have all provisions required of a Plan document
  - Supplement contracts using “Wrap Document”
    - Contains missing terms and wraps itself around insurance contract
      - Designation of Plan administrator
      - Designation of fiduciary
      - Plan Year and Plan Number
      - Plan name
      - Designation of how many Plans, Plan sponsor maintains



# Basic ERISA Rules

- Number of Plan Documents Depends on How Many Plans
  - ERISA Plan document requirements apply to each Plan an employer maintains
  - No hard-and-fast rules for determining how many Plans
  - Plan sponsor is free to determine number of Plans for ERISA compliance
  - (However, pension and 401(k) Plans must be maintained separately)
  - Failure to address this issue can create confusion



# Basic ERISA Rules

- Bundling Benefits in One or More ERISA Plan
  - Employers may choose to establish a single “bundled” Plan with all Welfare benefits, including Non-ERISA fringes such as Cafeteria and DCAP
  - Bundling ERISA and Non-ERISA benefits together does not make Non-ERISA benefits subject to ERISA
    - Employer can bundle different groups of benefits in different configuration
    - “Health, Dental, one Plan; STD and LTD under another Plan”
    - Or, treat each benefit as separate Plan



# Summary Plan Description (SPD)

- Who Must be Provided an SPD?
  - SPDs are not required for employer-provided day care centers and Plans benefiting select group of HCEs
  - No small Plan exception
    - Whether covers one individual or 2000
  - Must be furnished to Participants covered under ERISA Welfare Plan, not required to furnish beneficiaries
  - Must be furnished to COBRA qualified beneficiaries, parent or guardian under a QMCSO, and to spouse or dependent of deceased retiree who remains entitled to benefits



# Summary Plan Description (SPD)

- When and How to Furnish SPDs
  - Should generally be furnished within 90 days after Participant first becomes covered
  - NEW Plans – within 120 days after Plan becomes subject to ERISA
  - Updated SPDs must be furnished to all covered Participants every 5 years (every 10 years for a Plan that had no changes)
  - Must be furnished in a way “reasonably calculated to ensure actual receipt of the material,” using method “likely to result in full distribution”



# What Kind of Document Satisfies SPD Requirement

- Updating the SPD (Summary of Plan Description)
  - Any modification in the terms of the plan that is “material” and any change in information required in the SPD must be reported to Plan Participants
  - ERISA allows Plan administrators to report such changes through a Summary of Material Modification (SMM)
    - SMM provided in same manner to same individuals as SPD
    - Must be furnished within 210 days after the end of the Plan Year in which the modification changed
    - However, an SMM relating to a material reduction in covered services or benefits under a group health Plan must be furnished no later than 60 days after the date of the adoption of the reduction



# Health Care Reform & the ERISA SPD

- The PPACA adds a new twist to the ERISA SPD requirements by requiring insurers of insured health plans and plan administrators of self-insured health plans to provide applicants and enrollees a "summary of benefits and coverage" (SBC) .
- Proposed interim regulations were issued on August 17,2011. Applicability remains March 23, 2012
  - Stand alone document from the ERISA SPD



# Health Care Reform & the ERISA SPD (cont'd)

- Also included is a proposed uniform glossary of commonly used health insurance which GHP's MUST provide to participants.
- A group health plan with multiple coverage options would provide a separate SBC for each option.
- **Content and Appearance requirements in original regulations-**
  - Must be no longer than four (double –sided) pages and meet specific requirements for appearance .The New proposed template is six single-sided pages.
  - No print smaller than 12-point font
  - Language understandable by the average plan enrollee
  - Content uniform definitions, co-payments and other cost-sharing provisions, etc.



# Health Care Reform & the ERISA SPD (cont'd)

- Content Requirements expanded:
  - Four additional;
    - an Internet address to obtain list of network providers;
    - an Internet address for more inof about prescription drug coverage;
    - an Internet address to obtain uniform glossary of terms; and
    - premiums (or cost of coverage for self-insured GHP).
      - **Not to reflect any Employer subsidy.**



# Health Care Reform & the ERISA SPD (cont'd)

- Disclosure requirements
  - Proposed regulations do not change who must provide or receive the SBC.
  - If insurer provides or Plan sponsor the plan administrator's obligation is met
  - For ERISA plans..may be disclosed electronically using DOL safe harbor provisions



# Health Care Reform & the ERISA SPD (cont'd)

## • **Timing**

- must be provided as part of any written application materials that are distributed by the plan or health insurer for enrollment. If the plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage for the participant or any beneficiaries.
- If there is any change to the information required to be in the SBC before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.
- The plan or issuer must provide the SBC to special enrollees within seven days of a request for enrollment pursuant to a HIPAA special enrollment right.
- If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the coverage is renewed. If written application is required for renewal, the SBC must be provided no later than the date the materials are distributed. If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage under the new plan year.
- Finally, the plan or health insurer must provide the SBC to participants or beneficiaries upon request, as soon as practicable, but in no event later than seven days following the request.



# Health Care Reform & the ERISA SPD (cont'd)

- Penalties
  - \$1,000 may apply for each willful failure to provide a summary



# Other Disclosures to Participants and Beneficiaries

- Providing Copies of Documents on Written Request
  - Upon written request by a participant or beneficiary, the ERISA Plan administrator must furnish:
    - Copy of latest SPD and SMM,
    - Latest annual report,
    - Any terminated report,
    - Bargaining agreement,
    - Trust agreement,
    - Any contract,
    - Any other “instrument under which the Plan is established or operated”



# Other Disclosures to Participants and Beneficiaries

- Providing Copies of Documents on Written Request
  - Upon written request by a participant or beneficiary, the ERISA Plan administrator must furnish:
    - Must be provided within 30 days of request
    - Penalties of \$110.00 per day may be assessed for each day after the deadline that a Plan administrator does not respond
    - May charge reasonable amount for furnishing documents, not to exceed .25 per page



# Annual Form 5500 Reporting

- Filing Form 5500 with DOL
  - Unless exempted, Plan administrator of an ERISA Plan must report specified information each Plan Year using Form 5500
  - Reporting obligation applies to each ERISA Plan and employer sponsors



# Annual Form 5500 Reporting

- Penalties for 5500 Form Failures
  - Plan administrator subject to penalties up to \$1100.00 for every day form 5500 is missing or incomplete and can be subject to possible criminal penalties for willful failure to file
  - Penalties are cumulative;
    - Assessed separately for each missing or incomplete Form
    - No statute of limitations
    - DOL offers program for voluntary correction of Form 5500 filings



# Form 5500 Exemptions

- Small unfunded or insured plans completely exempt
  - To be considered a small Plan, you must have fewer than 100 covered Participants at the beginning of the Plan Year
  - Only Participants actually covered under Plan are counted
  - Includes COBRA qualified beneficiaries and retirees covered in the Plan, but does not include covered spouses and dependents
- Form 5500 exemption is available to:
  - Small unfunded Plans (benefits paid from the employer's general assets);
  - Small insured Plans (paid through insurance policies other than stop-loss coverage);
  - Small combination Plans (combination of general assets and insurance)



# Health Care Reform's Impact on Your Benefit Plans



## Sources of Law (cont')

- Many of the coverage changes affecting group health plans are amendments to the PHSA, which applies directly to insurers and governmental plans.
- PPACA makes these provisions applicable to employer-sponsored health plans (including self-insured plans) through new ERISA § 715 (which adds the new PHSA provisions to ERISA) and new Code § 9815 Code (which adds the new PHSA provisions to the Code).



# Grandfathered Plans (cont')

- **Grandfathered Health Plan Disclosure and Documentation Requirements**
  - In order to maintain grandfathered health plan status
    - The group health plan or group health insurance coverage must maintain records documenting the plan or policy terms in effect on the grandfather date;
    - These records must be made available to participants, beneficiaries, individual policy holders, or state or federal agencies upon request;



# Grandfathered Plans (cont')

- Records must be kept for as long as the plan or health insurance coverage takes the position that the coverage remains grandfathered;
- To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.



# Health Reform: What happens first?

- Effective Health Plan Years On Or After September 23, 2010- **All Health Plans** –Grandfathered or Non-Grandfathered
  - **No lifetime limits and only “restricted annual limit” on the value of essential benefits allowed**
    - Essential benefits: “include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care
  - **Minimum allowable annual restrictions- applies to HRA’s**
    - » \$750k PY before 9/23/2011
    - 1.25M PY before 9/23/2012
    - \$2M PY before 9/23/2014
- **Notice/re-enrollment required for individuals who exceeded limits**



# Reporting and Excise Taxes for Health Plan Noncompliance

- **Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code**
  - Historically, the IRS has not been very active in examining health plans for compliance
  - IRS final regulations require employers to self-report violations of these rules and pay related excise taxes
  - Must report health plan compliance failures annually on IRS Form 8928



# Reporting and Excise Taxes for Health Plan Noncompliance

- Violations of COBRA, HIPAA and the genetic anti-discrimination law (GINA) can result in excise taxes of \$100 per day per individual affected.
  - Federal health care continuation requirements (COBRA)
  - Health plan portability and nondiscrimination requirements (HIPAA)
  - Mental health parity (Mental Health Parity and Addiction Equity Act, or MHPAEA)
  - Minimum hospital stays for newborns and mothers (Newborns' and Mothers' Health Protection Act)
  - Genetic nondiscrimination requirements (Genetic Information Nondiscrimination Act, or GINA)
  - Coverage of dependent students on medically necessary leaves of absence (Michelle's Law)
  - Health savings account (HSA) and Archer medical savings account (Archer MSA) contribution comparability requirements.



# Reporting and Excise Taxes for Health Plan Noncompliance

- **How Can the Excise Tax Be Avoided?**

- No excise tax is imposed during the period when the employer did not know, or exercising reasonable diligence would not have known, a plan failure existed
- Once the plan failure is discovered, no excise tax will be imposed if the failure was attributable to reasonable cause and the failure is “corrected.”
  - “Corrected” means fixing the failure retroactively (to the extent possible) within 30 days of the first date on which the error was known or should have been known, and placing any affected individual in at least the same financial position as he or she would have been had the failure not occurred
  - Form 8928 and its instructions contemplate clearly that plan failures must be reported even when they were corrected fully in a timely fashion, such that no excise tax is due.
  - To avoid excise taxes under this new self-reporting regime, employers and administrators of group health plans should have procedures and processes in place that are designed reasonably to ensure compliance.



# Reporting and Excise Taxes for Health Plan Noncompliance

- **What Is the Penalty for Not Timely Filing Form 8928?**
  - If a liable entity fails to report and pay excise taxes in a timely manner, the IRS may increase the taxpayer's liability by assessing penalties and interest, unless the failure to file and pay is attributable to reasonable cause and not willful neglect. The penalty for filing Form 8928 late is 5 percent of the unpaid excise tax for each month the form is late, up to 25 percent.
  - A separate penalty calculation applies for late payment of the excise tax, assuming that the form has been filed.



# GINA - Title I

- The **Genetic Nondiscrimination Act of 2008** (GINA) (regulated by DOL ,HHS & IRS) Title I prevents discrimination in health insurance based on genetic information. GINA imposes new restrictions on group health plans and group health insurance issuers to prohibit against:
  - Using genetic information to discriminate with respect to premium or contribution amounts;
  - Requesting or requiring that individuals or their family members undergo genetic testing (with limited exceptions);
  - Collecting (by requesting, requiring or purchasing) genetic information for underwriting purposes and collecting genetic information with respect to any individual prior to enrollment or coverage under the health plan; and
  - Using genetic information to determine eligibility for coverage or to impose pre-existing condition exclusions.



# GINA - Title I

- Genetic information includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes—essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition.
- GINA's provisions became effective for group health plans in plan years beginning after May 21, 2009 (required for plan years beginning 1 year after the date of the Enactment (May 21, 2008)).



# GINA Title II

- Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA), which prohibits genetic information discrimination in employment, was effective on November 21, 2009. The **EEOC** enforces Title II of GINA .
  - The Equal Employment Opportunity Commission (EEOC) issued and published final regulations on November 9, 2010 that are in effect as of January 10, 2011 on November 9, 2010 that are in effect as of January 10, 2011.
  - Title II of GINA was enacted to protect job applicants, current and former employees, labor union members and apprentices and trainees for discrimination based on genetic information.
  - The final regulations are consistent with, but not identical to, the previously issued regulations under Title I of GINA



# GINA Title II

- Title II is applicable to Employers with 15 or more employees except for Indian Tribal Governments and bona-fide non-profit organizations.
- Illegal to discriminate against employees or applicants because of genetic information
- Title II of GINA prohibits the use of genetic information in making employment decisions, restricts employers and other entities covered by Title II (employment agencies, labor organizations and joint labor-management training and apprenticeship programs - referred to as "covered entities") from requesting, requiring or purchasing genetic information, and strictly limits the disclosure of genetic information



# GINA Title II

- **Genetic information (such as family medical history) may be obtained as part of health or genetic services, including wellness programs, offered by the employer on a voluntary basis, if certain specific requirements are met.**
  - The wellness program must be voluntary. The employee must provide prior, knowing, voluntary and written authorization. The authorization can be in electronic form, but must be recorded prior to asking for the genetic information, and the authorization must describe the information being sought and the safeguards in place to protect the privacy of the information.
  - All health risk assessments must clearly state that completing the section of the assessment seeking genetic information is optional and that any reward offered by the employer will be provided to the employee whether that portion is completed or not. Any incentives to participate in the program must be available to all workers who qualify for the program — those who volunteered genetic information and those who did not.



# GINA Title II

- Programs aimed at specific diseases or conditions must be offered to all. If part of the wellness program is offered to address a particular disease or condition, that part of the program must be offered to all employees, not just those employees who may be risk at risk for that disease or condition based upon the answers provided in their health risk assessments.
- If a HIPAA covered entity contracts with a third party to operate a wellness program or to provide other health or genetic services, the covered entity must ensure that “individually identifiable genetic information” is not accessible to managers, supervisors, or others who make employment decisions, or to anyone else in the workplace.



# Why ERISAEdge?

- Administrative Service
- Document and Form Preparation
- Mega-Wrap or Wrap document
- Plan Document and SPD
- IRS Form 5500 and Schedules
- Summary Material Modification
- Summary Annual Report
- ERISA and Health Care Reform Notices

**ERISAEdge**

Make sure your benefit plans pass the test with ERISAEdge

Many employers—and you may be one of them—do not fully understand **Employee Retirement Income Security Act (ERISA)**, how it impacts business and employees, and the possible risks it presents.

**ERISA...It's the Law!**

ERISA is a federal law that regulates Group-sponsored benefits (also called "welfare benefit plans"). Besides requiring the provision of specific Plan features and funding information, the law mandates employers to submit detailed reports to the government.

Employers face strict deadlines for disclosing Plan information to all eligible employees and all sponsors who administer ERISA plans must follow a strict fiduciary code of conduct.

You may be at risk and not even know it! Failure to comply with ERISA's requirements can mean costly government penalties, even employee lawsuits. Let ERISAEdge take care of all the necessary communications, forms, and record keeping for you.

**ERISAEdge Delivers Compliance**

- Maintains all required records for the mandated amount of time
- Provides instruction regarding required on-site record keeping
- Provides access to experienced employee benefits professionals
- Completes the required forms accurately and on time
- Assists with resolution in the event that employee benefit plans are reviewed by the DOL
- Maintains comprehensive record keeping
- Provides toll-free customer service
- Provides an Audit Guarantee
- Offers 35+ years of experience

**Employer Service Features**

- All inclusive fees – no additional charges or hidden fees
- Flexible Plan design – maintains separate ERISA Plans or instead bundle different benefits into a single Plan
- Complete document design and prepares the Plan Document and the Summary Plan Description
- Provides guidelines for disclosing required information to employees
- Prepares all applicable forms and schedules
- Assists in obtaining necessary information from insurance carriers to prepare required forms and filings
- Prepares the Summary of Material Modification (SMM) and Summary Annual Report (SAR) if required
- Prepares all required Healthcare Reform Notices to eligible employees (additional fee)

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## Why ERISAEdge? (cont'd)

- Record-Keeping Assistance
  - Assistance with document retention requirements
  - Guidance on document access and employee rights
- Technical and Customer Service Support
- Guaranteed Compliance
  - Monitor Legislative and Regulatory changes related to ERISA



# Service Features

- All-inclusive fees - no additional charges or hidden fees
- A funding arrangement unique in the industry
- Auto ACH of Plan funds
- No ties to any insurance or other employee benefit plan
- Audit guarantee
- ERISAEdge Administrative Manual

