ERISA GUIDELINES

The Employee Retirement Income Security Act (ERISA) of 1974 establishes minimum standards for retirement, health, and other welfare benefit plans, including life insurance, disability insurance, and apprenticeship plans. ERISA’s extensive rules address the federal income tax effects of transactions associated with employee benefit plans, with mandates that qualified plans must follow to ensure that plan fiduciaries do not misuse plan assets. ERISA has been amended repeatedly since being signed into law.

Also called the Pension Reform Act, ERISA protects the retirement assets of Americans. It is administered by the Employee Benefits Security Administration (EBSA), a division of the U.S. Department of Labor (DOL), along with the Department of Treasury and the Pension Benefit Guaranty Corporation.

Who must abide by ERISA?

The protective laws under ERISA apply to employer-sponsored health insurance coverage and other benefit plans offered to employees by private employers (only). Corporations, partnerships, sole proprietorships, and non-profit organizations are covered, but governmental employers and churches are not, and are exempt from the application of ERISA. ERISA does not require employers to offer plans; instead it sets the rules for the plans and benefits which employers choose to offer. ERISA laws apply to privately purchased, individual insurance policies or benefits only if (a) the employer allows those individual policies to be pre-taxed under a 125 plan, or (b) the employer endorses the policies as “voluntary policies” marketed and sold at the workplace.

What does ERISA regulate?

ERISA is sometimes used to refer to the full body of laws regulating employee benefit plans, which are found mainly in the Internal Revenue Code and ERISA itself. ERISA does not require that employers provide a benefits plan, but it regulates the operations of such health benefit plans. In sum, while offering such plans is optional, once offered they must be managed in compliance with the various provisions mandated under ERISA, which include the following:

Conduct: ERISA rules regulate the conduct for managed care (i.e., HMOs) and other fiduciaries (the person financially responsible for the plan’s administration).

Reporting and Accountability: ERISA requires detailed accountability and reporting to the federal government. Disclosures: Certain disclosures must be provided to plan participants (i.e. a written Plan Summary that clearly lists the benefits being offered, the rules for getting those benefits, the plan’s limitations, and other guidelines for obtaining benefits such as obtaining referrals in advance for surgery or doctor visits).

Procedural Safeguards: A written policy must be established to address how claims should be filed, and must detail a written appeal process for claims that are denied. ERISA also requires that claims appeals be conducted in a fair and timely manner.
Financial and Best-Interest Protection: ERISA acts as a safeguard to assure that plan funds are protected and delivered in the best interest of plan members. ERISA also prohibits discriminatory practice when granting plan benefits to qualified individuals.

ERISA has been amended to include two additional areas that specifically address health insurance coverage: the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

*Failure to comply with ERISA’s requirements can be quite costly, with possible DOL enforcement actions and penalty assessments and/or employee lawsuits resulting.*

**What is a Welfare Benefits Plan?**

Many employee benefits arrangements that provide non-pension fringe benefits are termed “employee welfare benefit plans” covered by ERISA. Meanwhile, important exemptions and “safe harbors” are provided for certain categories of employee benefits. ERISA’s definition of welfare benefits plan can be distilled into the following three basic elements: (1) there must be a plan, fund or program (2) that is established or maintained by an employer (3) for the purpose of providing the following listed benefits to participants and beneficiaries:

- Medical, surgical or hospital care or benefits
- Benefits in the event of sickness, accident, disability, death or unemployment
- Vacation benefits
- Apprenticeship or other training benefits
- Daycare centers Scholarship funds Prepaid legal services
- Holiday and severance benefits
- Housing assistance benefits

It is relatively simple to establish a plan, fund or program—any ongoing administrative scheme will satisfy this condition (although numerous court cases apply some fine distinctions when determining whether very simple plans, especially simple severance plans, have the necessary ongoing scheme). At the same time, it is not necessarily easy to comply with ERISA requirements. Showing that an employer maintains a plan is also straightforward—any contribution by the employer toward payment of benefits or administration of the plan is substantial (including a contribution toward insurance coverage).

**Are any businesses exempt from ERISA?**

There are important statutory exemptions and regulatory safe harbors carving out plans that might otherwise fall within the ERISA plan definition.

**Government, Church and Other Statutory Exemptions**

Governmental and church plans are exempt from ERISA’s mandates. Also exempt are programs maintained solely to comply with state-law requirements for workers’ compensation, unemployment compensation, or disability insurance, as are plans maintained outside the United States for nonresident aliens.

a) **“Payroll Practice” Exemptions**

Several important regulatory exemptions apply as well. For example, certain payments are exempt if made as part of the employer’s normal “payroll practice.” This includes payment of (1) wages, overtime
pay, shift premiums, and holiday or weekend premiums; (2) sick-pay or income replacement benefits; and (3) vacation, holiday, jury duty, and similar pay. The key to this payroll-practice exemption: the amounts must be paid out of the employer’s general assets and must be paid to currently employed individuals. Pre-funding (e.g., through Voluntary Employees' Beneficiary Association, or VEBA), use of insurance (e.g., insured short-term disability), or making payments (e.g., disability payments) to former employees can take an arrangement outside the exemption.

b) Voluntary Plans Exemption

The regulations also exempt certain “voluntary employee-pay-all” arrangements. Under such an arrangement, the employer allows an insurance company to sell voluntary policies to interested employees who pay the full cost of the coverage. The exemption permits employees to pay their premiums through payroll deductions and permits the employer to forward the deductions to the insurer. However, the employer may not contribute toward coverage and the insurer may not pay the employer for being allowed into the workplace.

c) Lastly, the employer may not “endorse” the program. In other words, the insurance company, not the employer, must be the entity offering the plan. Any involvement by the employer—beyond permitted activities in connection with premium/payroll deductions—may place the arrangement outside of the exemption. Among the activities identified as relevant by the many court cases interpreting this exemption are the following: (1) assisting employees with preparation of claims forms; (2) negotiating with insurers; (3) recordkeeping (other than maintaining a list of enrolled employees); and (4) allowing payroll deductions to be made on a pre-tax basis under an employer’s cafeteria plan.

What is the most basic ERISA rule?

ERISA does not require an employer to provide employee benefits. Likewise, as a general rule, it does not require that plans provide a minimum level of benefits. Employers-sponsors are generally free to design their own benefits plans.

Once an employer decides to provide benefits that are subject to ERISA, the plan’s operation is regulated by ERISA, and the benefits must be detailed through a written plan document (called a Summary Plan Description). While an ERISA plan can exist even without a written document, such a plan is considered out of compliance (with the written document requirement imposed by ERISA).

As mentioned above, ERISA specifically requires that an employee benefit plan, including a welfare benefit plan, be established in writing. Many employers fail to consider the requirements of having a written plan document, or mistakenly assume that written insurance policies or other booklets or summaries provided by the insurance company are sufficient to meet this document requirement. In reality these documents often fall short of the ERISA requirement.

Of course insurer documents should comply with all applicable legal requirements; insurers must provide adequate disclosures and notices, and must follow federal and state compliant claims procedures and applicable HIPAA regulations. Further, insurers assume responsibility only in regards to problems with insufficiency or inconsistency, or compliance failure with state regulations, not ERISA regulations. Most policies, certificates, summaries and other documentation produced and distributed by an insurer generally specify that the
employer is the plan sponsor, plan administrator, agent for service of process, and the named fiduciary. In sum, it is the employer who is held accountable for any plan failures or compliance issues.

**Who is responsible for furnishing Summary Plan Descriptions (SPDs)?**

Given that the employer-sponsor typically is the plan administrator, it follows that the employer (not the insurer) generally is responsible for furnishing Summary Plan Descriptions (SPDs), and that the employer will be held liable if adequate SPDs are lacking.

Of course insurance carriers are responsible for paying claims. Yet, as mentioned above, many employers mistakenly assume that carriers also provide SPDs. Instead, even when an insurer provides booklets describing benefits for distribution to participants, the insurer generally does not assume the statutory responsibility for SPDs.

**Who must be furnished with SPDs and/or Summary of Material Modifications (SMMs)?**

1. Covered participants but not beneficiaries

Under the literal language of ERISA, an SPD must be furnished to each participant and to each beneficiary receiving benefits under the plan. The Department of Labor (DOL) has authority, however, to exempt any welfare benefit plan from all or part of the reporting and disclosure requirements. Under DOL regulations, the plan administrator of a welfare benefit plan is required to furnish SPDs (and SMMs) to participants covered under the plan only, and not to beneficiaries.

   a. **Definitions of participant and beneficiary**

      By statutory definition, the term “participant” means an employee or former employee of any employer who is or may become eligible for benefits under an ERISA plan or whose beneficiaries are or may be eligible for benefits. Because the definition is not limited to current employees, it can include COBRA qualified beneficiaries, covered retirees, and other former employees who may remain eligible under a plan. The term participant does not specifically include a beneficiary, which is defined separately in ERISA to mean “a person designated by a participant, or by the terms of an [ERISA] plan, which is or may become entitled to a benefit there under.” While beneficiaries typically include covered spouses and children, other individuals can become beneficiaries under the terms of a plan (e.g., a healthcare provider that receives an assignment of benefits under a patient's health plan).

   b. **Definition of covered participant**

      A participant becomes “covered” under a plan on the earlier of (1) the date on which the plan provides that participation begins; (2) the date on which the individual becomes eligible to receive a benefit “subject only to the occurrence of the contingency for which the benefit is provided”; or (3) the date on which the individual makes a plan contribution, whether voluntary or mandatory. At least one court has determined that SPDs need not be distributed to employees before they join a plan.

2. **COBRA qualified beneficiaries**

   A covered employee, spouse, or dependent child who elects COBRA healthcare continuation coverage should be furnished with SPDs and SMMs while he or she receives COBRA coverage under the ERISA plan. Provided that
they all live at the same address, it appears that the SPD may be furnished, for example, to the covered employee on behalf of other qualified beneficiaries in the same family unit (or to the spouse who elects COBRA coverage for children in the same family unit).

3. QMCSO alternate recipients

An alternate recipient under a qualified medical child support order (QMCSO) is treated as a plan participant for ERISA disclosure purposes. The SPD and SMMs must, therefore, be provided to these children. Generally, the SPD should be furnished to the custodial parent or guardian of a minor child.

4. Spouses and other dependents of deceased participants

Despite the regulatory carve-out for beneficiaries as noted above, the spirit of the disclosure obligation suggests that, where there is no participant to receive an SPD, the document should be furnished to the persons who remain entitled to plan benefits. Thus, plan administrators should adopt a practice of furnishing SPDs and SMMs to spouses or other dependents of a deceased participant who continue to receive benefits after the participant's death (e.g., under a retiree medical plan).

5. Representatives or guardians of incapacitated persons

Under case law, SPDs and SMMs should be provided to a representative or guardian when the plan is on notice that the participant or other person entitled to an SPD is incapacitated.

6. Employees eligible to enroll in a plan

Even though an SPD technically is not required until an employee is covered by a plan, some employers provide SPDs (along with necessary enrollment forms) to employees who are eligible to enroll in a plan, when enrollment is necessary in order to be covered by the plan. Regardless of whether SPDs are furnished to eligible employees before they enroll, it is essential that these employees receive some kind of effective notice that active enrollment (and payment of premiums) is a condition of receiving benefits under the plan. If non-SPD enrollment materials are used for this purpose, the enrollment materials should contain information about where to obtain an SPD.

7. DOL only upon request

ERISA no longer requires the plan administrator to file a welfare plan's SPD or SMM with the DOL. However, these documents must be available for inspection upon request by the DOL and/or plan participants.

What happens when there is a conflict between SPD/SMM and plan documents or insurance contracts?

There are no initial penalties for failure to prepare or distribute a required SPD, unlike the case with Form 5500 reporting failures. Instead, repercussions from failing to have an adequate SPD arise when participants and beneficiaries sue to enforce plan rights. An inadequate SPD (for example, one that conflicts with the plan document it seeks to summarize) will normally be enforced by the courts in lieu of the underlying plan document, if doing so will favor the participant or beneficiary involved. In sum, without an adequate SPD in place employers can end up being liable for benefits they never intended to provide.

The courts typically view an SPD as part of the plan documents required under ERISA. If the plan sponsor’s intent in unclear within a provision in the SPD when read alone, the court will read the language of the SPD as a whole.
The courts have been relatively protective of the right of participants and beneficiaries to receive adequate SPDs. One court, for example, has described the SPD as the primary embodiment of participants’ reasonable expectations of coverage under an ERISA plan. Many reported cases address what should happen when a conflict exists between an SPD and the underlying plan document or insurance contract. Of course, an SPD that conflicts with the plan document fails to meet ERISA’s basic requirement that it be an accurate and comprehensive description of rights and obligations under the plan.

What is the four-page summary of benefits and coverage required by Healthcare Reform (SBC)?

The healthcare reform law expands ERISA’s disclosure requirements by mandating that a four-page “summary of benefits and coverage” be provided to applicants and enrollees before enrollment or re-enrollment. The summary (which we will refer to as the “four-page summary of benefits and coverage” or “four-page summary”), must accurately describe the “benefits and coverage under the applicable plan or coverage.” The four-page summary requirement applies in addition to ERISA’s SPD and SMM requirements. Although effective for plan years beginning on or after September 23, 2010, the four-page summary requirement contains a special distribution deadline of 24 months after the enactment of PPACA (March 23, 2010).

The four-page summary requirement applies to health plans “grandfathered” in by healthcare reform—that is, it is also a requirement of preexisting group health plans and health coverage.

The healthcare reform law requires the Secretary of Health & Human Services to issue guidance (referred to as “standards”) addressing the four-page summary requirement, and to do so by March 23, 2011 (i.e., 12 months after the enactment date). The standards are to be developed in consultation with the National Association of Insurance Commissioners (NAIC), a working group composed of (a) representatives of health insurance-related consumer advocacy organizations; (b) health insurers; (c) healthcare professionals; (d) patient advocates (including those representing individuals with limited English proficiency); and (e) other qualified individuals. Once developed, the standards are to be periodically reviewed and updated.

The four-page summary requirement applies to group health plans and insurers (as defined by applicable provisions of the PHSA, ERISA, or IRS Code) but not to certain “accepted benefits.” Grandfathered group health plans must comply with this mandate as well.

The four-page summaries must be provided by plan administrators (for self-insured health plans) and insurers (for insured health plans). Note that a different rule applies in the case of SPDs and SMMs, for which ERISA plan insurers are never directly liable.

Self-insured plans must prepare and provide the four-page summaries themselves or make arrangements with a third-party administrator to provide the notice on the plan’s behalf. Finally, if the third-party administrator fails to provide the four-page summaries, the plan will be out of compliance and subject to penalties, as required under the healthcare reform law, despite its arrangement with the third-party administrator.

What are the ERISA IRS reporting requirements?

The primary reporting obligation ERISA imposes on welfare benefit plans is IRS Form 5500 or “annual report” requirement (the Form 5500 requirement is subject to numerous exemptions). (Full title for Form 5500: Annual Return/Report of Employee Benefit Plan.) This requirement is detailed below.
ERISA also imposes an annual Schedule M-1 reporting obligation on multiple employer welfare arrangements (MEWAs) that provide health benefits. (Full title for Schedule M-1: Reconciliation of Income (Loss) per Books with Income per Return.)

In addition, if an ERISA welfare benefit plan uses a Voluntary Employees' Beneficiary Association (VEBA), the VEBA will be subject to a requirement under the IRS Code to file IRS Form 990, an annual information return. (Full title for Form 990: Return of Organization Exempt from Income Tax.)

What is the ERISA annual report requirement?

Unless an exemption applies, ERISA requires the plan administrator of each separate ERISA plan to file an “annual report” with the DOL containing specified plan information. IRS Form 5500 is used for this purpose. ERISA authorizes the DOL to issue regulations exempting welfare plans from all or part of the Form 5500 reporting requirements, and the DOL has issued numerous exemptions for health and welfare plans. Unless an ERISA welfare plan qualifies for one of the enumerated Form 5500 exemptions, it must file Form 5500.

“Small unfunded, insured, and combination unfunded/insured welfare plans” are, as noted above, completely exempt from the Form 5500 requirement. To qualify for this exemption, a plan must cover “fewer than 100 participants at the beginning of the plan year.”

What are the consequences of IRS Form 5500 noncompliance?

Under ERISA, penalties can be imposed by the DOL for any refusal or failure to file a required IRS Form 5500. Penalties may be assessed for late or un-filed Form 5500s as well as for incomplete or otherwise deficient Form 5500s.

What are the amount and period of statutory civil penalties?

ERISA §502 provides civil penalties for failure or refusal to file a required IRS Form 5500; for this purpose, a Form 5500 that has been rejected by the DOL for failure to provide material information will be treated as not having been filed. The penalties for noncompliance can be heavy: under ERISA §502, the DOL may assess a civil penalty against a plan administrator of up to $1,100 per day starting from the date of the administrator's failure or refusal to file the Form 5500.

a. Penalties are cumulative

The DOL takes the position that the penalties are cumulative so that the maximum per day penalty may be assessed for each Form 5500 that is not filed as required.

b. DOL Position: No statute of limitations

The DOL also apparently takes the position that it is not subject to a statute of limitations with respect to Form 5500. As such, it can assess penalties in connection with Form 5500 failures reaching as far back as the 1988 plan year (the first plan year following the ERISA amendment giving the DOL authority to assess Form 5500 penalties). Failure to correct a missed or incomplete Form 5500 may therefore leave the liability open and the potential penalty amount compounding.
c. Reduced penalties under DOL’s “Late-Filer Enforcement Program” and “Non-Filer Enforcement Program”

The DOL maintains two programs under which penalties of less than the full statutory amount ($1,100 per day) may be assessed for compliance failures identified by the DOL: one concerns Form 5500s that are filed after their due dates and one concerns Form 5500s that are not filed at all.

Under the Late-Filer Enforcement Program, plan administrators may be assessed $50 per day for each day a Form 5500 is filed after its required due date (determined without regard to any extensions of time for filing). Under the Non-Filer Enforcement Program, “to reflect the egregious nature of the [non-filing] violation,” a penalty may be assessed at a rate of $300 per day up to a maximum of $30,000 per year for each plan year filing.