

ERISA Welfare Plans: *It's a Wrap!*

Presented by Robert A. Browning, Esq.

Chapter Webinar Coalition

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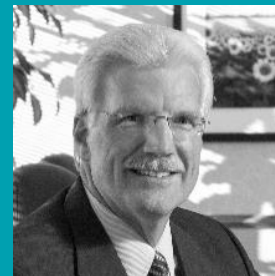
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Robert (Rob) Browning

Robert (Rob) Browning joined Spencer Fane in January 2008 as a Partner in the Employee Benefits Group.

Rob received his juris doctor at the University of Houston Law Center where he was Associate Editor of the Houston Law Review and a member of the Order of the Coif and Order of the Barons.

Before receiving his law degree, Rob was an optometrist and an associate professor at the University of Houston College of Optometry for more than 10 years.



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ERISA Welfare Plans: *It's a wrap!*

Robert A. Browning, Esq.

KC ISCEBS Presentation
September 24, 2020
(12:00 p.m. Central Time)



SpencerFane®

Presenter



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ERISA Requirements – Welfare Benefit Plans

- The Employee Retirement Income Security Act of 1974 (ERISA) requires that:
 - Employee benefit plans, including welfare benefit plans, must be established and maintained in writing (ERISA § 402(a)(1)); and
 - Plan Administrators of most welfare benefit plans must distribute a summary plan description (SPD) to plan participants.

ERISA Requirements – Form 5500 Annual Reports

- Each welfare benefit “plan” must file a Form 5500 annual return unless:
 - it is a “small” plan, meaning it covered fewer than 100 participants as of the beginning of the plan year (or can be “treated as” a small plan under the 80-120 participant rule, below); and
 - it is unfunded, fully insured, or a combination of both
- If # of participants at beginning of year is between 80 and 120, may elect same filing status (small vs. large) as previous year

ERISA Requirements – Counting Participants

- An individual becomes a “participant” in a welfare plan on the earlier of:
 - The date designated in the plan as the date of participation;
 - The date they are eligible for a benefit, subject only to the occurrence of a contingency (such as disability);
 - The date they make a contribution (whether required or voluntary)

Form 5500 Requirement – Small Plan Exception

- “Unfunded” means benefits are paid directly from the general assets of the plan sponsor
- “Fully insured” means benefits are provided solely through insurance where premiums are paid by employer (from general assets) or by employee contributions that are forwarded to insurer within 3 months of receipt

Form 5500 Reporting – Small Plan Exception

- “Unfunded” plans do not include:
 - Plans that receive employee contributions (unless those employee contributions are made pursuant to a Section 125 cafeteria plan)
 - Plans that use a trust or separate fund to hold plan assets

Form 5500 Reporting – Other “excepted” welfare plans

- Governmental plans
- Church plans
- Unfunded or insured “top-hat” plan
- Plan maintained solely to comply with worker’s comp., unemployment comp., or disability insurance laws
- Plans with no “employees” – cover only owner (or partners) and spouse(s)

Internal Revenue Code Requirements

- The Internal Revenue Code requires certain tax-favored arrangements to be set forth in a “written plan,” including:
 - Section 105(h) self-insured medical reimbursement plans, including HRAs
 - Section 120 group legal services plans
 - Section 125 cafeteria plans (including flexible spending accounts)
 - Section 129 dependent care plans

Welfare Benefit Plan – Defined

- An ERISA welfare benefit plan is any plan, fund, or program established or maintained by an employer or employee organization to provide, through the purchase of insurance or otherwise, certain benefits (other than pension benefits) for employees and/or their beneficiaries

ERISA-Covered Welfare Plans

- What plans are covered?
 - Employer-employee relationship required
 - Employer must “maintain” the plan
- Some plans are exempt
 - Governmental plans and church plans
 - Plans maintained solely for the purpose of complying with state law requirements for workers’ compensation, unemployment compensation, or disability insurance
 - Payroll practices exemption (i.e., certain STD plans)
 - “Voluntary” plans that satisfy safe harbor reg.

Voluntary Plans

- A group or group-type insurance program is not an ERISA welfare benefit plan if it meets the following conditions:
 - Participation is completely voluntary
 - The employer does not contribute
 - The employer does not negotiate premiums or benefits or assist employees with claims
 - The employer does not receive a contract in its name or choose the coverage and carrier
 - The employer does not receive any consideration from the plan other than reimbursement of administrative expenses
 - The employer's sole functions, without endorsing the plan, are to (1) permit an insurer to publicize the plan and (2) collect premiums through payroll deductions and remit them to the insurer
- Query: May employees pay with pre-tax dollars via a cafeteria plan?

Voluntary Plans – Endorsement

- The following actions by an employer constitute the endorsement of a group or group-type insurance program:
 - Encouraging employees to participate
 - Taking actions that lead an employee to reasonably conclude that the plan is part of the employer's benefit arrangement
 - Expressing enthusiasm about the plan or making statements demonstrating the employer's positive judgment about the plan

Examples of ERISA Welfare Benefits

- The following types of benefits may be ERISA welfare benefits:
 - Medical, surgical, hospital care benefits (including Rx drugs)
 - Benefits in the event of sickness, accident, disability, death, or unemployment
 - Vacation benefits
 - Severance benefits
 - Apprenticeship or other training programs
 - Daycare centers
 - Scholarship funds
 - Prepaid legal services
 - FSAs and HRAs

Plan Document – Required Provisions

- A welfare plan document must:
 - Provide procedures for establishing and carrying out a funding policy (not applicable to unfunded plans)
 - Describe any procedures for the allocation of responsibilities for the operation and administration of the plan
 - Specify one or more named fiduciaries who have authority to control and manage the operation and administration of the plan
 - Provide procedures for amending (and/or terminating) the plan and identify those who have authority to amend and/or terminate the plan
 - Specify the basis on which payments are made to and from the plan

Plan Document – Optional Provisions

- The welfare plan document may also provide that:
 - Any person or group of persons may serve in more than one fiduciary capacity
 - A named fiduciary, or a fiduciary designated by a named fiduciary, may employ one or more persons to provide advice with regard to any responsibility of such fiduciary
 - A person who is a named fiduciary with respect to the control or management of the assets of the plan may appoint an investment manager or managers to manage any assets of the plan

Plan Document – Group Health Plans

- Additional written provisions are required for ERISA welfare benefit plans that are “group health plans”
- Generally, a group health plan is an ERISA welfare benefit plan that provides “medical care”
- Medical care includes “amounts paid for
 - the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
 - amounts paid for transportation primarily for and essential to medical care, and
 - amounts paid for insurance covering medical care

Types of Group Health Plans

- The following welfare benefit plans *may* be ERISA-covered group health plans:
 - Health, prescription drug, dental, and vision benefits
 - Health FSAs
 - HRAs
 - EAPs

Plan Document – Group Health Plan Required Provisions

- Before a group health plan (other than a fully-insured plan) may disclose protected health information (PHI) to a plan sponsor, the plan document must include written privacy provisions and appropriate and reasonable security standards for the plan

Plan Document – Optional Provisions

- Firestone language – re: Plan Administrator discretion
- Exhaustion of Remedies
- Time to bring claim and venue for lawsuits
- Anti-assignment language

Summary Plan Description

- Summary Plan Description
 - Main source of information to participants about the plan
 - Summarizes material plan provisions in language that can be understood by the average plan participant
 - Explains claims procedures, lists ERISA rights
 - Plan administrator must furnish to participants and beneficiaries
 - Permitted to have different SPDs for different groups of participants if benefits differ among groups

SPD – Required Content

- Name of the plan
- Name and address of the employer
- EIN and plan number (i.e., 501, 502, etc.)
- Type of plan (e.g., medical, disability, etc)
- Type of administration (e.g., TPA)
- Name, address, and phone number of plan administrator
- Name and address of agent for service of legal process
- Name, title, and address of trustee(s), if any

SPD – Required Content

- Eligibility requirements
- Description of QMCSO procedures
- Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture, suspension, setoff or recovery of any benefits (including subrogation)
- Authority to amend and/or terminate plan
- Source of contributions and method of calculating contributions
- COBRA information

SPD – Required Content

- Funding medium (e.g., trust or insurer)
- Plan year
- Claims procedures (can be furnished as separate document)
- Statement of ERISA rights
- A description of any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts
- Any annual or lifetime caps or other limits on benefits under the plan

SPD – Required Content

- The extent to which preventive services are covered under the plan
- Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network, and whether, and under what circumstances, coverage is provided for out-of-network services
- Statement regarding hospital length of stay for mother and newborn child

SPD – Required Content

- Any conditions or limits on the selection of primary care providers or providers of specialty medical care
- Any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan
- Listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document (or on a company website)

SPD – Required Content

- Summary Plan Description – Foreign Language
 - If < 100 employees with > 25% literate only in same non-English language; or > 100 employees with lesser of 500 employees or 10% literate only in same non-English language, then:
 - *Must include prominent notice, in non-English language, offering assistance*
 - *Assistance does not need to be in writing*

SPD – Optional Provisions

- Firestone language – re: Plan Administrator discretion
- Exhaustion of Remedies
- Time to bring claims and venue for lawsuits
- Anti-assignment language

Consequences of Noncompliance – Civil Penalties

- No specific penalties for failure to provide SPD
- Plan participants and beneficiaries may bring a civil action
- Plan Administrator may be fined up to \$110 per day for failure to provide a plan document or SPD within 30 days of a request by a participant or beneficiary
- Plan Administrator may be fined up to \$159 per day for failure to provide a SPD within 30 days of a request by the DOL

Consequences of Noncompliance – Criminal Penalties

- Criminal penalties may be imposed on any individual or company that willfully violates any requirements of Title I of ERISA
 - Up to \$100,000 per conviction (\$500,000 for a company);
 - Up to 10 years in prison; or
 - Both

What Constitutes a “Plan” under ERISA?

- Whether a plan sponsor maintains one or more “plans” is based on the terms of the written plan document(s)
- A single ERISA welfare benefit “plan” may include multiple benefits (i.e., health, dental, vision, Rx drug, LTD, STD, life, AD&D, LTC, EAP, etc. may be combined in a single ERISA “plan”)

“Wrap” Documents

- A “wrap” plan document can be either or both:
 - Additional language designed to “wrap around” and incorporate the terms of a single insurance policy, services contract or benefits description (so that the combined document will satisfy the ERISA “plan document” requirements); or
 - A document that wraps several benefits into a single ERISA plan

“Wrap” Documents

- A “wrap” SPD (or SPD Supplement) can be either (or both):
 - A document designed to be provided along with a single certificate or benefit description so that the combined document will qualify as a SPD
 - A document that wraps multiple certificates or benefit descriptions into a single SPD for a multiple-benefit “plan”

Why Use a “Wrap” Plan Document or SPD?

- Ensure that documentation satisfies ERISA/Code requirements for plan document and/or SPD
 - Most insurance policies and services contracts don't qualify as plan documents
 - Most insurance certificates and benefit descriptions don't qualify as SPDs

Why Use a “Wrap” Plan Document or SPD?

- Document the employer’s decision to treat multiple benefits as a single “plan” for ERISA purposes
 - File a single Form 5500 annual report (if combined plan is a “large” plan)
 - Maintain one plan document, one SPD
- Communicate “single plan” status to participants (single SPD, single plan #)

Wrap Plans – Implications

- May be new plan or restatement of existing plan (i.e., medical plan)
- Will have single plan number (perhaps plan 501, if restatement of plan previously filed as plan 501)
- May have new “general” plan name (i.e., Employer X Welfare Benefit Plan)

Wrap Plans – Implications

- “Wrap” plan will have a single plan year
- Plan year may, but need not, coincide with “policy year” of insured benefits
- Each insured benefit may have different “policy year”
- Form 5500 – includes policy years that end with or within the plan year

Wrap Plans – Flexibility

- Plan document may not need to be amended for every change of benefits or change of providers (policies and/or service contracts are generally separate “attachments”)
- SPD may not need to be revised for every change of benefits or providers (can simply provide new certificate or benefit description)

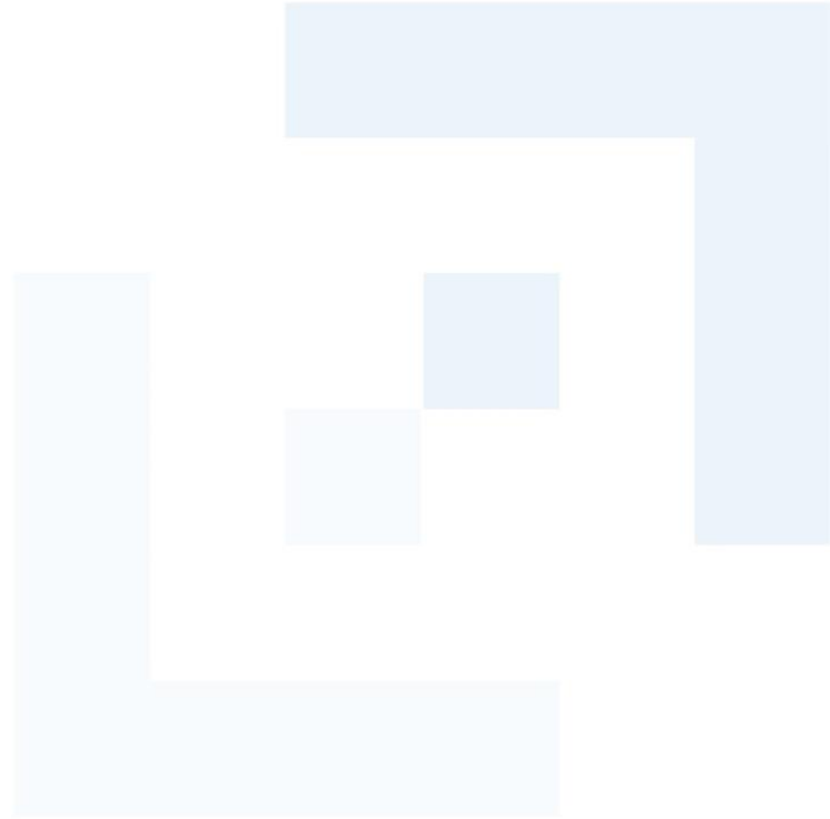
Wrap Plans – Cautions and Limitations

- Wrap plan documents still need to be updated for law changes (such as Health Care Reform)
- Disclosure of “grandfathered” status of group health benefits may have to be provided separately (or as part of each certificate or benefit description)
- Combining “small” plans could create one “large” plan – trigger Form 5500

Wrap Plan Documents – Non-ERISA Plans

- HIPAA Privacy/Security language
- COBRA Provisions (initial COBRA notice)
- Claims/Appeals language under PPACA
- “Grandfathered” status
- Subrogation/reimbursement language
- Federal law disclosures (NMHPA, WHCRA, QMCSOs, etc.)
- Eligibility provisions
- ERISA Overrides

Questions?





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