Health Plan Compliance for 2022:
ERISA Requirements for Employer Plan Sponsors; A Plan Compliance Bible

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Since the health insurance industry finally has some breathing space and feels some relief following the Single Payer threat, and the author removing AB-1400 from the assembly floor before a vote, we have at least a bit of time to concentrate on other things, before the next scare happens (which it undoubtedly will, as the Nurses Association reportedly intends to bring back a new Single Payer bill in 2023), and we will also have a new Healthy California For All Report, which will bring forth ideas of a "unified financing system" (another term for single payer) in California, I wanted to get back to basics for this feature article. I wanted to probably one of the most important things (besides cost) to employer plan sponsors… Plan compliance.

While preparing for a client in-person seminar, to be presented jointly by myself and my Benefits/ERISA attorney and friend Marilyn Monahan (Monahan Law Office), which was supposed to take place in January, 2022, for the first time since 2019 (due to COVID restrictions), and which was disappointingly interrupted and converted to yet another webinar (again, due to COVID restrictions), I decided that all of the research and preparation that I did was a good outline for my next feature article for The Statement, and would be a good reference article for our clients. Since Marilyn and I put the seminar turned webinar materials together, although I am writing this article, I am using as a guide the materials Marilyn and I put together for the seminar/webinar, so I am therefore including her name as a contributing author to this article. Thank you, Marilyn!

I do want to mention that a more detailed, two-part article on this topic will be published in the March and April, 2022 issues of California Broker Magazine. That article is more detailed, and covers old and new information on plan compliance. That article is entitled "Health Plan Compliance for 2022: *Something Old, Something New, Something Challenging, and Something to Pursue".* Additionally, this article is being published in the March-April issue of The Statement, but it is an agent version of this article. I'll be happy to provide links to anyone that wants to read both articles in print elsewhere.

Compliance of a health plan is an employer obligation, not an insurer or broker/consultant obligation, but we feel compelled to assist our employer clients in their journey to provide effective and important employee benefits for their employees and their families. After all, if employees are happy, those in top management of employers are generally happy. Happy clients generally mean happy brokers, so everyone wins!

Of course, it's also important to note that failure to be compliant could result in compliance penalties, not to mention employee complaints, plan participant lawsuits, audits and more. It's also important to note that in today's world of complex mergers and acquisitions, NOT being compliant could disrupt the deal, which affects all parties, and no one wants that.

ERISA – The Employer's Benefits and Compliance Bible

As a compliance geek, I really can't start a compliance article without starting with ERISA… It's been around since 1974, but it is still applicable and guides much of what we do for you, our employer clients, that sponsor health plans. It is, in many ways, the Health Plan Bible.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates employer-sponsored pension pans and welfare benefit (health) plans, regardless of whether they are fully insured or self-funded. The

reporting and disclosure requirements of ERISA are enforced by the Department of Labor (DOL), Employee Benefits Security Administration (EBSA). Although ERISA applies to all group health plans, there are certain types of plans that are exempt, including state and local government plans (regulated by the Public Health Services Act – PHSA), church plans, workers' compensation, and plans maintained outside of the US for non-resident aliens. Voluntary Benefit Plans that satisfy the DOL "voluntary" safe harbor are also exempt.

ERISA pre-empts state laws regulating covered health plans, with the exception of state insurance laws. California insurance laws continue to apply to fully insured plans and HMOs, but self-funded health plans are regulated by ERISA and not state laws.

The types of Employee Welfare Benefit Plans for which ERISA applies includes health, dental, vision, health FSAs, HRAs, short-term disability, long-term disability, life insurance, accidental death and dismemberment coverage, pre-paid legal plans, some EAP programs and some wellness programs.

ERISA Compliance

ERISA requires a series of disclosures, including a Plan Document, a Summary Plan Description (SPD), an SBC (which came from the ACA requirements) and a series of plan participant notices. In addition, a Form 5500 filing is required for plans with 100 or more participants (more information later in this article).

ERISA states that "every employee benefit plan shall be established and maintained pursuant to a written instrument," a legal document that governs the plan, or the Plan Document (not to be confused with a Summary Plan Description, which I will discuss next).

Plan Document

The Plan Document must contain certain terms required by ERISA; items that are most commonly not included in the insurer's documents, such as a Certificate of Coverage or Evidence of Coverage (EOC). This document is allowed to be written in "the language of lawyers," although, as someone who has written many, many plan documents, I tend to write them in more plain language (similar to the SPD). However, if the plan wants to get technical and include attorney verbiage, this is the document where that should be placed, as this is the legal instrument for the plan.

Unlike the SPD, the Plan Document is not meant for distribution to plan participants, but it must be provided upon request within 30 days of such request or pay a penalty. Unlike the 5500 form, the plan document does not have a small plan exemption. Therefore, all private sector employer group plans must have a Plan Document.

In the event of an audit, the Plan Document is generally number 1 or 2 on the documentation list from the DOL. The Plan Document must contain the following:

- Name of the plan fiduciary(ies);
- A procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of ERISA;
- A description of any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan, including any procedure for allocating or delegating fiduciary responsibilities;
- A procedure for amending the plan, and for identifying the person who has authority to amend the plan, and
- The basis on which payments are made to and from the plan.

Summary Plan Description (SPD)

The Summary Plan Description, or SPD, is the primary method of communicating the plan terms to the plan participants. Unlike the Plan Document, this should be written in a manner that is calculated to be understood by the average plan participant, with an objective of "clear, simple communication."

The SPD is required to comply with content regulations, style and format regulations, and foreign language regulations. It must be distributed in a manner that is "reasonably calculated to ensure actual receipt," whether that is in-person, by mail, or distributed electronically.

The SPD must include a comprehensive list of terms and provisions that are required, including the Plan Name, Plan Number, eligibility provisions, contribution information, funding sources and other content requirements. Required Notices must also be included in the SPD. It's important to note that there is guidance on this available on the DOL website: "Self-Compliance Tool for Part 7 of ERISA: Health Care Provisions." If you're involved in a DOL audit, they will look for the items described in this compliance tool, and the 5500 first (5500 if over 100 plan participants). You need to be sure to compare the language across all ERISA-required documents, and be sure that the language is clear and consistent. This includes the Plan Document, Summary Plan Description and Evidence of Coverage from carriers.

Again, the method of presentation for the SPD shall be that it is written in a manner to be understood by the plan participants and sufficiently accurate and comprehensive to reasonably notify plan participants and beneficiaries of their rights and obligations under the plan. The format must not have the effect of misleading, misinforming, or failing to inform the plan participants or beneficiaries.

Wrap Documents

Because ERISA requires a legal Plan Document and most fully insured carriers do not issue Plan Documents; they instead issue a Certificate of Coverage or Evidence of Coverage (EOC), plan sponsors can use the "Wrap" method to supply the terms and provisions required by ERISA but not necessarily included in the Certificate of Coverage or EOC. You can use a "Wrap" method for both the Plan Document and the SPD. Basically, you create a Wrap Document, which includes the ERISA-required items, and attach the insured carrier's Certificate of Coverage, EOC or other documentation, as a part of the Wrap Around Document. You can also "wrap" multiple fully insured plans/policies into one single Wrap Plan Document, so that the Plan Sponsor can have one legal plan, rather than several. For example, if a plan sponsor offers 2 medical plans from 2 carriers, a fully insured dental plan, and a vision plan, you can create a "Wrap Document" which has all of the ERISA requirements, and attach all noted/documented "plans" into the one Wrap Document. This method will reduce the number of 5500's that need filing, etc. (one plan means one 5500 filing, rather than one for each plan). If you're wrapping one or more medical, dental, and vision plans, you can include the medical EOC(s), the SBC, the dental EOC(s), the vision EOC(s), and incorporate any contribution information schedule, any benefit summaries, all of your annual notices required, etc. into the one Wrap Document.

Keep in mind, if the plan sponsor/employer is an ACA Applicable Large Employer (ALE), you can also incorporate the description of hours worked, the full-time status determination or 4980H measurement period methodology, the dependent eligibility, waiting periods, and coverage during leave terms into the Wrap Document.

Summary of Benefits and Coverage

Most employers and brokers are now very familiar with the Summary of Benefits & Coverage, or SBC requirements. It's a simple, concise explanation of benefits and is very prescriptive and recognizable (primarily due to its blue and black color combo)… All plans must be laid out in the same way for easy plan comparisons by the plan participants. They should be able to glace quickly at multiple SBCs, and since the benefits included are the

same on each page, in the same order, it is easy to compare plans. That is the idea behind an SBC. They are required only for Medical coverage, and not for stand alone dental, vision, or other benefits.

Plan Sponsors/plans must provide the SBC to all participants and all beneficiaries. In fully insured plans, the carrier will prepare the SBCs. In a self-funded plan, the Plan Administrator (the plan sponsor employer) must prepare them, or contract with someone to do them on the plan's behalf. As a self-funded plan consultant, I have prepared SBCs for my clients since their first requirement date.

An important quick fact about the SBC is that they are the major line of defense if the state or federal marketplace sends a letter to the plan sponsor regarding a Marketplace Appeal, where they state that a plan participant has received a subsidized health plan under the state or federal Marketplace (such as Covered California) which may not have been appropriate. The SBC states if the plan meets the ACA Minimum Value provisions (MV) and Minimum Essential Coverage (MEC) provisions. These can be found on page 4 of a standard 5-page SBC (note that self-funded plans may be more than 5 pages due to the complexity of their custom-designed health plan so page numbers may vary). I've seen instances where penalties were proposed simply because the SBC preparer did not say "YES" to those two items on the SBC. A "No" or leaving this area blank may automatically trigger a compliance penalty for the plan sponsor. If a plan should receive a Marketplace Appeal letter from a state or federal exchange, they should be prepared to submit a copy of the SBC to see that the plan or plans offered Minimum Value and Minimum Essential Coverage and therefore, in most cases, the plan participant, if offered coverage in the group health plan, would not be eligible for a subsidy.

The SBC must be provided in a "culturally and linguistically appropriate manner." It's important to note that new templates were issued for plan years starting on or after January 1, 2021, so if your client's SBCs have not been updated in the past year, there is a good chance they are out of compliance with the new templates and requirements. There are penalties, of course, for failure to provide an SBC in the required format.

Amendments to the Plan

In the event of an amendment to the plan, a Summary of Material Modification (SMM) must be provided in the event of any material modification to the plan, and any change to the information required by ERISA or the SPD content regulations. You must distribute an SMM no later than 120 days after the close of the plan year in which modifications or changes were adopted. It is always recommended that you get the SMMs out sooner rather than later. However, they are not needed if a new SPD is provided within that 120 days after the close of the plan year.

A Summary of Material Reduction (SMR) is required within 60 days of the adoption of a material reduction in covered services or benefits. The SMR applies only to group health plans. Again, like the SMM, the notice is not required if a new or restated SPD is provided. However, if the modification occurs mid-year, the plan sponsor must provide an SMR *60 days in advance of the plan modification* (assuming it is a reduction in coverage).

One thing attorneys will advise plan sponsors of is to not have a great number of plan amendments which plan participants must keep track of. When your number of plan amendments starts to grow (I've seen a rule of thumb of 6 or more amendments, but some may go as high as ten – I suggest seeking the advice of legal counsel if you have more than 6), you should instead restate the Plan Document and Summary Plan Description, or at least the SPD, as that is what the plan participants see.

Mandatory Notices & Open Enrollment Checklist of Materials

Each Plan should have an SPD, which could include a wrap SPD, the EOCs of each carrier, the SMMs, SMRs, eligibility provisions, waiting period provisions, contribution schedule for plan participants, and all other materials that are incorporated into the Wrap; a Summary of Benefits & Coverage (SBC) for the health plan; Women's Health & Cancer Rights Act notice; Newborns' and Mothers' Health Protection Act notice; a HIPAA Notice of Special

Enrollment Rights; a Michelle's Law Notice; a Medicare Part D Creditable Coverage Notice; a CHIP Notice, a Cafeteria Election Form (if applicable); HIPAA & ADA Wellness Notice (if applicable); Grandfathered Plan Notice (if applicable); and a Notice or Patient Protections (if applicable – due to the CAA – now applies to grandfathered plans).

Other items to be sure you have available are a HIPAA Notices of Privacy Practices, which are required if the plan is self-funded every three years, so the plan sponsor needs a way to track when the notices were provided, to be sure they are being distributed with Open Enrollment packets every three years, or when a change occurs to the privacy practices which affect the Notice.

The same items described above should apply to New Hire Packets; in a new hire packet, the plan participant should receive a HIPAA Notice of Privacy Practices, and the 3 year requirement will begin with that new hire date for that individual, but the plan sponsor can blend the new hire into the group's 3-year time-frame after the initial notice. New hire packets should also include an initial COBRA Notice (general notice).

Required Employer Communications

Plan sponsor employers are required to distribute the documents described above when prepared. ERISA has distribution rules for employees for the SPD, SBC and mandatory notices, using authorized methods of distribution.

ERISA requires a method reasonably calculated to ensure actual receipt of the materials. You cannot simply leave a stack of SPDs and SBCs in the break room for employees to pick up. Employer Plan Sponsors mut target their audience and determine the best way to distribute that particular population of the workforce. For example, those who sit at desks in the office may be distributed electronically, where those working remotely or teleworking, on leave, on vacation, outside sales reps, those enrolled in COBRA coverage, etc. would need to perhaps have an alternate means of distribution. Sales reps, for example, may be determined to have ample access to computers, so may qualify for electronic distribution, where warehouse or yard employees, those on construction sites, etc. may need to have the materials mailed to their homes.

Employers must also identify those with foreign language needs.

Electronic Distribution Rules

The electronic distribution rules were written in 2002, and therefore may not reflect the current usage of employers, particularly since COVID forced many workers to work remotely, where they historically have been in the office. However, since no revised rules have been released, we must use the old rules and modify when applicable to meet the general intent of the law.

Employees who have frequent and continual access to the employer's electronic information system which is an integral part of their duties are not required to provide the employer with written consent to provide materials electronically (although many employers gain authorization anyway to protect themselves). Those employees that are out in the field, work on construction sites, etc., or those with language barriers or without the financial means to have access to electronic documents will need to provide the employer with a formal authorization to receive information electronically; but if they do this, the employer must make alternative electronic devices available to them, such as work stations or kiosks. If they do use this method, however, the Plan Sponsor should follow the rules to ensure receipt, such as using a return-receipt, conduct periodic surveys or reviews to confirm receipt, etc. Many employers require employees to login to a payroll company's website to enter their hour tracking information in order to get paid… If that is the case, the employer would be allowed to provide the electronic documents within that payroll system, but they should set up a receipt verification within the software, so that the employee has to verify receipt of the materials. In addition, if these alternate methods are used, employers should furnish a paper copy of all materials upon request, at no charge to the employee or plan participant.

ERISA Reporting Requirements

Form 5500: The plan Administrator of an ERISA plan must file an "annual report" known as the Form 5500. This requirement applies to plan sponsors with 100 or more plan participants at the beginning of the plan year. There is a small plan exception for the Form 5500 for plans with fewer than 100 participants. This small plan exception applies only to the Form 5500 and not to other ERISA mandates. The form 5500 is due by the last day of the 7th month after the end of the plan year; therefore, January 1 plan years must file by July 31.

How many form 5500s need to be filed depends on the number of ERISA plans the plan sponsor has. As discussed above under Wrap Documents, if the plan sponsor "wraps" multiple plans into one plan, then they need only file one Form 5500. Plan sponsors must be cautious so that they do not duplicate plan numbers. The first ERISA plan established should be numbered Plan Number 501. This could have occurred with a pension plan, however, so be sure to check all other ERISA plans, whether a medical, dental, vision, or retirement plan to verify that you're not duplicating plan number 501. Other plans can be numbered 502, 503, and so on.

In the event of an audit, one of the first two items that the auditors will look at is the Form 5500. The Plan Document is the other most requested document (either are one or two on the list).

Failure to file a Form 5500 could result in a penalty of $2,400/day for failure to file a timely filing. There is a Delinquent Filer Voluntary Compliance Program window (DFVCP) available. Note that Form 5500 EZ or Form 5500-SF are not eligible to file under the DFVCP.

For more information on the DFVCP, you can refer to the Fact Sheet at: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf.

There is also a requirement for an SAR, or Summary Annual Report. The SAR, unlike the 5500, must be distributed to the plan participants within 9 months after the plan year ends (or for a January 1 plan year, by September 30). The SAR is a narrative summary of the financial information contained in the Form 5500.

Information that should be contained in the SAR include plan funding and insurance information, basic financial information, the rights to additional information, and the offer of assistance in a non-English language.

A template of the SAR can be found at 29 CFR Section 2520-104b-10.

Operational Compliance

The plan administrator is obligated to administer the plan in accordance with the plan terms. There is a fiduciary obligation when sponsoring an ERISA plan, which uses the "Prudent Man Rule." Simply stated, the Prudent Man Rule requires that the fiduciaries act in the best interest of the plan participants, and should act as any other prudent person would given similar circumstances. Plan assets can only be used for the benefit of plan participants and beneficiaries to offset certain plan expenses. There are Prohibited Transactions under ERISA; fiduciaries must identify "parties in interest" and transactions with them and ensure that any such transactions are compliant with ERISA.

Plans cannot discriminate among plan participants and beneficiaries. Failure to do so could result in the loss of stop loss coverage for self-funded plans, and could result in an employee complaint, and possible subsequent audit or litigation. In addition, fiduciaries must identify all service providers, determine if they are Business Associates under HIPAA Privacy Rules, and if so, execute a BA Agreement. Service providers must be monitored and audited, as appropriate, and all compensation paid must be reasonable according to standard benchmarks. All contracts should be reviewed to ensure that the plan's interests are protected.

Foreign Language Requirements
Certain documents require foreign language assistance for non-English speaking participants. The SPD requires a notice explaining that assistance is available in the common non-English language. The determination is made based on the employer's workforce, providing notice if the plan covers fewer than 100 participants at the beginning of the plan year and 25% or more are literate in the same non-English language, or the plan covers more than 100 participants at the beginning of the plan year, and the lessor of 500 or 10% or more are literate only in the same non-English language. *The SPD does not have to be translated to that language; only the notice does.*

Assistance must be calculated to provide participants a reasonable opportunity to become informed of their rights and obligations under the plan.

The SBC must be provided in a "culturally and linguistically appropriate manner." SBCs must include a notice within the SBC that a translated version of the SBC is available. Plan sponsors must then provide the translated SBC upon request. In my experience, it's just easier to have the SBC translated at each renewal, and include both English and Spanish in open enrollment packets with a high Hispanic population. In northern California, however, you may need to translate to Chinese or another language, depending on the population in that region. If the plan is self-funded, the plan sponsor is required to translate the SBC.

The determination of the population is based on the population within the *county that the employer is located in; not the employee census.*

The Plan Document does not need to be translated, and no notice is required.

The Affordable Care Act

The Affordable Care Act may not seem that old to some, but it was signed into law on March 23, 2010.

As a refresher, or for anyone new to benefits, the ACA has requirements for Applicable Large Employers (ALEs) with 50 or more calculated full-time employees beginning in 2016 and must offer coverage to at least 95% of its full-time employees. If the employer is an ALE, they must provide minimum essential coverage that offers minimum value, as defined by the ACA, and meets the affordability provisions of the ACA, or pay a penalty.

Minimum Essential Coverage
Minimum essential coverage is a type of health plan or policy that meets the ACA requirements for medical plans. Failing to meet the MEC coverage would result in a penalty, prior to the removal of such penalty under the Tax Cuts and Jobs Act. Some states, however, including California, have a state penalty similar to the former federal penalty for failure to have coverage meeting the ACA rules. Similar state rules apply in Massachusetts, Jew Jersey, Rhode Island, Vermont, and the District of Columbia.

Minimum Value
The ACA also requires plans to meet Minimum Value provisions of the ACA, meaning that plans must cover at least 60% of the total allowed cost of the plan.

Affordability
Under the ACA, plans must also be "affordable" by ACA standards. Employers can use safe harbors to determine affordability, including the W-2 method, the Rate of Pay method, or the Federal Poverty line.

ACA Reporting

The ACA requires ALEs to file forms 1094 and 1095. The complexity of those forms will not be covered in this article due to space limitations. However, I do want to mention that something "new" that has occurred to an "old" requirement is that the Good Faith Penalty Relief for filing incomplete or incorrect forms no longer applies. Employers are required to file the forms correctly now or pay a penalty.

Forms 1094/1095 Deadlines for federal forms for 2021 are as follows:

Employer Obligation	Due Date
Furnishing 1095-Cs to Employees	March 2, 2022 (no additional extensions will be granted)
Filing 1094-C and 1095-C with the IRS (on paper)	February 28, 2022
Filing 1094-C and 1095-Cs with the IRS (electronically) – (required if filing more than 250 1095-C forms)	March 31, 2022

California Minimum Essential Coverage Individual Mandate (SB 78)
Although the federal Tax Cuts and Jobs Act reduced the ACA's individual shared responsibility penalty to zero, effective 12/31/18, effective 1/1/20, Californians must have MEC or pay a penalty to the Franchise Tax Board. Other states with similar mandates include DC, MA, NJ, RI, VT.

SB 78 includes a reporting requirement, and has a $50 per form penalty for non-compliance. Employers must distribute and file with the FTB federal forms 1094/1095, unless the carrier files them. Therefore, self-funded plans must file these themselves in order to comply. If filing electronically, employers must register their plans with the MEC IR system. Resources that are available are the FTB website, Publications 3895B and 3895C, although those publications have not yet been issued for 2021 forms (as of the date I am writing this article in early February).

SB 78 Filing Deadlines

Insurer/Employer Obligation	Due Date (Tentative)
Furnishing Forms 1095-B/C to Employees	January 31, 2022
Filing Forms 1094/1095-B/C with the FTB (electronic filing required if filing more than 250 forms)	March 31, 2022 (deadline may be extended to May 31)

I hope this Health Plan Compliance Basics article was helpful to our clients. Skies are clear again and we are (temporarily at least) free to concentrate on other things, like health plan overall compliance. ##

Author's Note: I'd like to thank Marilyn Monahan of Monahan Law Office for assisting me with my client seminar/webinar preparation and participation, and therefore her assistance with this article. Marilyn can be reached at (310) 989-0993, or at marilyn@monahanlawoffice.com.

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References & Resources:

ERISA Resources:

U.S. Department of Labor, Employee Benefits Security Administration (EBSA):

- *Reporting and Disclosure Guide for Employee Benefit Plans*

- *Compliance Assistance Guide: Health Benefits Coverage under Federal Law,* including *Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions*
- *Understanding Your Fiduciary Responsibilities under a Group Health Plan*
- *An Employer's Guide to Group Health Continuation Coverage under COBRA*
- J. Hanley, Deskless Yet Informed, *Benefits Quarterly* (4th Quarter 2019)
- DOL Voluntary Delinquent 5500 filing - DFVCP Fact Sheet at: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/dfvcp.pdf.

IRS Resources: Website materials located at:

https://www.irs.gov/affordable-care-act

CAA Resources:

DOL: Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA):

https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

DOL: Understanding Your Fiduciary Responsibilities under a Group Health Plan:

https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf