PPI BENEFIT SOLUTIONS

ERISA COMPLIANCE CONSIDERATIONS FOR HEALTH AND WELFARE BENEFIT PLANS

The Employee Retirement Income Security Act of 1974 (ERISA) is a primary federal law that governs employee benefit plans, including group health and welfare plans. ERISA imposes significant fiduciary, disclosure and reporting obligations on covered plans.

Under ERISA, employers, in their roles as plan sponsors and administrators, must adhere to a fiduciary code of conduct that involves duties of loyalty, prudence, and impartiality. ERISA plans must maintain a written plan document and provide summary plan descriptions (SPDs) and other disclosures to participants and beneficiaries. Plan administrators must follow specific claims and appeal rules when administering plan benefits. Generally, large plans (those that cover 100 or more employees at the start of the plan year) must file annual financial reports with the DOL Form 5500.

Under ERISA, employers must adhere to a fiduciary code of conduct that involves duties of loyalty, prudence, and impartiality.

The DOL, through the Employee Benefits Security Administration (EBSA), is largely responsible for enforcing ERISA with respect to welfare benefit plans. Compliance failures can result in enforcement actions and penalty assessments. (For health plans, the DOL has primary authority to assess penalties under ERISA; the IRS also has authority but focuses primarily on retirement plans.) Additionally, ERISA mistakes can also bring about employee-initiated lawsuits.

This publication provides a high-level overview of some of the main ERISA compliance considerations that apply to welfare benefit plans. Employers should consult with counsel for specific legal advice regarding ERISA's application to their benefits plans.

BENEFITS SUBJECT TO ERISA

ERISA defines an "employee welfare benefit plan" as a plan, fund, or program that is established or maintained by an employer for purposes of providing specific benefits, through the purchase of insurance or otherwise, to participants and their beneficiaries. Under this broad definition, most employer-sponsored group health and welfare benefits, whether fully insured or self-insured, are employee welfare benefit plans subject to ERISA.

Therefore, ERISA benefits would include medical, prescription drug, dental, and vision plans, as well as health FSAs and HRAs. To illustrate, the chart of **Common Health and Welfare Benefit Plans** below lists several common plan types and indicates whether they are normally subject to ERISA.

Common Health and Welfare Benefit Plans

Type of Plan	Subject to ERISA?	Type of Plan	Subject to ERISA?
Dental plan	Yes	Major medical plan	Yes
Dependent care assistance program (DCAP)	No	Health reimbursement arrangement (HRA), including Excepted Benefit HRA (EBHRA), Individual Coverage HRA (ICHRA), and Qualified Small Employer HRA (QSEHRA)	Yes
Disability insurance (short-term or long-term)	Yes	Health savings account (HSA)	No*
Group term life insurance	Yes	Mini-med/limited benefit plan	Yes
Drug and alcohol treatment programs	Yes	Prescription drug plan	Yes
Health FSA (general or limited-purpose)	Yes	Vision plan	Yes

*HSAs are generally not subject to ERISA, provided the employer does not become overly involved in the arrangement or indicate that ERISA applies. For further information, refer to DOL Field Assistance Bulletin 2004-01 and the PPI publication **Health Savings Accounts: A Guide for Employers**.

Additionally, ERISA can apply to other benefit offerings, such as employee assistance programs (EAPs) and wellness programs, if these arrangements provide medical care or are staffed by healthcare professionals. For example, many employer-sponsored EAPs provide counseling by trained professionals and thus would be subject to ERISA. The ongoing payment of severance benefits can also potentially create an ERISA plan. Accordingly, applying ERISA to certain benefit types will require an evaluation of the particular facts and circumstances; employers should engage counsel for assistance with this assessment. For additional information about evaluating whether EAPs and other point solutions provide medical care, see the PPI publication **Point Solution Programs: A Guide for Employers**.

EXEMPTIONS FROM ERISA

Despite ERISA's far-reaching application, certain types of plans and programs are not subject to ERISA. Governmental plans (including state, city and county, public school, and school district plans) and church plans are statutorily exempt from ERISA. Programs maintained solely to comply with state law requirements for workers' compensation, unemployment compensation, or disability insurance are also exempt. Furthermore, ERISA does not apply to plans maintained outside of the US or its territories for nonresident aliens.

In addition to these statutory exemptions, the DOL has provided regulatory exceptions from ERISA's application for certain payroll practices and voluntary plans. Welfare benefit plan that do not satisfy an exception or safe harbor would generally be subject to ERISA.

Payroll Practice Exemption

Some types of employer-provided benefits, such as vacation, sick or holiday pay, or income replacement (e.g., short-term salary continuation by the employer), may qualify for the payroll practice exemption. Generally, a payroll practice is a benefit payment made by the employer solely out of the employer's general assets (and not through insurance or other funding arrangements), usually in the form of continuing salary payments made to the employee. To remain within the payroll practice safe harbor, the plan cannot cover former employees, such as retirees.

Voluntary Plan Safe Harbor

The DOL regulations also provide a safe harbor from ERISA's application for certain "voluntary" insurance arrangements. Under these arrangements, employees pay the full premium for coverage and the employer has minimal involvement. Voluntary plans include both group and individual insurance coverage, such as life and disability insurance, dental insurance, long-term care insurance, and some types of medical bridge insurance (e.g., for extended hospital stays, specified illnesses, or cancer treatment).

To qualify for the voluntary plan safe harbor, the employer's functions must be limited to allowing an insurer to offer and publicize a program to employees, collecting premiums through payroll deductions, and remitting these premiums to the insurer. The employer must not put any conditions on an employee's election of benefits nor profit from the program.

Importantly, the employer must be careful not to endorse the program. Employer actions that may be viewed as "endorsement" include:

- Assisting employees with preparation of claim forms
- Negotiating with insurers
- Record keeping (other than maintaining a list of enrolled employees)
- Permitting payroll deductions to be made on a pre-tax basis under the employer's cafeteria plan; payroll deductions, if any, should be made exclusively on an after-tax basis

Additionally, enrollment materials should make clear that the voluntary coverage is not an employer-sponsored ERISA plan (in contrast to other available benefits).

ERISA PREEMPTION

As federal law, ERISA generally preempts (i.e., supersedes) conflicting state laws that regulate welfare benefit plans. (One of the goals of ERISA was to promote centralized, uniform benefit administration, so employers operating in multiple states did not have to comply with various state laws.)

However, whether a state law regulates a welfare benefit plan is often not a clear-cut determination. Rather, ERISA preemption is a heavily litigated area of the law. For example, in *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474 (2020), a pharmacy association argued that an Arkansas law regulating generic drug reimbursement rates opharmacy benefit managers (PBMs) affected prescription drug costs under ERISA-governed benefit plans. However, in a unanimous decision, the US Supreme Court held that the law was not directed at ERISA plans, did not infringe upon central matters of plan administration, and thus was not preempted by ERISA. Since this decision, numerous states have proposed or passed legislation to regulate PBMs and control prescription drug costs.. Legal developments of this nature may impact ERISA plans, underscoring the importance of consulting with counsel for specific advice regarding ERISA's application to employer-sponsored benefit plans.

Significantly, ERISA preemption does not apply to state laws regulating insurance and insurers. Therefore, fully insured plans are subject to both ERISA and state insurance laws. By contrast, self-insured plans are not considered insurers and thus are not subject to state insurance laws. Nonetheless, self-insured multiple employer welfare arrangements are an exception and must comply with both federal and state requirements.

ERISA preemption is important from a litigation standpoint, particularly in terms of potential damages. ERISA has its own civil enforcement system that is intended to provide an exclusive set of remedies. ERISA remedies are generally limited to recovery of the benefits due under the plan and reasonable attorney's fees. So, a claim related to an ERISA plan needs to be brought in federal court and a plaintiff cannot recover punitive damages, damages for pain and suffering, or other types of state law damages.

ERISA FIDUCIARY ROLES AND OBLIGATIONS

Fiduciary Roles

Under ERISA, parties that have or exercise discretionary authority or control over the management of the plan or plan assets are plan fiduciaries. This status is significant because plan fiduciaries are held to a high level of conduct, similar to that of trustees, when performing plan obligations.

ERISA requires that a named fiduciary be specified in the written plan document. The plan administrator is typically the named fiduciary with overall responsibility for plan compliance, including selecting and monitoring service providers. As plan sponsor, an employer that establishes and maintains the plan is the default plan administrator in the absence of a designation. Accordingly, the sponsoring employer (or a committee or person working on behalf of the employer) typically assumes the plan administrator role, and therefore has significant fiduciary obligations with respect to the plan.

However, fiduciary status is not based on designations alone, but on the actual functions that a party performs. Accordingly, a service provider that exercises discretionary authority or control over plan management or administration will be a fiduciary with respect to those functions, even if the contract language states otherwise. For example, with a fully insured plan, an insurer that reviews plan claims and appeals is a fiduciary to the extent of such review authority. For a self-insured (including level-funded) plan, the claims administrator typically will not contractually agree to be a plan fiduciary, but may be deemed such if their duties include interpreting plan provisions and reviewing appeals. (Under ERISA, healthcare claims appeals must be reviewed by a plan fiduciary.)

Other third parties, such as health FSA vendors, typically are not plan fiduciaries because their roles are "ministerial" (i.e., non-discretionary and limited to following the plan sponsor's established rules and policies).

Fiduciary Liability

Fiduciaries may be personally liable for breaches that result in plan losses or harm caused to participants while they serve as fiduciaries. They can also be subject to DOL civil penalties for fiduciary breaches. Therefore, fiduciaries must know and understand their ERISA duties. They should also verify that their insurance provides adequate liability coverage for potential fiduciary breaches and protection from personal liability.

Furthermore, employers should take care to separate their business or "settlor" functions (e.g., plan design or termination decisions) from their plan fiduciary obligations (e.g., determining employee eligibility and benefits). In this respect, employers are

said to wear "two hats." Therefore, it is good practice to conduct affairs accordingly. For example, employers may establish separate committees and hold separate meetings to review plan business vs. administrative matters.

PLAN ASSETS

Before discussing specific fiduciary obligations regarding the plan and plan assets, it is important to understand which funds constitute "plan assets." Perhaps surprisingly, ERISA does not define this term. However, DOL guidance identifies the following three categories of funds as plan assets:

1. Participant contributions paid towards plan premiums (including salary deferrals made on a pre-tax basis through a Section 125 cafeteria plan as well as COBRA or retiree plan premiums paid on an after-tax basis outside a Section 125 cafeteria plan)
2. Certain amounts attributable to plan assets (e.g., medical loss ratio rebates and similar insurance company rebates or settlement fund proceeds, to the extent the plan premiums were paid from participant contributions)
3. Funds held in a separate account or trust for the purpose of paying plan benefits

Generally, under ERISA, a plan fiduciary must ensure that any plan assets are held in a trust (with a few exceptions, outlined in the following section). For example, a retirement plan (e.g., 401(k) plan) must maintain assets in a trust, as must a health plan in certain situations (including self-insured plans that don't pay benefits out of general assets), as outlined below.

Trust Requirement and DOL Limited Nonenforcement Policy

In the welfare benefit plan context, the DOL has adopted a limited nonenforcement policy with respect to the trust requirement for participant contributions that are forwarded to an insurer and/or made through a cafeteria plan (first category above), provided certain conditions are met. Under this policy (DOL Technical Release 92-01), such participant contributions generally are not considered plan assets until the earliest date these amounts can "reasonably be segregated from the employer's general assets." Although the DOL has referenced 90 days as an outer limit for this process, it is not a safe harbor. Rather, for many employers using electronic payroll systems and fund transmissions, a reasonable timeframe to segregate wage withholding amounts may be several days, if not sooner. For small employers (i.e., those with fewer than 100 participants at the start of the plan year), the DOL regulations provide a safe harbor for amounts deposited with the plan within seven business days after being withheld from pay or received by the employer.

Accordingly, for a fully insured plan, the trust exemption can apply to participant contributions received by the employer, whether through a cafeteria plan or on an after-tax basis, provided these amounts are timely segregated from the employer's general assets and forwarded to the carrier. For a self-insured plan, the trust exemption can apply to participant contributions made through a cafeteria plan (and would extend to plan COBRA and retiree premiums even if not made through the cafeteria plan), provided the employer timely applies the funds towards the payment of plan benefits. In either case, for the exemption to apply, the employer must make payments from its general assets and not maintain a separate plan account.

As a result of this nonenforcement policy, most welfare plans are considered "unfunded" plans and are not required to maintain a trust. However, an employer's failure to timely apply participant contributions towards plan benefits would fall outside of this limited exception and could be considered a mishandling of plan assets and a breach of fiduciary responsibility.

One practical example of potential plan asset and trust requirements issue, at least in the fully insured context, relates to medical loss ratio (MLR) rebates received from a carrier (usually in September of each year, if applicable). Employers that receive MLR rebates must determine the portion of the rebate that relates to employee contributions (usually the percentage of employee contributions toward premium) and then determine an appropriate method of distributing that portion back to employees (through a cash/check refund, premium holiday, or benefit enhancements). The portion of the premium that relates to employee contributions is considered plan assets; therefore, the MLR distribution method must be executed within 90 days of the employer's receipt of the MLR rebate from the carrier. If the employer takes longer than 90 days, then the employee portion of the rebate must be placed in trust to avoid a violation of the ERISA plan asset and trust requirements. (For further information about MLR rebates, see the PPI publication **MLR Rebates: A Guide for Employers**.)

Fidelity Bond and Accountant's Opinion Requirements

The fidelity bond requirement is designed to protect plan assets against loss due to fraud or dishonesty by plan officials. The requirement to obtain an accountant's opinion (which is filed in conjunction with the annual Form 5500) is also designed to protect plan assets against loss by requiring plan sponsors to have the plan's finances reviewed against generally accepted accounting principles. (The plan sponsor would need to engage an independent accounting firm with experience auditing employee benefits plans to provide this opinion.) Employers that sponsor unfunded health and welfare plans are generally not subject to ERISA's fidelity bond or accountant's opinion requirements. However, plan service providers that handle plan funds (e.g., a TPA that pays claims) may need to be bonded, and any such requirements should be specified in the service agreement.

PRINCIPAL FIDUCIARY OBLIGATIONS

The primary duties of an ERISA health and welfare plan fiduciary are:

- The duty of undivided loyalty to plan participants
- The duty of prudence
- The duty to act in accordance with the plan documents

Duty of Loyalty

The duty of loyalty encompasses ERISA's "exclusive benefit rule," which requires a plan fiduciaries to act for the sole purpose of providing benefits to participants and their beneficiaries. Therefore, fiduciaries should avoid conflicts of interest and prohibited transactions (i.e., transactions on behalf of the plan that benefit parties related to the plan, such as other fiduciaries, service providers, or the plan sponsor).

However, ERISA's prohibited transaction rules provide an exception that allows for payment of necessary and reasonable plan expenses, such as a service provider's fees. Under the Consolidated Appropriations Act 2021 (often referred to as CAA 2021), service providers are required to provide a written disclosure of direct and indirect compensation they expect to receive in connection with their plan services when entering or renewing a contract with the plan on and after December 27, 2021. This compensation disclosure is designed to help the plan fiduciary assess whether such compensation is reasonable. Similar requirements have been in effect with respect to ERISA-covered retirement plans since 2012.

Plan fiduciaries should recognize that the hiring of plan service providers is a fiduciary function. Therefore, when selecting a service provider (e.g., a benefits consultant or TPA), plan administrators should gather, review, document, and retain the fee and service information they obtain, even if they don't conduct a formal request for proposal. Counsel should be consulted to review the disclosures and related contracts.

The duty of loyalty (as well as the duty of prudence, discussed below) also encompasses a duty to disclose information to participants. ERISA specifically requires that a plan must disclose material plan information and changes and not mislead participants about their benefits. This duty is not limited to the distribution of SPDs and summaries of material modifications (which are explained in detail below).

Rather, group health plan sponsors have an affirmative obligation to provide participants with adequate information, in an understandable format, to enable them to make informed and cost-conscious decisions regarding their plan benefits. For example, employers that offer multiple medical plan options may determine that charts and other comparison tools should be provided to employees during open enrollment so they can effectively evaluate their choices and select the most appropriate option based on their individual situations. Additionally, employers should recognize that the Transparency in Coverage (TiC) internet self-service tool is a form of disclosure, which they should review carefully for accuracy and completeness. (The TiC tool, which is required for plan years beginning in 2024, enables participants to comparison shop for medical items and services and receive individualized cost estimates prior to receiving care. For further details, see the PPI publication **Transparency and CAA 2021 Obligations of Group Health Plans**.)

Duty of Prudence

The duty of prudence requires that a plan fiduciary act with the same care, skill, prudence and diligence as a comparable knowledgeable plan fiduciary acting under similar circumstances. This requirement is often referred to as the "prudent expert rule. "

Accordingly, fiduciaries must be well-informed in their areas of responsibility and, as necessary, hire or consult with experts with the requisite background and experience to give appropriate advice. For example, a plan fiduciary reviewing an appeal of a medical claim may recognize the need to consult with a doctor or other medical professional for guidance.

With the duty of prudence, the focus is on the fiduciary decision-making process as opposed to the results. Therefore, it is important for fiduciaries to establish and follow written procedures for their deliberations. They should also record their activities, keep minutes of meetings and discussions, and maintain any relevant documents, reports, legal opinions, or expert advice that they were considered in reaching their final conclusions.

Additionally, plan fiduciaries should recognize their obligations to carefully select and monitor plan service providers, such as TPAs and PBMs. The selected providers should be periodically reviewed and met with at least annually (whether electronically or otherwise). Plan administrators remain ultimately responsible for the plan's compliance with ERISA and other laws, so it is important to maintain oversight of third parties to whom certain plan duties have been delegated. The DOL has provided tips for ERISA plan fiduciaries regarding the selection and monitoring of service providers. Although originally designed for retirement plans, these tips generally also apply to health and welfare plans. The DOL has also provided tips for hiring service providers with strong cybersecurity practices. See the links to Working with Retirement Service Providers and Tips for Hiring a Service Provider with Strong Cybersecurity Practices in the Resources section below.

Duty to Act in Accordance with Plan Document

As explained in further detail below, ERISA requires every welfare benefit plan to have a written document in place that includes certain specific information. The plan administrator must operate the plan in accordance with the terms of the written plan document. Therefore, it is imperative that the plan administrator be familiar with the specific provisions (e.g., eligibility, waiting periods) of the plan document to properly administer the plan.

Situations may arise in which the plan administrator considers making an exception for a particular employee that would deviate from the terms of the plan document. For example, the administrator may want to continue providing coverage to an employee who no longer meets the eligibility requirements (such as during an extended non-FMLA leave). Such exceptions are generally inadvisable. From an ERISA standpoint, an exception would not only be a breach of the duty to adhere to the document terms but may set a precedent that would need to be applied to other similarly situated employees. Apart from ERISA, such an exception may also create potential liabilities with respect to the plan's insurer or stop-loss carrier, which may deny claims for ineligible participants. These parties may conduct periodic audits to ensure the plan is properly administering the eligibility provisions.

PRIMARY REPORTING AND DISCLOSURE REQUIREMENTS

Although the obligations of a plan fiduciary will vary by the plan and circumstances, there are certain basic requirements that apply to all ERISA plans. First and foremost, an ERISA plan is required to have a written plan document, which is the center of the ERISA universe. A summary of the plan document contents, and any amendments thereto, must be provided to participants in a reader-friendly form. Second, with the exception of certain small unfunded or fully insured plans, an ERISA plan must file an annual Form 5500 to report specific plan information to the DOL. Third, each ERISA plan must have established procedures for benefit claims and appeals. These core ERISA obligations are explained in further detail below.

WRITTEN PLAN DOCUMENT

ERISA requires that every welfare benefit plan be established and maintained pursuant to a written document. This basic ERISA requirement serves several purposes. First, the document allows participants to determine their benefits, rights, and obligations. Second, the plan document provides the guidelines within which the plan administrator must operate the plan and make decisions. Note, however, that an ERISA plan still exists without a written plan document, although such a plan would be out of compliance.

The plan document must include a description of benefits, eligibility, funding methods, claims procedures, and the plan amendment and termination process. As noted earlier, the document must designate a "named" fiduciary and specify the plan name, year, and number (which is important for Form 5500 filings, as outlined below). Generally, the plan document should also include subrogation, reimbursement, and coordination of benefit rules.

Optional provisions that are generally recommended for inclusion in an ERISA plan document include identification of the plan administrator and sponsor, language that gives the plan administrator discretionary authority to interpret the plan terms (which may provide a more favorable standard of review in the event of litigation), and deadlines for participants to file lawsuits (which cannot be enforced absent adequate advance disclosure).

ERISA does not require any specific style of document, so employers have flexibility with respect to the format. Many employers, particularly those with fully insured plans, opt for a "wrap" document that incorporates the applicable insurance contracts and provides the missing ERISA-required language. (Insurance contracts are drafted to comply with state insurance laws, and therefore do not alone satisfy ERISA requirements.) For example, the insurance policy normally describes the covered items and services, but the wrap document would supplement the policy by including the ERISA plan eligibility terms. So, the ERISA plan document would be comprised of the insurance policy and the wrap document (also referred to as a wrap plan).

A wrap document can also be effective in bundling several different types of benefits, whether fully insured or self-insured. This type of combined document is often referred to as a "mega" wrap document. A major benefit of the mega wrap document is that it creates a single plan for Form 5500 reporting and disclosure purposes; an ERISA document that wraps two or more ERISA benefit plans (e.g., major medical, dental, vision, and prescription drug coverage) into one document would be considered one plan for purposes of filing Form 5500. However, employers may not want to adopt this approach for component benefit plans with fewer than 100 participants, as this could subject the plan to a Form 5500 filing that would otherwise be unnecessary. (As explained below, plans with fewer than 100 participants at the beginning of the plan year are exempt from the Form 5500 filing requirement.) Further, employers should generally avoid including non-ERISA benefits in a mega wrap document, as this may compromise the employer's ability to defend the non-ERISA status of a bundled benefit in connection with employee-initiated complaints or lawsuits.

Although there is no requirement to distribute the written plan document, it must be provided to participants and beneficiaries (or their legal representatives) within 30 days of a written request. The ERISA penalty for failure to provide requested documents to plan participants within 30 days is up to $110/day, with no cap.

Summary Plan Description (SPD)

Plan administrators are required to provide each covered participant and beneficiary with an SPD, which explains their rights and obligations under the plan. The SPD should be written in plain language that the average participant can understand. The content must include plan eligibility requirements, a summary of benefits, applicable claims procedures, and ERISA rights and obligations. The document should also reference the plan name, employer name, plan and administration type, plan administrator contact information, and the name/address of the legal agent for process.

The SPD must be delivered within 90 days for newly covered participants or within 120 days for a newly established plan. However, participants do not have notice of the plan requirements until they receive the SPD, so it is advisable to distribute the SPD as soon as possible. In addition, an updated SPD is required every five years if material changes have been made; the updated SPD would incorporate the content of any material modifications (collectively a summary of material modifications or SMM) issued since the last SPD. Absent material changes, an updated SPD is required every ten years. In addition to covered employees, SPDs should be delivered to covered COBRA qualified beneficiaries, qualified medical child support order alternative recipients, spouses/domestic partners or dependents of deceased participants, and guardians for covered individuals.

The SPD must be delivered to plan participants in a manner calculated to ensure actual receipt and by a method of delivery likely to result in full distribution. Electronic delivery is allowed, so long as the DOL electronic delivery rules are followed. These rules essentially divide the workforce into two groups: those with integral access to the employer's computer system as part of their regular duties (who can be defaulted to e-delivery) and those without such access (who must provide affirmative consent to e-delivery). While electronic delivery can include posting to an employer's intranet or benefits portal or sending via email (among other electronic means), these measures alone do not satisfy the DOL's distribution requirements. Employers must also notify employees that the notice has been posted and must describe the significance of the notice and the employee's right to request a paper copy. For more information on the DOL e-delivery requirements, see the PPI publication **Electronic Distribution Rules: A Guide for Employers**.

Summary of Material Modification (SMM) and Summary of Material Reduction in Covered Services or Benefits (SMR)

When a plan is amended or when other material information changes in the SPD, ERISA requires that plan administrators deliver a summary notice of the amendment or change through either an SMM or SMR. Therefore, a plan's SPD should be distributed with all the SMMs and SMRs that have been provided but not yet incorporated into the SPD. As an alternative to an SMM or SMR (as applicable), the plan could instead update the SPD when the plan document is amended and distribute the updated SPD.

Under ERISA, plan administrators must provide an SMM within 210 days after the end of the plan year in which a change is adopted. However, any material reduction in covered services or benefits provided under the plan must be disclosed no later than 60 days after the date of adoption. Regardless of the legal deadline, the best practice is to distribute the notice in advance of the material reduction, if possible, to prevent a situation in which participants seek services that have been eliminated prior to receiving the notice. Note that ERISA does not provide a definition of "material" for this purpose. Generally, a plan change that the average participant would consider to be an important reduction in covered services or benefits would require the employer to distribute an SMR.

However, the ACA added the Summary of Benefits and Coverage (SBC) requirement. As a result, an SBC must be provided 60 days **in advance of** the effective date of any material change in benefits that affects the SBC content (e.g., increases in cost-sharing, additional coverage limitations). Therefore, if a material reduction in benefits affects the SBC content, the timely distribution of a complete, updated SBC may also satisfy the ERISA SMM or SMR requirements. Note that there are significant penalties for failure to provide an SBC; the maximum penalty for such failures increased from $1,406 to $1,443 per failure effective 1/15/2025 (adjusted annually by the DOL).

Absent timely delivery of an SMM, SMR or SBC, a plan change may not be enforceable, as participants may assert that they relied upon the prior provisions in making their benefit decisions. For additional information about the delivery of SMMs, SMRs, SBCs, and other ERISA plan documents during different periods of an employee's employment cycle, see the PPI publications **Required Group Health Plan Notices Overview** and **Required Group Health Plan Notices Chart**.

FORM 5500 AND SUMMARY ANNUAL REPORT (SAR)

Unless an exception applies, each group health plan subject to ERISA is required to file an annual report with the DOL via Form 5500 (Annual Return/Report of Employee Benefit Plan) and distribute a corresponding SAR to plan participants. One important exception is for plans with fewer than 100 participants as of the beginning of the plan year that are unfunded, fully insured, or a combination of unfunded and fully insured. As explained earlier, "unfunded" refers to a plan that pays benefits from the employer's general assets (and not through a trust or other funding vehicle).

The Form 5500 must be submitted electronically by the last day of the seventh month following the end of the plan year (i.e., July 31 for calendar-year plans). A two-and-a-half-month extension of the Form 5500 due date will be automatically granted by filing a

Form 5558 (Application of Extension of Time to File Certain Employee Plan Returns) on or before the normal due date. If the Form 5500 due date (with or without a Form 5558 extension) falls on a weekend or federal holiday, the due date is extended to the next business day.

Plans must maintain sufficient records to document information required by the plan's Form 5500. These records must be kept and made available for examination for six years after the filing date of the Form 5500. As a practical matter, this means that records should be retained for approximately eight years from their creation, which takes into account the plan year for which the form is being filed and the subsequent filing period.

Generally, if a group health plan is required to file a Form 5500, then it is also required to distribute a corresponding SAR to plan participants. However, self-insured unfunded welfare plans are not required to distribute SARs, even if they are subject to the Form 5500 requirement.

The SAR summarizes the Form 5500 financial information in narrative form. If the Form 5500 is filed without extension, the SAR must be distributed to participants and beneficiaries within nine months after the end of the plan year. If the Form 5500 is filed on extension, the SAR must be distributed within two months after the end of the extension period.

Delinquent Form 5500 Filers

Failure to file a Form 5500 as required can result in DOL civil penalties of up to $2,739 per day for penalties assessed after 1/15/2025 (adjusted annually by the DOL). This maximum per-day penalty may be assessed for each Form 5500 failure, with no statute of limitations. Therefore, failure to correct a missed or incomplete Form 5500 may leave the employer vulnerable to significant potential liability, particularly if the error involved multiple plans or spanned several plan years.

However, if a Form 5500 filing failure is first identified by the plan administrator (as opposed to the DOL), correction may be possible via the Delinquent Filer Voluntary Compliance (DFVC) Program. This program provides largely reduced civil penalties for missed or late Form 5500 filings. The employer would need to submit the completed Forms 5500 for the missed plan years and pay the specified penalty. Generally, the penalty amount is based on the plan size and number of days each Form 5500 is late. Collectively, the Forms 5500 and penalty payment are referred to as the "DFVC Program submission".

If the filing error is first discovered by the DOL, two other programs may potentially apply. Under these programs, employers may be assessed penalties less than the full statutory amount noted above. The first is the Late-Filer Enforcement Program for Forms 5500 filed after their due dates, which involves penalties of $50 per day with no cap. The second is the Non-Filer Enforcement Program for required Forms 5500 not filed at all; in these cases, penalties may be assessed at a rate of $300 per day up to a maximum of $30,000 per year for each missed filing. However, a plan sponsor's ability to utilize these programs will depend on their complete cooperation with the DOL once the filing error has been discovered. As such, employers that has failed to timely file Forms 5500 should consult with legal counsel concerning next steps.

CLAIM PROCEDURES

ERISA and DOL regulations have long required ERISA plans to maintain reasonable claims procedures for participants to file benefits claims and appeals and for the plan to provide notice of claims decisions. Specific notice timeframes apply depending upon the type of claim (e.g., urgent care, pre-service, post-service) and the particular circumstance (e.g., initial claim filing, incorrectly filed claim).

The ACA amended ERISA by enhancing internal claims and appeals requirements and by making external review procedures applicable to both group health plans and health insurers. For fully insured plans, the final internal appeal decision is normally made by the carrier.

For self-insured plans, the final internal appeal determination is typically made by the employer in its capacity as a plan fiduciary. Many employers set up an appeals committee for this purpose; although not required, this is generally considered a best practice. If an appeals committee is established, the members should receive training on their specific claims review responsibilities and general ERISA fiduciary obligations. In any event, the designated fiduciary should complete a thorough, impartial, and independent review of the claim appeal based on the plan terms and should not simply reaffirm the prior decision of the TPA.

External review, when applicable, is performed by an independent third party, i.e., an Independent Review Organization (IRO). For fully insured plans, the carrier is responsible for following the state approved external review process and for coordinating with the IRO. For self-insured plans, the plan is subject to the federal process, and the employer is responsible for contracting and coordinating with the IRO. TPAs will often will handle this IRO obligation on behalf of self-insured plan sponsors through a separate agreement or contract.

Accordingly, a plan's claim procedures should be clearly outlined in the plan document and SPD. Additionally, self-insured plan sponsors should have an established process for handling internal claims appeals and a contract for IRO services (in the event external review is necessary).

Finally, with respect to billing for medical claims, the CAA 2021 No Surprises Act amended ERISA to protect group health plan participants from surprise out-of-network medical bills for emergency services, air ambulance services, and certain nonemergency services at in-network facilities. Plan sponsors should be aware of these protections and the requirements to post a surprise billing notice for participants on the plan website.

SUMMARY

ERISA is a comprehensive federal law that significantly impacts group health plans. ERISA requires employers that sponsor and administer plans to act in a fiduciary capacity with respect to the plan and its assets. These fiduciary obligations, including duties of loyalty and prudence, are ongoing. Plan sponsors must also satisfy specific plan document, disclosure, and reporting responsibilities as well as specific claims review processes.

Although these core ERISA concepts will endure, it is important to recognize that the ERISA realm is a dynamic one. Court decisions will continue to affect the scope of ERISA's application. New regulations will amend ERISA and may impose new obligations and disclosures. Accordingly, employers should work closely with their consultants, counsel, and service providers to stay informed and compliant with ERISA's requirements.

RESOURCES

DOL Field Assistance Bulletin No. 2004-01 | US Department of Labor

DOL Guidance on Form 5500

DOL Technical Release 92-01

DOL Voluntary Correction Program

EBSA Disaster Relief Notice 2021-01

Employee Retirement Income Security Act of 1974

Rutledge v. Pharmaceutical Care Management Association (No. 18-540)

Tips for Hiring a Service Provider with Strong Cybersecurity Practices

Working with Retirement Service Providers

PPI BENEFIT SOLUTIONS