NEWFRONT

ERISA for Employers:

An Overview of EB's Overarching Legal Framework

2025 Edition

Audio

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Guide Topics

ERISA: The Big Picture

The Overarching Legal Framework for Employee Benefit Plans

- ERISA = The Employee Retirement Income Security Act of 1974 (as amended)
- Originally enacted largely in response to the collapse of Studebaker's pension plan in 1963 as a measure to better govern employer-sponsored benefits
- The comprehensive federal legal standard included employer-sponsored health and welfare plans (even though not the focus at the time)
- Particularly since the introduction of the ACA in 2010, group health and welfare plans have increasingly taken the spotlight in terms of ERISA-related compliance

ERISA for Employers Topics for Discussion

1. **Plan Document and SPD:** Understanding the role of wrap documents to satisfy ERISA requirements
2. **Form 5500:** When the reporting requirement applies, the potential penalties, and distributing the SAR to employees
3. **Fiduciary Duties:** A practical look into the core four ERISA fiduciary duties for employers
4. **Eligibility:** Establish clearly defined eligibility classes and conditions consistently applied to avoid issues
5. **Special Issues:** ERISA preemption, annual notices, benefits that may or may not be subject to ERISA

Which Employers are Subject to ERISA?

General Rule:

Employers Are Subject to ERISA Unless an Exception Applies

ERISA applies to certain employee benefit plans that are established or maintained by employers (or employee organizations representing employees) engaged in:

- **Commerce**
- **Any industry affecting commerce; or**
- **Any activity affecting commerce**

Designed as a sweeping coverage rule that is interpreted broadly by courts to include all employers (including nonprofits) with employees unless an exception applies.

Plan Must Have Employees

The plan must cover at least one employee for ERISA to apply. ERISA does not apply for plans covering only self-employed individuals or partners.

Exception: Governmental Employers

- ERISA does not apply to a plan sponsored by the federal government, a state or local government, or any agency or instrumentality of such governmental entity
  - Includes federal employees, school districts, state government agencies, cities, counties, etc.

Exception: Church-Based Employers

- ERISA does not apply to a plan sponsored by a church or by a convention or association of churches that is tax-exempt
  - Generally includes church-affiliated hospitals
  - Does not include plans for church employers where employee services are for unrelated trades or businesses

Exception: Indian Tribal Employers

- ERISA does not apply to a plan sponsored by an Indian tribal government, subdivision of an Indian tribal government, or an agency or instrumentality of either
  - Applies only where the employees' services are essential government functions (but not commercial activities)

01

Plan Document and SPD

The Wrap Documents

ERISA Plan Document and SPD

ERISA requires two different types of documents as the foundation of establishing and maintaining a health and welfare benefits plan.

Plan Document (§402)	Summary Plan Description (§102)
• Every employee benefit plan subject to ERISA must be established and maintained pursuant to its written plan document • Must meet a number of content requirements • Think of this as the formal legal document governing plan benefits • The plan document must be executed by the employer plan sponsor • Generally not provided to employees except upon a written request made by the employee or dependent • Must be provided within 30 days of the written request to avoid potential $110/day penalties • Request typically arises only in litigation context	• The SPD is the employee-facing version of the plan document • Must be “written in a manner calculated to be understood by the average plan participant” • Must meet a number of content requirements designed to satisfy requirement that it be “sufficiently accurate and comprehensive to reasonably apprise” employees of their “rights and obligations under the plan” • Employer must follow specific distribution method and timing rules in providing to employees • No specific penalties for failure to provide other than the $110/day penalty for failure to respond to written request within 30 days • However, failure to provide will cause problems!

The Wrap Plan Document and SPD

Two Sets of Documents in Aggregate for the Plan Doc and SPD

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The Wrap Plan Document and Wrap SPD

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Insurance Carrier and TPA Materials*

*Evidence of Coverage (EOC), Certificate of Coverage (COC), Policies, Certificates, Benefits Summaries, etc.

Why Use a Wrap Plan Document and SPD?

- No reason for employers to attempt to restate and maintain the detailed benefit listing in the documents already made available by carriers and TPAs
- Attempting to specifically list benefits would run serious risk of conflicting language between the two sets of documents—which is a recipe for challenges and lawsuits
- The wrap documents therefore “wrap” around the carrier and TPA docs to satisfy the ERISA-required plan document and SPD language

Typically Covers All H&W ERISA Benefits

- One “mega wrap” plan ensures one Form 5500

The Wrap Plan Document and SPD

ERISA H&W Plans to Include in Wrap Plan Document and SPD

Include (ERISA)	Do Not Include (Non-ERISA)
• Medical, Dental, Vision • HRA (may have separate document) • Health FSA (may have separate document) • Accidental Death and Dismemberment (AD&D) • EAP (even if embedded in LTD or GTL) • Disability (STD may not be subject to ERISA) • Wellness Program (if provides medical benefits like biometrics) • Executive Physical (may have separate doc) • Group Term Life (GTL) • Expatriate and BTA plans maintained in U.S. • Telemedicine • Prepaid Legal Services • Employee-Paid “Voluntary” Benefits (that don’t meet voluntary plan ERISA exemption)	• Adoption and Tuition Assistance • Dependent Care FSA and Cafeteria Plan POP • Commuter Benefits • Auto and Home Insurance • Vacation, Sick Pay, PTO (Unfunded) • Paid Family Leave • State Mandated Disability Insurance (including VDI) • Pet Insurance • HSA (the bank account, not the HDHP) • Workers’ Compensation • Identity Theft Protection • 401(k) (ERISA plan not included in H&W wrap) • Voluntary Plans (that meet the complex ERISA safe harbor exemption) • Lifestyle Spending Account (LSA)

Distribution Timing Rules for SPDs and SMMs

Employers must provide the SPD and any Summary of Material Modifications (SMM) within the timeframes set by ERISA:

General SPD Distribution Timing	• **New Plans**: Within 120 days of plan establishment • **Newly Covered Participants**: Within 90 days after participant first covered • **Ongoing Participants**: Every five years (210 days following the last day of the fifth plan year) assuming material changes were made in that five-year period • Every ten years if no material changes made during that ten-year period (unlikely)
General SMM Distribution Timing	• An SMM is required whenever there is a material change to the plan • **Material Reduction in Covered Services (Health Plans Only):** Within 60 days of adoption of the change (best practice to provide in advance where possible) • **All Other Material Changes:** Within 210 days after the end of the plan year (best practice to provide sooner where possible)
Other Important Notes	• No need to distribute an SMM if the changes are incorporated into an updated SPD that is distributed by the applicable SMM deadline • OE materials and new carrier/TPA documents typically satisfy the SMM rules (and are typically the only SPD content modified each year) • No requirement to provide new wrap SPD annually, no acknowledgement of receipt form required • U.S. mail delivery and in-hand delivery both permitted, electronic delivery rules on next slide

Electronic Distribution

The ERISA electronic disclosure safe harbor regulations for health and welfare plans are unfortunately becoming quite antiquated. Some employers choose to operate outside the safe harbor after carefully considering the landscape.

Safe Harbor Employees with Work-Related Computer Access Integral to Their Job Duties	• **No employee consent required**—these employees can receive electronic distribution of ERISA materials (e.g., SPD) by default (i.e., opt-out) • Must include notice of significance of the document in the disclosure, as well as the right to request and obtain paper version of the documents • Kiosk computer access is not sufficient as a means of distribution
Safe Harbor Employees without Work-Related Computer Access Integral to Job Duties	• Employee must electronically **affirmatively consent** to electronic disclosure (i.e., opt-in) • Form of affirmative consent must reasonably demonstrate the individual's ability to access information in the electronic form that will be used (e.g., the internet) • Opt-in electronic consent must meet a number of content requirements, including the right to request a paper version
Operating Outside the Safe Harbor	• Safe harbor is sometimes misunderstood as a requirement—it is not • Employers can choose to operate outside the safe harbor by using electronic disclosure without affirmative consent from employees without work-related computer access • **Non-Safe Harbor Standard: Employer must "use measures reasonably calculated to ensure actual receipt of the material"** • Be careful, though: Failure to properly distribute materials could result in employer not being able to enforce the written terms of the plan in a claim for benefits lawsuit

Best Practice Considerations

Posting on Intranet, Ben Admin, Benefits Portal or Website, etc.

Best Practice to Notify Employees of Newly Posted Materials

- Employers should provide notice to employees to inform them of the new materials posted apprising them of the significance of those documents. This can be via email, Slack, Teams, etc. Example for SPD:
  - The newly posted documents are part of your Summary Plan Description (SPD) to the [Enter Plan Name] (Plan). You should review this information carefully, share it with your covered dependents, and keep this information with other Plan materials for future reference. In the event of a conflict between the official Plan Document and these materials, other components of the SPD, or any other communication related to the Plan, the official Plan Document will govern.
- Fine to have some regular interval of notifying employees of newly posted materials if you don't want to notify on each posting
- Best practice to avoid harsh case law precedent from the early days of intranet posting where court found employee may be able to rely on prior documents because employer did not actually provide new documents where it posted without notice

  Gertjejansen v. Kemper Ins. Cos., 274 Fed. Appx. 569 (9th Cir. 2008):
  - A plan administrator satisfies those disclosure requirements by furnishing documents through electronic media as long as the administrator "takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents . . . [r]esults in actual receipt of transmitted information." 29 C.F.R. § 2520.104b-1(c)(1)(i). Lumbermens has submitted nothing on the record to suggest that the mere placement of an updated SPD on its intranet site could ensure that Gertjejansen would actually receive the transmitted information.

ERISA Record Retention: Best Practice to Retain Documents for Eight Years

- For employee benefit plan purposes, the general records retention best practice is to keep ERISA-related records for eight years to comply with the ERISA §107 to preserve for at least six years after the applicable Form 5500 filing deadline
  - Form 5500 may be filed up to 9 ½ months after the end of the plan year, so eight years will always satisfy that requirement (with an additional buffer)
  - Generally will apply to anything reported on the Form 5500, the plan document, SPD, any SMMs, the SAR, annual notices, and similar materials

02

Form 5500

Reporting Requirements

Form 5500 Reporting Requirements

Employers that sponsor ERISA health and welfare plans may be subject to Form 5500 reporting requirements. The Form 5500 is referred to as a "return/report" because it is a consolidated filing with both the IRS and the DOL.

General Filing Requirements:
Seven Months After the End of the Plan Year

ERISA Plan Year Controls:
- Governed by the wrap plan document and wrap SPD
  - Insurance policy year or OE timeframe not relevant
- Most wrap plan documents and wrap SPDs are a "mega wrap" plan 501 for all ERISA H&W benefits under one ERISA plan for one Form 5500 filing

Standard Deadline to File:
- Employer must file the Form 5500 with the DOL by the last day of the 7th month after the end of the plan year
  - July 31 deadline for calendar plan year

Extension to File:
- Automatic 2 ½ month extension available by filing Form 5558 with IRS in advance of deadline
  - October 15 deadline for calendar plan year

Small Plan Exception:
Fewer Than 100 Covered Participants

Participant Count Determined First Day of Plan Year:
- Form 5500 filing is not required if the plan had fewer than 100"covered participants" on the first day of the plan year
  - Looks only to covered employees or former employees on COBRA (does not include spouses and dependents)

Look to All H&W Benefits:
- Covered participant count includes any ERISA benefit
  - Plan with 100 employees covered by a GTL, disability, or AD&D benefits would require filing even if under 100 employees in medical, dental, vision benefits

Where the Small Plan Exception Does Not Apply:
- No exemption from Form 5500 filing for a MEWA, plan funded by a trust, or retirement plan (including 401(k)) regardless of covered participant count

Failure to Timely File the Form 5500

The Form 5500 penalties are potentially very large! Civil penalties can exceed $2k per day, which adds up to a very large liability for long-term failures. Fortunately, there is a DFVCP process to voluntarily come forward to the DOL and significantly reduce the potential liability.

Potential Civil Penalties for Failure to File	DFVCP Process to Avoid Large Penalties
$2,670/Day Maximum Indexed Annually for Inflation	**$10/Day Maximum $4,000/Plan Maximum**
• Up to $2,670/day late penalty for Form 5500 filing failures • DOL may not impose full penalties—they can take into consideration the degree and/or willfulness of the failure • Regradless, where the failure has been ongoing for a long period those penalties can be very larege • For multiple missed years, penalties apply to each year's Form 5500 cumulatively with no apparent statute of limitations for prior years • DOL may waive all or a part of the penalties upon written statement under penalty of perjury of reasonable cause for the failure based on all relevant facts • Potential criminal penalties for willful violations could include $100,000/individual, $500,000/employer fine and/or up to 10 years of imprisonment	• Delinquent Filer Voluntary Compliance Program (DFVCP) • Available as a way for employers to come forward with late and unfiled Forms 5500 for significantly reduced penalties • DFVCP filings are available only where the employer is voluntarily submitting the Forms 5500 prior to being notified in writing by the DOL of the failure to timely file • DFVCP penalty is $10 per day late based on the original deadline seven months after the end of the plan year (the Form 5558 2 ½ month extended deadline is not used) • The DFVCP penalty is capped at $2,000 per year, with a $4,000 overall per plan cap for multiple late filings • DOL DFVCP Penalty Calculator: https://www.askebsa.dol.gov/dfvcepay/calculator

The Summary Annual Report (SAR)

SAR Distribution Required to Employees

What is the SAR?

- An employee-facing summary of the information contained in the most recent Form 5500 filing
  - Think of it along the lines of an SPD designed as employee-facing material to summarize the plan document
  - Not required if no Form 5500 filing or if all H&W benefits in the plan are self-insured with no trust (rare for umbrella mega wrap H&W plans)

What Information is Contained in the SAR?

- Funding arrangement (self-insured or fully insured), insurance carrier information (including total premiums), financial statement where funded by trust (rare for H&W plans), disclosure about employee right to obtain additional information from the full Form 5500
  - Reality check: Vast majority of employees will not find anything in the H&W plan SAR particularly useful, relevant, or interesting

When to Distribute the SAR to Employees?

- General rule: Employer must provide the SAR within 9 months after the end of the plan year to all plan participants (including COBRA)
  - For calendar plan years: September 30 deadline
- Form 5500 extension: Employer must provide the SAR within 2 months after the end of the extended Form 5500 filing deadline
  - For calendar plan years: December 15 deadline

Potential Penalties?

- No penalties directly specified, but courts have imposed the $110/day penalty applicable to plan document/SPD for failure to respond to written request for SAR within 30 days

03

Fiduciary Duties

The Core Four Duties

ERISA Fiduciary Duties

Derived from trust law–described by courts as “the highest duties known to the law.”

1	Duty of Loyalty (Exclusive Benefit Rule)
2	Duty of Prudence
3	Duty of Diversification
4	Duty to Follow Plan Terms
*	The Named Fiduciary for Appeals

ERISA Fiduciary Duties

The Core Four Fiduciary Duties

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Duty of Loyalty (Exclusive Benefit Rule)

- Requires employers to act solely in the interest of plan participants and beneficiaries with respect to any fiduciary function
- Commonly arises in the context of MLR rebates or similar carrier rebates to the employer
  - Portion of the rebate attributable to employee contributions is considered plan assets that must be used for the exclusive benefit of participants and beneficiaries
- Also commonly arises in the context of health FSA experience gains caused by employee forfeitures (i.e., forfeitures in excess of losses from overspent accounts by mid-year terminations)
  - Means the experience gains cannot be retained by the employer

ERISA §404(a)(1)(A):

(1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

ERISA Fiduciary Duties

The Core Four Fiduciary Duties

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Duty of Prudence

- Employers must act with the skill, prudence, and diligence of prudent person acting in like capacity
- Commonly arises in the context of the fiduciary duty to prudently select and monitor plan service providers with an appropriate method based on the facts and circumstances
- Summarized in a DOL Information Letter as follows:
  - *In selecting a health care provider in this context, as with the selection of any service provider under ERISA, the responsible plan fiduciary must engage in an objective process designed to elicit information necessary to assess the qualifications of the provider, the quality of services offered, and the reasonableness of the fees charged in light of the services provided. In addition, such process should be designed to avoid self-dealing, conflicts of interest or other improper influence.*

ERISA §404(a)(1)(B):

(1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

…

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

ERISA Fiduciary Duties

The Core Four Fiduciary Duties

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Duty of Diversification

- Requires employers to diversify investments of the plan to minimize risk of large losses, unless clearly not prudent to do so under the circumstances, where there are plan assets held in trust
- Commonly arises in the retirement plan context where there are plan assets held in trust
  - Typical employer-sponsored health and welfare plans are either fully insured or self-insured with benefits paid from the general assets of the employer
  - A health and welfare plan funded by a trust would be subject to this diversification duty (e.g., a self-insured multi-employer plan, MEWA, or large employer plan utilizing trust)

ERISA §404(a)(1)(C):

(1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

…

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so;

ERISA Fiduciary Duties

The Core Four Fiduciary Duties

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Duty to Follow Plan Terms

- Must administer the plan in accordance with its written terms in documents governing the plan
- Commonly arises in the context of employee requests to make an exception to the plan terms to provide additional benefits not covered under the written terms of the plan
  - Plan will typically have a discretionary clause granting employer fiduciary right to interpret plan terms for purposes of eligibility for benefits
  - If the employer makes an exception, the employer has interpreted the plan terms to permit the exception, and must apply this interpretation consistently for all similarly situated employees
  - Effectively means that exceptions create an ERISA plan precedent, and a potential claim for breach of fiduciary duty (or claim for benefits) for any employees denied in similar circumstances

ERISA §404(a)(1)(D):

(1) Subject to sections 403(c) and (d), 4042, and 4044, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

…

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV.

ERISA Fiduciary Duties

The Named Fiduciary for Appeals

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Employers Need to Ensure Major Medical Plan TPA Designated Appeals Fiduciary

- ERISA requires that appeals be determined by a named fiduciary of the plan
- For fully insured plan, this is by default the insurance carrier
- For self-insured plans, the TPA has to acknowledge their status in writing as the named appeals fiduciary
- This is a critical point for employers to confirm for the major medical plan
  - With very few exceptions, employers should not assume the appeals fiduciary status for a major medical plan
  - Nearly all employers are not in a position to make medical necessity determinations (which require an experienced medical professional's judgment), work within the strict confines of the ERISA appeals procedures, address urgent care claims in as short a timeframe as 24 hours where required, etc.

29 CFR §2560.503-1(h)(1):

(h) Appeal of adverse benefit determinations.
(1) In general.
Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

ERISA Fiduciary Duties

The Named Fiduciary for Appeals

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Employers Need to Ensure Major Medical Plan TPA Designated Appeals Fiduciary

- Employers sponsoring a self-insured medical plan have greater flexibility with many aspects the plan
- However, it's a misconception that the employer can override the TPA's appeal denial to approve the claim
- Where TPA is the named fiduciary for appeals, any attempt to override the TPA's appeal determinations would violate the requirement that appeals be determined by a named fiduciary
  - This violation could result in the loss of the deferential standard of review in federal court in litigation
  - Known as the "Firestone standard," which provides that the participant can prevail on the claim only if the plan abused its discretion by acting in an arbitrary and capricious manner in making the determination
  - Failure to have appeals determined by TPA could cause the "de novo" standard of review to apply, and make it much more likely the plaintiff participant would prevail against the plan.

Template Language for TPA Agreement:

Notwithstanding any provisions in this Agreement to the contrary, TPA agrees to act as the Plan's named appeals fiduciary pursuant to 29 CFR §2560.503- 1(h)(1) with full and final discretionary authority to determine claims and appeals for benefits under ERISA. Plan Sponsor delegates only this appeals fiduciary status to TPA. All other ERISA fiduciary duties remain with the Plan Sponsor (or its delegate other than TPA).

ERISA Fiduciary Duties

The Named Fiduciary for Appeals

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Employers Need to Ensure Major Medical Plan TPA Designated Appeals Fiduciary

Employers have two options where they disagree with the TPA's (name appeals fiduciary's) determination:

1. Amend the plan for all participants to change the plan terms and specifically cover or exclude the item or service at issue
2. Alternatively, employers have the discretionary authority to interpret plan terms on a consistent basis for all participants
    - Employers can therefore direct the TPA in writing to interpret plan provision at issue in a manner consistent with the employer's understanding of those plan terms
    - TPA will generally accommodate such direction unless it clearly is contrary to the plan terms

The Comparative Analysis Employer Certification

Full Details: The Mental Health Parity Employer Certification Requirement

The Departments issued a lengthy set of new regulations in 2024 to address many of the specific aspects of the MHPAEA comparative analysis requirement added by the CAA. The rules are mostly effective for plan years beginning on or after January 1, 2025.

- *The new rules require that a named plan fiduicary (generally the employer) complete a certification contained within the the document.*

The Certification Requirement:	What the DOL Expects of Employers:	Enforcement Process:
Employer as fiduciary must certify: • They have engaged in a prudent process to select the service provider(s) to perform and document a comparative analysis in accordance with applicable law • The analysis is based on the imposition of any nonquantitative treatement limitations (NQTL) that apply to mental health and substance use disorder benefit (MH/SUD) under the plan • They have satisfied their duty to monitor the service provider(s) per the standard ERISA duty of prudence with respect to the performance and documentation of the comparative analysis	**DOL expects employers as fiduciary to:** • Review the comparative analysis prepared by or on behalf of the plan with respect to an NQTL applicable to mental health and substance use disorder benefits and medical/surgical benefits • Ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings and conclusions documented in the analysis • Ensure that the service provider provides assurance that the comparative analysis complies with the requirements of MHPAEA	**1) Available Upon Request** • The plan must provide the comparative analysis to the relevant department (DOL/IRS/HHS) within 10 business days of the relevant department's request • The plan has 45 calendar days to correct issues if determined to be noncompliant **2) Notify Employees** • If the plan receives a final determination of noncompliance, it has 7 business days to notify all enrolled employees • Header: "Attention! The Department of [X] has determined that [plan name] is not in compliance with the MHPAEA!"

New DOL Guidance on Cybersecurity

Full Details: Compliance Assistance Release No. 2024-01

The DOL put out cybersecurity guidance in 2021 that was widely regarded as directed toward retirement plans. In 2024, the DOL clarified that employers have the same fiduciary responsibility to include cybersecurity matters as part of the process to prudently select and monitor vendors for non-retirement plan benefits.

- *The guidance provides a useful set of materials that employers can use to satisfy the fiduciary standards for cybersecurity.*

Tips for Hiring a Service Provider:

- A number of tips for employers of all sizes and for all types of ERISA plans for what to ask and evalutate with respect to any service provider's cybersecurity practices.

Also includes suggested contractual terms:

- Information Security Reporting
- Clear Provisions on the Use and Sharing of Information and Confidentiality
- Notification of Cybersecurity Breaches
- Compliance with Records Retention and Destruction, Privacy and Information Security Laws
- Insurance

Cybersecurity Best Practices:

- 12 best practice approaches for plan service providers to ensure proper mitigation of cybersecurity risks.

Includes the following key themes:

- Identify the risks to assets, information and systems
- Protect each of the necessary assets, data and systems
- Detect and respond to cybersecurity events
- Recover from the event
- Disclose the event as appropriate
- Restore normal operations and services

Online Security Tips:

Tips for employees to reduce the risk of fraud and loss online:

- Register, set up and routinely monitor your online account
- Use strong and unique passwords/passphrases
- Use Multi-Factor Authentication
- Keep personal contact information current
- Close or delete unused accounts
- Be wary of free wi-fi
- Beware of phishing attacks
- Use antivirus software and keep apps and software current

The J&J Prescription Drug Case Makes Waves

Full Details: The J&J Case Practical Considerations (ERISA Fiduciary Duties)

Full Details: The J&J Case Practical Considerations (ERISA Trust Rules)

ERISA Fundamentals Revisited

The Allegation: Excessive Prescription Drug Costs

- The class plaintiff in *Lewandowski v. Johnson & Johnson, et. al.* principally allege that the company breached its fiduciary duty by mismanaging the health plan's Rx benefits
  - Argument is that cost employees millions in the forms of higher Rx payments, higher premiums, higher cost-sharing, and lower wages or limited wage growth
- Class plaintiff alleges that J&J breached its fiduciary duty of prudence by failing to engage in a prudent and reasoned decision-making process to lower the cost of drugs

Key Points to Keep in Mind

- The J&J case is merely at the initial complaint stage, and it is unclear whether these novel breach of fiduciary duty theories will be successful—so try to avoid knee-jerk overreactions
- The J&J plan is very large and *funded by a trust*, which allows the plaintiff to establish a clear connection between the employer's fiduciary duties and the trust funds held as plan assets
- Given that this area of law remains unsettled pending the J&J (and similar Wells Fargo) litigation, employers should be cautious considering any radical changes to plan governance
  - *Best practice:* **Return to the basics** of proven ERISA compliance methods/strategies while monitoring developments for any outcomes that may drive new best practices going forward

Will a Plan Committee Really Solve These Issues?

- J&J's plan had a fiduciary benefits committee but was still the target of this case
- The individuals serving on the committee were a clear target as defendants, with the CHRO and VPs of HR personally named
- Board delegation of fiduciary duties to a committee with oversight of H&W plan benefits traditionally has been a practice adopted only by very large employers because of the time and cost

04

Eligibility

Clearly Defined Classes

ERISA Plan Eligibility

Standard Health Plan Eligibility Structure

Most employers set health plan eligibility at 30 hours per week to align with ACA employer mandate full-time employee status

- ALEs will utilize monthly measurement method or look-back measurement method to determine full-time status
- Insurance carriers (and stop-loss providers) typically will permit plan eligibility as low as 20 hours per week for employers that want to be more generous
- Sometimes there will be variations in plan eligibility based on region, full time vs. part-time, contingent vs. regular, divisions, or other clearly defined classes

ERISA requires the plan be administered and maintained pursuant to its written terms (§402(a))

- If the employer makes an exception, the employer has interpreted the plan's terms to permit the exception, and this interpretation must be applied consistently for all similarly situated employees
- This means that eligibility exceptions (e.g., hours threshold or waiting period duration) create an ERISA plan precedent requiring the plan to impose the same conditions for those similarly situated
- Employees denied eligibility under similar circumstances would have an ERISA breach of fiduciary duty claim or claim for benefits
- Don't make eligibility exceptions to plan's set eligibility terms without formally doing so for the entire class!

When Changing Eligiblity

- Apply any changes in eligibility terms consistently across the class of eligible employees
- Confirm any changes in advance with the insurance carrier or stop-loss provider
- Communicate the changes to employees in any plan materials addressing plan eligibility

ERISA Plan Eligibility

Standard Health Plan Eligibile Individuals

Health plans almost uniformly limit eligibility to:

- Eligible employees (hours/week threshold to qualify)
- Spouse
- Domestic Partner (Registered or Company-Defined)
- Children Under Age 26
  - *Children typically include biological children, step-children, foster children, adopted children, and children placed for adoption*
  - *Most also include children for whom employee is legal guardian pursuant to a court order*
- Note: Immigration, visa, SSN, citizenship status are all irrelevant for eligibility purposes

ERISA requires the plan be administered and maintained pursuant to its written terms (§402(a))

- Must follow the eligibility terms set forth in the wrap plan document, wrap SPD, EOC, policy, certificate, open enrollment materials, new hire materials, handbook, etc.
- Cannot offer coverage to any other individuals (regardless of residence, tax dependent status, family relationship, etc.)
- Technically possible to offer coverage more broadly, but very rare and would require insurance carrier or stop-loss provider approval

Tax Dependent Status Not Relevant for Most Benefits

- Employees often ask to cover tax dependent individuals who are not in an eligible category
- Tax dependent status is relevant only for tax purposes and account-based plan (FSA/HRA/HSA) purposes
- Parents, siblings, nieces, nephews, grandchildren, grandparents, and all other individuals regardless of relationship are not eligible even if they are tax dependents

ERISA Plan Eligibility: Divorce vs. Legal Separation

Some plans terminate a spouse's coverage at the point of a court-ordered legal separation if it occurs prior to the finalized divorce. Loss of coverage for either reason is a qualifying event.

Plan Terminates Coverage Upon: Legal Separation or Divorce	**Plan Terminates Coverage Upon:** Only Final Divorce
• Spouse has COBRA rights if coverage is lost for either event • Note that not all married couples legally separate prior to a divorce • Legal separation requires a court order (merely living apart does not qualify as legally separated) • Employee or spouse must notify the plan within 60 days of the legal separation or divorce to preserve the spouse's COBRA rights	• An earlier legal separation prior to entering into the final divorce will have no effect on the spouse's eligibility for active coverage • Employee will not be able to remove the spouse from coverage at the point of legal separation (no permitted election change event where no loss of eligibility) • Employee or spouse must notify the plan within 60 days of final divorce to preserve spouse's COBRA rights

ERISA Plan Eligibility: Late Notice of Divorce/Legal Separation

A former spouse is not eligible for the plan and must be removed whenever the plan receives notice—even if received very late. (*Massachusetts fully insured plan exception)

Plan Terminates Coverage Upon: Legal Separation or Divorce	• ACA prohibition of rescission does not apply to late divorce notification • Means employer can terminate coverage retroactively to the date of divorce • Although the default termination date of coverage is always prospective, employer could terminate retroactively if it prefers to attempt to recoup back premiums (fully insured) or claims (self-insured) for the ineligible former spouse's coverage/benefits

COBRA for the Former Spouse	• COBRA rules provide 60 days from the date of the event to notify the plan of divorce/legal separation (included in initial COBRA notice to employee/spouse)
	• **If the employee/former spouse misses that 60-day notice window, the former spouse has technically lost all COBRA rights under the plan**
	  • In some situations, the carrier (or stop-loss provider if self-insured) may agree to an exception where notice is still reasonably close to the 60-day limit, must be applied consistently
	  • Ex-spouse should not receive COBRA election notice unless carrier confirms exception

Disciplinary Action	• Employer may have employment disciplinary policies to address this form of fraud or intentional misrepresentation of a material fact • Employer should consider reviewing its handbook and internal policies to determine if that's an option to pursue in this type of situation

05

Special Issues

The Other ERISA Highlights

ERISA Federal Preemption

Three Layers of Analysis

Express Preemption Clause

- **ERISA expressly preempts state laws that relate to employee benefit plans**
- Generally means that state laws and state court orders relating to employee benefit plans are not enforceable against the plans
- Federal law (ERISA) preempts the enforcement of such state laws and court orders
- Set forth in ERISA §514, U.S. Supreme Court has stated the purpose is *"to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States"*

The Savings Clause

- **Applies to fully insured plans**
- Provides that ERISA does not preempt any state insurance laws for a fully insured plan
- An exception from the express preemption clause
- Typically referred to as the "Savings Clause" because *state insurance mandates are "saved" from ERISA preemption with respect to a fully insured plan*
- Practical result is that employer-sponsored plan options that are fully insured must satisfy the state insurance coverage mandates for the state where the policy is situsedd

The Deemer Clause

- **Applies to self-insured plans**
- Self-insured plans are not subject to any state insurance mandates
- ERISA confirms that self-insured plans cannot be treated as subject to state insurance law
- Typically referred to as the "Deemer Clause" because *self-insured plans cannot be "deemed" to be an insurance policy subject to state* insurance mandates
- Practical result is employer-sponsored plan options that are self-insured (including level-funded) are not subject to any state insurance coverage mandates

ERISA Federal Preemption

State Insurance Mandates Preempted by ERISA

- The ERISA express preemption clause generally renders any state insurance mandate unenforceable against the plan—and therefore it has no effect and is to be ignored
- Employers may consider offering benefits mandated in certain states, but no requirement for self-insured plans
- Result: Employers have complete flexibility in plan design for covered benefits (other than federal law requirements)

Exceptions

- Fully insured plans have to offer state insurance mandates for the state in which the policy is sitused
- State criminal laws of general applicability apply to all plans, including self-insured plans
  - For example, state embezzlement laws and state slayer statutes that prohibit individuals from receiving a benefit caused by the death of a person if the beneficiary intentionally killed that person (e.g., life insurance proceeds)
  - Many questions outstanding about how this exception might apply in the abortion-related travel assistance area

Example	Result
• **Employer Empire State ERISA Services is based in New York and offers employees a self-insured group major medical plan** • New York imposes a state insurance mandate requiring health plans to cover three cycles of IVF used in the treatment of infertility →	• The New York state insurance mandate does not apply to Empire State ERISA Services' group health plan • **Employer can choose what (if any) infertility services to cover as a matter of plan design** • *Note: If plan were fully insured and sitused in NY, the IVF mandate would apply to all covered employees (regardless of state of residence)*

ERISA Federal Preemption

State Court Orders Preempted by ERISA

- The ERISA express preemption clause generally renders any state court order attempting to require coverage **not** enforceable against the plan—and therefore cannot be followed because it has no effect
- Unless an exception applies, state domestic relations and related court orders are preempted by ERISA
- Result: Terms of the plan govern as written and cannot be modified by the terms of any such state court order

Exceptions

- ERISA has created exceptions to federal preemption that make specific state domestic relations orders enforceable against an ERISA plan—*but no exception to give effect to an order requiring health plan coverage for a former spouse*
- Primary exceptions:
  - Qualified Medical Child Support Order (QMCSO): Requires employee to cover a child under the health plan
  - Qualified Domestic Relations Order (QDRO): Former spouse right to a portion of an employee's retirement plan

Example

- **Maria and Arnold divorce with a court order stating Maria must continue to cover Arnold in active coverage under her employer's group health plan**
- Maria's group health plan is subject to ERISA
- The health plan is not a fully insured plan sitused in Massachusetts

Result

- The order relating to Arnold's health coverage is preempted by ERISA and therefore has no effect
- **Plan cannot offer active coverage to former spouse**
- *Exception: Massachusetts state insurance law for fully insured plans recognizes the order to preserve former spouse's eligibility until the former spouse remarries*

Coordination of Benefits

Most Plans Follow NAIC Model COB Rules

Employees and Dependents May be Covered by More Than One Plan

- In this case, the plans will coordinate coverage to determine which pays as primary
- Plans will typically follow the NAIC model COB rules to determine coordination approach
- Primary plan pays first as though no other coverage exists
- Secondary plan then pays any remaining amount that would have been paid under its terms

Typical COB Situations

- Employee covered through own employer and spouse/domestic partner/parent employer plan
  - *Employee coverage is primary, dependent coverage through other employer is secondary*
- Child covered through both parents' employer plans, and parents are married or living together
  - *Birthday Rule: Plan of parent whose birthday falls earlier in calendar year is primary*
- New hire has DOH coverage with new plan and EOM or COBRA coverage through prior plan
  - *New plan covering as active employee is primary, prior employer plan is secondary*

Example #1

- Rudi has coverage through his employer the Beau Site Hotel and through his mom Frau's employer Kurtal, Inc.
- Rudi's coverage through the Beau Site Hotel is primary

Example #2

- Rudi has coverage through his dad Josef's (DOB 4/15) employer Guides, Inc. and his mom Frau's (DOB 9/3) employer Kurtal, Inc.
- Rudi's coverage through Guides, Inc. is primary

Example #3

- Rudi has coverage through his past employer the Beau Site Hotel and through his new employer Guides, Inc.
- Rudi's coverage through Guides, Inc. is primary

ERISA Plan Assets and Trust Relief

While retirement plans always must hold plan assets in trust, health and welfare plans largely avoid the trust requirements thanks primarily to the seminal DOL guidance issued in 1992.

Trust Requirement General Rule: Applies to Plan Assets	• ERISA requires that all plan assets be held in trust unless an exception applies • Employee contributions to the plan are treated as plan assets as soon as they can reasonably be segregated from the employer's general assets • Other employer funding can be treated as plan assets depending on how the funds are held and documented
Trust Relief Most Health and Welfare Plans Enjoy DOL Relief from Trust Requirements	• **DOL Technical Release 92-01 provides broad relief from the trust requirement for health and welfare plans, including the "cafeteria plan exception"** • Trust requirement not enforced for plan assets derived from employee health and welfare plan contributions where those contributions are made through a Section 125 cafeteria plan • Employee contributions are almost universally taken pre-tax through the cafeteria plan
Potential Pitfalls Multiple Areas Where Unsuspecting Employers Could Lose Trust Relief	• *Separate Accounts:* A separate account in the name of the plan would not be treated as a trust because it would not be the employer's general assets, and therefore relief would not apply • *MLR Rebates:* Failure to apply the portion of an MLR rebate attributable to employee contributions (plan assets) to a permitted purpose within three months of receipt causes loss of trust relief • *Independent Contractors:* Creation of a multiple employer welfare arrangement (MEWA) by providing benefits to independent contractors would likely cause the plan to lose trust relief • Loss of trust relief would require multiple layers of additional documentation and reporting

Non-English Language Assistance

Plans must offer non-English language assistance in the SPD in certain situations, depending on the size of the plan and the number of employees speaking the non-English language.

Language Assistance Thresholds: Depends on Plan Size and Employee Population	**Language Assistance Requirements:** SPD Notice of Assistance Available
Plan That Covers Fewer than 100 Participants at the Beginning of the Plan Year: • 25% or more of all plan participants are literate only in the same non-English language **Plan That Covers 100+ Participants at the Beginning of the Plan Year:** The lesser of: • (i) 500 or more participants, or • (ii) 10% or more of all plan participants are literate only in the same non-English language	• Rules provide that the SPD in English would not sufficiently inform these participants of plan provisions • The SPD must include a prominent notice in the non-English language offering assistance • Notice must include (in the non-English langauge) the procedures to follow to obtain the assistance • The assistance doesn't need to be written materials Reminder: • Different non-English lanugage requirements apply for the SBC, including full translations in some situations

Annual Notices: The Required Annual Notices

1

Medicare Part D Notice of Creditable or Non-Creditable Coverage

- When: Annually by October 15 (beginning of Part D open enrollment period)
- Why: Inform employees whether Rx coverage is at least as rich as Part D to avoid penalties
- Electronic Distribution: Permitted for employees meeting ERISA electronic disclosure safe harbor
- Penalties: No specific penalties, but employee would face late enrollment penalty if enrolled in non-creditable coverage
- *Model Notice:* https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters
- *Newfront Online Notice:* Medicare Part D Notice of Creditable Coverage; Part D Notice of Non-Creditable Coverage

2

Children's Health Insurance Program (CHIP) Notice

- When: Annually with no specific timeframe—recommend including with other required annual notices
- Why: Inform employees they may be eligible for premium assistance through CHIP or Medicaid state programs
- Electronic Distribution: Permitted for employees meeting ERISA electronic disclosure safe harbor
- Penalties: $137 per day per employee
- *Model Notice:* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra
- *Newfront Online Notice:* Children's Health Insurance Program (CHIP) Notice

3

Women's Health and Cancer Rights Act (WHCRA) Notice

- When: Upon enrollment and annually—recommend including with other required annual notices
- Why: Inform employees of coverage for reconstructive surgery and other items and procedures related to a mastectomy
- Electronic Distribution: Permitted for employees meeting ERISA electronic disclosure safe harbor
- Penalties: $100 per day per employee, potential ERISA breach of fiduciary duty claim
- *Model Notice:* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf
- *Newfront Online Notice:* Women's Health and Cancer Rights Act (WHCRA) Notice

Annual Notices: The Recommended Annual Notices

1

HIPAA Special Enrollment Notice

- Employers are required to provide this notice at or before the time an employee is initially offered the opportunity to enroll in the health plan (there is no requirement to distribute the notice annually)
- HIPAA special enrollment events include marriage, birth, adoption, loss of eligibility for other group coverage
- *Best Practice:* Although there is no requirement to re-distribute annually, we recommend providing the notice at the same time as the other required annual notices because of the importance of special enrollment rights
- *Model Notice:* https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

2

Patient Protections Notice

- Employers sponsoring a health plan with options that require designation of a primary care provider (e.g., HMOs) must provide the notice (there is no requirement to distribute the notice annually)
- Required to be included whenever an SPD or other similar description of benefits is provided
- *Best Practice:* Provide the notice with other required annual notices because the DOL asks for evidence the employer provided it to participants in its standard list of documents to be produced in an investigation/audit
- *Model Notice:* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/preexisting-condition-exclusions

3

ADA Wellness Program Notice

- This notice is difficult to address because a federal court ruled that components of the EEOC wellness program rules do not meet the requirements of the ADA, and the EEOC has formally vacated those components of the regulations
- Furthermore, new proposed wellness regulations issued at the end of the Trump administration would have removed the notice requirement, but the Biden administration pulled those proposed regulations
- *Best Practice:* Given the amazingly unclear landscape, employers should consider still providing this notice to be safe
- *Model Notice:* https://www.eeoc.gov/regulations/sample-notice-employer-sponsored-wellness-programs

Other Notices: Notices Typically NOT Provided Annually

1

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

- The NMHPA requires employers to include in the health plan SPD a statement describing the plan's required minimum hospital length of coverage in connection with childbirth for the mother and newborn child
- The NMHPA notice is not an annual notice requirement, and DOL guidance confirms that inclusion of the NMHPA notice in the SPD is sufficient
- Best Practice: Include the NMHPA notice in the wrap SPD
- Model Notice: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf

2

- **ACA Exchange Notice**
  - The ACA requires employers subject to the Fair Labor Standards Act (FLSA) to provide the Exchange notice to new hires within 14 days of the employee's start date
  - The notice informs employees how to access alternative individual coverage through the Exchange
  - The Exchange notice is not an annual notice, and DOL FAQ guidance confirms no penalties apply for failure to provide
  - Best Practice: Include the Exchange Notice with standard new hire materials
  - Model Notice: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice

3

HIPAA Notice of Privacy Practices

- Employers with a self-insured health plan must provide employees with a HIPAA Notice of Privacy Practices within 60 days of a material change to the notice—there is no requirement to re-distribute the notice annually
- Only recurring notice required is to inform employees of the availability of the NPP at least once every three years
- Best Practice: Consider including the notice of availability of the NPP with annual notices at least once every three years
- Sample Notice of Availability of NPP: https://www.newfront.com/blog/the-2025-required-annual-benefit-notices-to-employees

Benefits for Which ERISA Status is Difficult to Determine

General Rule: ERISA §3(1) Definition

Employer-sponsored health and welfare benefits that meet ERISA's definition of an "employee welfare benefit plan" are subject to ERISA:

- **Medical, surgical, hospital benefits**
  - E.g., Medical, dental, vision, health FSA, HRA, EAP
- **Benefits in the event of sickness, accident, disability, death, or unemployment**
  - E.g., Disability, life, AD&D, severance
- **Vacation benefits**
  - Only where funded by a trust (rare)
- **Apprenticeship or other training programs**
  - Only where funded by a trust (rare)
- **Day care centers**
- **Scholarship funds**
  - Only where funded by a trust (very rare)
- **Prepaid legal services**

Short-Term Disability Benefits

- Many employer-sponsored short-term disability benefit programs are exempt from ERISA under the payroll practice exception
  - There are multiple conditions to qualify for exception, and often employers prefer plan be subject to ERISA

Severance Benefits

- It's often a subtle and nuanced analysis under court precedent to determine whether severance benefits are subject to ERISA
  - ERISA applies if an ongoing administrative program and clear eligibility standards or benefit provisions

Voluntary Plans

- Although employers frequently refer to all benefits paid entirely by the employee as "voluntary," the voluntary plan safe harbor exemption from ERISA is more complex
  - Most difficult condition to satisfy is avoiding endorsement of the program

The Payroll Practice Exception: Disability Benefits

Many Employer-Sponsored Short-Term Disability Programs Meet ERISA Exception

The Payroll Practice Exception Defined

- "*Payment of an employee's normal compensation, out of the employer's general assets, on account of periods of time during which the employee is physically or mentally unable to perform his or her duties, or is otherwise absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment)*"

Five Main Requirements to Qualify for Exception

- **Not be insured:** Payment must be from employer's general assets
- **Not be funded by a trust:** Payment must be from employer's general assets
- **Not pay more than normal compensation:** Payment cannot exceed 100% of standard salary or wages
- **Not cover terminated employees:** Individuals receiving benefits must be employees (must cease for terminated employees)
- **Not declare ERISA status in plan materials:** Courts may find Form 5500 or SPD ERISA declaration to be determinative

Summary

- Short-term disability benefits are ideal candidate to take advantage of payroll practice exception
- Restrictions can be more limiting than employers are willing to follow, such as whether benefits continue post-termination
- Many employers also make the conscious choice to avoid the payroll practice exception and make STD subject to ERISA
- **Advantages:** Not subject to ERISA plan document, SPD, Form 5500, claims and appeals, fiduciary duties
- **Disadvantages:** No ERISA federal preemption, litigation in state court, restricted to general assets and current employees

The Fort Halifax Test: Severance Benefits

ERISA Status of Severance Benefits is Often a Difficult Analysis

Court Rulings Address ERISA Plan Status Question

- U.S. Supreme Court addressed ERISA status of severance benefits in 1987 case *Fort Halifax Packing Co. v. Coyne*
- **Court held that severance benefits give rise to an ERISA severance plan only "with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation."**
- Other court cases have held that ERISA plans must have sufficient detail to enable individuals to determine the plan benefits

Two Main Components of ERISA Plan Status Question

- Many court cases have addressed these issues in the past—these precedents are very useful examples in what qualifies
- Severance benefits must generally include the following two components to be an ERISA plan:
  1. **An ongoing administrative program; and**
  2. **Clear eligibility standards or benefit provisions**

Summary

- Dividing line between non-ERISA severance agreement and a severance plan subject to ERISA is nuanced and will generally depend on all the facts and circumstances of each situation
- Wherever the factors call into question whether severance benefit is subject to ERISA, employer should work with in-house or outside ERISA counsel to receive a legal opinion on the benefit's ERISA status
- ERISA severance benefits will need to comply with the standard ERISA welfare benefit plan (plan document, SPD, claims and appeals procedures, fiduciary duties, Form 5500, etc.)

The Voluntary Plan Safe Harbor

Voluntary Plan Safe Harbor Exempts Certain Employee-Paid Benefits from ERISA

Four Conditions to Satisfy Voluntary Plan Safe Harbor:

1. **No Employer Contributions**
   - Employees must pay the full amount of the premium—generally must be paid on an after-tax basis to qualify
2. **Completely Voluntary Participation**
   - Easiest condition to satisfy—state wage withholding law would prohibit any contribution that is not authorized by employee
3. **No Employer Endorsement of the Program**
   - Hardest condition to satisfy—could include employer selection of specific carrier or types of coverage, employer involvement in plan design, program structures available only to employees, materials that include employer name or logo, stating program is subject to ERISA, including in ERISA plan documents, providing claims and appeals assistance to employees
4. **Employer Receives No Compensation from the Insurance Carrier**
   - Receipt of any form of compensation from the insurance carrier (cash or otherwise) is not permitted under the safe harbor

Summary

- Employers frequently refer to supplemental type employee-paid programs as “voluntary plans” such as hospital or other fixed indemnity, cancer or other specific disease coverage, critical illness, or supplemental disability or life policies
- However, meeting the technical ERISA exemption under the voluntary plan safe harbor is quite difficult
- Treating a “voluntary plan” as exempt from ERISA where it doesn’t meet the voluntary plan safe harbor could cause DOL challenge, litigation, and ERISA penalties such as for failure to file Forms 5500 (up to $2,670/day)
- **Best Practice:** Treat a borderline benefit as subject to ERISA by including in wrap plan document/SPD and Form 5500

Wrap-up

Takeaways

ERISA for Employers

Top Five Issues for Employees

1. Plan Document/SPD

- Plan document is the formal legal document governing the plan
- SPD is the employee-facing version of the plan document
- "Wrap" plan document and SPD are used in conjunction with carrier/TPA materials to satisfy ERISA content requirements in aggregate
- ERISA electronic disclosure safe harbor generally requires employees have work-related computer access that is integral to their job duties

2. Form 5500

- Generally applies to plans with 100 or more covered participants on the first day of the plan year
- Filing is due to the DOL by the last day of the 7th month after the end of the plan year
- Automatic 2½ month extension available with Form 5558 filed with IRS
- Enormous potential penalties for filing failures can apply (up to $2,670/day)
- DFVCP is a great alternative to come forward and pay much reduced fee to avoid large penalties

3. Fiduciary Duties

- *Duty of Loyalty (Exclusive Benefit Rule):* Requires employers to act solely in the interest of plan participants and beneficiaries with respect to any fiduciary function
- *Duty of Prudence:* Common application is duty to prudently select and monitor plan service providers
- *Duty of Diversification:* Applies where plan assets held in trust, which is uncommon for health and welfare plans
- *Duty to Follow Plan Terms:* Common concern where employees request eligibility or benefits exceptions because of resulting ERISA plan precedent in interpreting plan terms

4. Eligibility

- Most employers set health plan eligibility at 30 hours per week (or lower) to align with ACA employer mandate
- Common eligible dependents are spouse, domestic partner, and children under age 26
- ERISA requirement to administer and maintain plan pursuant to written terms (and carrier/stop-loss concerns) make exceptions extremely problematic and to be avoided wherever possible
- Remember: Parents, siblings, and other relatives are not eligible even if tax dependents

5. Special Issues

ERISA Federal Preemption

- Express Preemption Clause
- The Savings Clause
- The Deemer Clause
- Self-insured plans not subject to state insurance mandates
- Most state court orders also preempted

Annual Notices

- Medicare Part D Notice of Creditable Coverage
- CHIP Notice
- WHCRA Notice
- Others are recommended

ERISA Status Difficult

- Short-term disability benefits
- Severance benefits
- Voluntary plan safe harbor

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ERISA for Employers

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Thank you

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