# AFFORDABLE CARE ACT – DOCUMENTING HEALTH CARE COMPLIANCE - 2016

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## I. INTRODUCTION

While many employers were focusing their efforts on avoiding the pay or play penalties contained in the Patient Protection and Affordable Care Act ("ACA") in 2015, they may have missed many of the other requirements for maintaining a group health plan. Substantial documentation is required for group health plans under the Internal Revenue Code and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), in addition to the requirements under the ACA.

## II. PLAN DOCUMENTATION AND DISCLOSURE REQUIREMENTS

### A. ERISA Plan Requirements.

#### 1. ERISA Section 402 – Establishment of Plan.

##### a. Named fiduciaries.

Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

##### b. Requisite features of a plan.

Every employee benefit plan shall (1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the

plan and the requirements of this subchapter, (2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan, (3) provide a procedure for amending such plan and for identifying the persons who have authority to amend the plan, and (4) specify the basis on which payments are made to and from the plan.

B. What is an Employee Benefit Plan?

ERISA Section 3 provides that the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act of 1947 (Taft Hartley), other than pensions on retirement or death, and insurance to provide such pensions.

C. Written Plan Requirements.

1. The written plan requirement is intended to enable the employees to determine their rights and responsibilities under the plan and to discover who is responsible for operating the plan.

    a. More than one document – A health and welfare plan can consist of more than one document.

i. Insurance company brochure to employees combined with the insurance policy and other documents can constitute the plan for purposes of ERISA.

ii. Wrap Plan Documents.

(A) Wrap plan document. A wrap plan typically “wraps” together the various welfare benefit plans of the employer into a single plan document. While the wrap plan document generally does not define plan terms or lay out plan benefits, it does provide the important documentation required under ERISA. Elements of the wrap plan usually include detailing who the participating employers are, who pays the cost of plan benefits, which employees are eligible, a claims procedure, language giving the plan sponsor and its delegates the power to amend or terminate the plan and to interpret the plan’s terms, plan administration rules, and other ERISA requirements.

(B) Multiple wrap plan documents. Some employers choose to insure certain welfare plans and self-fund others, often through a voluntary employees beneficiary association (“VEBA”). Such an employer might choose to sponsor two separate wrap plans – one for the insured

component plans, and another for the self-funded component plans funded through the VEBA. The reason for having two wrap plans is that only self-funded welfare plans funded through VEBAs or other funding arrangements are subject to the U.S. Department of Labor's audit requirement. By having two wrap plans, the time and expense of the audit will only apply to the VEBA.

iii. Summary Plan Description ("SPD") as plan document.

Some employers take the approach that the SPD, intended in ERISA to be a shorter, easier-to-understand version of the formal written document, is in fact also the plan document. Although this approach eliminates the need to maintain a separate plan document, it raises issues in its own right, such as whether there needs to be a formal process in place for adopting and amending the SPD, and whether the plan document provisions can be written in plain, understandable language that satisfies the SPD requirements.

D. Fringe benefits and "payroll practices."

While most of the welfare benefit programs are covered by ERISA, some fringe benefits, such as short-term disability, sick leave plans, and severance programs, fall in a gray area. It is often unclear

whether they are just “payroll practices,” which are not subject to ERISA, or whether they are ERISA-covered welfare plans.

The answer may depend in part on how the employer treats the benefits. We would suggest that the benefits be treated as ERISA covered benefits. Typically, it will be to the employer's advantage to have the plan covered by ERISA since the rules that have developed under ERISA are generally more favorable to plan sponsors than the rules that exist under state law. Therefore, employers should take steps to increase the likelihood of ERISA treatment – including asserting ERISA coverage of the plan in the plan document and SPD, complying with the form and filing requirements of ERISA (Form 5500, SPD requirements, claims procedures, etc.) and associating the plan with an insured plan (for example, combining short-term disability with your long-term disability plan) to the extent possible.

Payroll practices. For purposes of ERISA, the terms "employee welfare benefit plan" and "welfare plan" do not include:

1. Payment by an employer of compensation on account of work performed by an employee, including overtime pay, shift premiums, holiday premiums, weekend premiums;

2. 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); and

3. Payment of compensation, out of the employer's general assets, on account of periods of time during which the employee, although physically and mentally able to perform his

or her duties and not absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment) performs no duties; for reasons such as vacation or holidays, to an employee who is absent while on active military duty, while an employee is absent for the purpose of serving as a juror or testifying in official proceedings, while engaged in training (whether or not subsidized in whole or in part by federal, state or local government funds), and to an employee who is relieved of duties while on sabbatical leave or while pursuing further education.

4. On-premises facilities are excluded from ERISA welfare plan coverage. Such facilities would include recreation, dining or other facilities (other than day care centers) for use by employees or members, the maintenance on the premises of an employer of facilities for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours, and holiday gifts.

5. Voluntary group or group-type insurance programs. For purposes of ERISA, the terms "employee welfare benefit plan" and "welfare plan" do not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

   a. No contributions are made by an employer or employee organization;

   b. Participation the program is completely voluntary for employees or members;

   c. The sole functions of the employer or employee organization with respect to the program are, without

endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check-offs and to remit them to the insurer; and

d. The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check offs.

## III. LACK OF A WRITTEN PLAN

A. Although lack of written plan terms may seem to allow employers greater discretion in paying benefits, the absence of a written plan may actually restrict the employer's ability to amend or terminate a welfare benefit plan.

Numerous cases have found that where an employer handles its welfare benefits on an informal basis, the employer's past practices provide the basis on which employees may make a claim for the same benefits.

This type of claim rests on the premise that the employer's past practices have established an ERISA plan, and that the benefit levels previously paid by the employer must be paid to the terminated employees now claiming benefits because the employer has not reserved the express right to reduce them.

In addition, a written plan allows the employer to determine what benefits, if any, would be payable upon a specified event, such as a corporate sale, divestiture of a unit, restructuring, or a lay-off. Having a plan document also allows an employer to grant the plan

administrator or other plan fiduciaries the discretion to make all eligibility and benefit determinations, enabling the employer to have the benefit of deferential review of those determinations in the event of a lawsuit. If the discretion to grant or deny the benefit is not expressly stated in a written plan, then the employer may be left with a court determining what the benefits are.

B. Information Required to be Included in the SPD.

U.S. Department of Labor Regulation 29 CFR 2520.104b-2 provides that the Plan Administrator shall furnish a copy of the SPD and a statement of ERISA rights to each participant covered under the plan. Under 29 CFR 2520.102-3 and the requirements under HIPAA, a health and welfare plan SPD must contain directly or in combination with other documents the following information:

1. Official name of the plan;

2. Name, address and phone number of the plan sponsor;

3. Name, address and phone number of the plan administrator;

4. Employer Identification Number;

5. Plan number (e.g. 501);

6. Type of welfare plan (hospitalization, disability, etc.);

7. Type of administration of the plan (e.g. contract administration, etc.);

8. Name and address of the insurer(s), health service organization(s) or third party organization(s) responsible for the financing or administration of the plan;

9. Name of person designated as agent for service of legal process, address at which process may be served, and a statement that service of legal process may also be made upon a plan trustee (as applicable) or the plan administrator;

10. The plan's requirements respecting eligibility for participation and for benefits. The SPD shall also include a description or summary of the benefits;

11. The SPD must include directly or in combination with other documents, a description of:

    a. any cost-sharing provisions, including premiums, deductibles, coinsurance, and co-payment amounts for which the participant or beneficiary will be responsible;

    b. any annual or lifetime caps or other limits on benefits under the plan;

    c. the extent to which preventive services are covered under the plan;

    d. whether, and under what circumstances, existing and new drugs are covered under the plan;

    e. whether, and under what circumstances, coverage is provided for medical tests, devices and procedures;

    f. provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services;

    g. any conditions or limits on the selection of primary care providers or providers of specialty medical care; and

h. any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan.

12. In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the SPD contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document;

13. Description of relevant provisions of any collective bargaining agreement (as applicable);

14. A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits;

15. A summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated;

16. A summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan, and a summary of any plan provisions

governing the allocation and disposition of assets of the plan upon termination;

17. In the case of a group health plan subject to COBRA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage;

18. Source of contributions to the plan (employer and employee contributions);

19. Source of plan financing (insured, self-insured with no stop loss, etc.);

20. Date of the end of the plan year and whether plan records are kept on calendar, policy or fiscal year basis;

21. Qualified medical child support order procedure (or a statement indication where a participant can obtain a copy of a procedure) at no charge;

22. Statement of ERISA Rights;

23. Notice of Rights under the Newborn's and Mother's Health Protection Act;

24. Women’s Health and Cancer Rights Act Notice;

25. Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice;

26. Family Medical Leave Act (FMLA) Notice;

27. ERISA Claims and Appeals Procedure;

28. HIPAA Pre-Existing Condition Disclosure; and

29. HIPAA Special Enrollment Rights Notice.

C. We Pay Our Health Insurance Company Hundreds of Thousands of Dollars Each Year – Doesn't the health insurer make sure we are in compliance with ERISA?

1. The obligation to comply with the ERISA disclosure requirements and the corresponding liability belongs to the employer. Third parties, including insurance companies, health maintenance organizations and insurance consultants are not eager to share in this liability.

a. Section 10 of the Blue Cross Blue Shield of Michigan Group Enrollment and Coverage Agreement imposes on the group (the employer) the responsibilities for complying with ERISA, preparing and distributing the SPD, and advising all eligible employees of the benefits available and of any changes in benefits, the termination of coverage and the COBRA rights of the employees.

i. Blue Cross Blue Shield "Your Benefits Guide" does not meet the SPD requirements set out above.

ii. Some insurance consultants are assisting employers with SPDs for clients. These documents should be read carefully before distributing them to the employees.

## IV. PARTICIPANT DISCLOSURES

Section 102 of ERISA provides that a SPD of any employee pension plan and welfare plan must be furnished to participants and beneficiaries.

A. The SPD must include certain required information, must be written in a manner calculated to be understood by the average plan participant, and must be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.

Time of Distribution of SPD. New plan participants must receive a SPD within 90 days of first becoming eligible to participate, or if earlier, when first receiving benefits. If no changes are made to a plan, a new SPD must be provided every 10 years. If changes are made to the plan, a new document must be provided once every 5 years. Since employers change their welfare plans on a frequent basis, especially their health care plans, most employers will need to reissue the SPD every 5 years.

B. A summary of any material modification in the terms of the plan ("SMM") and any change in the information required to be included in the SPD must be written in a manner calculated to be understood by the average plan participant.

1. Time of Distribution of SMM. A SMM must be provided within 210 days after close of the plan year in which a change is effective.

2. Special Rule for Health Care Plans. If the material modification is to the health plan and the change is a reduction in covered benefits, the SMM must be distributed within 60 days of the adoption of the change. ERISA 104(b)(1).

## V. EMPLOYEE NOTIFICATION REQUIREMENTS

A. Health Care Notifications.

1. Summary of Benefits and Coverage.

The ACA mandated a new plan document called a Summary of Benefits and Coverage ("SBC"). Distribution of the SBC was required effective as of the first enrollment period beginning on or after September 23, 2012, and includes strict timeframes for the generation and distribution of the SBC — penalties apply for noncompliance.

On April 20, 2016, the Centers for Medicare and Medicaid Services (CMS) posted the final 2017 SBC template and sample completed SBC, along with group plan SBC instructions and an updated uniform glossary of health coverage and medical terms, now expanded by two pages.

Non-compliance with SBC regulations can result in a civil penalty of up to $100 per day per affected individual, an excise tax of $100 per day per affected individual, and fines of up to $1,000 per affected individual for willful violations.

a. Plans Covered. Government regulations provide that the SBC requirements apply to the following types of plans:

    i. Self-funded and insured medical plans.

    ii. Individual plans.

    iii. Limited benefit plans.

    iv. Student health insurance.

    v. Expatriate plans (U.S.-based benefits only).

    vi. Certain other plan types (e.g., HRAs, pharmacy and EAP if considered a group health plan).

The purpose of the SBC is to give eligible employees and beneficiaries information about a health insurance plan's benefits in "plain language," so they can make appropriate purchasing, enrollment and coverage decisions. All customers and insurers must use the SBC document format prescribed by the final regulations.

b. Who needs to provide the SBC?

All group health plans and health insurance issuers are required to provide a SBC. The requirement also applies to grandfathered health plans.

Responsibility for the preparation of the SBC depends on the nature of the plan. For self-insured group health plans, the plan (including the plan administrator) will be responsible for providing a SBC.

For fully-insured plans, both the insurer and the plan are jointly responsible. Generally, SBCs will be drafted by insurers and third-party administrators. The plan or insurer is not liable for enforcement if they have an arrangement with a TPA, they monitor the TPA, and they take action in the event of a violation.

The rules also apply to health reimbursement arrangements. However, if the health reimbursement arrangement is coordinated with another major medical plan, two separate SBCs will not be required.

The SBC requirements will also not apply to stand-alone retiree health plans.

c. When must SBCs be provided?

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012.

For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

The SBC is now part of the annual enrollment processes going forward.

There are basically six circumstances in which the document and the glossary will need to be provided:

i. At enrollment (i.e., initial enrollment) - with any written enrollment application materials the plan provides. If no such materials are provided, then no later than the first date the participant is eligible to enroll himself or any beneficiary in coverage.

ii. If there are changes to the SBC - no later than the first day of coverage.

iii. HIPAA special enrollees - no later than 90 days following enrollment. This time period is

coordinated with the requirement for providing the group health plan SPD.

iv. Early delivery required upon enrollee's request.

v. Upon renewal (i.e., annual enrollment) - if applicable, only for those benefit options in which the participant or beneficiary is enrolled, by either the date the written renewal application materials are distributed to the plan sponsor or, in the case of automatic renewal, no later than 30 days prior to the first day of the new plan year.

A participant or beneficiary can also request a SBC during renewal for an option in which they are not enrolled.

vi. Upon request – no later than seven business days.

d. What if plan coverage is materially modified (change to coverage that would be considered by the average plan participant to be an important change)?

i. ERISA requires participant notice to be provided within 60 days after a material reduction in benefits. Notice must be provided within 210 days after adoption of any other amendment.

ii. The SBC requirements impose an advance notice of material modifications if the material modification to the plan affects SBC content, and the modification occurs other than in connection with renewal (new enrollment period).

iii. The timing of the notice depends upon the effective date of the material modification. If a material modification is effective as of the first day of the plan year, the SBC to be provided in connection with the open enrollment preceding the effective date must reflect the modification.

iv. If a material modification is effective during the plan year, the notice of the material modification (or updated SBC) must be distributed at least 60 days before the change takes effect.

2. Grandfather Notice.

Summary of Grandfather Rules.

Group health plans that were in existence as of March 23, 2010 that meet the new grandfathering rules do not need to comply with many of the new health insurance reforms. These health plans are referred to as "grandfathered plans" under the HCA. This protection remains even when new employees or family members are added to the health plan.

a. Most health plans will lose the grandfather status and will be subject to the full rules of the HCA.

b. Disclosure Requirements. In order to maintain grandfather status, a plan or health insurance coverage must include a statement in any plan materials provided to participants that the plan believes it is a grandfathered health plan and must provide contact information for questions (and complaints). This required disclosure is required to be provided for each plan year following the effective date of the ACA (March 23, 2010).

**Most materials from insurance companies and insurance agents for fully-insured plans do not include this required language**.

c. Model Grandfather Notice. The DOL has provided the following model grandfather notice that can be used, as modified, for compliance with the ACA employer-sponsored health plans:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

d. Substantiation Requirements. For as long as a plan or insurance carrier takes the position that the plan or

coverage is grandfathered, the following records must be maintained:

i. Records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010; and

ii. Any documents necessary to support the status as a grandfathered plan (for example, a copy of a legally binding contract in effect on March 23, 2010).

These documents must be made available for examination by participants, beneficiaries, individual policy subscribers and federal agency officials.

e. Likelihood of Maintaining Grandfather Status. The Preamble to the Grandfather Regulations indicates that the government expects up to 80% of small plans and up to 64% of large plans to lose their grandfathered status. Due to the loss of flexibility in benefit design and well as mandates by insurance companies for fully insured plans, these percentages will likely be much higher.

f. U.S. Department of Labor ("DOL") Health Care Investigations. We have assisted a number of clients over the past few years with DOL health care investigations. The level of documentation that must be provided to the DOL is extensive.

The level of scrutiny and documentation required is magnified if the plan sponsor is claiming grandfather status.

3. 60 Day Advance Notice. The ACA requires plans and issuers to provide at least 60 days' advance notice of any material modification in plan terms or coverage that are not described in the most recent SBC. The DOL regulations offer additional guidance on when plans and issuers must provide the 60-day advance notice to enrollees.

   a. The regulations state that plans and issuers are required to issue the 60-day advance notice when:

      i. A material modification is made that would affect the content of the SBC;

      ii. The change is not already included in the most recently provided SBC; and

      iii. The change is a mid-plan year change (that is, it does not occur in connection with a renewal of coverage).

***<u>Note</u>: Under the regulations, plans and issuers must provide the SBC before the beginning of each plan year. Changes that occur in connection with a new plan year should be described in an updated SBC provided before the beginning of the plan year.**

When a plan timely provides the 60-day advance notice in connection with a material modification, the proposed regulations state that the plan will also satisfy ERISA's requirement to provide a SMM.

   b. Guidance on Material Modifications. The regulations describe a "material modification" as any change to a plan's coverage that independently, or in connection with other changes taking place at the same time, would be

considered by the average plan participant to be an important change in covered benefits or other terms of coverage.

A material modification may include:

i. An enhancement in covered benefits or services or other more generous plan or policy terms (for example, reduced cost-sharing or coverage of previously excluded benefits); or

ii. A reduction in covered services or benefits or more strict requirements for receiving benefits (for example, a new referral requirement or increased premiums or cost-sharing).

4. Insurance Exchange.

General Information. The ACA amended the Fair Labor Standards Act ("FLSA") to require that employers provide all new hires and current employees with a written notice about the federal health insurance Marketplace and some of the consequences if an employee decides to purchase a qualified health plan through the Marketplace in lieu of employer-sponsored coverage.

This new disclosure requirement is generally effective for employers beginning on March 1, 2013. Employees hired on or after the effective date must be provided the Notice of Exchange at the time of hiring. Employees employed on the effective date must be provided the Notice of Exchange no later than the effective date (i.e., no later than March 1, 2013).

Regulations implementing the Notice of Exchange requirement will be issued by the Secretary of Labor.

## VI. DISCLOSURE THROUGH ELECTRONIC MEDIA

The DOL regulations provide that the administrator of an employee benefit plan furnishing documents through electronic media is deemed to satisfy its disclosure requirements if the following apply:

A. The administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents:

1. Results in actual receipt of transmitted information (by using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information);

2. Protects the confidentiality of personal information relating to the individual's accounts and benefits (incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

3. Notice is provided to each participant, beneficiary or other individual, in electronic or non-electronic form, at the time a document is furnished electronically, that informs the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes changes in the benefits provided by your plan) and the right to request and obtain a paper version of such documents; and

4. Upon request, the participant, beneficiary or other individual is furnished a paper version of the electronically furnished documents.

B. Participants Who May Receive Electronic Disclosure.

1. Employees with work-related computer access. ERISA disclosures may be delivered electronically to employees that have the ability to effectively access documents furnished in electronic form at any location where the employee is reasonably expected to perform his or her duties, and such employees who have such access to the plan sponsor's electronic information system is an intricate part of such duties.

It should be noted that merely providing employees access to a computer in a common area is not a permissible means by which to deliver documents required to be furnished to plan participant.

2. For beneficiaries and other plan participants who do not have work-related computer access, electronic distribution may not be provided without the consent of such participant. The consent may be provided in either electronic or paper form. The consent must include the clear and conspicuous statement that explains:

a. The types of documents to which the consent will apply;

b. That the consent can be withdrawn at any time without charge;

c. The procedures for withdrawing consent and for updating the participant's, beneficiary's or other

individual's address for receipt of electronically furnished documents or other information; and

d. The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge;

## VII. FILING REQUIREMENTS FOR HEALTH AND WELFARE BENEFIT PLANS

A. General Information. U.S. Department of Labor ("DOL") regulations require an employer that sponsors certain health and welfare benefit plans covering 100 or more employees to file a Form 5500 for each plan.

Note: The failure to timely file the Form 5500 can cause the imposition of penalties of up to $1,100.00 for each day the filing is late.

B. Welfare Benefit Plans. A welfare benefit plan is defined by the DOL as:

Any plan providing medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services. 29 CFR §2510.3-1(a)(2).

Basically, the employee benefits that most businesses have that are welfare benefits plans are:

1. Health insurance benefits;

2. Dental insurance benefits;

3. Vision benefits;

4. Short-term disability benefits;

5. Long-term disability benefits;

6. Life insurance; and

7. Accidental death & dismemberment.

C. Annual Reporting Requirements.

1. General Requirements.

Plan administrators are generally required to file an annual report for each plan subject to Title I of ERISA. Plan administrators satisfy this filing requirement by filing the appropriate Form 5500 with the DOL's Employee Benefits Security Administration. There are exceptions to this general rule for certain welfare benefit plans that are unfunded or funded solely with insurance and have fewer than 100 participants at the beginning of the plan year.

2. Timing.

A plan's annual report must be filed for each plan year by the last day of the seventh month after the close of the plan's plan year. An extension of up to two and one-half months may be obtained by filing a request (Form 5558) with the DOL before the expiration of the seven-month period.

3. Exception for Small Welfare Plans.

Annual reports for unfunded welfare plans with fewer than 100 participants (determined as of the beginning of the plan year) are not required, provided that one of the following conditions is met:

a. Benefits under the plans are paid only from the general assets of the employer;

b. Benefits are provided exclusively through insurance policies the premiums for which are paid directly by the employer or employee organization from its general assets or from its general assets together with contributions from employees; or

c. Benefits are provided through a combination of insurance and the general assets of the employer or employee organization.

4. Sanctions for Failure to File.

The DOL may assess a civil penalty of up to $1,100 per day for failure to file an annual report. In practice, the DOL assesses penalties against non-filers of up to $300 per day until a complete annual return is filed. In addition, the DOL takes the position that it is not subject to a statute of limitations with respect to an unfiled annual report. To mitigate the penalties described in this section, a plan administrator that has not timely filed a Form 5500 may file such report under the DOL's Delinquent Filer Voluntary Compliance ("DFVC") program, which is further described below.

5. Use of a Wrap Plan to Minimize the Number of Forms 5500.

As opposed to filing a separate Form 5500 for each welfare plan that is subject to the reporting requirements, the plan sponsor can establish a "wrap" welfare plan. To create a single plan, the company would establish a plan that incorporates the various benefits or insurance policies into one comprehensive

plan document. This would allow the filing of a single Form 5500 going forward.

D. Delinquent Filer Voluntary Compliance ("DFVC") Program.

The Delinquent Filer Voluntary Compliance (DFVC) Program is designed to encourage voluntary compliance with the annual reporting requirements under ERISA. The DFVC Program gives delinquent plan administrators a way to avoid potentially higher civil penalty assessments by satisfying the program's requirements and voluntarily paying a reduced penalty amount.

1. Program Eligibility.

Eligibility for the DFVC Program is limited to plan administrators with filing obligations under Title I of ERISA who comply with the provisions of the program and who have not been notified in writing by the DOL of a failure to file a timely annual report under Title I of ERISA. For example, Form 5500-EZ filers are not eligible to participate in the DFVC Program because such plans are not subject to Title I of ERISA.

2 Program Criteria.

Participation in the DFVC Program is a two-part process. First, file with the Employee Benefit Security Administration ("EBSA") a complete Form 5500 Series Annual Return/Report, including all schedules and attachments, for each year relief is requested. To ensure proper processing, box "D" on the 5500 must be marked and a statement labeled "DFVC Program" must be attached. Special simplified rules apply to "top hat" plans and apprenticeship and training plans. Second, submit to

the DFVC Program a copy of the 5500, without the schedules and attachments, and the applicable penalty amount. The plan administrator is personally liable for the applicable penalty amount, and, therefore, amounts paid under the DFVC Program cannot not be paid from the assets of an employee benefit plan.

3. Penalty Structure.

Per day penalty. The basic penalty under the program is $10 per day for delinquent filings.

“Per filing” cap. The maximum penalty for a single late annual report has been reduced from $2,000 to $750 for a small plan (generally a plan with fewer than 100 participants at the beginning of the plan year) and from $5,000 to $2,000 for a large plan.

“Per plan” cap. The DFVC Program also includes a “per plan” cap. This cap is designed to encourage reporting compliance by plan administrators who have failed to file an annual report for a plan for multiple years. The “per plan” cap limits the penalty to $1,500 for a small plan and $4,000 for a large plan regardless of the number of late annual reports filed for the plan at the same time. There is no “per administrator” or “per sponsor” cap. If the same person is the administrator or sponsor of several plans required to file annual reports under Title I of ERISA, the maximum applicable penalty amounts would apply for each plan.

Small plans sponsored by certain tax-exempt organizations. A special “per plan” cap of $750 applies to a small plan sponsored by an organization that is tax-exempt under Internal

Revenue Code §501(c)(3). The $750 limitation applies regardless of the number of late annual reports filed for the plan at the same time. It is not available, however, if, as of the date the plan files under the DFVC Program, there is a delinquent annual report for a plan year during which the plan was a large plan.

"Top hat" plans and apprenticeship and training plans. The penalty amount for "top hat" plans and apprenticeship and training plans is $750.

4. Program Participation Procedures.

The procedures governing participation in the program are intended to make the program easy to use.

Plan administrators may use the Form 5500 for the year relief is sought or the most current form available at the time of participation. This option allows administrators to choose the form that is most efficient and least burdensome for their circumstances.

5. IRS Participation**.**

Although the DFVC Program does not cover late filing penalties under the Internal Revenue Code, the Internal Revenue Service has agreed to provide certain penalty relief for delinquent Form 5500s filed for Title I plans where the conditions of the DFVC Program have been satisfied.

6. Notification by the DOL Prior to Filing the Form 5500.

If the DOL determines that a Form 5500 filing has not been made or that the filing is incomplete, a Notice of Rejection will

be sent to the plan administrator. The following is what transpired in a recent case which we settled with the DOL.

a. Notice of Rejection. A Notice of Rejection notifies the plan administrator of a problem with the Form 5500 filing. A revised filing must be made within 45 days of the Notice in order to avoid an assessment of penalties.

b. Notice of Intent to Assess a Penalty. If the problem with the Form 5500 is not corrected with the 45 day period or if the DOL rejects the correction, a Notice of Intent to Assess a Penalty is issued. A Statement of Reasonable cause must be filed 35 days from the date of the Notice.

c. Notice of Determination on Statement of Reasonable Cause. This Notice informs the plan administrator as to whether the DOL finds a basis to excuse or modify the penalty based on the information provided in the Statement of Reasonable Cause. An unfavorable response by the DOL will require the plan administrator to either accept the imposition of the penalty or request a hearing and file an Answer within 35 days from the date of the Notice of Determination.

d. Notice of Docketing. This Notice advises the parties of the docketing of the case with the Office of Administrative Law Judges and notifies the parties of the required filing within 30 days of the date of the Notice of:

    i. a short statement of the issues believed to be in dispute;

    ii. a proposed witness list;

iii. a suggestion as to a suitable location for the trial; and

iv. state the approximate number of days for the trial.

e. Stipulation for Dismissal and Order. In this case, we were able to negotiate with the attorney for the DOL a reduction of the proposed assessment of almost $90,000 down to $13,000.

f. Order Approving Stipulation for Dismissal and Order. This Order approves the negotiated settlement and concludes the case.

## VIII. IRS W-2 REPORTING

The ACA requires employers to report the cost of coverage under an employer-sponsored group health plan on the employee's Form W-2. Until further guidance is issued, this requirement will only apply to employers that issue 250 or more Forms W-2 for the prior calendar year. The controlled group rules are not currently being applied for this 250 Forms W-2 requirement.

### A. What is Required to Be Reported?

Code Section 6051(a)(14) provides that the aggregate cost of employer-sponsored health insurance coverage must be included on the Form W-2. The reported costs are generally as used for COBRA purposes for "Applicable Employer-Sponsored Coverage".

Applicable Employer-Sponsored Coverage does not include:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Stand-alone dental and vision coverage (ex. employees can choose dental and/or vision and not health coverage);

3. Coverage issued as a supplement to liability insurance;

4. Liability insurance, including general liability insurance and automobile liability insurance;

5. Workers' compensation or similar insurance;

6. Automobile medical payment insurance;

7. Credit-only insurance;

8. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

9. Coverage for specific diseases or illness (ex. cancer insurance); or

10. Hospital indemnity or other fixed indemnity insurance.

**Note**: Until further guidance is issued by the IRS, contributions to union multiemployer health plans should not be reported on the Form W-2.

Only current and former employees who are required to receive a Form W-2 for the year are to have the cost of health benefits included on the Form W-2. If you are not required to issue a Form W-2 to the individual, there is no additional reporting required.

Current guidance provides that if an employee leaves employment during the calendar year and requests the issuance of a Form W-2 within 30 days of such termination of employment which is before the end of the calendar year, no health care costs are required to be

included. An exception is in the case of a Form W-2 required to be issued after the end of the calendar year. In such case, a reasonable method relating to the cost of such coverage must be listed on the Form W-2.

B. Calculating the Cost of Coverage.

1. Insured Plans. Use the premium charged by the insurance company rate for the employee's selected coverage. The costs reported on the Form W-2 are calendar year payments and not the payments for the insurance policy year.

2. Self-Insured Plans. Use the method currently used for COBRA purposes for the employee's selected coverage, except that the reported costs must be determined on a calendar year basis. The costs reported on the Form W-2 are calendar year payments and not the payments based on the self-insured plan's fiscal year.

3. Mid-Year Employee Coverage Changes. If an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods for which such coverage is elected.