theolsongroup
Benefits Team

ERISA FAQ

ERISA Compliance for Health Plans FAQs

The Employee Retirement Income Security Act (ERISA) is a federal law that sets minimum standards for group health plans. Among other things, ERISA generally imposes five key requirements on group health plans:

- Plan Document Requirement
- Summary Plan Description Requirement
- Form 5500 Requirement
- Summary Annual Report Requirement
- Fiduciary Requirements

Plan Document Requirement

All ERISA-covered benefit plans, including group health plans and other employee benefit plans, must, by law, be administered in accordance with a written plan document. Among other things, ERISA generally requires a welfare plan document to contain the following provisions:

- **Named fiduciaries:** The document must name one or more fiduciaries that have the authority to control and manage the operation and administration of the plan.
- **Allocation of responsibilities:** The plan must include a procedure for allocating responsibilities for plan administration and operation.
- **Benefit payment:** The plan must state the basis on which benefits are paid to and from the plan.
- **Claims procedures:** The plan must have a specific procedure for processing benefit claims and appeals that complies with DOL regulations.
- **Portability, special enrollment, and nondiscrimination provisions:** The plan must describe certificates of coverage, special enrollment rights, and nondiscrimination rules.
- **Privacy of health information:** Group health plans must contain plan language protecting the medical privacy of plan participants and beneficiaries.

Many employers assume that insurance contracts for fully insured products are written plan documents. Insurance companies, however, draft their contracts to comply with state insurance laws, and, as a result, the contracts do not contain many of the ERISA-required or recommended provisions. However, employers must draft an entire plan document or create a **"wrap" plan document** to meet ERISA's requirements. A wrap plan document is designed to meet plan documentation requirements under ERISA and other federal laws and to incorporate all other welfare plans, insurance contracts, and other relevant documents into a single plan. These materials can be kept together for administrative ease.

Unless requested, the written Wrap SPD plan document does not need to be furnished to employees.

Summary Plan Description Requirement

ERISA requires the administrator of an employee benefit plan to furnish participants and beneficiaries with a summary plan description (SPD). An SPD describes the rights and benefits of the plan written in terms understood by the average plan participant. Among other information, an SPD must describe:

- Cost-sharing provisions, including premium, deductible, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible
- The extent to which preventive services are covered under the plan
- Whether, and under what circumstances, existing and new drugs are covered under the plan
- Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures
- Provisions governing the use of network providers, the composition of provider networks and whether, and under what circumstances, coverage is provided for out-of-network services
- Provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan

Many employers mistakenly assume that documents provided by an insurance company for fully insured products satisfy the SPD requirements. However, employers must draft an entire SPD or create a **"wrap" SPD** to meet ERISA's requirements. A wrap SPD is designed to meet ERISA's requirements by incorporating and supplementing documents provided by insurance companies.

SPDs must be provided to plan participants as follows:

- Within **90 days** after the employee becomes a participant in the plan.
- Within **60 days** of adopting a material reduction in covered services or benefits.
- Within **30 days** of a participants written request for an SPD.
- No later than **210 days** after the end of a plan year in which a material modification that is not a material reduction in covered services or benefits is adopted.
- Every **5 years** if changes are made to SPD information or the plan that are not material modifications or reductions in covered services or benefits.
- Every **10 years** if no changes are made to SPD information or the plan.

SPDs may be distributed electronically if the plan administrator follows the U.S. Department of Labor regulations applicable to electronic delivery of SPDs. Alternate delivery methods include periodical distributions (union or company newsletter), U.S. mail, or hand delivery to employees.

Form 5500 Requirement

ERISA generally requires group health plans to annually file a report with the U.S. Department of Labor that contains financial and other information about the plan. This filing is made via **Form 5500**, and must be filed electronically by **July 31** using either the IFILE web-based filing system or an approved vendor's software. The following group health plans are generally exempt from the Form 5500 requirement:

- Fully insured group health plans with **fewer than 100 participants** at the beginning of the plan year
- Unfunded group health plans with **fewer than 100 participants** as of the beginning of the plan year. An unfunded group health plan has its benefits paid as needed directly from the general assets of the employer that sponsors the plan.
- Group health plans sponsored by **churches**
- Group health plans sponsored by **governments**

Summary Annual Report Requirement

Employers that are required to comply with the Form 5500 requirement must also provide each plan participant with a **Summary Annual Report (SAR)**, which provides a narrative summary of the information in the Form 5500. The Summary Annual Report generally must be distributed annually **within 9 months** after the end of the plan year.

Fiduciary Requirements

ERISA also sets standards and rules governing the conduct of plan fiduciaries. In general, a "fiduciary" is any person who exercises discretionary authority or control over the management of a plan, or management or disposition of the assets of a plan. Among other things, fiduciaries must discharge their duties **solely in the interest of plan participants and beneficiaries.**