ERISA Compliance

Benefits Resource Group
This Seminar and all materials presented are the property of TASC. No part of this seminar or any of the materials provided may be reproduced or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from TASC. To the extent allowed by law, TASC intends to recoup any value lost by an unauthorized use or disclosure including the TASC profits that may have been lost or the profits made by the disclosing party.

IRS Circular 230 disclosure: To ensure compliance with requirements imposed by the IRS, we inform you that if any advice concerning one or more U.S. Federal tax issues is contained in this seminar material or is provided by a speaker at the seminar, such advice is not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code; or (ii) promoting, marketing, or recommending to another party any transaction or matter addressed herein, and you should seek advice based on your particular circumstances from an independent tax advisor.
ERISA: Employee Retirement Income Security Act

- ERISA is governed by the U.S Department of Labor and enforced by the Employee Benefits Security Administration (EBSA).
- The EBSA’s primary responsibility is to ensure the integrity and compliance of the private employee benefits plan system in the United States.
- **EBSA Mission Statement**
  - The mission of the Employee Benefits Security Administration is to assure the security of the retirement, health and other workplace related benefits of America's workers and their families. We will accomplish this mission by developing effective regulations; assisting and educating workers, Plan Sponsors, fiduciaries and service providers; **and vigorously enforcing the law.**

Why are so many Employers out of Compliance?

- Overall Lack of Awareness in Marketplace
- Carrier Documents thought to be Compliant
- Confusion due to a Complexity of the Regulations
- Prior Limited Enforcement

- However, Compliance is “Not An Option”... *It’s the Law!*
  - *Statistics are that 90-95% of Employers have at least one violation of ERISA regulations.*
ERISA Topics

- ERISA Defined
- Employers Subject to ERISA
- Definition of Welfare Benefit Plans
- Benefits Subject to ERISA
- Safe Harbor Exemptions
- Key ERISA Requirements
- Basic ERISA Rules
- Summary Plan Descriptions (SPD)
- Disclosure to Participants and Beneficiaries
- Annual 5500 Reporting
- Healthcare Reform and How it Applies to ERISA
ERISA Defined

- **Employee Retirement Income Security Act (ERISA)**
  - Federal Law Enacted in 1974
  - Title 1 is part of U.S. labor laws; governs the structure of employee benefits plans.
    - Requires detailed disclosure to covered individuals. (Applies to all Private Sector Employers regardless of size)
    - Requires detailed reporting to the government. (Plans with 100+ participants)
    - Imposes strict fiduciary code of conduct on those who sponsor and administer ERISA Plans.
    - Imposes federal mechanism for enforcing rights and duties with respect to ERISA Plans and preempts a large body of state laws.
ERISA Defined (cont’d.)

• DOL (Department of Labor)
  – Failure to comply with ERISA’s requirements can be quite costly

• Through DOL enforcement actions
  – Government Penalties for Non-Compliance
    » Case Law:
      1) $86,500 – Failure to File Complete and Accurate Form 5500
         Airport Hospitality, LTD, King of Prussia, Penn., 2010

      2) $241,000 – Failure to Provide SPD to Participant

      3) $10,780 - Failure to Provide SPD to Participant
         Kasireddy v. Bank of America Corp. Benefits Committee,

      4) $13,750 - Failure to Provide SPD to Participant
New DOL Consumer Assistance Webpage Allows Users to Submit Questions and Complaints Electronically

The DOL’s Employee Benefits Security Administration (EBSA) has created a new consumer assistance webpage (also available in Spanish) that allows users to electronically submit questions and complaints about plans. The webpage also provides access to basic information relating to health and retirement benefits plans through several links under the following:

DOL Consumer Assistance Webpage; DOL News Release 11-1627-NAT (Nov. 10, 2011)

http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html
ERISA Titles

• “Title 1” Applies to H&W benefits
• 7 Parts (5 parts apply to H&W benefits)
  – Part 1: Reporting & Disclosure
  – Part 4: Fiduciary responsibility
  – Part 5: Administration & Enforcement
  – Part 6: COBRA and additional standards for group health plans
  – Part 7: HIPAA, Newborn & Mothers Health Protection, Mental Health Parity Act, Womens’ Health and Cancer Rights Act (WHCRA)
Definition of Welfare Benefit Plan

- Welfare Benefit Plan is:
  - a Plan, fund or program
  - Established or maintained by employer
  - Established to provide welfare benefits to Participants and beneficiaries

- Examples:
  - Health, Dental and/or Vision Insurance or plans
  - Health Flexible Spending Accounts (FSAs)
  - Health Reimbursement Arrangements (HRAs)
  - Accidental Death & Dismemberment Insurance
  - Group Term Life Insurance
  - Short- and Long-Term Disability
  - Severance Insurance
  - Wellness and Employee Assistance Programs
  - Voluntary Benefits offered as pre-tax benefits under any Section
Employers Subject to ERISA

• Private-Sector Employers
  – Corporations
  – Partnerships
  – Sole Proprietorships
  – Non-Profit Organizations
    • Unless Exempt under 501a as Governmental entity
      – (listing the following nine factors applied by the courts and the DOL in
determining whether the governmental plan exception applies: whether
(a) the state or local government exercised control over the plan; (b) the
plan provides for only employer or employee contributions or for both;
(c) government employees acted as fiduciaries under the plan; (d) the
state or local government created the entity; (e) the entity is
“administered by individuals who are responsible to public officials or to
the general electorate”; (f) the state or local government exercises
authority over the entity; (g) the entity performs traditional government
functions; (h) the entity's employees are considered government
employees under federal and state employment laws; and (i) the entity is
funded by state or local government taxes or bonds.)
Key ERISA Requirements

• Plan document must exist for each Plan.
• Plan terms must be followed and strict fiduciary standards adhered to.
• Summary Plan Description (SPD) must be furnished automatically to Plan Participants.
• Summary of Material Modifications (SMM) must be furnished automatically to Plan Participants when a Plan is amended.
• Copies of certain Plan documents must be furnished to Participants and beneficiaries on written request and made available for inspection.
• IRS Form 5500 must be filed annually for each Plan (over 100 Participants).
• Summary Annual Report (summarizing IRS Form 5500 information) must be furnished automatically.
Court Awards Maximum Statutory Penalty for Failure to Timely Honor Request for SPD


A group health plan participant sued her employer in its role as plan administrator and fiduciary for failing to timely provide a current SPD upon her written request. The participant requested the SPD in 2010, and the employer provided her with a 2006 SPD, even though there had been material modifications to the plan since 2006. When the participant asked whether there were more recent SPDs, the employer did not respond, so the participant hired an attorney to intervene. In response to the attorney’s letter, the employer again provided the 2006 SPD but stated that additional information would be furnished within two weeks. The employer failed to follow through, so the participant’s attorney arranged to visit the employer’s offices to inspect the plan documents. Only then—five months after the participant’s initial request—did the employer produce a summary of material modifications detailing the changes to the plan since the 2006 SPD.

The court held that the employer violated ERISA by failing to timely provide an accurate SPD and assessed the maximum statutory penalty of $110 dollars per day for a total of $13,750. The court was compelled by the employer’s unresponsiveness and lack of an excuse, noting that ERISA does not require plan participants to hire attorneys or go to the lengths seen here to find documents containing accurate and up-to-date plan information.

**EBIA Comment:** The court dealt harshly with this employer, observing that it was not entirely clear whether the employer “ever intended to cure the deficiencies” in its initial disclosure. We suspect, however, that the employer may have been caught unprepared. The case is a good reminder to plan administrators to be diligent about preparing and distributing SPDs or SMMs when plans are amended, and to be ready, with current documents in hand, to respond within 30 days after a participant’s request.
PLAN ADMINISTRATOR MUST PAY MAXIMUM PENALTY FOR DELAY IN PROVIDING REQUESTED SPD


A medical plan participant sued her employer's benefits committee, as plan administrator, for its failure to provide a copy of the plan's SPD in response to her written requests. The employer had amended the plan to add a new coverage option effective January 1, 2009, in which the participant had enrolled. In a letter to the plan administrator, dated March 2, 2009, the participant requested a copy of the "plan document" in order to review her coverage. The plan administrator sent several documents on April 2, 2009, including a handbook that predated the new coverage option, an announcement brochure, and an enrollment brochure.

The court interpreted the participant's letter as a request for a copy of the SPD. Citing the handbook's lack of any mention of the new coverage option and the other materials' lack of specific coverage information, the court held that none of the April documents, individually or collectively, constituted the SPD. The plan administrator argued that it had 210 days after the end of the 2009 plan year to distribute an SPD that reflected the new coverage. The court strongly disagreed, distinguishing the requirement to proactively distribute an SMM or updated SPD from the separate ERISA requirement to provide certain documents (including an SPD) within 30 days after a request. The court ultimately concluded that a subsequent set of documents, sent to the participant on July 9, 2009, did contain sufficient information. However, the court chose to impose the maximum statutory penalty ($110 per day) for the period between April 3, 2009 and July 9, 2009, citing its "dismay" that the participant had to make three written requests before receiving the relevant information and even suggesting bad faith by the plan administrator in sending over 300 pages of documents that, for the most part, did not even apply to the participant's coverage. ($10,780)
November 29, 2013

VIA EMAIL
AND U.S. MAIL

Attention: Employee Benefits Plan

Crestline, Ohio 44827

RE: Employee Benefits Plan

Dear Mr. 

The Department of Labor (the “Department”) has responsibility for administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (“ERISA”). Title I establishes standards governing the operation of employee benefit plans such as the Employee Benefits Plan (the “Plan”).

This office has scheduled a review of the above captioned plan to determine compliance with the provisions of ERISA. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part: “The Secretary shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder... to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this title...”

Additionally, the Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

Pursuant to the above, this office is requesting your cooperation with the investigation of the Plan to determine compliance with provisions of ERISA. This letter confirms your appointment for January 16, 2014 at 9:00 a.m. with Investigator Scott Stieritz of this office. You are requested to have all records related to the Plan available for inspection, particularly those listed...
on the attached page. Please note that the investigator will need to interview appropriate persons regarding the Plan, including but not limited to persons with fiduciary and/or decision-making authority with respect to the Plan or working knowledge of the Plan’s operations. Should you have any questions, feel free to contact Mr. Stieritz at (859) 578-4680 extension 1022.

Sincerely,

L. Joe Rivers
Regional Director
Cincinnati Regional Office

Attachment
Documents and Information Requested

The items below should be made available for review. Unless otherwise specified, the period covered by this request is from January 1, 2013 through the present. Please provide photocopies of documents with an asterisk (*). Additional documentation and photocopies may be requested as a result of our review.

1. **Signed** Plan Documents, Adoption Agreements, Trust Agreements, Wrap documents and Amendments to Date *
2. Summary Plan Description *
3. **Signed** Forms 5500, audited Plan Financial Statements (if applicable) and all supplemental schedules for the last three years filed*
4. Summary Annual Reports for the last three years filed*
5. Minutes of any Plan or Committee meetings*
6. Financial Records, including:
   a. Trust Reports,
   b. Bank and Brokerage Account Statements
   c. Account Ledgers/Journals (Receipts and Disbursements of Plan Assets)
   d. Invoices/Records relating to Expenses and/or Fees paid from Plan Assets
   e. Checkbook registry, canceled checks and deposit slips
7. Service Provider Contracts or Letters of Engagement (Investment Manager Agreements, Third Party Administrator Contracts, Attorneys, and Accountants) *
8. Latest Fidelity Bond Policy, including all Riders and Endorsements, covering fraud and dishonesty. *
9. Latest Fiduciary Liability Insurance Policy (if applicable) *
10. Listing of all officers of the Plan Sponsor and their tenure*
11. Listing of all Plan Trustees and/or Fiduciaries and their tenure *
12. All health insurance contracts and policies including all amendments and riders covering the Plan since January 1, 2013*
13. If self-insured, all contracts for claims processing, administrative services and reinsurance*
14. Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits
26. Materials describing any wellness programs or disease management programs offered by the plan. If the program offers a reward based on an individual’s ability to meet a standard related to a health factor, the plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative.

27. If the Plan is claiming or has claimed grandfathered health plan status within the meaning of section 1251 of the Affordable Care Act, please provide the following records:
   a. A copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan.
   b. Records documenting the terms of the Plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan. This may include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010.

28. Regardless of whether the Plan is claiming grandfathered status, please provide the following records in accordance with section 715 of ERISA as added by the Affordable Care Act:
   a. In the case of a plan that provides dependent coverage, a sample of the written notice describing enrollment opportunities relating to dependent coverage of children to age 26.
   b. If the Plan has rescinded any participant’s or beneficiary’s coverage, a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage.
   c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010.

Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan.

d. If the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010.
29. If the Plan is NOT claiming grandfathered health plan status under section 1251 of the Affordable Care Act, please also provide the following records:

   a. A copy of the choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women, and a list of participants who received the disclosure notice.

   b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010.

   c. Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010.

   d. Copy of the Plan’s Internal Claim and Appeals and External Review Processes.

   e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision.

   f. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review.

30. Notices provided to participants and beneficiaries explaining their rights to continuation of coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), including a list or logs of notices issued.

31. All documents relating to the use or collection of genetic information, for any reason, with respect to the Plan.

32. For Plan years or open enrollment periods beginning on or after September 23, 2012, a copy of the Summary of Benefits and Coverage and Uniform Glossary provided to participants (if applicable).

33. All documents relating to the receipt and disposition of any medical loss ratio rebate paid by an insurer.

34. Any other documents which may explain or clarify the above items.
Basic ERISA Rules (2)

- Insured Benefits Require “Wrap Document”
  - Insurers may not have all provisions required of a Plan document
  - Supplement contracts using “Wrap Document”
    - Contains missing terms and wraps itself around insurance contract
      - Designation of Plan Administrator
      - Designation of fiduciary
      - Plan Year and Plan Number
      - Plan name
      - Designation of how many Plans maintained by Plan Sponsor
Who must be provided an SPD?
- NO small plan exception (1 employee to thousands).
- Must be furnished to Participants covered under ERISA Welfare Plan; not required for beneficiaries.
- Must be furnished to COBRA qualified beneficiaries, parent or guardian under a QMCSO and retirees.

When and How to Furnish SPDs
- Generally within 90 days after Participant first becomes covered.
- NEW Plans – within 120 days after Plan becomes subject to ERISA.
- Updated SPDs must be furnished to all covered Participants every 5 years (every 10 years for a Plan that had no changes).
- Must be furnished in a way “reasonably calculated to ensure actual receipt of the material” using method “likely to result in full distribution.”
What Kind of Document Satisfies SPD Requirement?

- Updating the SPD (Summary of Plan Description)
  - Any modification in the terms of the Plan that is “material” and any change in information required in the SPD must be reported to Plan Participants.
  - ERISA allows Plan Administrators to report such changes through a Summary of Material Modification (SMM).
    - SMM provided in same manner to same individuals as SPD.
    - Must be furnished within 210 days after the end of the Plan Year in which the modification changed.
    - However, an SMM relating to a material reduction in covered services or benefits under a group health plan must be furnished no later than 60 days after the date of the adoption of the reduction.
Annual IRS Form 5500 Reporting

- Filing Form 5500 with DOL
  - Unless exempted, ERISA Plan Administrator must report specified information each Plan Year using Form 5500.
  - Reporting obligation applies to each ERISA Plan an employer sponsors.
Annual IRS Form 5500 Reporting

• Penalties for 5500 Form Failures
  – Plan Administrator subject to penalties up to $1,100 for every day Form 5500 is missing or incomplete and can be subject to possible criminal penalties for willful failure to file
  – Penalties are cumulative;
    • Assessed separately for each missing or incomplete Form.
    • No statute of limitations.
    • DOL offers program for voluntary correction of Form 5500 filings.
IRS Form 5500 Exemptions

- Small unfunded or insured plans are completely exempt.
  - To be considered a small Plan, you must have fewer than 100 covered Participants at the beginning of the Plan Year.
  - Only Participants actually covered under Plan are counted.
  - Includes COBRA qualified beneficiaries and retirees covered in the Plan, but does not include covered spouses and dependents.

- Form 5500 exemption is available to:
  - Small unfunded Plans (benefits paid from the employer’s general assets).
  - Small insured Plans (paid through insurance policies other than stop-loss coverage); Stop Loss policies are not insurance for this purpose since they pay no benefits on behalf of employees.
  - Small combination Plans (combination of general assets and insurance).
IRS Form 5500 Exemptions (cont’d.)

- DOL Reg. §2520.104-20 also provides a complete Form 5500 reporting exemption for certain small insured welfare plans. Remaining requirements of the small insured plan exemption, specifically that:
  - benefits must be paid exclusively through insurance policies issued by qualified insurance companies or similar organizations or through qualified health maintenance organizations;
  - premiums must be paid directly by the employer from general assets or partly from Participant contributions, provided that the Participant contributions are forwarded to the insurer or HMO as soon as possible but no later than three months after being withheld or contributed; and
  - insurance refunds to which contributing Participants are entitled must be refunded within three months, and Participants must be informed, when they enter the plan, about the plan's provisions for allocating refunds.
    - Large plans need only reimburse any refunds to EE within three months to avoid filing Schedule H.
Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code
(Under sections 4980B, 4980D, 4980E, and 4980G)

Filer tax year beginning _______ and ending _______.

Number, street, and room or suite no. (If a P.O. box, see instructions)

City or town, state, and ZIP code

E Plan sponsor’s EIN

C Name of plan

F Plan year ending (MM/DD/YYYY)

D Name and address of plan sponsor

G Plan number

Part I  Tax on Failure To Satisfy Continuation Coverage Requirements Under Section 4980B

Complete a separate Part I, lines 1 through 6 for failures due to reasonable cause and not to willful neglect, and a separate Part I, lines 12 through 14, for other failures, for each qualifying event for which one or more failures to satisfy continuation coverage requirements that occurred during the reporting period (see instructions).

Section A – Failures Due to Reasonable Cause and Not to Willful Neglect

<table>
<thead>
<tr>
<th>For IRS Use Only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enter the total number of days of noncompliance in the reporting period</td>
<td></td>
</tr>
<tr>
<td>2. Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event</td>
<td></td>
</tr>
<tr>
<td>3. If you entered 2 or more on line 2, multiply line 1 by $200. Otherwise, multiply line 1 by $100</td>
<td></td>
</tr>
<tr>
<td>4. If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and then go to line 5. Otherwise, enter the amount from line 3 on line 6 and go to line 7</td>
<td></td>
</tr>
<tr>
<td>5. If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply $2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by $15,000 to the extent the violations were more than de minimis for a qualified beneficiary). If the failures were corrected before the day a notice of examination was sent, enter -0-</td>
<td></td>
</tr>
<tr>
<td>6. Enter the smaller of line 3 or line 5</td>
<td></td>
</tr>
<tr>
<td>7. If there was more than one qualifying event, add the amounts shown on line 6 of all forms, and enter the total on a single “summary” form. Otherwise, enter the amount from line 6 above</td>
<td></td>
</tr>
<tr>
<td>8. Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care</td>
<td></td>
</tr>
<tr>
<td>9. Multiply line 8 by 10% (.10)</td>
<td></td>
</tr>
<tr>
<td>10. Amount from section 4980B(c)(4)</td>
<td></td>
</tr>
<tr>
<td>11. Enter the smallest of lines 7, 9, or 10. For a third-party administrator, HMO, or insurance company, the amount you enter on this line filed for all plans you administer during the same tax year cannot exceed $2 million; reduce the amount you would otherwise enter on this line to the extent the amount for all plans would exceed this limit</td>
<td></td>
</tr>
</tbody>
</table>

Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause

|  |
|------------------|---|
| 12. Enter the total number of days of noncompliance in the reporting period |
| 13. Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event |
| 14. If you entered 2 or more on line 13, multiply line 12 by $200. Otherwise, multiply line 12 by $100 |
| 15. If there was more than one qualifying event, add the amounts shown on line 14 of all forms, and enter the total on a single “summary” form. Otherwise, enter the amount from line 14 above |

Section C – Total Tax Due Under Section 4980B

16. Add lines 11 and 15 |

For Paperwork Reduction Act Notice, see instructions.
## Part II
### Section A – Failures Due to Reasonable Cause and Not to Willful Neglect

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Enter the total number of days of noncompliance in the reporting period</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Enter the number of individuals to whom the failure applies</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>Multiply line 17 by line 18</td>
<td>19</td>
</tr>
<tr>
<td>20</td>
<td>Multiply line 19 by $100</td>
<td>20</td>
</tr>
<tr>
<td>21</td>
<td>If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and then go to line 22. Otherwise, enter the amount from line 20 on line 23 and go to line 24.</td>
<td>21</td>
</tr>
<tr>
<td>22</td>
<td>If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply $2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by $15,000 to the extent the violations were more than de minimis for a qualified beneficiary). If the failures were corrected before the day a notice of examination was sent, enter -0- here.</td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td>Enter the smaller of line 20 or line 22</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td>If there was more than one failure, add the amounts shown on line 23 of all forms, and enter the total on a single &quot;summary&quot; form. Otherwise, enter the amount from line 23 above.</td>
<td>24</td>
</tr>
<tr>
<td>25</td>
<td>Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care.</td>
<td>25</td>
</tr>
<tr>
<td>26</td>
<td>Multiply line 25 by 10% (.10).</td>
<td>26</td>
</tr>
<tr>
<td>27</td>
<td>Amount from section 4980D(c)(3)</td>
<td>27</td>
</tr>
<tr>
<td>28</td>
<td>Enter the smallest of lines 24, 26, or 27.</td>
<td>28</td>
</tr>
</tbody>
</table>

### Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>Enter the total number of days of noncompliance in the reporting period</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Enter the number of individuals to whom the failure applies</td>
<td>30</td>
</tr>
<tr>
<td>31</td>
<td>Multiply line 29 by line 30</td>
<td>31</td>
</tr>
<tr>
<td>32</td>
<td>Multiply line 31 by $100</td>
<td>32</td>
</tr>
<tr>
<td>33</td>
<td>If there was more than one failure, add the amounts shown on line 32 of all forms, and enter the total on a single &quot;summary&quot; form. Otherwise, enter the amount from line 32 above.</td>
<td>33</td>
</tr>
</tbody>
</table>

### Section C – Total Tax Due Under Section 4980D

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Add lines 28 and 33</td>
<td>127</td>
</tr>
</tbody>
</table>

## Part III
### Tax on Failure To Make Comparable Archer MSA Contributions Under Section 4980E

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Aggregate amount contributed to Archer MSAs of employees within calendar year.</td>
<td>35</td>
</tr>
<tr>
<td>36</td>
<td>Total tax due under section 4980E. Multiply line 35 by 35% (.35).</td>
<td>128</td>
</tr>
</tbody>
</table>

## Part IV
### Tax on Failure To Make Comparable HSA Contributions Under Section 4980G

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>Aggregate amount contributed to HSAs of employees within calendar year.</td>
<td>37</td>
</tr>
<tr>
<td>38</td>
<td>Total tax due under section 4980G. Multiply line 37 by 35% (.35).</td>
<td>137</td>
</tr>
</tbody>
</table>

## Part V
### Tax Due or Overpayment

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>Add lines 16, 34, 36, and 38.</td>
<td>39</td>
</tr>
<tr>
<td>40</td>
<td>Enter amount of tax paid with Form 7004</td>
<td>40</td>
</tr>
<tr>
<td>41</td>
<td>Tax due. Subtract line 40 from line 39. If less than zero, enter -0-, and go to line 42. If the result is greater than zero, enter here and attach a check or money order payable to “United States Treasury.” Write your name, identifying number, plan number, and “Form 8928” on your payment.</td>
<td>41</td>
</tr>
<tr>
<td>42</td>
<td>Overpayment. Subtract line 39 from line 40.</td>
<td>42</td>
</tr>
</tbody>
</table>

## Sign Here

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

[Signature]

[Telephone number]
[Date]

[Preparer’s signature]
[Preparer’s name]
[Preparer’s EIN]

[Print/Type preparer’s name]
[Preparer’s address]
[Phone no.]
Medical Loss Ratio (MLR)

- The Patient Protection & Affordable Care Act (PPACA) requires that insurers spend a certain percentage of premium dollars on healthcare-related costs
  - 85% for large group plans and 80% for small and individual market.
- If an insurer does not meet the MLR standard, they are required to provide an annual rebate to each enrollee.
  - Payment of the first rebates was required by August 1, 2012.
  - Under the final rule adopted in December, 2011 insurers must provide the rebate to the policyholder, which is typically the employer.
- The Department of Labor (DOL) has determined the rebates are Plan assets.
- If the Plan Document/SPD is silent, 100% of the rebate falls under Plan assets.
- By adding the terms via the ERISA Plan Document Amendment/Summary of Material Modification (SMM), the employer can retain a prorated portion of the rebate equal to the percent of premium the employer paid.
- Only the percent of the rebate equal to the percent of premium the Participant paid is considered a Plan assets and must be used exclusively for the benefit of the Plan.
Healthcare Reform’s Impact on Your Benefits Plans
Healthcare Reform and ERISA SBC

• The PPACA adds a new twist to the ERISA SPD requirements by requiring insurers of insured health plans and Plan Administrators of self-insured health plans to provide applicants and enrollees a "summary of benefits and coverage" (SBC).

• **Modified** in final regulations (published 2-14-2012): Can be a “Stand alone” document or as combination with other summary materials;
  – In SPD: must be prominently displayed at beginning of the document; and in accordance with timing requirements for disclosure.

• **Applicability Date**: the first day of the first Plan year that begins on or after September 23, 2012.
Healthcare Reform and ERISA SBC (cont’d.)

- **Penalties**
  - HHS: $1,000 may apply for each willful failure to provide a summary.
  - IRS can impose $100 per day per individual affected.
  - DOL: can impose civil and criminal penalties.
Affordable Care Act (ACA) 2014 Provisions

- Coverage to be offered through a Health Insurance Marketplace (aka, the Exchange)
- Premium tax credits to assist individuals in purchasing such coverage
- Employer notice to employees of coverage options available through the Exchange

For more details please visit: [http://www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/)
Health Insurance Marketplace/Exchange

- Competitive, private market for individuals to access affordable healthcare coverage
- Open enrollment began October 1, 2013
- Access begins January 1, 2014
Notice of Exchange - Employer Requirements

• Employers must prepare written notice of coverage options through the Exchange

• Employers must have distributed Exchange Notice to all current employees (part- and full-time) by October 1, 2013

• Employers must distribute Exchange Notice to new employees hired after October 1, 2013 within 14 days from date of hire

• Delivery of Notice:
  – Must be automatically provided, free of charge
  – May be delivered via first class mail or electronically, provided the requirements of the DOL's electronic disclosure safe harbor are met

Do you know the DOL’s safe harbor requirements?
Employers Subject to Notice Requirement

• Employers under FLSA:
  – Employers that employ one or more employees who are engaged in, or produce goods for, interstate commerce
  – Most firms with an annual dollar volume of sales or receipts in the amount of $500,000 or more

• The FLSA also specifically covers the following entities:
  – hospitals; institutions primarily engaged in the care of the sick, the aged, mentally ill, or disabled who reside on the premises;
  – schools for children who are mentally or physically disabled or gifted; preschools, elementary and secondary schools, and institutions of higher education; and
  – federal, state and local government agencies

Exchange Notice - Required Content

• Exchange Notice must include the following content:
  – The existence of an Exchange, with a description of the services provided by the Exchange, and how to contact the Exchange to request assistance
  – Information regarding eligibility for a premium tax credit or premium through the Exchange if the employer plan's share of the total cost of benefits under the plan is less than 60%
  – Information notifying employees:
    • (a) if they purchase a qualified health plan through the Exchange, they may lose the employer contribution toward the cost of employer-provided coverage; and
    • (b) all or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes
Model Notice

Serves as a guideline template for employers to create their Exchange Notice.

Two Forms Available:
(1) Employers offering health coverage
(2) Employers not offering health coverage
Model Notice - SPD Referral

- Bottom of page 1 of Model Notice to employees:

“For more information about your coverage offered by your employer, please check your Summary Plan Description or contact_____________."

This statement refers to an ERISA Summary Plan Description (SPD)

Are you prepared to provide every employee with an ERISA SPD if requested?
Failure to Provide ERISA SPD

• Employers have only 30 days to provide an SPD to an employee upon written request
• After 30 days, the employee can collect $110/day from the employer until SPD is received

Can you afford to pay $110 per day to each employee requesting an SPD?
Key Points to Remember

- Employers must have distributed the Exchange Notice to all active employees by 10/01/2013
- Employers must have an ERISA SPD in place
- An insurance carrier’s “Certificate of Coverage” is not an ERISA SPD (a common misconception)
- Employers have only 30 days to provide an SPD to an employee upon written request without penalty
- Employers must maintain ERISA compliance throughout the Plan Year
- The DOL has bolstered their ERISA enforcement efforts with steep increases in auditing activity

Are you prepared for a DOL audit?
Reporting and Excise Taxes for Health Plan Noncompliance

- Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code
  - Historically, the IRS has not been very active in examining health plans for compliance.
  - IRS final regulations require employers to self-report violations of these rules and pay related excise taxes.
  - Must report health plan compliance failures annually on IRS Form 8928.
Reporting and Excise Taxes for Health Plan Noncompliance (cont’d.)

– Violations of COBRA, HIPAA and the genetic anti-discrimination law (GINA) can result in excise taxes of $100 per day per individual affected.

  • Federal healthcare continuation requirements (COBRA).
  • Health plan portability and nondiscrimination requirements (HIPAA).
  • Mental health parity (Mental Health Parity & Addiction Equity Act, or MHPAEA).
  • Minimum hospital stays for newborns and mothers (Newborns’ & Mothers’ Health Protection Act).
  • Women’s Health & Cancer Right Act (WHCRA).
  • Genetic nondiscrimination requirements (Genetic Information Nondiscrimination Act, or GINA).
  • Coverage of dependent students on medically necessary leaves of absence (Michelle’s Law).
  • Health savings account (HSA) and Archer medical savings account (Archer MSA) contribution comparability requirements.
How Can the Excise Tax Be Avoided?

- No excise tax is imposed during the period when the employer did not know, or exercising reasonable diligence would not have known, that a Plan failure existed.

- Once the Plan failure is discovered, no excise tax will be imposed if the failure was attributable to reasonable cause and the failure is “corrected.”
  - “Corrected” means fixing the failure retroactively (to the extent possible) within 30 days of the first date on which the error was known or should have been known, and placing any affected individual in at least the same financial position as he or she would have been had the failure not occurred.
  - IRS Form 8928 and its instructions contemplate clearly that Plan failures must be reported even when they were corrected fully in a timely fashion, such that no excise tax is due.
  - To avoid excise taxes under this new self-reporting regime, employers and administrators of group health plans should have procedures and processes in place that are designed reasonably to ensure compliance.
Compliance Solutions
Why ERISAEdge?

- Administrative Service
- Document and Form Preparation
- Mega-Wrap or Wrap Document
- Plan Document and SPD
- IRS Form 5500 and Schedules
- Free PCORI Services
- Model Exchange Notice with complete instructions for preparation
- Summary Material Modification
- Summary Annual Report
- ERISA and Healthcare Reform Notices
Why ERISAEdge? (cont’d.)

- Record-Keeping Assistance
  - Assistance with document retention requirements
  - Guidance on document access and employee rights
- Technical and Customer Service Support
- Guaranteed Compliance
  - Monitor legislative and regulatory changes related to ERISA
  - Establish a Hold Harmless Agreement
Service Features

• All-inclusive fees – no additional charges or hidden fees.
• No ties to any insurance or other employee benefits plan.
• ERISAEdge Administrative Manual.
• Dedicated ERISA Representative.
• Hold Harmless Agreement
• For additional Information please visit:
  – https://www.tasconline.com/compliance-seminar-materials
Thank You!