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May 2023

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Plan Sponsors Must Document Benefit Claim Procedures, Federal Appeals Court Says

By Claire Martin

In *Yates v. Symetra Life Insurance Company*, No. 22-1092 (8th Cir. Feb. 23, 2023), the Eighth Circuit Court of Appeals ("Eighth Circuit" or the "Court") reviewed an appeal of a district court ruling, which held that a plan participant was not required to her exhaust administrative remedies before contesting a benefit denial in court. The question before the Eighth Circuit was whether a participant was required to exhaust administrative remedies prior to filing a lawsuit when the Employee Retirement Income Security Act ("ERISA") plan's written document did not contain any appeal or review procedures. As detailed herein, the Eighth Circuit affirmed the district court's decision that a participant was not required to exhaust administrative remedies in this situation.

The plaintiff in this case was a participant in her employer's welfare benefits plan (the "Plan"), which included and accidental death and dismemberment ("AD&D") policy subject to ERISA. Following the death of her husband (who was covered under the Plan as a dependent) due to a heroin overdose, the plaintiff filed a claim for certain benefits under the Plan, including AD&D benefits. Symetra Life Insurance Company ("Symetra"), the issuer, denied the plaintiff's claim as the policy excluded losses caused by "intentionally self-inflicted injuries." Symetra reasoned that the death was not accidental because the underlying use of heroin was an intentional act.

In its claim denial, Symetra explained that the plaintiff could request a review of the denial within sixty (60) days and file a civil lawsuit following the internal appeal process. The Plan documents, however, did not include any information on the review and appeal process for claim denials.

The plaintiff did not request review of the denial and moved forward with filing a civil lawsuit to recover benefits under ERISA. Symetra sought to have the case dismissed on the basis that the plaintiff failed to exhaust her administrative remedies under the Plan before filing a civil lawsuit (which

courts have regularly found to be indirectly required under ERISA Section 503, which provides that plans must afford participants a full and fair review of a claim denial).

The district court denied Symetra's motion to dismiss the case on summary judgment, and instead granted summary judgment in favor of the plaintiff. The district court ultimately determined that the plaintiff was not required to exhaust administrative remedies before filing suit because the Plan document did not describe any review or appeals procedures for her to exhaust.

On appeal, the Eighth Circuit affirmed the district court's decision and agreed that the plaintiff did not first have to exhaust administrative remedies when the Plan documents lacked any mention of the review process or exhaustion requirement. In reaching this decision, the Eighth Circuit relied on cases within, and outside of, the circuit wherein the exhaustion requirement was enforced *only* when such administrative remedies (*i.e.*, review and appeal procedures) were expressly set forth in the written plan documents. The Court also emphasized its long-standing recognition of the importance and primacy of the plan document when reviewing ERISA benefit claims. The Court explained that one of the primary purposes of ERISA's written document requirement is so that participants can learn of and review their rights and obligations under the plan at any time; however, per the Court, they cannot reasonably be expected to know of such obligations, and thus, exhaust them, if such obligations are not disclosed in the documents. Accordingly, per the Eighth Circuit, in order for a plan administrator to avail itself to the exhaustion requirement (and bar claims for relief), the underlying plan document must describe the applicable claims and appeal procedures in order for a participant to have the opportunity to exhaust the Plan's administrative remedies. Last, the Court relied on the applicable Department of Labor regulations, which (i) require that a plan's claim procedures be set forth in the plan's summary plan description, and (ii) provide that a participant is deemed to have exhausted his or her administrative remedies (and can immediately file a lawsuit) when such procedures are not included therein.

This case serves as an important reminder for ERISA benefit plan administrators regarding their plan documents and compliance efforts. Plan administrators should review their ERISA plan documents, specifically their summary plan descriptions, to ensure they include their plan's claim procedures, including information on how to request a review or appeal of any claim denial. The failure to include the claims procedures in the plan documents can prevent plan administrators from being able to raise the exhaustion defense in response to a lawsuit over denied claims.

To Arbitrate or Not to Arbitrate: The Inclusion of Arbitration Procedures in Welfare Plans

By Kate Belyayeva

The Employee Retirement Income Security Act of 1974 ("ERISA") requires all private sector welfare plans to establish procedures to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review of the decision denying the claim." Many welfare plans provide for arbitration of benefit-claim disputes, some of which do so through the corresponding collective bargaining agreements ("CBAs"). Plans have the discretion as to whether arbitration is optional to the claim or the claimant (or both) or if it is required for all claims. This article provides a brief overview of the general enforceability of arbitration clauses for claims under ERISA.

Arbitration is generally considered a less expensive and faster method of claim resolution than litigation; however, repeated onerous arbitration of individual claims involving similar issues may be less cost-efficient than anticipated unless it is accompanied by a class action waiver.

From a broader policy perspective, mandatory class action arbitration may be viewed as restricting fiduciary accountability and participants' rights to the relief contemplated by ERISA. The legality of whether ERISA fiduciary breach claims may be subjected to mandatory individual and class action arbitration has been a hot topic in the welfare plan arena. In light of the inconsistency of the lower court decisions on this issue, formal guidance on the arbitrability of fiduciary breach claims is welcome.

The Federal Arbitration Act

Federal law generally cultivates a friendly environment for arbitration agreements. In 1925, Congress enacted the Federal Arbitration Act ("FAA") to reverse "longstanding judicial hostility to arbitration agreements" and "evince[] a national policy favoring arbitration" to encourage a more efficient way of claims resolution in comparison to traditional litigation. In particular, Section 2 of the FAA, which provides for arbitration agreements to be valid and irrevocable, has been consistently enforced due to "[the] liberal federal policy" favoring mandatory arbitration. There are three notable exceptions to the enforcement of the FAA: (1) where there is a "contrary congressional intent"; (2) the "savings clause" based on generally applicable contract principles; and (3) the "effective vindication" exception to prevent a prospective waiver of rights.

State Law

Although some attempts by states to limit mandatory arbitration of employment discrimination claims have been noted, it is not clear whether the FAA permits state action on this matter. However, the FAA does reflect that the fundamental principle of arbitration is contract law. Nevertheless, ERISA will likely preclude states from weighing in on this issue due to preemption by ERISA § 514(a).

Arbitration Under ERISA

Even though ERISA was enacted after the FAA, ERISA itself does not expressly displace any federal law. While not necessarily expected, Congress may pitch in on the matter by passing legislation expressly aimed at limiting mandatory arbitration of welfare plan disputes through the exclusion of ERISA claims from the scope of the FAA.

Until such a time, ERISA § 502(a)(1)(B) provides that a plan participant or beneficiary may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Thus, there is at least an argument that mandatory arbitration is inconsistent with ERISA due to the express grant of a right for ERISA claims to be decided in court. Notably, this section of the statute itself does not mention arbitration as a means to resolve benefit disputes. Further, the "effective vindication exception" to the FAA (described above) may preclude the enforcement of arbitration provisions in ERISA plans under the FAA since participants are effectively permitted to vindicate their statutory rights under ERISA. The U.S. Supreme Court has not formally spoken on whether this exception applies in the context of ERISA.

It is also important to note that the Senate version of ERISA presupposed arbitration but omitted this provision in the final bill. Further, the conference report on ERISA states that claims brought by participants or beneficiaries in state and federal courts "[are to] be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor Management Relations Act of 1947" ("LMRA"). Section 301 of the LMRA has been interpreted by multiple circuit courts as to support the dismissal of a suit for breach of a CBA if the plaintiff has not exhausted the arbitration remedies in the contract or if a final and binding arbitration award has been rendered.

ERISA Claim Review Procedures

As stated above, ERISA § 503 requires every employee benefit plan to adopt reasonable claims procedures. In connection therewith, the Department of Labor ("DOL") has issued regulations effectively endorsing the use of arbitration process to resolve ERISA benefit disputes. Overall, ERISA permits arbitration of benefit claims, including claims procedures for health benefits, if such arbitration is conducted as one of the two appeals and complies with the general requirements of the claims review regulations. For example, 29 CFR § 2560.503-1(c)(4)(ii) provides that a participant shall not be precluded from challenging the arbitrator's decision through the pursuit of an ERISA § 502(a) claim.

The courts differ in their opinions on whether mandatory arbitration for claim review procedures is permissible. Notably, the DOL regulations on claims procedures do not discuss the enforceability of voluntary arbitration agreements negotiated outside the plan.

ERISA Statutory Claims

Multiple circuit courts have expressly enforced arbitration agreement as to the legal rights of participants to bring ERISA statutory claims. For instance, the Ninth Circuit in *Dorman v. The Charles Schwab Corp. et al.* reversed the denial of the motion to compel arbitration and upheld the enforceability of a mandatory individual arbitration provision in an ERISA retirement plan, which can give plan sponsors the relief that at least some arbitration clauses may survive judicial scrutiny. Likewise, in *Smith v. Brd. of Dirs. of Triad Mfg.,Inc.,* the Seventh Circuit observed that individualized arbitration does not necessarily run afoul of ERISA and broadly approved arbitration of ERISA claims: "ERISA claims are generally arbitrable." Ultimately, the court found the specific arbitration provision in question to be unenforceable because such a provision precluded a participant from seeking relief under ERISA.

In *Cooper v. Ruane Cunniff & Goldfarb Inc.,* the Second Circuit held that mandatory arbitration was not inappropriate and that a class arbitration waiver in this case "would not necessarily eliminate" the participant's right to bring a claim under ERISA § 502(a)(2). However, the court suggested that the U.S. Supreme Court in *Am. Express Co. v. Italian Colors Restaurant* may generally prevent the enforcement of an arbitration provision that bars class actions. As predicted, in *Smith v. GreatBanc Trust Co.,* the district court found that, although mandatory arbitration of claims is generally permissible, an ESOP's arbitration provision acted as a prospective waiver of a participant's right from obtaining substantive relief that ERISA guarantees. Similarly, in *Smith v. Brd. of Dirs. of Triad Mfg., Inc.,* the Seventh Circuit observed that individual arbitration agreements barring class action claims were unenforceable as they limited their rights to relief under ERISA. Of note is the fact that the U.S. Supreme has yet to invalidate an arbitration provision on this ground.

Considerations

There are several advantages and disadvantages to the inclusion of mandated individualized arbitration in welfare plans. First, as mentioned above, individualized arbitration is likely to result in inconsistent and contradictory outcomes that could create confusion among participants as to the uniform and lawful administration of the plan. Second, individualized arbitration may cause concerns regarding compliance with ERISA fiduciary duties due to the potentially differing treatment of participants and thus a perceived unfairness of disparate treatment to such participants. Third, plan sponsors do not have the ability to apply prior arbitration decisions as precedents to later claims; thus, each claim must be separately considered, which can be burdensome.

While class action litigation has its own disadvantages, the ability to resolve all potential disputes arising out of the same facts and circumstances may be preferred. On the other hand, more likely than not individualized arbitration is still much less costly than defending against a class action suit. The process of determination of claims by an arbitrator is also more speedy than class litigation considering its potential to last years. It is also likely that both plan sponsors and participants may find the flexibility of arbitration beneficial because, due to the lack of binding

arbitration precedent, there is greater room for negotiations and settlement.

Employer Impact

While arbitration is generally a widely-accepted means of alternative conflict resolution, the enforcement of arbitrations in welfare plans is not as clear in the context of ERISA claims. Given the emerging split between the circuits regarding the enforceability of arbitration provisions, plan sponsors should weigh all of the aforementioned considerations and continue to look out for future clarification of the law. Plan sponsors may choose a "wait-and-see" approach prior to the inclusion of mandatory arbitration provisions in their welfare plans and instead consider voluntary arbitration procedures.

Update Regarding the End of the COVID-19 National Emergency & Outbreak Period

By Kate Belyayeva

As detailed in our last Client Alert, the Biden Administration previously announced that the COVID-19 National Emergency would end on May 11, 2023, which would operate to end the Outbreak Period on July 10, 2023 (*i.e.*, 60 days after the end of the National Emergency).

Despite these previously announced end dates, earlier this week, President Biden signed a bill that ended the National Emergency earlier than anticipated on **April 10, 2023**. Accordingly, the Outbreak Period will now end on **June 9, 2023** (*i.e.*, 60 days after the end of the National Emergency on April 10, 2023). As a result, any deadlines and time periods that were extended as a result of the Outbreak Period (*e.g.*, the 60-day COBRA election window, the 30-day grace period to make COBRA premium payments, the 30-day HIPAA special enrollment window), will start to run again following the end of the Outbreak Period on June 9, 2023.

Below is an example of how the end of the Outbreak Period (now on June 9, 2023) will apply in a COBRA election context:

Employee is terminated and loses his coverage under the employer's health plan. He receives his COBRA election notice on March 1, 2023. Under normal deadlines, he has 60 days to elect COBRA continuation coverage following receipt of his COBRA election notice. However, while the Outbreak Period is ongoing, his 60-day election period does not begin to run until *the earlier of* (1) one year after the date that the election period would have begun (*i.e.*, March 1, 2024) or (2) the end of the Outbreak Period (*i.e.*, June 9, 2023). In this case, the end of the Outbreak Period (on June 9, 2023) will come first, which means that Employee's 60-day COBRA election period will begin to run on June 9, 2023, and Employee will have until August 8, 2023 (*i.e.*, 60 days following the end of the Outbreak Period on June 9, 2023) to elect COBRA.

Notably, the early end of the National Emergency and Outbreak Period does not impact the Public Health Emergency ("PHE") (relating to the COVID-19 testing and vaccine mandate), which is still scheduled to end as announced on May 11, 2023 (as detailed in the linked Client Alert). There is separate legislation currently pending before Congress that, if enacted, would terminate the PHE immediately upon President Biden's signature (which could be earlier than May 11, 2023); however, it has not yet been passed or signed into law. Maynard Nexsen is monitoring the status of this bill and will provide updates if the PHE's end date changes.

If you have any questions or would like additional information about anything discussed in this Client Alert, please contact a member of the Maynard Nexsen's Employee Benefits and Executive Compensation practice group, all of whom are listed on page 10.

HIPAA Enforcement Discretion During Pandemic Set to End When Public Health Emergency Expires on May 11

By Seth Capper

On April 11, 2023, the Department of Health and Human Services' Office for Civil Rights ("OCR") confirmed that four notifications of enforcement discretion issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act during the COVID-19 public health emergency ("PHE") will expire on May 11, 2023, due to the expiration of the PHE.

In 2020 and 2021, OCR published four notifications of enforcement discretion in the Federal Register regarding how the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules would be applied with respect to certain violations during the PHE, specifically, to allow healthcare providers and other HIPAA covered entities greater flexibility while delivering services during the pandemic. Although HIPAA still applied during the PHE, OCR allowed compliance with HIPAA to be relaxed in certain contexts to facilitate the delivery of patient care.

The four notifications addressed the following topics: (i) telehealth services; (ii) business associate disclosures of COVID-19 data for public health and health oversight activities; (iii) COVID-19 community-based testing sites; and (iv) web-based scheduling applications for COVID-19 vaccinations.

OCR is allowing a 90-day transition period for telehealth services to be provided in full compliance with HIPAA, but this 90-day transition period does not apply to the other three notifications. The transition period for telehealth will commence on May 12, 2023 and expire on August 9, 2023. For the other three notifications, the relaxed enforcement will end with the expiration of the PHE on May 11, 2023.

The four notifications set to expire are described in greater detail below. Given the developments throughout the pandemic, the telehealth services notification is likely to be the most relevant for HIPAA covered entities.

Enforcement Discretion for Telehealth Services

On March 17, 2020, OCR issued a notification announcing that it would exercise enforcement discretion with respect to telehealth services during the PHE. Specifically, OCR would not impose penalties for noncompliance with HIPAA's requirements, provided that the noncompliance was in connection with the good-faith provision of telehealth services using a non-public-facing remote communication product for audio or video communication.

Due to the extra 90-day transition period, covered entities will have until August 10, 2023 to bring their telehealth services into full compliance with the HIPAA rules.

Enforcement Discretion to Allow Business Associate Disclosures for Public Health and Health Oversight Activities

On April 2, 2020, OCR issued a notification announcing its exercise of enforcement discretion (officially effective as of April 7, 2020) with respect to the Privacy Rule as it related to the good-faith use and disclosure of protected health information ("PHI") by business associates for public health and health oversight activities during the PHE.

To the extent that business associates are providing PHI under this notification, they must end that practice or otherwise bring it into compliance with the HIPAA rules on May 12, 2023.

Enforcement Discretion Regarding COVID-19 Community-Based Testing Sites

On April 9, 2020, OCR issued a notification (effective retroactively back to March 13, 2020)

announcing that it would exercise enforcement discretion and would not impose penalties for HIPAA noncompliance in connection with the good-faith operation of COVID-19 community-based testing sites. For the purposes of this enforcement discretion, community-based testing sites included mobile, drive-through, and walk-up sites providing COVID-19 specimen collection and testing service to the public. According to OCR's notification, the good-faith operation of community-based testing sites included all activities supporting the collection of specimens for COVID-19 testing.

Covered entities still operating community-based testing sites must comply with the HIPAA rules on May 12, 2023.

Enforcement Discretion Regarding Web-Based Scheduling Applications for COVID-19 Vaccinations

Effective as of December 11, 2020, OCR issued a notification announcing its exercise of enforcement discretion regarding the good-faith use of online or web-based scheduling applications for scheduling COVID-19 vaccinations. For purposes of the notification, a web-based scheduling application was a non-public-facing online or web-based application that provided scheduling of individual appointments for services in connection with large-scale COVID-19 vaccinations. A web-based scheduling application did not include an appointment scheduling technology that connected directly to electronic health records systems used by covered entities.

To the extent that covered entities are using web-based scheduling applications, they must fully comply with the HIPAA rules with respect such use beginning May 12, 2023.

Preparing for Expiration of the Notifications

HIPAA covered entities should prepare for the expiration of the above-described notifications of enforcement discretion by assessing whether they are relying on any of the notifications in providing benefits and services. Covered entities and their business associates should take steps to review current policies, procedures, and practices implicated by the termination of these notifications to identify whether there are any HIPAA non-compliant practices relying on relaxed enforcement during the PHE, and if so, they should consider how to revise their current policies, procedures, and practices in a way that fully complies with the HIPAA rules.

This Month's Compliance Corner: ERISA Compliance for Employer-Sponsored Health and Welfare Plans

By Seth Capper

The Employee Retirement Income Security Act of 1974 ("ERISA") is the comprehensive federal law that regulates group health and welfare plans, as well as retirement plans. ERISA's rules and requirements are found primarily in the statute and in regulations promulgated by the Department of Labor ("DOL").

For most plans, ERISA requires detailed disclosure to covered employees and beneficiaries, and for many plans, it requires detailed reporting to the government (mainly on Form 5500). ERISA also imposes fiduciary duties on those who sponsor and administer ERISA plans, and it includes federal mechanisms for enforcing rights and duties with respect to ERISA plans. This Compliance Corner article will explain what employers and plans are subject to ERISA and will provide an overview of the main ERISA requirements applicable to employer-sponsored ERISA health and welfare plans.

Which Entities and Plans Must Comply?

Most private-sector employers (including nonprofit organizations) are subject to ERISA. The plans of governmental employers and churches generally are exempt from most ERISA requirements; however, it is important to note that the determination of whether an organization constitutes a governmental employer or church for

purposes of this exemption is not always straightforward. For employers that are subject to ERISA, the requirements under ERISA Title I will apply to any "employee welfare benefit plans" sponsored by the employer. ERISA's definition of employee welfare benefit plan can be distilled into the following three basic elements: (1) there must be a plan, fund, or program; (2) that is established or maintained by an employer; and (3) for the purpose of providing one or more of the following listed benefits to participants and beneficiaries:

- Medical, surgical or hospital benefits;
- Benefits in the event of sickness, accident, disability, death or unemployment;
- Vacation benefits;
- Apprenticeship or other training benefits;
- Daycare centers;
- Scholarship funds;
- Prepaid legal services;
- Holiday and severance benefits; and
- Housing assistance benefits.

The following are examples of employer-sponsored benefits that typically constitute ERISA "employee welfare benefit plans": health (*i.e.*, major medical) plans; dental plans; vision plans; life and AD&D insurance; long-term and short-term disability benefits; health flexible spending arrangements (FSAs); health reimbursement arrangements (HRAs); health gap/bridge plans; wellness programs; EAPs; telemedicine programs; on-site medical clinics; disease management programs; and cancer, hospital, critical illness, or other fixed indemnity coverage.

There are important statutory exemptions and regulatory safe harbors that carve out certain benefits that might otherwise fall within ERISA's definition of employee welfare benefit plan. In addition to the governmental and church plan exemptions, programs maintained solely to comply with state-law requirements for workers' compensation, unemployment compensation, or disability insurance are exempt, as are plans maintained outside of the United States for nonresident aliens.

There are also several important regulatory exemptions. For example, certain payments are exempt if they are made as a normal "payroll practice" of the employer. The key to the payroll practice exemption is that the amounts must be paid out of the employer's general assets and must be paid only to currently employed individuals. Thus, for example, certain self-funded short-term disability benefits may qualify for this exemption, but short-term disability benefits that are fully insured or that cover individuals who are no longer currently employed would not.

The regulations also exempt certain "voluntary employee-pay-all" arrangements, where the employer allows an insurance company to sell voluntary policies to interested employees who pay the full cost of the coverage. The exemption permits employees to pay their premiums through payroll deductions and permits the employer to forward the deductions to the insurer; however, the employer may not make any contribution toward coverage, and the employer may not allow employees to pay their premiums on a pre-tax basis through the employer's cafeteria plan.

What are the Main ERISA Requirements?

Plan Document and Summary Plan Description

Once an employer provides benefits that are subject to ERISA, the benefits must be described in a written plan document. Copies of the plan document must be made available at the plan administrator's principal office (and certain other locations as specified in 29 CFR § 2520.104b-1(b)), and they must be furnished to participants and beneficiaries no later than 30 days after a written request.

ERISA plans also must have a written summary plan description ("SPD"), which must be provided to participants within 90 days of becoming covered by the plan. For new plans, an SPD must be provided to participants within 120 days after the new plan is adopted. Updated SPDs must be furnished at least once every 5 years if changes have been made to SPD information or the plan has been amended over that time period. Otherwise, they must be furnished at least once every 10 years.

It is not uncommon for plan sponsors to have one document that serves as both the formal plan document and the SPD (including by using one "Wrap Plan" document to meet the plan document and SPD requirements for all of an employer's ERISA plans, as discussed later in this article). Meeting both requirements with a single document is permissible; provided, however, that the

document must be written to comply with both ERISA's plan document and applicable SPD rules. The following list summarizes the items that must be included in a welfare plan document and SPD (note, however, that many of these requirements are much more detailed than this summary can reflect):

- Basic plan-identifying information (including items such as the plan name, plan number, plan administrator and employer's name, address, and phone number, name of agent for service of legal process, and plan year);
- Description of plan eligibility provisions;
- Description of plan benefits;
- Description of circumstances that may result in loss or denial of benefits;
- Plan amendment/termination provisions;
- Description of plan subrogation provisions (if any);
- Information regarding plan contributions and funding;
- Information regarding claims procedures and, for group health plans, external review procedures;
- Statement of ERISA rights;
- For plans covering minimum numbers of non-English speaking participants, a prominent offer of assistance in the non-English language; and

For group health plans SPDs only: a detailed description of group health plan benefit provisions, a description of the role of health insurers (*i.e.*, whether the insurer actually insures benefits or merely provides administrative services), information regarding COBRA continuation coverage, disclosures regarding other federal mandates (*e.g.*, HIPAA, NMHPA, WHCRA, QMCSOs, MHPAEA, etc.), a statement regarding grandfathered status of the plan (if applicable), and an explanation that fraud or intentional misrepresentation of a material fact may result in retroactive termination of coverage and other related consequences (if applicable).

After an SPD has been provided to plan participants, if there are any modifications in the plan terms that are "material" and/or that change the information in the SPD, those modifications must be timely reported to plan participants. This can be done through the issuance of updated SPDs; however, ERISA also allows plan administrators to report such changes through a summary of material modifications ("SMM"), which limits itself to describing only the given change.
An SMM is provided in the same manner and to the same individuals as the SPD, and it generally must be furnished within 210 days after the end of the plan year in which the given change is adopted. 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 adoption of the reduction. Notwithstanding these relatively long statutory deadlines, there will often be times, depending on the type of amendment, when SMMs should be furnished well before the deadline (or even in advance of the effective date of the change).

Form 5500 and Summary Annual Report

Subject to several important exemptions, the plan administrator of an ERISA plan must report specified plan information to the DOL each plan year by filing an annual Form 5500 for each ERISA plan.

Small welfare plans are exempt from the Form 5500 filing requirement for any year in which they satisfy certain conditions. A small plan for this purpose is one that has fewer than 100 covered participants as of the first day of the plan year. Under the regulations, this Form 5500 exemption is available to (1) small unfunded plans (where benefits paid solely from the employer's general assets); (2) small insured plans (where benefits are paid through policies of insurance other than stop-loss); and (3) small combination (unfunded and insured) plans. Plans that satisfy specified requirements are considered unfunded for purposes of this exemption.

An annual Form 5500 must be filed for each ERISA welfare plan that is subject to the reporting obligation; however, a plan sponsor is free to bundle two or more welfare benefits into a single plan for Form 5500 and other ERISA compliance purposes.

The deadline for filing Form 5500 is the last day of the seventh month following the end of the plan year—for calendar-year plans, that is July 31st of the following year. A 2½-month extension may be automatically obtained by filing Form 5558.
A summary annual report ("SAR") summarizes key information from an ERISA plan's annual Form

5500 filing. If a plan is not required to file Form 5500, then there is nothing to summarize—plans exempt from the Form 5500 requirement are therefore also exempt from the SAR requirement. In addition, under the DOL's SAR regulations, a totally unfunded welfare plan, regardless of size, need not provide SARs. Plan administrators that file Form 5500 must provide SARs to participants covered under the plan, and to others receiving SPDs, within nine months after the close of the plan year. If the time to file the Form 5500 is extended, the SAR may be furnished within two months of the end of the extension period.

Other Key ERISA Requirements

- Plan terms must be followed and strict fiduciary standards must be adhered to by those who are fiduciaries with respect to the plan(s).
- Claim procedures must be established and carefully followed when processing benefit claims and when reviewing appeals of denied claims; health care reform included enhanced internal claims and appeals requirements and external review procedures for group health plans and health insurers.
- Exclusive Benefit Rule: plan assets, including participant contributions, may be used only to pay plan benefits and reasonable administrative expenses.
- Sufficient records must be maintained to document information required by the plan's Form 5500, and those records must be maintained for a period of not less than six years after the Form 5500 filing date.
- Funded plans must meet the trust requirement, fidelity bond requirement, and must include audit reports with annual Form 5500 filings.

Wrap Plan Documents

One of the ways employers can simplify ERISA compliance for their health and welfare plans is by adopting a "wrap plan" document, which works with the insurers' and TPAs' existing documents to create a single, "wrapped" ERISA plan document and SPD for all of the employer's health and welfare benefits. The documents provided by the insurers and TPAs often are insufficient to meet all of ERISA's language and content requirements applicable to health and welfare plans. One of the main advantages of having a wrap plan document in place is that it can include broadly-applicable provisions that "fill the gaps" in the insurers/TPAs' documents by including ERISA-required language and content that was not included in the insurers/TPAs' documents for the given component benefits.

Additionally, for purposes of complying with ERISA and all other federal (and, to the extent applicable, state) laws affecting health and welfare plans, the wrap plan document serves to "bundle" or "wrap" all of the component benefits together under a single plan document and SPD for the purpose of establishing and/or restating *one* ERISA plan. Among other things, this means that the employer is only required to file one annual Form 5500 for the wrap plan, as opposed to filing separate annual Forms 5500 for each component benefit.
Employers that would like to put in place wrap plan documents or that have any other questions or concerns regarding ERISA compliance for their health and welfare benefits should contact their benefits broker-consultants for further assistance.

2023 Deadline Reminders	
Prescription/medical plan cost (RxDC) Reporting	June 1, 2023
Anticipated End of COVID-19 National Emergency	May 11, 2023
Anticipated End of COVID-19 "Outbreak Period" (assuming May 11, 2023 end to National Emergency)	July 10, 2023
PCORI Fee	July 31, 2023
Annual Medicare Part D Notice of Creditable (or Non-Creditable) Coverage to Eligible Individuals	October 14, 2023
Health Plans Must Submit Gag Clause Attestations	December 31, 2023

**While some deadlines are the same date for all plans ("fixed deadlines"), many important deadlines are different for each plan depending on, for example, when the plan year ends. The above is a snapshot of upcoming fixed deadlines that apply to many plans and plan sponsors. Contact your benefits consultant regarding important reporting and disclosure deadlines specific to your plan(s), including deadlines for the Forms 5500 and Summary Annual Reports.*

STAY IN THE KNOW...

The IRS recently released final regulations amending the rules for filing certain health information forms electronically (*i.e.*, those required under Internal Revenue Code Sections 6055 and 6056 related to the ACA's employer mandate). Previously, employers were not required to file their forms electronically unless the employer was required to file at least 250 forms. This threshold has been reduced to 10 (aggregated across all types of applicable returns, *e.g.*, Forms 1099 and W-2).

The federal Office of Federal Contract Compliance Programs ("OFCCP") has released an updated copy of the voluntary self-identification forms for applicants and employees to disclose their disability status. All federal contractors subject to OFCCP jurisdiction and affirmative action obligations must update their disability self-identification forms no later than July 25, 2023. The new form is available for download from the OFCCP's website.

After five straight years of a decline in discrimination charges filed with the federal Equal Employment Opportunity Commission ("EEOC"), a trend that began in fiscal year 2017, the EEOC announced last month that fiscal year 2022 saw nearly a 20% increase in charges filed. Total charges filed rose to 73,485, the highest since 2018. EEOC found merit in 18.6% of all charges it handled last year.

This Month's Contributors

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Claire focuses her practice on assisting clients with all aspects of employee benefits and compensation plans and programs, including ERISA, health care, plan design and implementation, taxation, and employment discrimination claims arising under Title VII, the Age Discrimination Employment Act, the Americans with Disabilities Act, and other federal and state anti-discrimination statutes.

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Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.