



WHAT EMPLOYERS NEED TO KNOW RIGHT NOW ABOUT HEALTH CARE REFORM

Reporting and Plan Documents under ERISA and Cafeteria Plan Rules

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The Employee Retirement Income Security Act (ERISA) was signed in 1974. The U.S. Department of Labor (DOL) is the agency responsible for administering and enforcing this law. For many years, most of ERISA's requirements applied to pension plans. However, in recent years that has changed, and group plans (called "welfare benefit plans" by ERISA and the DOL) now must meet a number of requirements.

Generally, ERISA applies to:

- Health insurance – medical, dental, vision, prescription drug, health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs) (Health savings accounts are not governed by ERISA but the related high deductible health plan is.)
- Group life insurance
- Disability income or salary continuance unless paid entirely by the employer from its general assets
- Severance pay
- Funded vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, and prepaid legal services
- Any benefit described in section 302(c) of the Labor Management Relations Act (other than pensions on retirement or death)

Cafeteria plans, or plans governed by IRS Code Section 125, allow employers to help employees pay for expenses such as health insurance with pre-tax dollars. Employees are given a choice between a taxable benefit (cash) and two or more specified pre-tax qualified benefits, for example, health insurance. Employees are given the opportunity to select the benefits they want, just like an individual standing in the cafeteria line at lunch.

Cafeteria plans are not ERISA plans, but many of the components benefit plans offered through a cafeteria plan are subject to ERISA. This is because a cafeteria plan serves as a vehicle for employees to elect benefits and pay for them. This can create confusion for plan sponsors when they determine what ERISA obligations they have in relation to their cafeteria plan, as well as to their individual offerings.

Only certain benefits can be offered through a cafeteria plan:

- 1) Coverage under an accident or health plan (which can include traditional health insurance, health maintenance organizations (HMOs), self-insured medical reimbursement plans such as HRAs, dental, vision, and more)
- 2) Dependent care assistance benefits (DCAPs)
- 3) Group term life insurance
- 4) Paid time off, which allows employees the opportunity to buy or sell paid time off days
- 5) 401(k) contributions
- 6) Adoption assistance benefits
- 7) Health savings accounts (HSAs) under IRS Code Section 223

Not all benefits offered under a cafeteria plan can or will be subject to ERISA, and employers should take care to understand the distinctions and interplay between ERISA requirements and cafeteria plan requirements.

Reporting

Arrangements that are subject to ERISA must meet these reporting and disclosure requirements:

- [Form 5500](#) annual reports and summary annual reports,
- A written plan document and summary plan description (SPD), and
- Participant notices.

Cafeteria plan sponsors should be aware of the cafeteria plan specific reporting that might be required, depending on a number of factors in the plan design and size:

- Form 5500 and schedules as required by ERISA for components of the plan
- Form W-2 reporting of DCAP benefits (if they are a benefit offered by the plan)
- [Form W-2 reporting](#) of employer-sponsored health coverage
- Employer shared responsibility and individual mandate reporting on employer-sponsored health coverage

ERISA affects cafeteria plans with ERISA subject components, and should be taken into account by cafeteria plan sponsors as they determine their total reporting and disclosure requirements.

Form 5500

Prior to 2002, cafeteria plan sponsors were required to file an annual return using Form 5500. In 2002 the IRS removed that requirement with [IRS Notice 2002-24](#). Form 5500 is the annual report that plans make to the DOL and IRS to report required information about the plan's financial condition and operations. There is, however, an exception for group plans with fewer than 100 participants as of the first day of the plan year and that are unfunded, insured, or a combination of unfunded and insured. A plan is considered unfunded if the employer pays the entire cost of the plan from its general accounts. A plan with a trust is considered funded.

Health FSAs are employee welfare benefit plans, and unless they fall under a regulatory exemption, employers must file an annual Form 5500 for those plans. Health FSAs are exempt from the annual filing if they:

- Cover fewer than 100 participants **and** are unfunded, fully insured, or a combination of insured and unfunded;
- Are a governmental plan; or
- Are a church plan under ERISA.

Many health FSAs are not fully or partially insured, so they would not fall under the first exemption. An unfunded welfare benefit plan is one that "has its benefits paid as needed directly from the general assets of the employer or employee organization that sponsors the plan." Plans that use employee contributions or use a trust or separate fund to hold plan assets would be considered funded, unless the welfare benefit plan with employee contributions is offered under a cafeteria plan. In that instance, the plan would be considered unfunded.

A DCAP can, in the rare instance that it offers a medical or disability benefit, be considered a welfare benefit plan, in which case, it would need to file a Form 5500.

The Form 5500 is due by the last day of the seventh month following the end of the plan year. For a calendar year plan, the deadline is July 31. A two-and-a-half-month extension is available.

Plan sponsors of cafeteria plans with multiple components that require Form 5500s must decide if they will use separate Form 5500s or use one Form 5500. Plan sponsors that want to use one Form 5500 would need to ensure their plan documents indicate that the components are being offered under a single plan. The calendar year in which the plan year begins dictates which Form 5500 should be used. For example, a plan year beginning in December 2014 would use the 2014 Form 5500 for that year.

Plan sponsors that prefer to report on each cafeteria plan component separately must give each plan its own plan number. All welfare plans that are subject to ERISA must choose a three-digit ERISA number that begins with a "5," such as 501. This number is primarily used for Form 5500 purposes, although it must be included in the SPD. Each plan needs a discrete plan number. Once a plan number is used, it cannot be reused.

Plan Documents

Cafeteria plan sponsors will need to consider the ERISA requirements for plan components that are subject to ERISA, as well to the requirements for cafeteria plan documents.

Cafeteria Plan Documents

An employer must decide to adopt a cafeteria plan prior to the plan's effective date. A duly authorized officer of the corporation should then execute plan documents.

Cafeteria plan documents should contain the following information:

- Description of available benefits
- Participation rules
- Election procedures
- Manner of contributions
- Maximum amount of contributions
- The plan year
- Rules for purchasing and selling paid time off
- Provisions for FSAs
- Grace period provisions, if applicable
- Provisions relating to distributions from a health FSA to an HSA, if applicable

Cafeteria plans will also need documentation evidencing the adoption of the plan, any agreements with third parties that relate to the plan, election forms and salary reduction agreements, reimbursement request forms, forms for mid-year election changes due to permissible events, employee communications materials, COBRA forms, HIPAA disclosures and notices, privacy notices and business associate agreements, and claim denial forms. Cafeteria plans should also have applicable plan documents for the plans' underlying components.

ERISA Plan Documents

A plan document is the official governing document for the plan. ERISA requires that it include the plan's terms for a number of items including eligibility, benefits, exclusions, a named fiduciary and plan

administrator, claims and appeals procedures, funding information, and other items. In most situations a group insurance policy will not include all of the required information and so will not qualify as a plan document. A written plan document should allow every employee, upon examination, to understand his or her rights and obligations under the plan.

A summary plan description, or SPD, is the document provided to participants to explain their rights and obligations under the plan. It is intended to provide a summary of the plan's terms and should be written in a way the average participant can understand it. It has become increasingly common for plans to use a combination plan document/SPD, and most DOL offices permit this. If a combined document is used, the document must comply with both ERISA's plan document requirements and applicable SPD format and content rules. Some courts have found, however, that it is unacceptable to have one document serve as a summary of itself, so employers who wish to use one document should consult their legal counsel. For some plans, it will be impossible to fulfill both plan document and SPD requirements in a single document.

Another option is to use a wrap plan, which is a plan document, or a combination plan document/SPD, that is designed to include all of the information required by ERISA through a combination of the information included in the insurance policy or certificate and additional information required by ERISA. Many employers use a wrap document that includes all or most of their group benefits, such as medical, dental, and life benefits.

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