

Adding Value to Your Organization: Benefits Best Practices to Avoid Common Mistakes

A Benefits Emerging Leaders Working Group Webinar

AGENDA ITEMS

- ERISA Benefit Claim and Inquiry Best Practices
- Review of Plan Compensation Definitions and Payroll Codes
- Corrections Using the Voluntary Fiduciary Correction Program (VFCP)
- Document Retention Requirements

ERISA Benefit Claim and Inquiry Best Practices

Claim or Inquiry

- In administering claims procedures consider whether a Participant's question is a claim or an inquiry
- An **inquiry** simply asks a question about the Plan's terms or the process by which benefits are paid or calculated
 - A **claim** typically challenges the level or duration of benefits under a plan. The Participant believes he has been wronged by the Plan
 - A claim triggers the timing and substantive requirements of ERISA's claims procedures. A simple inquiry or question does not.

Respond to an Inquiry

- IF IT IS AN **INQUIRY**:
- Respond to the question succinctly and accurately
 - If the question is not answered correctly, the letter could impact future administrative review and litigation
- Notify the Participant of his ability to submit a claim – list claim procedures.
 - This should protect against the claimant reasonably believing that the response is an initial claim determination
- A quick and accurate response may decrease the chance of a future claim and litigation
- Control the process: Include language in SPD explaining inquiry vs. claim, insist that claim be made in writing to proper party (e.g., plan administrator)
 - But note urgent care claims

Respond to a Claim

- IF IT IS A **CLAIM**:
 - Send a letter to the claimant acknowledging that the Plan Administrator is treating the submission as an ERISA claim
 - Defines the start of the claims review process
 - ERISA claims and appeals rules apply
 - Ensure that the initial letter and initial claim determination set forth all appeal rights and any limitations periods
 - Places the claimant on notice of limitation periods that may cut-off their claim if not followed.

Claims and Appeal Procedures – Governing Law

- Section 503 of ERISA:
 - Benefit plans must provide adequate notice in writing if claim is denied
 - Notice must:
 - Include specific reasons for such denial
 - Be “written in a manner calculated to be understood by the participant”
 - Benefit plans must “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim”
- Final Department of Labor claims procedure regulations
 - Reasonable Procedures: Every employee benefit plan under ERISA must establish “reasonable” claims and appeals procedures
 - Different rules for group health, disability, and retirement plans

Claims and Appeal Procedures – Governing Law

- In addition, group health plans must provide for the following:
 - No more than two appeals of an adverse benefit determination can be required prior to bringing a civil action. Any statute of limitations or other defense based on timeliness is tolled during the time the voluntary appeal is pending
 - The claimant may elect to submit to the voluntary level of appeal only after exhausting appeals otherwise required by the regulations
 - The plan or procedures can provide for mandatory arbitration as one of the two levels of appeal, but an individual may still bring a civil action under ERISA after the appeals are exhausted

Timing of Claims and Appeals

- A full and fair review must be afforded to a claimant, *i.e.*: the claims procedures must provide for the following:
 - the claimant must be able to submit written comments, documents and records;
 - the claimant must be able to obtain free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
 - the review must take into account all comments, documents, records and other information submitted by the claimant, whether or not such information was submitted or considered at the initial benefit determination
- Claim and appeal responses must be made within specific timeframes.
 - Pension Plan Example:
 - Plan Administrator must notify claimant of its adverse determination no later than 90 days after receipt of the initial claim. 90-day extension available.
 - Plan Administrator must notify the claimant of its determination no later than 60 days after receipt of the appeal. 60-day extension available.
 - Shorter response periods apply to health and disability claims

Timing of Appeals

	Pre-Service Health Claims	Post-Service Health Claims	Disability Claims	Urgent Claims	All Other Claims
Claims Administrator to Provide Notice of Initial Denial	15 days after receipt of claim. Plan can request an additional 15 days if request is made during the original 15 day period	30 days after receipt of claim. Plan can request an additional 15 days if request is made during the original 30 day period	45 days after receipt of claim. Plan can request two additional 30-day periods if request is made during the original 45 day period	48 hours after receipt of claim	90 days after receipt of claim. Plan can request an additional 90 days if request is made during the original 90 day period
Claimant Deadline to Appeal	180 days	180 days	180 days	180 days	60 days
Appeals Committee to Provide Notice of Appeal	15 days after receipt of appeal	30 days after receipt of appeal	45 days after receipt of appeal. Plan can request an additional 45 days if request is made during the original 45 day period	72 hours after receipt of appeal (appeal is to Claims Administrator)	60 days after receipt of appeal. Plan can request an additional 60 days if request is made during the original 60 day period

Content of Claim and Appeal Determination Notices

- Claim and appeal determinations must contain specific content. Carefully review to ensure that all required information is included.
- Adverse benefit determinations for group health or disability plans must also specify the following:
 - any internal rules, guidelines, protocols or criterion relied upon in making the determination; or a statement that it is available upon request free of charge;
 - if the adverse determination is based on a medical necessity, experimental/investigational or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - for urgent care claims only, a description of the expedited review process
- New requirements for claims adjudication of disability claims under welfare and retirement plans apply to all claims for disability benefits filed on or after January 1, 2018.

Impact of ERISA Regulations in Court

- Why is it important to follow ERISA's claims regulations?
 - Provides for a deferential standard of review in litigation
 - Allows greater control over administrative record
 - Ensures exhaustion of all administrative remedies
 - Retains possible procedural defenses to a lawsuit
 - If time deadlines for claims and claim appeals are not met, it may result in litigation with appeals committee members being sued, which will make any litigation defense more costly

Best Practices

- Most benefit litigation is won or lost not in court, but in the administrative review process
- Claim Responses
 - Ensure all ERISA Regulation requirements are satisfied
 - Is the applicable plan provision cited?
 - Are all specific reasons for the denial stated?
 - Are the plan's claim appeal and limitation period provisions explained?
 - Ensure the claim or claim appeal is reviewed and decided by the proper entity
 - Is the entity reviewing the claim authorized by the plan document?
 - For health care claims, is the claim appeal review performed by a party different from the initial claim determination?

Best Practices

- Ensure that requests for plan-related documents are responded to timely and completely
 - ERISA requires that if a Participant requests certain plan documents (plan document, SPD, annual statement), the Plan Administrator must produce the documents within 30 days of receipt of the request
 - A failure to produce required plan documents may be subject to civil penalties of up to \$110 per day for **each** violation
 - For example, a failure to produce a requested SPD for one year could produce a civil penalty of over **\$40,000 plus attorneys' fees for the plaintiff!**

Review of Plan Compensation Definitions and Payroll Codes

Plan Compensation Definitions and Payroll Codes Summary

- Failure to follow plan's definition of eligible compensation is a key IRS audit issue
 - Compensation is important for several different purposes: (1) determining an employee's allocation in a defined contribution plan or benefit accruals in a defined benefit plan, (2) calculating the 415 limits, (3) performing nondiscrimination tests (e.g., ADP/ACP), and (4) determining whether a plan is top-heavy
 - Definition of compensation in the plan document and/or summary plan description should be reflected in plan administration

Plan Compensation Definitions and Payroll Codes Failures

- Common Failures:
 - Failure to notice that executive's pay reaches the 401(a)(17) limit (\$270,000 in 2017)
 - Confusion for employees regarding different definitions of compensation for different purposes
 - Confusion for employers regarding equity compensation (e.g., exercise of stock options or early sales in 423 stock purchase plan generates W-2 income – does your plan require you to take deferrals from ALL W-2 income?)

Plan Compensation Definitions and Payroll Codes Failures

- Many failures can occur for large corporations with numerous payrolls resulting in inconsistent application of compensation definition

Best Practices

- IRS suggests:
 - Annual self-audit of payroll codes;
 - Annual check-in with service providers
- Compare payroll codes to plan document definition of eligible compensation

Corrections Using the Voluntary Fiduciary Correction Program (VFCP)

VFCP Summary

- The Department of Labor created the Voluntary Fiduciary Correction Program (“VFCP”) to encourage employers to voluntarily comply with ERISA by correcting certain breaches of fiduciary duty under ERISA.
- Full correction under the VFCP will allow employers to avoid civil penalties under ERISA and excise taxes under the Internal Revenue Code.
- There is no application or penalty fee to use the VFCP.

Types of Transactions Covered by VFCP

- The VFCP covers 19 different transactions that constitute breaches of fiduciary duty under ERISA and how to correct such transactions. The most frequent transactions covered by the VFCP are the following:
 - a. Delinquent participant contributions under 401(k) plans (this includes delinquent employee salary reduction contributions);
 - b. Delinquent loan repayments under 401(k) plans;
 - c. Delinquent participant contributions to welfare plan trusts;
 - d. Participant loans failing to meet prescribed interest rate, amortization or other required loan terms under a 401(k) plan; and
 - e. Improper payment of plan expenses by the plan.

Eligibility to Participate in VFCP

- Any employer/plan sponsor or fiduciary of a plan covered by ERISA may apply for the VFCP.
- The applicant must be willing to fully correct any covered transactions and must not be “under investigation.”
 - The term “under investigation” generally means that the Department of Labor, the Internal Revenue Service or the Pension Benefit Guaranty Corporation has initiated an examination or investigation of the plan or the plan sponsor or the applicant in connection with an act or transaction directly related to the plan or that any governmental agency is conducting a criminal investigation of the plan or the plan sponsor or applicant in connection with an act or transaction directly related to the plan.

VFCP Correction Methodology

- In general, corrections are made with a view towards putting the plan and the participants back in the position they would have been in had the breach of fiduciary duty not occurred.
 - The VFCP has developed an on-line calculator to assist applicants in determining correction amounts and has developed correction procedures for the 19 covered transactions.
- For example, the VFCP requires that earnings be calculated on any delinquent contributions from the date withheld from participant's paychecks to the date of actual contribution to the plan's trust. A correction would consist of actually contributing the employee salary reduction contributions to the plan's trust and also contributing the earnings amount calculated using the on-line calculator.

VFCP Application Process

- The Department of Labor has provided a model application form and checklist to use in applying for relief under the VFCP (not required to use).
 - In addition, applicants must submit supporting documentation such as plan documents, lost earnings amounts, proof of restitution of amounts to the plan and other documents relevant to the transaction for which the applicant is seeking relief.
 - The VFCP application must be signed by a representative of the applicant under penalty of perjury.
- Often VFCP filing will also require a filing to the IRS on Form 5330 to pay excise taxes
- Upon satisfaction of the terms of the VFCP, DOL will issue a no-action letter. The no-action letter states that the DOL will not initiate a civil investigation under Title I of ERISA regarding responsibility for any transaction described in the no-action letter, nor assess a Section 502(l) penalty. Other government agencies or any other persons may still enforce their rights.

VFCP Documentation

- Under the VFCP, applicants must provide supporting documentation to the appropriate regional office of EBSA. Required documentation generally includes:
 - Copy of relevant portions of plan and related documents;
 - Documents supporting transactions, such as leases and loan documents, and applicable corrections;
 - Documentation of lost earnings amounts;
 - Documentation of restored profits, if applicable;
 - Proof of payment of required amounts;
 - Specific documents required for relevant transactions, as outlined in VFCP;
 - Signed checklist; and
 - Penalty of perjury statement.

VFCP Class Exemption

- The class exemption provides relief from certain excise tax provisions of the Internal Revenue Code if the terms of the VFCP and exemption are met.
- The class exemption only covers six of the prohibited transactions identified in the VFCP, including failure to timely transmit participant contributions and loan repayments.
- DOL adopted IRS recommendation to eliminate the notice requirement in some delinquent employee contribution situations if the amount of the excise tax is less than or equal to \$100 and certain requirements are met.
- You do not have to send a notice to interested parties if you meet certain requirements, including, for example, the excise tax otherwise payable to the IRS is less than or equal to \$100, that would-be excise tax is allocated to participants and beneficiaries, and you provide a copy of the Form 5330 (or the same information) to the DOL.

Best Practices

- Coordinate with payroll provider to determine the earliest date the company can reasonably segregate participant deferrals and loan repayments from the company general assets (do not have to be same date). Set up procedures to ensure that the company makes deposits by that date.
- If the company fails to timely remit participant deferrals and loan repayments to the plan trust, contact recordkeeper and legal counsel as soon as possible to contribute the late deferrals and/or loan repayments to minimize lost earnings owed to the plan and excise taxes owed to the IRS.

Best Practices

- Ensure at least two levels of review each pay period to confirm that participant elective deferral elections are timely remitted to the plan's trust within the normal timeframe for such contributions.
- If participant deferral and/or loan repayment deposits are late, keep a record of why those deposits were late (e.g., because of vacations or other disruptions).
- Implement practices and procedures and a recordkeeping process that the company will explain to new personnel, as turnover occurs, to ensure that they know when deposits must be made.

Document Retention Requirements

Document Retention Requirements Summary

- Document retention requirements are complex
- We generally recommend that plan sponsors retain most benefits documents indefinitely
 - Keep a plan documents file
- Some exceptions for documents filed with DOL and/or PBGC, HIPAA documents and COBRA documents
 - Electronic records generally permissible, assuming creation of adequate records management practices

Best Practices

Plan Documents File – All Plans

- Plan document (if prototype, include both adoption agreement and underlying plan document)
- All amendments
- SPD(s)
- Delegations of authority for administration, plan amendments, etc.
- Committee minutes
- Committee charter
- Latest Form 5500

Best Practices

Plan Documents File – Retirement Plans

- Trust agreement and all amendments (if applicable, master trust agreement)
- IRS determination letter (if pre-approved plan, include the notification letter)
- Investment Policy Statement
- Latest 408(b)(2) disclosures (“all-in fees”)
- QDRO procedures (if applicable, model QDRO)
- Sample of benefit election forms (if DB plan, include relative value notice)

Best Practices

Plan Documents File – Retirement Plans

- 402(f) Notice (Notice of Special Tax Withholding) if any eligible rollover distributions offered
- Copy of most recent agreements/contracts with:
 - Auto IRA rollover vendor (if applicable for \$1001-\$5000 auto rollovers)
 - Investment Consultant/Adviser
- SOC Report from your investment provider (Type 1 or Type 2)
- Latest 410(b) test results (no older than 3 years)
- Latest 401(a)(4) test results (no older than 3 years)

Best Practices

Plan Documents File – Retirement Plans

- Latest Top Heavy test results (annual)
- Latest Definition of Compensation test results, if applicable (414(s)) (no older than 3 years)

Best Practices

Plan Documents File – 401(k) Plans

- Loan policy, if applicable
- Hardship withdrawal documentation/guidelines
- Latest annual ADP/ACP test results (or safe harbor notice to participants if applicable)
- Copy of sample of Automatic enrollment notice (if applicable)
- If company stock fund, copy of prospectus
- Copy of latest 404(a)(5) fee disclosures to participants
- Copy of most recent agreement with recordkeeper
- Recordkeeper's Administrative Manual

Best Practices

Plan Documents File – Defined Benefit Plans

- If applicable, copy of sample suspension of benefits notice
- Investment Management Agreements (if applicable)

Best Practices

Plan Documents File – Nonqualified Plans

- Copy of plan document and evidence of adoption (signed plan or board minutes)
- Signed copy of rabbi trust, if applicable
- If deferred compensation plan, copy of sample deferral election form