Advisory Council on Employee Welfare and Pension Benefit Plans

Report to the Honorable R. Alexander Acosta,
United States Secretary of Labor

Reducing the Burden and Increasing the Effectiveness of Mandated Disclosures with Respect to Employment-Based Health Benefit Plans in the Private Sector

November 2017

NOTICE

This report was produced by the Advisory Council on Employee Welfare and Pension Benefit Plans, usually referred to as the ERISA Advisory Council (the "Council"). The Council was established under section 512 of ERISA to advise the Secretary of Labor on matters related to welfare and pension benefit plans. This report examines the regulatory rules implementing the disclosure requirements for welfare benefit plans required by title I of the Employee Retirement Income Security Act of 1974 ("ERISA").

The contents of this report do not represent the position of the Department of Labor.

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ABSTRACT

The 2017 ERISA Advisory Council examined ways in which the regulatory burden of mandated disclosures for health and welfare plans[1] could be reduced while simultaneously satisfying the disclosures' objectives and improving the usefulness of such disclosures. The 2017 Council asked witnesses to focus on (1) the elimination of the Summary Annual Report ("SAR") requirement for health benefit plans not already exempt, (2) the consolidation of the various annual notices into a single annual notice issued in a standard format, and (3) the modification of the Summary Plan Description ("SPD") distribution requirements to allow a short resource reference tool updated annually as a safe harbor method of compliance.

Based upon testimony received during two days of hearings supplemented by submissions of written material from interested stakeholders, the Council further developed recommendations of less burdensome and more effective methods to deliver the SAR information, the annual notices and the SPD content, including a model of a short quick reference guide as part of the SPD to illustrate a potential safe harbor approach for the Department to consider to satisfy the SPD distribution rules. Additionally, because many witnesses commented on electronic communications, the Council summarized this commentary as an appendix for future consideration.

[1] In considering the mandated disclosures applicable to employee welfare benefit plans, the Council studied health benefit plans exclusively. Nothing that the Council learned in studying health benefit plans suggested that similar concepts would not be equally applicable to other employee welfare benefit plans generally.

ACKNOWLEDGEMENTS

The Council recognizes the following individuals and organizations who contributed to the Council's deliberations and final report. Notwithstanding their contributions, any errors in the report rest with the Council alone.

Mark Buckberg	Bond Beebe
Pat Castelli	Niles Bolton Associates, testifying on behalf of the Society of Human Resource Management (SHRM)
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I. EXECUTIVE SUMMARY

The 2017 ERISA Advisory Council assessed how to reduce the burden and increase the effectiveness of mandated disclosures with respect to employment-based health benefit plans in the private sector. The work of the 2017 Council expanded on the findings of prior Council reports: *Health and Welfare Benefit Plans' Communications: ERISA Requirements, Employers' Compliance, and Participants' Utility* ("the 2005 Report"), and *Promoting Retirement Literacy and Security by Streamlining Disclosures to Participants and Beneficiaries* ("the 2009 Report"). To move beyond generalities, the 2017 Council asked witnesses to consider three proposals:

(1) Eliminating the SAR requirement for health benefit plans not already exempt;

(2) Consolidating the required annual notices for group health plans into a single annual notice issued in a standard format; and

(3) Modifying the SPD regulatory requirements to allow for an optional, annually-distributed quick reference guide that would point participants and beneficiaries[2] to source materials to answer questions regarding the plan's contents, their rights, and additional important information required by title I of ERISA.

This 2017 Council report presents the Council's analysis of these specific proposals based on witnesses' testimony and their responses to the Council's questions. The analysis considered testimony from communication experts, plan sponsors, plan service providers, and participant representatives regarding the three proposals and their potential impact on a plan sponsor's cost burden, as well as whether the proposals would better serve the mandated disclosures' statutory purposes.

Based upon testimony received during two days of hearings, supplemented by written submissions from interested stakeholders, the 2017 Council concluded that mandated disclosures currently do not address the underlying statutory purpose of providing important information in a useable framework, and they are burdensome for plan administrators. Accordingly, the Council made several recommendations with the goal of providing plan administrators with options for reducing compliance burdens while improving the communication effectiveness of mandated information. Many witnesses commented on the use of electronic communications, so the Council summarized this commentary in an Appendix to the report, recommending this topic for potentially a future Council's or the Department's consideration.

[2] Throughout this report, whenever the term "participants" is used, it is intended that that reference should be understood to apply to both participants and beneficiaries, unless the context suggests otherwise.

II. RECOMMENDATIONS

A. Based upon witness testimony and Council research, the 2017 Council recommends the following:

1. The Department create a **safe harbor** whereby employee health benefit plan administrators distributing an **annual quick reference guide** (along the lines of the model described below) in coordination with the Summary of Benefits and Coverage ("SBC") are **not** required to **distribute automatically** any of the following:

- An updated complete SPD every five (5) or ten (10) years (as applicable).
- An annual SAR.
- A Summary of Material Modifications ("SMM") for the year.
- Any annual notice not triggered by an event required under part 1of title I of ERISA.

Note: The safe harbor would have no impact on other initial notices that by regulation may be included in the initial complete SPD, such as COBRA notices. Similarly, any changes to the complete SPD must be made in accordance with existing law, and those changes must be highlighted in the safe harbor's annual quick reference guide. Annual quick reference guides must be archived or otherwise preserved and maintained to document all modifications over time. Thus, the safe harbor would not change the following current disclosure requirements:

- The complete SPD must be updated formally every five years or ten years as applicable.
- A complete SPD must be provided upon initial eligibility along with applicable quick reference guides since the complete SPD was last updated. This approach is currently required for SMMs. A printed SPD must be available upon request.
- Plan administrators must continue to comply with the SPD requirements with regard to content, uses, or purposes.

2. As referenced in the first recommendation, the Department develop and publish a model quick reference guide, an example of which is in the appendix to this report.

3. In addition to the first recommendation, the Department establish an alternative method of compliance with the SAR requirements applicable to all employee health benefit plans, in which the plan sponsor satisfies the SAR requirement by informing participants of the annual report's availability either in a separate notice or incorporated in another annual plan notice required to be distributed under part 1of title I of ERISA.

4. In addition to the first recommendation, the Department permit the annual required notices to be consolidated into one notice that must be furnished either at the date of the earliest required notice or at the outset of any applicable annual open enrollment period for such employee health benefit plan.

B. Although the Council focused principally on the content of disclosures, the Council recommends that the Department further explore the utility and effectiveness of electronic delivery mechanisms, inasmuch as witness testimony suggested that permitting electronic delivery options may reduce the burden on plan administrators while helping many participants better navigate and understand their benefits.

III. BACKGROUND

A. Disclosure Requirements for Health Care Plans

The Council focused on regulations exclusively within the jurisdiction of the Department, rather than disclosures within the joint purview of the Department and other regulatory bodies. Specifically, the Council focused on the SAR, the annual notices required by title I of ERISA, and the SPD. Each requirement is summarized below.

SAR

Prior to the enactment of ERISA, the Welfare and Pension Plans Disclosure Act of 1958 ("WPPDA") required the disclosure of limited information to participants to enable them to determine whether a plan was financially sound and being administered as intended. The purpose of the WPPDA disclosure requirements was to enable participants to monitor their own plans; however, Congress found that the disclosure requirements under the WPPDA were inadequate to achieve this objective. The more expansive disclosure requirements enacted by ERISA are designed to increase the scope and detail of disclosed data and information.

With respect to a group health plan, section 104(b)(3) of ERISA requires that each participant and each beneficiary receiving benefits be furnished with a SAR describing:

- A statement of the plan's assets and liabilities aggregated by categories and reflecting their current value. The same data must be displayed in comparative form as of the plan's previous fiscal year end.
- A schedule of receipts and disbursements during the preceding 12-month period aggregated by general sources and applications.
- Other materials necessary to fairly summarize the latest annual report.

The information is based on the plan's most recent annual report (Form 5500) and must be distributed no more than nine months after the close of the plan year or, if an extension of time to file the annual report is granted, two months after the close of such extension period.

Exercising its authority under section 104(a)(3) of ERISA, the Department has exempted certain group health plans (along with other welfare plans) from the SAR requirements. Consequently, no SAR is required for:

- An unfunded plan.
- A plan covering fewer than 100 participants at the beginning of the year that is unfunded, funded exclusively by insurance contracts, or both (and not otherwise funded).

- A plan covering only a select group of management and highly compensated employees that is unfunded, funded exclusively by insurance contracts, or both (and not otherwise funded).
- A plan that is financed solely by union dues sponsored by a union that files an LM-2 or LM-3 and that describes the plan in the union constitution or bylaws.

Accordingly, SARs are required only for the following:

- Any group health plan funded with plan assets other than those funded exclusively by insurance contracts or union dues.
- Any insured or funded plan (other than exclusively by union dues) covering 100 or more participants at the beginning of the year except if all of the participants are within a select group of management or highly compensated employees. In case of the latter situation, a SAR is required only if the plan is funded in whole or in part by plan assets other than insurance contracts.

Annual Notices

Currently, the following notices are required to be distributed to participants either upon coverage or annually, or upon an event with respect to a group health plan subject to title I of ERISA:

- SPD: upon initial eligibility and every five years thereafter.
- SAR: after each year for certain plans.
- Newborns' and Mothers' Health Protection Act ("NMHPA"): with SPD.
- Women's Health and Cancer Rights Notice ("WHCRA"): upon enrollment and annually thereafter.
- SMM: after any year in which a material change to the plan is adopted.
- COBRA: upon enrollment; with SPD: upon election right, unavailability, early termination, or rescission of continuation coverage; late or insufficient premium.
- SBC: upon initial, open, and special enrollment; material modification; and request.
- Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Notice: upon initial enrollment; material modification; every three years thereafter.
- HIPAA Special Enrollment Notice: upon enrollment.
- Medicare Part D Notice: upon initial enrollment: annually, with changes to creditable prescription drug coverage and upon request.
- Michelle's Law Notice: upon initial eligibility, open, and special enrollment and certification of student status for coverage.
- Wellness Program Disclosure: with SPD: upon failure to satisfy standard.
- Summary of Material Reduction in Coverage ("SMR"): after reduction.
- Qualified Medical Child Support Order Procedures ("QMCSO"): with SPD; upon receipt of order and by request.

- Mental Health Parity ("MHPAEA"): upon request, cost exemption, and denial.
- Affordable Care Act ("ACA") Grandfather Plan Notice: with enrollment materials and SPD.
- ACA Internal Claims and External Review Notice: with SPD: upon denials.
- ACA Primary Care Provider Notice: with SPD.
- Children's Health Insurance Program (CHIP): annually.
- ACA Cost of Health Care Report: with Form W-2.
- ACA Notice of Exchange: upon hire.

Some initial and reoccurring notices are expressly permitted to be included in the SPD. A separate notice must be provided for annual or reoccurring notices, unless the SPD is produced annually.

SPD Formatting and Delivery Method

The SPD is central to ERISA disclosure requirements. Section 102 of ERISA sets out the specific information that must be included in the SPD. Section 102 also directs that the information be written so an average plan participant can understand the material and the communication be sufficiently accurate and comprehensive to reasonably apprise participants and beneficiaries of their rights and obligations under the plan. The second part of this dual mandate creates a substantial challenge, because the first part requires communicating a significant volume of information. As provided in section 2520.102-3 of the Department's regulations, an SPD for an employee welfare benefit plan that constitutes a group health plan must contain:

- The name of the plan.
- The name and address of the employer(s), the employee organization(s), joint board of trustees, etc. that establish and maintain the plan, including a list of employers and employee organizations sponsoring the plan, or a statement that information about plan sponsors and addresses are available upon request.
- The plan sponsor's employee identification number.
- The type of plan.
- The type of plan administration.
- The name, address, and telephone number of the plan administrator.
- The name and address of the agent for legal process on behalf of the plan.
- A statement that a copy of any collective bargaining agreement through which the plan is maintained is available upon request.
- The plan's eligibility requirements, including any conditions for receiving benefits.
- A summary of benefits and a statement that a detailed schedule of benefits is available upon request without charge.
- A description of the procedures governing QMCSO, or a statement that a copy of the procedures is available upon request.

- A description of the cost-sharing provisions including premiums, deductibles, and copayment amounts.
- A description of the annual or lifetime caps or other limits on benefits under the plan.
- A description of what existing and new drugs are covered under the plan.
- A description of the coverage of medical tests, devices and procedures.
- A description of the use of network providers, the composition of the network providers, the coverage for out-of-network services.
- A description of any conditions or limits on the selection of primary care providers or providers of specialty medical care.
- A description of the coverage for emergency medical care.
- A description of preauthorization or utilization review conditions for benefits or services under the plan.
- A statement that a list of network providers will be provided upon request.
- A statement clearly identifying the circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant might otherwise expect to receive under the plan.
- A description of the authority of plan sponsors to terminate or amend the plan or eliminate benefits under the plan.
- A description of any fee or charge imposed on participants under the plan.
- A description of the rights and obligations of participants with respect to continuation coverage, including qualifying events, qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.
- The sources and medium of funding for the plan, including identifying any insurance company, trust fund, or institution maintaining plan assets; and the contact information of the issuer of any policy and the types of services provided under the policy.
- The plan year end date.
- The claims procedure, including:
    - The procedures for preauthorizations, approvals, utilization reviews, filing claims forms, providing notice of benefits determinations, and reviewing denied claims.
    - The applicable time limits and remedies available under the plan for the redress of claims denied in whole or in part, or a statement providing that the claims procedure will be furnished upon request without charge.
- A statement of ERISA rights.
- A description of maternity or newborn infant coverage.

B. Prior Council Reports

Two prior Councils have studied various aspects of participant and beneficiary disclosures. The 2005 Report assessed how well employer sponsor materials distributed to health and welfare plan participants and beneficiaries achieved various policy-oriented goals, including

accessibility, understandability, conciseness and timeliness. The 2005 Council also examined the media mix used to deliver disclosures, e.g. hard copy, on-line, and other media. The 2005 Report focused on the SPD requirement. Witnesses testifying before the 2005 Council did not focus on the SAR's adequacy. A conclusion of the 2005 Council was that SPDs were becoming increasingly detailed and using legalistic language to mitigate the litigation risks because judicial decisions were awarding more favorable benefits as described in the SPD over an unambiguous plan document. Additionally, there were rulings that ambiguities between the SPD and the plan document should be construed in favor of the plan participant. The 2005 Report also concluded that the complexity of plan terms required a variety of communication tools in lieu of a single document, and that the limited "shelf life" of hard copy SPD documents had caused employer sponsors to rely more heavily on electronic communications.

The 2005 Report made two short-term recommendations that are relevant to the 2017 Council's scope. First, the 2005 Council recommended that the Department provide additional regulatory or advisory guidance to help plan administrators prepare understandable and user-friendly SPDs, and suggested that the Department could further help by affirming the use of Executive Summaries or Life Event Summaries as an administrative best practice. Second, the 2005 Council recommended that the Department enhance or create mechanisms to enforce the regulatory requirement that SPDs be understandable by the average plan participant.

The 2009 Report primarily studied the efficacy of ERISA's pension plan reporting and disclosure scheme. The 2009 Council's findings concluded that the growth in required disclosures to participants since ERISA in 1974 resulted in twin problems of employer burden and participant information overload. Both these issues are relevant to the 2017 Council's scope.

The 2009 Report recommended that the Department encourage employers to use a "quick start" summary guide in addition to a more lengthy and detailed SPD. This recommendation was based on witness testimony from behavioral economists that participants and beneficiaries learn and retain information better through a "progressive access" disclosure scheme. Under a progressive access disclosure approach, participants are first furnished with simple and fundamental plan information and progressively learn more detailed plan information. Witness testimony before the 2009 Council further indicated that the enhanced use of modern technology and electronic delivery of information incorporated into a progressive access disclosure system would reduce the employers' administrative compliance costs while enabling participants to access more detailed plan information.

The 2009 Council also heard repeatedly in witness testimony that the multiplication of required disclosures was burdensome to plan sponsors, and that the use of model disclosure notices could both increase participant understanding and reduce compliance costs. The 2009 Report recommended that the Department determine whether notice requirements could be streamlined and combined into a more cohesive participant notice system that utilized a model notice approach as a compliance safe harbor.

To date, the Department has not taken regulatory action in response to the recommendations of the 2005 and the 2009 Council reports.

IV. DISCUSSION

A. The Overriding Tension

There is a statutory tension between making disclosures understandable to the average plan participant while including sufficiently accurate and comprehensive information to enable informed participant decision-making. According to witness Professor Wiedenbeck of Washington University in St. Louis School of Law, ERISA notices and disclosure requirements have three core policy functions:

1. Promoting compliance.
2. Enabling participants to have informed decision-making with regard to career and financial planning.
3. Creating discussion among workers about their benefits.

Professor Wiedenbeck testified that ERISA's disclosure obligations were designed to promote compliance by informing the participants of the plan's key terms so that they'd be in a position to monitor fiduciaries' and plan sponsors' conduct and, if necessary, sue for enforcement under the civil enforcement provisions of ERISA. According to Professor Wiedenbeck:

"The goal of deterring abuse or remedying abuse if it occurs is explicit in the committee reports on ERISA. Not quite as explicit is … the central function, which is to allow participants and beneficiaries to better plan their affairs, to give them enough information so that they can basically make intelligent choices about how this benefit package should affect their job choices, their career planning, for example." Despite these laudable goals, one countervailing outcome is the inherent litigation risks borne from incomplete or inaccurate disclosure. Litigation risks require employers and plan sponsors to balance brevity and readability with accuracy and completeness requirements. This tension creates, as Professor Wiedenbeck characterized it, a "no-win situation" for employers. Employers have responded by adding more language to set up a liability shield, so that documents, as noted in 2005 Council report, are written "by lawyers for lawyers."

Broadly, employers and plan sponsors deal with this "no-win situation" by complying with the letter of the law but they recognize that the disclosures are not meeting the laws' underlying goal or spirit, which is providing important information to participants. According to Terry Dailey of Mercer:

> *"…employers feel that they are administratively burdened by all of the disclosure requirements. They also feel that these disclosure requirements don't serve the participants in the intent that they were required or designed to by Congress and by the agencies, and they don't serve the goals of the disclosure requirements."*

Instead, when plan administrators want to communicate effectively, they use documents and other modalities that are separate from the legally mandated documents. To be effective in this endeavor, they need flexibility.

B. Timing, Consolidation and Flexibility

Workforces and participants have a wide variety of demographic traits, behaviors, literacy, knowledge and abilities that make standardization difficult. Several witnesses discussed generational differences in how people obtain and consider information in their decision-making. Other witnesses discussed how individuals consume disclosure and health plan information differently when they are making decisions in open enrollment versus when they or a family member are a patients considering care options. The mandatory disclosures and documents are trying to achieve multiple, complex purposes with one set of documents.

Several witness panels, including expert behavioral scientists, testified that employers should have room to create disclosures that address the realities of their workplaces and accommodate different workplace demographics. Mandatory disclosures have a clear purpose and the ability to achieve their goals is dependent on whether participants can access what they need, when they need it and understand what it means; particularly for health and welfare plans. For different companies and / or different parts of a workforce, flexibility with timing and presentation provides an opportunity to engage more people when they are open to being engaged. According to Glenn Willocks of TradeWinds Island Resorts and representing the Society of Human Resource Management (SHRM):

> *"SHRM encourages the Council to emphasize the need for flexibility regarding how disclosures are presented, including electronic disclosure, and as much flexibility as possible regarding the timing of these disclosures so plan sponsors can customize the needs of their workplace. At TradeWinds, we find it beneficial to distribute annual notices during our open enrollment period. That's the one time of the year where we generally get everyone together in face-to-face interaction. In our experience, that face-to-face interaction is far more valuable than sending out a notice every so often when participants may or may not get the notice, and then they have no one to ask the questions of when they get that notice. Distributing notices at open enrollment creates efficiencies for us because we're already focused on providing those employee health enrollment notices and answering those questions. We find employees to be much more engaged at that time... Many of our employees do not speak English. Many of our employees share an email address or do not have an email address. We find it far more practical and effective to deliver a lot of these notifications in person, as I mentioned, at our annual enrollment meetings."*

Pat Castelli from Niles Bolton Associates, testifying on behalf of SHRM, suggested:

> *"Where there is information that we have to present… for example, how I define my eligibility so that my participants understand that information…give me the opportunity to communicate the information to my employees in a way that they understand it. Possibly it's in a way that I'm presenting the rest of my benefits so it's familiar to them, so that we're not using terms that they're not familiar with and we're not trying to identify ideas that they haven't already seen before."*

Many witnesses suggested that the Department define a minimum set of standards that plan administrators could flexibly present through a variety of means. The witnesses asserted that this flexibility would better enable communication clarity and quality, and improve participant engagement. Some witnesses suggested that a minimum standard approach be accompanied by

guidance on demonstrating compliance. One way to achieve flexibility is through electronic communications; however, many witnesses cautioned that electronic communication is not the answer to all the disclosure issues and such an approach could increase confusion and complexity. Additionally, many plan administrators use electronic access as a separate participant communication tool, but this tool might not be designed to comply with the current regulatory standards for electronic disclosures.

Several witness panels testified about challenges associated with distribution and the inability to use electronic methods to maintain documents and communicate with participants. In particular, witnesses said that using paper distribution mechanisms is less precise than electronic and a plan administrator cannot be certain that participants have actually received the mailed documents, whereas the plan administrator can determine whether participants opened an electronic communication and how they interacted with message. Second, many participants no longer distinguish hard copy documents from junk mail, even with employer logos. Third, plan administrators often must mail out several documents as they might not be certain which health and welfare plan the participant will choose. Finally, paper documentation often becomes stale quickly and updating this information in print is expensive.

Providing a streamlined document in paper format is extremely challenging. Witnesses testified that people like to consume information in a hierarchy – starting broad and high level, then drilling into specific areas of interest. The ability to use electronic communications could resolve many simplicity, readability and understandability issues, as well as empower participants to have the information most relevant to them. Additionally, electronic SPDs mean that an employer could change the document in real time and participants would have the most up to date information at their fingertips.

Many witnesses urged the Council to recommend that the Department consider updating the electronic disclosure rule along with evaluating mandatory disclosures. Other witnesses cautioned about electronic distribution rules being different on an interagency basis, e.g. the Department being different from the IRS. These witnesses would like one overall standard within which plan administrators could operate.

Although the focus of the Council's report in 2017 is on the form, content, timing and frequency of plan disclosures, because many witnesses discussed electronic delivery in their testimony, an Appendix to this report has been prepared to provide a separate summary of the testimony related to electronic delivery for possible consideration by the Department at a future date.

C. Proposals and Recommendations

Against this broad brush back drop, each section below discusses the witness feedback and analysis on the three proposals as well as the Council's recommendations.

1. SARs

The Council evaluated the SAR's value in informing participants about non-exempted group health plans. To assess the value, the Council reviewed whether the SAR requirements for these group health plans are necessary or helpful in fulfilling the Congress's expressed purpose for

enacting the ERISA reporting and disclosure regime. Specifically, the Council considered whether:

- A SAR generally empowers participants to police an employee benefit plan.
- A SAR helps participants evaluate group health plans.
- A SAR must contain specific elements to be a valuable and useful tool.
- Any group health plans not exempted by the Department are likely to have characteristics necessary to make the SAR valuable to participants.
- There is evidence that participants in the non-exempted group review their plans differently than participants in the exempted group.
- The exempted group could be exempted consistent with the Congressional purpose.
- The specific regulatory requirements could be reduced or simplified consistent with the Congressional purpose.
- A different delivery mechanism would be more effective or preferable in fulfilling the Congressional purpose.

The disclosure regime's legislative history with respect to SARs suggests that the Congressional purpose in requiring the SAR was to ensure that employees had sufficient information to enable them to know whether a plan was financially sound and if the plan was being administered as intended. The witness consensus was that the SAR does not achieve the intended purpose, as it does not have information that would allow such oversight. Witnesses believe the 5500 should provide sufficient information, and the 5500 is available online free from the Department.

The oft-stated opinion was that participants do not read SARs. One witness testified that he had one employer that had less than 0.2% of participants open the SAR on the website. According to Mark Buckberg of Bond Beebe:

> *"…everyone…wants to know how does this [SAR] affects me, not the general big picture of the fund."*

An example of generic and redundant SAR information is the requirement for fully insured health and welfare plans that the SAR identify the carrier and total premiums paid. Individuals have no mechanism for evaluating the carrier's quality or whether the premiums are in line with expectations. Additionally, these facts are disclosed numerous times in a variety of ways through open enrollment materials, SPDs, and other plan documents.

Most people do not understand how the SAR is relevant to them. Witnesses suggested moving SAR distribution to an event-based approach, whereby if funding went below a specific ratio, for example, a SAR would be distributed. This approach means that participants would receive relevant information when needed versus non-relevant information with a specified frequency. Witnesses questioned whether the SAR served any greater purpose for the non-exempt plans relative to the exempt plans. For example, witnesses doubted that requiring the SAR for employers with 100 or more participants was a reasonable approach. If the information in the SAR is important to understand, then all participants should have a SAR, not just employees of

larger companies. Arguably, employees of smaller employers may be at greater risk than those at large firms.

Beyond the information and content, the SAR is required to be distributed nine months after year end or if the period of time to file the Form 5500 is extended, the time to file the SAR is extended two months after the close of the 5500 extension period. This timing means that for a calendar year fund, for example, the SAR does not have to be sent until December 15 of the next calendar year, if the maximum extension is granted for the filing of the 5500. The delay means participants may be receiving stale information that could be potentially misleading, rather than receiving current information about the plan.

Nevertheless, the participant advocate witnesses urged the Council not to eliminate the SAR requirement in its entirety – advocating that participants continue to receive sufficient information to alert them of the availability of the Annual Report.

Recommendation:
After careful consideration the Council recommends that a group health plan administrator not be required to furnish a separate SAR if the plan administrator combines sufficient information with other required communications (or the quick reference guide discussed below) to notify participants of the Annual Report's existence and where to find it. The Council concluded that notifying participants of the annual report's availability directs the participant to financially relevant information; however, the other information currently required is not valuable, does not achieve the SAR's purpose, and is burdensome to furnish.

2. Annual Notices

The 2017 Council assessed whether plan administrators could consolidate annual notices into a single notice and maintain effective communications. For example, a plan administrator could combine the SBC, HIPAA Privacy, WHCRA, Medicare Part D, SMM (if applicable), SAR (if applicable) and CHIP required notices into one annual integrated mailing or electronic posting. Witnesses provided testimony on whether annual and reoccurring notices would remain effective in communicating the required messages if they were consolidated and used model formats. They also testified as to whether such consolidation and model formatting would be helpful in reducing the administrative burden.

Annual notices are delivered at different times during the plan year. Many witnesses testified that the ad hoc nature of notice timing, coupled with the volume of notices throughout the year, caused participants to ignore notice content. Several witnesses testified that many employers simply put notices in the back of an open enrollment booklet. Many witnesses testified that notices are usually captioned as legal notices and written using legal boilerplate language. This approach contributes to participant perceptions that the notices are for compliance purposes only and do not contain useful or meaningful information. Witnesses agreed that harmonizing the timing would reduce the employers' administrative burden significantly.

The second recommendation was that the notices move away from legalese language and be allowed to present information in a more participant-friendly format. Specifically, witnesses

recommended having notices that clearly identify "why" the notice is being sent, "how" the notice is important for the participant and "what" specifically the participant needs to know. Witnesses also agreed that employers would welcome model notices and model language from the Department, but emphasized that plan administrators need flexibility to tailor the notices to their workforce. Witnesses recommended consolidating the notices and aligning the timing, perhaps developing a booklet of notices accompanied by brief, clear and non-legal explanations of what each notice is and what they mean to the employee.

Recommendation:
On this matter, there was virtually no dissenting opinion. Based on the witness testimony, the Council recommends that the Department permit the annual notices required under part 1 of title I of ERISA be consolidated into one notice that must be furnished either at the date of the earliest required notice or at the outset of any applicable annual open enrollment period for the employee health benefit plan. Alternatively, these annual notice requirements may be satisfied by incorporating the notices in a quick reference guide under the Council's SPD safe harbor proposal as discussed more fully below. All event-based notices (other than the event of first becoming eligible to participate in the plan) must be furnished regardless of whether the safe harbor has been adopted. A waiver of the current annual notice requirement will be necessary to permit substituting a quick reference guide for the notices. The rationale for the waiver is that each required disclosure is briefly described in the quick reference guide with directions about how and where to access the required disclosures' full contents. To the extent that the Department cannot unilaterally apply a waiver for a required program notice because another agency along with the Department oversees the disclosures, the Council proposes that the Guide include a brief description of the notice even if the waiver is not extended (at least during a period within which the other agency can be consulted).

3. SPD

The witness consensus was that the SPD's summary information function has been largely eliminated and that, in practice, plan administrators are distributing plan documents rather than SPDs to their group health participants. Instead of having a comprehensive plan with a brief, understandable summary document, as originally intended; the SPD typically serves as the plan document. Most witnesses agreed that the current approach is burdensome and expensive for plan sponsors.

According to Anthony Sorrentino of Silverstone:

> *"[Our clients are] spending a lot of money, anywhere from $500 to $5,000 a year, on printing costs, [having] anywhere from half an employee to two full-time employees to take care of [SPDs]…and follow up with … questions and any comments…."*

Mr. Sorrentino further noted that many employers have multiple health and welfare plans, so they must prepare these documents for each plan, which in aggregate becomes quite cumbersome. Other witnesses estimated SPD administration and distribution costs between $20,000 -$120,000 per annum. The third party plan administrator panel advised that legal costs for SPDs can run between $5,000 and $50,000 per document.

A typical group health plan SPD is very long and complex because the courts rely heavily on the language used in the SPD in deciding benefits claims disputes. The SPD's length and complexity are also due to the fact that health care administration and participant decision-making have become increasingly complicated. The Department's current guidance on the required SPD format does not provide a foundation for simplicity or clarity. The Department's regulations currently appear to focus on preventing plan administrators from misleading or failing to inform participants, with an emphasis on not minimizing or obscuring exceptions, limitations, reductions, and restrictions of plan benefits. This approach encourages plan sponsors and plan administrators to be overly inclusive in terms of the information presented in the SPD, rather than emphasizing the most useful and important information.

Even with more content, the typical SPD still does not provide all the information that participants need. Deborah Harrison, of the National Business Group on Health, noted that despite the typical SPD's length and complexity, the SPD is not comprehensive, because critical information is not, and cannot be, included. Participants must obtain additional, crucial documents to use the plan appropriately. For example, participants must obtain information on participating providers and approved drugs. Similarly, participants typically rely on their doctors to determine which services require pre-authorization, are experimental, cosmetic, and medically necessary. Obtaining generalized information, then needing to find additional information is a common experience for most participants.

Accordingly, given strong and credible criticisms of current SPD rules, the Council focused on whether the Department could sanction an alternative format and/or delivery mechanism for a group health plan SPD. Specifically, the Council explored whether the SPD could consist of (1) an outline of the plan's rules and requirements with only summary information and (2) explicit instructions as to the ways a participant or beneficiary could access the full description of each topic therein. This document would be distributed to each participant and would be updated regularly. Comprehensive, detailed information would be readily available and distributed to participants upon request without delay. The Council sought testimony from expert witnesses who could evaluate whether an alternative format would protect participants' and beneficiaries' rights, be more effective as a communication tool, and reduce administrative burden. Witnesses indicated that employers would welcome a "quick reference guide" if this document is incorporated into the SPD and is not produced in addition to the SPD.

The witnesses agreed that in practice, plan sponsors today use the SPD as the written plan document required by section 402 of ERISA and not as a summary document to communicate important information about the plan to participants as required by section 102 of ERISA. To that extent, the SPD as Plan Document serves important administrative functions. Plan sponsors, third-party plan administrators, and plan auditors rely on the SPD's provisions to review plan claims, determine eligibility for plan benefits, and process reimbursement payments to health care providers. As a result, over time, the SPD's language has become more technical and the SPD longer. Accordingly, most witnesses welcomed a streamlined "summary" as long as it was not yet another requirement.

According to the witness testimony, most participants use health and welfare SPDs on an event-driven basis, i.e. when they have a health concern or need to know information relative to a specific set of circumstances. Witnesses represented that the most effective SPDs in terms of

participant communication are drafted in a user-friendly manner and focus on how an employee uses the document to obtain relevant information when a decision must be made.

Many witnesses stated that they know how best to communicate effectively with their participants. They testified that to distribute important information, plan administrators use a variety of communication mechanisms, including using electronic media, post cards, magazines, videos, websites, apps, phone calls, or whatever they find works best for their particular workforce demographic. Several witnesses testified that using a variety of communication methods was more effective that a single method. According to the witness testimony, participants perceive that the SPD and other disclosures are distributed solely to meet regulatory requirements and are not designed to communicate important information or to engage employees. Consequently, the witnesses were supportive of the Council's proposed quick reference guide as an introduction to the SPD.

While this report was being drafted, the United States Court of Appeals for the Ninth Circuit published a decision relevant to our findings. In *King v. Blue Cross and Blue Shield of Illinois, et al.*, No. 15-55880 (9th Cir. Sept. 8, 2017), the Court held, among other things, that the plan administrators of a retiree-only health care benefits plan violated statutory and regulatory requirements by failing to provide a reasonably understandable SMM, and that the plan administrators could be found liable for breaching their fiduciary duty by failing to comply with ERISA's disclosure requirements. The court found that the SMM, which announced changes to the lifetime benefit maximum as a result of the ACA, failed to apprise the average participant of the retiree-only plan that the change did not apply to them. The SMM required participants to understand the significance of different font sizes and to follow asterisks to comprehend that the elimination of the lifetime maximum only applied to the active employee plan.

The Council found the case instructive because the case demonstrated that compliance with ERISA's disclosure requirements is not achieved merely by providing a document that describes the elements of a benefit or a benefit change if the average plan participant cannot understand the description. This conclusion is consistent with the witnesses' testimony that, for many of the complex subjects incorporated into the SPD or SMM, comprehension is better achieved by providing clear notice of the subject and an instruction regarding where and how to get detailed information about the issue. In this way, participants are more likely to read the notice, remember the subject when it might apply to them, and then read the detailed information when it becomes relevant to them. Our recommendations start from this premise.

The lynchpin of the 2017 Council's recommendation is developing a new model introductory portion of the SPD. This model is called the quick reference guide and is designed to be a safe harbor that plan administrators could adopt to comply with their disclosure obligations under part 1 of title I of ERISA. It is important to note that the quick reference guide is **not** a separate document, but rather is the first few pages of the SPD for the group health plan. The quick reference guide is, however, the only automatically deliverable portion of the SPD, and is designed to be delivered annually to each participant as a companion to the SBC. The safe harbor is conceived as a method of achieving the twin goals of improving the effectiveness and reducing the burden of the disclosures; thereby resolving issues witnesses raised in the Council's first hearing.

The quick reference guide would have the following required features:

- Notify participants annually that the Form 5500 for the previous year had been prepared and where and how to locate a copy of the full annual report.

- Remind participants annually about the contents of each initial and annual notice, including where and how to locate a copy of these notices.

- Identify for participants annually each material topic described in the remainder of the SPD, including where and how to locate a copy of the SPD's text for each topic.

- Inform participants annually of each material modification of benefits during the last 12-month period; thereby eliminating the need for a separate SMM.

The Council proposes that if a plan administrator adopted the new safe harbor and satisfied all the conditions, the quick reference guide would be the only required automatically deliverable communication to the participants and beneficiaries in a group health plan – other than event based notices – under part 1 of title I of ERISA. All the disclosures required under current law would be required to be made available upon request at any time, but would not be furnished absent such a request (except event-based notices).

The quick reference guide's contents under the safe harbor would contain enumerated mandated information, which in each circumstance would be accompanied by an electronic reference (e.g., a hyperlink or website reference) and by a manual reference, (e.g., a telephone number or plan administrator's location), to permit the participant to access the SPD's full language regardless of whether the participant was reviewing the quick reference guide electronically or in hard copy. The mandated content of the quick reference guide would include:

- A brief description of the enumerated information required in section 2550.102-3 of the Department's regulations applicable to group health plans, except cross references to the SBC may be substituted for the information contained therein.
- A brief description of each notice that is required to be furnished to a participant upon his or her initial eligibility to join the plan or annually.
- A reminder of the availability of the annual report for the last year as to which the annual report was due.
- A summary description of any material modification of the SPD during the last 12-month period.

After the Council's first hearing in June 2017, the Council prepared a model quick reference guide to elicit comments from witnesses testifying in August 2017. The model is based on an illustrative group health plan with typical features. The model is designed to introduce and provide navigation tools to find every concept required by section 2520.102-3 of the Department's regulations, each annual notice required by part 1 of title I of ERISA, the SMM for the year, and the Council's proposed substitute for the SAR.

The Council distributed the draft model quick reference guide to the August witnesses. Nearly every witness commented that the model was a substantial improvement to the typical complete SPD currently distributed in terms of simplicity, ease of use, and effectiveness in communicating plan terms and furthering the SPD's purposes. Many commenters provided useful feedback, including ideas on how to improve the quick reference guide. Specifically, the witnesses nearly uniformly sought to make the quick reference guide shorter and simpler to read. Several witnesses suggested fewer words be placed on each page and that different fonts be utilized to highlight key information. Those witnesses also urged the Council to reform the model quick reference guide to emphasize how participants could get more information and where to direct questions. Based on this testimony, the Council modified the model quick reference guide to shorten sentences, utilize bullet points, and remove distracting elements.

The Council's model is attached as an Appendix. The Council recognizes that plan designs vary significantly; therefore, sponsors and plan administrators could not adopt the model without material modification. The model is merely to provide an example of a document that the Council believes could better serve the mandated disclosure purposes versus the current approach. The Council does not intend the model to be anything other than an illustration.

Recommendation:

The vast majority of the testimony focused on the current SPDs' length and complexity. Recognizing that the SPD typically serves as the plan document and is not a summary, as was originally intended, and that printing and distributing a lengthy SPD is burdensome, the Council recommends that:

(a) The Department create a **safe harbor** whereby group health plan administrators distributing an **annual quick reference guide** (along the lines of the model described below) in coordination with the SBC are **not** required to **distribute automatically** any of the following:

- An updated complete SPD every five (5) or ten (10) years (as applicable).
- An annual SAR.
- A SMM for the year.
- Any annual notice not triggered by an event required under part 1of title I of ERISA.

Note: the safe harbor would have no impact on other initial notices that by regulation may be included in the initial complete SPD, such as COBRA notices. Similarly, any changes to the complete SPD must be made in accordance with existing law, and those changes must be highlighted in the safe harbor's annual quick reference guide. The annual quick reference guides must be archived or otherwise preserved and maintained to document all modifications over time. Thus, the safe harbor would not change the following current disclosure requirements:

- The complete SPD must be formally updated every five or ten years (as applicable).

- A complete SPD must be provided upon initial eligibility along with applicable quick reference guides since the complete SPD was last updated. This approach is currently required for SMMs.
- A printed SPD must be available upon request.
- Plan administrators must continue to comply with the SPD requirements with regard to content, uses, or purposes.

(b) The Department develop and publish a **model** of a quick reference guide described in (a) above, an example of which is in the Appendix to this report.

V. APPENDICES

A. The Quick Reference Guide

ABC Sponsor Health Care Plan

20 Quick Reference Guide**

This Guide is a brief introduction to the ABC Sponsor Health Care Plan. The Guide is the first few pages of the Summary Plan Description (the "SPD"). You may ask to have the complete Summary Plan Description delivered to you at no cost at any time.

To get the Complete Summary Plan Description (the "**SPD**")
- Visit the website www.abchealthcareinfo.com and click on the "See Complete SPD" tab;
- Call the *ABC Health Care Plan Answer Line* at 888-888-8888; or
- Stop by the ABC Human Resource Department.

The Guide will provide you quick facts about the Plan regarding who is eligible, how to enroll, how to file claims, and how to get more information. It also provides a brief summary of your rights under the Plan.

In addition to the Guide, you received the 20** Summary of Benefits and Coverages (the "SBC"). The SBC describes the specific Plan coverage programs and their cost to you.

Updated versions of the Guide and the SBC will be delivered to you before the annual enrollment period each year, usually around October 1st.

Note: The SPD (including this Guide) and the SBC are only summaries. If you want to learn all of the details, ask for a copy of the Plan document (available online or upon request). If the information in SPD or SBC is different than the information in the Plan, the information in the Plan will apply.

Questions?
- Call the *ABC Health Care Plan Answer Line* at 888-888-8888;
- Stop by the ABC Human Resource Department;
- Leave a question after clicking the "Contact Us" tab on the website www.abchealthcareinfo.com.

Also: If you are viewing this Guide online, or want to get more information online, you can click on the tabs or hyperlinks embedded in or next to each section of the online version of the Guide.

A. *What's New?*

Since last year, there have been changes to the charges of certain co-pays and deductibles for the coverages. These changes are described in the new 20** Summary of Benefits and Coverage ("SBC").

B. *What Types of Health Coverages Are Available?*

- Health Maintenance Organization ("HMO");
- Preferred Provider Organization ("PPO"); and
- High Deductible Healthcare Program ("HDHP").

If you are a retired employee who is age 65 or older or otherwise qualifies for Medicare, the only coverage available to you under the Plan is the Medicare Advantage Prescription Drug Coverage ("MAPD").

In addition, you (whether active or retired) may enroll separately in the dental care coverage and vision care coverage.

Go to the Summary of Benefits and Coverages ("**SBC**") to Learn about:

- The Benefits under each Coverage;
- The Cost ("Premiums") to you for each Coverage; and
- The Co-Pays and Deductibles under each Coverage

Here are some important things to know about all of the coverages:

- There is no annual or lifetime limit on benefits.
- You do not have to see a designated primary care doctor before you can see a specialist.
- You do not need prior authorization for gynecological or obstetrical care.
- Each coverage –
  - Provides preventive care services;
  - Guarantees 48 hours of maternity coverage for hospitalization for after a vaginal birth and 96 hours after a cesarean section;
  - Provides for reconstructive surgery after a mastectomy;
  - Provides for mental health and substance abuse disorder coverage; and
  - Honors qualified medical and child support orders.

Note: If your dependent child is enrolled in Medicaid or the Children's Health Insurance Program ("CHIP"), you might be eligible for premium assistance.

Need a List of Participating Medical Service **Providers** or a List of **Prescription Drugs** Available under Each Program?

- Visit the website www.abchealthcareinfo.com and click on the "See Provider List" or the "See Prescription Drug List" tabs;
- Call the *ABC Health Care Plan Answer Line* at 888-888-888; or
- Stop by the ABC Human Resource Department.

C. *Who May Enroll?*

- *Active Employees*: You are eligible to participate in the Plan if you are scheduled to work regularly at least 30 hours per week.
- *Retired Employees*: You are eligible to continue to participate in the Plan after you terminate employment if are immediately eligible to receive a pension benefit from the ABC Retirement Plan and you enroll in Parts A and B of the Medicare Program.
- *Spouses and Dependents:* If you are participating in the Plan, you may enroll your spouse and dependents in the Plan.

D. *What If You Have a Pre-Existing Health Condition?*

Your enrollment and your coverage options will not be affected by any health condition that you might have.

Note: your personal health information will not be disclosed without your permission to anyone not involved with the administration or operation of the Plan.

E. *When May You Enroll?*

You may enroll within 60 days of date that you were first eligible to participate in the Plan. You may re-enroll or change your election during each annual enrollment period beginning around October 1st and ending around November 30th. Also, you may make changes during the year if you have a life event, such as, you get married, you get divorced, you have or adopt a child, your dependent turns 26, your spouse or dependent become disabled or pass away, or your spouse or dependent loses his or her coverage from another employer or his or her premium assistance from Medicaid or CHIP. You must report any of these changes to the ABC Human Resources Department. You may be asked to provide evidence of the event resulting in the change.

F. *How Do You Enroll?*

You enroll in the Plan by submitting a completed enrollment form to the ABC Human Resources Department, or online by visiting www.abchealthcareinfo.com and clicking on the "Enrollment" tab. You may not enroll by telephone.

Note: included with the enrollment form (either in paper or online), is information regarding the public health care exchanges that are available to you.

G. *When Does Your Coverage Begin?*

Your coverage begins on the first day of the month on or following the date that you became eligible and submitted your completed enrollment form to the ABC Human Resources Department.

H. *How Long Will Your Coverage Continue?*

Unless your coverage is terminated, your coverage will continue until the end of the calendar year. Each open enrollment period you are required to re-enroll in the Plan for the new calendar year. Special Rules apply if you go on leave or if you become disabled.

I. *When Will Your Coverage End?*

Your Coverage ends the last day of the month in which:

- You are no longer employed in an eligible position and you do not continue your coverage under COBRA;
- The employee through whom you are eligible to participate in the Plan, stops participating in the Plan;
- You no longer qualify as a spouse or dependent, and you do not continue your coverage under COBRA;
- Your annual coverage expires because you do not renew your coverage;
- You do not pay your premiums on time;
- Your continuation coverage under COBRA expires;
- You choose to stop your coverage based on a permissible life event that happens;
- You are a retired employee and you do not enroll in Medicare Parts A and B;
- Your employer stops providing coverage the Plan;
- The Plan is terminated; or
- You pass away.

Note: your dependent child could be protected from loss of coverage as a result of the loss of student status if that status was lost due to a medical condition.

J. *How Do You Learn More about Continuation Coverage ("COBRA")?*

Go to the last page of this Guide to learn more about COBRA.

K. *How to Get More Information if You Do Not Understand Your Explanation of Benefits ("EOB")?*

Each time that you receive benefits under the Plan you will receive an EOB. If you have trouble understanding it, or if you believe that the EOB is inaccurate, call the *ABC Healthcare Hotline* at 888-888-8888, stop by the ABC Human Resources Department, or visit www.abchealthcareinfo.com and click on the "Contact Us" tab and leave a question.

L. *How Do You Make a Claim if Your Benefit Is Denied?*

If you believe that a benefit should have been covered that was not, you may file a claim within 180 days of the date you received the EOB. You have a right to have the plan administrator review a denial of a benefit claim and to appeal that denial. For certain claims you have a right to have an

independent professional review your claim. Your claim must be made in writing and it may be dropped off or mailed to the ABC Human Resources Department or filed electronically at www.abchealthcareinfo.com by clicking on the "File a Claim" tab.

M. *What Legal Rights Do You Have?*

As a participant in the Plan or as a beneficiary of a participant in the Plan, you have significant legal rights under federal law. The SPD describes those rights and it is important that you learn about them and refer to them whenever you have questions about the Plan's operations or the benefits that are made available to you under the Plan. To review your legal rights or to receive a copy, visit the website at www.abchealthcareinfo.com and click on the "*Know Your Rights"* tab, or call the *ABC Health Care Plan Answer Line* at 888-888-8888, or stop by the *ABC Human Resources Department* and ask for a copy of the "ERISA Rights Statement." You may also visit the U.S. Department of Labor, Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call the DOL EBSA at 1-866-444-3272.

N. *Basic Information about the Plan*

The Plan is called the *ABC Sponsor Health Care Plan.* The Plan describes the health care benefits made available to you by ABC as required by the *ABC-Union* collective bargaining agreement, covering your employment beginning January 1, 20__ and ending December 31, 20__. The Plan's IRS identification number is 88-8888888. The Plan is self-insured, which means that ABC is fully responsible for paying for the costs of the benefits provided under the Plan and of the Plan's administration other than the costs under the Plan that you are required to pay. ABC established a trust, called the *ABC Health Care Trust*, to put aside funds to help pay for the Plan's costs. The Plan is administered by ABC. Both the Plan and the *ABC Health Care Trust* keep their books and records on a calendar year basis with each year running from January 1st to December 31st. A legal claim against the Plan will be accepted by the plan administrator. If you would like to send a letter to the plan administrator or to the trustee of the ABC Health Care Trust, address your letter to the ABC Sponsor Health Care Plan Administrator, c/o Human Resources Department, ABC, 888 XYZ Lane, DEF City, VW State, 88888; or to the Trustee of ABC Health Care Trust, c/o Human Resources Department, ABC, 888 XYZ Lane, DEF City, VW State, 88888. You may also get a copy of the Plan's annual report.

Note: the Plan may be changed or terminated at any time by the Plan sponsor subject to any collective bargaining obligations.

Want More Information?

- Visit the website at www.abchealthcareinfo.com and click on any of the following tabs:
  - *"See Plan Document,"*
  - *"See Trust Document,"*
  - *"See Collective Bargaining Agreement,"*
  - *"See Annual Report,"* or
  - "Contact Us;"
- Call the *ABC Health Care Plan Answer Line* at 888-888-8888; or
- Visit the ABC Human Resources Department, and ask for any of these documents.

COBRA

O. *When Are You Eligible for Continuation Coverage ("COBRA")?*

You, your spouse, and your dependents are eligible for COBRA if one of you loses coverage under the Plan because

- You cease employment (for reasons other than gross misconduct);
- You change positions to one in which you are not scheduled to work regularly 30 hours per week;
- You become disabled and eligible for Social Security disability benefits;
- You and your spouse divorce or get separated;
- You pass away;
- Your child no longer qualifies as a dependent or turns 26.

Note: it is your responsibility to report a divorce, legal separation, or loss of a child's dependent status.

P. *How Long May You Stay on COBRA?*

COBRA resulting from terminating employment or changing positions is available for up to 18 months. COBRA resulting from disability is available for up to 29 months. COBRA resulting from death, divorce, legal separation, or loss of dependent coverage is available for up to 36 months.

Q. *How Do You Enroll for COBRA?*

You enroll in COBRA by submitting a completed COBRA enrollment form to the ABC Human Resources Department, or online by visiting www.abchealthcareinfo.com and clicking on the "COBRA" tab. You may not enroll by telephone.

Note: there are strict deadlines for enrollment. For details call the ABC Healthcare Hotline at 888-888-8888, stop by the ABC Human Resources Department, or click on the "COBRA" tab at www.abchealthcareinfo.com.

R. *How Much Does COBRA cost?*

You will be charged 102% of the actual cost of the COBRA coverage. The costs are set annually. Ask for the current rates by calling the *ABC Healthcare Hotline* at 888-888-8888, stopping by the ABC Human Resources Department, or visiting www.abchealthcareinfo.com and clicking the "COBRA" tab.

B. Electronic Disclosure

Background

Although the 2017 Council's primary focus is on the burden and effectiveness of the content of mandated disclosures, many witnesses stated that to discuss this topic adequately, the Council must also consider delivery. Given that electronic disclosures play a significant role in current plan administration, many witnesses testified to their experiences with electronic media and plan participant engagement. Individual preferences on the medium and mode of delivery vary, so plan administrators have utilized a variety of approaches to better communicate with participants. The Council's findings are summarized below.

Lower distribution costs, reduced administrative burden, and more timely information updates are some of the generally accepted electronic delivery benefits. David Kritz of Norfolk Southern, testifying on behalf of the American Benefits Council, stated:

> *"We believe that distributing required communications electronically offers approaches that can better serve employees because it's easily accessible, searchable, low in cost, and satisfies the statutory notice requirements."*

In addition, witness testimony indicated that standard paper disclosures are not as effective as intended, because notices get ignored or lost, and plan administrators cannot be certain that participants have actually received the documents. Electronic delivery can be provided in a more consistent, consumable format that is personalized to the intended reader. Most witnesses also testified that most day-to-day information is disseminated electronically, and that consumers have a broad expectation of receiving information electronically.

Witnesses discussed the notion of electronic delivery as the default delivery mechanism for disclosures, with the right to receive paper materials only upon request. Brennan McCarthy of Willis Towers Watson noted that

> *"Probably the most thorny of the suggestions, is considering passive consent for electronic receipt of documents, but believes that "most employees would opt to receive their SPD electronically."*

Mr. Kritz supported the notion that

> *"…electronic should be the default method of delivery."*

Mr. Hadley, cited a SPARK Institute study that estimated that

> *"…switching to an electronic delivery default would produce $200 to $500 million in aggregate savings annually that would accrue directly to individual retirement plan participants.*"

Several witnesses pointed to other federal agencies, such as the IRS and SEC, that have advanced electronic dissemination of important information. Similar to the proposed Quick Reference Guide, Will Hansen of the ERISA Industry Committee observed that the SEC instituted an e-proxy system permitting delivery of post-cards with instructions to publicly accessible websites for proxy materials.

Michael Hadley of Davis & Harman LLP observed that the Federal Thrift Savings Plan moved to default electronic delivery years ago.

Conversely, we heard testimony that generational, socioeconomic, and accessibility limitations should be considered in understanding that for some participants, traditional paper communications are still the preferred method of delivery. Sanford Walters of Kelly & Associates Insurance Group pointed out that

> *"…only a third of people with less than a high school degree have internet access. Only 45 percent of people who make less than $25,000 a year have internet access. People who live in rural areas don't have great connectivity."*

Mary Smith, speaking for Insurance Management Administrators, observed that

> *"We really do not feel that senior and lower income people are electronically, technically up to date… there's still, we think, too big a part of the population that are not sophisticated enough to receive required notices in that fashion."*

Mr. Walter's further cautioned:

> *"It's just not fair to employees to put the burden on them to have to go search out for information about when they can have a pension, what their investment options should be, when they should have health benefits."*

Glen Willocks of TradeWinds Island Resorts, testifying on behalf of SHRM, observed that electronic disclosure for his company's participants is not feasible:

> *"Many of our employees do not speak English. Many of our employees share an email address or do not have an email address. We find it far more practical and effective to deliver a lot of these notifications in person at our annual enrollment meetings."*

Jane Smith of the Pension Rights Center testified that disclosures should continue to be provided in hard copies, as they do not believe participants would or should have to take the additional steps to obtain the information needed in lieu of hard copy disclosures. Michele Varnhagen of AARP referenced AARP surveys on preference for electronic versus paper:

> *"We have asked people over 50, we've asked people under 50: do you want your information on paper or do you want it electronically? And overwhelmingly people have said they want paper."*

Jeanne Medeiros of the Pension Action Center stated that

> *"…moving to an all-electronic system of delivery would have a negative impact on our most economically vulnerable seniors…any method of delivery which requires the participant to take additional steps, such as visiting a library or senior center or asking a friend or family member if they can use their computer or having to make a specific written or verbal request for required disclosure is a disservice to participants."*

Notwithstanding witnesses who advocate paper disclosures, the majority of witnesses concluded that participants do not read the paper that is sent to them, and many have difficulty navigating and understanding the paper disclosures.

From the above summary of the testimony, the Council concludes that an effective disclosure protocol might include aspects of electronic and paper delivery. In fact, although plan administrators comply with disclosure mandates through paper delivery, most use electronics when they want to be more targeted and effective in their communications. Further work and exploration is required to do this subject justice. Nevertheless, we summarize below some advantages discussed by witnesses.

Best Practices in Electronic Delivery

These best practices can be grouped into the following categories:

1. Content navigability
2. Layered or nested presentation of information
3. Enhanced user interaction including real-time call-to-action, where applicable
4. Cross device and platform compatibility

Content navigability

Content navigability is comprised of several components. The ability to easily search a table of contents and a document creates a more relevant and user-friendly experience for participants. Mr. McCarthy commented:

> *"If you're going to focus on electronic distribution, maybe consider some guidelines around ease of navigation of the documents so that it's not just an exercise of taking an existing SPD that maybe doesn't have much communications value and putting it online. It's really being thoughtful about how it should be reformatted."*

Additional navigability features include hyperlinked terms, definitions for terminology provided through links or hover texts, cross linked or referenced sections and plain language search capability, whereby user queries can be mapped or translated to generate applicable results.

Information nesting

Information nesting, which was mentioned by multiple witnesses, refers to the practice of layering information in accordance with the most relevant and most frequently searched. Nesting enables a drill down into various layers of information as needed by participants. Nesting has the potential to provide a simple experience and in-depth, relevant content simultaneously. Users can move from a high level to very detailed information without causing disengagement, which often accompanies a participant's lack of confidence when presented with too much content.

Electronic delivery

Electronic delivery presents opportunities to increase user interaction and related calls-to-action by acting as a gateway. Witness examples include embedded links to tools such as asset allocation illustrations or retirement income calculators. An additional example is providing a link to the participant's account login screen at the relevant communication points, such as beneficiary designation or electing deferral amounts.

Cross-device compatibility
Participants today have varying preferences with regard to their preferred electronic device and many may interchange among devices and device types. To preserve choice and flexibility, content presentation and navigability must be tailored to be functional across platform types. Additional flexibility to save and share across devices, such as opening content where the user's previous query left off may be useful.

Data Collection and Analysis Related to Disclosure Utilization and Engagement
A by-product of electronic delivery is the ability to collect and analyze data with regard to user utilization. By measuring communication effectiveness, one can improve future disclosures regardless of the delivery format.

Unlike traditional paper delivery, electronic communications are easily tracked for receipt without materially increasing cost or administrative burden. This point was noted as important to some witnesses. Beyond delivery, data related to "open rate", "engagement time", "download", "exploration beyond disclosure", and "click through to action" are also available for collection. Mr. McCarthy provided the eMag (electronic magazine) as an example:

> *"The value to an eMag…is that you get analytics. So we can tell how much time employees spend on a certain page and where their points of interest are, and that can help inform future communications."*

Data aggregation data may potentially lead to harmonizing accuracy and understandability.

Innovation in Language Regulating Electronic Delivery
Recognizing that regulations are generally static, but technology continues to evolve, the Council also heard testimony about the language regulating electronic delivery. Generally, the witnesses believed that making regulations more 'evergreen' and relevant is important even with continued innovation. Language in regulations and requirements often reflect the current standard of technology, which may not be applicable in the future. Mr. Hadley cautioned

> *"I don't think whatever [language guidance and standards] we come with next should be tied to a particular electronic technology, because it's moving way too fast. …You want a flexible standard."*

David Levine of Groom Law Group concurred, recommending a path

> *"…that addresses certain principles about how people received things, because for what works today for instance, may be passé tomorrow."*

Guiding Principles
The witnesses offered the following guiding principles:

1. Regulation should not be tied to any current form of technology as it is rapidly changing;
2. Regulation should not preclude innovation and needs to be broad in application to future technology; and
3. Language in regulations, guidance and model examples should provide flexibility to plan administrators so they may utilize features and capabilities to enhance participant engagement,

such as the aforementioned best practices including navigable and hyperlinked documents among others.

Professor Peter Wiedenbeck of Washington University in St. Louis, while applauding and encouraging the Council to

> *"…explore the advantages of increased reliance on electronic nested, progressive disclosure and maybe mobile access to plan information."*

He also cautioned that

> *"the Labor Department is going to need to insist upon archiving of all that electronic disclosure and every version of that electronic disclosure in order to monitor and enforce the plan administrator's obligations under the various disclosure rules that are embedded in ERISA. You've got to be able to have access to the information that was provided if it's later challenged as inaccurate or incomplete."*

References

The following references have been provided as resources for additional information:

- SEC e-proxy system – links to full proxy statements
- Social Security Administration – Nearly all new claims are made on-line (mostly seniors)
- FINRA
- Department of Labor's EFAST
- OMB "Reducing Reporting and Paperwork Burdens" (6/22/12)
- PEW "Internet and American Life Project" on daily rates of internet use by age
- Other
    - OMB: Reducing Reporting and Paperwork Burdens 6/22/12
    - EBSA: Final Rules Relating to Use of Electronic Communication and Recordkeeping Technologies by Employee Pension and Welfare Benefit Plans 4/9/02
    - IRS: Use of Electronic Media for Providing Employee Benefit Notices and Making Employee Benefit Elections and Consents
    - GAO: Private Pensions Revised Electronic Disclosure Rules Could Clarify Use and Better Protect Participant Choice (Sept 2013)