Brown & Brown

EMPLOYEE BENEFITS

Employee Assistance Programs (EAPs)

Compliance Considerations for Employers

May 2023

The term “employee assistance program” (EAP) is not defined under federal law, and the specific benefits and services offered under these programs will vary from employer to employer. For the most part, EAPs are employment-based programs that offer employees benefits ranging from financial planning and childcare to substance abuse counseling and mental health support. EAP benefits are typically provided through third-party EAP vendors and can be offered as stand-alone programs or coordinated with an employer’s wellness program. Life and disability carriers frequently include EAP programs as a value-added benefit in conjunction with a long-term disability (LTD) policy.

When determining an employer’s compliance obligations pertaining to EAPs, the most important factor will be whether the EAP provides medical care/benefits.

ERISA

EAPs Providing Medical Benefits

To the extent an EAP provides medical benefits, and assuming the plan sponsor is otherwise subject to ERISA[1], the EAP will be an employee welfare benefit plan subject to ERISA’s reporting and disclosure requirements. ERISA section 3(1) defines the term “employee welfare benefit plan” as:

> “any plan, fund, or program…established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USC §186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).”

[1] *The plan sponsor will be subject to ERISA if it is a private for-profit or not-for-profit entity that does not fall under the governmental/church exemption under ERISA.*

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Whether a particular EAP provides medical benefits will depend on the services offered through the program and the circumstances in which they are provided. For example, an EAP that offers counseling sessions (regardless of the number of sessions) by a trained professional will likely be considered to offer medical benefits and therefore be subject to ERISA.[2] On the other hand, an EAP that provides only referrals based on publicly available information and is staffed by personnel with no special training in counseling or a related discipline most likely does not provide medical benefits and, therefore, would not be subject to ERISA.[3]

Employers must consult with their employee benefits attorney for a legal opinion on whether their specific EAP is subject to ERISA.

[2] "It has consistently been the view of the Department that benefits for treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems constitute "medical" benefits or "benefits in the event of sickness" within the meaning of [ERISA] section 3(1)." ERISA Opinion Letter 91-26A , 07/19/1991.

[3] ERISA Opinion Letter No. 91-26A

ERISA Plan Documents

If the plan sponsor of the EAP is subject to ERISA, the plan sponsor will need to consider its ERISA plan document and disclosure obligations. Employee welfare plans subject to ERISA must include all the benefits offered by the plan (including an EAP that provides medical benefits) within a written plan document. Furthermore, a Summary Plan Description (SPD) must also be furnished to plan participants describing all the benefits included in the plan (including an EAP that provides medical benefits).

Employers/plan sponsors who offer their EAP through a contract with a third-party service provider will need to determine whether the material provided by the EAP vendor satisfies ERISA's plan document and SPD requirements. The documentation provided by EAP vendors often lacks the required provisions under ERISA, as they are typically not drafted for the purpose of ERISA compliance, so a plan sponsor may need to consider drafting a separate disclosure (e.g., wrap document) describing the benefits offered under the EAP.

Wrap Document –

To satisfy ERISA's plan document and disclosure requirements, plan sponsors can often incorporate a third-party SPD/EOC that may/may not meet all of the requirements under ERISA into their existing ERISA plan and SPD documents using what is referred to as a "wrap document." Although the use of a wrap document is never required, it can be a valuable tool to tie together all of the disclosure documents under the plan and supplement any necessary ERISA language/content that may be missing from the disclosures provided by a third-party vendor's SPD/EOC. Therefore, the wrap document's intent is to assist a plan sponsor in forming the necessary elements of a compliant plan document and SPD under ERISA. Plan sponsors offering multiple benefits can also take a single bundled plan approach whereby they incorporate all benefits into a "mega-wrap" document that combines ERISA benefits under a single plan. This method is commonly used for Form 5500 reporting purposes discussed below. If using a single plan approach, the plan language should clearly describe the plan sponsor's intention to do so.

Plan sponsors with an EAP can choose to include the EAP within a wrap document, such as with a single bundled plan approach, or keep the EAP benefit as a separate group health plan from the other benefits offered under a separate plan. If kept separate, an EAP subject to ERISA will need its own ERISA plan document and SPD.

Form 5500 Obligations

A Form 5500 will be required for the separate EAP benefit if the EAP and plan sponsor are subject to ERISA, the plan sponsor chooses to maintain the EAP benefit as a separate group health plan and the EAP does not fall within the small plan exception (i.e., it has at least 100 participants on the first day of the plan year). Plan sponsors that incorporate the EAP into a single bundled health and welfare benefit plan (as evidenced by a single wrap document) may file one Form 5500 that includes the EAP as a part of the many benefits offered under the same plan (if the plan is required to do so).

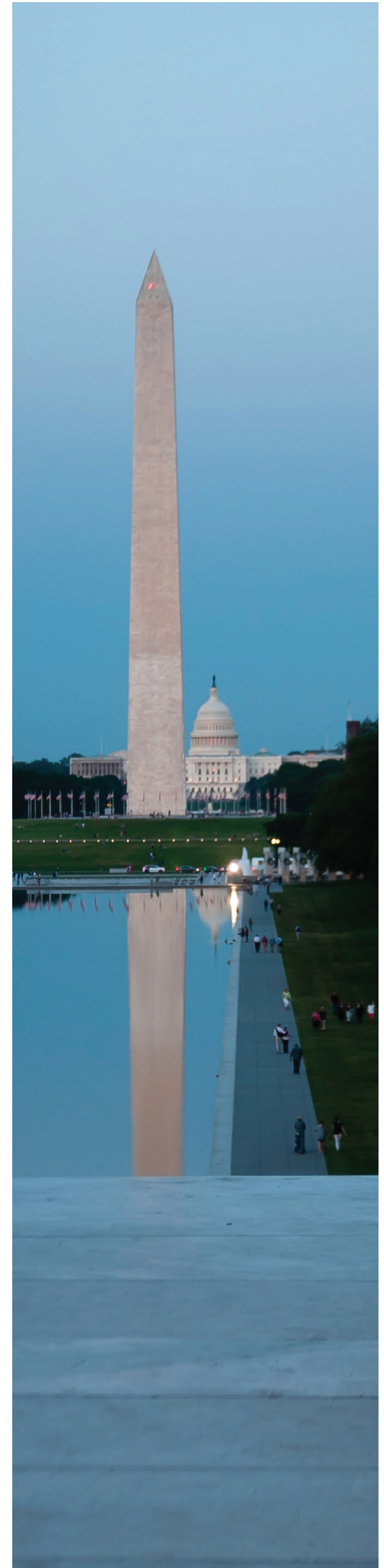
One common issue facing plan sponsors of EAPs is whether the EAP should be reported as a fully insured or self-insured plan for purposes of the Form 5500 reporting requirement. The applicable rules do not provide a clear answer. ERISA §103(e) indicates that a Schedule A must be included when "some or all of the benefits under the plan are purchased from and guaranteed by an insurance company, insurance service, or other similar organization." The Form 5500 Instructions indicate that a Schedule A must be included "if any benefits under the plan are provided by an insurance company, insurance service, or other similar organization (such as Blue Cross, Blue Shield, or a health maintenance organization)." They further direct plan administrators "to not file Schedule A for a contract that is an Administrative Services Only (ASO) contract."

The above guidance provides little clarity in the context of EAPs. Although some EAPs are provided as a value-add along with disability or life insurance coverage, the EAP benefits typically are not provided under a group insurance policy issued by an insurance carrier. Instead, they are more commonly administered by an entity other than the insurance carrier. On the other hand, depending on the fee structure, an EAP contract may not be an ASO contract (e.g., where the employer pays a specific fee per employee/participant (e.g., a per employee, per month fee) that pays for the services provided regardless of the number of services used by employees).

Whether the EAP is considered a fully insured or self-insured benefit impacts how it should be reported in the Form 5500. If the EAP is fully insured, the Form 5500 will need to include a Schedule A that reports certain financial information related to the EAP. When it is unclear whether the EAP is fully insured or self-insured, the safest course of action would be to request from the EAP provider a Schedule A as part of its overall Form 5500 reporting process. In any case, plan sponsors should consult with their employee benefits attorney for guidance on whether the EAP should be treated as a fully insured or self-insured plan for Form 5500 purposes.

Plan sponsors may find themselves in situations where a fully insured EAP vendor is not prepared to provide the necessary information for Schedule A of Form 5500. This does not absolve the plan sponsor's responsibility to include information related to the EAP within its Form 5500. The plan sponsor should work with legal counsel on properly reporting the EAP information on its Form 5500.

If the EAP is self-insured, no information related to the EAP would need to be reported through a Schedule A. In that case, the Form 5500 would reflect information for the EAP using code 4A on line 8b and by checking "General assets of the sponsor" on lines 9a(4) and 9b(4).



COBRA

EAPs that provide medical care and qualify as a group health plan[4] will be subject to COBRA. If the EAP is subject to COBRA, there are several compliance considerations the employer must consider.

Employers offering an EAP subject to COBRA will need to consider which employees are eligible for the EAP. If the EAP is offered to all employees regardless of their eligibility for other group health benefits (e.g., medical coverage), the employer will likely have a larger population of COBRA-qualified beneficiaries under the EAP program than for other group health plans. This effectively means that there may be a larger group of individuals eligible for the EAP coverage who must be furnished with the COBRA initial notice and election notice. Additional COBRA notices for the EAP are not required when the EAP is offered as an integral part of the employer-sponsored group health plan by only being available to employees (and dependents) enrolled in the other group health plan (e.g., medical coverage).

When an individual experiences a COBRA qualifying event, the employer must determine the benefits to which the qualified beneficiary is entitled and the applicable COBRA premium for those benefit coverage options. COBRA continuation coverage must be offered to a qualified beneficiary on the same basis as similarly situated active employees. Therefore, COBRA-qualified beneficiaries covered under an EAP who were in a class of employees who were not eligible for other benefits under the group health plan at the time of their qualifying event may be restricted to choosing either continued enrollment/disenrollment in the EAP during the annual open enrollment period and need not be offered other benefits under the group health plan.

However, if a COBRA-qualified beneficiary was only enrolled in the EAP coverage at the time of their qualifying event but as an active employee was eligible for benefits in addition to the EAP coverage (e.g., medical coverage), they must be offered coverage under all of the benefits for which the qualified beneficiary was eligible for as an active employee at the time of open enrollment. For EAPs that provide benefits outside of healthcare (e.g., financial, job or legal counseling), COBRA continuation coverage need not be offered for any non-medical benefits offered under the EAP if they can be separately offered from the healthcare coverage under the EAP. In addition, these non-medical benefits will generally be excluded when calculating the applicable COBRA premium for the EAP coverage.

COBRA compliance complications also arise when the EAP is offered as a value-add or component of long-term disability (LTD) coverage. An EAP that provides medical care will remain subject to COBRA even when offered as a component of a benefit not subject to COBRA, such as LTD coverage. Employers may find it difficult to get LTD carriers to provide the fair market value of the EAP component, which will be necessary when determining the applicable COBRA premium.

Given the administrative and compliance burdens in offering the EAP plan to qualified beneficiaries under COBRA, some employers may offer EAP coverage automatically to all qualified beneficiaries for the maximum COBRA continuation coverage period (typically 18 or 36 months) following the occurrence of a qualifying event. However, if an employer chooses to continue offering the EAP as a non-COBRA benefit to employees (and family members) after an individual experiences a qualifying event, any increase to the cost of coverage paid by the qualified beneficiary for the EAP could be considered a loss of coverage, which could unintentionally trigger a new obligation for the employer to offer COBRA. Therefore, employers that offer non-COBRA EAP coverage after an employee (or family member) experiences a qualifying event typically will not require a premium contribution from the employee (or family member).

Failure to comply with COBRA's requirements can result in significant monetary penalties. Employers should work closely with their employee benefits attorney to ensure that all applicable COBRA obligations are satisfied as they relate to the employer's EAP.

[4] "The term "group health plan" means an employee welfare benefit plan providing medical care (as defined in section 213(d) of title 26) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of title 26). Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26)." 29 U.S. Code § 1167.

HIPAA

EAPs that qualify as a HIPAA excepted benefit are not subject to Health Care Reform's prohibition on annual dollar limits, Health Care Reform's preventive care mandate and HIPAA portability requirements (including HIPAA's special enrollment requirements or health status nondiscrimination rules). Other exemptions may apply to EAPs that qualify as an excepted benefit, such as requirements regarding PCORI fees, Transparency in Coverage, Mental Health Parity and Addiction Equity Act (MHPAEA) and SBC disclosures.

Final regulations state that to qualify as an excepted benefit, the EAP must satisfy the following four conditions:

> "(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.
>
> (B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:
>
>> (1) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and
>>
>> (2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.
>
> (C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.
>
> (D) There is no cost sharing under the employee assistance program."[5]

Concerning section (A) above, the regulations do not define "significant benefits in the nature of medical care" and do not specify the minimum number of consultations/visits that would equate to providing "significant benefits." The preamble to the regulations does, however, include two examples of EAPs that may help employers make the determination:

- "An EAP that provides only limited, short-term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or review for medical necessity does not provide significant benefits in the nature of medical care."
- "A program that provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions, such as diabetes, does provide significant benefits in the nature of medical care."[6]

Employers wishing to design their EAP to qualify as an excepted benefit will need to consider how this would impact their COBRA obligations or obligations under ERISA (if applicable), as discussed above. To qualify as an excepted benefit, eligibility for the EAP cannot be conditioned on the individual's participation in the employer-sponsored group health plan. Therefore, when EAP eligibility is extended to all employees (so that the EAP can qualify as an excepted benefit), separate COBRA obligations will apply to the EAP, independent of the COBRA obligations under the major medical plan.

As indicated above, EAPs that qualify as excepted benefit EAPs are not subject to HIPAA's portability requirements. However, they remain subject to HIPAA's privacy and security rules.

[5] *Treas. Reg. §54.9831-1(c)(3)(vi).*
[6] *Amendments to Excepted Benefits, 26 CFR Part 54.*

EAPs and HSA Eligibility

IRS guidance indicates that under certain circumstances, an individual will not fail to be HSA-eligible solely because the individual is covered under an EAP. The key factor in determining whether participation in an EAP results in HSA ineligibility depends on whether the EAP is considered a "health plan" under Code §223, which governs HSAs. To be HSA eligible, an individual may not be covered under any disqualifying non-HDHP coverage. According to IRS guidance, an EAP will not be considered a "health plan" under §223 (i.e., non-HDHP disqualifying coverage) if the program does not provide "significant benefits in the nature of medical care or treatment."[7] While the IRS guidance does not define what constitutes "significant benefits," they do provide detailed examples of programs that the IRS determines do not provide "significant benefits" that would prevent HSA eligibility.

> "Example (1). An employer offers a program that provides employees with benefits under an EAP, regardless of enrollment in a health plan. The EAP is specifically designed to assist the employer in improving productivity by helping employees identify and resolve personal and work concerns that affect job performance and the work environment. The benefits consist primarily of free or low-cost confidential short-term counseling to identify an employee's problem that may affect job performance and, when appropriate, referrals to an outside organization, facility or program to assist the employee in resolving the problem. The issues addressed during the short-term counseling include, but are not limited to, substance abuse, alcoholism, mental health or emotional disorders, financial or legal difficulties, and dependent care needs. This EAP is not a "health plan" under section 223(c)(1) because it does not provide significant benefits in the nature of medical care or treatment."[8]

It should be noted that the determination as to whether an EAP constitutes a "health plan" for purposes of the HSA rules under §223 does not affect whether the EAP is considered a health plan for other purposes such as ERISA, COBRA and HIPAA addressed above.

Employers offering an EAP and HDHP/HSA program should consult with their legal counsel for a specific legal opinion on whether their EAP provides "significant benefits in the nature of medical care or treatment" to ensure the EAP does not adversely affect HSA eligibility.

[7] *IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-10.*
[8] *IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-10.*

Conclusion

There are many decisions a plan sponsor/employer must make when offering an EAP, including considerations related to what kind of coverage should be included in the EAP plan and how robust such coverage should be, along with who should be eligible to enroll in the EAP benefit. Plan sponsors/employers should consider the above compliance rules and regulations when offering an EAP plan. Due to the complexity of these issues, it is always advisable to consult with qualified benefits counsel before making any decision or changes.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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