

# The Affordable Care Act (ACA) Preparing for a Health Plan **Audit**



Presented by Sheyna Stroh



# The ACA: Health Plans Overview

# Agenda

- What is the legal status of the ACA?
- Which plans must comply?
- Reforms currently in place
- 2013 compliance deadlines
- 2014 compliance deadlines
- Current compliance deadlines
- Future compliance deadlines
- Questions

# Legal Status of the Affordable Care Act

# Health Care Reform

- Affordable Care Act enacted in March 2010
  - Patient Protection and Affordable Care Act (March 23)
  - Health Care and Education Reconciliation Act (March 30)
- Makes significant changes to health care system and coverage rules over several years
- Provisions for:
  - Health insurance issuers
  - Employers
  - Health plan sponsors

# What Will Be Next?

- Implementation of the ACA continues as scheduled for now
  - Supreme Court has continued to uphold the law as constitutional
- Changes to the ACA may come from Congress
  - Some changes already made
  - Democrats will likely oppose any major changes, and President Obama has promised to veto
  - Republicans want to repeal or revise.
- Courts may address other aspects of the law
  - For example, the Supreme Court has ruled on the ACA's contraceptive coverage mandate, allowing an exemption for certain religious employers

# Which Plans Must Comply?

# Plans Subject to the ACA

- The ACA's health plan rules generally apply to **group health plan** coverage
- Exceptions
  - Excepted benefits
  - Retiree-only plans
  - Group health plans covering fewer than 2 employees
- Excepted Benefits
  - Accident or disability income coverage
  - Separate dental and vision plans
  - Liability insurance
  - Some FSAs

# Grandfathered Plans

- **Grandfathered plan:** group health plan or health insurance coverage in which an individual was enrolled prior to March 23, 2010
- Certain ACA provisions don't apply to grandfathered plans, even if coverage is later renewed
- A plan can lose grandfathered status by making certain prohibited changes to benefits or costs
  - Plans will have to analyze status and changes at each renewal

# Which ACA Rules Don't Apply to Grandfathered Plans?

- Patient protections
- Nondiscrimination rules for fully-insured plans
- Preventive care coverage
- New appeals process
- Quality of care reporting
- Insurance premium restrictions
- Guaranteed issue and renewal of coverage
- Nondiscrimination based on health status/in health care
- Comprehensive health insurance coverage
- Limits on cost-sharing
- Coverage for clinical trials

# Reforms Currently in Place

# Provisions Effective before 2013

- Small employer tax credit
- Dependent coverage up to age 26
- No lifetime limits/restrictions on annual limits
- No rescissions
- No pre-existing condition exclusions for children
- No cost-sharing for preventive care services (non-GF plans)
- Appeals process changes (non-GF plans)
- No reimbursement for OTC medicine or drugs (without a prescription)
- Medical loss ratio rules
- Form W-2 reporting

# Provisions Effective in 2013

- Uniform Summary of Benefits and Coverage (SBC) requirement
- No cost-sharing for preventive care services for women
- Increased Medicare tax
- Health FSA contribution limits
- Whistleblower protections
- Patient-Centered Outcomes Research Institute Fees (PCORI) Fees
- Notice of Exchange

# Provisions Effective in 2014

- Individual shared responsibility provision (**individual mandate**)
- Health insurance Exchanges
- Exchange premium assistance
- Limits on out-of-pocket expenses and cost-sharing
- Waiting period limitation
- Restriction on annual limits for essential health benefits
- Prohibition on pre-existing condition exclusions
- Essential health benefits requirement and premium rating restrictions in the small group market
- Wellness program changes
- Reinsurance fees

# Provisions Effective in 2015

- Employer shared responsibility provision (**employer mandate** or **pay or play rules**)
- Health plan reporting requirements under Section 6055 and Section 6056

# 2013 Compliance Deadlines

# Summary of Benefits and Coverage

- Simple & concise explanation of benefits and costs
  - Template provided
  - Can provide in paper or electronic form
- Applies to:
  - Issuers and health plans (plan sponsors)
  - GF and non-GF plans
  - No duplication required: if issuer provides to enrollees, plan doesn't have to
- Providing to participants and beneficiaries
  - 1st day of **1st open enrollment period** on/after Sept. 23, 2012
  - 1st day of **1st plan year** on/after Sept. 23, 2012 (for other enrollment)
  - Must provide at various points thereafter

# SBC Standards

- Appearance
  - Cannot be longer than 4 double-sided pages
  - 12-point or larger font
  - May be color or black and white
  - Paper or electronic form
  - Template available
- Language:
  - Easily understood language
  - “Culturally and linguistically appropriate manner” – interpretive services and written translations upon request
  - Translations are available

# SBC Content

- Uniform definitions of standard terms
- Description of plan's coverage
- Exceptions and limitations
- Cost-sharing provisions
- Renewability and continuation
- Coverage examples
- Required statements and contact information
- Internet address for obtaining the uniform glossary of terms

# 60-Day Notice Rule

- Effective once SBC rule is effective for a plan
- Material modifications **not in connection with renewal** must be described in a summary of material modifications (SMM) or an updated SBC
  - Must be provided at least **60 days BEFORE** modification becomes effective
- Material modification:
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits

# Preventive Care for Women

- New guidelines for preventive care for women on **Aug. 1, 2011**
- Must provide coverage for women's preventive health services without any cost-sharing
  - Applies to non-GF plans
  - No deductible, copayment or coinsurance
- Effective for plan years beginning on or after **Aug. 1, 2012**

# Covered Health Services

- Well-women visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling
- Contraceptives and contraceptive counseling (certain exceptions apply to religious employers)

# Increased Medicare Tax

- Medicare tax rate increased for high-earners for **2013 tax year**
  - 0.9 percent increase (from 1.45 percent to 2.35 percent)
- High-earner threshold
  - Single: \$200,000
  - Married : \$250,000
- Individual liability for tax depends on filing status and household income
- Employer responsibilities
  - Withhold additional amounts from wages in excess of \$200,000
  - No requirement to match additional tax
  - No requirement to notify employees

# Health FSA Limits

- Before the ACA, there was no limit on salary reductions
  - Many employers imposed limit
- Beginning with 2013 plan year, limit was **\$2500/year**
  - Does not apply to dependent care FSAs
  - Per FSA limit
- Limit is indexed for inflation for later years
  - 2014: **\$2500/year**
  - 2015: **\$2550/year**
  - 2016: **\$2550/year**

# Whistleblower Protections

- OSHA final rule clarifies protections for employees under ACA
- Employers may not retaliate against employees for:
  - Providing information or filing a complaint regarding ACA violations
  - Objecting to or refusing to participate in violations of the ACA
  - Receiving a premium credit or subsidy for coverage through an Exchange
- Employees can file complaints with OSHA if they experience retaliation
  - Discharge, demotion, discipline, etc.

# PCORI Fees

- Apply to plan years ending on or after **Oct. 1, 2012**
  - End with the 2018 plan year—do not apply for plan years ending on or after Oct. 1, 2019
  - Paid annually on Form 720 by July 31 each year
- Amount of fees (for 2014 and beyond, dollar amount increases based on National Health Expenditures)
  - 2012 plan year: \$1 x average number of covered lives
  - 2013 plan year: \$2 x average number of covered lives
  - 2014 plan year: \$2.08 x average number of covered lives
  - 2015 plan year: \$2.17 x average number of covered lives
  - 2016 plan year: \$2.25 x average number of covered lives (projected)

## Who pays?

- Insurance carriers and self-funded plan sponsors
- Special rule for HRAs

# Notice of Exchange

- Employers subject to the FLSA must notify new and current employees of Exchange information
  - New employees **beginning Oct. 1, 2013** (within 2 weeks)
  - Current employees **no later than Oct. 1, 2013**
- Notice must include information about:
  - Existence of health benefit Exchange and services provided
  - Potential eligibility for subsidy under Exchange
  - Risk of losing employer contribution if employee buys coverage through an Exchange
- Model notice available (will need some customization)
- Notice can be provided by mail or electronically (if DOL requirements met)

# 2014 Compliance Deadlines

# Individual Mandate

- Effective Jan. 1, 2014: Individuals must enroll in health coverage or pay a penalty
- Penalty amount: Greater of a flat dollar amount or a percent of income
  - 2014 = \$95 or 1%
  - 2015 = \$325 or 2%
  - 2016 = \$695 or 2.5%
- Family penalty capped at 300% of the adult flat dollar penalty or “bronze” level Exchange premium
- Some exceptions apply

# Health Insurance Exchanges

- Health insurance Exchanges must be established in each state (by the state or the federal government)
- State action for 2016:
  - 13 (and D.C.) declared state-based Exchange
  - 4 federally-supported Exchanges
  - 7 Partnership Exchanges
  - 27 default to federal Exchange (To Include ND)
- Deadlines:
  - Initial open enrollment: 10/1/13 – 3/31/14
  - 2015 open enrollment: 11/15/14 – 2/15/15
  - 2016 open enrollment: 11/1/15 – 1/31/16
  - 2017 open enrollment: 11/1/16 – 1/31/17
- Individuals can be eligible for tax credits
  - Limits on income and government program eligibility
  - Employer plan is unaffordable or not of minimum value

# Health Insurance Exchanges

- Individuals and small employers can purchase coverage through an Exchange
- Small Business Health Option Program (SHOP)
  - Small employers = up to 100 employees under the ACA
  - Before 2016, states could define small employers as having up to 50 employees
  - In 2017, states can allow employers of any size to purchase coverage through Exchange
- **On Oct. 7, 2015, President Obama signed the Protecting Affordable Coverage for Employees (PACE) Act into law**
  - Repeals the ACA's definition of "small employer"
  - Gives states the option of expanding their small group markets to include businesses with up to 100 employees; **ND defines small group as having up to 50 employees.**

# Exchange Premium Assistance

- Individuals can be eligible for two types of federal subsidies to help pay for coverage through an Exchange—**premium tax credits** and **cost-sharing reductions**
- Employees who are **not offered employer coverage**
  - Not eligible for government programs (like Medicaid – up to 138% FPL in ND)
  - Meet income requirements (less than 400% of FPL)
- Employees who are **offered employer coverage**
  - Not enrolled in employer's plan
  - Not eligible for government programs (like Medicaid)
  - Meet income requirements (less than 400% of FPL)
  - **Employer's coverage is unaffordable (greater than 9.5% of income for single coverage, adjusted annually for 2015 and beyond) or not of minimum value (covers less than 60% of cost of benefits)**
- Employee eligibility for premium assistance triggered employer penalties starting in 2015.

# Limits on Out-of-Pocket Expenses and Cost-Sharing

- Non-GF group health plans subject to limits on out-of-pocket costs
  - Applies to all non-GF group health plans
  - Limit indexed for inflation
- Out-of-pocket expenses may not exceed:
  - 2014: \$6,350 for self-only coverage/\$12,700 for family coverage
  - 2015: \$6,600 for self-only coverage/\$13,200 for family coverage
  - 2016: \$6,850 for self-only coverage/\$13,700 for family coverage
  - 2017: \$7,150 for self-only coverage/\$14,300 for family coverage
- **Deductible limit was repealed on April 1, 2014**
  - Protecting Access to Medicare Act of 2014 repealed the deductible limit, effective retroactively to the date the ACA was enacted (March 2010)

# Waiting Period Limitations

- Waiting periods limited to 90 days beginning with 2014 plan year
  - First of the month following 90 days not permissible
- Employers can use up to a 12-month measurement period to determine FT status for variable hour employees
  - Coverage must be effective by 13 months from start date (plus remaining days in the month)

# Plan Changes

- Annual limits eliminated
  - Prohibited on essential health benefits with 2014 plan year
  - Essential health benefits to be determined according to state benchmark plan
- Preexisting condition exclusions prohibited
- Small group and Individual policies (non-GF plans)
  - Must provide essential health benefits package
  - Premium rating restrictions apply

# Reinsurance Fees

- Transitional reinsurance program to operate **2014-2016**
  - Fees imposed on health insurance issuers and self-funded plan sponsors of major medical plans (with some exceptions)
  - **Exemption for self-funded, self-administered plans for 2015 – 2016**
- Fees based on annual national contribution rate
  - 2014: \$5.25/month (\$63/year) x average number of covered lives
  - 2015: \$3.67/month (\$44/year) x average number of covered lives
  - **2016: \$2.25/month (\$27/year) x average number of covered lives**
- Payment of fees
  - Nov. 15: issuers/sponsors submit annual enrollment count to HHS
  - Dec. 15 (or within 30 days): HHS to notify issuer/sponsor of amount due
  - **Payment due in two installments:** 1<sup>st</sup> payment due in January, 2<sup>nd</sup> payment due late in Q4

# 2015 Compliance Deadlines

# Employer Responsibility

- Applicable large employers (ALEs) subject to employer shared responsibility “pay or play” rules
  - Delayed for one year, until 2015—penalties did not apply for 2014
  - Delayed for an additional year, until 2016, for ALEs with 50-99 full-time employees (including full-time equivalents)
- Applies to employers with 50 or more full-time and full-time equivalent employees in prior calendar year
  - Full-time employee: employed an average of at least 30 hours of service per week
- Penalties may apply if the ALE:
  - Fails to offer minimum essential coverage to all full-time employees (and dependents) OR
  - Offers coverage that is not affordable or does not provide minimum value
- Penalties triggered if any full-time employee gets subsidized coverage through Exchange

# Employer Penalty Amounts

- Employers that fail to offer coverage to substantially all full-time employees (and dependents):
  - \$2,000 per full-time employee (excludes first 30 employees)
  - **Transition relief for 2015: employers with 100 or more full-time employees (including FTEs) can reduce their full-time employee count by 80 when calculating the penalty**
- Employers that offer coverage to substantially all full-time employees (and dependents) **but not all full-time employees** OR coverage is **unaffordable** or **not minimum value**:
  - \$3,000 for each full-time employee who receives subsidized coverage through an Exchange
  - Capped at \$2,000 per full-time employee (excluding first 30 full-time employees, or 80 in 2015 for ALEs with 100 or more full-time and FTE employees)
  - Dollar amounts adjusted each year, beginning in 2015

# Safe Harbors

- Employer penalties: who is a full-time employee?
  - Ongoing employees
  - New full-time employees
  - New seasonal and variable hour employees
- Affordability safe harbors
  - Three optional safe harbors for determining affordability—W-2 wages, rate of pay and federal poverty line
- Waiting periods
  - Cannot exceed 90 days
  - No penalty for employees in waiting period
- Options for determining minimum value (MV)
  - MV calculator, design-based safe harbor checklist, actuary certification or metal level (small group plans)

# Employer Reporting

- Employers will have to report certain information about health coverage to the government and individuals (Internal Revenue Code Section 6055 and Section 6056)
- Applies to:
  - 6055: providers of minimum essential coverage, including employers that sponsor self-insured plans
  - 6056: ALEs subject to the employer shared responsibility rules—generally, employers with at least 50 full-time and FTE employees
  - No additional delay for ALEs with fewer than 100 FTE employees

# Information Required

- Employer identifying information
- Whether employer offers health coverage to full-time employees and dependents
- Number of full-time employees and total number of employees for each month
- Monthly employee's share of the premium for lowest-cost self-only coverage
- Names and contact info of employees and months covered by employer's health plan

# Future Compliance Deadlines

# 2020—Cadillac Plan Tax

- 40% excise tax on high-cost group health plans
  - **Delayed until 2020** under a federal budget bill for 2016, enacted on Dec. 18, 2015
- Based on value of employer-provided health coverage over certain limits
  - \$10,200 for single coverage/\$27,500 for family coverage
  - Certain adjustments will apply for 2020 and later years
- To be paid by coverage providers
  - Fully insured plans = health insurer
  - HSA/Archer MSA = employer
  - Self-insured plans/FSAs = plan administrator
- More guidance expected

# Nondiscrimination Rules Coming for Fully-Insured Plans

- Will apply to non-grandfathered plans
- Discriminating in favor of highly-compensated employees (HCEs) will be prohibited
  - Eligibility test
  - Benefits test
- HCEs
  - 5 highest paid officers
  - More than 10% shareholder
  - Highest paid 25% of all employees
- Effective date delayed for regulations

# Automatic Enrollment Rules

- Will apply to large employers that offer health benefits
  - Applies to Grandfathered and non-Grandfathered plans
  - Large employer = more than 200 employees
- Must automatically enroll new employees and re-enroll current participants
- Adequate notice and opt-out option required
- DOL:
  - Regulations are not ready to be taken to effect and monitored.
  - Employers not required to comply until regulations issued **and** applicable.

A black and white photograph of a modern office interior. In the foreground, two men are looking at a laptop. In the background, two women are standing and talking, one holding a folder. To the right, another woman is working at a laptop. The office has large windows with a grid pattern, and the scene is brightly lit from the windows. A green decorative shape is in the top right corner, and a blue one is on the right edge.

# Preparing for a DOL Health Plan Audit

Presented by: Stroh & Associates

# Overview

- Department of Labor (DOL) Audits
- ERISA
- Audit triggers and process
- Plan compliance review
- Plan document requirement
- Reporting and disclosure
- Fiduciary responsibility
- Affordable Care Act and group health plan requirements
- Recordkeeping

# ERISA

## Employee Retirement Income Security Act

- Enacted in 1974
- Sets minimum standards for pension and welfare plans provided by employers to protect employees

## Title I: Protection of Employee Benefit Rights

- Part 1: Reporting and Disclosure
- Part 4: Fiduciary Responsibility
- Part 5: Administration and Enforcement
- Part 6: COBRA Continuation Coverage and Additional Standards for Group Health Plans
- Part 7: Group Health Requirements (HIPAA, NMHPA, MHPA, WHCRA)

# Department of Labor (DOL) Audits

## DOL has broad authority to audit compliance with ERISA

- Audits performed by Employee Benefit Security Administration (EBSA)
- Focus is on ERISA compliance

Affordable Care Act

(ACA)

# Serious Consequences

Health plan audits are on the rise due to ACA enforcement

- Audits are stressful and time consuming
  - Disruption of day-to-day operations
- ERISA violations can be costly
  - Penalties
  - Corrective action
  - Civil litigation and criminal prosecution

During 2015 fiscal year, most DOL investigations resulted in penalties or other corrective action for employers or benefit plans

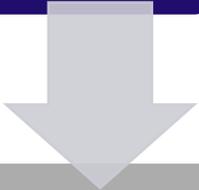
# Minimize Your Risk



- Important to know how to prepare for (and potentially avoid) an audit
- Best time to analyze whether you are ready for an audit is **before DOL knocks on your door**

# Key Action Items

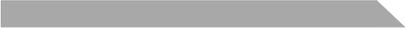
Understand common audit triggers  
and audit process



Confirm compliance with  
applicable law



Maintain documents to show  
compliance



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# **Audit Triggers and Process**

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# Common Audit Triggers

## Participant complaints

- Plan participants may complain to the DOL about ERISA violations
- In fiscal year 2015, participant complaints triggered 589 new DOL investigations

## Form 5500

- Incomplete or inconsistent information is reported on plan's Form 5500

## National enforcement priorities

- DOL's national enforcement priorities or projects target agency resources on certain issues
- For example, DOL's Health Benefits Security Project focuses on ACA compliance

# Avoiding an Audit

Employers can take steps to help minimize exposure to a DOL audit

- Respond to participant questions and requests for information in a timely manner
- File Form 5500 on time and make sure it's accurate and complete
- Distribute participant materials (for example, SPDs) by deadline
- Keep plan documents up-to-date



# Common Audit Steps

## Step One: Receive Audit Letter

- DOL sends a letter to notify employer it has been selected for audit
- Scope of audits can be full-scale or limited review

## Step Two: Respond to Document Request

- DOL audit letter will request certain plan-related information
- May request a large number of documents

## Step Three: Comply with Deadlines

- Audit letter will include a deadline for providing documents
- Important to respond by deadline
- Late or incomplete responses may trigger additional document requests, interviews, on-site visits, or even DOL enforcement action

# Standard Document Request

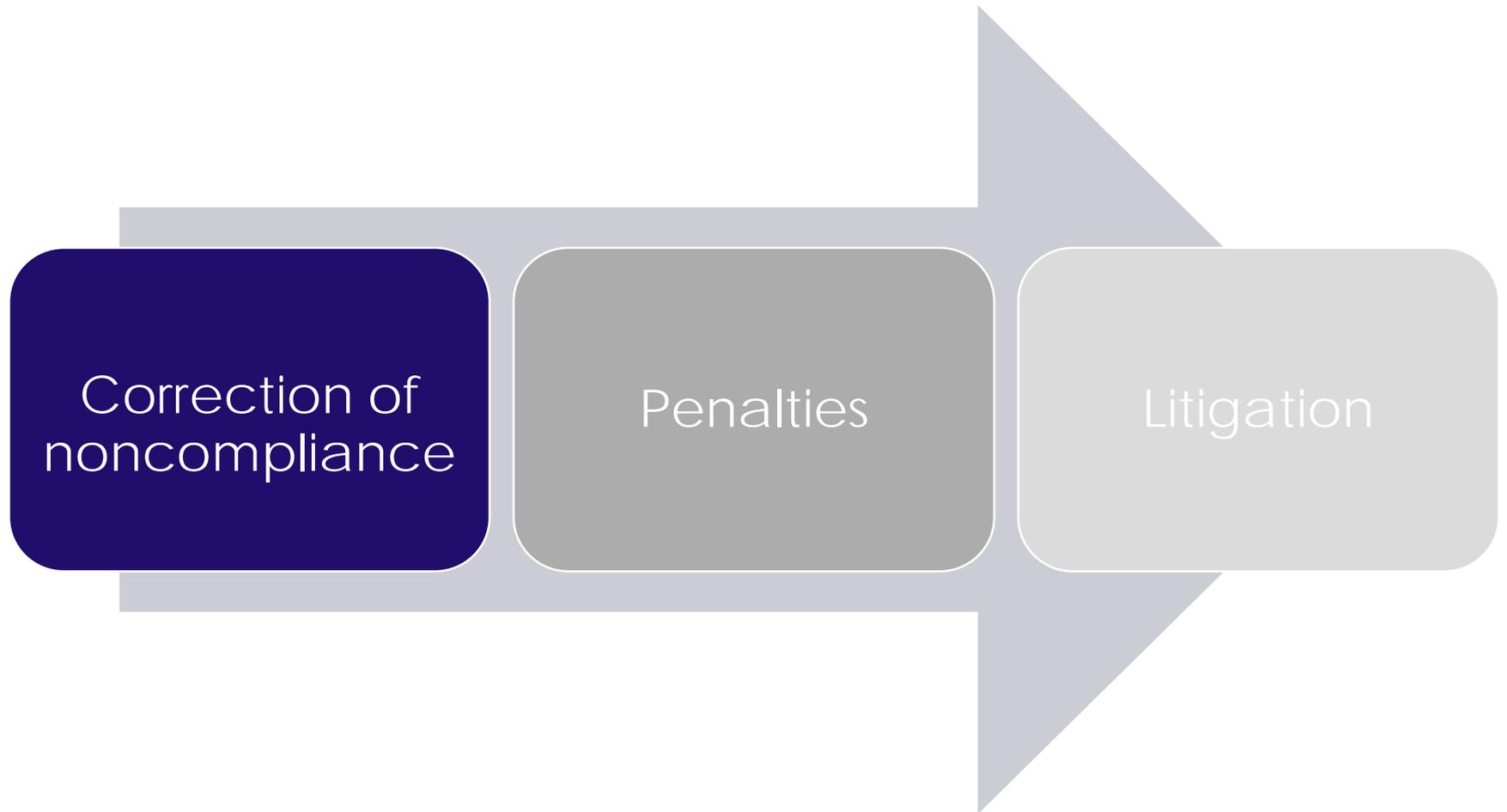
- Plan document
- Summary plan description
- Forms 5500
- Summary annual reports
- List of all plan service providers and related contracts
- All insurance contracts
- Open enrollment materials
- Newborns' and Mothers' Health Protection Act notice
- Women's Health and Cancer Rights Act notice
- Children's Health Insurance Program (CHIP) notice
- Wellness program materials
- Plan provisions for mental health benefits
- HIPAA compliance documents
- COBRA compliance documents
- Notice of grandfathered status (if applicable)
- Information on coverage rescissions, including 60-day advance notice
- Plan provisions on annual and lifetime limits
- Plan enrollment rights for dependents up to age 26
- Summary of benefits and coverage (SBC) and any 60-day advance notices of material changes
- For non-grandfathered plans, notice of patient protections and selection of providers
- Procedures for claims and appeals

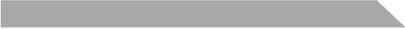
# Prepare for Investigation

If you are selected for audit, consider these steps:

- Establish contact person at company
- Consider hiring legal counsel
- Negotiate or clarify scope of document request and ask for deadline extension, if necessary
- Review documents for accuracy and consider providing explanation of any discrepancies
- Prepare staff for on-site visits and interviews

# Possible Audit Outcomes





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# Compliance Review

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# Health Plans Subject to ERISA

Most health plans maintained by private sector employers are subject to ERISA

## Subject to ERISA

- Corporations
- Partnerships
- Sole proprietorships
- Nonprofit organizations

## Exempt from ERISA

- Governmental plans
- Church plans

# ERISA Requirements

Plan Document

Reporting and  
Disclosure

Fiduciary  
Responsibility

ACA

COBRA

Group Health Plan  
Requirements



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# Plan Document

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# Plan Document

- Every ERISA plan must have a **written plan document** describing the benefits provided
- Wrap document for insured benefits
  - Insured benefits controlled by terms of contracts/policies
  - Wrap document is combined with contract/policy to provide missing provisions
  - Wrap plan can include multiple benefits

# Plan Document Provisions

## Plan document should address:

- Benefits and eligibility
- Funding of benefits
- Treatment of insurance refunds and rebates
- Standard of review for benefit decisions
- Designation of named fiduciary
- Plan amendment and termination procedures
- Required provisions for group health plans
- Other substantive provisions applicable to certain plans (such as subrogation and reimbursement clauses and coordination of benefits provisions)
- Procedures for allocating and delegating plan responsibilities



# Reporting and Disclosure

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# Summary Plan Description (SPD)

- Document used to communicate plan benefits, rights and obligations
- Terms will generally be enforced if more beneficial to participants than the plan document
- Most plans must have an SPD
  - Very limited exceptions apply
  - No exception for small plans
- Provided by Plan Administrator
  - Even if another entity drafts the SPD

# SPD Distribution

- Provide within 90 days after participant becomes covered under the plan
- Updated SPD must be provided every 5 years (10 years if no changes)

- First-class mail
- Hand delivery
- Electronic distribution if requirements met

# SPD Content

## ERISA provides detailed content requirements for welfare plan SPDs

- Plan identifying information
- Description of benefits and eligibility rules
- Statement regarding circumstances causing loss or denial of benefits
- Description of amendment, termination and subrogation provisions
- Information regarding contributions and funding
- Claims procedures
- Statement of ERISA rights
- Additional group health plans requirements
- Prominent offer of assistance in a non-English language (if required)

**Insured plans:** Insurance booklet will usually **not** meet requirements  
**Solution:** Wrap SPD document that contains ERISA elements

# Summary of Material Modifications (SMM)

- Material changes to information contained in SPD must be communicated to plan participants
- Plan Administrator can use a summary of the material modifications instead of issuing a new SPD
- Deadlines:
  - 210 days after the end of the plan year in which a modification is adopted
  - If change is a material reduction in group health plan benefits or services, deadline is 60 days after date of adoption
  - ACA imposes 60-day advance notice rule

# Summary of Benefits and Coverage (SBC)

- Short summary of benefits and coverage under the plan required by the ACA
- Must be provided by Plan Administrator and insurer
  - Non-duplication rule allows one party to distribute SBC
  - At enrollment, re-enrollment and upon request

Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage Period: [See Instructions]  
 Coverage for: \_\_\_\_\_ | Plan Type: \_\_\_\_\_

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.\[insert\]](#) or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$	
Are there other deductibles for specific services?	\$	
Is there an out-of-pocket limit on my expenses?	\$	
What is not included in the out-of-pocket limit?		
Is there an overall annual limit on what the plan pays?		
Does this plan use a network of providers?		
Do I need a referral to see a specialist?		
Are there services this plan doesn't cover?		

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

Questions: Call 1-800-[insert] or visit us at [www.\[insert\]](#). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.\[insert\]](#) or call 1-800-[insert] to request a copy.

- Must provide **60 days' advance notice** of any material modification of plan terms or coverage not reflected in most recent SBC

# Participant Requests for Documents

- The Plan Administrator must furnish certain documents upon written request by a participant or beneficiary
  - Latest SPD, SMMs and annual report
  - Any bargaining agreement, trust agreement or contract
  - Any other “instrument under which the plan is established or operated”
- Documents must also be available at plan office
- Copies must be provided within 30 days (reasonable copying fees may be charged)

Penalties of up to \$110/day may be assessed for failing to respond to request

# Form 5500 Reporting

Many ERISA plans must report plan information to the DOL each year using Form 5500

## Small Welfare Plan Exemption

- Fewer than 100 covered participants at the beginning of the plan year (includes employees, not dependents)
- Must be unfunded (benefits paid from general assets of employer) or insured (benefits paid through an insurance policy that is not stop-loss insurance) or a combination
- Can accept participant contributions if conditions met



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# **Fiduciary Responsibility**

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# ERISA Fiduciaries

Anyone performing fiduciary functions is an ERISA fiduciary

- Exercising discretionary authority or control regarding management of an ERISA plan
- Exercising any authority or control over management or disposition of plan assets
- Rendering investment advice for a fee
- Having discretionary authority or responsibility in administration of the plan

# Fiduciary Duties

- **Duty of Undivided Loyalty**
  - Act solely in the best interest of plan participants and beneficiaries
- **Exclusive Benefit Rule**
  - To use plan assets for the exclusive purpose of paying plan benefits or reasonable expense of plan administration
- **Prudent Person Standard**
  - To act with the care, skill, prudence and diligence that a prudent person in similar circumstances would use
- **Duty to Diversify Investments**
  - To diversify the plan's investments to minimize the risk of large losses
- **Duty to Act in Accordance with the Documents Governing the Plan**

# Fiduciary Issues

## Settlor Functions

- Fiduciary duties do not apply
- Include business decisions such as amending and terminating plans

## Delegating Fiduciary Duties

- Duties can be delegated to others if permitted by the plan
- Plan sponsor retains ultimate responsibility

## Fiduciary Breaches

- Personal liability for damages or profits
- DOL may assess a **20 percent penalty**
- Removal
- Criminal penalties
- Voluntary correction program is available



# **Affordable Care Act**

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# ACA

DOL is using audit authority to enforce compliance with certain ACA mandates

## Grandfathered Plans

- Records supporting grandfathered status
- Participant notice regarding grandfathered status

## Non-grandfathered Plans

- Coverage of preventive care services
- Participant notice regarding patient protections
- Claims and appeals procedures

## All Plans

- Enrollment opportunities for children up to age 26
- Information on any coverage rescissions
- Lifetime and annual limits
- Summary of benefits and coverage (SBC)

# ACA

## DOL audit requests may also include:

- Prohibition on excessive waiting periods
- Required coverage for clinical trial participants
- Prohibition on pre-existing condition exclusions for all enrollees
- Cost-sharing limits on essential health benefits (out-of-pocket maximum)



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**COBRA**

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# COBRA

- Requires most group health plans to provide a **temporary continuation of group health coverage** that otherwise might be terminated due to:
  - Termination of employment or reduction in hours
  - Death of or divorce/legal separation from the employee
  - Loss of dependent status under the plan
- Plan administrators are required to provide **COBRA notices** to plan participants and qualified beneficiaries
- Employers may charge up to 102% of the cost of coverage

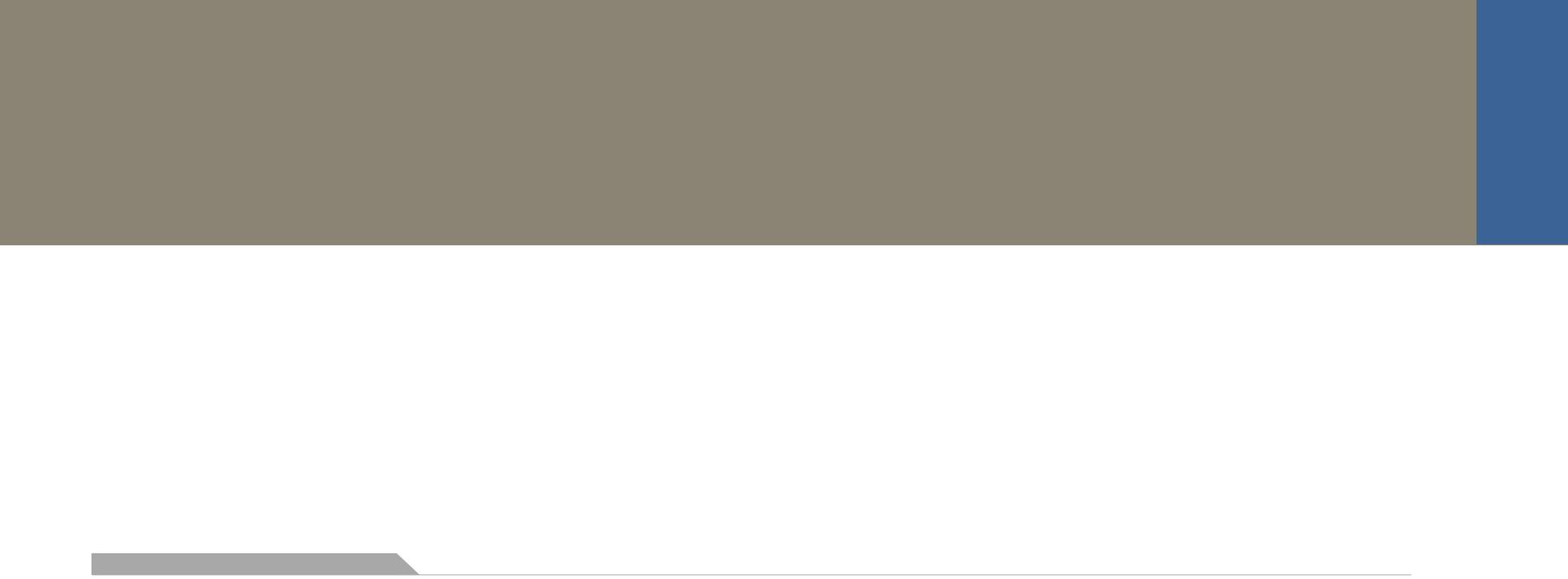
# Who Must Comply with COBRA

## Must comply:

- All private-sector group health plans maintained by employers that have at least 20 employees on more than 50 percent of business days in previous calendar year
- Plans sponsored by state and local governments

## Not Required to Comply:

- Health plans sponsored by:
  - Federal government
  - Churches and certain church-related organizations



# **Group Health Plan Requirements**

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# HIPAA

## Health Insurance Portability and Accountability Act

Key provisions govern:

- Health coverage portability
- Health information privacy and security
- Administrative simplification

# HIPAA Portability Rules



Previously required certificates of prior creditable health coverage (through 2014)



Provide special enrollment rights when specific events occur (like marriage or birth of a child)



Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors



Guarantee that health coverage be available to, and can be renewed by, certain employers (expanded by ACA)

# Other Group Health Plan Requirements

## Newborns' and Mothers' Health Protection Act (NMHPA)

- Requires minimum hospital stays after childbirth
- Notice must be included in SPD

## Mental Health Parity

- Requires plans that cover mental health and substance use disorders to maintain parity between these benefits and their medical/surgical benefits

## Women's Health and Cancer Rights Act (WHCRA)

- Requires benefits for reconstructive surgery following mastectomy
- Notice must be provided at enrollment and annually

## Children's Health Ins. Reauthorization Act (CHIPRA)

- Provides special enrollment rights for employees and their dependents
- Annual notice requirement for employers in states that provide premium assistance subsidy



# Recordkeeping

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# Recordkeeping System

Establishing a recordkeeping system for important benefit plan documents is a key step in preparing for a DOL audit



- Retaining complete and accurate records helps:
  - Move the audit process along
  - Provide accurate picture of your employee benefits
- Keep copies of participant notices and records showing distribution
- As a general rule, keep these records for at least **seven years**
- If service provider keeps records, verify retention and availability

# Recordkeeping System – Example

## Rule

- Plans that require designation of a primary care provider must provide a **notice of patient protections** whenever the SPD or similar description of benefits is provided to participants

## Recordkeeping

- Keep a copy of the notice of patient protections
- Document when it was provided
- Keep list of participants who received it



**Questions?**

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# Thank you!



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