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UBA

Today's webinar will begin shortly.
We are waiting for attendees to log on.

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Please remember, employment and benefits law compliance depends on multiple factors – particularly those unique to each employer's circumstances. Numerous laws, regulations, interpretations, administrative rulings, court decisions, and other authorities must be specifically evaluated in applying the topics covered by this webinar. The webinar is intended for general-information purposes only. It is not a comprehensive or all-inclusive explanation of the topics or concepts covered by the webinar.

Preparing for a Department of Labor Audit in 2022

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Agenda – Preparing for a Department of Labor Audit in 2022

The new year is expected to start with a bang! With new rules coming into effect, such as provisions of the Consolidated Appropriations Act and No Surprises Act, and new scrutiny under existing laws such as Mental Health Parity and Addiction Equity Act, preparation is key. This webinar will:

- Review the changes made to Form 1095 reporting and the shift from good-faith transitional relief to enforcement.
- Refresh understanding of the Mental Health Parity rules, especially for self-funded plans
- Talk about the DOL focus on non-quantitative treatment limitations and autism spectrum disorder treatments.
- Review how to avoid common audit pitfalls, including how to avoid accidentally creating a MEWA.
- Offer tips on how to be ready for a DOL audit at a moment's notice.

EMPLOYEE BENEFIT PLAN COMPLIANCE LANDSCAPE

EMPLOYEE BENEFIT PLAN COMPLIANCE LANDSCAPE

- Various government agencies regulate employee benefit plans and enforce those regulations
  - U.S. Department of Labor (DOL)
    - Employee Benefit Security Administration (EBSA)
  - U.S. Department of Treasury/Internal Revenue Service (IRS)
    - Tax treatment of employee benefits
    - Various Affordable Care Act (ACA) issues
      - Internal Revenue Code (IRC) section 4980H – Employer Shared Responsibility rules

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EMPLOYEE BENEFIT PLAN COMPLIANCE LANDSCAPE

- State insurance laws and regulations
  - States have authority to regulate insurance
  - Group health insurance is generally subject to the laws of the state where the group plan is issued – not where the employer is located or where the employee lives
  - Due to ERISA preemption, states may not regulate the terms of employers' health and welfare plans
- Plan participants and beneficiaries
  - ERISA § 502(a) authorizes private litigation after exhausting administrative remedies

ERISA & DOL ENFORCEMENT

EMPLOYERS SUBJECT TO ERISA

- ERISA applies to virtually all private-sector employers that maintain welfare benefit plans for their employees, **regardless of the size of the employer**.

- To qualify as an ERISA plan, there must be a plan, fund or program that is established by the employer for the purpose of providing ERISA-covered benefits (through the purchase of insurance or otherwise) to participants and their beneficiaries.
  - many employment plans or programs that provide nonretirement benefits to employees are considered employee welfare benefit plans that are subject to ERISA

DOL STRUCTURE

- U. S. Department of Labor (DOL)
  - Employee Benefit Security Administration (EBSA)
  - Regional offices
    - Boston, New York, Chicago, Kansas City, Philadelphia, Atlanta, Cincinnati, Dallas, San Francisco, Los Angeles
- Mission statement
  - *[T]o assure the security of the retirement, health and other workplace related benefits of America's workers and their families. We will accomplish this mission by:*
    - *developing effective regulations;*
    - *assisting and educating workers, plan sponsors, fiduciaries and service providers; and*
    - *vigorously enforcing the law*

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DOL ENFORCEMENT SCOPE

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- DOL enforces numerous benefits-related laws
  - Employee Retirement Income Security Act of 1974 (ERISA)
    - Includes Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Patient Protection and Affordable Care Act (ACA)
  - Mental Health Parity and Addiction Equity Act (MHPAEA)
  - Newborns' and Mothers' Health Protection Act (NMHPA)
  - Women's Health and Cancer Rights Act (WHCRA)
  - Health Insurance Portability & Accountability Act (HIPAA – Title I)
  - Genetic Information Nondiscrimination Act (GINA)
  - Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Michelle's Law
  - 21st Century Cures Act (Cures Act)
  - No Surprises Act

RANGE OF INVESTIGATIVE ISSUES

- Compliance with ERISA
- Unpaid or improperly processed benefit claims
- Excessive service provider fees
- Systemic denial of promised benefits
- Criminal misconduct by plan fiduciaries or medical providers

RANGE OF INVESTIGATIVE ISSUES

- Multiple Employer Welfare Arrangement (MEWA)
  - A multiple Employer Welfare Arrangement (“MEWA”) is defined as (1) an employee welfare benefit plan or (2) other arrangement that is established or maintained for the purpose of offering or providing medical or other welfare benefits to employees of TWO OR MORE unrelated employers, including self-employed individuals.

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RANGE OF INVESTIGATIVE ISSUES

- Multiple Employer Welfare Arrangement (MEWA)
  - A MEWA exists if the elements of the definition are satisfied – the intent to create a MEWA is not required
  - An employer can create a MEWA if it allows other employers (outside of its controlled group) to participate in its welfare plans
  - Affiliated service group rules do not apply under ERISA in determining related employers – different results IRC and ERISA
  - Carefully review common ownership interests of employers participating in a single plan
  - An employer may create a MEWA by extending coverage to an individual who is not a common-law employee – i.e., a leasing/staffing organization can create a MEWA if it is not the "common-law employer" and it allows individuals who work for several recipient employers to participate in its health plan
  - An employer can create a MEWA following a corporate transaction or reorganization if it continues to provide health and welfare benefits to employees who are transferred to an unrelated buyer

RANGE OF INVESTIGATIVE ISSUES

- Inadvertent MEWA
  - MEWAs can be inadvertently created by employers covering non-employees under a group health plan or by mistakes in determining members of a controlled group
  - Consequences could include
    - Penalties for failure to comply with ERISA reporting and disclosure obligations – (i.e., Form 5500 and Form M-1 violations)
    - Operation of a self-funded MEWA in states in which it is prohibited
    - State requirements that require advance notice or certification by the state's department of insurance or limit what types of entities may sponsor a MEWA (e.g., association)
    - Employers with < 20 employees may be required to comply with Medicare Secondary Payer rules if another member of the MEWA has 20 or more employees

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RANGE OF INVESTIGATIVE ISSUES

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- ACA Employer Reporting
  - 2021 individual statements due January 31, 2022; Forms 1094/1095 due to IRS February 28, 2022 (paper) or March 31, 2022 (electronic)
  - IRS announced last year that it would not be granting automatic extension for individual statements this cycle
  - Also announced no longer considering good faith effort for filing errors or inaccuracies
  - IRS has proposed dropping electronic filing threshold from 250 to 100 in 2022 and to 10 in 2023
  - New guidance indicates deadline for individual statement will be permanently extended 30 days

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RANGE OF INVESTIGATIVE ISSUES

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- Group health plan duties (DELAYED ENFORCEMENT)
  - Advance explanation of benefits
  - Public disclosure of in-network rates and out-of-network allowed amounts
  - Rx drug pricing disclosures and reporting
  - Price comparison tool
  - Periodic provider directory updates (good faith standard for now)
  - Expanded insurance card information (good faith standard for now)
  - Treat ongoing care as in-network for 90 days following provider change to out-of-network (good faith standard for now)

RANGE OF INVESTIGATIVE ISSUES

- Recent guidance provides that Departments will not deem plan sponsors to be out of compliance with many transparency and disclosure provisions until final regulations issued
- Expected to begin issuing final rulemaking in 2022
  - Rx information reporting delayed until December 27, 2022
  - No Surprises Act price comparison information delayed until January 1, 2023
  - In-network rates and out-of-network charges disclosure delayed until July 1, 2022

RANGE OF INVESTIGATIVE ISSUES

- Settlements with carriers signal aggressive shift in DOL priority regarding Mental Health Parity and Addiction Equity Act (MHPAEA)
  - Consolidated Appropriations Act, 2021 added new documentation requirement for comparative analysis of nonqualified treatment limitations (NQTL)
  - Must provide within 30 days of participant request comparative information (and comparative analyses) on medical necessity for mental health/substance use disorder benefits and other information regarding NQTL application
  - Work with carrier or TPA to perform and document comparative analyses
  - Review service agreements to account for MHPAEA compliance

EMPLOYER OBLIGATIONS

EMPLOYER OBLIGATIONS UNDER ERISA

- Reporting Requirements
  - Certain plans with 100+ participants at beginning of plan year must file Annual Report (Form 5500)
- Disclosure Requirements
  - Written Plan Document
  - Summary Plan Description (SPD)
  - Summary of Material Modification (SMM)
  - Summary of Benefits and Coverage (SBC)
  - Adverse benefit determinations and other disclosures as required by ERISA Section 503 claims procedure rules
  - Notice of special enrollment rights
  - COBRA notices
    - Plan design rules
    - Fiduciary standards

EMPLOYER OBLIGATIONS UNDER ERISA

Internal Claims and Appeals and External Review

- Under the Affordable Care Act (ACA), non-grandfathered group health plans and insurers with respect to non-grandfathered policies must implement an effective internal claims and appeals process.
- The process must take into account the following requirements:
  - **Expanded Adverse Benefit Determination definition** – the definition of adverse benefit determination must include coverage rescissions.
  - **Expedited Notification Requirements** – plans and insurers must notify a claimant of a benefit determination involving an urgent care claim as soon as possible, but no later 24 hours after receipt of the claim
  - **Additional Review Criteria** – a plan must provide a claimant, free of charge, any new or additional evidence considered or generated by the plan and any new rationale in connection with the claim.

EMPLOYER OBLIGATIONS UNDER ERISA

- **Internal Claims and Appeals and External Review**
  - **Conflicts of Interest** – plans and insurers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making a decision.
  - **Notifications** - notices must be provided in a "culturally and linguistically appropriate" manner.
  - **Noncompliance** - A claimant will be deemed to have exhausted the internal claims and appeals process with respect to a claim if a plan or insurer fails to meet the requirements described above.
- **State and Federal External Review**
  - The regulations also require that non-grandfathered group health plans and insurers comply with either a compliant state external review process or the federal external review process.

DOL
AUDIT PROCESS

DOL ENFORCEMENT FIGURES

- What is the likelihood of a civil audit?
  - EBSA's oversight authority extends to nearly 734,000 retirement plans, approximately 2 million health plans, and more than 660,000 other welfare benefit plans (such as life or disability insurance plans)
  - In FY 2021, EBSA closed 1,072 civil investigations, with 69% resulting in monetary results for plans or other corrective action
  - DOL last year recovered almost $2 billion in plan assets, participant benefits, fines, fees and other monetary benefit recoveries from informal complaint resolution

DOL ENFORCEMENT FIGURES

- Civil penalty assessments
  - DOL has authority to assess penalties for numerous ERISA violations.
  - Common penalty assessments:
    - Failure to file Form 5500s (including failure to file complete Form 5500s)
      - Voluntary Fiduciary Correction Program (VFCP) and Delinquent Filer Voluntary Correction Program (DFVCP)
        - 1,201 and 22,553 filings last year, respectively
    - Failure to timely respond to requests for information
    - Prohibited transactions
    - Other breaches of fiduciary duty

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DOL ENFORCEMENT FIGURES

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- Criminal audits
  - 2021: 208 criminal audits closed
    - 38 resulted in guilty plea or conviction (72 indictments)
  - A criminal audit may result from an initial civil audit

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DOL ENFORCEMENT AUTHORITY

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- DOL's audit powers
  - DOL may commence an audit and require records whether or not it has reasonable cause to believe any particular violation exists
  - ERISA §504(a)(1) permits DOL to investigate whether any person has violated or will violate ERISA
  - ERISA §504 states that the DOL may make available to any person actually affected by any matter which is the subject of an audit (and to any department or agency of the United States), information concerning any matter which may be the subject of an audit
  - In addition to its power to obtain documents in connection with an audit, the DOL has the broad general authority to request production of documents “relating to” an ERISA plan

DOL AUDIT TRIGGERS

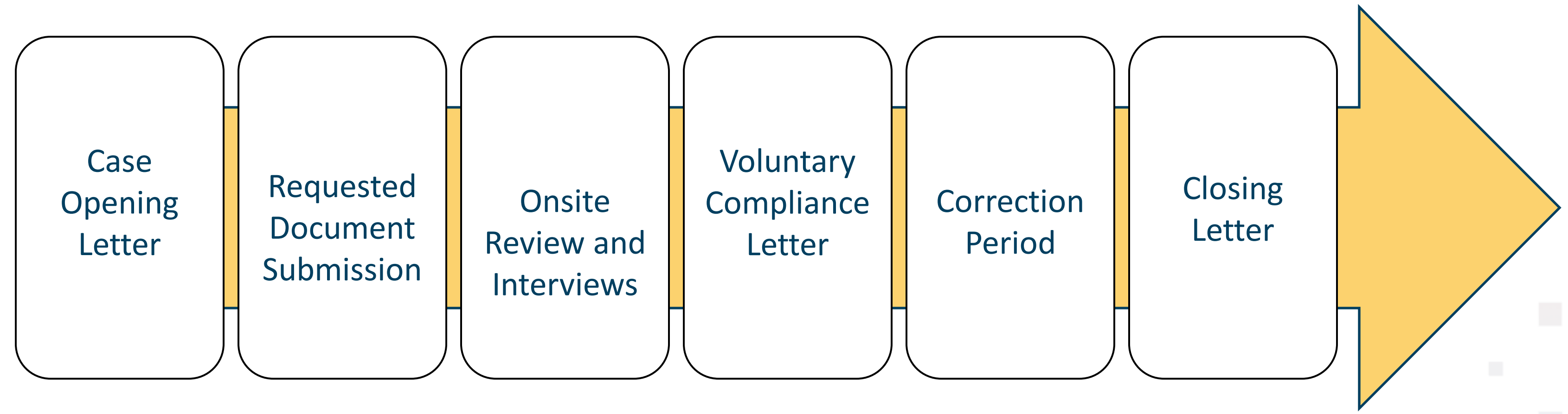
- Sources for targeted audits
  - PARTICIPANT COMPLAINTS – number one . . . by far
  - Form 5500 reviews
  - Referrals
    - IRS reporting per inter-agency letter of understanding
    - State insurance departments
    - Advocacy groups

DOL AUDIT TRIGGERS

- Sources for general audit
  - Compliance initiatives
    - Health Benefits Security Project
      - Established in 2012
      - Comprehensive national project
      - Part 7 of ERISA
      - Unpaid or improperly processed claims
      - Excessive service provider fees
      - Systemic denial of promised benefits
      - Criminal misconduct of plan fiduciaries or medical providers
  - Multiple Employer Welfare Arrangement (MEWA) audit
  - Random chance

DOL ENFORCEMENT PROCESS

- General process for plan audit



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DOL ENFORCEMENT PROCESS

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- What is the process of a DOL audit?
  - Initial contact and correspondence
    - Document request letter
    - Confirm scope of request
    - Ask for extension for document delivery, in writing
    - Retain copies of all correspondence
    - Identify known compliance problems in advance and determine what can be corrected even before receiving Voluntary Compliance Notice Letter

DOL ENFORCEMENT PROCESS

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- What is the process of a DOL audit?
  - Document production
    - Pre-screen materials before providing to auditor
    - Provide only those documents that respond to specific requests
  - Physical facilities
    - On-site visit
    - Control the environment and limit contact
  - Voluntary compliance letter
    - Identifies discovered problems
    - Offers chance to discuss corrective action
    - If corrections not made, potentially referred to Solicitor's Office

DOL ENFORCEMENT PROCESS

- What is the process of a DOL audit?
  - Results
    - Closing letter
      - Identifies problems and corrective actions taken
      - Indicates case is closed
    - Settlement agreement
      - Notice to participants and beneficiaries
      - New internal controls
      - Re-adjudication of claims or paying unpaid claims
      - Penalties
      - Removal of fiduciaries or service providers

DOL ENFORCEMENT PROCESS

Documentation and procedures should be complete and readily accessible

- Inventory and assemble current documentation to show compliance, such as:

Plan Documents	Summary Plan Descriptions	Employee Health Plan Notices	HIPAA Certificates of Creditable Coverage
Vendor Agreements	Eligibility & Enrollment Process	Internal /External Claim & Appeal Procedures	Plan Sponsor and Plan Administrator Authority Delegations

- Identify sources of reportable information (benefit/payroll staff, outside vendors, health insurers); verify reporting capabilities and related contractual obligations.
- Determine what materials will demonstrate compliance with items in DOL document request letter
- Establish process needed to complete missing documentation or other information
- If DOL document request letter received, contact benefit advisers and legal counsel immediately

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DOL DOCUMENT REQUEST

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- Plan documents, Insurance policies and Riders
- Service provider agreements
- Summary Plan Descriptions ("SPDs"), Benefit Booklets, and/or Wrap Document including any amendments and/or riders showing changes in Plan benefits and entitlement to benefits for plan years beginning on or after March 23, 2010
- Signed copies of all Forms 5500 for the last 2-3 years including Schedules, auditors' reports, and any other data to support Form 5500 entries
- Plan financial statements, cancelled checks, payroll records
- Trustee/corporate minutes
- Summary annual reports ("SARs")

DOL DOCUMENT REQUEST

- If self-funded, all contracts for claims processing, administrative services and reinsurance, actuarial analysis showing feasibility of self-funding by employer
- Copies of all required notices, including lists and logs of issued notices and a description of procedures for distribution
- Participant records, provider agreements, and fiduciary bonds
- Employee handbooks discussing employee benefits
- New hire and open enrollment documentation including a Sample blank enrollment form given to participants and/or beneficiaries to complete for coverage
- Names, home address, phone numbers, email addresses and Social Security Numbers of all Plan Trustees, Plan Administrators and named fiduciaries

HIPAA DOCUMENT REQUEST

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- Under HIPAA
  - Copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including eligibility)
  - Copy of the special enrollment rights notice(s) provided to employees, including any lists or logs an administrator may keep of issued notices
  - If the Plan is in a state with a CHIP or Medicaid program that provided for premium assistance for group health plan coverage, a copy of the Employer CHIP Notice provided to employees
  - Material describing any wellness programs or disease management programs offered by the plan, including rewards based on a health factor and Notice of "reasonable alternative standards" *(GINA compliance evaluated in wellness also)*

HIPAA DOCUMENT REQUEST

- Under HIPAA Portability
  - Copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including eligibility)
  - Copy of the special enrollment rights notice(s) provided to employees, including any lists or logs an administrator may keep of issued notices
  - If the Plan is in a state with a CHIP or Medicaid program that provided for premium assistance for group health plan coverage, a copy of the Employer CHIP Notice provided to employees

ACA DOCUMENT REQUEST

- Under ACA (regardless of whether the plan is claiming grandfather status)
  - A sample written notice describing enrollment opportunities relating to dependent coverage of children to age 26 if the Plan provides dependent coverage
  - List of participants or beneficiaries whose coverage has been rescinded, reason for the rescission, and a copy of the written notice of rescission providing 30-days advance notice of any rescission of coverage
  - Documents showing the limits applicable for each Plan year on or after September 23, 2010 if the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010
  - Documents showing limits applicable each Plan year on or after September 23, 2010 if the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010.

ACA DOCUMENT REQUEST

- Under ACA if the Plan is claiming or has claimed grandfathered health plan status within the meaning of Section 1251 of the Affordable Care Act
  - Copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan
  - Records necessary to verify, explain or clarify status as a grandfathered health plan which may include documents showing Plan terms in effect on March 23, 2010 , changes toward cost-sharing provisions, changes to contributions towards cost of coverage, and change in health insurance issuers since March 23, 2010

MHPAEA DOCUMENT REQUEST

- Under MHPAEA, plan sponsors must ensure that any financial or treatment limitations on benefits under a group health plan are not more stringently applied to mental health and substance use disorder benefits than to medical/surgical benefits.
- How plan sponsors can gauge compliance
  - Use plan-specific data when making compliance projections
  - Review the plans' nonquantitative treatment limitations ("NQTLs")
- Not an objective standard – must analyze claims paid

MHPAEA DOCUMENT REQUEST

- Examples of MHPAEA Violations
  - Not offering out-of-network providers or inpatient benefits to treat mental health or substance use disorders
  - Charging higher copays
  - Use plan-specific data when making compliance projections
  - Imposing broad preauthorization requirements on all mental health and substance use disorder treatments
  - Use plan-specific data when making compliance projections
  - Requiring written treatment plans for mental health services

MHPAEA DOCUMENT REQUEST

- Under MHPAEA
  - Documents relating to any analyses the Plan has done regarding testing the parity of the non-quantitative treatment limitations or the quantitative treatment limitations when compared to the medical/surgical limitations
  - Breakdown of medical surgical claims paid showing the amount of medical surgical claims paid for each co-payment level applicable under the Plan for each plan year that the Plan covers mental health and/or substance abuse

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GINA DOCUMENT REQUEST

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- Title I generally prohibits group health plans from:
  - Adjusting premium or contributions amounts based on genetic information;
  - Requesting/requiring genetic testing;
  - Requesting/requiring/purchasing genetic information for underwriting purposes or in connection with open enrollment.
- No HRA during open enrollment or after if reward tied to premiums (considered underwriting)
- DOL does not audit EEOC wellness rules, but may refer violations

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OTHER DOCUMENT REQUEST

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- Under NMHPA
  - Newborns' Act: lists or logs of distributed notices
  - Plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth
- Under COBRA
  - Sample notices, all election packages mailed, copies of elections, length of coverage and premium payment records
- Under WHCRA
  - Sample notice and distribution logs

DOL AUDIT TIPS

- Advice from former DOL auditor on how to get through the audit smoothly
  - Notify legal counsel
  - Produce all documents in an organized and timely manner
    - DOL has subpoena power, so cooperate
    - Explain any deficiencies
  - Be courteous and professional, but auditor is NOT your company's friend
  - Give the auditor a space to work that is private during the on-site visit
    - Restrict auditor's access to company premises and employees
  - Have legal counsel prepare employees or fiduciaries before the interview
  - Designate a senior employee with plan knowledge or an attorney to handle all contact and communication between the employer and auditor
  - Be patient: audits typically take between 6-18 months . . . or more

EMPLOYER ACTION STEPS

EMPLOYER ACTION STEPS

- Identify an individual to coordinate compliance efforts
- Identify all group plans subject to compliance concerns
- Routinely conduct self-audits and correct failures
- Retain documentation and procedures that support compliance measures
- Maintain compliance documents in a central location
- Respond to participant questions and requests on a timely basis
- File Form 5500s timely and accurately (key trigger is a retirement plan with over 100 participants and no welfare 5500)
- Distribute required participant notices timely and keep records of distribution

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EMPLOYER ACTION STEPS

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- Make timely updates to plan document and SPDs to reflect legal and design changes
- Confirm that vendors are following contract terms and administering plans in compliance with federal and other requirements
- Require vendors to immediately report instances of potential noncompliance to plan
- Train applicable staff on compliance obligations and procedures to address violations
- Work with legal counsel to minimize or correct any potential violations
- Respond promptly and thoroughly to any governmental inquiry related to health and welfare plans

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EMPLOYER ACTION STEPS

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- Self-audit for common group health plan violations
  - Failure to provide benefits in accordance with plan terms
  - Improper or arbitrary claims adjudication
  - Failure to follow DOL claims procedure rules
  - Failure to forward employee premiums to the insurance provider
  - Failure to provide mental health and substance use benefits in parity with medical/surgical benefits in accordance with applicable rules
  - Failure to provide required notices

Final Questions

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HRCI –

SHRM –

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Thank You

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