McDermott Will & Emery

U.S. Department of Labor Health and Welfare Plan Audits

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Governing Law

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- Employee Retirement Income Security Act of 1974 (ERISA)
  - Title I: Protection of Employee Benefit Rights
    - Enforced by the Department of Labor (DOL)
  - Title II: Amendments to the Internal Revenue Code (IRC)
    - Enforced by the Internal Revenue Service (IRS)

Audit Overview – Enforcement

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- DOL Enforcement
  - Reporting and disclosure
  - Fiduciary standards
  - Voluntary Fiduciary Correction Program
  - Delinquent Filer Voluntary Compliance Program

DOL Audit Triggers

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- Participant complaints
- Form 5500 review
- At-risk employers vulnerable to selection for audit
- Specific DOL reasons for certain audits (*e.g.* looking into plan administration at certain industries)
- Random selection

DOL Audit Triggers

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- EFAST2 system challenges
  - DOL will take into account good faith attempts to file correctly
- Failure to file Form 5500 or late filing
  - Delinquent Filer Voluntary Correction (DFVC) program available
- Incomplete filing
  - Plan administrator can file a revised Form 5500 within 45 days of the DOL's notice of rejection
- Failure to maintain proper records
  - Informal comments indicate plans should keep an actual signed copy of the Form 5500, even though submitted using an electronic signature

Audit Overview – Procedure

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- General procedure for DOL audits
  - Selection for audit
  - Initial contact by the DOL
  - Document request
  - Site visit
  - Additional requests
  - Discussion of issues
  - Correction of failures
  - Completion of audit

DOL Audits – Document Requests

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- Typical Document Request Includes:
  - Plan Document (including proof of adoption) and SPD
  - Form 5500s for the past three years
  - Service provider agreements
  - Meeting minutes related to plan
  - Asset records and payroll/contribution records

DOL Audits – Document Requests

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- Typical Document Request Includes:
  - Women's Health and Cancer Rights Act (WHCRA) Notice
  - The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) Notice
  - Plan's rules for pre-authorization for a hospital length of stay in connection with childbirth
  - Written description of benefits mandated by WHCRA
  - Materials describing wellness programs or disease management programs

DOL Audit Requests—ACA

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- Affordable Care Act Requests:
  - Grandfathered status
  - Dependent Coverage to Age 26
  - Rescissions of coverage
  - Lifetime limits
  - Annual limits

DOL Audit Requests—ACA

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- Affordable Care Act Requests for non-grandfathered plan
  - Choice of provider notices-right to designate any participating primary care provider, physician specializing in pediatrics or healthcare professional specializing in obstetrics or gynecology
  - Emergency services
  - Preventative services
  - Internal appeal process and external review
  - Independent Review Organization contracts

Grandfathered Plans Under the ACA

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- Plans in effect as of March 23, 2010
- Examples of changes resulting in a loss of grandfathered status
  - Changing the plan to eliminate all or substantially all benefits to diagnose or treat a particular condition, or to eliminate benefits for any necessary element to diagnose or treat a condition
  - Increasing any percentage cost-sharing requirement (*e.g.*, coinsurance)
  - Increasing a fixed-amount cost-sharing requirement, other than a copayment (*e.g.*, a deductible or out-of-pocket limit), if the total percentage increase in the cost-sharing requirement exceeds the "maximum percentage increase" (the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15%)

Grandfathered Plans

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- **Examples of changes resulting in a loss of grandfathered status (continued)**
  - Increasing a fixed-amount copayment, if the total increase in the copayment exceeds the greater of: $5 increased by medical inflation measured from the grandfather date, or a total percentage measured from the grandfather date that is more than the sum of medical inflation plus 15%
  - Decreasing the employer or employee organization's contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5%
    - The cost of coverage is determined in the same way the premium is calculated for COBRA continuation coverage purposes
  - Decreasing or imposing a new annual limit on the dollar value of benefits (subject to limited exceptions)

Grandfathered Plans

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- Possible DOL ACA audit request
  - 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 documenting the terms of the plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan (*e.g.*, documentation relating to the terms of cost sharing, contribution rate of the employer or employee organization towards the cost of coverage, annual and lifetime limits on benefits, or any contract with a health insurance issuer in effect on March 23, 2010)

Dependent Coverage

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- Coverage of adult children to age 26
- Possible DOL ACA audit request
  - Sample of each written notice describing enrollment opportunities relating to dependent coverage of children to age 26 utilized by the plan

Rescission of Coverage

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- No retroactive termination of coverage (except under limited circumstances)
  - Exceptions for intentional misrepresentation or fraud
- Possible DOL ACA audit request
  - List of any participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage

Lifetime Limits

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- No lifetime dollar limits on essential health benefits
- Possible DOL ACA audit requests
  - Documents showing the lifetime limits, if any, applicable for each plan year beginning on or after September 23, 2010
  - Sample of each form of notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan

Annual Limits

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- **Phase out of annual limits on essential health benefits began in 2011, and annual limits on essential health benefits were totally prohibited beginning in 2014**
  - For plan years beginning on or after September 23, 2010, but before September 23, 2011, the limit was $750,000
  - For plan years beginning on or after September 23, 2011, but before September 23, 2012, the limit was $1.25 million
  - For plan years beginning on or after September 23, 2012, but before December 31, 2013, the limit is $2 million
    - Waiver process was available for plans and coverages that included "limited benefit" or "mini-med" plans
    - Intended for lower-cost coverage to part-time workers, seasonal workers, and volunteers who otherwise may not be able to afford coverage at all
- **Possible DOL ACA audit requests**
  - Documents showing the annual limits applicable for each plan year beginning on or after September 23, 2010, including any waivers

Choice of Providers

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- Participants must be allowed to choose primary care providers, pediatricians, obstetricians, and gynecologists
  - Effective in 2011 (non-grandfathered plans only)
- Possible DOL ACA audit requests
  - Copy of each form of choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women utilized by the plan on or after September 23, 2010, and a list of participants who received the disclosure notice

Emergency and Preventive Services

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- First dollar preventive care coverage and emergency care coverage without prior authorization
  - Effective in 2011 (non-grandfathered plans only)
- Possible DOL ACA audit requests
  - Copies of documents relating to any benefits with respect to emergency services in an emergency department of a hospital for each plan year beginning on or after September 23, 2010
  - Copies of documents relating to the provision of preventive services for each plan year beginning on or after September 23, 2010

Claims and Appeals

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- Increased internal claims and external review requirements
  - Effective in 2011 (non-grandfathered plans only)
- Possible DOL ACA audit requests
  - Copy of the plan's internal claims and appeals and external review processes
  - Samples of each form of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision, utilized by the plan on or after September 23, 2010
  - Any contract or agreement for an independent review organization or third party administrator providing external review