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2024 Compliance Targets for Health & Welfare Plans

Why is Compliance Important?

DOL has broad authority to audit compliance with ERISA

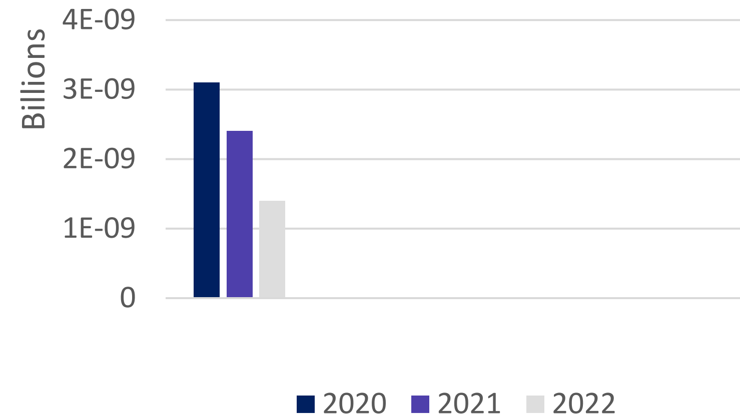
- Audits performed by the Employee Benefit Security Administration (EBSA)
- Focus is on ERISA compliance:
  - Fiduciary obligations
  - Reporting and disclosure
  - Group health plan requirements
  - Compliance with the Affordable Care Act (ACA)
  - Compliance with the Consolidated Appropriations Act (CAA) of 2021

In 2022, EBSA saw a significant decrease in enforcement actions for the second consecutive year.

EBSA's recent pause in enforcement (EBSA Notice 2020-01) expires 60 days after the announcement of the end of the COVID-19 National Emergency (5/11/2023).

DOL's enforcement activity is expected to return to more typical levels due to the expiration of the NE.

Increase in requirements under the Consolidated Appropriations Act (CAA)



Why is Compliance Important?

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

Recovered in 2022

Enforcement Actions	Voluntary Correction Program	Abandoned Plan Program	Informal Complaints
• $931 million	• $8 million	• $84 million	• $422 million

ERISA Requirements

Most group health plans sponsored by private sector employers ARE subject to ERISA.

Subject to ERISA

- Corporations
- Partnerships
- Sole Proprietorships
- Nonprofit organizations

Exempt from ERISA

- Governments
- Churches

Internal Use

ERISA Requirements

Plan Document

Reporting & Disclosure

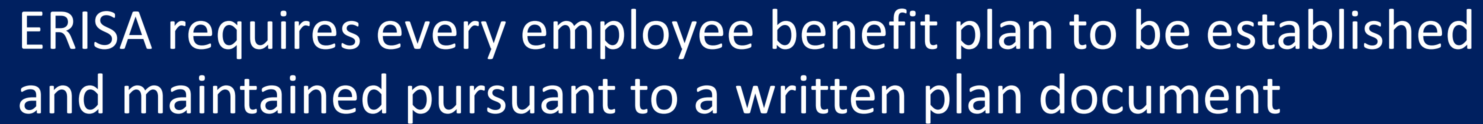
Fiduciary Responsibility

ACA

COBRA

Group Health Plan Requirements

Plan Document



Common Compliance Issues			
Undocumented arrangements – Flex Plans, HRAs and EAPs	Relying on “Certificate of Coverage” as the plan document for fully insured plans	Poor documentation of benefits for self-funded plans	Plan documents not properly amended for applicable law or benefit changes

Tip: Consider a wrap document to supplement insurance documents and provide missing ERISA provisions.

Summary Plan Description (SPD) & Summary of Material Modifications (SMM)

- Purpose is to communicate plan benefits, changes, rights and obligations to plan participants and beneficiaries
- Must be provided to plan participants and beneficiaries within 90 days of the effective date of coverage
- Must be re-distributed every 5 years if there have been any changes, 10 years if there have been no changes
- SMM or updated SPD must be provided to plan participants and beneficiaries no later than 210 days after the end of the plan year in which the change is adopted, if no material reduction in benefits or 60 days after the effective date of the change if there is a material reduction in benefits
- Best practice to distribute SPD with annual enrollment materials

Common Compliance Issues				
Failing to distribute timely	Benefit booklets provided by health insurance carriers are not SPDs	SPD does not properly reflect eligibility requirements	Failing to distribute a SPD for each benefit plan	Does not include required provisions (WHCRA, claims procedures, ERISA rights, etc.)

Participant Disclosures

Notices Required to be Distributed

- Medicare Creditable Coverage
- Women’s Health & Cancer Rights Act (WHCRA)
- Newborns’ & Mothers’ Health Protection Act (NMHPA)
- Premium Assistance under Medicaid & the Children’s Health Insurance Program (CHIPRA)
- HIPAA Notice of Privacy Practices
- HIPAA Special Enrollment Rights
- Notice of Grandfathered Status (if applicable)
- Patient Protection Notice (if applicable)
- COBRA Notices
- Wellness Notice of Reasonable Alternative(s)
- ADA Wellness Notice (if applicable)
- Marketplace Exchange Notice
- COBRA compliance documents
- Surprise Billing Rights Notice
- ICHRA Notice
- QSEHRA Notice

Internal Use

Form 5500

- Must be filed by the end of the 7th month following the end of the plan year (July 31 for calendar year plans)
- 2 ½ month extension is available if Form 5558 is timely filed
- Required for all retirement plans
- Required for “unfunded” welfare benefit plans covering more than 100 participants as of the first day of the plan year
- Required for welfare benefit plan regardless of size if “funded”

Common Compliance Issues			
No blanket exemption for non-profit organizations	Filing a consolidated Form 5500 without a wrap document in place	Failing to identify which benefits are subject to the filing requirement	Don’t forget health FSAs, HRAs and certain EAPs

Summary Annual Report (SAR)

- Summary of the information submitted on the annual Form 5500
- Prescribed format
- Must be provided by the end of the ninth month following the end of the plan year (September 30 for calendar year plans)
- Extension of 2 ½ months available if Form 5558 is timely filed

Common Compliance Issues

Common misconception SAR is not required for group health plans	If fully-insured or plan is "funded," SAR is required

HIPAA

- Increased penalty provisions under HITECH
- Limit plan's uses and disclosures of protected health information (PHI)
- Minimum necessary use and disclosure
- Business Associate Agreements
- Privacy and Security Policies and Procedures

- Appointment of HIPAA Privacy & Security Officers
- Breach/encryption protocols
- Access controls
- Risk assessment
- Annual HIPAA training for employees with access to PHI

Common Compliance Issues		
"Hands-on" fully-insured plan without proper HIPAA Privacy and Security Policies and Procedures	Lack of required "ongoing" HIPAA training for employees with access to PHI	Failing to complete ongoing risk assessments

Internal Use

Affordable Care Act (ACA)

DOL uses audit authority to enforce compliance with the ACA

Grandfathered Plans	Non-Grandfathered Plans
• Records supporting grandfathered status • Participant notice regarding grandfathered status	• Coverage of preventive services • PPA Notice • Claims and appeals procedures

All Plans

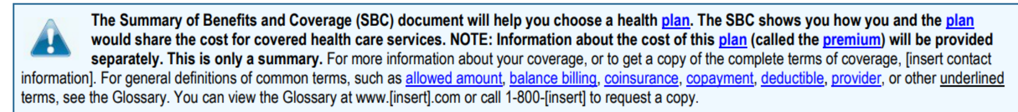
- Enrollment opportunities for children up to age 26
- Coverage rescission rules
- Lifetime and annual limits
- Summary of Benefits & Coverage (SBC)
- Marketplace Notice
- W-2 reporting
- Excessive waiting periods
- Eligibility requirements
- Cost-sharing limits on essential health benefits (out-of-pocket maximum)
- Form 1094/1095 reporting
- PCORI Fees

Common Compliance Issues

Failing to count part-time and seasonal employees	Not issuing a Form 1095-C to all full-time employees	Failing to track hours for part-time and variable hourly employees	Failing to document offers of coverage

Summary of Benefits & Coverage (SBC)

- Prescribed format
- Required by the ACA
- Short summary of benefits and coverage under the plan
- Must be provided at enrollmen re-enrollment and upon reques



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: [See Instructions]

_____________________:_______________ Coverage for:__________ | Plan Type:____

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$	
Are there services covered before you meet your deductible?		
Are there other deductibles for specific services?	$	
What is the out-of-pocket limit for this plan?	$	
What is not included in the out-of-pocket limit?		
Will you pay less if you use a network provider?		
Do you need a referral to see a specialist?		

Employer must provide 60 days' advance notice of any material modifications of plan terms or coverage not reflected in the most recent SBC.

Common Compliance Issues		
Failing to distribute timely	Information in SBC does not match SPD	Failing to provide updated SBC if benefits change mid-year

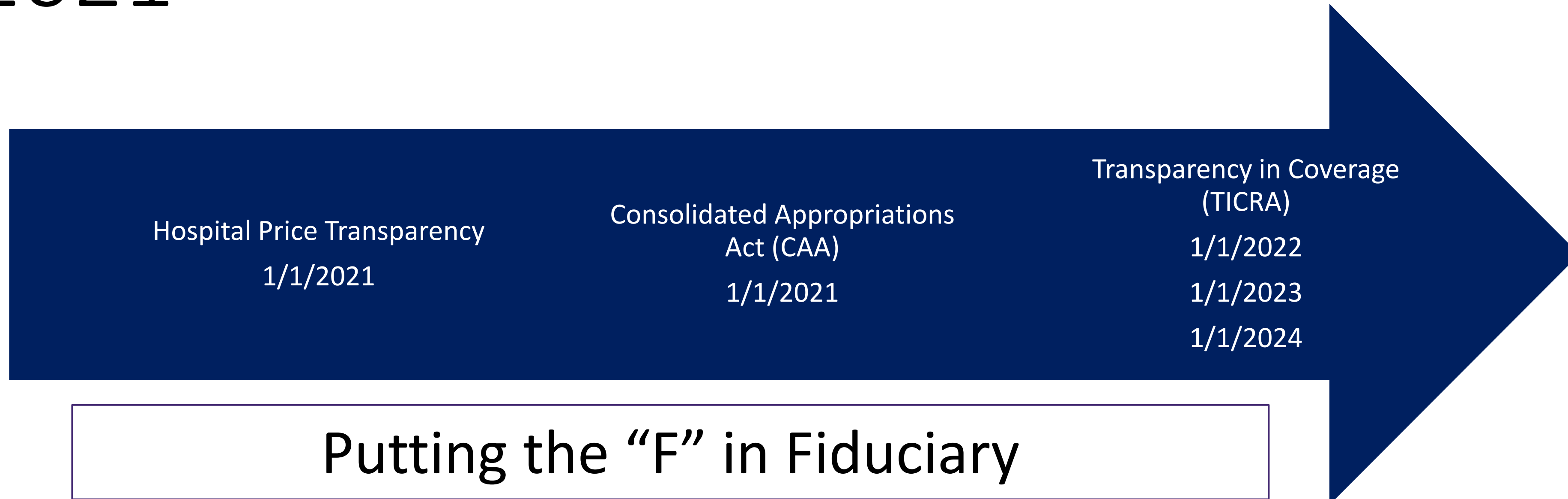
Affordable Care Act (ACA)

Annual ACA Reporting

	Fully Insured < 50 FTEs	Fully Insured > 50 FTEs	Self-Funded < 50 FTEs	Self-Funded > 50 FTEs
Forms to Employees	1095-B	1095-B/1095 – C(Parts I and II Only)	1095-B	1095-C (Parts, I, II and III)
Issued by	Insurer	Insurer/Plan Sponsor	Plan Sponsor	Plan Sponsor
Forms to IRS	1094-B and copies of 1095-B	1094-B and copies of 1095-B 1095-C and copies of 1095-C	1094-B and copies of 1095-B	1094-C with copies of 1095-C
Filed by	Insurer	Insurer/Plan Sponsor	Plan Sponsor	Plan Sponsor

Note: Effective with the 2023 reporting due in 2024, electronic filing is mandatory if employer is filing 10 or more returns in aggregate (includes Forms W-2s, 1099s and 1095s.

Consolidated Appropriations Act (CAA) of 2021



- Lack of clarity before CAA for the role of Plan Sponsor as the Fiduciary under ERISA/PHSA
- Contracts that restrict Plan Sponsors from full access to their data
- Lack of transparency in pricing and benefit plan administration
- Accountability for services provided
- Need for more aggressive enforcement of the federal Mental Health Parity and Addiction Equity Act (MHPAEA)

Consolidated Appropriations Act (CAA) of 2021

Employer Fiduciary Responsibilities Across 4 Key Areas:
• Removes gag clauses from service provider contracts on price and quality information
• Establishes reporting requirements for prescription drugs and other medical spending
• Requires the disclosure of direct and indirect compensation from all service providers
• Requires annual Non-Quantitative Treatment Limitations (NQTL) analysis to demonstrate mental health parity

Gag Clause Attestation

Contracts with service providers cannot restrict (directly or indirectly) the Plan Sponsor's access to provider-specific cost or quality of care information necessary to meet their **fiduciary duties**:

- Operate the plan solely in the best interest of participants and beneficiaries
- Verify that claims are properly processed and paid
- Identify waste and fraud through comparative analytics
- Verify that fees associated with the plan are reasonable
- Provide participants and beneficiaries with access to information to make informed, cost-effective healthcare decisions

Plan Sponsors are required to attest annually starting 12/31/2023

Plan Sponsors should ensure they have documented their due diligence and can attest truthfully

Compensation Disclosure Requirement

To assist Plan Sponsor in fulfilling their **fiduciary duty** to ensure fees are "reasonable"

- Must be provided to fiduciaries annually
- Service provider reasonably expects to receive $1,000 or more in direct or indirect compensation
- Requires disclosure of service provider's fiduciary status

- Development or implementation of plan design
- Recordkeeping
- Pharmacy benefit management
- Medical management
- Benefits administration
- Wellness services
- Transparency tools and vendors
- Disease management
- Compliance services
- EAPs
- Third-party administration
- Other services listed in the statute

Prescription Drug Reporting (RxDC)

Requires Plan Sponsors to report certain prescription (and health care) spending to HHS, DOL and Treasury by **June 1st** annually:

- Top 50 most frequently dispensed brand drugs
- Annual amount spent by the top 50 most costly drugs
- Amount spent for the top 50 most costly drugs in the prior year
- Total health care spending for the year
- Premiums and rebates

Annual reporting requirement allows Plan Sponsors to demonstrate their **fiduciary duty** by obtaining information necessary to evaluate the economic interest of participants and beneficiaries. Employers should document requests for the RxDC plan-level information.

The filing of the reports can be delegated to a third-party. However, the Plan Sponsor has the legal obligation to ensure timely, and complete filing.

Internal Use

MHPAEA Non-Quantitative Treatment Limitations (NQTL)

The CAA requires plan sponsors to analyze non-quantitative treatment limitations on mental health/substance abuse disorder (MH/SUD) benefits to show parity with medical and surgical care (Med/Surg):

- Required as of 2/10/2021
- NQTLs are limits on the scope or duration of treatment that are not expressed numerically (such as medical management standards, formulary design, step therapy protocols and methods for determining usual, customary and reasonable charges)
- NQTL must be performed annually and is extremely complex
- The law requires plans to make their NQTL comparative analysis available upon request by any government agency (CMS, HHS, DOL, state authorities)

*Does not apply to small self-funded plans of less than 50 employees

Fully-insured plans who rely on the insurance carrier to complete the analysis should verify compliance and retain a copy on file in case of an audit.

Self-funded plans will need to perform analysis using the DOL's MHPAEA Self-Compliance Tool or contract with a third-party vendor.

Internal Use

MHPAEA Non-Quantitative Treatment Limitations (NQTL)

- The Departments of Labor, Health and Human Services and 2022 Report to Congress
- **NONE** of the comparative analyses initially reviewed to date have been sufficient (156 letters were issued)
- Deficiencies identified:
  - Failed to identify the benefits, classifications or plan terms to which NQTL applies
  - Failed to describe in sufficient detail how the NQTL was designed or how it is applied in practice to MH/SUD benefits and Med/Surg benefits
  - Failed to analyze in sufficient detail the stringency with which factors, sources, and evidentiary standards are applied
  - Failed to demonstrate parity compliance of NQTLs as written and in operation

Internal Use

MHPAEA Non-Quantitative Treatment Limitations (NQTL)

Potential Red Flags

These types of plan provisions should be investigated to determine if they also apply to medical/surgical benefits and if they are being applied in a manner that complies with MHPEA.

- Preauthorization and pre-service notification requirements
- Fail-first protocols
- Probability of improvement
- Written treatment plan required
- Patient non-compliance
- Residential treatment limits
- Geographical limitations
- Licensure requirements

MHPAEA Non-Quantitative Treatment Limitations (NQTL)

July 2023, Agencies proposed new MHPEA regulations to bolster mental health parity rules and solidify NQTL comparative analysis		
Confirms eating disorders and autism spectrum disorder (ASD) are considered mental health conditions	Adds additional requirements for plans that impose NQTLs to MH/SUD benefits	Provides additional details on form and content of the NQTL comparative analysis

N.R. v. Raytheon Co. – Appellate court reinstates class action lawsuit for plan's denial of speech therapy for Autism Spectrum Disorder

Miscellaneous

Section 125

- Cafeteria Plan Document if withholding employee premiums pre-tax through payroll
- Annual nondiscrimination testing (Safe Harbor for POP Plans)

FMLA

- FMLA Poster
- General Notice
- Eligibility Notice
- Rights & Responsibilities Notice

Annual CMS Reporting

- Online submission, due within 60 days of the beginning of the plan year

Annual 105(h) Nondiscrimination Testing

- Applies to elf-funded plans including HRAs

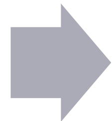
Internal Use

Minimize Risk

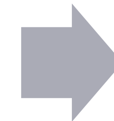
Important to know how to prepare for (and potentially avoid) an audit

Best time to analyze whether you are ready for an audit is **before the DOL knows on your door**

Understand common audit triggers and the audit process



Confirm compliance with applicable law



Maintain documents to show compliance

Questions?

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