Craig Sayers

Subject: FW: DOL audits of ERISA article for you and your clients.

How to avoid an EBSA investigation

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Commentary: The Department of Labor fiscal year fact sheet for 2014 has some real interesting — and scary — facts.

The DOL claims that the Employee Benefits Security Administration (EBSA) oversees the administration of 684,000 retirement plans, 2.4 million health plans and probably as many other welfare plans like disability and life insurance plans. That's a lot of benefit plans.

Of course, it also touts more than $832 million in monetary recoveries that the agency collected of which about $600 million went back to plan participants. Those are some pretty heady figures.

Back in 2013, I made mention of the fact that the DOL was hiring some 1,000 new investigators to help in the audit and enforcement process. You can imagine with millions of plans and an army of investigators, it's not difficult for the EBSA to find plans that are deficient, improperly administered or subject to some corrective process.

That means restoring plan assets, maybe additional benefits, and probably fines and penalties — all of which mean added costs to plan sponsors.

Tucked in the middle of the fact sheet is a figure that is worth noting. The DOL reports that it received 1,643 Voluntary Fiduciary Correction Program (VFCP) applications and 25,060 applications under the Delinquent Filer Voluntary Compliance Program (DFVCP).

The VFCP process is available to anyone who may be liable for fiduciary violations under ERISA, including employee benefit plan sponsors, officials, and parties in interest, may voluntarily apply for relief from enforcement actions, while the DFVCP program allows for plan administrators to pay reduced civil penalties if the required filings are made prior to the date on which the administrator is notified in writing by the DOL of a failure to file a timely annual report.

Why is that so important?

Well, for fiduciaries and plan administrators, the VFCP process and the DFVCP process present them with the opportunity to avoid becoming one of the "bad" statistics. In many ways, it is better to confess and correct instead of being discovered and penalized.

Chances are pretty good that if your plan is the subject of an EBSA investigation, things are going to turn up that have to be corrected. Self-policing, self-reporting and self-correcting before there is an investigation presents plan sponsors and administrators with a better opportunity to control the costs and mechanisms of the corrective process.

It's certainly not a guarantee that everything will come out rosy, but it is better than having mistakes pointed out by the government's auditing team.

So we know that the EBSA has a lot of investigators that take pride in reporting annually all of the money they recover on behalf of participants. And we know from practical experiences that with all of the rules and regulations governing benefit plans, chance are pretty good that we have made a mistake somewhere.

Thus, it is a good idea to take a serious look at the plans you sponsor and see if there are errors that can be self-corrected. Your plan professionals should be able to help guide you through that process.

As a side note, the DOL also reports that 106 individuals were criminally indicted in 2014. You definitely don't want to be someone who falls into that statistic if you can avoid it.

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The DOL Storm is Coming. *Are employers ready?*

Have you heard that the DOL expressed its goal to audit all employee benefit Plans by the end of 2015? Is this a feasible task? With increasing budgets and resources, DOL activity is hitting employers hard and only getting stronger. Are you as an employer prepared for a DOL audit? Are you aware of what an audit involves and the fines for non-compliance? The DOL typically requests information for three to four prior years plus current year.

Note: ERISA disclosure requirements applies to all Private Sector Employers, with exception of Church Plans, regardless of size. Reporting requirements generally to all plans with 100+ participants.

A health and welfare Plan audit is a review of documents and other Plan materials to ensure Plan Sponsors comply with federal law. This includes having and distributing the correct documents, and administering those documents consistent with federal laws and regulations. A DOL Plan auditor reviews many things, each aimed at compliance or a host of fines for non-compliance. Following is a partial list of potential items to be examined by during DOL audits: Take a few moments to determine if you are prepared for an audit.

YES	NO	
☐	☐	1) ERISA Plan documents.
☐	☐	2) Summary Plan Description (SPD) from including any changes in Plan benefits and entitlement to benefits. Please indicate the date of the SPD and the most recent date and method of distribution.
☐	☐	3) Summary of Benefits and Coverage (SBC), Notices of Material Modifications, and Uniform Glossary.
☐	☐	4) Copies of the annual open enrollment information.
☐	☐	5) Copies of the employee handbook describing or explaining the Health Plan eligibility and benefits.
☐	☐	6) All contracts with insurance companies for the provision of health benefits.
☐	☐	7) If self-insured, all contracts, fee schedules, and written guidelines/procedures for: a. Claims processing (including claims installation documents); b. Administrative services including utilization review and claim appeals; and c. Reinsurance
☐	☐	8) Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.
☐	☐	9) In accordance with the Health Insurance Portability and Accountability Act of 1996, please provide the following records: a. Copy of the Plan Rules for Eligibility to enroll under the terms of the Plan (including continued eligibility). b. Sample copy of a Certificate of Coverage provided to an employee who lost health care coverage after December 1, 2012, which certifies creditable coverage earned under this Plan;

c. Copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan, or requested certificates from January 1, 2013;

d. Copy of the written procedure for individuals to request and receive Certificates of Credible Coverage;

e. Copy of the necessary criteria for an individual without a Certificate of Creditable Coverage to demonstrate creditable coverage by alternative means;

f. Sample General Notice of pre-existing condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of individuals to demonstrate creditable

g. coverage (and any applicable waiting or affiliation periods) to reduce the pre-existing condition exclusion period, or proof that the Plan does not impose a pre-existing condition exclusion;
Copies of individual Notices of pre-existing condition exclusion issued to certain individuals since January 1, 2012 per the regulations (including any lists or logs an administrator may keep of issued Notices), or proof that the Plan does not impose a pre-existing condition exclusion;

h. Records of claims denied due to the imposition of the pre-existing condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable), or proof that the Plan does not impose a preexisting condition exclusion;

i. Copy of the written procedures that provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption, including any lists or logs an administrator may keep of issued Notices; and

j. Copy of the written appeal procedures established by the Plan.

☐ ☐ 10) Copy of the Plan rules regarding coverage of medical/surgical and mental health benefits, including information as to specific limitations related to those benefits.

☐ ☐ 11) The Plan's Newborns' Act Notice including lists or logs of Notices an administrator may keep of issued Notices.

☐ ☐ 12) Copy of the Plan Rules regarding preauthorization for a hospitalization in connection with child birth or mental health benefits.

☐ ☐ 13) Sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries upon enrollment.

☐ ☐ 14) Copy of the most recent annual WHCRA Notice, with notation of date and method of distribution.

☐ ☐ 15) Materials describing any wellness programs, disease management programs, or health-related incentive programs or benefit offered by the Plan, employer, or service provider.

☐ ☐ 16) If the Plan has claimed grandfathered health Plan status within the meaning of section 1251 of the Affordable Ca re Act, please provide the following records:

a. 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.

b. 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.
    i. May include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010.

☐ ☐ 17) Regardless of whether the Plan has claimed grandfathered status, please provide the following records in accordance with Section 715 of ERISA as added by the Affordable Care Act:

a. In the case of a Plan that provides dependent coverage, please provide a sample of the written Notice describing enrollment opportunities relating to dependent coverage of children to age 26;

b. If the Plan has rescinded any participant's or beneficiary's coverage, supply a list of 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;

c. If the Plan imposes, or had imposed an annual or lifetime limit, or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each Plan Year on or after September 23, 2010;

d. Please provide a sample of any 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.

☐ ☐ 18) If the Plan has NOT claimed grandfathered health Plan status under Section 1251 of the Affordable Care Act, please also provide the following records:

a. Copy of the 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, and a list of participants who received the disclosure Notice;

b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each Plan Yea r on or after September 23, 2012;

c. Copies of documents relating to the provision of preventive services for each Plan Year on or after September 23, 2012;

d. Copy of the Plan's Internal Claim and Appeals and External Review Processes;

e. Copies of Notice of Adverse Benefit Determination, Notice of Final Internal Adverse Determination Notice, and Notice of Final External Review Decision;

f. If applicable, any contract, agreement and fee schedule with all independent review organization or third party administrator providing external review.

☐ ☐ 19) Minutes of Board of Directors, Plan Committee, and/or any other committee meetings where Plan health benefits were discussed. **Note**: Do not make copies, but please make records available for our review.

☐ ☐ 20) A copy of any Fidelity Bond and Fiduciary Liability Policy, including any riders and amendments.

- ☐ ☐ 21) All correspondence relating to the Plan's health benefits, including participant complaints about claims payment or processing, denials and appeals, and including carrier or third party administrator responses. **Note:** Do not make copies, but please make records available for our review.
- ☐ ☐ 22) The Plan's accounting records, including bank statements, trust, and brokerage statements and canceled checks [bank transaction reports may be used if a bank trustee controls the assets] from January 1, 2012, to the present.
- ☐ ☐ 23) Documents identifying Plan assets, liabilities, revenues, and expenses.
- ☐ ☐ 24) Please provide the names, phone numbers, and addresses (on company letterhead) of parties-in-interest to the Plan including:
    a. Actuary
    b. Attorney(s)
    c. Accountant and/or Auditor(s)
    d. Investment Advisor/Manager(s)
    e. Insurance Agent(s)
    f. Contract Administrator(s) (and copy of the engagement letter)
    g. Trustee(s)
    h. Plan committee members
    i. 10% or more owners of the Plan Sponsor
    j. Affiliated entities to the Plan Sponsor or 10% owners

Potential Fines

ERISA's disclosure requirements, for instance, can carry a fine of $110 per day, per person, per violation for every Plan Participant who was covered under a single contract. That fine increases to $200 for Plan Participants covered by a family contract. ERISA fines represent just one flag from the DOL auditor and can cost the Plan Sponsor dearly. Most fines for noncompliance under the ACA are *not* tax-deductible.

Please use the previous DOL audit items to determine when your ERISA Health & Welfare are audited that you can pass this audit and provide the requested items to them upon request.

The numbers don't lie:

- ERISAEdge has received over 100 new clients in past twelve months in a DOL audit. Large and small, size doesn't matter.
- 2014: EBSA estimated it will collect $1,172,108,000 in total monetary results.
- DOL reports an estimated 95% of all employers out of compliance.
- The IRS can impose an excise tax for certain ERISA violations at $100 per day, per participant.

Do you ...

1) Have an SPD and all other Plan Documents in place and make available to participants?
2) Properly file Form 5500 every Plan Year?
3) Follow all annual Notification requirements (ERISA, PPACA, etc.)?

Learn how partnering with ERISAEdge (with 75+ years management experience) can assist you in avoiding fines and penalties for non-compliance.

ERISA Requirements and *ERISAEdge*

Many employers—and you may be one of them—do not fully understand **Employee Retirement Income Security Act** (ERISA), how it impacts business and employees, and the possible risks it presents. Failure to comply with ERISA requirements can lead to costly government penalties and even employee lawsuits.

***ERISAEdge* is here to help by handling all of the necessary communications, forms, and record-keeping for you!**

The following chart offers a basic breakdown of Title 1 disclosure and reporting requirements under ERISA (governing health and welfare benefit plans), and which functions are covered by ERISAEdge.

	ERISAEdge	
Employer/Plan Sponsor Requirements under ERISA Law:	**Functions Performed by ERISAEdge:**	**Action Required of Employer:**
Plan Document Must have a written Plan Document in place for each benefits Plan offered to one or more employees. Must include ERISA plan numbers.	**Provides complete document design, prepares the Plan Document, and provides online storage.** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must **maintain the Plan Document and make it readily available for inspection by DOL at all times.**
Summary Plan Description (SPD) All participating employees must receive a copy of the SPD **within 90 days** of Plan enrollment. *New* Plans require distribution **within 120 days** after the benefit becomes subject to ERISA. EOC's/ certificates of coverage from the Insurance Carriers do not meet these requirements.	**Prepares the Summary Plan Description (SPD) and provides online storage.** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must distribute the SPD to all applicable employees within the required time period.
Summary of Material Modification (SMM) When there is a material change to any benefits Plan (i.e., carrier change, eligibility change, benefit structure change), all participating employees must receive a copy of the SMM **within 210 days** after the Plan Year-end in which the change occurred. However, an SMM relating to a material reduction in covered services or benefits under a Group Health Plan must be furnished no later than **60 days** after the date of the adoption of the reduction.	**Prepares the Summary of Materials Modification (SMM), as required.** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must distribute the SMM to all applicable employees within the required time period.
IRS Form 5500 You must file a Form 5500 with applicable schedules every Plan year for each Plan where you have 100+ participating employees. The Form must be filed **within 7 months** after the Plan Year-end. If an extension is filed, you are allowed an additional 2½ months to file. **See below MLR potential requirement for small plans.*	**Prepares Form 5500 with all applicable schedules and provides secure software for employer to upload to DOL.**	Employer must file the Form 5500 with DOL within the required time period.

Summary Annual Report (SAR) Must be completed by employer and distributed to all participating employees in any Plan that files a Form 5500. Employees must receive the SAR **within 9 months** after Plan Year-end, or **2 months** after Form 5500 is filed.	**Prepares the Summary Annual Report (SAR), as required.** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must distribute the SAR to all applicable employees within the required time period.
Medical Loss Ratio (Affordable Care Act) • Determine if the rebate is a Plan Asset under the ERISA Plan and add those terms to the Plan Document/SMM so they can retain a prorated portion of the rebate equal to the percent of premium paid by the employer. • Group health insurance MLR rebates only affect fully-insured major medical Plans. Both grandfathered and non-grandfathered Plans may be eligible for a rebate. • Each enrollee must receive a rebate that is proportional to the premium amount paid by that enrollee. *The handling of these MLR rebates have potential ramifications for employers both small and large as it regards annual Form 5500 filing requirements. ***For example:*** small Plans that hold onto these rebates past ninety (90) days and do not have a policy in place could be subject to Form 5500 filing requirements; large Plans could have additional reporting requirements related to their Form 5500 filings.	**The Medical Loss Ratio Rebate language is incorporated into your ERISAEdge document. Otherwise the Summary of Material Modification/Plan Amendment fulfills the refund allocation policy requirement under current regulations** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must distribute SPD or SMM based upon applicable timing requirements.
ERISA and Healthcare Reform Notices The Patient Protection and Affordable Care Act (PPACA) requires annual notices to eligible employees based upon the status of any new or renewed Group Health Plan. These Notices must be provided to all eligible employees **on or prior to the first day of the Group Health Plan effective date.**	**Prepares all required annual ERISA and Healthcare Reform Notices to eligible employees.** **(additional fee applies)** ***Provides employer with guidelines on disclosing required information to employees.***	Employer must distribute notices **on or prior to the first day of the Group Health Plan effective date.**
Discrimination Testing Section 105(h) of the Internal Revenue Code requires all self-insured Health Plans perform Discrimination Testing. **This has been suspended for Fully-Insured Plans awaiting final regulations from the IRS.**	**Performs Section 105(h) Discrimination Testing for Self-Insured Health Plans.**	Employer must maintain test results for inspection by IRS/DOL for 8 years.

Contact TASC for additional information pertaining to your ERISA requirements and obligations.

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