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Employee Benefits | Life Insurance | Risk Management

VOLUME 10
ISSUE II
APRIL
2013

INSURANCE BRIEF

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90-day Waiting Periods

On March 21st the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury issued Proposed Rules implementing the 90-day waiting period limit under health care reform. The rules also amend existing regulations to reflect changes made by health care reform, including rules relating to preexisting condition limitations and other portability provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Background: The 90-day waiting period limit applies for plan years beginning on or after January 1, 2014 and both to grandfathered and non-grandfathered group health plans and insurers offering group health insurance coverage.

Key provisions:

- The proposed regulations are consistent with – and no more restrictive on employers than – guidance previously issued in August 2012. Therefore, plans may follow either the earlier guidance or proposed regulations through at least the end of 2014.
- A waiting period is defined consistent with prior HIPAA regulations as the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.
- The proposed regulations prohibit requiring eligible participants and beneficiaries from having to wait more than 90 days for their coverage to become effective. They do not, however, require a plan sponsor to offer coverage to any particular employee or class of employees, such as part-time employees. *Cont'd on page 2*

SF HCSO Annual Reporting

The HCSO Annual Reporting Form is now available for on-line submission! To avoid penalties of $500 per quarter, "covered employers" must submit the Form by April 30, 2013.

As a reminder: you are not a "covered employer" under the HCSO and you should not submit the Form if (1) you employed fewer than 20 persons – including those employed outside of San Francisco – in each of the four calendar quarters of 2012 or (2) if you did not have any employees in San Francisco in 2012. If you are not required to submit the Form, no further action is required.

If you have any questions about this update or the HCSO generally, please visit the Office of Labor Standards Enforcement's HCSO website to access the text of the HCSO, the implementing regulations, answers to "Frequently Asked Questions," and other helpful forms and notices. You can also contact the OLSE by phone at (415) 554-7892 or by email at hcso@sfgov.org.

90-day Waiting Periods *cont'd*

- A waiting period does not include the time before an employee or dependent enrolls as a late enrollee or special enrollee. Existing HIPAA regulations govern the effective dates of coverage for special enrollment.

- All calendar days are included in the 90-day period, including weekends and holidays. The enrollment date counts as day one of the waiting period. If the 91st day is a weekend or holiday, a plan or insurer can allow coverage to be effective earlier than the 91st day, for administrative convenience. However, the effective date of the coverage cannot be later than the 91st day.

- Plans can still have other substantive eligibility criteria. Examples of "substantive eligibility conditions" include job classifications, completion of certain training, obtaining a commission goal or a sales goal. Once the employee meets the criteria then the 90-day clock starts.

- An eligibility criterion requiring completion of a certain number of hours is not considered to be designed to avoid compliance with the 90-day limit if the hours of service requirement does not exceed 1200 hours. The proposal emphasizes that this is a one-time eligibility requirement.

- A health insurance issuer can rely on the eligibility information reported to it by the employer or plan sponsor.

  The Certificates of Creditable Coverage required under HIPAA will be phased out by 2015. With the prohibition on pre-existing condition exclusions (PCE) effective 1/1/14 these certificates will no longer be necessary. Certificates are required through 12/31/14 to allow individuals joining plans in 2014 that have non-calendar plan years to avoid or reduce a PCE.

Action Items:
Employers with waiting periods exceeding 90 days need to change their eligibility rules.

Caution:

- plans with a "3 month" waiting period. This will not comply as this can exceed 90 calendar days.

- Reminder to California small group contract clients: your maximum waiting period will be 60 days.

We will continue to update you as regulations are published. Please contact your SML Account Team if you have any questions.

DOL Audits

The following article is courtesy of Alfred B. Fowler, Attorney at Law, Kutak Rock LLP

Department of Labor Steps up Pace for Conducting Random Welfare Plan Audits

We've known for over a year that the Department of Labor's (DOL) regional offices are conducting random welfare plan audits. Currently, our office is involved as counsel to nine such audits in California alone. The purpose of this Memorandum is to take the surprise and delight/fear and loathing out of the event. As Alexander Pope once said, *"a little knowledge is a dangerous thing."* By going into a little depth, here, we may assist plan sponsors to set accurate expectations in the event of an audit. By the way, usually audits are directed at plans with more than 100 lives.

Scope of the Audit

In the old days, the DOL limited its random audits to the Employee Retirement Income Security Act's (ERISA) notices, content of summary plan descriptions (SPD), and Consolidated Omnibus Budget Reconciliation Act (COBRA) procedures. Well, times have changed! The DOL now examines employer and insurer compliance with the portability and other select provisions of the Health Insurance Portability and Accountability Act (HIPAA), including bona fide HIPAA wellness programs, health factors in setting rates or employee contributions, certificates of creditable coverage (sample notices, records of who got them) and related provisions. It leaves the HIPAA privacy and security rules for the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) to pursue through its own random audit process.

But wait. There's more. The DOL also examines records demonstrating plan sponsor compliance with the Affordable Care Act (ACA), including non-grandfathered status, age 26 notices, etc. Finally, the DOL looks for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and wellness programs, in general. The DOL, under federal law, has jurisdiction over various aspects of each of these pieces of legislation.

The Audit Process

Once the DOL chooses a group health plan for audit, the investigation usually follows a predictable path that can take up to 18 months:

1. The plan sponsor receives a letter from a regional DOL investigator, either by mail or email, explaining the audit and requesting a list of plan documents (usually between 2 to 3 years worth) be sent to him or her within 10 business days;
2. The plan sponsor sends the requested documents to the investigator (paper and/or electronic format);
3. The investigator will set up telephonic meetings with plan officials;
4. The investigator asks for more documents!;
5. Occasionally, an investigator will request on-site review of documents and interview of plan officials;
6. The investigator will identify any violations, or send a closing letter if no violations are found;
7. If violations are found, the parties come to an agreement as to what needs to be done and, upon completion of the agreed upon activities, the investigator sends a closing letter;
8. Very rarely, if voluntary compliance fails, the investigator will forward a recommendation to its litigation group that litigation be initiated;
9. It is somewhat rare that the DOL issues penalties in this process.

Discussion

1. <u>The Initial Letter</u>

A plan sponsor of a group health plan receives a letter or an email advising plan officials that the DOL has opened an investigation of the group health plan along with an extensive request for plan documents due within 10 days of

DOL Audits *cont'd*

the date of the letter. The random investigation typically will be general in nature.

Occasionally the DOL will conduct an audit with a target in mind (i.e. participant complaint). In that event, the investigator usually will not disclose the reasons behind the investigation or the sources of information (if any) that led to the plan's selection for investigation, until late in the process.

2. The 10-Day Drill

The investigation consists primarily of an examination of plan records (usually 2 to 3 years worth). Attachment A to the initial audit request letter contains a daunting list of documents to be sent to the investigator. The documents requested often include insurance policies, EOCs, certificates of coverage, and riders; service provider agreements; plan documents and SPDs; summaries of benefits and coverage (SBC); summaries of material modifications; Form 5500s, including Schedules, auditors' reports, and other data to support Form 5500 entries; plan financial statements; trustee/corporate minutes; correspondence; summary annual reports; participant records; bonds; and trust documents.

The DOL almost always will grant extensions for furnishing these documents with a nice letter from the plan sponsor's ERISA counsel. The request should be made as soon as possible.

3. The Document Request

Please refer to our sample self-audit checklist (Word format) for a list of documents typically requested.

4. A Word of Advice

Plan sponsors should respond promptly to any telephone calls or letters from the DOL. We suggest an immediate call to the investigator upon receipt of the letter to discuss the purpose, scope, and timing of the investigation and to address any schedule conflicts or timing demands, right away. Of course, we also suggest that the plan retain competent legal counsel!

5. The Teleconference

After reviewing the document submission, the investigator will propose a phone call with the plan officials and counsel to discuss in more detail what he/she has found in reviewing the documents submitted. If it includes accounting records (self-insured plans, third party administrators, etc.), some investigators will do a line by line review (typically more thoroughly if there is a benefit trust involved) by teleconference. Generally, the initial teleconference will result in a request for even more information, especially regarding ACA notices and related records.

6. On-Site Review

The risk of an onsite review is directly related to the plan sponsor's distance from a local DOL office. The visits may be over one or two days and may relate to looking at payroll records, COBRA systems, etc.

7. Bringing It to a Conclusion

It may seem like the investigation has become the investigator's career opportunity. It may be weeks or months following the initial phone calls or visits, before the DOL issues another letter stating its findings. If the investigator finds imperfection, he/she will spell out what it is (legal citations included) and, in most instances, allow the plan sponsor to correct its errors (e.g. amended and restated plan documents, distribution of notices that should have gone out, proof that the open enrollment materials have been revised, etc.).

If the DOL believes there is fraud or criminal misconduct, or where removal of a fiduciary is warranted, where the individuals have previously been determined to have violated ERISA or other federal statutes, or where the proposed correction of violations will exceed a one-year period, the next steps are very different!

8. The Closing Letter

At the point the DOL is satisfied with the plan sponsor's completion of any remedial work (seems there is always something), the DOL will issue its closing letter. We suggest the plan sponsor keep a complete record of the proceedings

DOL Audits *cont'd*

along with the closing letter as a permanent record, much like one would do in the event of litigation.

9. The Potential Penalties

In cases where voluntary compliance efforts have failed, or which involve issues for which voluntary compliance is not appropriate, the DOL either will assess penalties or make a recommendation to its litigation group that litigation begin. Common penalty assessments can include failure to file Form 5500s, failure to timely respond to requests for information, prohibited transactions, and other breaches of fiduciary duty.

ERISA § 502 penalties include:

- A penalty of 5% of "amount involved" against a party in interest who engaged in a prohibited transaction and 100% of that amount if the transaction is not corrected;
- A civil penalty against a fiduciary who breaches fiduciary responsibility, or against any person who knowingly participates in such breach (penalty is 20% of "applicable recovery amount" recovered); and,
- A civil penalty against plan administrator who fails to file required annual reports (Form 5500).

ERISA § 506(b) authorizes the Secretary of Labor to investigate and refer criminal violations involving employee benefit plans for such issues as material false statements to executive agency, false statements in documents required by ERISA such as Form 5500 filings, solicitation to influence operations of a plan, willful violation of Title I, and coercive interference with participants' rights.

In 2011, DOL investigators (welfare and pension plans combined) closed 3,472 cases nationwide and filed litigation on just 144 of those cases. Also in 2011, the DOL received 233,780 employee complaints against ERISA plans (welfare and pension plans combined) from which 896 plan investigations were ultimately opened. We do not have numbers for 2012 at this time. We understand that the DOL currently is conducting over 3,000 random audits.

Action Plan

- Conduct regular compliance audits of your welfare plans.
- If audited, provide the investigator with all documents in an organized and timely, courteous, and professional manner.
- As soon as the initial document request is received, consult with legal counsel that is experienced in the employee benefits area.
- Designate 1 or 2 senior employees who will be responsible for all contact and communication between the employer, attorney, and investigator.
- Consult with any service providers that may be involved in the investigation and establish a method to ensure that responses are coordinated, timely, and consistent.
- Make copies of the requested documents (other than any that counsel advises should not be produced) for the investigator and retain a set of copies.
- If the investigator requests an on-site review, obtain a list of the records that the investigator wishes to review, discuss it with legal counsel, and discuss scheduling with the investigator.
- Have legal counsel prepare employees or fiduciaries before the interview.
- Be patient, investigations often take between 6-18 months with gaps of silence in between.

Now that we have removed the mystery from the audit process, we must note that the DOL investigators are human folk. They usually remain courteous and flexible throughout the entire process, unless they begin to doubt the entity's integrity. At that point, the DOL has the ability to assert its subpoena powers. As we have stated, the odds of a random audit have increased substantially. If one occurs, feel free to contact our office, or seek other counsel.