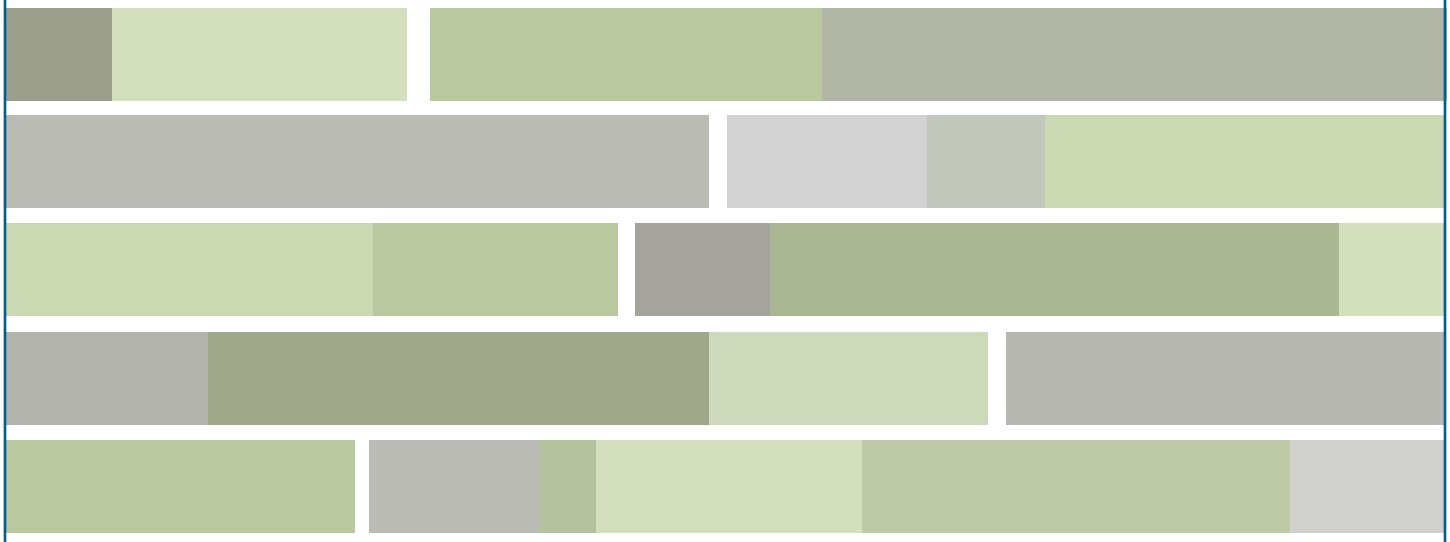
Employee Benefits Series

DOL Audit Survival Guide

CHECKLISTS, TIPS & TOOLS

THE SCHELLER BRADFORD GROUP



DOL Audit Survival Guide

OVERVIEW

U.S. Department of Labor (DOL) audits of welfare benefit plans are happening with greater frequency to companies of all sizes. Reasons for an audit include:

- Complaints by welfare benefit plan participants to the Employee Benefits Security Administration (EBSA), the DOL agency responsible for administering and enforcing the provisions of Title I of the Employee Retirement Income Security Act (ERISA);
- Inaccurate or late filings of the Form 5500 Annual Report;
- National enforcement initiatives investigating compliance with ERISA and the Affordable Care Act (ACA);
- The transfer of cases from the Internal Revenue Service (IRS) to the DOL; or
- Random selection.

This guide will help you prevent, prepare for, and successfully navigate through a DOL health plan audit.

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HOW TO LOWER THE RISK OF A DOL HEALTH PLAN AUDIT

A DOL audit of your welfare benefit plan could happen at any time. The checklist below can help you lower the risk of a DOL audit.

- ☐ Maintain all documents related to welfare benefit plans in one location.
- ☐ Designate one person at the company to take charge of the welfare benefit plans.
- ☐ Respond in a timely fashion to all participant and beneficiary questions.
- ☐ Review and understand all plan documents.
- ☐ Make sure all ERISA-covered benefit plans comply with relevant laws, including the ACA and the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ Distribute Summary Plan Descriptions (SPDs) with accompanying benefit plan component documents, such as benefits booklets and certificates of insurance, to all plan participants within 90 days of their becoming covered under the plan.
- ☐ Administer all ERISA-covered benefit plans, including group health plans and other welfare plans, in accordance with a written Plan Document.
- ☐ Respond to written participant and beneficiary requests for an SPD and/or Plan Document within 30 days or risk a penalty of $110 per day per participant or beneficiary.
- ☐ Inform participants of any material change to the plan either through a revised SPD or in a separate document, called a Summary of Material Modifications (SMM).
- ☐ Distribute required benefits notices within required timeframes.
- ☐ If Form 5500 must be filed, be sure to complete all components accurately and file before the required deadline.
- ☐ Establish written procedures for disputes and claims resolution that comply with federal regulations.

MOST COMMON SUMMARY PLAN DESCRIPTION (SPD) MISTAKES

One of the most important documents participants must receive automatically when becoming covered under a health benefit plan subject to ERISA is a summary of the plan, called the **Summary Plan Description (SPD)**. Many employers are confused about this very important ERISA-required disclosure, which in turn can put them at risk. The Q&As below highlight the most common misunderstandings related to complying with the SPD requirement and outline how employers can avoid costly problems and potential penalties.

Isn't the information distributed by carriers considered an SPD?

ERISA requires plan administrators (typically the employer that sponsors the group health plan) to maintain and distribute SPDs that accurately reflect the contents of the plan and include specific information required under federal law—much of which is typically missing from the benefit summaries and insurance certificates distributed by insurance companies.

While carriers do provide plan information, this information typically does not include the required provisions that must be included in an SPD. As a result, an employer/plan administrator will not be compliant with the SPD requirements and may face the risk of penalties and other complications.

Can the SPD just be made available upon request? Does it actually have to be distributed to plan participants?

The SPD is required to be distributed to all participants in a manner reasonably calculated to ensure actual receipt, which means it may be hand-delivered or sent by first-, second-, or third-class mail. The SPD also may be delivered electronically (for example, by e-mail or intranet), if it is reasonably expected that eligible employees will receive it and if certain DOL electronic delivery requirements are satisfied.

Electronic Disclosure Guidelines

As a general rule, materials required to be furnished under ERISA may be provided electronically if the plan administrator takes necessary measures reasonably calculated to ensure that the system for furnishing documents results in receipt of the material. **Ways to ensure receipt of an SPD include using return-receipt or notice of undelivered email features or conducting periodic reviews or surveys to confirm receipt.** In addition, in order to provide materials electronically:

- The administrator must take steps reasonably calculated to ensure that the system protects the confidentiality of personal information relating to the individual's accounts and benefits;
- The electronically-delivered documents must be prepared and furnished in a manner consistent with the style, format, and content requirements applicable to the particular document;
- Notice must be provided to each participant, beneficiary, or other individual, at the time a document is furnished electronically, that informs the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., "the attached document describes changes in the benefits provided by your plan") and of the right to request and obtain a paper version of the document; and
- Upon request, the participant, beneficiary, or other individual must be furnished a paper version of the electronically furnished documents.

With limited exceptions, affirmative consent to receive documents through electronic media must also be obtained. For more information on this requirement, as well as information regarding the distribution of SPDs in general, click here.

My company has never distributed an SPD, why now?

Every employer that sponsors a group health plan must comply with this important ERISA requirement or run the risk of exposure to a number of serious problems, including:

- Failing a DOL audit; and
- Penalties of up to $110 per day, per participant or beneficiary, for failing to provide an SPD or plan document within 30 days of receiving a request.

Perhaps most importantly, distributing SPDs to plan participants will protect against dissatisfaction or complaints from employees if issues regarding benefit plan coverage arise.

Isn't the SPD the same as a Plan Document?

In addition to providing an SPD, all ERISA-covered benefit plans (including group health plans and other welfare plans) must, by law, be administered in accordance with a **written Plan Document**. ERISA, as amended by HIPAA and other federal laws, requires the Plan Document to contain certain specified provisions. Many employers assume that insurance contracts for fully insured products are written Plan Documents. Insurance companies, however, draft their contracts to comply with state insurance laws, and as a result, the contracts do not contain many of the required or recommended provisions that protect the plan, the employer, and plan fiduciaries. The Plan

Document does not have to be distributed automatically—rather, it must be kept on file with the employer/plan administrator should a participant or beneficiary request it.

Will employers be compliant if they distribute Wrap SPDs to plan participants?

A Wrap SPD is designed to incorporate—or "wrap around"—existing certificates of insurance and benefit plan booklets to provide the information necessary to comply with ERISA's reporting and disclosure requirements. To be compliant with ERISA's reporting and disclosure requirements, the Wrap SPD and accompanying benefit plan component documents must be distributed to plan participants. The Wrap SPD and benefit plan component documents do not have to be distributed at the same time as long as plan participants receive all of the required documents with the most current information that applies to plan benefits.

Does a new SPD have to be distributed if there is a change to the benefit plan?

ERISA requires plan administrators to notify plan participants of material plan changes by **either** updating the SPD **or** distributing a Summary of Material Modifications (SMM) describing the change to plan participants.

When to Distribute an SMM or Updated SPD

The following are some basic timelines for distributing an updated SPD or SMM:

- Under the ACA, group health plans and carriers are required to provide **at least 60 days' advance notice** to participants before the effective date of any material modification to the plan that would affect the content of the Summary of Benefits and Coverage (SBC) and that is not reflected in the most recently provided SBC, **unless the change occurs in connection with a renewal or reissuance of coverage**.
- **If a change occurs in connection with a renewal or reissuance of insurance contracts and results in a material reduction in covered services or benefits**, then participants have to be notified **within 60 days after the modification is adopted**.
- If neither of the two preceding rules apply, the plan administrator has until **210 days after the end of the plan year** to notify participants of the change. However, it is always prudent to notify participants of any material modifications as soon as possible.

TOP TIPS FOR NAVIGATING THROUGH A DOL HEALTH PLAN AUDIT

The following chart outlines the steps that are generally involved in a DOL audit of a welfare benefit plan, with tips to help employers/plan sponsors or plan administrators navigate through the process.

Step 1	Document Request Letter

The DOL typically initiates a welfare benefit plan audit with a letter requesting an extensive range of documents related to your group benefit plan, including:

- Administration of the group benefit plan;
- Required notices; and
- Compliance with a number of laws, such as:
  - ERISA, ACA, HIPAA, the Newborns' and Mothers' Health Protection Act (Newborns' Act), the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Genetic Information Nondiscrimination Act (GINA).

Examples of the types of documents typically requested:

- **Required Plan Documentation** — such as SPDs and Plan Documents, including amendments.
- **Administrative Records** — such as insurance billing invoices and records of payroll deductions for employee premiums.
- **ACA-Related Documents** — such as the plan's SBC and Health Insurance Exchange Notices.
- **HIPAA-Related Documents** — such as the plan's eligibility rules and Notice of Privacy Practices.
- **Other Health Insurance Law-Related Documents** — such as Consolidated Omnibus Budget Reconciliation Act (COBRA) and Newborns' Act notices.

Step 2	Document Production

Providing all of the requested documents during the audit process in an organized and timely manner will reflect an employer's good-faith efforts to cooperate as fully as possible and will help facilitate the entire audit.

The following are some "Do's and Don'ts" for producing the required documents:

- **Do** submit all requested documents to the DOL by the specified deadline.
- **Don't** ignore or delay compliance with the DOL document request letter.
- **Do** create a binder with tab headings indexed in the order the documents were requested and organized chronologically (the DOL typically requests documents from the last 3-5 years).
- **Don't** provide documents that are not requested.
- **Do** provide a written explanation of the reason for any missing documents, as well as a proposed resolution.

Step 3	On-Site Interviews

The following are tips and guidelines to help you through the on-site interview process:

- Designate a staff person knowledgeable about your welfare benefit plan to be interviewed and represent the company.
- If you don't have an appropriate staff person, retain an ERISA attorney or other qualified benefits compliance professional to do the job.
- Review all documents in advance of the on-site interview with an ERISA attorney (if possible) and your designated representative.
- Find a quiet and comfortable location for the on-site interview.
- Respond only to the questions asked—don't volunteer additional information or documentation.
- Ask for further clarification if you don't understand a particular question.
- Make any corrections or additions to your documentation, as instructed by the DOL.
- Have patience—a DOL audit can last from a few months to two or more years.

Remember: The more organized and complete your documentation, the less time the DOL will spend during the on-site interview. In fact, an organized and complete response may actually eliminate the DOL's need to conduct such an interview altogether.

Step 4	How DOL Audits Are Resolved
A range of outcomes can result from a DOL audit of a welfare benefit plan:	
No Violations Found	If no violations are found, the employer/plan sponsor or plan administrator will be informed of the results by letter.
Minimal Violations Found	Violations in areas such as reporting and disclosure, or improper administrative practices of a de minimis nature, generally will be resolved as long as corrective steps were taken and are documented in the case file. Generally, if all documents are provided to the DOL as requested, edited per the DOL's direction, and submitted to the DOL in a timely manner, no further action will be taken.
Other Violations Found	Examples of violations found during a DOL audit of a welfare benefit plan include: • Failure to properly select and monitor service providers; • Taking any adverse action against an individual for exercising his or her rights under the plan (e.g., being fired or otherwise discriminated against); or • Failure to comply with ERISA Part 7, including the ACA.
Criminal Violations Found	The EBSA also conducts investigations of criminal violations regarding welfare benefit plans, such as embezzlement, kickbacks, and false statements under Title 18 of the U.S. Criminal Code. Prosecution of these criminal violations is handled by U.S. Attorneys' offices.

DOL Policy—Promote Voluntary Compliance

If an investigation reveals an ERISA violation, the DOL takes action to obtain correction of the violation. It is the policy of the DOL to promote voluntary compliance whenever possible. Making corrections to the plan includes:

- Ensuring that claims are properly processed and paid; and
- Paying penalty amounts (when applicable).

If corrective actions are taken, the DOL generally will not bring a civil lawsuit. When voluntary compliance is not achieved, the DOL may refer a case for litigation.

Even if the DOL decides against taking action, it may still refer the plan to another governmental agency, such as the IRS or the U.S. Department of Health and Human Services. In addition, plan

participants or beneficiaries can still initiate litigation against the employer/plan sponsor, regardless of the DOL determination.

Delinquent Filing Program for Form 5500

In an effort to encourage the filing of Form 5500s, the DOL provides plan administrators with the opportunity to pay reduced civil penalties for voluntarily complying under the Delinquent Filer Voluntary Compliance Program (DFVCP). In general, plan administrators are eligible for relief under the DFVCP if they comply with the program's filing requirements **before receiving written notice from the DOL of a failure to file a timely annual report.**

For guidance on how to participate in the DFVCP, please click here.

Be Ready for a DOL Audit—Conduct Your Own "Self-Audit"

Finally, the best way to prepare for a DOL audit is to make sure your welfare benefit plan documents are organized and compliant and notices have been distributed in a timely fashion. A great way to get started is to review HR360's DOL Health Plan Audit Document Checklist and conduct your own "self-audit" to see if you have all of the required documents.

5 MOST COMMON DOL HEALTH PLAN AUDIT MISTAKES

The following is a list of the most common mistakes employers/plan sponsors make in preparing for and during the audit process:

Mistake 1	No SPD or Plan Document
No SPD. The DOL typically requests a number of documents as part of its investigative process, one of which is an SPD. **Many employers think a benefits summary or certificate of coverage fulfills the regulatory requirements of an SPD, only to discover during an audit that these documents are inadequate.** An SPD or Wrap SPD must include specific provisions required under ERISA as well as important information about the plan. SPDs must be distributed to all welfare benefit plan participants and must be written in language that can be understood by the typical participant.	
No Plan Document. All ERISA-covered benefit plans, including group health plans and other welfare plans, must be administered in accordance with a written Plan Document. ERISA, HIPAA, and other federal laws require the Plan Document to contain certain specified provisions. **Many employers assume that insurance contracts for fully insured products are written Plan Documents, but they are not.** Insurance companies draft their contracts to comply with state insurance laws and, as a result, the contracts do not contain many of the required or recommended provisions that protect the plan, the employer, and plan fiduciaries.	
Mistake 2	**Not Communicating Changes to Plan Participants**
During a DOL audit, an investigator will review whether plan participants were notified of any changes made to the welfare benefit plan, such as carrier changes, or adding or eliminating different types of benefits. **Many employers simply do not have the documentation to properly communicate these changes.** Generally, participants must be informed of benefit changes **either** through a Summary of Material Modifications (SMM) **or** a revised SPD, both of which may be requested as part of an audit.	
Mistake 3	**Not Informing Plan Participants of Special Enrollment Rights**
DOL auditors will also review an employer/plan sponsor's compliance with HIPAA's special enrollment notification rules. Under HIPAA, certain events that happen to employees or their dependents trigger a right to "special enroll" in an employer-sponsored group health plan. Special enrollment generally means that the employee or dependent will have 30 or 60 days from the date of the event to request coverage in the employer's group health plan, **regardless of the open enrollment period**. **This right must be communicated to employees**.	
Mistake 4	**Submitting Required Documentation in a Disorganized Way**
The DOL typically begins an audit with a "DOL Audit Document Request Letter," which requires the submission of a large number of documents. A common mistake is to send such documents in a disorganized fashion. The best way to respond is to **create a binder with tab headings, indexed in the order the documents were requested and organized chronologically**. The DOL typically requests documents from the last 3-5 years.	
Mistake 5	**Providing Too Much Documentation**
Another common mistake is for employers/plan sponsors to provide more documentation than is requested in the hope that this will make a better impression. However, the more information that is provided, the more opportunity the DOL will have to find something wrong. **The most prudent response is to provide only the information requested and provide answers only to the questions asked.**	

DOL HEALTH PLAN AUDIT DOCUMENT REQUEST CHECKLIST

The following checklist provides a summary of documents that may be requested from employers who sponsor group health plans in the event of a DOL audit. This checklist is for general reference purposes only. DOL auditors may request various documents that do not appear on this list, depending on the plan and other issues that may arise during the audit. If you have questions regarding your responsibilities, please contact a knowledgeable attorney or benefits professional.

Plan Documents		
Document	**Complied**	**N/A**
Summary Plan Description (SPD), including any changes in plan benefits and entitlement to benefits		
All Summaries of Material Modifications for requested plan years		
Plan Document, including all amendments for relevant plan years		
All insurance plan contracts (applies to fully insured plans)		
Any trust documents relating to plan assets		
All contracts for claims processing, administrative services, and reinsurance (applies to self-insured plans)		
Documents which describe the responsibilities of both the employer and employees with respect to the payment of costs associated with the purchase and maintenance of health and welfare benefits		
Form 5500 filings		
Summary Annual Reports for requested plan years		

Administrative Records		
Document	**Complied**	**N/A**
Insurance billing invoices, premium schedules, employer and employee contribution schedules, and payroll records of withholdings for benefits		
Documents evidencing payroll deductions for employee premiums to the plan		
Documents evidencing current outstanding medical claims		
List of COBRA participants, including their COBRA start dates and COBRA payment amounts		
Copy of any rebate paid pursuant to the medical loss ratio (MLR) requirements under ACA, as well as documentation of what was done with the rebate		

Note: Some of the information on the following pages may appear in the plan's SPD, while certain notices must be provided separately due when they are required to be provided. In addition, certain information appearing on this list may no longer be applicable for a particular plan year but may still be requested as part of a DOL audit covering previous years.

Health Care Reform-Related Documents		
Document (All Plans)	**Complied**	**N/A**
Summary of Benefits and Coverage (SBC), Notices of Material Modifications, and Uniform Glossary		
Copy of the Health Insurance Exchange Notice		
Sample of the notice describing enrollment opportunities relating to dependent coverage of children to age 26 (for a plan that provides dependent coverage)		
A list of any participants and beneficiaries whose coverage has been rescinded, the reasons for rescission, and a copy of the Notice of Rescission that was provided 30 days in advance of any rescission of coverage		
Documents showing the lifetime limits applicable for each plan year on or after September 23, 2010 (if the plan imposes, or has imposed, a lifetime limit at any point since that date)		
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		
Documents showing the annual limits applicable for each plan year on or after September 23, 2010 (if the plan imposes, or has imposed, an annual limit at any point since that date)		
Document (Non-Grandfathered Plans)	**Complied**	**N/A**
Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010		
Copies of documents relating to coverage of emergency services for each plan year on or after September 23, 2010 (if the plan provides any benefits with respect to emergency services in an emergency department of a hospital)		
Copy of the Notice of Patient Protections informing participants of the right to designate any participating primary care provider or pediatrician and obtain OB/GYN care without prior authorization for plans that provide OB/GYN coverage (if the plan requires or allows for the designation of a primary care provider)		
Copy of the plan's internal claim and appeals and external review processes		
Copies of a Notice of Adverse Benefit Determination, Notice of Final Internal Adverse Determination, and Notice of Final External Review Decision		
Any contract or agreement with any independent review organization or third party administrator providing external review		

Health Care Reform-Related Documents, *Continued*		
Document (Grandfathered Plans)	**Complied**	**N/A**
Copy of the Disclosure of Grandfathered Status, 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 grandfathered status. This may include documentation relating to the terms of cost-sharing, the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and any contract with a health insurance issuer which were in effect on March 23, 2010.		

HIPAA-Related Documents		
Document	**Complied**	**N/A**
Copy of the plan's rules for eligibility to enroll under the terms of the plan, including continued eligibility		
Copy of a blank enrollment application for the plan		
Sample Certificate of Creditable Coverage, a copy of the record or log of all certificates for individuals who lost coverage under the plan or requested certificates, a copy of the written procedure for individuals to request and receive certificates, or proof that the plan does not require certificates		
Sample General Notice of Preexisting Condition Exclusion informing individuals of the exclusion period and its terms, and of the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the plan does not impose a preexisting condition exclusion		
Copies of Individual Notices of Preexisting Condition Exclusion issued to certain individuals as required under the law (including any lists or logs of issued notices), or proof that the plan does not impose a preexisting condition exclusion		
Copy of the necessary criteria for an individual without a Certificate of Creditable Coverage to demonstrate creditable coverage by alternative means, or proof that the plan does not require certificates		
Records of claims denied due to the imposition of a preexisting 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		
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 of issued notices)		
Copy of the written appeal procedures established by the plan		

HIPAA-Related Documents, *Continued*		
Document	**Complied**	**N/A**
Materials describing any wellness programs or disease management programs offered by the plan and, if the program offers a reward based on an individual's ability to meet a standard related to a health factor, the plan's wellness program disclosure statement regarding the availability of a reasonable alternative		
Copy of the plan's HIPAA Notice of Privacy Practices, including any lists or logs of issued notices		

Other Health Insurance Law-Related Documents		
Document	**Complied**	**N/A**
The plan's Newborns' Act Notice (this should appear in the SPD), including any lists or logs of issued notices		
Copy of the plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth		
Sample of the written description of benefits mandated by the Women's Health and Cancer Rights Act, required to be provided to participants and beneficiaries upon enrollment, and annually thereafter		
Sample COBRA notices provided to participants and beneficiaries, including the General Notice of COBRA Rights, COBRA Election Notice, Notice of Unavailability of COBRA Coverage, and Notice of Early Termination of COBRA Coverage, including any lists or logs of issued notices		
Copy of the plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits		

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