BASIC®

HR Solutions Come Full Circle

Compliance Requirements for Health and Welfare Benefits

Presented by: Mary Bauman

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- HR Management
- HR Services

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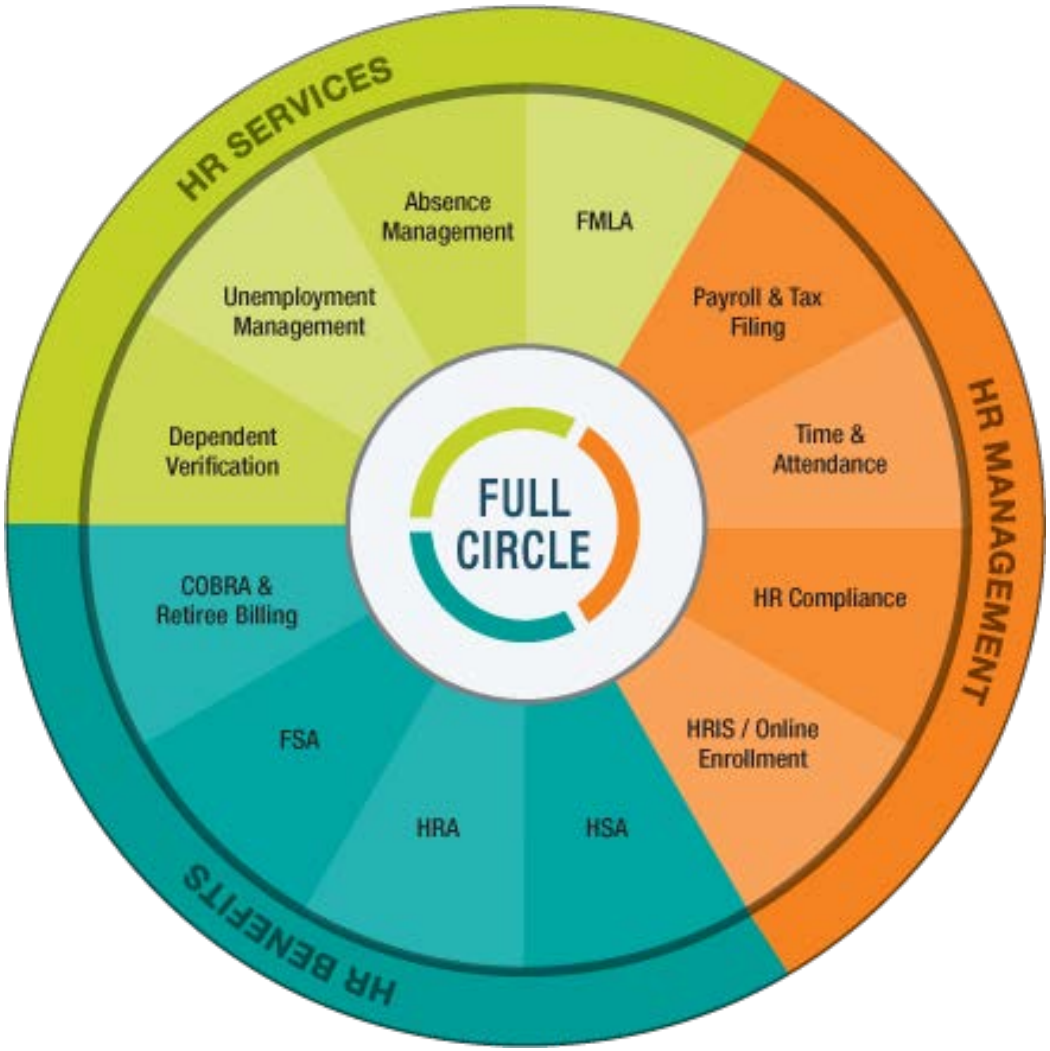
HR Solutions Come Full Circle



HR solutions should be simple.
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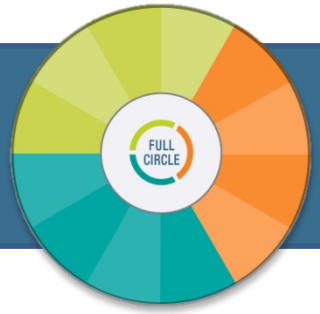
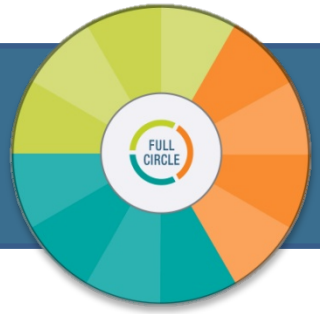
Form 5500

Form 5500



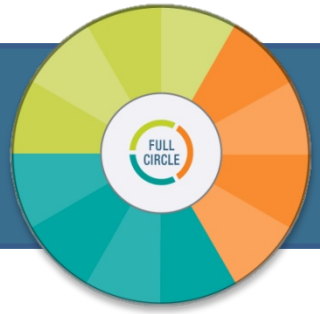
- Form 5500 is the annual report form that must be filed with the federal government with regard to a plan that is subject to ERISA
- Welfare plans subject to the Form 5500 requirement
  - Fully-insured plans with 100 or more employees or retirees enrolled as of the beginning of the plan year

Form 5500



  - Self-insured plans funded through the employer's general assets with 100 or more employees or retirees enrolled as of the beginning of the plan year
  - Self-insured plans funded through a trust regardless of the number of enrolled employees or retirees
- Plans not subject to ERISA are not required to file a Form 5500

Form 5500

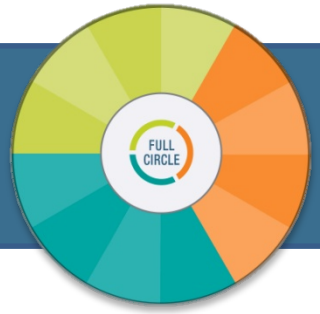


- Previously, a Form 5500 was required for all aspects of a Section 125 cafeteria plan. The IRS discontinued that filing obligation in 2002, but a Form 5500 filing is still required if
  - The cafeteria plan includes medical FSAs; and
  - At least 100 employees are enrolled in the medical FSA portion of the plan as of the beginning of the plan year

Form 5500

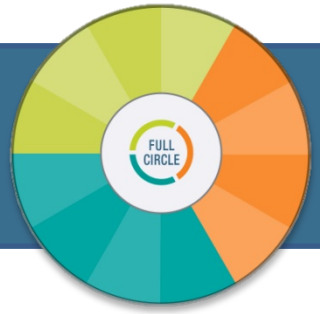
- A Form 5500 must be filed for each plan. An employer can adopt a wrap or umbrella plan to consolidate all of its various health and welfare benefit plans into a single plan for Form 5500 filing purposes
- The Form 5500 filing for a fully-insured plan must include a Schedule A for each insurer

Form 5500



- The Form 5500 filing for a large (100+) self-funded health plan must include a Schedule C for each service provider (such as a TPA) if the service provider was paid $5,000 or more
  - However, unfunded self-funded plans where any employee contributions are paid on a pre-tax basis under a Section 125 plan are exempt from the Schedule C requirement
  - As a result, Schedule C is generally not required except where a self-insured plan is funded through a trust

Form 5500

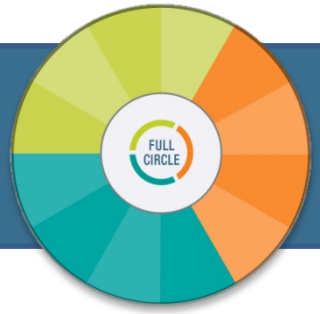


- The due date for filing the Form 5500 is the last day of the 7th month after the plan year ends. The employer may file for a 2½-month extension
- The DOL can assess a penalty of up to $1,100 per day for a late Form 5500 filing per plan per plan year
- The DOL has a delinquent filer voluntary compliance program (DFVC program) which caps penalties

Form 5500

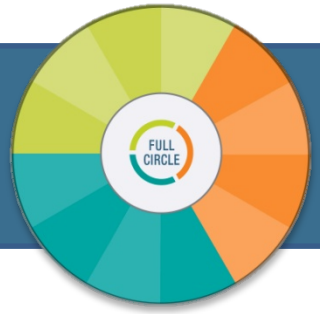
- The penalty for a late filing under the DFVC program is $10 per day up to a maximum of $2,000
- There is also a per plan maximum penalty that applies regardless of how many late filings (plan years) for the plan are being filed under the DFVC program. The maximum penalty is $4,000

Form 5500



- In 2016, the DOL, IRS and PBGC jointly proposed significant changes to the Form 5500, targeted to take effect with the 2019 plan year filings
- Health and welfare plans will be impacted by the proposed changes (if implemented)

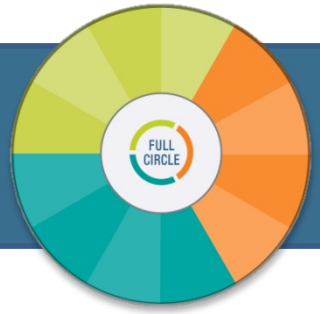
Form 5500



  - The revised form will require all group health plans covered under Title I of ERISA to file a Form 5500, including those covered by the current exemption for small unfunded, insured or combination unfunded/insured plans

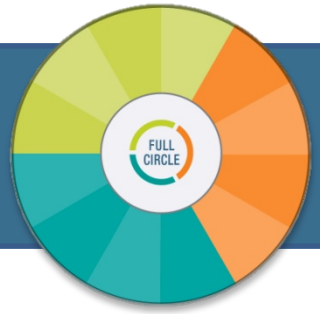
- Included in the filing is a new schedule, Schedule J which requires extensive information the operation of health and welfare plans

Form 5500



- Some of the information required under the proposed Schedule J includes:
  - Information about COBRA offers and individuals receiving COBRA coverage
  - Types of group health benefits offered and eligibility information (employee only, retirees, dependents)
  - Funding information (insured, funded through a trust, paid out of employer's general assets)
  - Information about rebates, refunds or reimbursements from service providers

Form 5500



- Information on stop loss premiums, attachment points, claim limits, and aggregate claim limit information
- Detailed claims payment data, including information on appeals, denials and compliance with required timelines
- Compliance information about SPDs, SMMs, SBCs, GINA, HIPAA portability and discrimination, MHPAEA, Newborns and Mothers' Health Protection Act, Women's Health and Cancer Rights Act and the ACA

Form 5500

- As a result of the Trump Administration's "freeze order" it is unclear if and when the new requirements will take effect

Claims Procedures

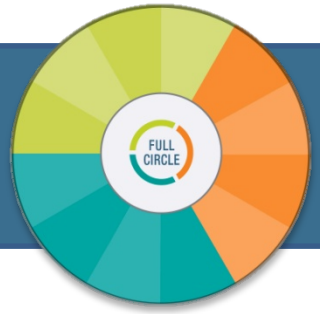
Claims Procedures

- A plan must adopt claims procedures that comply with DOL regulations
- Special rules apply to claims procedures under a group health plan
- It is important to have followed the claims procedures if there is litigation relating to a benefit dispute

Claims Procedures

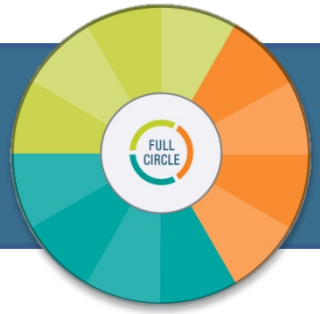
- If a plan fails to follow the claims procedures
  - The claimant may file suit without exhausting the claims procedures
  - A court may apply a less deferential standard of review

Claims Procedures



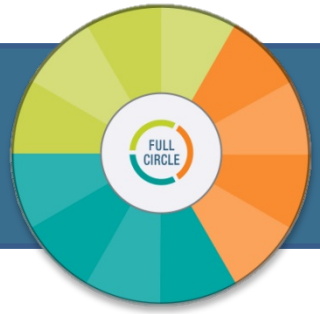
- The time period to file and respond to a claim depends upon the type of claim
  - Pre-service claims – only applies to a claim that requires pre-authorization
  - Urgent care claims – type of pre-service claim where the application of time periods for non-urgent care determinations could jeopardize the patient's life or health or subject the patient to severe pain
  - Post-service claims – most claims

Claims Procedures



- Time period for plan to respond to claim
  - 15 days for pre-service claims
  - 72 hours for urgent care claims
  - 30 days for post-service claims
  - The plan can obtain additional time to make these determinations where additional information is necessary in order to process the claim

Claims Procedures



- If a claim is denied, notice must be provided within the above time frames and the notice must contain specific information such as the reason(s) for the denial, the additional information which could be provided to cause a reversal, and an explanation of the participant's rights to appeal

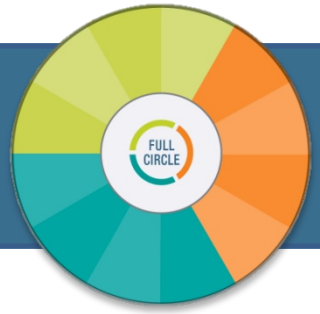
Claims Procedures

- The claimant may appeal
  - The claimant has 180 days to appeal a denied health claim or disability claim
  - The claimant has 60 days to appeal other welfare benefit claims such as for group term life or AD&D insurance

Claims Procedures

- Typically, there will be one level of appeal
  - However, there may be two levels of appeal for pre-service and/or post-service health claims
  - Often times health plans will opt for the two-level appeal approach

Claims Procedures

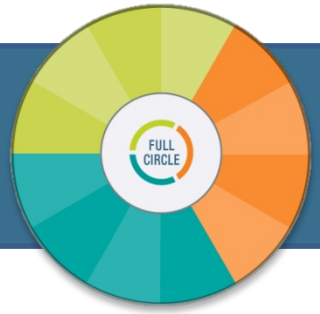


- If a two-level appeal approach is elected, historically in the case of a self-funded plan, the TPA would be responsible for the first-level appeal and the employer would be involved in the second-level appeal
- However, if the self-funded plan isn't grandfathered under the ACA, an external review will be required and to coordinate it the TPA will now frequently also want to administer the second-level appeal
- If there are two levels of appeal, the plan should specify a time period for claimants to timely file second-level appeals

Claims Procedures

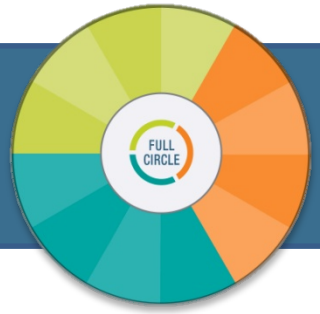
- The time period to file a second-level appeal must be a reasonable period
  - 60 days appears to be a reasonable period for this purpose

Claims Procedures



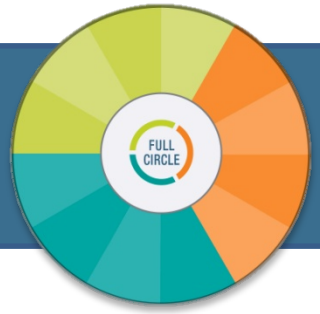
- After the internal appeal process has been completed, there will be an external review available for non-grandfathered plans
- If the claim has still been denied, the participant can file a lawsuit
- If a time for filing the lawsuit is not specified in the plan/SPD, the analogous state law limitations period will apply (typically, 6 years)

Claims Procedures



- A fully-insured plan will have the limitations period under the applicable state insurance law (typically, 3 years)
- A self-funded plan can specify a shorter limitations period
- Any reasonable limitations period will be allowed
  - Example: One year after a denial has been issued in connection with the final level of plan appeal

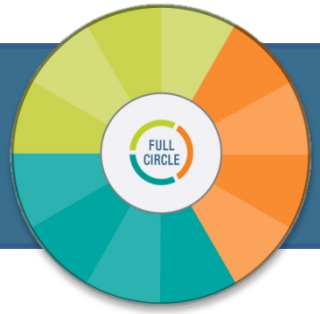
Claims Procedures



- Key point – it is critical to contain a thorough explanation of the claim and appeal procedures in the plan's SPD
- New claim and appeal procedures for ERISA disability plans begin to apply for claims filed after April 1, 2018
- The new regs attempt to align the disability plan rules with the health plan rules

Nondiscrimination Requirements

Nondiscrimination Requirements

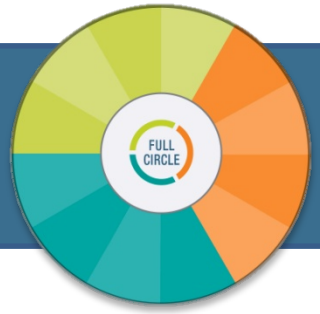


- Fully-insured group health plans are currently not subject to any IRC nondiscrimination requirements
- However, the ACA added rules for non-grandfathered fully-insured plans which will take effect after regulations are issued (if and when now uncertain due to Trump freeze order)

Nondiscrimination Requirements

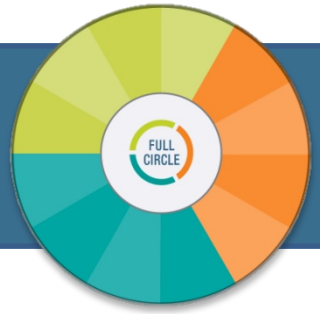
- Self-funded group health plans are subject to IRC nondiscrimination rules which prohibit discrimination in favor of the highly compensated in terms of eligibility and benefits

Nondiscrimination Requirements



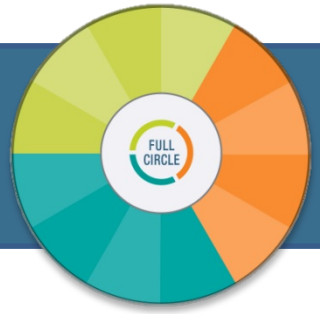
- If a self-funded group health plan has different eligibility rules, contribution rates or benefit structures for various groups of employees, there may be a concern
- However, it may be possible to “disaggregate” the plan into multiple sub-plans to conduct the testing
- If each sub-plan covers a nondiscriminatory group, the testing may still be satisfied

Nondiscrimination Requirements



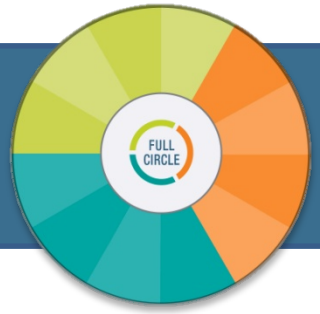
- Examples
  - Hourly vs. salary – if the salaried group includes a significant number of non-highly compensated employees, this may be a workable structure
  - Senior management vs. all other employees – it is unlikely that this design would pass
- Consequence of failure of the nondiscrimination tests
  - The highly compensated receive imputed income equal to the value of the discriminatory coverage

Nondiscrimination Requirements



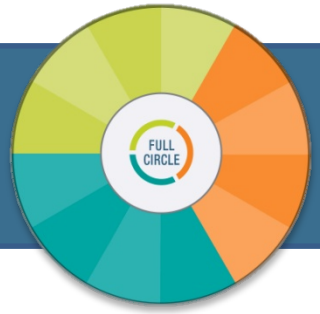
- Disability plans are not subject to any nondiscrimination rules
- Group term life insurance plans are subject to nondiscrimination rules with respect to coverage under $50,000 which is provided on a discriminatory basis
  - The consequence is that the key employees (owners and officers) must receive imputed income equal to the value of the discriminatory coverage

Nondiscrimination Requirements



- Section 125 cafeteria plans are subject to nondiscrimination rules with respect to the plan overall as well as the medical flexible spending account (FSA) and dependent care FSA portions of the plan
  - If there are any variations in your benefits (including but not limited to eligibility, costs and benefits provided), nondiscrimination testing compliance should be reviewed

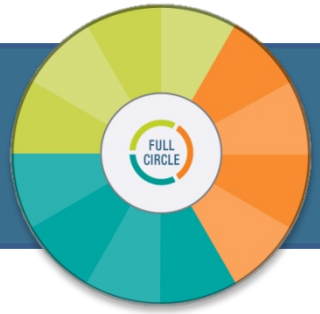
Nondiscrimination Requirements



- If the TPA for the employer's group health plan or cafeteria plan indicates it will conduct nondiscrimination testing, ask for a more complete explanation of what the testing will entail
  - Many times the administrator will conduct the more "numerical" type tests but the compliance of the other tests which are more design-based should still be examined

Third Party Administrator (TPA) Contracts

TPA Contracts

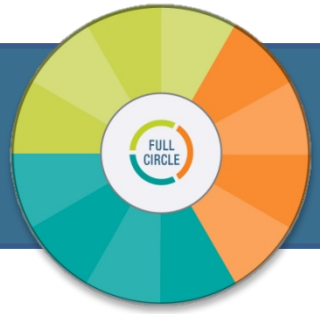


- Liability under law remains with plan administrator/employer –plan sponsor
- Most TPAs disclaim any role as fiduciary
- Don’t overlook importance of reviewing contract before signing
  - Terms and length of agreement
  - Options to terminate

TPA Contracts

- Procedures if termination (run-out administration)
- Indemnification provisions
- Performance guarantees in terms of accuracy and/or timeliness

TPA Contracts



- Transparency in fees and basis for compensation
  - Per employee per month (PEPM) administrative fee
  - Commissions
  - Other
- Clarification that employer either owns all plan records or at a minimum, has access to the records

Record Retention

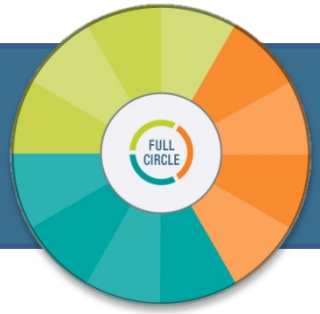
Record Retention

- Obligation to keep records primarily rests on the plan administrator/employer
  - Make sure service agreement with TPA and all other service providers preserves employer's right of access to all plan related records
  - Why maintain?
    - Required by ERISA

Record Retention

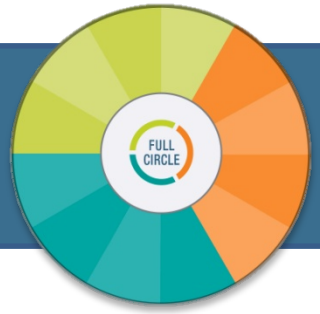
- Necessary to comply with governmental audits
  - DOL
  - IRS
  - HHS
  - State insurance bureau
- Necessary to respond to participant lawsuits

Record Retention



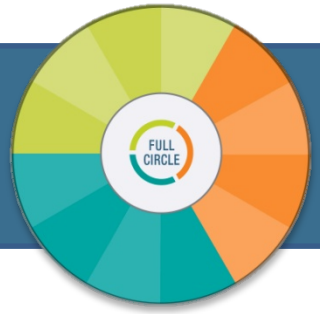
- What records should be maintained?
  - Board resolutions pertaining to the plan
  - Plan documents and amendments
  - Insurance policies and insurance booklets/certificates
  - Contracts with any service providers
  - SPDs and SMMs
  - Administrative policies

Record Retention



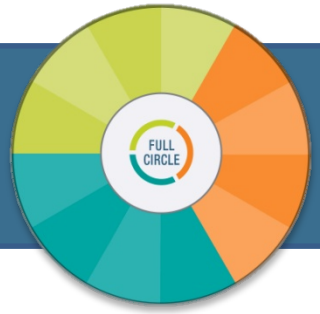
- Initial and annual enrollment materials and forms
- COBRA notices, forms and other documents evidencing compliance
- Other administrative forms
- Nondiscrimination testing documents and evidence of compliance
- Form 5500s and back-up documentation
- SARs

Record Retention



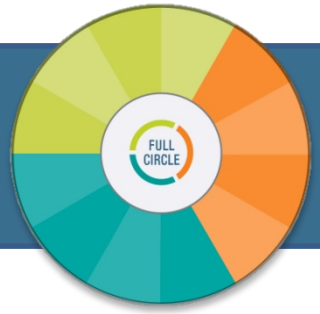
- Appeals of benefit denials including benefit denial letters and minutes from any benefit review committee
- Participant requests for information/documents and responses
- Orders submitted as QMCSOs and disposition
- Participant notices
- Financial information reflecting claims payment, contribution records, premium payments

Record Retention



- Evidence of compliance with various ACA market reforms
- HIPAA documentation to show steps taken to comply with privacy and security rules such as notice to participants, privacy policies, written risk analysis for security rules, training materials and business associate agreements
- Evidence of the procurement of fiduciary bond/liability insurance

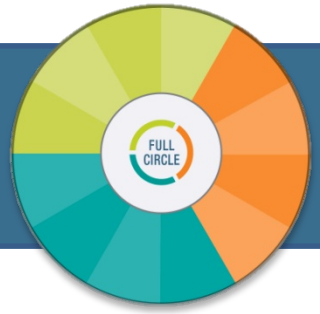
Record Retention



- How long should records be retained?
  - At a minimum, for each plan year, 6 years after the Form 5500 for the year has been filed (the 5500 is due 7 months after the plan year ends with a potential 2½-month extension)
  - Many employee benefit practitioners view 7 years after the end of the plan year as an advisable time frame to comply with all potential reasons why the information in the records may be needed

PCORI Fee

PCORI Fee

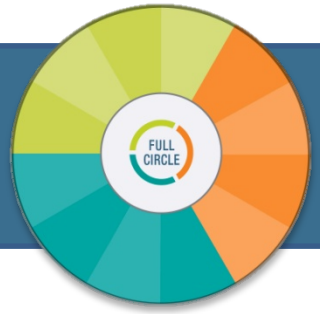


- PCORI Fee – For plan years ending on and after October 1, 2012, a fee is assessed to finance comparative clinical effectiveness research through the Patient-Centered Outcomes Research Institute (PCORI)
  - For the first plan year the fee was based on the average number of covered lives (employees and dependents) under a health plan multiplied by $1
  - The multiplier increased to $2 for the next plan year ending on or after October 1, 2013

PCORI Fee

- For plan years ending on or after October 1, 2014 the fee increases based on national health spending
- For the plan year ending on or after October 1, 2017 and before October 1, 2018 the fee is $2.39 per covered life (up from $2.26 for the prior 12-month period)
- The fee no longer applies for plan years ending after October 1, 2019
- The fee is based upon number of covered lives, so both employees and dependents are counted

PCORI Fee



- The PCORI fee generally applies only to the employer's medical plan
  - If an HRA is integrated with the employer's self-funded group health plan, no separate fee applies
    - However, if the HRA is integrated with the fully-insured group health plan, a separate fee does apply (but is only based on employees; dependents disregarded)
  - Retiree only plans are subject to the fee

PCORI Fee

- In the case of fully-insured plans, the fee is payable by the insurer. In the case of self-funded plans, the fee is payable by the employer
- The fee is reported on IRS Form 720 and paid once per year by July 31
- The PCORI fee must be paid by July 31 of the calendar year immediately following the last day of the plan year

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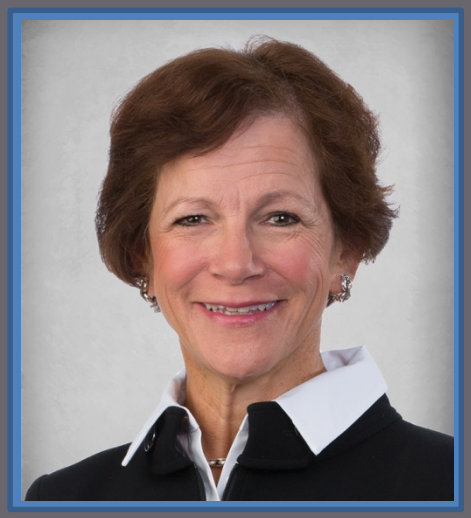

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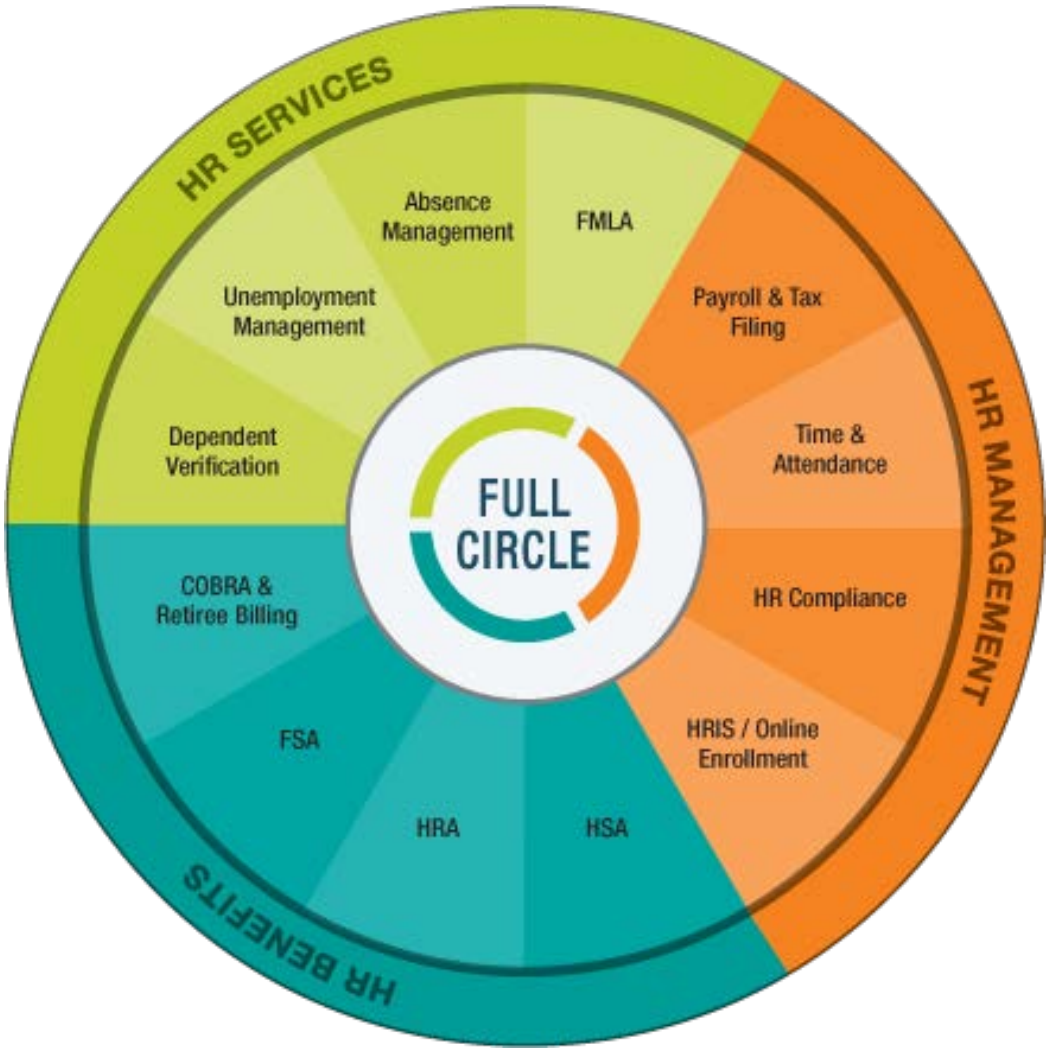

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