ERISA & PPACA Compliance for Welfare Plans

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Today’s Overview

- Provide a listing of all documents required for a Welfare benefit plan.
- Description of documents and when what plans are required to produce the document.
- Timeframes for distribution
Documents

• Summary Plan Description
• Summary Material Modifications
• Summary Annual Report
• Notice of Benefit Determination
• Summary Material Reduction in Costs/Benefits
• COBRA
Documents

- Notice of Creditable Coverage
- General Notice Of Pre-existing Condition Exclusion
- Notice of Special Enrollment Rights
- Wellness Program Disclosure
- Women’s Health and Cancer Rights Notice
- Medical Child Support Notice
Documents

• National Medical Support Notice
• CHIPRA
• IRS Form 5500 & Form M-1
• Form 5500 Schedules & Attachments
• PPACA
  – Grandfather Notice
  – Uniform Benefit Summaries
  – More to come
The SPD is the primary document for informing participants and beneficiaries about their plan and how it operates. This document is to be written for average participant and must sufficiently explain to the participants their benefits, rights, and obligations under the plan. It also must accurately reflect the plan’s contents as of the date not earlier than 120 days prior to the date the SPD is made available.
SPD Distribution

- Must be given to participants receiving benefits.
- When to distribute: automatically to participants within 90 days of coverage beginning.
Summary Material Modification (SMM)

• The SMM describes material changes to a plan and changes in the information required to be in the SPD (i.e. address, phone)
• It must be distributed to participants receiving benefits.
• This document must be automatically given to participants receiving benefits; not later than 210 days after the end of the plan year during which the change is adopted.
Summary Annual Report

• This is a narrative summary of the Form 5500.
• The SAR is distributed to participants receiving benefits.
• The SAR is due to participants receiving benefits within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension).
Notification of Benefit Determination
(claims notices or “EOBs”)

Benefit determinations must be given to the claimants and include required disclosures (e.g., the specific reason(s) for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan’s appeal procedures).

The requirements for this notification were updated by PPACA and are handled by the insurance carrier for fully insured plans.
Summary of Material Reduction in Covered Services or Benefits

• This is a summary of group health plan amendments and changes in information required to be in SPD that constitute a “material reduction in covered services or benefits.”

• This document must be given to participants.

• It is given within 60 days of adoption of material reduction in group health plan services or benefits.
Initial COBRA Notice

• This is the notice to participants of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.
• The initial COBRA notice must be given to covered employees and covered beneficiaries.
• It is distributed at the time group health plan coverage commences.
COBRA Election Notice

• This is the notice to “qualified beneficiaries” of their right to elect COBRA coverage upon occurrence of qualifying event.

• This notice must be given to covered employees, covered spouses, and dependent children who are qualified beneficiaries.
Notice of Creditable Coverage

• This notice is from the employee’s former group health plan documenting prior group health plan creditable coverage.

• It must be provided to participants and beneficiaries who lose coverage or who request a certificate.

• This notice is provided automatically upon losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases.

• A certificate may be requested free of charge anytime prior to losing coverage and within 24 months of losing coverage.
General Notice Of Pre-Existing Condition Exclusion

• This notice describing a group health plan’s preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period is given to all plan participants.
• It must be provided as part of any written application materials distributed for enrollment.
• If the plan does not distribute these materials, by the earliest possible date following a request for enrollment.
Notice of Special Enrollment Rights

• Notice describing the group health plan’s special enrollment rules including the right to special enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption.

• This notice must be given to all employees eligible to enroll in a group health plan at the time they are eligible to enroll.
Wellness Program Disclosure

• This notice must be given by any group health plan offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward.
• The notice must disclose the availability of a reasonable alternative standard (or possibility of waiver).
• This notice must be in all plan materials that describe the terms of the wellness program.
Women’s Health and Cancer Rights

• This notice describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy must be given to all plan participants.

• It must be furnished upon enrollment and annually – generally, this is included in the insurance carriers information.
Medical Child Support Notice

• This is a notification from the plan administrator disclosing the receipt of a MCSO which directs the plan to provide health insurance coverage to a participant’s noncustodial children. The plan administrator must issue this notice promptly upon receipt of the MCSA.

• The administrator must also issue a separate notice as to whether the MCSO is qualified within a reasonable time after its receipt.

• Both notices must be given to the applicable participant, any child named in a MCSO, and his or her representative.
National Medical Support Notice

• This notice is used by the state agency responsible for enforcing health care coverage provisions in a MCSO. Within 20 days, the employer must either complete and return Part A of the NMS notice to the State agency; or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified MCSO.

• The administrator must reply within 40 days to the state agency regarding qualified status
CHIPRA

- This notice must be distributed annually by the first day of the plan year to all employees.
- The CHIP Notice must appear as a separate and prominent document but may be included with other enrollment materials.
- The notice must be distributed if the employer maintains a group health plan in a state that provides a premium assistance subsidy program under Medicaid or CHIP.
# CHIPRA

**Applicable States***:

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*as of March 2010*
Part D Creditable Coverage

• Employers must provide creditable or non-creditable coverage notice to all Medicare eligible individuals who are covered under, or who may apply for, the employers prescription drug plan both before AEP and the group plans open enrollment.

• In addition, employers are required to provide CMS with their plan's creditable or non-creditable coverage status annually.
IRS Form 5500 & Form M-1

- Welfare plans:
  - Small plans (with fewer than 100 participants as of the beginning of the plan year) if funded or uses a trust.
  - Large plans (with 100 or more participants as of the beginning of the plan year) that is fully-insured or unfunded.
  - A health FSA that pays benefits directly from the employer’s general assets or from a trust account.
  - Welfare benefit plans that are associated with fringe benefit cafeteria plans must file.
• Administrators of multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide coverage for medical care to employees of two or more employers are generally required to file the Form M-1 (Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)).

• The Form M-1 is generally due no later than March 1, following any calendar year for which a filing is required.
PPACA REQUIREMENTS
Grandfathered Notice

A grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language whenever a summary of the benefits under the plan is provided to participants and beneficiaries.
Claims Appeals

- This rule applies to both fully insured and self-funded plans (unless grandfathered), but for fully-insured plans the rules apply directly to the insurance carrier.
- A plan must notify a claimant of a benefit determination for an urgent care claim no later than 72 hours after the receipt.
- Notices must be provided in a culturally and linguistically appropriate manner.
Summary of Benefits & Coverage

- Beginning with plan years on or after September 23, 2012, health insurers and group health plans must provide the summary of benefits and coverage and the uniform glossary to eligible employees.
- The SBC may be provided either as a stand-alone document or in combination with other summary materials (i.e. summary plan description); however, the SBC must be prominently displayed at the beginning of the materials.
- The document must be produced in either color or a grayscale.
- Plans and issuers must provide notices in a culturally and linguistically appropriate manner when 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language.
PENALTIES
ERISA Penalties

- The Department of Labor has authority to bring a civil action to correct violations of ERISA and impose criminal penalties on any person who willfully violates any provision of Part 1 of Title I.
- EBSA has authority under ERISA Section 502(c)(2) to assess civil penalties for reporting violations. A penalty of up to $1,000 per day may be assessed against plan administrators who fail or refuse to comply with annual reporting requirements.
PPACA Penalties

- Failure to provide “grandfathered” status notice results in loss of grandfathered status.
- The penalty for failure to “manage” claim appeals properly is not unclear.
- Willful failure to provide SBC is $1000 per failure.
Resources

• www.dol.gov/ebsa/healthreform
• EBSA’s reporting and disclosure requirements, Form 5500 & EFAST Help Line at 1-866-463-3278.
• Form M-1, call (202) 693-8360
• Publications that may be helpful can be obtained at www.dol.gov/ebsa:
  ➢ An Employer’s Guide to Group Health Continuation Coverage Under COBRA
  ➢ QDROs: The Division of Retirement Benefits Through Qualified Domestic Relations Orders
  ➢ Compliance Assistance Guide: Health Benefits Coverage Under Federal Law
QUESTIONS?

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