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Better Safe Than Sorry

Preparing for a DOL Health and Welfare Plan Audit

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Although the federal Department of Labor (DOL) has a history of rigorously auditing 401(k) and pension plan compliance, health and welfare plans have not been as high on the agency's agenda. In 2000, the DOL began auditing health and welfare plan audits, focusing on a sample of employers to measure compliance with, among other laws, the pre-existing condition exclusion requirements under the Health Insurance Portability and Accountability Act (HIPAA). A representative of the DOL recently informed a national audience of benefits lawyers that these "random selection" audits ceased in 2003, and it appears that the DOL is intensifying its health and welfare plan audit activities in response to specific complaints. A DOL audit can present a significant burden for employers, given the volume of documentation the agency asks to review, and the penalties imposed for findings of noncompliance can be considerable, depending on the particular statutory requirement in question. The following checklist highlights issues you may want to review to avoid potential problems, should the DOL come calling.

Documentation of Notices

DOL not only audits plan language; it looks for documentation regarding your plan's compliance with a laundry list of notice obligations, including COBRA notices, annual notices under the Women's Health and Cancer Rights Act, and those regarding special enrollment rights or certificates of creditable coverage under HIPAA. Review your policies or discuss these obligations with your plan administrator to ensure that have appropriate documentation in place.

A 2003 DOL report found the various notice requirements to be the most prevalent area of noncompliance. The DOL will be looking for documentation, such as copies of all notices sent in the last 12 months, or logs showing that notices were distributed. Consider adopting a policy that makes the distribution of such notices a part of your regular business and personnel activities.

Mental Health Parity Act (MHPA)

The MHPA prohibits annual and lifetime limits on mental health benefits that are less than the limits for general medical and surgical benefits. The MHPA originally expired on Sept. 30, 2001, but there have been a series of Congressional extensions (currently, it expires Dec. 31, 2004). The DOL has taken the position that the MHPA prohibits "constructive dollar limits" (*ie*, provisions that couple a limitation on the number of visits with limits on the amount that will be paid for each visit), unless all benefits are subject to the same limits. Make sure your plan's annual and lifetime limits on mental health visits are equivalent to the limits for general medical/surgical benefits.

The DOL has found that nearly 20% of plans audited had MHPA violations, primarily concerning such "constructive dollar limits." Find and fix any such limits in your plan by, for instance, eliminating the visit limitation but keeping the amounts-per-visit limitations.

Pre-existing Condition Exclusions

Another common error is for plans to include "hidden" pre-existing condition exclusions, such as plan terms covering reconstructive surgery related to an accident only if the accident occurred while the individual was covered under the plan. Review your plan terms to clarify whether any such "hidden" exclusions are lurking there.

Special Enrollment Rights

Under HIPAA, plans must permit individuals who have declined health coverage under the plan because they had other group health coverage to enroll in the plan through special enrollment whenever there is any "loss of eligibility" for the other coverage. "Loss of eligibility' includes legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children aging out of coverage, moving out of an HMO service area, and when the other employer terminates the coverage. Plans must also permit individuals to enroll in the case of birth or adoption of a new dependent. Some plans place more stringent limitations on enrollment outside of open enrollment; be sure your plan has the appropriate language, and that any communications to employees do not misstate the special enrollment provisions.

A common mistake about special enrollment rights relates to the effective date of special enrollment coverage. While most coverage must be effective no later than the first day of the first calendar month following the date a request for special enrollment is received, coverage relating to the "acquisition of a dependent" must be effective *as of the date* of the birth, adoption or placement for adoption. Check your plan documents and your employee communications to be sure you are properly explaining the effective dates of HIPAA special enrollment coverage.

Claims Regulations

Final ERISA claims regulations significantly revised the time frames for handling health and disability claims, and impose specific requirements for the content and form of any claim denials. These regulations were effective for plan years beginning on or after Jan. 1, 2003, but many plans have yet to incorporate the requirements into their plan documents and their internal procedures. Confirm that any health and welfare plan documents include updated language on claims processing, and that contracts with any vendors or third party administrators obligate them to follow these regulations when processing your employees' benefit claims.

COBRA Notices And Policies

At the end of May 2004, the DOL issued final regulations that impose additional notice requirements on both plan sponsors and third parties that administer your plan's COBRA obligations. Plan administrators must provide initial notices that describe COBRA in general, and must provide notices to employees about their right to elect COBRA coverage upon the occurrence of a COBRA "qualifying event" (such as divorce, termination of employment or reduction in hours). Model notices containing all of the required language are available at http://www.dol.gov/ebsa/compliance_assistance.html.

Continuing and expensive litigation regarding COBRA coverage highlights the importance of getting your notice procedures right. Check with your COBRA administrator or your human resources/benefits department to ensure that proper notices are being distributed at the right time.

Summary Plan Description (SPD)

ERISA requires that employers sponsoring health and welfare benefit plans provide SPDs to all enrollees. The regulations are quite specific about the content of SPDs, and threaten significant penalties for non-compliance (for instance, $100 per day for each day that an employee who has requested an SPD is not provided with one). Electronic distribution is permitted in some circumstances, subject to certain conditions. Check that your human resources or benefits department has an appropriate policy for distributing SPDs — and documenting that the distribution requirements have been met.

Additional Considerations

A review of your plan provisions can not only help protect your plan against the disruption and costs of a DOL audit, you may also be able to prevent future litigation by plan participants. Look for subrogation provisions that adequately outline your plan's legal rights to recover benefits paid under the plan when a participant recovers damages from a third party (as a result of the U.S. Supreme Court's decision in the recent *Great West v. Knudson* case, a plan's ability to recover in these circumstances is extremely limited unless the plan document terms include certain provisions). In addition, ensure that the plan includes a provision reserving the plan sponsor's rights to amend or terminate the plan, and that no promises to the contrary (such as guarantees of life-time benefits) have been made in the SPD or other employee communications.

Penalties

The penalties that can be imposed by the Department of Labor vary for each statutory and regulatory requirement. For instance, a group health plan can be fined up to $100 a day for failure to provide COBRA notices, along with an excise tax of the same amount. Certain HIPAA violations carry a potential penalty of $110 a day. While it is more likely that a DOL auditor would simply ask a plan to correct the violation by, for instance, issuing an appropriate notice, the plan also could be subject to private ERISA suits by individual beneficiaries. In a recent case, a federal court in Nebraska awarded beneficiaries over $300,000 in penalties for a plan's failure to provide COBRA notices.

Conclusion

The DOL has a number of helpful publications available on its Web site

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Check your plan documents and internal policies to ensure the following:

- Required notices (COBRA, Women's Health, Newborns' Act, etc.) are being distributed, and you have policies and documentation to prove it.
- Your plan contains no "constructive" limits on mental health benefits that might violate the Mental Health Parity Act.
- Your COBRA notices and policies comply with the newly-issued regulations (effective for plan years beginning after Nov. 26, 2004).
- Your plan applies the proper effective date for HIPAA special enrollment coverage, and contains no "hidden" pre-existing condition limitations.
- Be sure you can document the fact that summary plan descriptions (SPDs) were appropriately distributed to all employees.

(www.dol.gov./ebsa), including a self-audit checklist, a guide summarizing the various notice requirements, and updated tips for avoiding common mistakes. The agency is also promising to sponsor compliance assistance workshops around the country. Check your company's plan documents and internal policies and procedures and make any necessary revisions, consulting with benefits counsel as appropriate. You will be ready in the event of a DOL audit, and such "preventive medicine" can also guard against employee and beneficiary lawsuits.

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