

How to Prepare for a DOL Audit

With increasing budgets and resources, the Department of Labor (DOL) is hitting employers hard with increasing audits to their Health and Welfare Plans, and it's only getting stronger. As an employer, are you prepared for a DOL audit? And are you aware of what an audit involves and the fines for non-compliance? The DOL typically requests information for three to four prior years, plus current year.

Note: ERISA disclosure requirements applies to all Private Sector Employers, with exception of Church Plans, regardless of size. Reporting requirements generally apply to all Plans with 100+ Participants.

A Health and Welfare Plan audit is a review of documents and other Plan materials to ensure Plan Sponsors comply with federal law. This includes having and distributing the correct documents, and administering those documents consistent with federal laws and regulations. A DOL Plan Auditor reviews many things, each aimed at compliance accompanied by a host of fines for non-compliance.

Below is a partial list of potential items to be examined during a DOL audits. Please take a few moments to determine if you are prepared for such an audit by checking Yes or No to each item listed:

Yes No

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1) ERISA Plan Documents.
<input type="checkbox"/>	<input type="checkbox"/>	2) Summary Plan Description (SPD) including any changes in Plan benefits and entitlement to benefits. <u>Must indicate the date of the SPD and the most recent date and method of distribution to employees.</u>
<input type="checkbox"/>	<input type="checkbox"/>	3) Summary of Benefits and Coverage (SBC), Notices of Material Modifications, and Uniform Glossary.
<input type="checkbox"/>	<input type="checkbox"/>	4) Copies of the annual open enrollment information.
<input type="checkbox"/>	<input type="checkbox"/>	5) Copies of the employee handbook explaining the Health Plan eligibility and benefits.
<input type="checkbox"/>	<input type="checkbox"/>	6) All contracts with insurance companies for the provision of health benefits.
<input type="checkbox"/>	<input type="checkbox"/>	7) <i>If self-insured</i> , all contracts, fee schedules, and written guidelines/procedures for: <ul style="list-style-type: none"> a. Claims processing (including claims installation documents); b. Administrative services including utilization review and claim appeals; and c. Reinsurance
<input type="checkbox"/>	<input type="checkbox"/>	8) Documents describing the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of Health and Welfare Benefits.
<input type="checkbox"/>	<input type="checkbox"/>	9) In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are you able to provide the following records: <ul style="list-style-type: none"> a. Copy of Plan rules for eligibility to enroll under the terms of the Plan (incl. continued eligibility); b. Sample copy of Certificate of Coverage provided to an employee who lost healthcare coverage after 12/01/2012, which certifies creditable coverage earned under this Plan; c. Copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan, or requested certificates from January 1, 2013; d. Copy of written procedure for individuals to request and receive Certificates of Credible Coverage; e. Copy of necessary criteria for an individual without a Certificate of Creditable Coverage to demonstrate creditable coverage by alternative means;

	<ul style="list-style-type: none"> f. Sample General Notice of pre-existing condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the pre-existing condition exclusion period, or proof that the Plan does not impose a pre-existing condition exclusion; g. Copies of individual Notices of pre-existing condition exclusion issued to certain individuals since 01/01/2012 per the regulations (including any lists or logs an administrator may keep of issued Notices), or proof that the Plan does not impose a pre-existing condition exclusion; h. Records of claims denied due to the imposition of the pre-existing 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; i. 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 an administrator may keep of issued Notices; and j. Copy of the written appeal procedures established by the Plan.
<input type="checkbox"/> <input type="checkbox"/>	10) Copy of the Plan Rules regarding coverage of medical/surgical and mental health benefits, including information as to specific limitations related to those benefits.
<input type="checkbox"/> <input type="checkbox"/>	11) The Plan's Newborns' Act Notice including lists or logs of Notices an administrator may keep of issued Notices.
<input type="checkbox"/> <input type="checkbox"/>	12) Copy of the Plan Rules regarding preauthorization for a hospitalization in connection with child birth or mental health benefits.
<input type="checkbox"/> <input type="checkbox"/>	13) Sample of the written description of benefits mandated by WHCRA required to be provided to Participants and beneficiaries upon enrollment.
<input type="checkbox"/> <input type="checkbox"/>	14) Copy of the most recent annual WHCRA Notice, with notation of date and method of distribution to employees.
<input type="checkbox"/> <input type="checkbox"/>	15) Materials describing any wellness programs, disease management programs, or health-related incentive programs or benefit offered by the Plan, employer, or service provider.
<input type="checkbox"/> <input type="checkbox"/>	16) If the Plan has claimed grandfathered health Plan status within the meaning of Section 1251 of the Affordable Care Act (ACA), can you provide the following records: <ul style="list-style-type: none"> a. Copy of the grandfathered health Plan status disclosure statement that was required to be included in Plan materials provided to Participants and beneficiaries describing the benefits provided under the Plan; and b. Records documenting the terms of the Plan in effect on 03/23/2010 and any other documents necessary to verify, explain, or clarify status as a grandfathered Health Plan. <ul style="list-style-type: none"> i. May include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on 03/23/10.
<input type="checkbox"/> <input type="checkbox"/>	17) Regardless of whether the Plan has claimed grandfathered status, are you able to provide the following records in accordance with Section 715 of ERISA as added by the Affordable Care Act: <ul style="list-style-type: none"> a. In the case of a Plan that provides dependent coverage, provide a sample of the written Notice describing enrollment opportunities relating to dependent coverage of children to age 26; b. If the Plan has rescinded any Participant's or beneficiary's coverage, supply a list of Participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written Notice of rescission that was provided 30-days in advance of any rescission of coverage; c. If the Plan imposes, or had imposed an annual or lifetime limit, or has imposed a lifetime limit at any point since 09/23/2010, provide documents showing the limits applicable for each Plan

	<p>Year on or after 09/23/2010; and</p> <p>d. A 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.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>18) If the Plan has NOT claimed grandfathered Health Plan status under Section 1251 of the Affordable Care Act (ACA), are you able to provide the following records:</p> <p>a. Copy of the Choice of Provider Notice informing Participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or healthcare professional specializing in obstetric or gynecology in the case of women, and a list of Participants who received the Disclosure Notice;</p> <p>b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, provide copies of documents relating to such emergency services for each Plan Year on or after 09/23/2012;</p> <p>c. Copies of documents relating to the provision of preventive services for each Plan Year on or after 09/23/2012;</p> <p>d. Copy of the Plan's Internal Claim and Appeals and External Review Processes;</p> <p>e. Copies of Notice of Adverse Benefit Determination, Notice of Final Internal Adverse Determination Notice, and Notice of Final External Review Decision; and</p> <p>f. <i>If applicable</i>, any contract, agreement and fee schedule with all independent review organization or third-party administrator providing external review.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>19) Minutes of Board of Directors, Plan Committee, and/or any other committee meetings where Plan health benefits were discussed.</p> <p>Note: Do not make copies, but please make records available for our review.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>20) A copy of any Fidelity Bond and Fiduciary Liability Policy, including any riders and amendments.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>21) All correspondence relating to the Plan's health benefits, including Participant complaints about claims payment or processing, denials and appeals, and including carrier or third party administrator responses.</p> <p>Note: Do not make copies, but please make records available for our review.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>22) The Plan's accounting records, including bank statements, trust and brokerage statements, and canceled checks [bank transaction reports may be used if a bank trustee controls the assets] from 01/01/2012 to the present.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>23) Documents identifying Plan assets, liabilities, revenues, and expenses.</p>
<input type="checkbox"/> <input type="checkbox"/>	<p>24) The names, phone numbers, and addresses (on company letterhead) of parties-in-interest to the Plan including:</p> <p>a. Actuary</p> <p>b. Attorney(s)</p> <p>c. Accountant and/or Auditor(s)</p> <p>d. Investment Advisor/Manager(s)</p> <p>e. Insurance Agent(s)</p> <p>f. Contract Administrator(s) (and copy of the engagement letter)</p> <p>g. Trustee(s)</p> <p>h. Plan committee members</p> <p>i. 10% or more owners of the Plan Sponsor</p> <p>j. Affiliated entities to the Plan Sponsor or 10% owners</p>

Potential Fines

ERISA's disclosure requirements, for instance, can carry a fine of \$110 per day, per person, per violation for every Plan Participant who was covered under a single contract. That fine increases to \$200 for Plan Participants covered by a family contract. ERISA fines represent just one flag from the DOL auditor and can cost the Plan Sponsor dearly. Most fines for noncompliance under the ACA are *not* tax-deductible.

Please use the above listed DOL audit items to determine that you can pass an ERISA Health & Welfare audit and provide the requested items to the DOL upon request.

The numbers don't lie:

- ERISAEdge has received over 100 new clients in past twelve months in a DOL audit. Large and small, size doesn't matter.
- 2014: EBSA estimated it will collect \$1,172,108,000 in total monetary results.
- DOL reports an estimated 95% of all employers out of compliance.
- The IRS can impose an excise tax for certain ERISA violations at \$100 per day, per Participant.

Do you...

- 1) Have an SPD and all other Plan Documents in place and make available to Participants?
- 2) Properly file Form 5500 every Plan Year?
- 3) Follow all annual Notification requirements (ERISA, PPACA, etc.)?

Learn how TASC ERISAEdge (offering 75+ years compliance management experience) can assist you in avoiding fines and penalties by achieving and maintaining compliance for all applicable laws and requirements.