

How Healthy Are Your Health and Welfare Plans?

Compliance Issues for Health and Welfare Plans

Presented by

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No one should rely on this outline as legal advice. In every situation, the application of the rules requires careful analysis by counsel who is familiar with your particular situation.

Table of Contents

“Employee Welfare Benefit Plan” Defined	1
A. ERISA Definition	1
B. Exemptions	1
C. Examples of Welfare Plans.....	2
D. Plans Not Subject to ERISA.....	3
E. ERISA Requirements	4
Written Plan Document.....	4
A. Content Requirements.....	4
B. Wrap Document for Insured Plans.....	5
C. Consequences of Noncompliance	6
Fiduciary Responsibility	6
A. “Fiduciary” Defined	6
B. Fiduciary Duties.....	7
C. Consequences of Fiduciary Breaches	7
D. Fidelity Bond Requirement.....	7
Summary Plan Description (“SPD”).....	8
A. When SPD Must Be Furnished	8
B. Content Requirements	8
C. Wrap SPD for Insured Plans	9
D. Consequences of Inadequate or No SPD	10
Summary of Material Modifications (“SMM”).....	10
Other Disclosure Requirements.....	11
Annual Report Filing (Form 5500 Series).....	12
A. Filing Due Date	12
B. Small Plan Exception	12
C. Limited Filing For Large Unfunded or Insured Plans.....	13
D. Non-ERISA Fringe Benefits	13
E. Consequences of Failure to File Form 5500.....	13
Summary Annual Report (“SAR”).....	13
Claims Procedures.....	13

- A. Initial Benefit Claims 13
 - 1. Timeframes for Deciding Initial Benefit Claims 13
 - 2. Additional Notices for Group Health Urgent Care and Pre-Service Claims 14
 - 3. Written Notice of Adverse Benefit Determinations 14
- B. Appeals 15
 - 1. Timeframes for Claimant to File Appeal 15
 - 2. Full and Fair Review 15
 - 3. Comments and Documents 15
 - 4. Medical Judgment 15
 - 5. Time Frames for Deciding Appeals 15
 - 6. Written Notice of Adverse Benefit Determination On Review 16
 - 7. Inadequate Notice of Benefit Determination On Review 16
- Funded v. Unfunded 17**
 - A. Funded, Unfunded or Insured 17
 - B. Funded Plan Requirements 17
 - C. Plan Assets 17
 - 1. Participant Contributions 17
 - 2. Employer Contributions 17
 - 3. Trust Requirement 18
 - 4. Consequences of Violation of Trust or Exclusive Benefit Rule 18
 - 5. Violation of Prohibited Transaction Rules 18
- Group Health Plans 19**
 - A. Welfare Plans That Are Group Health Plans 19
 - 1. Plans which are group health plans 19
 - 2. Plans which may be group health plans 19
 - 3. Plans which are not group health plans 19
 - B. Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”).... 20
 - 1. Notice Requirements 20
 - 2. Cal-COBRA Extension of Period of Coverage 23

C. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)..... 24

 1. Special Enrollment Rights 24

 2. Portability 24

 3. Administrative Simplification 24

 4. Nondiscrimination..... 24

D. The Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”) 24

E. Women’s Health and Cancer Rights Act of 1998 (“WHCRA”)..... 25

F. Mental Health Parity Act of 1996 (“MHPA”) 25

Other Federal Laws that Affect Welfare Plans 26

Self-Insured Plans..... 26

Nondiscrimination Rules 27

Domestic Partner Coverage..... 27

Further Information and Assistance 28

How Healthy Are Your Health and Welfare Plans?

Compliance Issues for Health and Welfare Plans

Employers provide a diverse range of benefits to their employees. Some of these benefits are subject to the Employee Retirement and Income Security Act of 1974 (“ERISA”) as welfare plans (also known as “employee welfare benefit plans”). Health plans are a subset of welfare plans. In addition to ERISA, the Internal Revenue Code (the “Code”) and other federal laws affect health and welfare plans. Plan sponsors need to be aware of these laws and ensure that their health and welfare plans are in compliance with the many applicable requirements.

“Employee Welfare Benefit Plan” Defined

A. ERISA Definition

ERISA § 3(1) defines a “welfare plan” or “employee welfare benefit plan” to mean “any plan, fund or program which ...is ...established or maintained by an employer ...for the purpose of providing to participants and beneficiaries, through the purchase of insurance or otherwise, (a) medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services...”

1. “Plan, fund or program” - Generally, any benefit that requires an ongoing administrative scheme.
2. “Established or maintained by the employer” - Determined by facts and circumstances such as contribution by employer (payment of benefits, administrative costs).

B. Exemptions

The following benefits are exempt from ERISA:

1. Governmental and church plans.
2. Plans maintained solely for the purpose of complying with state-law requirements for workers’ compensation, unemployment compensation or disability insurance.
3. Payroll Practices

Certain payments made as a normal “payroll practice” of the employer such as payment of wages, overtime pay, shift premiums, and holiday or weekend premiums; sick-pay or income replacement benefits, vacation, holiday, jury duty and similar pay. Payments must be made from the general assets of the employer.

4. Voluntary, Employee-Pays-All Programs

A group or group type insurance program offered by an insurer to employees under which-

- a. no contributions are made by an employer or employee organization;
- b. participation in the program is completely voluntary for employees or members;
- c. the sole function of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and remit them to the insurer; and
- d. the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check-offs.
- e. Examples of Employer Endorsement:
 - i. selecting insurer;
 - ii. negotiating plan terms or linking coverage to employee status;
 - iii. using employers name or associating the plan with other employer plans;
 - iv. recommending plan to employees;
 - v. saying that ERISA applies;
 - vi. doing more than permitted payroll deductions;
 - vii. allowing use of employer cafeteria plan; or
 - viii. assisting employee with claims or disputes.

C. Examples of Welfare Plans

1. Medical, dental and vision plans;
2. Long-term disability ("LTD") and short-term disability ("STD") plans;
3. Group term life insurance;
4. Health flexible spending accounts;
5. Accidental death and dismemberment insurance ("AD&D");
6. Prescription drug plan;

7. Severance plans;
 - a. Severance plans with minimal administration may not be ERISA plans; and
 - b. Despite ERISA compliance obligations, being subject to ERISA also protects the plan sponsor from state law claims and possibly larger damage awards.
8. Wellness programs and employee assistance programs (“EAPs”) (can be health plans if offering medical care).

D. Plans Not Subject to ERISA

1. Dependent care assistance program (“DCAP”), cafeteria plan (§ 125 premium-only plan) (but component plans may be);
2. Adoption assistance, educational assistance if unfunded, transportation benefits; and
3. Health Savings Account (“HSA”) not ERISA plan if it meets the qualifications of Department of Labor (“DOL”) Field Assistance Bulletin 2004-1 (April 7, 2004):
 - a. No employer, or if there is an employer involved, the employer does not contribute to it;
 - b. Employee participation is voluntary;
 - c. No employer endorsement is made;
 - d. The employer is paid only reasonable payroll expenses.
 - e. If employer contributes to HSA, may avoid ERISA status as long as:
 - i. The employee’s establishment of HSA is completely voluntary;
 - ii. Employer does not--
 - (A) Limit the ability of the eligible employees to move funds to another HSA other than as restricted by the Code;
 - (B) Impose conditions on using HSA funds beyond those imposed by the Code;
 - (C) Make or influence the investment decisions with respect to funds contributed to the HSA;
 - (D) Represent the HSA is an employee welfare benefit plan established or maintained by the employer; or
 - (E) Receive any payment or compensation in connection with the HSA.

E. ERISA Requirements

Health and welfare plans are subject to Title I of ERISA other than Part 2 (Participation and Vesting) and Part 3 (Funding). However, it should be noted that courts have found that welfare benefits can vest under general contract law principles.

Written Plan Document

ERISA requires a written plan document for all health and welfare plans. ERISA § 402.

A. Content Requirements

1. Named Fiduciary. The plan must specify one or more “named fiduciaries” who have authority or control and manage the operation and administration of the plan. ERISA § 402(a)(1).
2. Procedure for Allocation of Responsibilities. ERISA § 402(b)(2).
3. Funding Policy (not required for an unfunded plan). *Voyk v. Brotherhood of Locomotive Engineers*, 198 F.3d 599 (6th Cir. 1999).
4. How payments are made to and from the plan. ERISA § 402(b)(4).
5. Claims Procedures (still a good idea even if in the SPD).
6. Amendment Procedure.
 - a. Plan and SPD should give plan sponsor the clear authority to amend or terminate the plan at any time.
 - b. Plan must (SPD should) also specify a procedure for amending the plan and for identifying the persons who have authority to amend the plan. ERISA Sectio 402(b)(3).
7. Distribution of Assets on Plan Termination. Even though most welfare plans do not have a trust, there are still plan assets. ERISA § 403(d)(2).
8. Special Content Requirements for Group Health Plans
 - a. COBRA Rules;
 - b. HIPAA Portability, Special Enrollment and Nondiscrimination Provisions;
 - c. HIPAA Privacy and Security;
 - d. Minimum Hospital Stays After Childbirth;
 - e. QMCSO Rules. Every health plan must provide benefits in accordance with the applicable requirements of any qualified medical child

support order (“QMCSO”). Plan should contain a statement that, notwithstanding any plan provision to the contrary, the plan will provide benefits in accordance with the applicable requirements of any such QMCSO. Procedures for determining whether a QMCSO exists should be included in the plan or in a separate document cross-referenced by the plan. ERISA § 609(a).

9. Other Important Provisions

- a. Use of plan assets to pay plan administrative expenses.
- b. Provisions required to be in SPD-
 - i. Eligibility;
 - ii. Benefits;
 - iii. Exceptions and limitations that can result in the loss or denial of benefits;
 - iv. How plan is administered;
 - v. Provisions required by other laws (such as FMLA provisions relating to health plan coverage).
- c. Administrative Provisions
 - i. Persons delegated to act on behalf of the plan sponsor;
 - ii. Governing state law, subject to preemption by applicable federal law;
 - iii. No contract of employment;
 - iv. No guarantee of tax consequences.
- d. Other Provisions
Subrogation and coordination of benefits provisions

B. Wrap Document for Insured Plans

1. Insurance contracts are not sufficient for ERISA plan document purposes, nor do they contain other important provisions:
 - a. Provisions designed to protect the plan, the plan administrator and other plan fiduciaries;
 - b. Designation of plan administrator;
 - c. Designation of named fiduciary;
 - d. Right of employer to amend or terminate the plan;
 - e. Termination of plan upon termination of the insurance contract;

- f. How plan assets will be handled upon termination of the plan;
 - g. COBRA, USERRA and HIPAA should be addressed in the insurance documents, but may not be adequate;
2. Wrap document incorporates the insurance contracts.
 3. Wrap document can be drafted to be both a plan and SPD (but should clearly state that it is intended to meet both requirements).

C. Consequences of Noncompliance

1. No specific penalties;
2. ERISA general enforcement provisions (Part 5 of Title I of ERISA) allow plan participants and beneficiaries sue to enforce the written plan document;
3. Criminal penalties may be imposed on any individual or company that willfully violates any requirement of Title I of ERISA. Penalty per conviction could be \$100,000 and/or imprisonment for up to ten years. The fine can be increased up to \$500,000 if it is against a company;
4. Written plan is one of the documents that must be furnished in response to a participant's written request. Plan administrator can be fined up to \$110 per day if the plan document is not furnished within 30 days of the participant's request;
5. Extrinsic evidence allowed in lawsuits; and
6. Less favorable standard of review ("de novo") in a lawsuit.

Note: The Code has a similar plan document requirement for cafeteria plans and component plans.

Fiduciary Responsibility

The fiduciary responsibility provisions of Part 4 of Title I of ERISA (§§ 401 to 414) apply to health and welfare plans.

A. "Fiduciary" Defined

A "fiduciary" is a person or entity to the extent that they-

1. Have discretionary control regarding the management of an ERISA plan;
2. Have any authority or control respecting the management or disposition of plan assets;
3. Render investment advice for a fee; or

4. Have discretionary authority or discretionary responsibility in the administration of the plan.

B. Fiduciary Duties

Fiduciary duties include-

1. To act solely in the best interest of plan participants and beneficiaries (the duty of undivided loyalty);
2. To use plan assets for the exclusive purpose of paying plan benefits or reasonable expenses of plan administration (the exclusive benefit rule);
3. To act with the care, skill, prudence and diligence that a prudent person in similar circumstances would use (the prudence rule);
4. To diversify the plan's investments (if any) to minimize the risk of large losses (the duty to diversify investments); and
5. To act in accordance with the documents governing the plan.
6. To not engage in specified prohibited transactions.

C. Consequences of Fiduciary Breaches

1. Personal Liability of Fiduciaries;
2. DOL Penalties (20% of DOL settlement agreement);
3. Removal of Breaching Fiduciaries;
4. Criminal Penalties. Criminal penalties may be imposed on any individual or company that willfully violates any requirement of Title I of ERISA. Penalty per conviction could be \$100,000 and/or imprisonment for up to ten years. The fine can be increased up to \$500,000 if it is against a company.

D. Fidelity Bond Requirement

ERISA requires every fiduciary of an employee benefit plan and every person who handles plan funds or other property be bonded under a fidelity bond. The bond is intended to protect the plan from losses due to fraud or dishonesty on the part of the fiduciary or other person handling funds

1. Bond must be in place at the beginning of the plan year in an amount equal to at least 10% of the funds handled during the prior reporting year, subject to a minimum of \$1,000 and a maximum of \$500,000.
2. A plan that does not have funds or property does not need a bond.
3. In most cases, a plan with plan assets will need a bond.

4. Participant contributions are plan assets once they can be segregated, but not plan funds or property until actually segregated from employer's general assets.
5. Plans accepting participant contributions under a cafeteria plan and insured plans accepting contributions will not need a bond unless the contributions are actually segregated from general assets before being used to pay plan benefits.
6. Can add welfare plans to 401(k) plan bond.

Summary Plan Description ("SPD")

A. When SPD Must Be Furnished

The SPD must be furnished to participants and beneficiaries–

1. Within 90 days after the participant or beneficiary becomes covered under the plan;
2. Within 120 days after plan first becomes covered under ERISA; and
3. An updated SPD every 5 years, or if no changes to the plan, every 10 years.
4. There is no small plan exception to the SPD requirement.

B. Content Requirements

1. The SPD must contain the following minimum content:
 - a. Plan name;
 - b. Plan number;
 - c. Name, address and phone number of plan administrator and employer;
 - d. Plan sponsors employer identification number ("EIN");
 - e. Agent for service of legal process;
 - f. Plan year;
 - g. Description of plan eligibility provisions;
 - h. Description of plan benefits;
 - i. Statement clearly identifying circumstances that may result in loss or denial of benefits;
 - j. Plan amendment and termination provisions;

- k. Subrogation provisions (if any);
 - l. Information regarding plan contributions and funding;
 - m. Claims procedures; and
 - n. ERISA rights statement.
2. Special Content Requirements for Group Health Plans
- Group health plans have additional content requirements–
- a. Detailed description of group health plan benefit provisions, including:
 - i. Cost-sharing provisions such as–
 - (A) Premiums
 - (B) Deductibles
 - (C) Co-insurance
 - (D) Co-payments
 - ii. Annual or lifetime caps or other plan limits;
 - iii. Provisions governing the use of network providers and the composition of provider networks;
 - iv. Any conditions or limits applicable to obtaining emergency medical care; and
 - v. Any provisions requiring pre-authorization or utilization review.
 - b. Description of the role of health insurers (insurer or administrative service provider);
 - c. Information regarding COBRA continuation coverage;
 - d. Disclosures regarding certain federal mandates, such as–
 - i. HIPAA pre-existing condition and special enrollment rules;
 - ii. Rights to minimum hospital stays after childbirth; and
 - iii. Qualified medical child support order procedures.

C. Wrap SPD for Insured Plans

- 1. Insurer’s “employee booklets” or “certificates of insurance” usually describe the benefits thoroughly, but do not have all of the information necessary, such as–
 - a. Required references to ERISA;
 - b. The number of plans the employer maintains;

- c. The plan number(s) for Form 5500 purposes;
 - d. The plan year (may be different from the insurance policy year);
 - e. The identity of the plan administrator and named fiduciary;
 - f. The plan's agent for service of process in a lawsuit;
 - g. The ERISA statement of rights;
 - h. COBRA, HIPAA and other health-mandate information for group health plans;
 - i. The fact that an employer has multiple locations;
 - j. The fact that an employer is part of a controlled group.
2. *Paulson v. Paul Revere Life Ins. Co.*, 2004 U.S. Dist. LEXIS 12157 (S.D. Iowa 2004). The court held that certificate issued by the insurer lacked many of the required provisions of an SPD and was therefore not an SPD.

D. Consequences of Inadequate or No SPD

1. The consequences of non-compliance regarding the SPD are the same as those discussed regarding the plan document requirement above.
2. Liability for unintended benefits can occur when participants and beneficiaries sue to enforce rights:
 - a. Inadequate SPD can result in liability for benefits not intended by employer where it conflicts with the underlying plan document but court enforces the SPD rather than the underlying plan document; and
 - b. Lack of SPD can result in court enforcing informal benefit summaries, enrollment materials, correspondence and even oral communications ("extrinsic evidence"), which can also result in unanticipated benefit liabilities.

Summary of Material Modifications ("SMM")

Any material modification or modification of information required to be in the SPD must be reported to plan participants and beneficiaries. ERISA permits plan administrators to report these changes in SMMs, which are limited to describing the modification.

- A. Provided within 210 days after the end of the plan year in which the change was made;
- B. Material reduction in covered benefits under a group health plan must be furnished no later than 60 days after the date of the adoption of the reduction.

Other Disclosure Requirements

- A. Upon written request of the participant or beneficiary, the plan administrator must furnish a copy of the latest SPD and SMMs, the latest Form 5500, any terminal report, any bargaining agreement, any trust agreement, any contract, and any other “instrument under which the plan is established or operated.”
 - 1. These documents must be provided within 30 days of the request.
 - 2. Penalties of \$110 per day may be assessed for each day after the deadline that the plan administrator does not respond. The requesting participant or beneficiary can sue to recover these penalties;
 - 3. The plan administrator may charge a reasonable amount to cover the actual cost of furnishing requested documents, not to exceed 25 cents per page.
- B. A plan administrator must make these same documents available for inspection by participants and beneficiaries at the principal office of the plan administrator.
 - 1. Documents must be “current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries.”
 - 2. Documents must be available at all times at the principal office of the plan administrator.
 - 3. Within 10 calendar days after notice by a participant or beneficiary, the documents must also be made available at:
 - a. The principal office of the employer (if different than the plan administrator);
 - b. Each employer establishment where at least 50 participants covered by the plan in question customarily work.
 - 4. The plan may impose reasonable procedures for participants and beneficiaries wishing to examine documents.

Annual Report Filing (Form 5500 Series)

Health and welfare plans must file an annual report with the DOL for each plan year.

A. Filing Due Date

1. Filing generally due by the last day of the seventh month after the close of the plan year (for calendar year plans this would be July 31st);
2. Date mailed is the date filed;
3. By filing a Form 5558 (Application for Extension of Time to File Certain Employee Plan Returns) with the Internal Revenue Service (the "IRS") before the due date for the Form 5500, an automatic 2 ½-month extension is granted (for calendar year plans this would be November 15th)(must file a copy of the Form 5558 with the Form 5500 when filing under an extension).

B. Small Plan Exception

Small unfunded or insured plans are completely exempt from the annual report filing requirement.

1. Small Plan:
 - a. Fewer than 100 participants at the beginning of the plan year;
 - b. Participants means actually covered under the plan;
 - c. COBRA qualified beneficiaries included;
 - d. Retirees covered under a retiree plan included;
 - e. Covered spouses and dependents not included; and
 - f. Individuals eligible but not enrolled are not included.
2. Unfunded Plan: Benefits are paid from the employer's general assets.
3. Insured Plan: Benefits are paid through policies of insurance other than stop-loss insurance.
4. Combination: A plan can be a combination of 2. and 3.
5. Participant Contributions.

Plans that accept participant contributions are generally treated as having plan assets. There is a special rule for participant contributions under a cafeteria plan. If this is the sole reason plan is considered funded, it will be considered unfunded for Form 5500 purposes if it meets requirements of Technical Release 92-01.

C. Limited Filing For Large Unfunded or Insured Plans

Large unfunded or insured plans are exempt from providing some of the information on the Form 5500 (Schedule H, Financial Information and audited accountant's opinion)

D. Non-ERISA Fringe Benefits

Non-ERISA fringe benefits are no longer subject to Form 5500 reporting. Certain fringe benefit plans (including cafeteria plans) which are not subject to ERISA, were required to file annual information returns under Code § 6039D (Form 5500 with Schedule F).

E. Consequences of Failure to File Form 5500

1. The DOL can impose fines of up to \$1,100 for every day a Form 5500 is missing or incomplete (cumulative).
 - The DOL has the Delinquent Filer Voluntary Compliance Program (DFVCP) under which reduced penalties are paid.
2. Can be a breach of fiduciary duty.
3. Criminal penalties may be assessed as discussed above.

Summary Annual Report ("SAR")

The SAR summarizes key information from the Form 5500.

- A. The plan administrator must issue an SAR to participants covered under the plan and others who receive an SPD.
- B. Must be furnished within nine (9) months after the close of the plan year (e.g. for plans with calendar plan years, no later than September 30th). If Form 5500 is filed under an extension, the SAR must be furnished within two (2) months of the end of the extension period (for calendar year plans this would be the following January 15th).
- C. Plans exempt from filing a Form 5500 are also exempt from issuing an SAR.

Claims Procedures

A. Initial Benefit Claims

1. *Timeframes for Deciding Initial Benefit Claims*

Type of Claim	Initial Benefit Determination	Extensions
Urgent care claims	ASAP = 72 hours	None
Pre-service claims	Reasonable period = 15 days	15-days with notice
Post-service claims	Reasonable period = 30 days	15 days with notice
Concurrent care claims	When plan reverses pre-approval, in time to permit appeal before treatment ends or is reduced or When request for extension involves urgent care, ASAP < 24 hours (if request is made within 24 hours of end of treatment series)	
Disability claims	Reasonable period = 45 days	Two 30-day extensions with notice
All other claims	Reasonable period = 90 days	90 days with notice

2. *Additional Notices for Group Health Urgent Care and Pre-Service Claims*

Notice must be given when an urgent care or pre-service claim is filed incorrectly under the plan’s procedures, or if an urgent care claim is incomplete.

Type of Claim	Notice
Urgent care claims, incorrect or incomplete	ASAP = 24 hours
Pre-Service claims, incorrect	ASAP = 5 days

3. *Written Notice of Adverse Benefit Determinations*

Written notice of adverse benefit determinations (and also non-adverse benefit determinations for pre-service and urgent care decisions) must be given to the claimant. The written notice must be understandable and address:

- a. The specific reasons for the denial and the plan provisions relied on;
- b. A description of any additional information required from the claimant;
- c. A description of the appeals process;

- d. For group health and disability claims, a statement that a copy of “internal rules or guidelines” relied on in denying the claim may be obtained on request and without cost; and
- e. For group health and disability claims, a statement that a written explanation of any “scientific or clinical judgment” relied on in denying the claim may be obtained on request and without cost.

B. Appeals

1. Timeframes for Claimant to File Appeal

Type of Claim	Claimant must be given
Group Health and Disability	At least 180 days
Other Claims	At least 60 days

A claimant who fails to appeal within this time period generally loses his or her right to pursue the claim any further with the plan or in court. However, if adequate notice of the benefit determination was not given, the time frame for filing appeal does not start and a denied claim can remain open for an indefinite period of time.

2. Full and Fair Review

Every appeal must receive a “full and fair review” by the named fiduciary of the plan.

3. Comments and Documents

Claimant must be permitted to submit written comments and must be given access to relevant documents or other information (including material considered in connection with the initial claim, even if not actually relied on in making the denial).

4. Medical Judgment

When an appeal involves medical judgment, the named fiduciary must consult with a medical or vocational expert with relevant experience and must disclose the identity of the expert.

5. Time Frames for Deciding Appeals

Type of Claim	Initial Benefit Determination	Extensions
Urgent care claims	ASAP = 72 hours	None
Pre-service claims	Reasonable period = 30 days	None
Post-service claims	Reasonable period = 60 days	None

Concurrent care claims	When plan reverses pre-approval, before treatment ends or is reduced	
Disability claims	Reasonable period = 45 days	45 days with notice
All other claims	Reasonable period = 60 days	60 days with notice

6. *Written Notice of Adverse Benefit Determination On Review*

Written notice of adverse benefit determination on review (and also non-adverse benefit determinations on review for pre-service and urgent care decisions) must be given to the claimant. The written notice must be understandable and address-

- a. The specific reasons for the denial and the plan provisions relied on;
- b. A description of any additional information required from the claimant;
- c. A description of the claimant’s right to obtain relevant documents and other information;
- d. A description of any additional required or voluntary appeals and a statement of the claimant’s right to sue;
- e. For group health and disability claims, a statement that a copy of “internal rules or guidelines” relied on in denying the claim may be obtained on request and without cost; and
- f. For group health and disability claims, a statement that a written explanation of any “scientific or clinical judgment” relied on in denying the claim may be obtained on request and without cost.

7. *Inadequate Notice of Benefit Determination On Review*

An inadequate notice of benefit determination on review does not start the time for filing suit running, which allows a denied claim to remain open for an indefinite time.

Funded v. Unfunded

A. Funded, Unfunded or Insured

1. Funded: Benefits paid from plan assets.
2. Unfunded: Benefits paid solely from the general assets of the employer.
3. Insured Plan: Benefits paid through purchase of insurance. Not an unfunded plan.

B. Funded Plan Requirements

1. Some plans are subject to ERISA if funded;
2. Subject to trust requirement under ERISA § 403;
3. Form 5500 requirements (small funded plans must file);
4. Must have a funding policy and method;
5. ERISA bonding requirement on some funded plans;
6. Plan assets, including participant contributions, may be used only to pay plan benefits and reasonable administrative costs (exclusive benefit rule and fiduciary requirements).

C. Plan Assets

1. Participant Contributions

- a. Participant contributions are always plan assets.
- b. Participant contributions become plan assets on the earliest date they can reasonably be segregated from the employer's general assets.
- c. Participant contributions are plan assets even if not actually segregated from employer's general assets.

2. Employer Contributions

Employer contributions can become plan assets even if that is not the employer's intent.

- a. Separate account in Employer's name does not create plan assets or funded plan;
- b. Separate account in plan's name creates plan assets and funded plan;

- c. Separate account in third-party's name may create plan assets and funded plan (but a separate account in the employer's name where the third-party had check-writing ability would not necessarily create plan assets; and
 - d. Mere appearance that assets are held for plan may create plan assets.
3. *Trust Requirement*

Generally, where there are plan assets, ERISA requires that the plan assets be held in a separate trust by one or more trustees. ERISA § 403(a).

- a. DOL Non-Enforcement Policy.
 - i. DOL Technical Release 92-01 provides that the DOL will not enforce the trust requirement against an employee welfare benefit plan solely because it accepts participant contributions under a cafeteria plan. This policy also extends to after-tax COBRA and retiree contributions.
 - ii. This policy does not provide protection against lawsuits by parties other than the DOL.
 - iii. Exclusive benefit rule and other fiduciary duties still apply.
 - iv. Insured Plans.
 - (A) Non-Enforcement Policy also applies to insured plans where participant contributions are applied to payment of premiums per certain DOL regulations.
 - (B) Insured plan participant premiums must be paid directly to insurer.
 - (C) Certain insurance refunds must be returned to participants.
 - (D) Assets held by insurance company are exempt from trust requirement.

4. *Consequences of Violation of Trust or Exclusive Benefit Rule*

- a. Lawsuits by participants and beneficiaries;
- b. DOL enforcement actions; and
- c. Criminal penalties may be imposed as discussed above.

5. *Violation of Prohibited Transaction Rules*

- a. Liability for losses to plan, if any;
- b. IRS excise taxes (15% of the amount involved for each year);

- c. DOL civil penalties against parties-in-interest (parallel to IRS excise taxes);
- d. DOL fiduciary penalties (20% of DOL settlement agreement); and
- e. Potential for second tier IRS excise tax of 100% of the amount involved if prohibited transaction is not corrected.

Group Health Plans

Group health plans are a subset of welfare plans. Group health plans are subject to the same requirements as other welfare plans, with several additional requirements. This outline does not address state laws that regulate insured group health plans and HMOs such as California's Knox-Keene Health Care Service Plan Act of 1975 or state confidentiality laws.

A. Welfare Plans That Are Group Health Plans

Plans which provide medical care are group health plans.

1. *Plans which are group health plans*
 - a. Medical;
 - b. Dental;
 - c. Vision;
 - d. Health flexible spending accounts;
 - e. Prescription drug plans; and
 - f. Drug or alcohol treatment programs.
2. *Plans which may be group health plans*
 - a. Employee assistance plans;
 - b. Wellness programs;
 - c. Executive medical reimbursement;
 - d. Cancer policies; and
 - e. Long-term care plans.
3. *Plans which are not group health plans*

Plans that do not provide medical care are not group health plans. The following plans usually do not provide medical care:

- a. Accidental death & dismemberment plans;
- b. Group term life insurance plans;
- c. Long-term and short-term disability plans;

- d. Exercise/fitness programs; and
- e. On-site first aid.

B. Consolidated Omnibus Budget Reconciliation Act of 1986 (“COBRA”)

COBRA provides continued coverage under a group health plan for qualified beneficiaries who experience a loss of coverage due to a specified qualifying event.

1. *Notice Requirements*

a. The General (Initial) Notice

- i. COBRA provides minimum timing and content requirements for the general notice (also called the “initial notice”).

(A) The general notice must be provided within 90 days from the date on which the employee or spouse first becomes covered under the plan. However, if a qualifying event occurs in the first 90 days of coverage, and prior to the provision of the general notice, only the election notice need be provided.

(B) The general notice may be provided in a SPD. Note that the SPD must be mailed and addressed to both the covered employee and the covered spouse to be valid notice to all qualified beneficiaries.

(C) The general notice may be delivered electronically if standards for electronic delivery are met.

(D) There are minimum content requirements for the general notice which may be met by providing a customized version of the model general notice provided with the COBRA regulations. Note that provision of the model notice previously published in ERISA Technical Release 86-2 (June 26, 1986) will not longer be considered to be good faith compliance with the requirements of the regulations.

(E) The model general notice can be found on the website of the DOL’s Employee Benefits Security Administration (the “EBSA,” formerly known as the Pension & Welfare Benefit Administration or “PWBA”) at:

http://www.dol.gov/ebsa/compliance_assistance.html#section2

b. Notice to Plan Administrator of Qualifying Event

i. By Employer

(A) The employer must notify the plan administrator within 30 days of the following qualifying events (if the plan provides for continuation coverage to begin with the date of loss of coverage, then the 30-day period in which the employer must notify the plan administrator must also begin with the date of the loss of coverage):

- (1) Termination or reduction in hours of employment;
- (2) Death of employee;
- (3) Employee entitled to Medicare; and
- (4) Employer bankruptcy.

(B) The employer must provide the plan administrator with enough information to determine the identity of the plan, the covered employee, the qualifying event and the date of the qualifying event.

ii. By Qualified Beneficiary

(A) The qualified beneficiary must notify the plan administrator within 60 days of the following qualifying events (or if later, loss of coverage):

- (1) Divorce or legal separation; or
- (2) Child's loss of dependent status.
- (3) In the case of a disability determination by the Social Security Administration ("SSA"), the later of-
 - (a) The date of SSA determination;
 - (b) The date of the qualifying event;
 - (c) The date of the loss of coverage; or
 - (d) The date the qualified beneficiary is informed of the obligation to provide notice of the disability determination.

Plans cannot decline to provide the disability extension due to failure to provide a timely disability notice unless the affected qualified beneficiaries were adequately notified, in advance, of the notice obligation.

- (B) Plans must establish reasonable procedures for qualified beneficiaries to provide these notices.
- (1) Procedures will be deemed reasonable if provided in the SPD, specify who is designated to receive notices and specify the means qualified beneficiaries must use for giving notice and the required content of the notice.
 - (2) If the plan does not have reasonable procedures, the qualified beneficiary will be deemed to have provided the notice if specified information is provided to parties customarily in charge of the plan.
 - (3) The plan may require a form to be used for notices if the form is easily available to qualified beneficiaries without cost, and may require that specific information be provided.
 - (4) An incomplete notice that is otherwise timely cannot be rejected if it contains specified minimum information (identity of plan, the qualified beneficiaries, the qualifying event or disability determination, and the date on which it occurred), however the plan administrator can require that the missing information be provided.
 - (5) Qualified beneficiary's notice period does not begin to run unless and until the plan has satisfied the general (initial) notice requirements. Note that it is through the provision of the general notice that qualified beneficiaries learn of their notice obligations, and if the plan administrator fails to provide the general notice, the qualified beneficiary cannot be expected to know what circumstances require him or her to give notice to the plan administrator, the time period during which the notice must be provided and the consequences of not providing timely notice.
- (C) If the plan provides for continuation coverage to begin with the date of loss of coverage, then the 60-day period in which the qualified beneficiary must notify the plan administrator must also begin with the date of the loss of coverage.

c. Notice to Qualified Beneficiary of Right to Elect COBRA

- i. The plan administrator must provide notice of the qualified beneficiaries right to COBRA coverage within 14 days of receiving notice of a qualifying event.
- ii. There are minimum content requirements for the election notice which may be met by providing a customized version of the model election notice provided with the COBRA regulations. The model election notice can be found on the EBSA website at:
http://www.dol.gov/ebsa/compliance_assistance.html#section2.

d. Notice of Ineligibility for COBRA

The plan administrator must also notify the qualified beneficiary if the plan administrator receives a notice of a qualifying event from a participant or beneficiary and there is a determination that he or she is not eligible for continuation coverage.

e. Notice of Termination of COBRA Coverage

The plan administrator must provide a notice to qualified beneficiaries in the event that the plan administrator terminates a period of continuation coverage before the end of its maximum duration.

2. *Cal-COBRA Extension of Period of Coverage*

The California Continuation Benefits Replacement Act, known as Cal-COBRA, is a program similar to federal COBRA. Recent legislation amended Cal-COBRA to provide for the extension of the 18-month period of coverage to 36-months. This change not only affects small employers subject to Cal-COBRA, but it also affects larger California employers subject to federal COBRA (other than employers with self-insured medical plans).

HMOs and insured medical plans of larger employers subject to federal COBRA must generally provide the following continuation coverage for qualified beneficiaries entitled to less than 36 months of coverage under federal COBRA:

- a. Coverage is extended to 36 months from the date of the original qualifying event.
- b. Applicable to qualifying events occurring after January 1, 2003.

- c. Federal COBRA must be exhausted before the qualified beneficiary is eligible for this extension.
- d. Applicable to medical plans only (not dental or vision).
- e. Premium for the extended period of coverage is 110% of the applicable premium (150% for disability extension).

C. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

1. *Special Enrollment Rights*

Group health plans and group health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll (without having to wait until the next open enrollment period). A special enrollment period can occur if a person with other health coverage loses eligibility for that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption.

2. *Portability*

Under HIPAA there are limitations on the exclusions for pre-existing conditions. Also requires group health plans and health insurance issuers to provide a certificate of creditable coverage to an individual to provide documentation of the individual’s prior creditable coverage.

3. *Administrative Simplification*

The Administrative Simplification provisions of HIPAA (Privacy, Electronic Data Interchange (EDI), Security) are intended to facilitate electronic interchange of information among covered entities while protecting the health information of individuals.

4. *Nondiscrimination*

Under HIPAA nondiscrimination provisions, individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of a group health plan based on any health factors. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factors.

D. The Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”)

- 1. Group health plans, insurance companies and HMOs may not restrict benefits for a hospital stay in connection with childbirth to less than 48

- hours following a vaginal delivery or 96 hours following a delivery by cesarean section.
2. The attending physician may decide, after consulting with the mother, to discharge the mother and her newborn child earlier.
 3. In any case, the attending physician cannot receive incentives or disincentives to discharge the mother and her child earlier than 48 hours (or 96 hours); and
 4. Requires disclosure in the SPD.
- E. Women's Health and Cancer Rights Act of 1998 ("WHCRA")
1. Under WHCRA, group health plans, insurance companies and HMOs offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy in a manner determined in consultation with the attending physician and the patient.
 2. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to produce symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedemas.
 3. Notice required upon enrollment in the plan and annually.
- F. Mental Health Parity Act of 1996 ("MHPA")
- The MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits.

Other Federal Laws that Affect Welfare Plans

- A. Americans with Disabilities Act of 1990 (“ADA”)
- B. Family and Medical Leave Act of 1993 (“FMLA”)
- C. Age Discrimination in Employment Act (“ADEA”)
- D. Pregnancy Discrimination Act (“PDA”)
- E. Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”)
- F. Medicare Secondary Payer (“MSP”) Rules
- G. National Labor Relations Act (“NLRA”)
- H. Fair Labor Standards Act (“FLSA”)
- I. Rehabilitation Act of 1973 (“Rehab. Act”)
- J. Title VII of the Civil Rights Act of 1964 (as amended) (“Title VII”)
- K. HMO Act

Self-Insured Plans

ERISA generally pre-empts state laws regulating insurance for self-insured plans (plans that provide benefits to participants directly out of the employer’s general assets and not through the purchase of insurance). State laws that regulate insurance will not apply to such plans.

Nondiscrimination Rules

The Code imposes discrimination testing requirements to prevent discrimination in favor of highly compensated employees as a condition of favorable tax treatment for certain plans or benefits:

- A. Dependent care assistance plans (Code § 129);
- B. Group term life insurance plans (Code § 79);
- C. Self-insured medical reimbursement plans (Code § 105(h));
- D. Benefits provided through a VEBA (Code §§ 501(c)(9) and 505(b)); and
- E. Cafeteria plans (Code § 125)

Domestic Partner Coverage

- A. The California Insurance Equality Act (AB 2208):
 - 1. Requires HMOs and insurers to provide equal coverage for registered domestic partners to the same extent, and subject to the same terms and conditions as, spousal coverage under the plan, if any.
 - 2. This includes health coverage as well as all insured benefits regulated by the California Department of Insurance such as life and disability insurance.
 - 3. The HMO or insurer may require a copy of the Declaration of Domestic Partnership filed with the Secretary of State or equivalent and notification of termination of the domestic partnership, but only if similar verification of marital status and dissolution of marriage is required for spousal coverage.
 - 4. Effects all policies issued, amended, delivered or renewed on or after:
 - a. Health plans: January 2, 2005;
 - b. All other insurance policies effective January 1, 2005.
 - 5. This law does not require employers to provide coverage for spouses or registered domestic partners. However, if the employer provides coverage for spouses, the employer will only be able to buy a plan that provides equal coverage for registered domestic partners.

B. Federal Taxation Issues:

1. Employee contributions for premiums paid for domestic partner coverage must be paid on an after-tax basis;
2. Imputed income is attributed to the employee in an amount equal to the difference between the employee contribution and the fair market value of the group health plan coverage for the domestic partner; and
4. Effective January 1, 2002, for California state income tax purposes, the registered domestic partner is considered a spouse and the domestic partner health coverage receives the same tax treatment as spouse coverage (that is, employee contributions are paid on a before-state-income-tax basis and the “excess” value of the domestic partner coverage is not included in the income of the employee for state income tax purposes).

C. There are no Federal COBRA rights for domestic partners.

Further Information and Assistance

A. Department of Labor, Employee Benefits Security Administration (“EBSA”)

EBSA Los Angeles Regional Office:

1055 East Colorado Blvd., Suite 200

Pasadena, CA 91106-2341

Billy Beaver-Director

Phone (626) 229-1000

Fax (626) 229-1098

EBSA Website: www.dol.gov/ebsa/

B. Health and Human Services, Centers for Medicare and Medicaid Services (CMS)

CMS E-Mail box: Send your HIPAA Administrative Simplification questions to askhipaa@cms.hhs.gov.

CMS HIPAA Hotline: (866) 282-0659 - This toll-free hotline has been established to help answer your HIPAA administrative simplification questions. Also available toll free HIPAA TTY (877) 326-1166.

CMS Website: www.cms.hhs.gov

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