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LFG BENEFITS

Sample Documents

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COMPLIANCE BULLETIN

DOL Continues Vigorous Enforcement of Mental Health Parity Law

The Employee Benefits Security Administration (EBSA) released its annual enforcement report on the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA is an agency within the U.S. Department of Labor (DOL). According to EBSA, vigorous enforcement of MHPAEA is one of its **top enforcement priorities**.

MHPAEA is a federal law that prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than medical and surgical benefits.

Since October 2010, EBSA has conducted approximately 2,000 investigations in which MHPAEA compliance was reviewed, and cited approximately 345 violations that involve MH/SUD benefits. These MHPAEA violations included impermissible annual and lifetime dollar limits, improper financial requirements, treatment limitations such as higher copayments or lower visit limits than for medical/surgical services, and impermissible nonquantitative treatment limitations (NQTLs), including overly restrictive fail-first policies, prior authorization requirements and written treatment plan requirements.

Generally, if violations are found by an EBSA investigator, the health plan must remove any noncompliant plan provisions and pay any improperly denied benefits.

Action Steps

Employers should work with their issuers and benefits administrators to confirm that their health plan's coverage of MH/SUD benefits complies with MHPAEA, including any NQTLs.

Active Enforcement

- EBSA conducts MHPAEA compliance reviews in all its investigations where MHPAEA applies.
- When EBSA identifies MHPAEA violations, it asks the plan to make necessary changes to any noncompliant plan provision and to pay any improperly denied benefit claims.
- EBSA may also require the plan or service provider to provide notice to potentially affected participants and beneficiaries.

Parity Requirements

MHPAEA requires parity between a plan's MH/SUD benefits and medical and surgical benefits with respect to:

- Financial requirements (for example, copayments)
- Treatment limitations (for example, visit limits)
- NQTLs (for example, prior

Mental Health Parity

MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable limitations on those benefits than on medical and surgical coverage. MHPAEA's parity requirements generally apply to group health plans and health insurance issuers that provide coverage for MH/SUD benefits in addition to medical and surgical benefits.

Applicable Health Plans

MHPAEA generally applies to plans sponsored by employers with **more than 50 employees**, including self-insured plans and fully insured arrangements. MHPAEA does not require large group health plans and their health insurance issuers to cover MH/SUD benefits. MHPAEA's requirements apply only to large group health plans and their health insurance issuers that choose to include MH/SUD benefits in their benefits packages. However, other state and federal laws may require a plan to provide these benefits.

The Affordable Care Act (ACA) requires some plans to cover MH/SUD services as an essential health benefit. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements.

Nonfederal governmental plans that are self-funded may elect to opt out of MHPAEA's parity requirements. In order to opt out, the plan must file an election with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each plan year and must notify the plan participants of its choice to opt out.

Parity Requirements

MHPAEA contains the following parity requirements:

- ☐ The **financial requirements** (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- ☐ **Treatment limitations** (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements.

In addition, MHPAEA imposes parity requirements on the **nonquantitative treatment limitations (NQTLs)** that plans may place on MH/SUD benefits. NQTLs include, for example, medical management standards, formulary designs for prescription drugs, plan methods for determining usual, customary and reasonable charges, exclusions based on a failure to complete a course of treatment and restrictions based on facility type or provider specialty.

Available Resources

The Departments' final FAQs and warning signs of problematic NQTLs highlight aspects of plan design that should be carefully reviewed for MHPAEA compliance. The self-compliance tool includes a questionnaire that employers can complete to help determine whether their group health plan complies with MHPAEA.

COMPLIANCE OVERVIEW

2024 Open Enrollment Checklist

To get ready for open enrollment, employers who sponsor group health plans should be aware of the legal changes affecting the design and administration of their health plans for plan years beginning on or after Jan. 1, 2024. These changes include limits that are adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2024 plan year should be communicated to plan participants through an updated summary plan description (SPD) or a summary of material modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, when applicable, such as the summary of benefits and coverage (SBC). Some participant notices must also be provided annually or upon initial enrollment. To minimize costs and streamline administration, employers should consider including these notices in their open enrollment materials.

LINKS AND RESOURCES

- Revenue Procedure 2023-23, which includes the inflation-adjusted limits for health savings accounts (HSAs) and HDHPs for 2024
- Model notices for group health plans, including the Women's Health and Cancer Rights Act (WHCRA) notice
- Model COBRA notices for group health plans

Plan Design Issues

- Applicable large employers (ALEs) should confirm that at least one of their health plans offered to full-time employees satisfies the ACA's affordability standard.
- For HDHPs, employers should confirm that the plan's deductible and out-of-pocket maximum comply with the 2024 limits.
- Employers should communicate plan design changes to employees as part of the open enrollment process.

Notices to Include

- SBC
- Annual Children's Health Insurance Program (CHIP) notice
- Medicare Part D creditable coverage notice
- WHCRA notice
- Wellness program notice

COMPLIANCE OVERVIEW

PLAN DESIGN CHANGES

ACA Affordability Standard

Under the ACA's employer shared responsibility rules, ALEs are required to offer affordable, minimum value health coverage to their full-time employees (and dependent children) or risk paying a penalty. The employer shared responsibility requirements are also known as the "pay or play" rules.

Under the ACA, an ALE's health coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year (as adjusted each year). The adjusted percentage is 9.12% for 2023. On Aug. 23, 2023, the IRS announced that the affordability percentage will decrease to **8.39% for plan years that begin in 2024.** This is a substantial decrease in the affordability percentage and the lowest this percentage has ever been set. **As a result, many employers may have to significantly lower their employee contributions for 2024 to meet the adjusted percentage.**

- ☑ If you are an ALE, confirm that at least one of the health plans offered to full-time employees satisfies the ACA's affordability standard.

Out-of-Pocket Maximum Limits

Non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). The annual limits on total enrollee cost sharing for EHB for plan years beginning on or after Jan. 1, 2024, are **$9,450** for self-only coverage and **$18,900** for family coverage. With this in mind, employers should consider these next steps:

- ☑ Review the out-of-pocket maximum limits for your health plan to ensure they comply with the ACA's limits for the 2024 plan year.
- ☑ Keep in mind that the out-of-pocket maximum limits for HDHPs compatible with HSAs must be lower than the ACA's limits. For the 2024 plan year, the out-of-pocket maximum limits for HDHPs are **$8,050** for self-only coverage and **$16,100** for family coverage.

Preventive Care Benefits

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (e.g., deductibles, copayments or coinsurance) when the services are provided by in-network health care providers. The recommended preventive care services covered by these requirements include the following:

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings included in the Health Resources and Services Administration (HRSA) guidelines for infants, children and adolescents; and
- Evidence-informed preventive care and screenings included in HRSA-supported guidelines for women.

COMPLIANCE OVERVIEW

ERISA Compliance FAQs: Enforcement

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for employee benefit plans maintained by private-sector employers. ERISA includes requirements for both retirement plans (for example, 401(k) plans) and welfare benefit plans (for example, group health plans). ERISA has been amended many times over the years, expanding the protections available to welfare benefit plan participants and beneficiaries.

The Department of Labor (DOL), through its Employee Benefits Security Administration (EBSA), enforces most of ERISA's provisions. Violating ERISA can have serious and costly consequences for employers that sponsor welfare benefit plans, either through DOL enforcement actions and penalty assessments or through participant lawsuits.

This Compliance Overview includes a set of frequently asked questions (FAQs) to help employers understand how ERISA's requirements for welfare benefit plans are enforced.

LINKS AND RESOURCES

Department of Labor resources:

- Webpage on ERISA enforcement
- 2022 Fiscal Year Audit Summary (and Dec. 12, 2022 news release)
- Webpage on Correction Programs (Voluntary Fiduciary Correction Program and Delinquent Filer Voluntary Compliance Program)

Health Plan Investigations

- The DOL audits employee benefit plans for compliance with ERISA, the Affordable Care Act (ACA) and other federal laws.
- Participants may also sue their welfare benefit plans for violations.
- Noncompliance may result in civil penalties or criminal charges.

Common Violations

- Failures to file complete/correct Form 5500
- Failures to respond to participant requests for information
- Breaches of fiduciary duties

Provided to you by [B_Officialname]

How Does the DOL Enforce ERISA?

The DOL has broad authority to investigate or audit an employee benefit plan's compliance with ERISA. The DOL's EBSA division handles audits of employee benefit plans. To perform these audits, EBSA employs investigators working out of field offices, many of whom are lawyers or CPAs or who have advanced degrees in business or finance.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants. The DOL also uses its investigative authority to enforce compliance with the Affordable Care Act (ACA).

> ***Enforcement Statistics***: During the 2022 fiscal year, EBSA closed 907 civil investigations. Of these, 66% resulted in monetary results for employee benefit plans or other corrective action.
>
> In addition, EBSA referred 55 cases for civil litigation and closed 164 criminal investigations. EBSA's criminal investigations led to the indictment of 103 individuals—including plan officials, corporate officers and service providers—for offenses related to employee benefit plans.

What Are the Possible Consequences of a DOL Investigation?

Being selected for a DOL audit can have serious consequences for an employer. According to a DOL audit report for the 2022 fiscal year, 66% of civil investigations resulted in penalties or required other corrective action, such as paying amounts to restore losses, disgorging profits and ensuring claims were properly processed and paid. In addition, a DOL audit may negatively affect an employer's normal business operations because the audit process can be both stressful and time-consuming.

The DOL has the authority to assess civil penalties for many different types of ERISA violations. Common penalty assessments involve the following:

Form 5500 violations (for example, not filing a Form 5500 when required or filing an incomplete Form 5500)	The DOL has the authority under ERISA to assess penalties of up to $2,586 per day for each day an administrator fails or refuses to file a complete Form 5500. This maximum penalty amount is adjusted each year for inflation. The penalties may be waived if the noncompliance was due to reasonable cause.
Failing to respond to participants' requests for plan information	If a plan administrator fails to respond to a participant's request for plan documents (for example, the latest summary plan description) within 30 days, the plan administrator may be charged up to $110 per day from the date of the failure or refusal to provide the information.
Breaches of fiduciary duty	For fiduciary duty breaches, the DOL will assess a civil penalty against the fiduciary in an amount equal to 20 percent of the applicable recovery amount. If a fiduciary breach has been found, the penalty is mandatory. In general, the penalty is assessed after payment of the applicable recovery amount pursuant to a settlement agreement with the DOL.

Courtesy of LFG Benefits

Q **What notices must employers provide to employees regarding the FMLA?**

A Employers must provide employees with the following notices regarding the FMLA:

- General Notice
- Eligibility Notice
- Rights and Responsibilities Notice
- Designation Notice

Each notice is explained briefly in the following paragraphs.

General Notice

Employers covered by the FMLA must prominently post a general FMLA notice where it can be readily seen by employees and applicants. The general notice explains an employee's rights and responsibilities under the FMLA. The Department of Labor (DOL) provides a model general notice for employers to use.

Covered employers must post this general notice even if no employees are eligible for FMLA leave. Covered employers that have eligible employees must also provide this notice to each employee by including it in any written guidance given to employees or by distributing a copy to each new employee upon hire.

Eligibility Notice

When an employee requests FMLA leave, or when the employer learns that an employee's leave may be for an FMLA-qualifyied reason, the employer must notify the employee of his or her eligibility to take FMLA leave within **five business days**, absent extenuating circumstances. The DOL provides a sample eligibility notice for employers to use.

Rights and Responsibilities Notice

Each time the eligibility notice is provided, the employer must also provide a written notice detailing the employee's specific expectations and and explaining any consequences of failing to meet these obligations. The DOL provides a sample rights and responsibilities notice for employers to use. This notice is often combined with the eligibility notice.

If the information provided by the rights and responsibilities notice changes, the employer must notify the employee of the change.

DOL AUDIT GUIDE:
Employee Benefit Plans

Presented by **LFG Benefits**

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This guide is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. This guide may not address all compliance issues with federal, state and local laws or identify all possible requests that may be made in connection with an audit. Compliance with all applicable legal requirements is the responsibility of the health plan sponsor. Using the materials in this guide does not guarantee that a plan sponsor will be able to avoid an audit or is in compliance with all applicable requirements. Use this guide as reference, but contact legal counsel to discuss compliance requirements.

INTRODUCTION

The Department of Labor (DOL) has broad authority to investigate or audit an employee benefit plan's compliance with the Employee Retirement Income Security Act (ERISA). Audits are performed by the DOL's Employee Benefits Security Administration (EBSA). To perform these audits, EBSA employs over 400 investigators working out of field offices, many of whom are lawyers or CPAs or have advanced degrees in business and finance.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants, such as the special enrollment rules or mental health parity requirements. The DOL also uses its investigative authority to enforce compliance with the health care reform law, or the Affordable Care Act (ACA).

Traditionally, DOL audits of employee benefit plans have focused primarily on retirement plans, such as 401(k) plans. However, now that the DOL is enforcing compliance with the ACA, health plan audits are on the rise.

Being selected for a DOL audit can have **serious consequences** for an employer. According to a DOL audit report for the 2016 fiscal year, almost 7 out of every 10 investigations resulted in penalties or required other corrective action, such as paying amounts to restore losses, disgorging profits and ensuring claims were properly processed and paid. In addition, a DOL audit may negatively affect an employer's normal business operations because the audit process can be both stressful and time-consuming. The best time for an employer to analyze whether it is ready for a DOL audit is **before** the DOL comes knocking.

This Guide is your manual for preparing for a DOL audit of your HEALTH PLAN. This Guide is designed to provide you with an overview of why certain health plans are selected for audit and what you can do to prepare for an audit and reduce your risk of being audited. It also describes what is typically required of an employer during a health plan audit. It includes:

- Suggestions on how to prepare for a DOL audit;
- Tips for responding to a DOL audit letter;
- A list of documents that DOL investigators commonly request during an audit; and
- A list of available resources and sample documents to help you prepare for an audit.

if necessary, ask for an extension to the response deadline

- ☐ Make copies of all the requested documents for the DOL and review them for accuracy