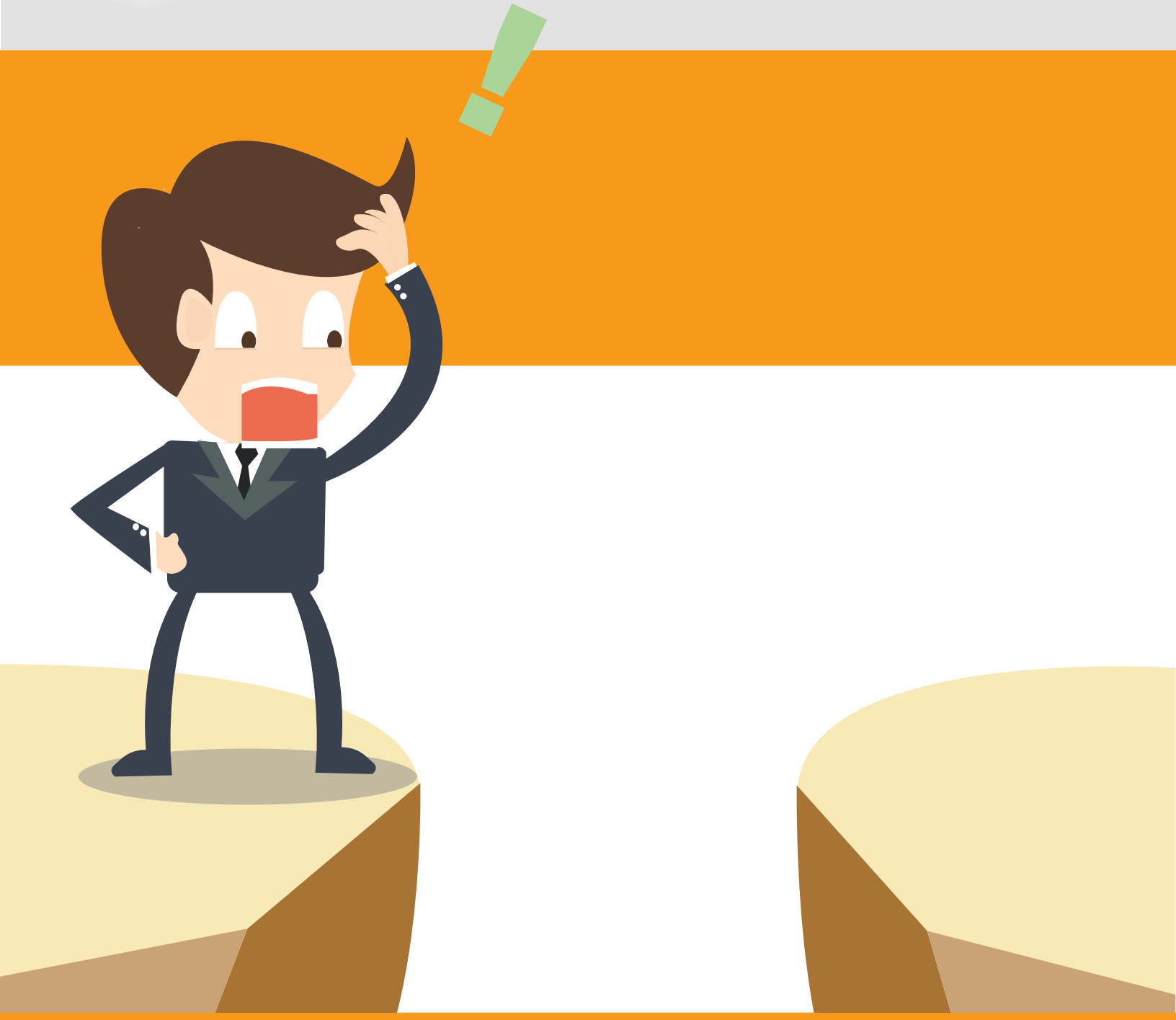
25 YEARS filice
hr compliance



Solution Tool

ERISA Gap Assessment

Introduction

The Employee Retirement Income Security Act of 1974 (ERISA) is federal law that sets minimum standards for employer-sponsored group health plans. ERISA and related federal regulations such as COBRA, HIPAA, and ACA set strict requirements for employers, as well as fiduciary standards of conduct.

While the law is complex, employers can take steps to prevent the costly consequences of noncompliance. An ERISA gap assessment can provide an employer the opportunity to identify areas of compliance weakness and address vulnerabilities. Ideally, an assessment should be performed every 2-4 years and can be approached in five different steps.

Step 1: Review Plan Documents

Plan Document

ERISA requires all group health plans to have a written plan document. The plan document contains a description of the terms and conditions for the operation and administration of the plan. **There is no distribution requirement, but it must be provided to a participant within 30 days of a request.***

Summary Plan Description

The Summary Plan Description (SPD) contains essential plan information including the benefits, rights and obligations of the covered participant. It must be written in a style and format that can be easily understood by the average plan participant. **The SPD must be provided to participants within 90 days of becoming covered under the plan, and within 30 days of a request.***

*Health plan sponsors may elect to utilize a single Wrap Document to meet both of these requirements.

Summary of Material Modification

The Summary of Material Modification (SMM) describes material changes made to a plan that necessitate a change in the information contained in the SPD. **The SMM must be distributed to participants no later than 210 days after the end of the plan year in which the changes were made, or within 60 days if the change is material.** The distribution of an updated SPD satisfies the requirement to distribute an SMM.

Summary Annual Report

This report is a narrative summary of the Form 5500 and includes a statement of the participant's right to receive the annual report. Plans that are exempt from annual 5500 filing are generally exempt from the Summary Annual Report (SAR) requirement. The SAR must be provided to participants no later than **210 days after the plan year-end, or two months following the Form 5500 due date.**

Summary of Benefits and Coverage

The Summary of Benefits and Coverage (SBC), required under the ACA, must be provided to participants upon application for coverage and upon renewal. **60 days advance notice must be provided to participants** when a material change to the SBC is made mid-year.

Step 2: Verify Annual Disclosure & Filings

W-2 Reporting

Form W-2 reporting under the ACA applies to employers that filed 250 or more Forms W-2 in the prior year. These employers must disclose the aggregate cost of employer-sponsored medical coverage provided to the employee.

Sections 6055 & 6056 Reporting

The ACA's Code Sections 6055 and 6056 reporting applies to "applicable large employers" (generally those with 50 or more full-time employees) and to small employers that sponsor a self-funded medical plan. Reporting is required for 2015, with Forms 1094 and 1095 due beginning in January through March 2016.

CMS Disclosure

Within 60 days after the start of the plan year, and thereafter upon any change that affects the plan's creditable prescription drug coverage status, employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the plan's prescription drug coverage is creditable.

Form 5500 Report

The Form 5500 requirement applies to plan administrators of ERISA plans, unless an exception applies. Health plans with fewer than 100 active participants are generally exempt from the filing requirement. Form 5500 must be filed by the last day of the seventh month following the plan year-end.

Step 3: Review Participant Notices & Communication Materials

Required Federal Notices

- Employee Notice of Exchange
- HIPAA Notice of Privacy Practices
- Notice of Special Enrollment Rights
- General COBRA Notice
- Medicare Part D Notice of Creditable or Non-Creditable Coverage
- CHIP Notice
- Women's Health and Cancer Rights Act Notice
- Newborns' and Mothers' Health Protection Act Notice

Distribution Method

Materials may be distributed electronically to employees who have regular work-related computer access as part of their daily job. For employees without regular work-related computer access, the plan sponsor must obtain written consent to utilize electronic distribution. Without consent (which can be withheld), the employee must be provided with hard copies of all required notices. This includes the SPD and SBC.

Anyone may request a hard copy of a required notice, even when he or she consented to electronic distribution.

Step 4: Examine Administrative Procedures

Benefits Communication

Examine the manner in which benefits information is communicated to new hires and active participants. Be sure that open enrollment materials, new hire packets, and onboarding systems include any required notices or disclaimers, and that employees are able to effectively access and utilize online enrollment systems. Also review materials such as benefit brochures, employee handbooks, and benefit websites or intranet sites. **Ensure information is accurate, clearly conveyed, and doesn't conflict or contradict other materials.** Verify that mid-year changes to the plan are reflected in updates to all materials and that these updated materials are timely provided to all participants – including COBRA participants.

Enrollment

Various aspects of enrollment procedures should be evaluated. Eligibility determinations are particularly important, especially for employers with variable-hour employees. **Ensure eligibility definitions are in place and are administered consistently. Also examine the annual open enrollment process and any changes participants make mid-year.** Mid-year election changes are allowed only under specific circumstances (qualifying events). Outside of these circumstances, employers should not allow employees to enroll, make changes, or cancel participation outside of open enrollment.

Employee Contributions

Employee contributions to the plan constitute plan assets and must not be commingled with the general assets of the business. **Where employee contributions are required to pay for some of the premium cost, the employer must promptly remit contributions to the appropriate insurance carrier(s).** A self-funded plan that requires employee contributions must retain contributions in a separate fund or account. Also verify that MLR rebates (if any) are properly applied to the plan or distributed to participants within 90 days of receipt.

Terminations

Ensure coverage terminations are promptly reported to relevant parties, including insurance carriers and COBRA administrators. Coverage should terminate at a time specified in the plan documents and insurance policies (typically, medical coverage terminates the last day of the month). Also be sure that proper notice is provided, including the COBRA Election Notice, if applicable.

HIPAA Privacy and Security

The plan must adhere to HIPAA Privacy and Security guidelines in all aspects of plan administration. **Protected Health Information (PHI) must be safeguarded and procedures must be in place in order to prevent the unauthorized disclosure of PHI.** Also verify that a Business Associate Agreement is in place where required.

Step 5: Check In with Third-Party Administrators & Vendors

Insurance Carriers

- Reconcile billing to ensure accurate enrollment and that appropriate amounts are being paid
- Review claims administration procedures and follow up on any participant complaints
- Read through the policy and confirm that the plan documents don't contradict the policy terms

COBRA Administrators

- Confirm the General Notice and Election Notice are provided to appropriate participants within the required timeframe
- Verify election changes are promptly communicated to carriers
- Evaluate the reasonableness of the fees charged

Flex Plan & HRA Administrators

- Review the administrator's handling of PHI and confirm compliance with HIPAA
- Evaluate the reasonableness of the fees charged

Payroll & HRIS Vendors

- Exercise quality control over the information provided by vendors concerning determinations of employee eligibility and other reporting capabilities, particularly as they relate to ACA
- Ensure premium contributions deducted from employee pay are done in the correct amounts
- Evaluate the reasonableness of the fees charged

The obligations imposed under ERISA and its related federal regulations can be complicated. This guide is intended to serve as a starting point for plan sponsors and administrators to evaluate the essential elements of a plan and to facilitate an efficient compliance assessment. For more information on plan compliance, contact a member of the Filice Compliance Team. For specific questions that address areas of fiduciary compliance or voluntary correction, always consult with competent counsel.

Additional Resources:

- **Understanding Fiduciary Responsibilities**
  www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html

- **Self-Compliance Checklist for HIPAA and Other Health Care-Related Provisions**
  www.dol.gov/ebsa/pdf/part7-1.pdf

- **Self-Compliance Checklist for ACA Provisions**
  www.dol.gov/ebsa/pdf/part7-2.pdf

- **Benefit Plan Compliance Publications**
  www.Filice.com/publications/benefit-plan-compliance?page=1

Founded in 1989, Filice Insurance was the first consultancy in Northern California to offer a full suite of employee benefits and business insurance services. Filice offers clients a holistic approach to benefits consulting, including HR compliance, employee advocavcy, health management, and system implementation.

The in-house Compliance Team at Filice Insurance is comprised of various industry experts who provide valued HR support services and benefit plan compliance consultation to clients of all sizes and across various industries. Through personalized, tailored guidance, the Team prepares clients to meet the challenges of ever-evolving benefit laws without sacrificing the success of their health plans. Additionally, each client has direct, daily access to the Team professionals.

At Filice, we serve as a trusted partner to clients by providing proactive solutions to further overall business growth and development. Experience the difference with Filice Insurance.

We Deliver. You Benefit.