



UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
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Introduction



Offering a group health plan can be one of the most challenging, yet rewarding, decisions an employer can make. The employees participating in the plan, their beneficiaries, and the employer benefit when a group health plan is in place. Administering a plan and managing its assets, however, require certain actions and involve specific responsibilities.

To meet their responsibilities as plan sponsors, employers need to understand some basic rules, specifically the Employee Retirement Income Security Act (ERISA). ERISA sets standards of conduct for those who manage an employee benefit plan and its assets (called fiduciaries). An ERISA-covered group health plan is an employment-based plan that provides coverage for medical care, including hospitalization, sickness, prescription drugs, vision, or dental. A group health plan can provide benefits by using funds in a plan trust, the purchase of insurance, or by self-funding benefits from the employer's general assets. **Understanding Your Fiduciary Responsibilities Under A Group Health Plan** provides an overview of the basic fiduciary responsibilities applicable to group health plans under the law.

This booklet addresses the scope of ERISA's protections for private-sector group health plans (public-sector plans and plans sponsored by churches are not covered by ERISA). It provides a simplified explanation of the law and regulations. It is not a legal interpretation of ERISA, nor is it intended to be a substitute for the advice of a health benefits professional. Also, the booklet does not cover those provisions of the Federal tax law or state insurance law that may impact group health plans.

What Are The Essential Elements Of A Plan?

Each plan has certain key elements. These include:

- A written plan that describes the benefit structure and guides day-to-day operations;
- A trust fund to hold the plan's assets;¹
- A recordkeeping system to track contribution and benefit payments, maintain participant and beneficiary information, and to accurately prepare reporting documents; and
- Documents to provide plan information to employees participating in the plan and to the government.

Employers often hire outside professionals (sometimes called third-party service providers) or, if applicable, use an internal administrative committee or human resources department to manage some or all of a plan's day-to-day operations. Indeed, there may be one or a number of officials with discretion over the plan. These are the plan's fiduciaries.

¹ If a plan is set up through an insurance contract, then the contract does not need to be held in trust. If a plan is self-funded (paid from the employer's general assets), those funds are not plan assets except for any participant contributions withheld or received.

Who Is A Fiduciary?

Many of the actions involved in operating a plan make the person or entity performing them a fiduciary. Using discretion in administering and managing a plan or controlling the plan's assets makes that person a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.

As noted above, group health plans can be structured in a variety of ways. The structure of the plan will affect who has fiduciary responsibilities. Most employers sponsoring fully or partially self-funded group health plans exercise some discretionary authority and therefore are fiduciaries. If the employer sponsors a fully insured plan, fiduciary status depends on whether the employer exercises discretion over the plan.

A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation. The named fiduciary can be identified by office or by name. For some plans, it may be an administrative committee or a company's board of directors.

A plan's fiduciaries will ordinarily include plan administrators, trustees, investment managers, all individuals exercising discretion in the administration of the plan, all members of a plan's administrative committee (if it has such a committee), and those who select committee officials. Attorneys, accountants, and actuaries generally are not fiduciaries when acting solely in their professional capacities. Similarly, a third party administrator, recordkeeper, or utilization reviewer who performs solely ministerial tasks is not a fiduciary; however, that may change if he or she exercises discretion in making decisions regarding a participant's eligibility for benefits. The key to determining whether individuals or entities are fiduciaries is whether they are exercising discretion or control over the plan.

A number of decisions are not fiduciary actions but rather are business decisions made by the employer. For example, the decisions to establish a plan, to determine the benefit package, to include certain features in a plan, to amend a plan, and to terminate a plan are employer business decisions not governed by ERISA. When making these decisions, an employer is acting on behalf of its business, not the plan, and, therefore, is not a fiduciary. However, when an employer (or someone hired by the employer) takes steps to implement these decisions, that person is acting on behalf of the plan and, in carrying out these actions, may be a fiduciary.

What Is The Significance Of Being A Fiduciary?

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries. These responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
- Carrying out their duties prudently;
- Following the plan documents (unless inconsistent with ERISA);

- Holding plan assets (if the plan has any) in trust; and
- Paying only reasonable plan expenses.

The duty to act prudently is one of a fiduciary's central responsibilities under ERISA. It requires expertise in a variety of areas. Lacking that expertise, a fiduciary will want to hire someone with that professional knowledge to carry out those functions. Prudence focuses on the process for making fiduciary decisions. Therefore, it is wise to document decisions and the basis for those decisions. For instance, in hiring any plan service provider, a fiduciary may want to survey a number of potential providers, asking for the same information and providing the same requirements. By doing so, a fiduciary can document the process and make a meaningful comparison and selection.

Following the terms of the plan document is also an important responsibility. The plan document serves as the foundation for plan operations. Employers will want to be familiar with their plan document, especially when it is drawn up by a third-party service provider, and periodically review the document to make sure it remains current. For example, if a plan official named in the document changes, the plan document must be updated to reflect that change.

Limiting Liability

With these fiduciary responsibilities, there is also potential liability. Fiduciaries who do not follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions.

However, fiduciaries can limit their liability in certain situations. One way fiduciaries can demonstrate that they have carried out their responsibilities properly is by documenting the processes used to carry out their fiduciary responsibilities.

A fiduciary also can hire a service provider or providers to handle fiduciary functions, setting up the agreement so that the person or entity then assumes liability for those functions selected. If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the individual decisions of that provider. However, an employer is required to monitor the service provider periodically to assure that it is handling the plan's administration prudently.

Other Plan Fiduciaries

A fiduciary should be aware of others who serve as fiduciaries to the same plan, since all fiduciaries have potential liability for the actions of their co-fiduciaries. For example, if a fiduciary knowingly participates in another fiduciary's breach of responsibility, conceals the breach, or does not act to correct it, that fiduciary is liable as well.

Bonding

As an additional protection for plans, every person, including a fiduciary, who handles plan funds or other plan property generally must be covered by a fidelity bond. A fidelity bond is a type of insurance that protects the plan against loss by reason of acts of fraud or dishonesty on the part of persons covered by the bond. Many persons dealing with group health plans that pay benefits from the general

assets of an employer or union (unfunded) or group health plans that are insured (benefits are paid through the purchase of a group health insurance contract from a licensed insurer) may be eligible for exemptions from the fidelity bonding requirements. For more information, request a copy of **Protect Your Employee Benefit Plan with an ERISA Fidelity Bond**.

How Do These Responsibilities Affect The Operation Of The Plan?

Even if employers hire third-party service providers or use internal administrative committees to manage the plan, there are still certain functions that can make an employer a fiduciary.

Employee Contributions

If a plan provides for salary reductions from employees' paychecks for contribution to the plan or participants make payments directly, such as the payment of COBRA premiums, then the employer must deposit the contributions in a plan trust in a timely manner. The law requires that participant contributions be deposited in the plan as soon as it is reasonably possible to segregate them from the company's assets, but no later than 90 days from the date on which the participant contributions are withheld or received by the employer. If employers can reasonably make the deposits sooner, they need to do so. For plans with fewer than 100 participants, salary reduction contributions deposited with the plan no later than the 7th business day following withholding by the employer will be considered contributed in compliance with the law.

For participant contributions to cafeteria plans (also referred to as (Internal Revenue Code) Section 125 plans), the Department will not assert a violation solely because of a failure to hold participant contributions in trust. Other contributory health plan arrangements may obtain the same trust relief if the participant contributions are used to pay insurance premiums within 90 days of receipt.

Medical Loss Ratio (MLR) Rebates

Under the Affordable Care Act, insurance companies must rebate a portion of insurance premiums to policyholders, including health plans, when the insurance company's spending for clinical services and health care quality improving activities, in relation to the premiums charged, is less than established medical loss ratio (MLR) standards. These rebates may be assets of the health plan.

To determine whether any part of the rebate is an asset of the health plan, consider factors such as whether the plan or the employer is the policyholder, the terms of the plan documents, and whether any portion of the premiums were paid by plan participants. If any part of the MLR rebate is the plan's asset, the decision on how to apply it is a fiduciary function. In deciding on the allocation method (such as distribution to participants, enhancing plan benefits or reducing future participant premiums), a fiduciary may consider the costs and benefits of each option. The plan asset, similar to employee contributions discussed above, must be held in a plan trust.

Hiring A Service Provider

Hiring a service provider in and of itself is a fiduciary function. When considering prospective service providers, provide each of them with complete and identical information about the plan and what services you are looking for so that you can make a meaningful comparison.

Some actions fiduciaries need to consider when selecting a service provider include:

- When searching for a firm, get information from more than one provider;
- Compare firms based on same information – services offered, experience, costs, etc.;
- Obtain information about the firm itself: financial condition and experience with group health plans of similar size and complexity;
- Evaluate information about the quality of the firm’s services: the identity, experience, and qualifications of professionals who will be handling the plan or providing medical services; any recent litigation or enforcement action that has been taken against the firm; and the firm’s experience or performance record; ease of access to medical providers and information about the operations of the health care provider; the procedures for timely consideration and resolution of patient questions and complaints; the procedures for the confidentiality of patient records; and enrollee satisfaction statistics; and
- Ensure that any required licenses, ratings or accreditations are up to date (insurers, brokers, TPAs, health care service providers).

An employer should document its selection (and monitoring) process, and, when using an internal administrative committee, should educate committee members on their roles and responsibilities. Read, understand, and keep a copy of all contracts.

Fees

Fees are just one of several factors fiduciaries need to consider in deciding on service providers. When the fees for services are paid out of plan assets, fiduciaries will want to understand the fees and expenses charged and the services provided. While the law does not specify a permissible level of fees, it does require that fees charged to a plan be “reasonable.” After careful evaluation during the initial selection, the plan’s fees and expenses should be monitored to determine whether they continue to be reasonable.

In comparing estimates from prospective service providers, ask which services are covered for the estimated fees and which are not. Some providers offer a number of services for one fee, sometimes referred to as a “bundled” services arrangement. Others charge separately for individual services. Compare all services to be provided with the total cost for each provider. Consider whether the estimate includes services you did not specify or want. Remember, all services have costs.

Some service providers may receive additional fees from third parties, such as insurance brokers. Employers should ask prospective providers whether they get any compensation from third parties, such as finder’s fees, commissions, or revenue sharing.

Who pays the fees? Plan expenses may be paid by the employer, the plan, or both. In any case, the plan document should specify how fees are paid, and the fiduciary must ensure that those fees and expenses are reasonable, necessary for the operation of the plan, and not excessive for the services provided.

Monitoring A Service Provider

An employer should establish and follow a formal review process at reasonable intervals to decide if it wants to continue using the current service providers or look for replacements. When monitoring service providers, actions to ensure they are performing the agreed-upon services include:

- Reviewing the service providers' performance;
- Reading any reports they provide;
- Checking actual fees charged;
- Asking about policies and practices (such as a TPA's claims processing systems);
- Ensuring that plan records are properly maintained; and
- Following up on participant complaints.

Maintaining The Plan's Benefits Claims Procedure

Group health plans must establish and maintain reasonable claims procedures that allow participants and beneficiaries to apply for and receive the plan's promised benefits. Fiduciaries must maintain the plan's procedures. The Department of Labor issued rules setting minimum standards for benefit claims determinations for ERISA plans (including insured and self-funded plans). While many plans hire benefits professionals or insurance companies to process claims, it is important for an employer to understand the requirements before selecting a service provider who can comply with the standards.

A claim for benefits is a request for a plan benefit made in accordance with the plan's procedures by a claimant (participant or beneficiary) or a claimant's authorized representative. Questions concerning plan benefits, coverage and eligibility questions, and casual inquiries are generally not considered claims for benefits.

The key issues to become familiar with are the timeframes for deciding claims, the contents for the notices of benefit denials, and the standards for appeals of benefit denials.

Once a claim is received by the plan, the timeframe for making and providing notice of the claim determination varies based on the type of claim filed -

- urgent care, as soon as possible but not later than 72 hours after the plan receives the claim;
- pre-service claims, within a reasonable period of time not later than 15 days after the plan receives the claim;
- post-service claims, within a reasonable period of time not later than 30 days after the plan receives the claim; and

- disability claims, within a reasonable period of time not later than 45 days after the plan receives the claim.

In the case of pre- and post-service claims, 15 day extensions may be available.

For claims that are appealed, the timeframe also varies based on the type of claim –

- urgent care claims, as soon as possible but not later than 72 hours after the plan receives the request to review a denied claim;
- pre-service claims, within a reasonable period of time not later than 30 days after the plan receives the request to review a denied claim;
- post-service claims, as soon as possible but not later than 60 days after the plan receives the request to review a denied claim; and
- disability claims, within a reasonable period of time but not later than 45 days after the plan receives the request to review a denied claim.

No extensions are available for making decisions on appeals unless the claimant consents.

The notice of a claim denial, referred to as an adverse benefit determination, must contain the following information:

- Specific reasons for denial (for example, not medically necessary, not covered by the plan, or reached maximum amount of treatment permitted under the plan);
- A reference to the specific plan provision(s) relied upon for the denial;
- If denied for a lack of information, the notice must include a description of any additional material(s) needed to perfect the claim and an explanation of why such additional material is necessary;
- A description of the plan's review procedures (for example, how appeals work);
- If used, either a description of rules, guidelines, or protocols relied upon in denying the claim, or that a copy of such items will be provided free upon request;
- If denial is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- A description of the claimant's right to go to court to recover benefits due under the plan.

The notice of a claim denial on appeal must include the same information as noted above (except the description of the plan's appeal process) as well as:

- A statement of the claimant's right to receive, free of charge, relevant documents (documents and records upon which the decision is based and other documents prepared or used during the process); and
- A description of any voluntary processes offered by the plan to resolve claims disputes.

The plan's claims procedure must provide for a full and fair review of a benefit claim if a claimant files an appeal of the denial. The minimum standards for appeals are:

- Claimants must be given 180 days to file an appeal;
- A *de novo* review, that is, a review that affords no deference to the initial determination, must be conducted;
- When the denial is based on determinations of whether a particular treatment, drug or other item is experimental, investigational, or not "medically necessary," the reviewer must consult with a qualified health professional (and others as needed);
- No more than 2 appeals levels are allowed; and
- Mandatory binding arbitration of claims is generally prohibited. However, non-binding arbitration would be permissible if done within the required timelines.

For more information, request a copy of **Compliance Assistance - Group Health and Disability Plans Benefit Claims Procedure Regulation**.

For plans not grandfathered under the Affordable Care Act (those established, or that have made certain significant changes, after March 23, 2010), there are additional claims procedure standards.

The claims and appeal process must cover rescissions (retroactive cancellations) of coverage, as well as other denials of benefits. Non-grandfathered health plans, or insurers to those plans, also must:

- provide claimants with new or additional evidence or rationale before a final decision is made on the claim;
- ensure that claims and appeals are adjudicated in an independent and impartial manner;
- provide detail on the claim involved, the reason for denial, internal and external appeals processes that are available, and information on consumer assistance, in all claims denial notices;
- provide, on request, diagnosis and treatment codes (and their meanings) for any claim denial;
- provide notices in a culturally and linguistically appropriate manner; and
- allow claimants to resubmit an internal claim if a request for immediate external review is rejected.

Non-grandfathered plans also must provide a process for an external review of claim denials by an independent party. The external review process used depends on whether the plan is self-funded or provides benefits through an insurance company.

Self-funded plans generally must comply with the procedures set by the Department of Labor. A plan may choose to refer requests for external review to an accredited Independent Review Organization (IRO), or may voluntarily comply with a state external review process if the state allows access. For more information, visit the Department of Labor's Web page on internal claims and appeals and external review at dol.gov/ebsa/healthreform/regulations/internalclaimsandappeals.html.

For insured plans, plans and insurance companies generally must comply with their state's external review process, if the state process includes minimum consumer standards set by the Department of Health and Human Services (HHS). If the state process does not meet these standards, group health plans and insurers may use either the accredited IRO process or an HHS-administered Federal external review process. For the status of your state's external process, see cms.gov/CCIIO/Resources/Files/external_appeals.html.

Are There Some Transactions That Are Prohibited? Is There A Way To Make Them Permissible If The Actions Will Benefit The Plan?

Certain transactions are prohibited under the law to prevent dealings with parties who may be in a position to exercise improper influence over the plan. In addition, fiduciaries are prohibited from engaging in self-dealing and must avoid conflicts of interest that could harm the plan.

Prohibited Transactions

Who is prohibited from doing business with the plan? Prohibited parties (called parties in interest) include the employer, the union, plan fiduciaries, service providers, and statutorily-defined owners, officers, and relatives of parties in interest.

Some of the prohibited transactions are:

- A sale, exchange, or lease between the plan and party in interest;
- Lending money or other extension of credit between the plan and party in interest; and
- Furnishing goods, services, or facilities between the plan and party in interest.

Other prohibitions relate solely to fiduciaries who use the plan's assets in their own interest or who act on both sides of a transaction involving a plan. Fiduciaries cannot receive money or any other consideration for their personal account from any party doing business with the plan related to that business.

Exemptions

There are a number of exceptions (exemptions) in the law that provide protections for the plan in conducting necessary transactions that would otherwise be prohibited. The Labor Department may grant additional exemptions.

Exemptions are provided in the law for many dealings that are essential to the ongoing operations of the plan. One exemption in the law allows the plan to hire a service provider as long as the services are necessary to operate the plan and the contract or arrangement under which the services are provided and the compensation paid for those services is reasonable.

The exemptions issued by the Department can involve transactions available to a class of plans or to one specific plan. Both class and individual exemptions are available at dol.gov/ebsa under **Technical Guidance**. For more information on applying for an exemption, see the procedures on the exemption Web pages at dol.gov/ebsa.

How Do Employees Get Information About The Plan? How Are Employers Required To Report Plan Activities?

ERISA requires plan administrators to furnish plan information to participants and beneficiaries and to submit reports to government agencies.

Informing Participants And Beneficiaries

The following documents must be automatically furnished to participants and beneficiaries.

The **Summary Plan Description (SPD)** – the basic descriptive document – is a plain language explanation of the plan and must be comprehensive enough to apprise participants of their rights and responsibilities under the plan. It also informs participants about the plan features and what to expect of the plan. Among other things, the SPD must include basic information such as:

- Plan name, address, and contact information;
- What the plan benefits are;
- How to get the benefits; and
- Duties of the plan and/or employee.

More specific information must also be provided, including:

- The plan's claims procedure (either in the document or as separate attachment);
- A participant's basic rights and responsibilities under ERISA (model language is provided in the SPD rules);
- Information on any applicable premiums, cost-sharing, deductibles, co-payments, etc.;
- Procedures for using network providers (if PPO/HMO) and composition of network;

- Conditions regarding pre-certification;
- A description of plan procedures governing Qualified Medical Child Support Orders (see below); and
- Notices and descriptions of certain rights under the Health Insurance Portability and Accountability Act (HIPAA) and other health coverage laws, described below.

This document is given to employees within 90 days after they are covered by the plan and within 30 days of a request. Generally, SPDs also must be redistributed every 5th year. The SPD must be current within 120 days.

The **Summary of Material Modification (SMM)** apprises participants and beneficiaries of material changes to the plan or to the information required to be in the SPD. The SMM or an updated SPD for a group health plan must be furnished automatically to participants within 210 days after the end of the plan year in which such material change was adopted. However, if the changes to the plan or changes to the required information in the SPD result in a material reduction in covered services or benefits, then the SMM must be distributed no later than 60 days from the date the change was adopted. A material reduction is any plan change that eliminates benefits, reduces benefits payable, increases premiums, deductibles, coinsurance or co-payments, reduces the service area covered by an HMO, or establishes new conditions or requirements (such as pre-authorization) for obtaining services or benefits.

A **Summary of Benefits and Coverage (SBC)** is a uniform template that uses clear, plain language to summarize the key features of a plan, such as covered benefits, cost-sharing provisions and coverage limitations. The SBC must include an internet address where an individual can review a Uniform Glossary of medical and insurance-related terms designed to help consumers compare the terms of their coverage and the extent of medical benefits, as well as contact information for obtaining a paper copy. Plans and insurance companies must provide the SBC to participants and beneficiaries with the plan's enrollment or application materials, upon renewal or reissuance of coverage, or within 90 days of special enrollment. The SBC and a copy of the Uniform Glossary also must be provided within 7 business days of a request. A template for the SBC and the Uniform Glossary can be found at dol.gov/ebsa/healthreform.

A **Summary Annual Report (SAR)** outlines in narrative form the financial information in the plan's Annual Report, the Form 5500 (see below for those plans required to file this report), and is furnished annually to participants in plans that are required to file the Form 5500.

Other Group Health Plan Notices

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Women's Health and Cancer Rights Act (WHCRA)). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided. For more information on these notices, see the **Reporting and Disclosure Guide for Employee Benefit Plans**. For more information on COBRA, HIPAA, the Affordable Care Act, and

the other provisions in ERISA related to group health plans, see **Resources** below for publications on these provisions.

Disclosures Upon Request

In addition to the SPD, participants can also request the plan document, insurance contracts, and other documents under which the plan is operated. A reasonable copying fee may be charged.

Qualified Medical Child Support Orders (QMCSO)

Plans may receive either private medical child support orders (MCSO) or an order from a state agency regarding an employee's medical child support obligations. Plans must have procedures to receive, process, and implement qualified medical child support orders. If a plan receives an MCSO, the plan administrator has to provide a notice to the participant and any child named in the MCSO (and the child's representative) of the receipt of the MCSO and the plan administrator's determination whether the MCSO is qualified. The notice must be furnished within a reasonable time period after receipt of the MCSO. For more information on QMCSOs and the standards plans must use to determine whether MCSOs are qualified, request a copy of **Qualified Medical Child Support Orders** (see **Resources** below).

Reporting To The Government

Plan administrators generally are required to file a Form 5500 Annual Return/Report with the Federal Government. The Form 5500 reports information about the plan, its finances, and its operation. This information is used by the U.S. Department of Labor, the Internal Revenue Service (IRS), other government agencies, organizations, and the public. Participants and beneficiaries can receive a copy of the Form 5500 upon request from the plan. Depending on the number of participants covered and plan design, there may be exemptions from the full filing requirements. A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) does not need to file an annual report. Plans with 100 or more participants that are fully insured or self-funded (or a combination) can file a limited report. Plans that have relief from the trust requirement discussed in **Employee Contributions** above are treated as self-funded.

The form is filed and processed under EFAST2. For more information on the forms, their instructions, and the filing requirements, see efast.dol.gov. See the **Resources** section to obtain a copy of the publication **Reporting and Disclosure Guide for Employee Benefit Plans**.

Administrators of multiple employer welfare arrangements (MEWAs) generally are required to file a Form M-1 Report with the Federal Government. The Form M-1 reports information about compliance by MEWAs with the requirements of Part 7 of ERISA (which includes HIPAA, the Newborns' Act, WHCRA, and the Mental Health Parity and Addiction Equity Act (MHPAEA)). This one-page form is generally required to be filed once per year. For more information on the Form M-1, see dol.gov/ebsa and request the publication **Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation**.

There are penalties for failing to file required reports and for failing to provide required information to participants.

How Do Other Laws Affect Fiduciary Responsibilities?

As noted above, there are other provisions in ERISA, as well as other Federal and state laws that affect group health plans. A fiduciary's responsibilities include making sure the plan complies with ERISA, which includes the COBRA, HIPAA, the Affordable Care Act and other group health plan provisions in the law.

The COBRA continuation coverage provisions require that participants and their covered dependents have the opportunity to maintain coverage under their group health plan for a limited period of time, which they may be required to pay for, upon the occurrence of certain qualifying events that would otherwise result in a loss of coverage. For a more detailed discussion of COBRA requirements, see **An Employer's Guide to Group Health Continuation Coverage Under COBRA - The Consolidated Omnibus Budget Reconciliation Act** (See **Resources** to obtain a copy).

HIPAA provides special enrollment rights for certain events and prohibits discrimination in eligibility, benefits, or premiums based on a health factor.

The Affordable Care Act provisions include the extension of dependent coverage until age 26, the prohibition of preexisting condition exclusions, a prohibition on waiting periods of more than 90 days and a ban on lifetime and annual limits on coverage for most benefits. Additional protections apply to non-grandfathered health plans (those established, or that have made certain significant changes, after March 23, 2010). These include the internal claims and appeal and external review standards discussed above, coverage for certain preventive services without cost sharing and certain patient protections, including coverage for emergency services in an emergency department of a hospital outside of a plan's network without prior plan approval. For more information on the Affordable Care Act, see dol.gov/ebsa/healthreform.

Other group health plan provisions in ERISA include the Newborns' and Mothers' Health Protection Act, which provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth; the Women's Health and Cancer Rights Act, which provides protections for individuals who elect breast reconstruction or certain other follow-up care after a mastectomy; MHPAEA and the Mental Health Parity Act (the Mental Health Parity provisions), which provide for parity in mental health benefits and medical/surgical benefits; and the Genetic Information Nondiscrimination Act, which prohibits discrimination in group health plan coverage based on genetic information. For more detailed information on these provisions, see the **Resources** section to obtain a copy of **Compliance Assistance Guide... Health Benefits Coverage Under Federal Law**.

With respect to other laws, ERISA generally supersedes state laws as they relate to employee benefit plans. However, state insurance laws applicable to health insurance coverage often continue to apply. Therefore, if health coverage is offered through an HMO or insurance policy, check with your state insurance department for more information on that state's insurance laws.

Can A Fiduciary Terminate Its Fiduciary Duties?

Yes, but there is one final fiduciary responsibility. Fiduciaries who no longer want to serve in that role cannot simply walk away from their responsibilities, even if the plan has other fiduciaries. They need to follow plan procedures and make sure that another fiduciary is carrying out the responsibilities left behind. It is critical that a plan has fiduciaries in place so that it can continue operations and participants have a way to interact with the plan.

What Help Is Available For Employers Who Make Mistakes In Operating A Plan?

The Department of Labor's Voluntary Fiduciary Correction Program (VFCP) encourages employers to comply with ERISA by voluntarily self-correcting certain violations. The program covers 19 transactions, including failure to timely remit participant contributions and some prohibited transactions with parties in interest. The program includes a description of how to apply, as well as acceptable methods for correcting violations. In addition, the Department gives applicants immediate relief from payment of excise taxes under a class exemption.

In addition, the Department's Delinquent Filer Voluntary Compliance Program (DFVCP) assists late or non-filers of the Form 5500 in coming up to date with corrected filings.

For an overview of both programs, visit **Corrections Programs** at dol.gov/ebsa.

Tips For Employers With Group Health Plans

Understanding fiduciary responsibilities is important for the security of a group health plan and compliance with the law. The following tips may be a helpful starting point:

- Have you identified your plan fiduciaries, and are they clear about the extent of their fiduciary responsibilities?
- If you are hiring third-party service providers, have you looked at a number of providers, given each potential provider the same information, and considered whether the fees are reasonable for the services provided? Have you documented the hiring process?
- Are you prepared to monitor your plan's service providers?
- Are you aware of the schedule to deposit participant contributions and payments by participants to the plan and forwarding them to the insurance company, and have you made sure it complies with the law?
- Have you reviewed your plan document in light of current plan operations and made necessary updates? After amending the plan, have you provided participants with an updated SPD or SMM?
- Does your plan have a reasonable claims procedure that is being followed by plan fiduciaries?
- Does your plan have a procedure for handling QMCSOs?
- Have you identified parties in interest to the plan and taken steps to monitor transactions with them?
- Are you aware of the major exemptions under ERISA that permit transactions with parties in interest, especially those key for plan operations (such as hiring service providers)?
- Have required reports (i.e. Form 5500) been filed timely with the government?

Resources

The U.S. Department of Labor's Employee Benefits Security Administration offers more information on its Website and through its publications. To order publications or to request assistance from a benefits advisor, contact EBSA electronically at askebsa.dol.gov or call toll free 1-866-444-3272.

For Employers

Compliance Assistance Guide... Health Benefits Coverage Under Federal Law

An Employer's Guide to Group Health Continuation Coverage Under COBRA - The Consolidated Omnibus Budget Reconciliation Act

Reporting and Disclosure Guide for Employee Benefit Plans

Protect Your Employee Benefit Plan with an ERISA Fidelity Bond

Qualified Medical Child Support Orders

Compliance Guide - Group Health and Disability Plans Benefit Claims Procedure Regulation

VFCP Fact Sheet | FAQs

DFVCP Fact Sheet | FAQs

For Employees

Top 10 Ways To Make Your Health Benefits Work For You

Life Changes Require Health Choices...Know Your Benefit Options

Work Changes Require Health Choices...Protect Your Rights

An Employee's Guide to Health Benefits Under COBRA

Filing A Claim For Your Health Or Disability Benefits



EMPLOYEE BENEFITS SECURITY ADMINISTRATION
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