

UNITED STATES  
DEPARTMENT OF LABOR  
EMPLOYEE BENEFITS  
SECURITY ADMINISTRATION

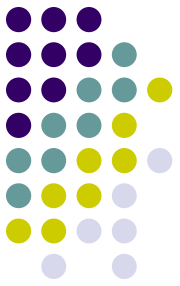
**Title I of ERISA**

**Pension & Health Care Provisions**

Fara Goodwin  
Lead Benefits Advisor  
Seattle District Office



# EBSA Regional Jurisdiction

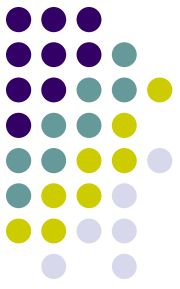


## **Seattle District Office**

- Washington
- Oregon
- Idaho
- Alaska

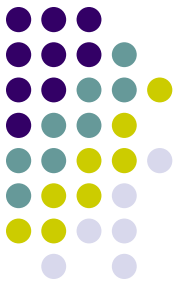
- Seattle District Office is under San Francisco Regional Office
- San Francisco Regional Office is responsible for: Utah, Nevada, and Northern California

# EBSA's Mission



- to deter and correct violations of the relevant statutes
- assist plan officials in understanding the requirements of relevant statutes in order to meet their legal obligations
- develop policies and laws that simplify compliance, and;
- encourage the growth and preservation of employment-based benefits

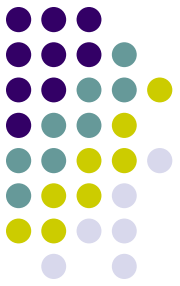
# Investigators/Auditors



- An Investigator or Auditor performs **formal** audits or investigations to ensure the **plan** is operating within the provisions of Title I of ERISA

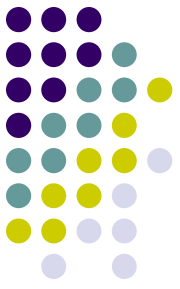


# Technical Benefit Advisors



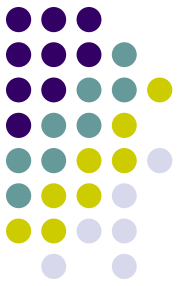
- Benefit Advisors conduct **informal resolution** for the **individual** and advise employers
  - Advise participants of rights and responsibilities IAW Title I of ERISA
  - Provide guidance to employers and service providers regarding compliance issues
  - Obtain benefit recoveries
  - Perform outreach to increase participant awareness and encourage employer compliance

# EBSA Enforces

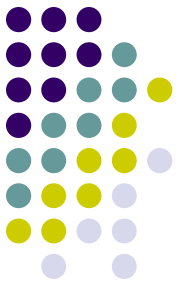


- **Title I of the Employee Retirement Income Security Act (ERISA)**
- Title II & III - IRS
- Title IV - PBGC
- Title I addresses private-sector employer based pension & welfare benefit (health) plans
  - Fiduciary (plan official) responsibilities
  - Reporting and disclosure
  - Participant contributions
  - Amended Health Care Legislation

# Pensions – What We Do...



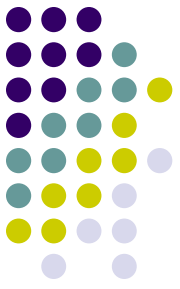
- Look to Fiduciary Duties to determine proper plan administration
  - Ensure the participant/beneficiary receives the benefit to which entitled
  - Assist in obtaining benefit claims
  - Obtain disclosure materials, SPD, etc.
  - Ensure participant contributions deducted from pay is deposited into the retirement account in a timely manner



# Types of Retirement Plans

- 401(k)
- Profit Sharing
- 403(b)
- Defined Benefit Plans
- IRA Based Plans
  - Payroll Deduction IRA
  - SEP
  - Simple IRA Plan
- Other types of Plans through IRS

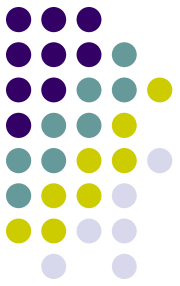
# Fiduciary Responsibility Overview



- What is a “fiduciary”?
- **In general** – position of trust, acting for the benefit of others with a high duty of care and loyalty
- **ERISA** – any person who exercises discretionary authority or control over plan assets or administration, or gives investment advice

# Basic Fiduciary Duties

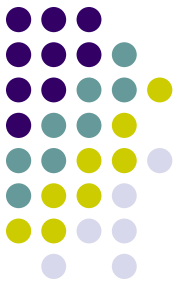
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- Acting **solely** in the interests of the participants and their beneficiaries
- Being prudent
- Paying only **reasonable and necessary** expenses of the plan
- Following the terms of the plan

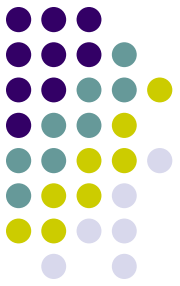
# Welfare Benefit (Health) Plans

## What We Do...



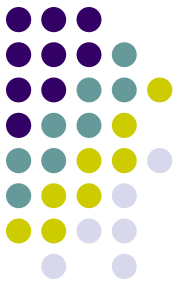
- Assist participants and beneficiaries in obtaining their rightful benefits
- Assist in ensuring claims are processed in a timely manner
- Ensure participants/beneficiaries are enrolled upon eligibility
- Advise of appeal rights under ERISA
- Ensure all provisions of health legislation is observed, i.e. COBRA Notices, special enrollment, Certificates of Creditable Coverage issuances, etc.

# ERISA's Health Legislation

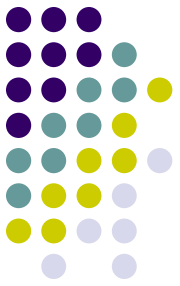


- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Women's Health and Cancer Rights Act
- Newborns' and Mothers' Health Protection Act
- The Mental Health Parity and Addiction Equity Act
- The Genetic Information Non-discrimination Act (GINA)
- Michelle's Law (phasing out due to ACA)

# COBRA - What is it?



- It is continuation coverage that group health plans are required to offer to qualified beneficiaries (i.e., employees, spouses, dependents) when group health plan coverage would otherwise be lost due to a qualifying event (such as termination or reduction of hours of employment, divorce, death of covered employee, etc.).



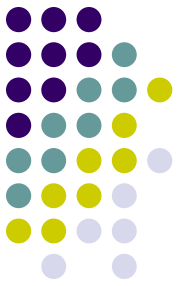
# Who is Entitled to COBRA?

**An individual will be entitled to COBRA if they meet the 3 basic requirements**

- The group health plan is covered by COBRA (plan coverage)
- A qualifying event occurs (QE)
- They are a qualified beneficiary (QB)

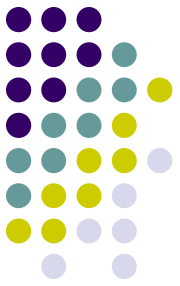
# Qualifying Events

## What is a qualifying event?



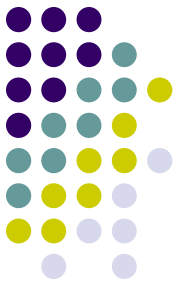
- Qualifying Events for Employee
  - Voluntary or involuntary termination
  - Reduction in hours of employment
- Qualifying Events for spouse and dependents
  - Termination of covered EE's employment
  - Reduction in EE's hours of employment
  - EE becoming entitled to Medicare
  - Divorce or legal separation from covered EE
  - Death of covered employee
  - Loss of "dependent child" status under Plan rules

# Who is Entitled to COBRA?



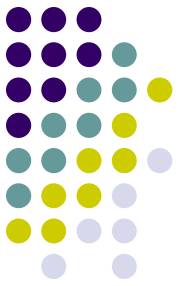
- **Qualified Beneficiaries**
  - Enrolled in group health plan on the day before the Qualifying Event
    - Employee
    - Spouse
    - Dependent children
  - Exception: Employee dismissed for gross misconduct
    - Not defined by COBRA statute
    - Liability v. Risk

# COBRA Timeframes: Notice and Election Procedures



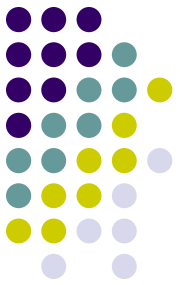
- COBRA Notices – 44 Days from the date of the QE
- Each QB has 60 days to elect COBRA from the later of:
  - Date coverage is actually lost; or
  - Date QB furnished an Election Notice
- Each QB can elect independently to elect COBRA
- A QB can decline COBRA and later change their mind as long as it is done before the end of the election period
- If the QB overturns a former declination, the Plan may begin benefits as of the later date, coverage does not have to go retroactive to the date of loss of coverage

# Who Pays For COBRA?



- Plan limited to charging 102% of premiums (for disability extension - 150%)
- Plan must allow QBs at least 45 days from COBRA election to make initial premium payment.
- Must give a minimum 30-day grace period for payment of any premium

# Benefits Under COBRA



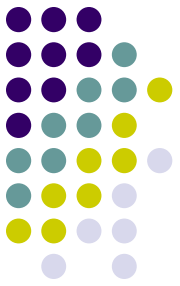
- A QB is entitled to the same benefits as a similarly situated active EE
  - Benefits, choices, and services
- A QB is subject to the same rules and limits
  - Co-payments, deductibles, and coverage limits
- A QB must comply with rules of the plan
  - Filing benefit claims and following the appeals process

# COBRA Coverage



- Timeframes for COBRA
  - Termination/reduction in hours – 18 mos.
  - Death of covered employee – 36 mos.
  - Divorce or legal separation – 36 mos.
  - Loss of dependent child status – 36 mos.
  - Multiple Qualifying Events – 36 mos. *from the date of first Qualifying Event*

# Extension of COBRA Coverage

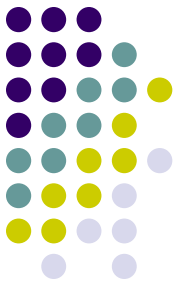


## Disability (additional 11 months)

(covered EE, spouse, or dependent child)

- Determined disabled by Social Security Administration w/in first 60 days of COBRA coverage
- Disability continues through 18-month COBRA period
- The disabled QB notifies plan of disability determination 60 days after the later of:
  - Date SSA issues disability determination
  - Date QE occurs
  - Date QB receives the COBRA General Notice
- Total up to 29 months

# Early Termination of COBRA



The group health plan may terminate COBRA early if:

- Premiums not paid in full on a timely basis
- The ER ceases to maintain any group health plan
- A QB begins coverage under another plan, as long as the new plan does not impose an exclusion or preexisting condition on the QB
- A QB becomes entitled to Medicare after electing COBRA
- A QB engages in certain types of conduct (such as fraud)

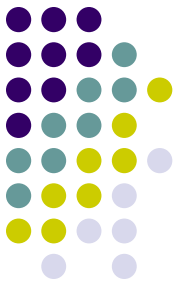


# Health Insurance Portability and Accountability Act (HIPAA)

## What is it?

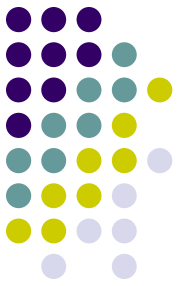
- Limits pre-existing condition exclusions
- Prohibits discrimination based on health factors
- Created a special enrollment right
- Created “Creditable Coverage”
- Requires plans to issue Certificates of Creditable Coverage
- Coverage guarantees

# Pre-existing Condition



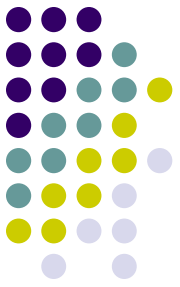
- Any condition for which medical advice, treatment, diagnosis, or care was recommended or received during the 6-month period ending on an individual's enrollment date in the plan (look back period)
- Pre-existing condition exclusion must run concurrently with any waiting period for coverage
- Must begin on "enrollment date" which is **earlier** of first day of coverage or first day of waiting period

# Pre-existing Condition



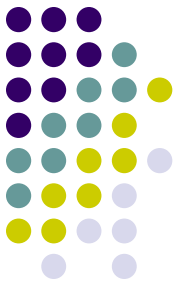
- Waiting period is not considered:
  - Creditable Coverage
  - Nor treated as a break in coverage (even if the participant serves part or all of the waiting period, but coverage never begins)
- Requires both a general notice of pre-ex and an individual notice of pre-ex

# Pre-ex exclusions cannot be applied to the following:

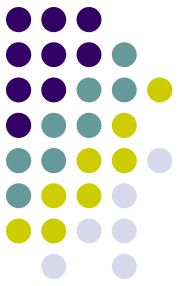


- Pregnancy
  - Genetic information
  - Newborns
  - Adopted children
  - Children placed for adoption
- 
- Must enroll within 30 days for newborns, adopted children, and children placed for adoption to avoid a preex.

# Discrimination



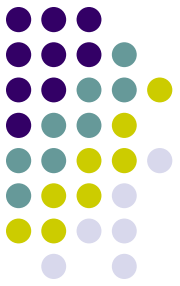
- Plan may not establish eligibility rules based on health related factors such as a health condition or genetic information
- Require a higher premium based on health related factors
- Terminate coverage for health reasons



# Creditable Coverage

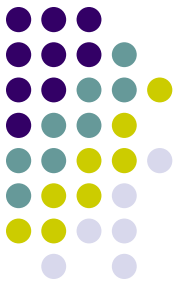
- Most health coverage qualifies
- Includes:
  - Group health coverage  
(whether self-insured or fully insured)
  - COBRA coverage
  - Individual health coverage
  - Medicare and Medicaid (Indian, State High Risk, Tri-care, Federal Health Plan)
  - Governmental plans
  - Church plans

# Creditable Coverage



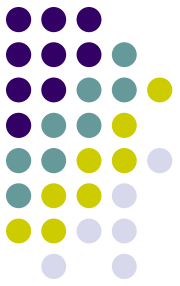
- Created creditable coverage which off-sets any pre-ex exclusion
- Requires the issuance of certificates of creditable coverage
- Tolls break in coverage rules during waiting periods for new group health plans
- Most health coverage qualifies

# Certificates of Creditable Coverage



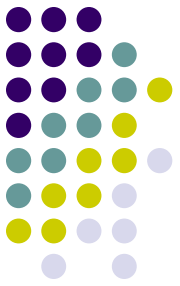
- Automatically issued to those who lose coverage and are entitled to elect COBRA
- Automatically issued to those who lose coverage and are not entitled to elect COBRA
- Automatically issued to those terminating COBRA coverage
- Upon request to individuals at any time before or within 24 months after losing coverage under the plan

# Certificates



- Certificates describing family coverage must contain dependent coverage information
- Issuers and Plans must use reasonable efforts to obtain the dependent coverage information

# Issuance of Certifications



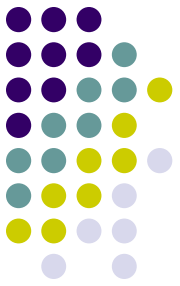
- The time period for COBRA election notices
- A reasonable time after the loss of coverage
- A reasonable time after the plan learns that COBRA continuation coverage has ceased

# Special Enrollment



- Requires a group health plan to allow an employee/spouse/dependent to enroll for coverage upon loss of other health coverage
- Loss of coverage includes the termination of employer contributions toward other coverage even if coverage continues by participant paying 100% of the cost
- Also created special enrollment rights for certain life events
- Special enrollment notice must be provided to employee at or before the time the employee is first offered the opportunity to enroll in the plan

# Guaranteed Coverage



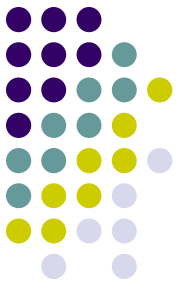
- Guaranteed right to individual coverage without pre-ex exclusions OR
- Entrance into the State Pool (“alternative mechanism”)

# Disclosure Changes



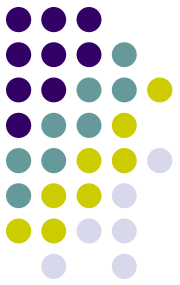
- **Notification** to participants of “material reductions in benefits” (within 60 days after adoption)
- Required **disclosure** to participants about the role of insurance issuers
- ALL amended health care law contains additional disclosure requirements
- **Inform** participants which DOL office to contact for ERISA and HIPAA assistance

# Women's Health and Cancer Rights Act



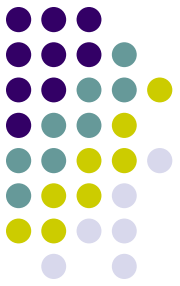
- In a manner determined in consultation with the attending physician and the patient
- If plan provides benefits for mastectomies then plan must also cover:
  - All stages of reconstructive surgery on mastectomy breast
  - Surgery and reconstruction of other breast for symmetry
  - Prostheses and physical complications of mastectomy, including lymphedemas

# Newborns' and Mothers' Health Protection Act



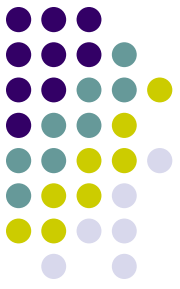
- Minimum hospital stay of 48 hours for vaginal delivery and 96 hours for cesarean delivery.
  - Subject to early discharge by the attending provider in consultation with the mother.
- Plan may not require providers to obtain pre-authorization in order for plan to cover 48/96 hour hospital stay in connection with childbirth
- Plans are not required to cover maternity benefits.

# Mental Health Parity Act



- Provisions that are annual or lifetime dollar limits on mental health (including constructive dollar limits) should be eliminated if they are lower than annual or lifetime dollar limits imposed on medical/surgical benefits

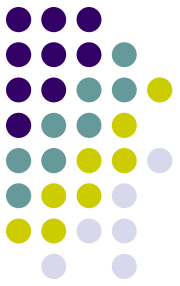
# The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)



## New!

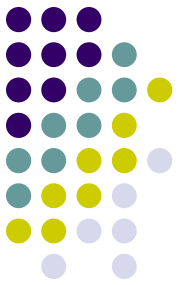
MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

# MHPAEA - Background



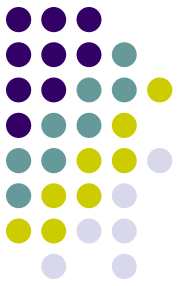
- Applies to plans *and insurance issuers* sponsored by private and public sector employers w/ >50 employees (self and fully insured)
- DOL & IRS enforce ERISA plans
- HHS enforces self-funded, non-Federal governmental plans
- State Insurance Commissioners enforce issuers in the large group market. HHS has secondary enforcement authority

# MHPAEA



- Continues and expands MHPA
- Additional protections relating to financial requirements
- Additional protections relating to treatment limitations
- Parity with respect to Out of Network Benefits
- Additional disclosure requirements
- Small employers are exempt - IRS
- The Interim Final Rule is intended to address most pressing issues, comments have been requested on specific issues - published EBSA's website

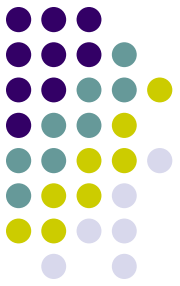
# The Genetic Information Nondiscrimination Act (GINA)



New!

- Signed into law May 21, 2008
- Health Insurance Provisions effective July 1, 2010/January 1, 2011 for calendar year plans
- Employment Provisions effective November 21 2009
  - Employment Opportunity Commission
  - Department of Health and Human Services
  - Department of Labor
  - Department of Treasury

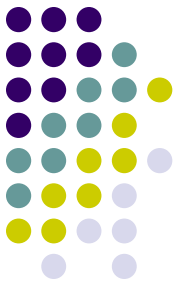
# GINA



- Will stop both employers and insurers from requiring applicants to submit to genetic tests,
- maintain strict use and disclosure requirements of genetic test information, and
- impose penalties against employers and insurers who violate these provisions.

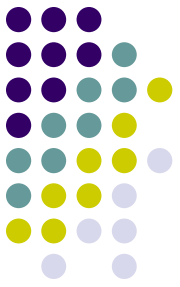
# Michelle's Law

# New!



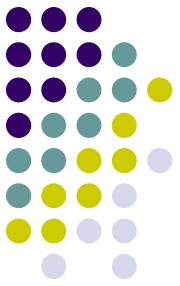
- Signed into law October 9, 2008
- Effective for plan years beginning on or after October 9, 2009
  - The Department of Labor
  - The Department of Health & Human Services
  - The Department of Treasury
- Phasing out as a result of Affordable Care Act provisions

# Michelle's Law



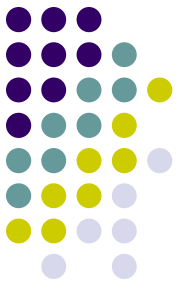
Provides that a group health plan may not terminate a college student's health coverage simply because the student takes a medically necessary leave of absence from school or changes to part-time status

# Michelle's Law



- The student must have been enrolled in the group health plan on the basis of being a student at a post-secondary educational institution immediately before the first day of the leave
- Coverage must extend for one (1) year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan)
- Student on leave is entitled to the same benefits as if they had not taken a leave
- If coverage changes during the student's leave, then law applies in the same manner as the prior coverage

# Michelle's Law



- The group health plan must receive written certification by the child's physician stating the child is suffering from a serious illness or injury, and the leave (or change of enrollment) is medically necessary.

# THE END

U.S. Department of Labor  
Employee Benefits Security  
Administration

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