HIC Health Insurance Cooperative Agency

UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN

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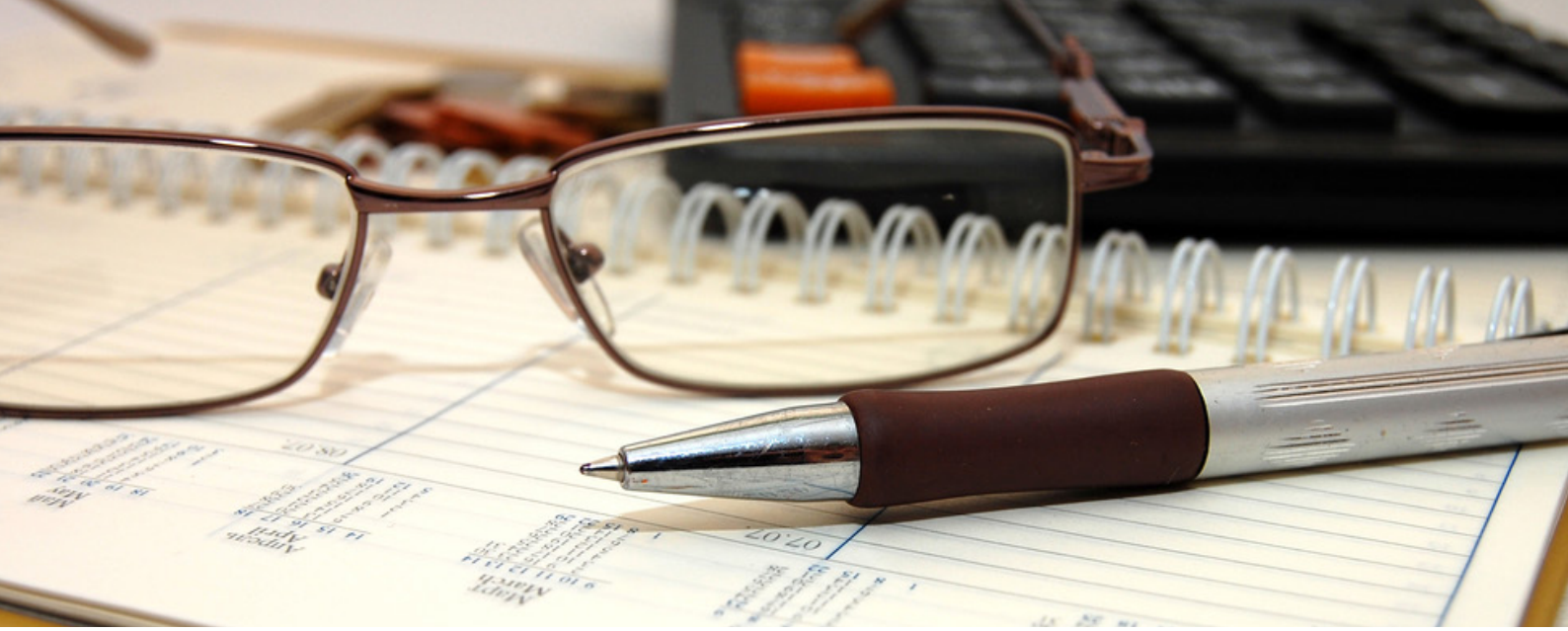
Content



Introduction

A group health plan is one of the most rewarding decisions you can make for your business as an employer. The significant investment you make in a group health plan could reap maximum returns that offer the greatest benefits to your business and your employees. However, administering a plan and being able to manage its assets will require a certain set of actions and involve specific responsibilities.

To meet your responsibilities as a group health plan sponsor, you'll need to understand some basic rules, including those surrounding the Employee Retirement Income Security Act (ERISA).

ERISA enforces standards of conduct for employers who manage an employee benefit plan and its assets, which are referred to as fiduciaries. A group health plan covered by ERISA is an employment-based plan that provides coverage for a number of healthcare-related expenses, including medical care, hospitalization, illness, prescription drugs, dental, and vision.

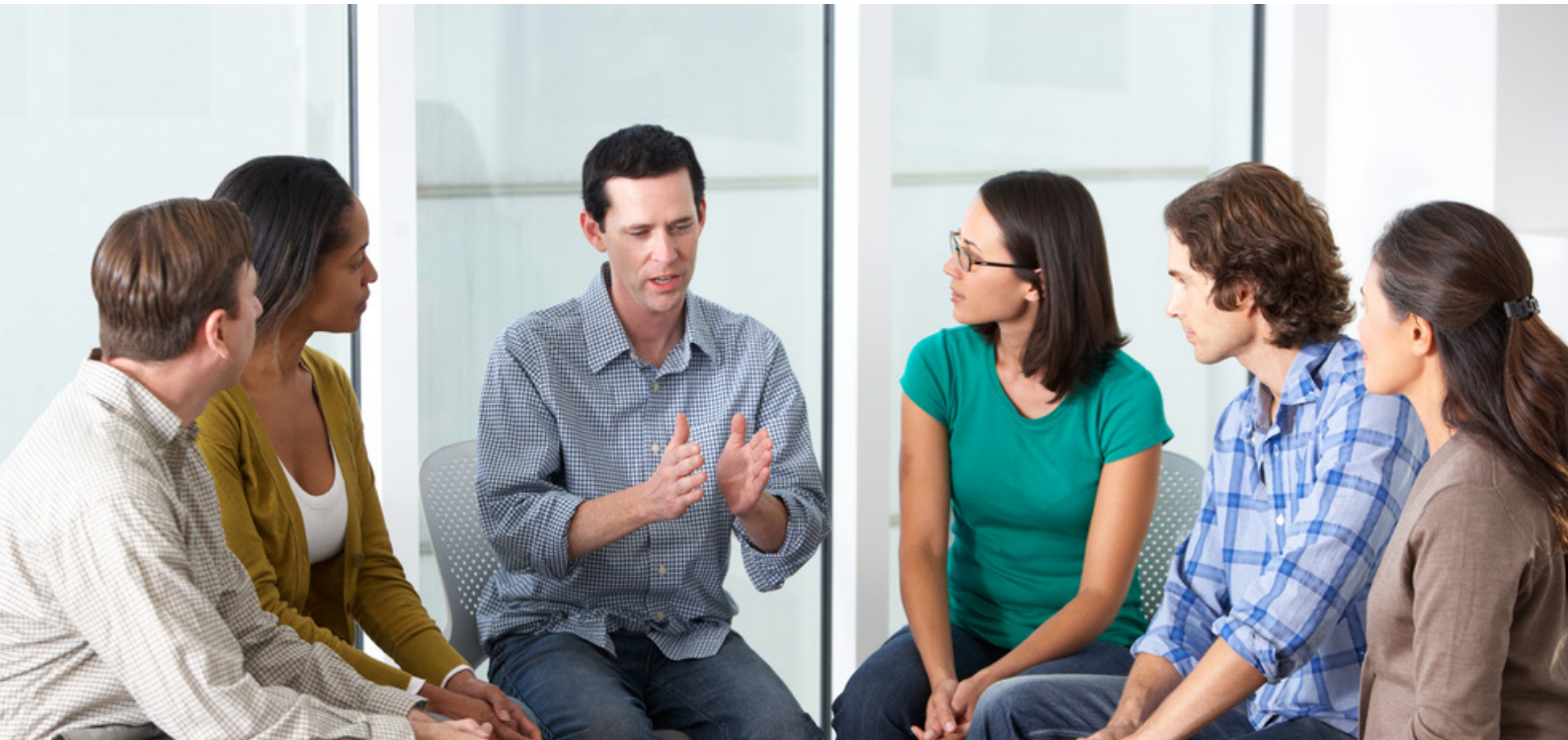
A group health plan can provide benefits either by using funds in a plan trust, purchasing insurance, or through self-funding benefits provided by the employer's general assets. This ebook will provide you with an overview of the basic fiduciary responsibilities that are applicable to group health plans under the Affordable Care Act.

The essential elements of a group health plan

Each type of group health plan consists of certain key elements, including:

- A written plan that fully describes the structure of benefits and guides daily operations
- A trust fund that holds the group health plan's assets
- A bookkeeping and reporting system that tracks contributions and benefit payments, maintains participant and beneficiary information, and provides documentation
- Documents that provide group health plan information to participants and the government

Employers sometimes hire third-party service providers to manage a group health plan's daily operations. There may also be cases in which one or more officials have discretion over the plan, and these individuals are known as fiduciaries.



All about fiduciaries

A fiduciary is a person or entity that becomes involved with operating a group health plan. However, using discretion in the administration and management of a plan or controlling the plan's assets will also make a person a fiduciary. Fiduciary status is usually based on the functions that are being performed for the plan, and not just on a person's title.

A group health plan can be structured in a variety of different ways. The structure of a group health plan will play a role in determining the entity that has fiduciary responsibilities. The majority of employers that sponsor full or partial self-funded plans often demonstrate discretionary authority and become fiduciaries as a result. If an employer decides to sponsor a fully insured plan, then the fiduciary status will depend largely on whether the employer demonstrates discretion over that particular plan.

A group health plan must have at least one fiduciary named in the written plan. A plan's fiduciaries will usually include trustees, plan administrators, investment managers, individuals who exercise discretion in plan administration, members of the plan's administrative committee (if applicable), and those who select committee officials. The key to determining whether an individual or entity is a fiduciary depends on whether they actually have discretion or control over a group health plan.

The significance of being a fiduciary

Since fiduciaries act on behalf of participants and beneficiaries in a group health plan, they must follow certain standards of conduct. These responsibilities include:

- Acting solely in the interest of participants and their beneficiaries
- Making well-advised decisions that ensure participants can benefit in the future
- Adhering to the group health plan documents
- Keeping plan assets in trust, if applicable
- Paying reasonable plan expenses

Acting prudently is one of the central responsibilities of a fiduciary under ERISA, and requires the fiduciary to have expertise in multiple areas. A fiduciary lacking in expertise will most likely need to hire an entity that has the knowledge to carry out certain functions.

The group health plan document is the foundation for plan operations, so following the terms of the document is another major fiduciary responsibility. All employers must be familiar with their plan document, including those drawn up by service providers, and should review them periodically to make sure the document remains current and compliant.

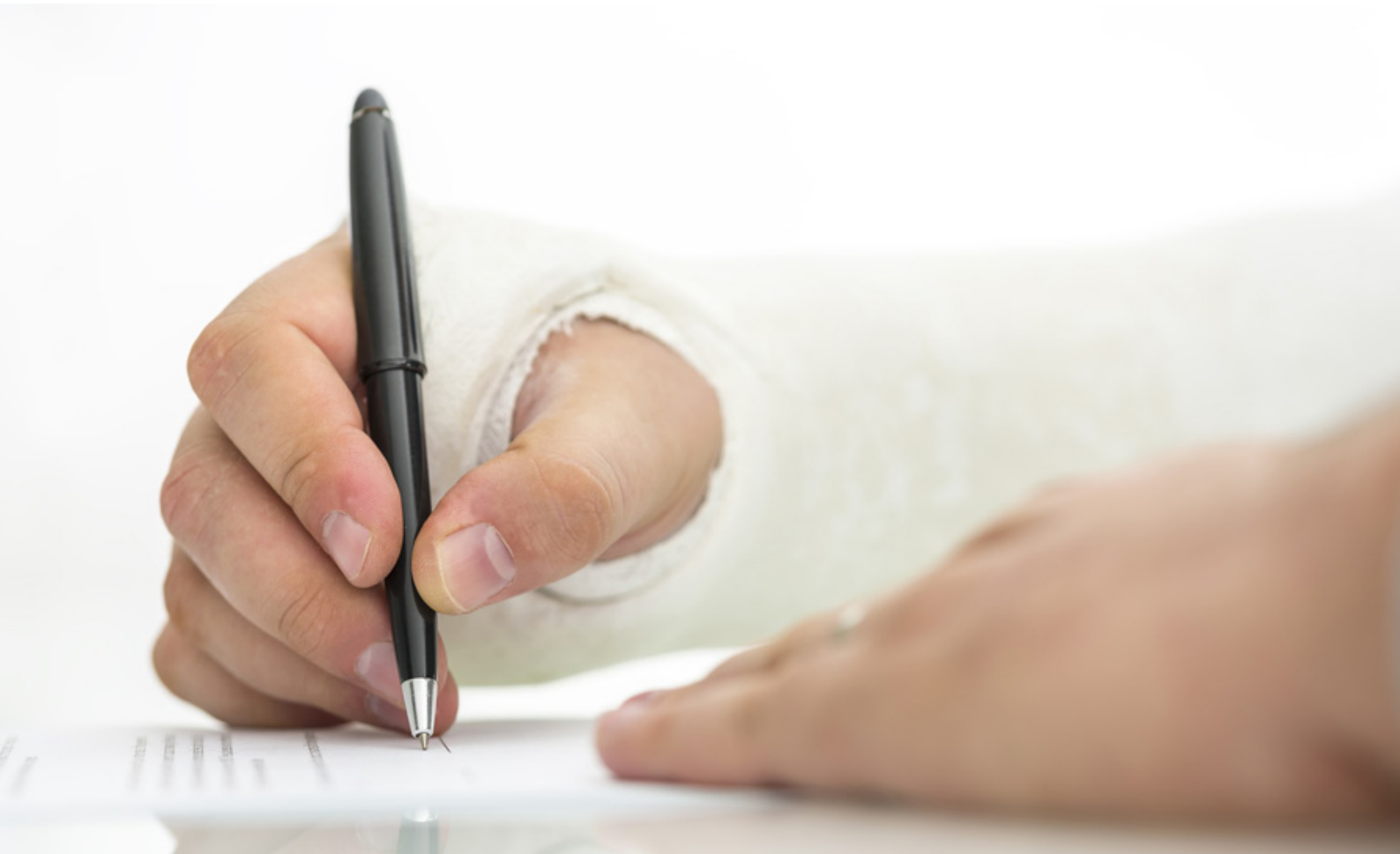
Limiting liability

Fiduciaries that do not comply with the basic standards of conduct will often be held personally liable, and will be responsible for restoring any losses that were suffered. However, fiduciaries can limit their liability by demonstrating that they have been responsible in documenting all processes. A fiduciary may also hire a third-party service provider to handle fiduciary responsibilities, and can set up the agreement in a manner that makes the fiduciary liable for certain predetermined functions.

A fiduciary should also always be aware of other fiduciaries that serve the same group health plan because all fiduciaries could be potentially liable for the actions of the other fiduciaries.

Bonding

All people that handle group health plans, including fiduciaries, must be covered by a fidelity bond, which serves as an additional protection that backs all plans. A fidelity bond is a form of insurance that will protect a group health plan against loss should it occur as a result of fraud or dishonesty by those covered by the fidelity bond.



The effect of responsibilities on plan operation

When employers hire third-party service providers to manage a group health plan, an employer can still become a fiduciary by performing certain key functions.

Contributions from employees

If a certain group health plan processes salary reductions from the paychecks of employees as a result of plan contributions, such as for COBRA premium payments, then an employer must deposit the contributions into the plan's trust within a timely and acceptable manner. The law states that participant contributions must be deposited into the plan's trust as soon as reasonably possible and no later than 90 days from the date when the employee's contributions were withheld or received by the employer. If employers have the ability to make the deposits sooner, they are encouraged to do so.

Hiring a third-party service provider

The hiring of a third-party service provider is often considered a fiduciary function. When taking prospective third-party service providers into consideration, you must provide each with the same, complete information about the group health plan, and mention the type of services your business is looking for so you can accurately compare service providers against one another.

Here are considerations to keep in mind when searching for a service provider:

- Compare firms against one another using the same information, such as costs, experiences, and services offered
- Seek information about the firm's own financial condition and their experience with group health plans the same size as yours
- Do research on the quality of the firm's services, such as the experience and qualifications of professionals handling plans, any enforcement action that has been taken against the firm, a history of the firm's performance record, and the firm's ability to access medical provider information
- Verify that all required licenses and accreditations currently are up-to-date

Service provider fees

When fees for third-party service providers are paid using group health plan assets, fiduciaries will need to fully understand all fees and expenses associated with the services being provided. When fiduciaries make their selection for a service provider, they should continue to monitor all fees and expenses to ensure that the pricing continues to be reasonable over time.

When comparing fees between prospective service providers, you must verify which services are being covered by each fee. While some providers offer multiple services for just one fee, others will bill you separately for individual services. Make sure you compare all services and fees between each provider when making your decision, and keep in mind that all services are associated with costs.

Plan fees may be paid by the employer, the group health plan, or both. Your group health plan document should outline how all fees are to be paid, include the names and entities of responsible parties, be handled by the fiduciary to ensure that all associated fees are reasonable given the services being provided.

Monitoring the third-party service provider

Employers should implement a formal review process schedule to evaluate whether they want to continue to use a particular service provider. The actions they take should involve:

- Reviewing the performance as provided by the service provider
- Reviewing any reports they have provided about your plan
- Verifying the actual fees that have been charged
- Asking about current policies and practices
- Verifying that plan records are being properly maintained and are up-to-date
- Following up on all participant concerns and complaints

Maintaining the claims procedures for plan benefits

All group health plans must develop and maintain a set of claims procedures that allow employees and their beneficiaries to apply for and receive any of the plan's benefits that were initially promised, and all procedures must be maintained by fiduciaries. Employers must understand the requirements as enforced by the Department of Labor for all ERISA plans, and must choose a service provider that can remain compliant with the standards.

Fiduciaries must familiarize themselves with the timeframes for deciding claims, and with the standards for making appeals when certain benefits are denied.

When a plan has received a claim, the timeframe in which they should make and provide notice of the outcome of the claim will depend on the type of claim being filed:

- Urgent care as soon as possible but not more than 72 hours after the claim has been received by the plan
- Pre-service claims within a reasonable period of time no later than 15 days after the claim has been received by the plan
- Post-service claims within a reasonable period of time no later than 30 days after the claim has been received by the plan
- Disability claims within a reasonable period of time no later than 45 days after the claim has been received by the plan

When pre- and post-service claims have been made, 15-day extensions could be made available. For claims that have been appealed, the timeframe will also vary based on the type of claim filed:

- Urgent care claims as soon as possible but no later than 72 hours after the plan has received the request to review a claim that has been denied
- Pre-service claims within a reasonable period of time no later than 30 days after the plan has received the request to review a claim that has been denied
- Post-service claims as soon as possible but no later than 60 days after the plan has received the request to review a claim that has been denied
- Disability claims within a reasonable period of time but no later than 45 days after the plan has received the request to review a claim that has been denied

Extensions will be available for time spent making decisions on appeals only if the claimant consents. The notice for a claim denial must always contain the following information:

- Specific reasons a claim has been denied
- A reference to the specific plan provision or provisions that were used as a reference for the denial
- Notices for claims that have been denied due to a lack of information must include descriptions of additional materials needed to perfect the claim and an explanation as to why the materials are needed
- A full description of the plan's review procedures
- A full description of rules, guidelines, and protocols that were used as a reference when the claim was denied
- A scientific explanation as to why a claim was denied if the claim was based on medical necessity or treatment
- A full description of the claimant's right to go to court to recover the benefits that were due under the plan

The notice of a claim denial that has been appealed must include the same information as noted above, except the full description of the plan's appeal process. This information must also include:

- A statement of the claimant's right to receive relevant documents free of charge
- A full description of any voluntary processes offered by the group health plan to resolve claim disputes

The claims procedure for the group health plan must provide a full review of a benefit claim if a claimant files an appeal for their denial. The minimum standards for appeals are:

- Claimants must be given a full 180 days to file an appeal
- A review that affords no deference to the initial determination must be conducted
- When a denial is based on the determination behind whether a particular treatment or drug was experimental or considered not "medically necessary," the reviewer must consult with a qualified health professional
- No more than 2 appeal levels will be allowed
- Mandatory binding arbitration of claims is generally prohibited; however, non-binding arbitration would be acceptable if done within the required time frame

Prohibited transactions, and ways to execute transactions that benefit the plan

Certain types of transactions are prohibited under the law to prevent fiduciaries from engaging and dealing with parties that could exercise unethical and improper influences over the group health plan. Fiduciaries must also stay away from engaging in conflicts of interest that could harm the plan.

Transactions that are prohibited

Parties that are prohibited to work with include the employer, the union, plan fiduciaries, service providers, and all statutorily-defined owners, officers, and relatives of the parties in interest. Transactions that are prohibited include:

- Sales, exchanges, and leases between the group health plan and party in interest
- The lending of money or other type of credit between the plan and party in interest
- Furnishing goods, services, or facilities between the plan and party in interest

Exemptions

The Department of Labor may grant additional exemptions if they provide protection for the plan in regards to conducting necessary transactions that would otherwise be prohibited. One such exemption in the law allows the plan to hire a third-party service provider as long as the services being provided are necessary and as long as the compensation being paid for those services is considered reasonable.

How employees get information about the plan, and how employers report plan activities

ERISA requires group health plan administrators to provide plan information to employees and to submit reports at the request of government agencies.

Informing employees and their beneficiaries

The following documents must be provided to employees and their beneficiaries at all times.

The Summary Plan Description (SPD) is the most basic descriptive document that clearly explains the plan, and is written in a manner to inform employees of the rights and responsibilities under the group health plan, as well as what to expect from the health plan.

The SPD must include basic information such as:

- The name, address, and contact information of the plan
- A description of the plan's benefits
- How employees can receive their benefits
- The duties of the plan and employee

Additionally, the SPD must contain more specific information, such as:

- The plan's claims procedure in full detail
- An employee's basic rights and responsibilities under ERISA
- Information on any premiums, cost-sharing, deductibles, and co-payments that may apply
- Any annual or lifetime caps and limits on benefits
- Detailed procedures for using network providers and composition of network
- Conditions outlining pre-certification
- A description of plan procedures that govern Qualified Medical Child Support Orders
- Notices and descriptions of certain rights under the Health Insurance Portability and Accountability Act (HIPAA) and other health coverage laws, as described below

This document should be distributed to all employees and beneficiaries within 90 days after they have been covered by the plan. SPDs must then be redistributed every fifth year and provided within 30 days of a request made by any beneficiary. Additionally, the SPD must be up-to-date within 120 days.

The Summary of Material Modification (SMM) is a document that informs employees and their beneficiaries of changes that have been made to the group health plan. The SMM must be provided immediately to all employees within 210 days after the end of the plan year in which the changes were made.

A Summary Annual Report (SAR) is a report that outlines financial information from the plan's annual report in an easy-to-understand narrative form. The SAR is distributed to all employees that are required to file Form 5500 on an annual basis.

How other types of laws affect fiduciary responsibilities

A fiduciary is responsible for making sure a group health plan complies with ERISA, which includes group health plan provisions such as COBRA and HIPAA.

The provisions of COBRA continuation coverage require that employees and their beneficiaries are able to maintain coverage under their group health plan for a limited time only, which they may also be required to pay for depending on certain qualifying events.

The provisions of HIPAA place limits on certain preexisting condition exclusions, and provide special enrollment rights for certain types of events. HIPAA provisions also prohibit discrimination in regards to eligibility, benefits, and premiums based on certain health factors.

Terminating fiduciary duties

Fiduciaries that no longer want to serve as fiduciaries are unable to walk away from their responsibilities, even if there are other fiduciaries responsible for the group health plan. All fiduciaries must follow proper plan procedures and make sure that another fiduciary will be assuming the remaining responsibilities.

Health Insurance Cooperative Agency has the experience needed to assess your company's employee benefits needs and the expertise to implement a plan that meets those needs. Contact us today at 913-649-5500 to learn more about group health benefits plans.

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