DOL Audits

DOL audits

U.S. Department of Labor (DOL) audits of welfare benefit plans are happening with greater frequency to every size company. Reasons for a DOL audit include:

- Complaints by welfare benefit plan participants to the Employee Benefits Security Administration (EBSA), the DOL agency responsible for administering and enforcing the provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA).
- Inaccurate or late filings of the Form 5500 Annual Report.
- National enforcement initiatives investigating compliance with ERISA and the Affordable Care Act (ACA).
- Transfer of cases from the IRS to the DOL.
- Random selection.

How to lower the risk of a DOL audit

A U.S. Department of Labor (DOL) audit of your welfare benefit plan could happen at any time. The checklist below can help you prevent and be prepared for a DOL audit:

- Maintain all documents related to welfare benefit plans in one location.
- Designate one person at the company to take charge of the welfare benefit plans.
- Respond in a timely fashion to all participant and beneficiary questions.
- Review and understand all plan documents.
- Make sure all ERISA-covered benefit plans comply with relevant laws such as health care reform and HIPAA.
- Distribute Summary Plan Descriptions (SPDs), with accompanying benefit plan component documents such as benefits booklets and certificates of insurance, to all plan participants within 90 days of becoming covered under the plan.

- Administer all ERISA-covered benefit plans, including group health plans and other welfare plans, in accordance with a written plan document.
- Respond to participant and beneficiary requests for an SPD and plan document within 30 days after a written request or risk a penalty of $110 per day, per participant or beneficiary for each violation.
- Inform participants of any material change to the plan either through a revised SPD or in a separate document, called a Summary of Material Modifications (SMM).
- Distribute required notices, such as COBRA and SBC notices, within required timeframes.
- If Form 5500 must be filed, be sure to complete all components accurately and file before the required deadline.
- Establish written procedures for disputes and claims resolution.

Please Note: This list is for general reference purposes only and is not all-inclusive. The information is subject to change based on new requirements and amendments to the law.

DOL health plan audit: document request checklist

The following checklist provides a summary of documents that may be requested from employers who sponsor group health plans in the event of a U.S. Department of Labor (DOL) audit. This checklist is for general reference purposes only and DOL auditors may request various documents that do not appear on this list, depending on the plan and other issues that may arise during the audit. If you have questions regarding your responsibilities, please contact a knowledgeable attorney or benefits professional.

- Summary Plan Description (SPD), including any changes in plan benefits and entitlement to benefits.
- All summaries of material modifications for requested plan years.
- Plan document, including all amendments for relevant plan years.
- All insurance plan contracts (fully-insured plans).
- Any trust documents relating to plan assets.
- All contracts for claims processing, administrative services, and reinsurance (self-insured plans).
- Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.
- Form 5500 filings.

Administrative records

- Insurance billing invoices, premium schedules, employer and employee contribution schedules and payroll records of withholdings for benefits.
- Documents evidencing payroll deductions for employee premiums to the plan.
- Documents evidencing current outstanding medical claims.
- List of COBRA participants, including COBRA start date and amount of COBRA payment.
- Copy of any rebate paid pursuant to the medical loss ratio (MLR) requirements under health care reform and documentation of what was done with the rebate.

Some of the information below may appear in the plan's SPD, while certain notices must be provided separately due to the timeframes for when they are required to be provided. In addition, certain information appearing on this list may no longer be applicable for a particular plan year, but may still be requested as part of a DOL audit covering previous years.

Health care reform related documents

- Summary of Benefits and Coverage (SBC), Notices of Material Modifications, and Uniform Glossary.
- Copy of the Health Insurance Exchange Notice (Notice of Coverage Options).
- Sample of the notice describing enrollment opportunities relating to dependent coverage of children to age 26 (for a plan that provides dependent coverage).
- A list of any participants and beneficiaries whose coverage has been rescinded, the reasons for rescission, and a copy of the notice of rescission that was provided 30 days in advance of any rescission of coverage.
- Documents showing the lifetime limits applicable for each plan year on or after September 23, 2010 (if the plan imposes, or has imposed, a lifetime limit at any point since that date).
- Sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan.
- Documents showing the annual limits applicable for each plan year on or after September 23, 2010 (if the plan imposes, or has imposed, an annual limit at any point since that date).

Document (non-grandfathered plans)

- Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010.

- Copies of documents relating to coverage of emergency services for each plan year on or after September 23, 2010 (if the plan provides any benefits with respect to emergency services in an emergency department of a hospital).
- Copy of the Notice of Patient Protections informing participants of the right to designate any participating primary care provider or pediatrician and obtain OB/GYN care without prior authorization for plans that provide OB/GYN coverage (if the plan requires or allows for the designation of a primary care provider).
- Copy of the plan's internal claim and appeals and external review processes.
- Copies of a notice of adverse benefit determination, notice of final internal adverse determination, and notice of final external review decision.
- Any contract or agreement with any independent review organization or third party administrator providing external review.

Document (grandfathered plans)

- Copy of the disclosure of grandfathered health plan status, required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the plan.
- Records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify grandfathered health plan status (this may include documentation relating to the terms of cost-sharing, the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and any contract with a health insurance issuer, which were in effect on March 23, 2010).

HIPAA related documents

- Copy of the plan's rules for eligibility to enroll under the terms of the plan, including continued eligibility.
- Copy of a blank enrollment application for the plan.
- Sample certificate of creditable coverage, a copy of the record or log of all certificates for individuals who lost coverage under the plan or requested certificates, and a copy of the written procedure for individuals to request and receive certificates.
- Sample general notice of preexisting condition exclusion informing individuals of the exclusion period and its terms, and of the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the plan does not impose a preexisting condition exclusion.

- Copies of individual notices of preexisting condition exclusion issued to certain individuals as required under the law (including any lists or logs of issued notices), or proof that the plan does not impose a preexisting condition exclusion.
- Copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means.
- Records of claims denied due to the imposition of a preexisting condition exclusion (as well as the plan's determination and reconsideration of creditable coverage, if applicable), or proof that the plan does not impose a preexisting condition exclusion.
- Copy of the written procedures that provide special enrollment rights to individuals who experience certain events, including, but not limited to, the loss of other coverage or the acquisition of a new dependent (including any lists or logs of issued notices).
- Copy of the written appeal procedures established by the plan.
- Materials describing any wellness programs or disease management programs offered by the plan. If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the plan's wellness program disclosure statement regarding the availability of a reasonable alternative.
- Copy of the plan's HIPAA notice of privacy practices (including any lists or logs of issued notices).

Other health insurance law related documents

- The plan's Newborns' Act Notice (this should appear in the SPD), including any lists or logs of issued notices.
- Copy of the plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth.
- Sample of the written description of benefits mandated by the Women's Health and Cancer Rights Act, required to be provided to participants and beneficiaries upon enrollment and annually thereafter.
- Sample COBRA notices provided to participants and beneficiaries, including the General Notice of COBRA Rights, COBRA Election Notice, Notice of Unavailability of COBRA Coverage, and Notice of Early Termination of COBRA Coverage (including any lists or logs of issued notices).
- Copy of the plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits.