Compliance Corner Webinar:

Fuzzy on ERISA Required Disclosures?

October 19, 2017

Q: Are Teledoc plans subject to ERISA?
A: Telemedicine benefits would be subject to ERISA if it is bundled in the medical benefits. Standalone telemedicine benefits could also be subject to ERISA if the benefits provide significant care. If the telemedicine program is offered separately from the group health plan – meaning that employees who are not enrolled in the group health plan are still eligible to participate in the telemedicine program (for example, employees who are not benefits eligible or who have waived coverage) – then the telemedicine would be looked at on its own to determine if ERISA, COBRA and PPACA apply. For all three, this appears to be an analysis focused on whether the telemedicine program is providing medical care. Employers are advised to seek advice from their legal counsel.

Q: If a benefit is subject to ERISA like Prepaid legal, does the employer need to offer Cobra
A: Prepaid legal is not a benefit subject to COBRA regulations. COBRA regulations specifically relate to plans that cover health care benefits (medical, dental, vision) and the reimbursement accounts used for these expense (HRA, HSA, FSA).

Q: Notices of spouses & dependents: how are Employers expected to notify?
A: There are a few circumstances that require notice to both the employee and "beneficiaries". The Summary of Benefits and Coverage (SBC) should be sent separately if any dependents have a separate address from the enrollee. The COBRA general notice must be provided to the employee and spouse. The Wellness Notices must also be provided to the beneficiaries at different addresses. An employer could mail all applicable notices. They also may provide these notices electronically if the employee "opts in" to electronically delivery.

Q: Does Willful Violation on SBCs, mean per entire group? Not per employee?
A: The willful violation provision on SBCs applies to each affected beneficiary.

Q: It was my understanding that the CHIP notice must be provided annually, but does NOT have to be provided when coverage is first offered. Has that changed, or did I misunderstand the requirements?
A: The CHIP notice should be provided to all eligible employees upon enrollment and annually. The CHIP Notice must be sent not just to plan participants but also to each employee who is or might become eligible for employer group health benefits. You can include this annual notice as part of your Open Enrollment packet.

Q: NMHPA does not require annual notice, just "Notice must be included in the Summary Plan Description"
A: The Newborns' and Mother's Health Protection Act (NMHPA) does not require annual notice. It is a short notice and can be combined with other language (Women's Health and Cancer Rights Act, Genetic Information Nondisclosure Act) Our agencies include this information in our annual notice packets.

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Q: I thought the Newborns Act Notice has to be provided in the SPD, but does not have to be provided annually. Since the SPD only has to be provided every 5 years (10 if unchanged), would it not be compliant to include in the SPD and not include with separate notices at renewal?
A: The Newborns' and Mother's Health Protection Act (NMHPA) does not require annual notice. It is a short notice and can be combined with other language (Women's Health and Cancer Rights Act, Genetic Information Nondisclosure Act) Our agencies include this information in our annual notice packets.

Q: I am confused that the notices are being said to be required at Open Enrollment however the DOL disclosure guide does not specify annually, i.e. NMHPA and GINA https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/reporting-and-disclosure-guide-for-employee-benefit-plans_0.pdf
A: The Newborns' and Mother's Health Protection Act (NMHPA) and Genetic Information Nondisclosure Act (GINA) does not require annual notice. In general, they are brief notices and can be combined with other language (Women's Health and Cancer Rights Act, etc.) Our agencies include this information in our annual notice packets.

Q: Are you saying the GINA disclosure has to be provided even if genetic information is not requested or collected? I agree it should be in the SPD, but is it really needed when offered coverage and at open enrollment each year?
A: The Genetic Information Nondisclosure Act (GINA) does not require annual notice. In general, it is a brief notice and can be combined with other language (Newborns' and Mother's Health Protection Act (NMHPA) and Women's Health and Cancer Rights Act, etc.) Our agencies include this information in our annual notice packets.

Q: You are mentioning requirements, i.e. requirements for rewards, etc. that are not in presentation - will you be providing this information?
A: The following link is to the Department of Labor overview on wellness program provision. Please note that the EEOC has been asked to review their latest guidelines and changes may be forthcoming.
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/wellness-programs

Q: So the wellness program has a stop smoking piece and will gives a break on premiums. This is the only piece available. Does an employer have to create something for non-smokers? Smokers are being rewarded for smoking (stop smoking) but non-smokers are penalized for not smoking already?
A: A change in how the program is presented would alter the perception. The employer should set the contributions for all employees and offer the tobacco cessation program. Any employee who would not complete the program would be charged a higher premium and would be a penalty to the tobacco user. The non-tobacco user has already received the incentive.

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Q: Is there a requirement of grandfather status each plan year?
A: The notice for grandfathered plans is required annually prior to the renewal.

Q: What about changing your waiting period outside of open enrollment?
A: A change in waiting period is considered a material change to the offering of coverage and subject to the 60-day advance notice of material modification.

Q: if a plan is fully-insured, does the employer have to report to CMS or will the carrier do that for them?
A: Medicare Part D notification of creditable coverage status is an employer requirement and applies to all fully-insured and self-funded plans.

Q: If we took a realistic look, 99% of all employer groups are out of compliance. Also, the brokers are getting very little compensation for all the work that is needed to make sure their clients are fully compliant. Are there any service companies we can hook up with to provide us services to introduce to their clients?
A: There are several vendors who can provide these types of services and assistance. Refer to the Member Benefits section of the NAHU Resource page.

Q: what if Teledoc is a separate benefit?
A: Telemedicine benefits would be subject to ERISA if it is bundled in the medical benefits. Standalone telemedicine benefits could also be subject to ERISA if the benefits provide significant care. If the telemedicine program is offered separately from the group health plan – meaning that employees who are not enrolled in the group health plan are still eligible to participate in the telemedicine program (for example, employees who are not benefits eligible or who have waived coverage) – then the telemedicine would be looked at on its own to determine if ERISA, COBRA and PPACA apply. For all three, this appears to be an analysis focused on whether the telemedicine program is providing medical care. Employers are advised to seek advice from their legal counsel.

Q: Aren't many of these notices provided by the health insurance carriers for fully insured plans? (Newborns Act, WHCRA, etc)
A: While some carriers may provide these notices, it is the employer responsibility for delivery.

Q: Does Disclosure to CMS have to be completed each year even if an employer has no Medicare-eligible employees covered under their group health plan?
A: Yes. Annual disclosure to CMS is required regardless of Medicare-eligible employee count.

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Q: Are DPC (Direct Primary Care) plans subject to ERISA
A: Direct Primary Care (DPC) is not normally qualified as an insurance plan. However, each state may have oversight for this service. Employers are advised to seek advice from their legal counsel.

Q: What if state requirement and federal requirement's conflict each other....do you follow federal or state law?
A: Federal requirements would be the first level of guidance. Any state requirements for additional notices, benefits and restrictions would also apply.

Q: Does the CHIPRA notice have to be a "separate" document or can it be included in a Combined Compliance Notice?
A: Yes. The CHIPRA notice, and all others, can be combined in one notice. There are conflicting rules on which needs to be most prominent. It is our suggestion that the Summary of Benefits and Coverage (SBC) be first, Medicare Part D creditable coverage notice second and all others follow.

Q: Can NAHU provide sample notifications referenced on this webinar on their website so we can make certain we are in compliance with all and able to notify our clients?
A: All sample notices and/or language are provided in separate links.

Q: Where do I find the language regarding the rules on providing these notices electronically? Where do I find the language regarding the rules on providing these notices electronically?
A: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/11-03

Q: Which notice did you say needs to be on top?
A: There are conflicting rules on which needs to be most prominent. It is our suggestion that the Summary of Benefits and Coverage (SBC) be first, Medicare Part D creditable coverage notice second and all others follow.