Health Plan Investigations

1. Purpose. The purpose of this section is to provide guidance on health case openings and initial reviews.

2. Criteria. RO should open a case involving a group health plan or health service provider (other than criminal health fraud) as a Program 50.

a. Health investigations may include a review of all applicable ERISA provisions including: (1) disclosure provisions under Part 1; (2) the fiduciary provisions under Part 4; (3) the benefit claims procedure regulations under Part 5; and (4) group health plan requirements under ERISA Parts 6 and 7 relating to all applicable health laws including:

i. Consolidated Omnibus Budget Reconciliation Act (COBRA);
ii. Health Insurance Portability and Accountability Act (HIPAA);
iii. Mental Health Parity Act (MHPA);
iv. Mental Health Parity and Addiction Equity Act (MHPAEA);
v. Women's Health and Cancer Rights Act (WHCRA);
vi. Newborns' and Mothers' Health Protection Act (Newborns' Act);
vii. Genetic Information Nondiscrimination Act (GINA);
viii. Michelle's Law;
ix. Children's Health Insurance Program Reauthorization Act (CHIPRA);
x. Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

b. If an enforcement action raises issues under the shared provisions of Part 7, it must reflect interpretations of the laws cleared by the Departments of Labor, Treasury and Health and Human Services.[1]

c. ERISA also requires group health plans to:

i. Provide participants with plan information, including important information about plan features and funding;

ii. Provide fiduciary responsibilities for those who manage and control plan assets;

iii. Plan to establish a grievance and appeals process for participants to get benefits from their plans;

iv. Give participants notice of their right to sue for benefits and breaches of fiduciary duty; and

v. Include rules relating to plan eligibility and coverage requirements.

3. Plan-level Investigations. The ROs conduct plan-level investigations of fully and self-insured group health plans to ensure compliance with ERISA Title I group health plan requirements and to pursue widespread compliance opportunities when appropriate. In addition

to Part 7 of Title I, these cases will also examine compliance with other ERISA provisions such as claims administration, failure to provide promised benefits, reasonable administrative fees, potential prohibited transactions, and other issues.

4. Service Provider Investigations. Generally, any service provider that exercises discretionary authority or discretionary control respecting the management or administration of the plan is a fiduciary. Many self and most fully insured plans frequently include a health insurance issuer that exercises discretion or control over benefit claims decisions.

Issuers offering health insurance coverage in connection with group health plans are also subject to Part 7 provisions through parallel state and federal laws, and states maintain primary enforcement authority over issuers regarding these rules.

Service provider investigations typically require an investigation of systemic ERISA violations to ensure service providers, servicing numerous ERISA-covered group health plans, comply with plan documents, and pay health benefit claims according to plan terms and applicable claims processing regulations. These cases focus on procedural, substantive and disclosure violations related to the denial of promised health benefits. Service provider cases may involve the same investigative issues as plan-level cases, although they generally are more complex due to the large number of transactions at issue (e.g., plan-wide patterns of claim processing errors).

5. Elements of Violations of Part 7. The following are basic elements of Part 7 violations:

a. The provisions of Part 7 of Title I of ERISA cover the subject plan(s) involved.

b. The plan provisions or practices did not comply with the requirements under Part 7. Collect sufficient evidence to establish the plan's non-compliance with one or more statutory and regulatory provisions of Part 7.

6. Widespread Compliance. In the health insurance industry, it is common for issuers or other service providers to issue standardized plan documents and other material to ERISA plan clients. To leverage its resources, EBSA identifies service providers who provide non-compliant health insurance policies or standardized plan documents and pursues global corrections, affecting all plans governed by the faulty policies or plan documents.

7. Case Development. Enforcement strategies, annual operating plans, and National Office policy statements provide direction to identify areas of potential non-compliance and may emphasize the review and investigation of certain types of plan-level cases, service providers, MEWAs, or other specific matters. All identification of areas for potential non-compliance reflects, and is consistent with, such direction. Additionally, ROs should consider implementing supplemental efforts to national enforcement strategies, annual operating plans, and policy guidance. Supplemental efforts may reflect factors such as local economic conditions, geographical coverage within an RO jurisdiction, and specialized plan types.

Sources for potential health plan investigations include:

a. Computer generated compilations of selected employee health benefit plans or service providers derived from reports filed with EBSA;

b. Information derived from detailed review and analysis of annual reports, supporting financial statements, schedules, exemption application files, ERISA Section 502 complaints, and other internal EBSA sources;

c. Information concerning employee health benefit plans or service providers derived from other governmental agencies such as HHS and state insurance agencies;

d. Information concerning employee health benefit plans or service providers derived from non-governmental sources such as newspapers, industry journals and magazines, or leads from knowledgeable parties such as patient advocacy groups, or private litigation;

e. Complaints from participants, fiduciaries, informants, or other sources in the community. Allegations of acts against a participant or beneficiary for exercising any right to which he/she is entitled under the provisions of an employee benefit plan, or interfering with the attainment of any right to which the participant may become entitled, should be handled as described in the Participant Rights section;

f. Compilations of selected employee health benefit plans or service providers derived by using combinations of the sources.

For additional methods of case identification, please refer to the Fiduciary Investigations section.

8. Case Opening. Please refer to the Fiduciary Investigations section.

9. Investigative Activity, Full Review. Health investigations should include a review for compliance with all applicable ERISA provisions. This includes review for compliance with the fiduciary provisions, claims procedure rules, and Parts 6 and 7. Generally, the Investigator/Auditor should evaluate every health plan/benefit package option offered for Part 7 compliance. This review will typically include an operational review of claims data, claims listings and/or claims.

10. Document Request Letters and Subpoenas. After case opening, the Investigator/Auditor may use a document request letter to request information beyond what is necessary to support information filed with the Secretary under Title I of ERISA. Such letters may not request creation of documents, but may request production of existing documents. The Investigator/Auditor may send letters to the Plan, Plan Sponsor, and Plan service providers (including but not limited to health insurance issuers and third party administrators).

Figure 1 is an example of a health request letter. The information requested for any particular investigation may vary from these examples depending on the facts and circumstances of the investigation. Depending on the circumstances, the Investigator/Auditor may send a subpoena

pursuant to Subpoena section in conjunction with or in lieu of a Document Request Letter. Subsequent document requests or subpoenas for information may be necessary. The HIPAA privacy regulations, collectively known as the "Privacy Rule," set forth several "permitted uses or disclosures" or "standards" that allow covered entities to disclose protected health information without patient authorization.

In consultation with its SOL and before issuance of a subpoena, EBSA reviews its investigatory objectives in a specific investigation to ensure that the information requested is the minimum necessary to accomplish its investigative objectives. Special procedures are necessary when a RO receives such information.

For additional techniques relating to Investigative Activity, please refer to the Fiduciary Investigations Manual section.

(Figure 1)
Model Health Plan Document Request Letter

Certified Mail No.
Return Receipt Requested
xx
Plan Administrator
xx Health Plan
xx
xx
RE: xx Health Plan
Case No.
Dear Plan Administrator:

The Department of Labor has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I establishes standards governing the operation of employee benefit plans such as the xx Health Plan (the Plan).

The Plan is scheduled for investigation by this office. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part:

> The Secretary [of Labor] shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder...to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this title....

Additionally, the Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (collectively, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

We have found in the past that submission of relevant documents to our office prior to the inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on, plan and corporate officials and may eliminate the need for an on-site visit entirely. To that end, we ask that you submit to this office, *within ten business days* of your receipt of this letter, the documentation listed on the enclosed Attachment A. If any items are not applicable, please so indicate and provide an explanation.

Thank you in advance for your cooperation. Should you have any questions, please contact the undersigned at XXX-XXX-XXXX.

Sincerely,
Attachment

Footnotes

1. To be used when appropriate.