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NAVIGATING (AND AVOIDING) DOL ENFORCEMENT ACTIONS AGAINST ERISA GROUP HEALTH PLANS AND PROVIDERS

Sage Fattahian, Elizabeth Goldberg, and Robert Hunter
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Presenters

Sage Fattahian

Elizabeth (Liz) Goldberg

Robert (Bob) Hunter

Morgan Lewis

BACKGROUND ON DOL INVESTIGATIONS OF HEALTH PLANS AND INSURERS/ADMINISTRATORS

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AGENCY LANDSCAPE FOR ERISA ENFORCEMENT

FEDERAL

UNITED STATES DEPARTMENT OF LABOR
Civil and Criminal ERISA Matters

UNITED STATES DEPARTMENT OF JUSTICE
Criminal ERISA Matters

STATE

State Insurance Regulators
Regulate Insured Benefits (Even for ERISA Plans)

ERISA ENFORCEMENT: INSURED PLANS VS. ASO PLANS

- ERISA regulates both ASO and insured plans.
- Insured Plans:
  - Generally insured plans are subject to state law regulation.
  - Generally the insurer to an ERISA group health plan accepts fiduciary responsibility for the design of the plan and the administration of the plan.
- ASO Plans:
  - ASO plans are not subject to state law regulation.
  - Generally the administrator is not a fiduciary with respect to the design of the plan. May have limited fiduciary responsibility such as for claims and adjudication.
  - The employer is thus primarily responsible for both payment of the claims and the fiduciary responsibility for benefit design (but possibly not claims and appeal adjudication).

OTHER FEDERAL LAW APPLICABLE THROUGH ERISA

- Through ERISA Parts 6 and 7, there are a number of other federal laws that are made applicable to ERISA group health plans, namely:
  - Consolidated Omnibus Budget Reconciliation Act (COBRA);
  - Health Insurance Portability and Accountability Act (HIPAA);
  - Mental Health Parity and Addiction Equity Act (MHPAEA);
  - Women's Health and Cancer Rights Act (WHCRA);
  - Newborns' and Mothers' Health Protection Act (Newborns' Act);
  - Genetic Information Nondiscrimination Act (GINA);
  - Children's Health Insurance Program Reauthorization Act (CHIPRA); and
  - Patient Protection and Affordable Care Act (Affordable Care Act or ACA).

FOCUS OF DOL ERISA HEALTH ENFORCEMENT

ERISA (1974)

Requires plan fiduciaries of group health plans to comply with fiduciary duties, duties of loyalty to the plan, and prohibited transaction rules.

Obligations include complying with health plan claims and appeal regulations under 29 CFR § 2560.503-1, and satisfying statutory and regulatory disclosure obligations.

MHPAEA (2008)

Applies to group health plans through Part 7 of ERISA.

Requires health insurers as well as group health plans to guarantee that financial requirements on benefits (co-pays, deductibles) and treatment limitations (visit caps) for mental health or substance abuse benefits are not more restrictive than medical and surgical benefits.

ACA (2010)

Applies to group health plans through Part 6 and Part 7 of ERISA.

Three parts: Individual Mandate, Employer Mandate, and Plan Mandates.

Fees: PCORI

ACA Reporting

DOL ENFORCEMENT – BACKGROUND

The DOL has civil and criminal investigatory and litigation enforcement authority over ERISA (including MHPAEA and ACA).

- The DOL operates out of regional offices, with direction from its national office.
- Unlike some other federal agencies, the DOL's civil litigation authority is independent of the DOJ.
- Criminal actions are handled by the DOJ (with DOL assistance).

Civil remedies include payments to the plan or repayment of fees, monetary penalties for disclosure failures, statutory penalties, and other measures.

- These other remedies include removal of plan fiduciaries, imposition of an independent fiduciary, and injunctive actions.
- Reputational risk is also a key concern.

The DOL can refer matters to other agencies for criminal enforcement.

The DOL has an active criminal enforcement program, working with the DOJ.

DOL ENFORCEMENT RELATED TO HEALTH BENEFITS

- The DOL has a very active enforcement program involving examinations and enforcement actions related to ERISA group health plans.
- The DOL enforcement activities in this space have increased significantly over the last five or so years.
- The focus of the DOL in health investigations includes the following four areas, which will be the focus of today's presentation:
  - MHPAEA
  - ACA
  - Benefit claims, disclosure, and fiduciary duties
  - Fraud and service provider self-dealing

DOL ENFORCEMENT: WHO IS INVESTIGATED

- The DOL conducts investigations of both individual plans and service providers:
  - Plans are examined through "plan-level investigations"
    - The DOL conducts plan-level investigations of both insured and ASO group health plans.
    - The DOL identifies its focus in these "plan-level investigations" as being compliance with ERISA's fiduciary provisions, claims administration, failure to provide promised benefits, reasonable administrative fees, and potential prohibited transactions.
  - These investigations can involve insurers and administrators as the service provider to the plan.

DOL ENFORCEMENT: WHO IS INVESTIGATED

- The DOL also conducts "service provider investigations."
  - In fact, in recent years the DOL has identified service provider investigations as an enforcement priority.
- These investigations can implicate insurers and administrators of group health plans.
  - The DOL identifies its focus in these "service provider investigations" as being:
    - "systemic ERISA violations"
    - ensuring "service providers . . . comply with plan documents, and pay health benefit claims according to plan terms and applicable claims processing regulations"
    - 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., planwide patterns of claim-processing errors).

DOL ENFORCEMENT: SOURCES OF INVESTIGATION

- The DOL identifies investigation targets through:
  - National targets: National enforcement strategies, annual operating plans, and National Office policy statements
    - The DOL identifies "Health Enforcement Initiatives" as one such enforcement priority.
  - Locally developed priorities of regional offices

Health Enforcement Initiatives - EBSA is focusing its efforts on returning money to plans and their participants adversely affected by improper administrative practices or the mishandling of plan funds. EBSA continues its ongoing efforts to detect and correct violations found in Part 7 of ERISA. Although the ACA introduced broad reforms, most of Part 7's protections remain in effect for ERISA plans, such as those contained in the Women's Health and Cancer Rights Act (ERISA Section 713), the Newborns' and Mothers' Health Protection Act (ERISA Section 711), the Mental Health Parity Act and Mental Health Parity and Addiction Equity Act (ERISA Section 712), the Genetic Information and Nondiscrimination Act, and Michelle's Law (ERISA Section 714). Common issues include proper plan administration, proper claims payment, service provider fees, compliance with claims procedure rules, and compliance with health care laws under Part 7 of ERISA in stated plan terms and operations. Investigations also examine compliance with applicable provisions of the ACA, which includes market reforms, patient protections, extension of dependent coverage, internal claims and appeals and external reviews and grandfathered health plans.

The national initiatives for health enforcement include mental health parity, emergency services, and health service providers' self-dealing.

DOL ENFORCEMENT: SOURCES OF INVESTIGATION

- Sources for potential health plan investigations include:
  - Computer-generated targets derived from reports filed with the DOL
  - Information derived from review and analysis of internal DOL sources (such as annual reports, supporting financial statements, schedules, and exemption application files)
  - Information from other governmental agencies such as HHS and state insurance agencies
  - Information from nongovernmental sources such as newspapers, industry journals, and magazines, or leads from knowledgeable parties such as patient advocacy groups or private litigation
  - Complaints from participants, fiduciaries, informants, or other sources in the community
  - Compilations of selected employee health benefit plans or service providers derived by using combinations of the sources

DOL ENFORCEMENT REMAINS ROBUST

The current administration is not having a cooling effect on the DOL enforcement. Instead, DOL enforcement, including of health plans, has been very active—and growing.

In Fiscal Year 2019, the DOL conducted 186 health plan investigations.

For all enforcement activities (not limited to health enforcement), the DOL recovered $2.57 billion, including $2.02 billion in enforcement actions.

The amount recovered was a 38% increase from 2018, showing an upward trend.

In 2019, the DOL referred 89 cases for civil litigation.

In Fiscal Year 2018, the DOL investigated and closed 285 health plan investigations.

For all enforcement activities, the DOL recovered $1.6 billion, including enforcement action recoveries, which were $1.1 billion.

The amount recovered was a 45% increase from 2017, showing an upward trend.

In Fiscal Year 2017, the DOL closed 347 health investigations.

For all enforcement activities, the DOL recovered $1.1 billion, including enforcement action recoveries, which were $1.1 billion, including $682.3 million in enforcement recoveries.

- In recent years there has also been pressure from the House of Representatives on the DOL to increase enforcement activities.
- COVID-19 has not slowed down the pace of DOL investigation and enforcement activities.

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ACA & CARES ACT ENFORCEMENT

ACA COMPLIANCE AND MANDATES

- ACA Mandates
  - Preventive care services covered at no cost-sharing
  - Emergency room (ER) mandate requirements
  - Medical loss ratio calculations
  - SBC requirements
  - Adjudication of claims
  - ERISA claims procedure compliance
  - External review compliance

RECENT EXAMPLES OF ACA ENFORCEMENT: ER MANDATE

ER mandate enforcement background

- One of the ACA coverage mandates is that ER services not distinguish between in- and out-of-network coverage.
- The DOL has been examining whether claim administration denies ER claims—or imposes out-of-network cost-sharing—based on improper determination that the treatment was not emergent.

ER mandate enforcement example

- In July 2017, the DOL announced an agreement with a plan administrator to settle claims related to application of the ACA ER services mandate for $1.5 million.
- The DOL alleged that the administrator violated ERISA because it made a determination regarding whether a participant was experiencing an emergency using a prudent layperson table without allowing the member to provide input on his or her presenting symptoms.

CARES ACT ENFORCEMENT

- Requires coverage requirements related to the diagnosis of COVID-19 at no cost-sharing (no deductibles, co-pay, co-insurance), without any prior authorization or other medical management requirements
- Includes items and services furnished to an individual during healthcare provider office visits (including telehealth), urgent care visits, and emergency room visits that result in an order for a COVID-19 test
- In recent audits, the DOL has requested claims data related to this requirement, including ongoing investigations

EBSA NOTICE 2020-01: EXTENDED TIMEFRAMES FOR ERISA COMPLIANCE

- Extended deadlines for disclosure documents required under Title I of ERISA
- Extended deadline to request special enrollment
- Extended deadline for making COBRA premiums, notifying a plan of a qualifying event or determination of disability
- Extended deadline to file for claims and appeals
- Guidance did not require notification
- During the audit, the DOL has requested evidence for any communication to participants

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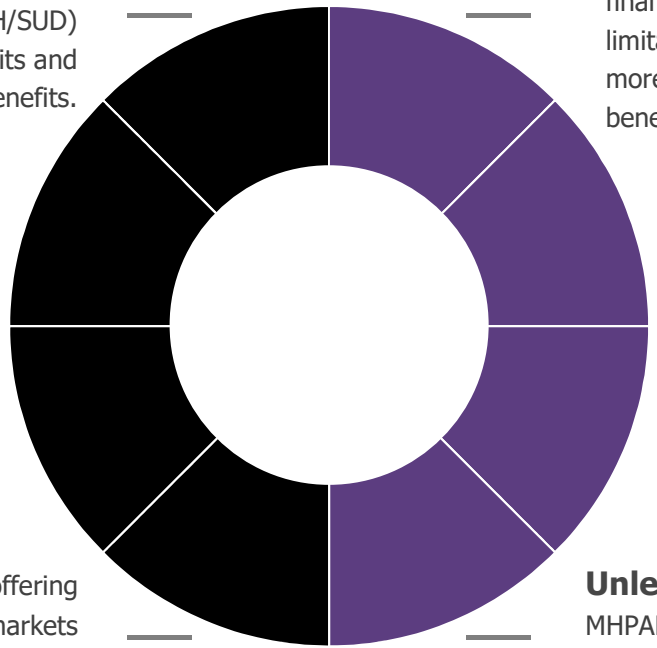
MHPAEA ENFORCEMENT

MHPAEA

MHPAEA sets minimum standards for group health plans and issuers that provide coverage for mental health/substance use disorder (MH/SUD) benefits to ensure parity between those benefits and medical/surgical benefits.

Nongrandfathered group health plans and group and individual health insurance plans are required to provide coverage for certain preventive services with no cost-sharing, which includes, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening.

ACA also requires plans and issuers offering coverage in the individual and small group markets to cover certain "essential health benefits," including MH/SUD benefits.



Generally requires that group health plans and health insurance issuers ensure that the financial requirements and quantitative treatment limitations on MH/SUD benefits they provide are no more restrictive than those on medical or surgical benefits.

Also requires that the factors used to determine when nonquantitative treatment limitations will apply to MH/SUD benefits are comparable to (and applied no more stringently than) the factors used in applying the limitation to medical/surgical benefits.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and nongrandfathered group health plans and large group health insurance coverage.

WHAT DOES "NO MORE RESTRICTIVE" MEAN?

- If a plan or issuer provides MH/SUD benefits in **any "classification"** (see below), those benefits must be provided in **every classification** in which medical/surgical benefits are provided.
- The six **classifications** of benefits for MHPAEA purposes are:

  1) inpatient, in-network;*
  2) inpatient, out-of-network;
  3) outpatient, in-network;**
  4) outpatient, out-of-network;**
  5) emergency care; and
  6) prescription drugs.

  * Subclassifications permitted for multiple tiers of network providers.

  ** Subclassifications permitted for (1) office visits and (2) all other outpatient items and services.

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

- Financial requirements include deductibles, co-payments, co-insurance, and out-of-pocket expenses
- Quantitative treatment limitations include limits on the frequency of treatment, the number of visits, days of coverage, days in a waiting period, or "other similar limits on the scope or duration of treatment"
  - Note that a permanent exclusion of all benefits for a particular condition or disorder is not considered to be a "treatment limitation"
- In addition, a plan can have no separate cost-sharing requirements that are applicable only with respect to MH/SUD benefits
- In addition, a plan or issuer may not impose an annual or lifetime limit on MH/SUD benefits unless such limit applies to substantially all medical and surgical benefits, which would not be permitted under ACA's prohibition on annual or lifetime limits

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

- The application of these rules is complicated—but won't stop the DOL from asking!
- Unless a requirement or limitation applies to "substantially all" (i.e., two-thirds) of the medical/surgical benefits in a classification, it cannot be applied to MH/SUD benefits in that classification.
- If a requirement or limitation does apply to "substantially all" of the medical/surgical benefits in a classification, that requirement or limitation cannot be applied to MH/SUD benefits in that classification at a "level" that is more restrictive than the "predominant level" of that requirement or limitation applicable to medical/surgical benefits (e.g., the one that applies to more than ½ of such benefits).

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

- For example, assume a plan has two copay levels that apply to all in-network, outpatient office visits—$20 for a primary care provider and $50 for a specialist. No other financial requirements apply to office visits.
- Since the copay applies to all in-network, outpatient office visits, that financial requirement applies to substantially medical/surgical benefits in that classification.
- If a $20 copay applies to more than ½ of all office visits in this classification, the copay that applies to MH/SUD benefits cannot be more than $20.
  - This is true even if an MH/SUD provider might otherwise be considered a specialist.

NONQUANTITATIVE TREATMENT LIMITATIONS

- Meeting these requirements does not involve mathematical precision
- The processes, strategies, evidentiary standards, or other factors used to apply the nonquantitative treatment limitation to MH/SUD benefits in the classification must be comparable to (and applied no more stringently than) the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification
- Nonquantitative treatment limitations include:
  - standards used to determine medical necessity or medical appropriateness
  - standards used to determine whether treatment is experimental or investigative
  - formulary design for prescription drugs
  - plan methods for determining usual, customary, and reasonable charges
  - exclusions based on failure to complete a course of treatment
  - restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan

MHPAEA ENFORCEMENT EFFORTS BY THE DOL

- The DOL self-identifies MHPAEA as a national enforcement priority.
- Since 2010, there have been more than 1,700 targeted MHPAEA investigations and more than 300 violations cited.

FY 2019 THE DOL ENFORCEMENT: MHPAEA

1. As noted above, the DOL closed 186 health investigations in FY 2019.

2. Of these 186 closed investigations in FY 2019, 183 involved MHPAEA compliance.

3. Of these 183, the DOL cited 12 violations for MHPAEA noncompliance.

2019 MHPAEA DOL ENFORCEMENT EXAMPLES

Annual visit limits for mental health and substance use disorder treatment eliminated.

The Cincinnati Regional Office investigated group health plans that put an annual office visit limit on benefits for alcohol and chemical abuse. This was a violation of MHPAEA, as the plans imposed cumulative treatment limitations that applied only to substance use disorder benefits. In response, the plans removed the improper visit limits. The Regional Office ensured that the plan reprocessed and paid claims for substance use disorder treatment that had been improperly denied due to the impermissible visit limit.

Restrictive financial requirements eliminated and participants reimbursed for excessive cost-sharing amounts.

A Seattle District Office investigation found a plan that applied disparate cost-sharing requirements for medical/surgical visits as compared to MH/SUD visits. As a result, claims were readjudicated and excessive MH/SUD cost-sharing payments totaling $1,559 were reimbursed. In addition, the plan trustees changed the financial requirements to comply with MHPAEA.

2019 MHPAEA DOL ENFORCEMENT EXAMPLES

Restrictive visit limits for outpatient mental health and substance use disorder treatment eliminated.

The Kansas City Regional Office (KCRO) review found plans that imposed a medical necessity review requirement on outpatient MH/SUD benefits after 30 visits, but permitted 52 visits before requiring a medical necessity review of medical/surgical benefits. As a result, the number of MH/SUD office visits allowed before the plan would conduct a medical necessity review was increased to 52 per 12-month period. Additionally, 198 claims were readjudicated and the plan service provider issued payments totaling $19,744 to 29 participants.

Limits for drug screening related to substance use disorder treatment removed.

The KCRO investigation also revealed that drug-screening tests, only for individuals who had been diagnosed with a substance use disorder, were deemed not medically necessary and therefore not an eligible expense. As a result, the service provider amended its manual to allow drug-screening claims with a diagnosis of addiction. A review of drug-screening claims resulted in a readjudication and payments totaling $146,278 issued to 32 plan participants.

2017 MHPAEA DOL ENFORCEMENT EXAMPLES

Restrictions on residential treatment removed.

The Los Angeles Regional Office uncovered a plan that imposed an impermissible annual day limit on residential treatment for substance use disorders. As a result of this investigation, the plan issued a special notice to all participants notifying them of a 30-calendar-day window for submission of claims affected by the previous limitation. Four claims, with billed amounts totaling $74,165, were submitted, reprocessed, and paid by the plan. The plan also revised its documents to remove the impermissible limitation for future plan years.

More restrictive financial requirements eliminated and participants reimbursed for excessive copayments.

The New York Regional Office reviewed a plan that charged a higher specialist co-payment of $25 for all in-network MH/SUD outpatient visits while only a $20 copay was charged for all primary care in-network medical/surgical outpatient visits. As a result of this investigation, the plan refunded the $5 difference from 2010 through the 2016 plan years. In total, $11,340 was reimbursed to more than 200 participants. The plan has removed the impermissible financial requirement for future years.

2017 MHPAEA DOL ENFORCEMENT EXAMPLES

Additional coverage for mental health and substance use disorder treatment.

The Los Angeles Regional Office discovered that a plan failed to provide out-of-network coverage for inpatient and outpatient MH/SUD benefits. As a result of the investigation, 52 MH/SUD claims were reprocessed and the plan paid $24,152 in previously denied MH/SUD benefits. The plan also revised its documents to comply with parity requirements.

Overly stringent precertification requirements eliminated.

The Dallas Regional Office investigated a self-funded plan that required precertification for some outpatient medical/surgical services but required precertification for all outpatient psychiatric, chemical dependency, and substance use disorder therapies. As a result, the plan agreed to remove the impermissible precertification requirement from its plan documents.

2017 MHPAEA DOL ENFORCEMENT EXAMPLES

Denied claims repaid.

A plan precertified 12 counseling visits and an outpatient program for the beneficiary's PTSD. The plan subsequently denied both the counseling and outpatient hospital claims. The participant timely submitted an appeal, but the plan failed to respond. A Benefits Advisor from the DOL's Cincinnati Regional Office contacted the plan's service provider and the plan sponsor, explained the requirements of the law, and asked that the plan review the claims and the participant's numerous contacts with the service provider about these issues. The service provider determined that there were errors made in the claim administration process and paid approximately $1,700 in claims.

Overly stringent benefit requirements eliminated.

A fully insured plan required each participant to demonstrate, before he or she could receive in-patient treatment of a mental health condition, that his or her mental illness affected more than one area of daily living to such an extent that he or she was dysfunctional and required the participant to demonstrate that, without such inpatient treatment, the participant's condition would deteriorate. There were no similar requirements for medical/surgical treatment. The plan removed these onerous requirements for mental health treatment as a result of the DOL's enforcement efforts.

MHPAEA SELF-COMPLIANCE ASSISTANCE TOOL

- Published by the DOL to help group health plans' sponsors and administrators, group and individual market health insurance issuers, state regulators, and other stakeholders determine whether a group health plan or health insurance issuer is in compliance with MHPAEA
- https://www.dol.gov/sites/dolgov/files/the DOL/laws-and-regulations/laws/mental-health-parity/compliance-assistance-guide-appendix-a-mhpaea-proposed-updates.pdf
- Helpful sections:
  - FAQs on the implementation of MHPAEA
  - Multiple examples of noncompliance with explanations of how plans and issuers can correct the violation (two such examples were used in this presentation)
  - Best practices for establishing an internal compliance plan
  - Examples of "warning signs"—examples of treatment limitations that may be red flags for potential violations of MHPAEA

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OTHER ENFORCEMENT AREAS

DOL ENFORCEMENT RELATED TO BENEFIT CLAIMS PROCEDURES, DISCLOSURE, AND FIDUCIARY DUTIES

- The DOL also conducts investigations on the following rights that must be provided by ERISA group health plans:
  - Providing participants with plan information, including important information about plan features and funding;
  - Meeting fiduciary responsibilities (to the extent of fiduciary status);
  - Complying with ERISA's claims and appeals procedures;
  - Providing participants with required notice of their rights; and
  - Properly disclosing rules relating to plan eligibility and coverage requirements.

RECENT EXAMPLES OF ENFORCEMENT: BENEFIT CLAIMS PROCEDURES, DISCLOSURE, AND FIDUCIARY DUTIES

DOL claim related to failure to update SPD to disclose out-of-network provider reimbursement methodology.

- In 2017, the DOL sued an ASO group plan sponsor and two third-party administrators because the group health plan applied a different provider reimbursement rate for out-of-network charges without updating the out-of-network provider reimbursement methodology outlined in the plan's summary plan description (SPD).
- The DOL claimed that the failure to outline the correct out-of-network provider reimbursement methodology in the plan document constituted a breach of fiduciary duty by the plan administrator and the third-party administrators.

FRAUD AND SERVICE PROVIDER SELF-DEALING

- Fraud related to group health plans
  - Arises in relation to fraud and theft of assets by plan fiduciaries and TPAs.
  - Focused on returning money to plans and their participants adversely affected by fraud and on obtaining criminal enforcement.
- Service provider self-dealing (undisclosed/hidden/excessive fees)
  - Service providers such as TPAs, insurance companies, and pharmacy benefit managers provide services to group health plans for a fee. Sometimes, these fees or additional hidden costs are not disclosed to the plans in their service contracts or in monthly billing statements.
  - Because the fees are unknown to the plan fiduciaries, the service provider is exercising discretion over plan assets, setting its own compensation, and dealing with the plan's assets for its own gain, a fiduciary breach.
  - The DOL seeks disgorgement of the ill-gotten gains and correction of the illegal practices prospectively.

RECENT EXAMPLES OF FRAUD AND SERVICE-PROVIDER SELF-DEALING ENFORCEMENT

Undisclosed Fees

- In July 2017, the DOL announced a settlement of $14.5 million with a third-party administrator regarding alleged lack of transparency related to "network management fees" in its administrative services agreement, specifically that the third-party administrator failed to disclose and obtain consent for this fee.

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ENFORCEMENT CONSIDERATIONS

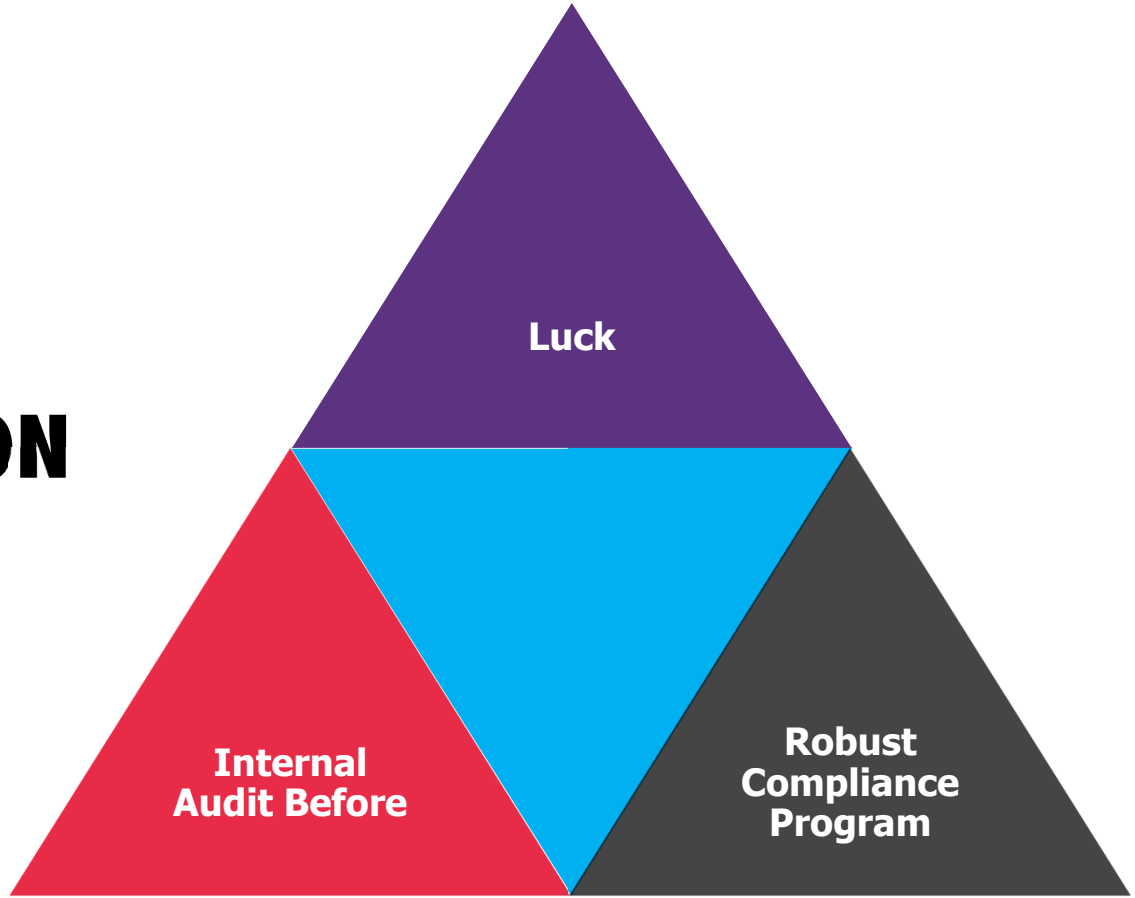
CONSIDERATIONS IN DEALING WITH A FEDERAL ENFORCEMENT REGULATOR

- Federal document request power is strong and difficult to fight.
- Federal investigators often have contempt powers for noncooperation.
  - Best to avoid altogether.
  - Know the law and the risks and err toward compliance.
- Attempt to build a cooperative relationship with the investigator/examiner.
  - Build a proactive relationship with your regulators (through internal and/or outside counsel).
  - Keep an open dialogue with regulators during an examination or investigation to clarify any issues and address concerns.
  - In-person (or virtual) meetings, where possible, are often productive.
- Keep an eye toward possible future litigation.
  - Create a record of communications.
  - Develop a detailed action plan for how to proceed with measurable steps, firm deadlines, and accountability measures.

CONSIDERATIONS IN DEALING WITH A FEDERAL ENFORCEMENT REGULATOR

- Material considerations and traps:
  - Record creation concerns
    - For example: confidentiality, HIPAA and other privacy law needs, PHI and FOIA claims
  - Preserving attorney-client privilege, to the extent possible
  - Interaction of nonattorneys with investigators/examiners
- Risks
  - Liability
  - Reputational risks
  - Referrals to other agencies
    - For example, the DOL has a Memorandum of Understanding with Treasury and HHS that formally establishes an interagency agreement relating to HIPAA and other laws among the three agencies.
  - Private litigation

HOW TO AVOID A DOL INVESTIGATION



FREE FOR ATTENDEES...

If you enjoyed today's presentation, please check out these complimentary materials prepared by Morgan Lewis legal professionals:

- From our *ML BeneBits* blog – **DOL's ERISA Enforcement Activities Focus on Health Plan Compliance**
- One of our recent LawFlashes – **COVID-19: Agencies Issue Disaster Relief for Welfare Plans**

And remember that our Trending Topics pages are great resources updated daily with the latest information on COVID-19 and Navigating the Next.

QUESTIONS?

Elizabeth Goldberg
Pittsburgh
elizabeth.goldberg@morganlewis.com

Liz advises clients on ERISA matters with a focus on fiduciary responsibility provisions, prohibited transaction rules and exemptions, and the management of employee benefit plan assets. She negotiates investment-related agreements on behalf of plans and financial services providers; designs, implements, and administers employee benefit plans; and counsels clients on DOL investigations, plan fiduciary governance structures, ERISA reporting and disclosure obligations, ERISA litigation, and general benefit plan compliance considerations. Liz's work experience includes several years at the DOL's Office of the Solicitor.

Sage Fattahian
Chicago
sage.fattahian@morganlewis.com

Sage counsels clients on all aspects of health and welfare plans. She works with clients to comply with the complicated, shifting requirements under the US Internal Revenue Code, ERISA, ACA, COBRA, HIPAA, MHPAEA, GINA, and state and local laws. She assists health and welfare plans and their sponsors with daily operations and plan administration, including preparing and maintaining plan documents and related materials; reviewing and negotiating services agreements with third parties; consulting on operational issues; and assisting with claims and appeals.

Robert Hunter
Philadelphia
robert.hunter@morganlewis.com

Bob is involved in a variety of aspects of the firm's employee benefits practice, with particular emphasis on issues related to welfare benefit plans, including cafeteria/flexible benefit arrangements, consumer-directed health plans, COBRA, PPACA, HIPAA, reporting and disclosure, and review of vendor contracts.

Bob holds a certificate of graduation from the Institute for Paralegal Training, Institute for Employee Benefits Training (The Philadelphia Institute).

Our Global Reach

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Asia Pacific
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Latin America
Middle East
North America

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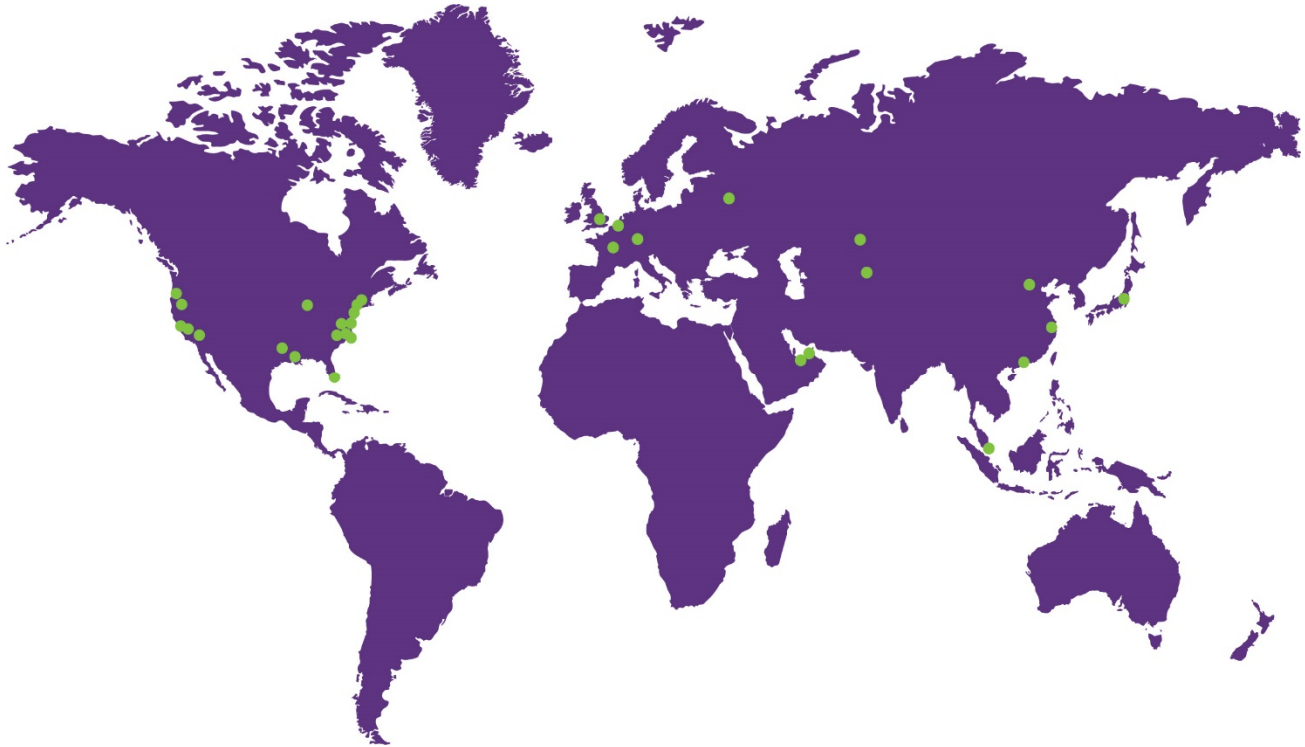

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