Health and Welfare Plans Under the Employee Retirement Income Security Act:

Guidelines for State and Federal Regulation

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Guidelines for State and Federal Regulation

ERISA Working Group of the
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The third section of this handbook explores in a question and answer format a number of timely

ERISA PREEMPTION OF STATE REGULATION

The Scope Of Preemption

The scope of ERISA preemption is sweeping. With the exception of state regulations applied to MEWAs, any state law that attempts to regulate ERISA-covered employee benefit plans is preempted due to federal occupation of the field.[8] However, ERISA exempts from federal

empowers states to enforce all state laws that regulate insurance. The broad language of the saving
he statute, which has been judicially interpreted to mean
that an employee benefit plan covered by ERISA cannot be deemed to be an insurance company or engaged in the business of insurance for the purposes of the application of state laws which regulate insurance.[9] Because little legislative history exists with respect to these clauses, the

and the DOL to establish a clear and effective regulatory framework for multiple employer plans. These provisions are discussed in more detail in the section on multiple employer welfare arrangements (MEWAs).

Although the 1983 amendment to ERISA reduced the scope of ERISA preemption, for non-MEWA ERISA plans the potential for ERISA preemption of state laws remains significant.

under any such law. [22] K ï9iP Vº%Ef fÔBÅ?‰a@ñBf”AAB4F4Ò/rE’1Ep ï‘a'ßf’à8M y.1/sf’ƒ`a'5(‰pA a'ï2iD
Ferguson Act from being superseded or modified by ERISA.

The Deemer Clause

ich is not
exempt under §1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an

... disability insurance laws [31] Consequently, the Court held that states cannot apply their laws to multi-benefit ERISA plans which may include disability benefits, but can require the employer to administer a separate disability plan which does comply with state law.[32]

METROPOLITAN LIFE INS. CO. v. MASSACHUSETTS, 471 U.S. 724 (1985)

In *Metropolitan Life v. Massachusetts*, the Court reviewed whether a state statute mandating coverage of mental health care was preempted by ERISA as applied to insurance policies purchased by employee welfare benefit plans. All insurance policies within the scope of the statute, including policies purchased by ERISA health plans, were required to include the mandated mental health benefit. Because the statute had the effect of requiring insured employee benefit plans to

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(2) er and

(3)

The Supreme Court opinion that established this three-pronged test, *Union Labor Life v. Pireno.*[42] specifically stated that not all of these prongs are necessary and noted, in particular, that the third prong of the test was not dispositive to a determination whether or not an entity was engaged in the business of insurance.[43]

The Court held that the Massachusetts law met all three of the *Pireno* criteria derived from the McCarran-Ferguson Act. It found that:

(1)
the risk associated with mental health services should be shared;
(2) The law directly regulated an integral part of the relationship between the insurer and the policyholder;
(3) The law met the third prong because it only imposed requirements on insurers.[44]

n results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so

of which Co

not regulate it. [70]

DIS

the surcharge was imposed irrespective of whether the insurance was purchased by an ERISA plan, private individual, or other purchaser.[76]

acknow

[81]

statute as a guide to the scope of state law that Congress understood would survive [ERISA preemption] as well as to the nature of the effect of state law on ERISA plans [82]

With respect to the issue of Congressional intent, the
presumption against preemption Congress did not intend to preempt areas of traditional state regulation absent evidence that it was the clear and manifest purpose of Congress.[83] In *Travelers,* he preemption of areas of traditional state regulation where ERISA has nothing to say would be [84]
surcharge law at issue in the *Travelers* case, involved issues traditionally regulated by the states. In addition, the Court observed that the areas covered by the state laws at issue in both cases were reporting, disclosure, fiduciary responsibility, and the like. [85] Therefore, the Supreme Court was not persuaded that it was the intent of Congress to have ERISA preempt state laws addressing apprentice wages and wages to be paid on public works contracts.

or their administration. [86] The Court compared the effect of the New York law on ERISA plans in the *Travelers* case to the effect of the California law on ERISA plans in the instant case. The indirect economic influence that resulted from the state law at issue in *Travelers* did not force ERISA plans to make a particular choice, nor did it regulate the ERISA plan itself. Similarly, g wage statute did not bind ERISA plans to any particular decision.[87] The

facing ERISA plans. [88] The Court reasoned that the California minimum wage law was no subject to local regulation, which Congress

De BUONO v. NYSA-ILA MEDICAL AND CLINICAL SERVICES FUND, 520 U.S. 806 (1997)

At issue in *De Buono v. NYSA-ILA Medical and Clinical Services Fund* was the application of a

state law.[98]

The Court explained that the New York hospital tax was a law of general applicability. All hospitals were required to pay the tax regardless of their relationship to an ERISA plan. Laws of general applicability may impose burdens on the administration of ERISA plans and still not .[99]

cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute. [100] In a footnote the Court reiterated a statement from *Travelers* conceding that there may be a situation where the economic impact of the state law is so great that an ERISA plan would be forced to buy certain coverage or not use certain insurers, in which case there may be preemption.[101] However, the tax at issue in this case was not such a law. The tax was held not .[102]

UNUM LIFE INS. CO. v. WARD,
526 U.S. 358 (1999)

UNUM Life Ins. Co. v. Ward
policy provided by his employer. Mr. Ward filed his claim with UNUM Life Insurance Company after the expiration of the deadline provided for in his insurance policy. Consequently, UNUM denied his claim. Mr. Ward filed suit under ERISA §502(a) for benefits due under the terms of the plan, claiming that under California law, *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731(1967), UNUM had rece *Elfstrom*, an employer that administers a group health plan is the agent of the insurer. Therefore, the notice that Ward provided to his employer, which was within the timeframe set forth in the insurance policy, served as notice to UNUM. The district court, however, disagreed and granted summary judgment in favor of UNUM. The district court reasoned that the *Elfstrom* therefore preempted.

decision and remanded. First, the Ninth Circuit held that a doctrine of California law, known as the notice-prejudice rule, operated to pr
unless UNUM could show that it had been prejudiced by the delay. Alternatively, the Ninth Circuit held that, if UNUM could show that it was prejudiced by the delay, the *Elfstrom* rule would not prevent UNUM f
notice-
in the
meaning of ERISA § 514(b)(2)(a). The *Elfstrom* rule also was not preempted, according to the

98 *Id.*
99

pointed out that, under this argument, ERISA § 504 preempts any state law contrary to a written s scant sense [111]
of ERISA. [112] The Court, citing *Metropolitan Life*[113] and *FMC Corp.*,[114] pointed out that it had

to submit to an extra layer of review for certain benefit denials [119] and would be preempted unless

The Court held that an HMO is both a health care provider and an insurer.[120] By underwriting and spreading the risk of treatment costs among the HMO participants, the HMO performs a traditional insurance function. The fact that an HMO may also provide medical services or that it may transfer some of its risk to the providers does not take the HMO out of the insurance business.[121] The Court also recognized that Congress intended for state insurance laws to apply to HMOs and that most state insurance departments are primarily responsible for the regulation of HMOs.[122] The Court stated that the application of the law to HMOs acting solely as administrators did not lead to preemption of its application to HMOs acting as insurers.[123]

The Court applied the three McCarran-Ferguson factors,[124] pointing out that all three factors are not required in order for a law to regulate insurance within the meaning of the saving clause.[125] The at least two of the three factors: (i) it regulated an integral part of the policy relationship between the insured

authoritative determination of the HMO s medical o [126] and (ii) the statute was aimed at a practice limited to entities within the insurance industry for the same reasons it satisfied the common sense test.[127]

The Court then addressed the *Pilot Life* doctrine. [128] , the Court also noted that the [129] The Court explained that

we have in the past pe [133] The Court observed further that, in contrast to a traditional arbitration proceeding, the law free- Instead, the law established a process that relied

[134]

The *Rush Prudential* Court ruled that the Illinois independent revie

offering chiropractic benefits include in their networks all chiropractors willing to accept the terms of the contract.

In determ -
part test for determining whether a state law regulates insurance.[140] The first part of the new test aged in insurance [141] To explain this test, the Court referred to its previous opinions in *Pilot Life, Rush Prudential and FMC Corp.*[142]
state law must be more than a law of general application with some bearing on insurers.[143] But even a law specifically directed at the insurance industry must regulate an insurer with respect to .[144]

Further, the Court made impact on non-insurers is not inconsistent with the

The Court employed

-

insured plans. The Court concluded that the activity of administering a self-insured plan, which the Court already explained engages in risk-spreading functions identical to insurers, is sufficient

In 1997, the Texas Legislature enacted a provision in its Civil Practice and Remedies Code establishing that a health insurance carrier, HMO, or other managed care entity has a duty to exercise ordinary care when making health care treatment decisions, and creating a private cause of action for insureds and enrollees who claim to be harmed by a carrie [161] Juan

METROPOLITAN LIFE INS. CO. v. GLENN,
554 U.S. 105 (2008)

In *Metropolitan Life Ins. Co. v. Glenn,* the Supreme Court held that the principles set forth in *Firestone* still apply when the benefit plan is fully insured. If the insurer has been granted valid discretionary authority,[169] it is entitled to deference when its decisions are reviewed in ERISA lit

170

approved the terms under which the Plan would be administered by the same company that was paying the benefits.[177] It argued further that when claim decisions are made by a professional insurance company, paying claims is its business and the market provides strong incentives to make accurate claim decisions.[178]

The Court agreed that the insurer was entitled to deference under *Firestone*, and that its self-interest in the outcome did not require *de novo* review of its claim denials.[179] It did not consider the possibility that a *Firestone*
whether an insurer has complied with its contractual obligations under an insurance policy,[180] when the insurer is not merely the administrator of the contract but one of the parties. However,

evaluate

[181]

Thus, a nuanced, case-specific, multi-factor analysis is required. The Court held that the Sixth Circuit had properly applied this standard, enumerating the various factors that were weighed,

Administration that she could do no work, received the bulk of the benefits of her success in doing
[182]

Therefore, the Court affirmed the ruling that Glenn was entitled to reinstatement of her benefits.

GOBEILLE v. LIBERTY MUTUAL INS. CO.,
577 U.S. ---, 136 S.Ct. 936 (2016)

In *Gobeille v. Liberty Mutual Ins. Co.*, the Court held that states cannot require self-insured ERISA plans or their third-party administrators to participate in all-payer claims databases, which provide a comprehensive resource intended to track substantially all health care expenditures in the state.

capacity as an insurer.[183] The plaintiff, Liberty Mutual, provided a self-funded employee health plan for its 80,000 U.S. employees. Fewer than 200 were located in Vermont, so Liberty Mutual was below the mandatory reporting threshold. However, the plan was administered by Blue Cross

required to report claims to the database on behalf of all of its Vermont clients.[184] Liberty Mutual instructed BCBSMA not to report any information from the Liberty Mutual plan, and sought a declaratory judgment that the statute was preempted by ERISA.

Vermont asserted that the statute was a public health law rather than an employee benefit law, and that it did not impose any material costs on employers, so that its incidental impact on employee *Travelers.*[185]

The Court, however, described reporting as a core obligation under ERISA, particularly so because

substantive requirements on benefit plans.[186]

necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans, [187] and because federal authority occupies the field, preemption does not require any inquiry into whether a particular state requirement is in fact novel, inconsistent or burdensome.[188] Although ERISA reporting concentrates on financial matters, that does not mean reporting of health data is reserved for the states to regulate; the Court held that it is sufficient that USDOL has the authority to require reporting of health data and has chosen not to do so.[189]

requirements included the ability to collect this data for the states or to mandate compliance with state reporting requirements.[190]

Justice Ginsburg dissented, joined by Justice Sotomayor. She interpreted *Travelers, Dillingham* and *De Buono* no longer operate as a

plans or address relationships between entities that are subject to ERISA.[195]

RUTLEDGE v. , 141 S.Ct. 474 (2020)

In *Rutledge v. PCMA*, the Court upheld an Arkansas law, Act 900, which required pharmacy benefits [196] to reimburse pharmacies at a price equal to or higher than what the pharmacy paid to buy the drug. Act 900 required PBMs to provide administrative appeal

acquisition costs, and it also authorized pharmacies to decline to dispense drugs when a PBM would provide a below-cost reimbursement. Act 900 applied to all transactions between PBMs and pharmacies, including transactions where the PBM was acting on behalf of a self-insured ERISA plan. Thus, the saving clause was not at issue in this case.

In a suit brought by
association representing 11 PBMs, the Eastern District of Arkansas had ruled that Act 900 was preempted by ERISA, and the Eighth Circuit affirmed.[197] Both courts relied on a recent Eighth

Subject to
preempted by ERISA.

A state law of general applicability that has an indirect economic influence on ERISA

laws that impose such high indirect costs on ERISA plans that the laws force ERISA plans to adopt a certain scheme of substantive coverage or ef
administration may be preempted by ERISA.

if the law has the effect of indirectly regulating the substance of ERISA plans that purchase insurance.
While states can regulate the business of insurance and the terms of insurance contracts purchased by employee welfare benefit plans, they cannot apply those laws directly to employee welfare benefit plans.

to noninsurers is preempted.

-by-case analysis of the statute in question, the parties involved, and the facts at issue.

ERISA PLAN CHARACTERISTICS AND RELATIONSHIP TO STATE REGULATION

The relevance of the preemption analysis discussed in the preceding section presupposes the existence of an ERISA-covered plan. However, not all entities meet the criteria defining an ERISA-covered plan.[208] In addition, some arrangements that meet the criteria to be a plan are exempted from ERISA coverage generally or specifically from the ERISA preemption provisions. Such entities are generally subject to state law. Problems occur when certain operators seek to take advantage of the complexities in ERISA and illegitimately claim exemption from state laws under ERISA. It is crucial that state regulators understand what constitutes an ERISA-covered plan.

This chapter begins with an overview of the scope
benefit arrangement must meet to be an ERISA plan. In the health insurance context, ERISA addresses three specific forms of employee welfare benefit plans:

Single-employer plans (including certain groups of closely affiliated employers);
Multiemployer plans (plans established pursuant to bona fide collective bargaining agreements); and
Multiple employer welfare arrangements (MEWAs).[209]

The following pages contain discussions of these three different ways in which employee benefit arrangements can be structured and their relationship to state law. This section also includes a discussion of MEWAs and the ERISA Section 3(40)(A) exception to the definition of MEWA for

.[210] ERISA also excludes governmental plans and church plans.

Regulators will find that some arrangements obviously fall under the governmental and church

covering police and firefighters, and plans covering employees of a specific church. However, many more plans fall outside the coverage of ERISA than may be immediately obvious. For example, many hospitals are publicly funded, and their plans may be governmental plans under ERISA. The same is true of public educational institutions. Similarly, many hospitals, schools, and nursing homes are owned by religious organizations. The plans that these organizations offer may be church plans.[211]

Plans excluded from ERISA coverage normally fall within the jurisdiction of the state unless they are specifically excluded under state statutes. Knowledge of the exclusion of certain types of plans from ERISA may be useful when a state wishes to assess the potential impact of legislation on n, or seeks to assist a consumer who may appear at first glance to be covered by an ERISA plan.[212]

General Characteristics of an ERISA Plan

The statutory definition of an employee welfare benefit plan outlines four elements. State insurance regulators should look for whether each of the elements are met when analyzing whether an arrangement is a plan, fund, or program:

established or maintained;
by an employer or by an employee organization, or by both;
for the purpose of providing medical, surgical, hospital care, sickness, accidei4BT/F8 12 Tf1 0 0 1 90.02

task of providing guidance to state insurance regulators and legislators, insurance industry representatives, and employers on what makes an arrangement an employee welfare benefit plan within the meaning of ERISA.

To provide guidance, the DOL has issued regulations discussing certain payroll practices, including those related to group benefits, and advisory opinion letters. Circuit courts have issued a number of opinions, which have also helped somewhat to clarify the meaning of the term. Below is a review of some of the criteria that DOL and the circuit courts have identified as useful in determining whether an arrangement is an ERISA plan.

Plan, Fund, or Program Established or Maintained Requirement

The first element of the definition of an employee welfare benefit plan is whether an arrangement

.

specifically discussed this requirement in the much-cited *Donovan v. Dillingham.*[215] In its analysis, the court stated that the minimum criteria to use to determine whether there was a plan, fund, or program was whether there were:

> intended benefits,
> intended beneficiaries,
> a source of financing, and
> a procedure to apply for and collect benefits.[216]

The *Donovan*
reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.[217]

To prove the existence of an employee benefit plan, the employer must provide evidence that its decision has actually been implemented. Furthermore, although the purchase of health insurance is substantial evidence that a plan has been established, the Court stated that it is not by itself conclusive proof.[218]

In 1978, DOL provided guidance in the matter by issuing a safe harbor regulation for certain group arrangements. An employer or employee organization providing group health insurance has not established an employee benefit program if all four of the following criteria apply:

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[215] *Donovan v. Dillingham,* 688 F.2d 1367 (11th Cir. 1982). At issue in *Donovan* was whether the District Court had subject matter jurisdiction to decide if a particular multiple employer trust was subject to the fiduciary requirements of ERISA. The Eleventh Circuit held that the District Court did have subject matter jurisdiction. The Court stated that a consensus existed among the courts, congressional committees, and the Secretary of the U.S. Department of Labor that multiple employer trusts are generally not employee welfare benefit plans. *Id.* at 1372. However, they may be

such as in this case. *Id.* at 1372 n.10.

[216] *Id.* at 1372.

[217] *Id.* at 1373.

[218] *Id.*

No contributions are made by an employer or employee organization;

Participation [in] the program is completely voluntary for employees or members;

The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.[219]

In *Johnson v. Watts*,[220]
the context of this regulation. It specifically focused on the meaning of the third criterion of

... if, in light of all the surrounding facts and circumstances, an objectively reasonable employee

nd parcel

[221]

In this case, the court held that the employer had not endorsed the program although it had collected premiums through payroll deductions, remitted insurance premiums to CIGNA, issued certificates, kept track of employee eligibility, distributed sales brochures and other materials necessary for enrollment, and recommended enrollment through a letter to employees in which the letter

the employer had sufficient involvement with the administration of the plan.[225]

Empl

3(5) of ERISA [230] which

:

> health coverage or other em
> coverage as its primary purpose [231]
> Each participating employer must be the direct employer of at least one participating employee; however, working owners (partners, shareholders, and sole proprietors) are considered employees for this purpose if they work at least 20 hours per week or 80 hours per month, or earn enough from the business to pay for the coverage;[232]
> ructure with a governing body and has by-laws or [233]
> ;[234]
> Member employers must either be in the same trade, industry, line of business, or profession, or be located in the same region within a single state or metropolitan area;[235]
> Coverage must be limited to current or certain former employees and their beneficiaries;[236]
> It may not engage in underwriting or rating discrimination on the basis of health status, nor use a facially neutral criterion such as geography as a pretext for prohibited discrimination. This prohibits experience rating at the employer level, but does not prohibit occupation or industry rating based on aggregate claims experience; [237] and
> It may not be a health insurance issuer, nor be owned or controlled by an issuer; this does not prohibit an issuer or its affiliate from being a member employer.[238]

The Rule is effective September 1, 2018, for fully insured plans, on January 1, 2019, for existing non-fully-insured plans, and on April 1, 2019 for all other plans. The accompanying DOL Fact Sheet describes the Rule for establishing AHPs, while it also [239] In other words, the criteria set forth in the Rule are a safe harbor recognition as a but arrangements qualifying as employee benefit plans under prior DOL guidance will continue to be recognized as employee benefit plans. The Rule explains that it *additional*

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[230] 83 F.R. 27812, June 21, 2018.

[231] 29 CFR § 2510.3-5(b)(1).

[232] *Id.* §§ 2510.3-5(b)(2) & (e)(2)(iii). Except for purposes of participation in AHPs, working owners and their spouses are not considere *Id.* § 2510.3-3(c). [illegible] partners to be covered by group health plans as employees, but sole proprietors may only be covered as non-employee participants; therefore, a sole proprietor is ineligible to buy0.60001 r-5(p)-5(r)-3(ieto)6(e)8(p)-5(r)-3(o)-5(p)-5(r)-3(ieto)-5(r)-3(s)3( )9(m)-4(ay)-7( )9(o)6(n)-5(

mechanism

any particular employer, union, or industry, but made the benefits available to any individual who was employed.[245] Consequently, the entity did not meet the definition of an employee organization.

Purpose Requirement

benefits that are covered under ERISA. The plan must be established or maintained for the purpose ical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or any benefit described in section 186 (c) [referring to Taft-Hartley trusts] of this subchapter (other than pensions on [246]

As mentioned previously, however, ERISA specifically exempts plans maintained solely to .[247]

Participants Requirement

benefits are provided to plan participants or their beneficiaries. The statute defines a participant as

employee organization, who is or may become eligible to receive a benefit of any type from an employee

Single-Employer Plans and State Regulation

State insurance regulators faced with a suspected unauthorized health insurance operation should

the obligation of the insurance licensee to ensure that the health benefit arrangement in

ce

Conclusion

ERISA plans sponsored by one employer or employers under common ownership or control are exempted from state laws as a result of ERISA preemption. Since the critical analysis of whether a single-employer plan exists usually arises when analyzing a suspected unauthorized insurer claiming ERISA exemption from state insurance regulation, these statutory definitions serve as a starting point for any analysis. Two other forms of arrangements multiemployer plans and MEWAs are also governed by ERISA. They each have their own unique characteristics and relationship to state law.

Collectively Bargained Multiemployer Plans

Characteristics of a Multiemployer Plan

multiemployer plan does not simply mean a plan maintained by more than one employer. ERISA draws a fundamental distinction between multiemployer plans, discussed in this section, and multiple employer welfare arrangements (MEWAs) discussed in the next section. The terminology is confusingly similar, but the difference is important because To qualify for must be maintained pursuant to a collective bargaining agreement between one or more employee organizations and must have more than one contributing employer.[260]

As a practical matter, multiemployer plans are plans jointly established by employers and labor organizations.

Multiemployer Plans and State Regulation

As with single-employer plans, the ability of states to regulate multiemployer plans is very limited. Generally, states do not have the authority to regulate a multiemployer plan directly,[263] although they retain the authority to regulate organizations that contract with multiemployer plans to provide benefits, including the authority to regulate the underlying insurance contracts if a multiemployer plan is fully insured or protected by stop-loss insurance. As will be discussed below in the section on multiple employer welfare arrangements,[264] not all arrangements that ostensibly involve collective bargaining agreements are covered by ERISA or are exempted from the application of state law. They may, in fact, be multiple employer welfare arrangements and consequently, subject to state insurance law.

Conclusion

Multiemployer plans are exempted from state laws as a result of ERISA preemption. However, not all arrangements that involve collective bargaining arrangements are subject to ERISA coverage or ERISA preemption. Arrangements that do not involve bona fide collective bargaining agreements are MEWAs and are subject to state law.

Multiple Employer Welfare Arrangements[265]

Characteristics of MEWAs

The previous sections explained that benefit plans operated by a group of affiliated employers under common ownership are deemed to be single-employer plans, and that certain collectively
With two extremely narrow exceptions, all
other benefit plans involving more than one employer fall into a third category. They are classified
ERISA defines a MEWA as:

maintained for the purpose of offering or providing any benefit described in paragraph 1[266] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, unless a specific statutory exception applies.[267]

263
§ 2910.3-37, but is nevertheless subject to state regulation as a MEWA because it fails to meet the more stringent standards required to qualify as a pl
1002(40)(A)(i) and
29 CFR § 2910.3-40.

264 *See* discussion below of the DOL Final Rules Regarding Section 3(40) of ERISA.

265 Regulators are encouraged to read the DOL MEWA Guide, *supra* note 209, for a more detailed discussion of MEWAs and state regulation.

266 The benefits may include, *inter alia*, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services.

267 29 U.S.C. § 1002(40)(A) (2018). The only exceptions, other than the exceptions discussed earlier for collectively bargained plans and for plans that are deemed to be single-employer plans based on common ownership and control, are plans established or maintained by a rural electric cooperative or by a rural telephone cooperative association. *Id.* §§ 1002(40)(A)(ii) & (iii).

MEWAs have had a troubled history since the enactment of ERISA. Originally, with the exception

distinctions between single-employer and multiple employer benefit plans. While Congress had intended that multiple employer plans be set up at the grassroots level by small business owners and local unions, Congress had not anticipated the involvement of third party promoters using multiple employer plans as profit making vehicles. The 1977 Activity Report of the House Committee on Education and Labor indicates that abuses started almost as soon as ERISA became law in 1974.[268] The lack of adequate consumer protection standards at the federal level and misunderstanding the scope of ERISA preemption of state laws facilitated abusive and fraudulent practices by MEWAs that resulted in significant sums of unpaid claims and the loss of health insurance for participants.

Congress enacted the Erlenborn-Burton Amendment in 1983 because of a concern regarding the financial insolvency of multiple employer welfare arrangements and a desire to remove impediments to action by state regulators to prevent those abuses. The amendment saved state [269] permitting state insurance regulators to regulate risk-bearing MEWAs as insurance companies. The extent to which state law applies to a MEWA depends on whether the MEWA is an ERISA covered plan and on

The definition of MEWA An

might b

employers, and it subjects indirect employers to the same regulatory requirements as direct employers when they sponsor benefit plans. However, ERISA occasionally uses the term
mployer. This is
-law
throughout.

DOL has issued two separate rules construing the d
provides criteria for qualifying as a direct employer, while the other, issued in 2018, provides criteria for qualifying as an indirect employer.

the coverage must be issued by an authorized insurer, not a surplus lines company, risk retention group, or offshore insurer), the state has full authority to regulate the terms of the insurance contract, the rates the insurer charges, and the sales practices and personnel used by the insurer.

laws that go too far in regulating non-fully-insured AHPs in ways that interfere with the [283]

No state is required to take specific legislative action in order to regulate MEWAs. States may regulate MEWAs under their general insurance statutes. However, some states have chosen to adopt MEWA-specific laws, making alternative licensing or registration frameworks available to MEWAs meeting certain statutory qualifications. Unless the state has adopted such a law, a non-fully-insured MEWA is simply a type of insurer. In either case, it is illegal for the non-fully-insured MEWA to do business without meeting the qualifications set forth in the applicable state laws and obtaining the necessary authorization in each state where the MEWA has participating employers, unless DOL issues regulations exempting certain MEWAs from state licensing requirements.

Federal Authority to Exempt Plan MEWAs from Certain State Insurance Laws: Although non-fully-insured MEWAs are currently subject to state insurance regulation even if they are employee benefit plans, Congress did grant DOL the power to issue regulations that would limit state jurisdiction in this area. Such an exemption may be granted either individually *i.e.,* qualifying MEWAs would be able to obtain a federal license, or its equivalent, rather than being required to obtain state licenses

Requirements for Licensees Seeking To Do Business with Certain Unauthorized MEWAs Model Regulation[286] is designed to assist states in becoming aware of the operation of MEWAs within their jurisdiction before an insolvency occurs. In addition, several states have enacted specific statutory structures that govern PEOs.[287]

On August 1, 1995, the DOL published a Notice of Proposed Rulemaking setting forth criteria that must be met in order for the Secretary of Labor to find that an agreement is a collective bargaining agreement for purposes of the exception to the MEWA definition.[294] The proposed rule also set forth criteria for determining when an employee benefit plan is established or maintained under or pursuant to such an agreement. The DOL received many critical comments. Due to the numerous concerns raised in those comments, rather than publish a final rule, the DOL decided in 1998 to terminate the pending rulemaking and initiate a new proceeding

lost their investment in the employee benefit they sought to offer and employees are left with unpaid claims and no health insurance.

Because employee welfare benefit plans offered through single-employer plans and collective bargaining arrangements are exempted from state regulation under ERISA, effective regulation of MEWAs requires an ongoing cooperative relationship with the DOL. The states and the DOL have worked together to make great strides to curtail this fraudulent activity and maximize the effective regulation of MEWAs. In its 2018 AHP Rule, DOL acknowledged the history of abusive practices, and reaffirmed its commitment to work cooperatively with the states as more Plan MEWAs commence operation under the rule, subject to concurrent state and federal enforcement authority.

[301]
terms of an employee benefit plan, who is [302]

insurance law. ERISA does not preempt state insurance regulation because:

A. The plan is not established for the purpose of providing benefits for participants (employees and former employees) and their beneficiaries.

employees) and their beneficiaries.
an employee or retired employee.
is not an employee welfare benefit plan.

employee welfare benefit plan to include anyone by its terms.[303] However, these cases are not consistent with *Nationwide v. Darden.*[304] In that case the U.S. Supreme Court rejected

Fourth Circuit had already disposed of that argument at a much earlier stage of the case:

> B]
> service resulted in the accrual of the benefits, but who is designated as the recipient of benefits accrued through the service of another. 29 [305]

B. Such a plan is a employer welfare subject to state insurance regulation as provided by 29 U.S.C. § 1044 (6).

(other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, [306] Since the consumer enrollees are not employees of the entity offering
yees of
multiple employers, or self-employed, and the plan is a multiple employer welfare arrangement subject to state insurance jurisdiction.

C.

in fact enroll to obtain the offered coverage, not to act as agents for the entity. The entity is an entrepreneurial operation, and therefore not an employee welfare benefit plan.[307]

Purported "Single-Employer" Plans—Out Of

go straight into the pockets of the promoters. When this level of fraudulent behavior is involved the arrangement is not materially different from other unlicensed entity scams and should be pursued in the same manner, although it may be necessary to address some of the jurisdictional issues discussed below, depending on how the promoters respond.

On the other hand, as noted above, the insurance coverage is often provided by a licensed insurer. This makes damage control easier, since there may be ways to hold the insurer responsible for unpaid claims even though there is no direct contractual relationship between the insurer and the covered individuals. However, the participation of a licensed insurer also lends an aura of

illegal transactions were involved.

That aura of legitimacy is misplaced. The regulatory arbitrage carried out by substituting stop-loss coverage for traditional health insurance harms consumers, employers, and the overall health insurance market in a number of ways, including but not limited to the following:

1. The coverage is medically underwritten. allowing a licensed company to undercut the market price because it is not playing by the same rules. This in turn adds to the stresses on the legitimate guaranteed-issue small employer market. Similarly, stop-loss coverage is also exempt from small group rating laws.

2. The patient has no contractual relationship with the insurer. At worst, the shell game could leave the claimant holding the bag with a claim against an uncapitalized shell entity. In any event, there is no regulatory authority to resolve a claim dispute, unless the state orders the insurer to assume direct responsibility for claims as part of its remedial action. Even if the insurance department is prepared to do this, the consumer complaint may never be processed correctly because the intake person takes at face value the representation that the
   -

3. The benefit contract does not contain the dispute resolution mechanisms, minimum benefits, or other consumer protection provisions required by state law. In fact, strictly

4. The employer may be surprised by gaps in coverage or onerous contract conditions such

   whether or not the stop-loss carrier pays the employer.

usually fairly easy to identify who is acting as an insurer and who is acting as a producer. The hard work, when pursuing enforcement actions, is being able to respond effectively to their defenses and excuses:

Recall the marketing blurb quoted at the beginning of this section:
-funded plan is

reinsurance unless the ceding company is reg

unregulated entity first cedes risk to a regulated entity is a regulated insurance transaction.[308]

-

a red flag) that, if i -insured component and an insurance policy. The self-insured component of the plan will likely be of interest to federal investigators, but our concern is the state-regulated insurance policy. Our lack of authority to regulate the self-insured component of these plans is no great loss, since the self-insured component typically represents 5% or less of the dollar value and essentially none of the risk.

regulation of stop- Although nothing in the text of ERISA or the relevant Supreme Court jurisprudence would remotely suggest such a result, the Fourth Circuit has ruled that ERISA places some limitations on how states can regulate stop-loss insurance.[309] However, even in jurisdictions where *American Medical Security* is

group insurance market in context of association group policies and multiemployer trust policies, and states can and should exercise the same regulatory authority here.

The producers, licensed or unlicensed, who sell this product to the employer will try to distance themselves by claiming that they only market the ERISA plan, not the insurance. However, the employer would not buy the -funded. Sometimes

even if the producer avoids that pitfall, somewhere in the marketing or application of materials there will have to be some discussion of the stop-loss coverage.

out-of-state trust documentation, the product was bought and paid for by the employer, who was almost certainly solicited

insurance risk is actually passed on to the stop-loss insurer. Here, by contrast, an unlicensed insurer, usually structured as a multiple
of its reinsurance arrangements.

Unlike many MEWAs, these entities will often admit to being MEWAs, because the provision of ERISA they seek to exploit applies by its terms to MEWAs. The ultimate goal is to try to have it both ways to argue that the MEWA is exempt from regulation because it is fully insured, but then to turn around and argue that the insurer standing behind the MEWA is somehow also exempt

MEWA!

To see why these arguments lack merit it is necessary to analyze the relevant provision in ERISA,

§514(b)(6)(A)(i) [(29 U.S.C. § 1144(b)(6)(A)(i)] provides that:

> [I]n the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured ... any law of any State which regulates insurance may apply to such arrangement to the extent such law provides
>
> (i) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
>
> (ii) provisions to enforce such standards.

And ERISA § 514(b)(6)(D) [(29 U.S.C. § 1144(b)(6)(D)] clarifies when this clause applies by clarifying that:

> [A] multiple employer welfare arrangement shall be considered fully insured only

Regulators must never take

ERISA benefits without being an ERISA plan.[314] In that case, the state can regulate the MEWA as an insurer (or if it chooses, as a state-licensed MEWA) without ERISA entering the picture at all.

compliance with the entire framework of state and federal regulatory requirements for fully insured plans is precisely what the promoters are trying to avoid. In particular, many such plans have

ty bond, or other

contract between a state-licensed or surplus-lines-

their employers are covered under the policy ERISA neither requires such regulation nor does ERISA restrict it in any way.

Finally, regulators must also keep in mind that ERISA does not preempt state solvency regulation of fully insured MEWAs. As the DOL explains in its MEWA Guide,[316]
Department of Labor that 514(b)(6)(A)(i) clearly enables states to subject [fully insured] MEWAs to licensing, registration, certification, financial reporting, examination, audit and any other requirement of State insurance law necessary to ensure compliance with the State insurance

Non-Fully-Insured Multiple Employer Arrangements Claiming "Single-Employer" Plan Status—Issues Related to Profes2s4Cr42 Tm0 grofePrn4m0 G7s2s4Cr)52q0000009 2 0 612 2 reW* nBT/

G

certain standards for the MEWA itself. The state has far greater authority in the situation where the MEWA is not fully-insured. Regardless of the employer status of the PEO or the employee leasing company, the DOL has indicated in these decisions that if one or more of the client companies is also deemed to be an employer under common-law standards, the arrangement is a MEWA and the self-funded plan is subject to state regulation.

States may allow PEOs to self-fund, but they may not dictate how ERISA treats such plans. This is true despite a contract purporting to designate the PEO as the sole employer

5. the location of the work;
6. the right of the hiring party to assign additional projects to the hired party;
7.
8. the method of payment;
9.
10. whether the work is part of the regular business of the hiring party;
11. whether the hiring party is in business;
12. the provision of employee benefits; and
13. the tax treatment of the hired party.[322]

The few DOL opinions on this topic have generally concluded

PREVENTION

contact information prominently displayed on the website. In addition, the entire department should know to refer all related inquiries to that individual. The NAIC website contains links to the individual state insurance department websites as well as a list of 50 state MEWA contacts.

agreement, the department may not regulate the plan. (Rural electric cooperatives and rural telephone cooperative associations are also excluded from the definition of MEWA and thus exempt from state regulation.)

If the arrangement is a MEWA, even if it is covered by ERISA, it is also subject to state insurance regulation.

the insurer, the sales personnel, and the insurance contract. The state may also enforce standards such as those related to reserves and contributions.

If the arrangement is a MEWA in the same manner that it regulates any other insurer.

If the arrangement is subject to state insurance laws and an insurance license has not been obtained, then there is probably a violation of the state s Unauthorized Insurers Act. Go to step (4) below.

Step 4: If the entity is in violation of the state s Unauthorized Insurers Act (*i.e.*, it is not a bona fide single-employer plan or bona fide collectively bargained multiemployer plan), the next step is to take the enforcement action your department would take against any other kind of unauthorized insurer offering insurance in your state. You might also check the NAIC s database to see if the organization or its principals are in the Special Activities Database (SAD).[331]

[331] For further discussion on state regulation and unauthorized entities, see *State Departments of Insurance*.

Table: Regulatory Jurisdiction over Employee Benefit Plans

	SUBJECT TO FEDERAL REGULATION	SUBJECT TO FEDERAL AND STATE REGULATION	SUBJECT TO STATE REGULATION ONLY
Single-Employer Plans	Sponsored by Single Employer Meets ERISA Coverage Test		

When the initial report is filed, the OLMS assigns a six-digit file number to the organization that is shown on the annual financial reports. These reports are due 90 days after the end of the

The courts have permitted Taft-Hartley trusts to cover a broad range of employee classes, including employees who are not in a collective bargaining unit or whose employer does not have a collective

Can employers avoid state laws requiring workers' compensation coverage by providing workers' compensation through ERISA plans that also provide other benefits?

No, an employer cannot use an ERISA plan to avoid complying with a state law requiring the

mechanisms for state law benefits, directly infringe on such core ERISA concerns as self-funded health and pension plans.

The *Delta Air Lines* analysis applies to state laws that permit employers to use ERISA plans to

ough a separate plan not covered by ERISA. For example, the Maine law upheld by the First Circuit in *Combined Management* allows an employer participating in state-approved 24-hour coverage pilot projects to provide comprehensive medical or disability benefits through an ERISA plan, but only upon conditions which include the

If at any time the plan is not found to be in compliance with state requirements, pilot project

against the small group market. Some actuaries believe the destabilizing impact could be significant.

This framework entitles individuals to the same consumer protections whether they buy their

for small employers that maintain group health plans. It reduces the opportunity for regulatory arbitrage by providing a level playing field where carriers competing for the same customers are subject to the same rules. The only way in which HIPAA recognized any difference between association coverage and coverage sold directly to individuals or employers was through limited

coverage under such plans to employers that were not association members and to terminate such coverage if association membership ceased. However, the ACA repealed the bona fide association exception to guaranteed issue. The guaranteed renewal exception remains in force, but applies only to the remain -

Individual Market Coverage

If health insurance coverage offered to an individual through an association is not offered in connection with a group health plan, it is defined in PHS Act §§ 2791(b)(5) and (e)(1)(A) as

that is provided to associations, but not related to employment, and sold to individuals is not [364] Th
both employers and individuals; the individual members of the association are part of the individual market risk pool in the state and the carrier providing the association coverage must comply with individual market rating rules.

Until 2018, DOL regulations provided that working owners of small businesses and their spouses [365] This meant that coverage issued to
sole proprietors and sole shareholders was considered individual coverage under sole shareholders was consi

Group Market Coverage

Employment-related coverage, on the other hand, is classified as either small group coverage or large group coverage, depending on the size of the

[368] regardless of whether the employer has purchased that coverage directly or through some other arrangement, such as an association. However, because the ACA has imposed more

The CMS Bulletin discussed how the look-through principle applies to
offered to collections of individuals or employers through entities that may be called associations,
As discussed
above, the statute classifies all such coverage, regardless of how it is structured, as either individual coverage, small group coverage or large group coverage, depending on whether it is sold to individuals and families, sold to small employers providing group health plans, or sold to large employers providing group health plans. But what, precisely, does the statute mean when it says
through a group health plan maintained by a small employer
considered small group coverage, whether the employer directly or
through any arrangement

employee status, and different occupations, [378] but classification based on any health factor is not a bona fide employment-based classification, [379]

A VEBA may be, but is not always, associated with an employee welfare benefit plan under Title I of ERISA. To be an employee welfare benefit plan, a plan must be established or maintained by an employer or employee organization. A VEBA is not an employer association because its members are the employees, not their employers. A VEBA does not necessarily meet definition of an employee organization either. The fact that a VEBA has been recognized under the Internal Revenue Code does not mean that it will be recognized as an employee organization under ERISA.

insurance policies they may sell to AHPs, and they can regulate self-insured AHPs to the extent the regulation is not inconsistent with ERISA. The new rule does not diminish state oversight. Employers and plan administrators should check with the applicable state [390]

What arrangements involving multiple employers that provide health benefits on a "self-funded" basis ease the administrative burden of providing those benefits?

Can managed care organizations that are sponsored by providers and accept insurance risk from ERISA plans be required to obtain an insurance license and be regulated under state insurance laws?

To the extent that such an organization assumes insurance risk through the receipt of a prepayment from a purchaser for the delivery or the arrangement of the delivery of health care benefit services, it is subject to state insurance laws.

The nature of the business of insurance has changed dramatically over the past several decades. The market dominance of traditional commercial indemnity insurers and Blue Cross and Blue Shield plans has been eclipsed by the dramatically increased market share of managed care plans. Managed care plans contract with the policyholder individuals, employers, or other groups to deliver or facilitate the delivery of health care services. In the contract, the managed care organization may also assume the insurance risk associated with the cost of providing health care benefits, or may arrange for some other entity to assume that risk.

Health maintenance organizations (HMOs) are the most prominent form of managed care insurance risk. Recently, employers have begun to focus more on relationships with managed care organizations

minimal eligibility criteria related to age, competency and reputation, level of financial responsibility, and education. The administrator must also have paid the established fee and have not had a previous license or application terminated for cause.[409]

The court rejected the TPA s argument that the state statute was preempted by ERISA and thus, the Commissioner lacked the authority to mandate a license as a requirement to conduct business in the state. The court held that ERISA did not preempt the state licensing statute. It reasoned that

the type of plans they serviced (ERISA or non-ERISA). The court also explained that, even if the statute related to an ERISA plan in some respect, it fell within the
exception to ERISA preemption recognized by the Supreme Court in *Shaw v. Delta Air Lines.*[410]

Other cases, however, held that state laws relating to third party administrators of ERISA-covered plans are preempted. These cases involved more significant requirements than the Kentucky statute at issue in *Benefax*. In *Self-Insurance Institute of America v. Gallagher,*[411] the court held that Florida statutes regulating plan administrators were preempted by ERISA because the laws did not regulate the business of insurance. In *Gallagher,* the Self-Insurance Institute of America (SIIA) objected to a series of state statutes that imposed various requirements upon contract administrators of ERISA employee benefit plans. Among other things, the regulations required that administrators enter into written agreements and identified what must be contained within such agreements. The regulations also required that administrators pay a bonding fee, obtain a certificate of authority to conduct business, and file extensive organizational and financial information.

SIIA asserted that the Florida statute that governed activities of SIIA members was preempted by ERISA. The state argued that the statute regulated insurance and therefore was not preempted by ERISA. The Eleventh Circuit affirmed, without opin s holding that the state's law did not regulate the business of insurance. Consequently, the administrative requirements imposed on employer/plan sponsors or contract administrators of ERISA plans, were preempted by ERISA.

In *E-Systems, Inc. v. Pogue,*[412] the appeals court upheld a district court opinion that granted summary judgment to plan sponsors challenging the Texas Administrative Services Tax Act (ASTA), enjoined further enforcement of the statute as it applied to ERISA plans, and held that the act was preempted by ERISA. The ASTA placed a 2.5 percent annual tax on persons receiving administrative and service fees for services provided to what are essentially ERISA plans. The state claimed that the district court did not have the jurisdiction to enjoin a tax statute under circumstances where the state courts could evoke an efficient remedy under the Tax Injunction Act. The appeals court dismissed this reasoning and held that it was s intent that any law that contradicted ERISA, including state tax law, was preempted by the federal statute.

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[409] Ky. Rev. Stat. § 304.9-052.
[410] *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).
[411] *Self-Insurance Institute of America v. Gallagher*, 11 Employee Benefits Cas. (BNA) 2162 (N.D. Fla. 1989),

ACA CHANGES INCORPORATED INTO ERISA

Historical Background: HIPAA and the ACA

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010, and some additional amendments have been made since that date, notably the 90.624 613.06 Tm0 Gs date, notabl

2719A incorporate, in revised form, the basic portability framework originally enacted by HIPAA, and add many new protections. Sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Thus, all these ACA provisions now apply to both insured and self-insured health benefit plans, with one noteworthy exception. Certain plans existing on the date

from many of the new provisions of the PHS Act if they remain in force without material changes.[430] In addition, these provisions do not apply to retiree-only or excepted benefits plans

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issuing guidance and regulations on an ongoing basis since May 2010.

Generally, the relationship between ERISA and state law is unchanged. Section 731 (formerly numbered 704) of ERISA mirrors Section 2724 of the PHS Act, and provides that the requirements of the ACA are not

implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent such

requirements will generally not be superseded by the ACA. However, ERISA § 734(a)(2) clarifies

-insured group health plans, but

does not include the insurance policies issued to insured plans, leaving them subject to state

alth

insurance coverage, but does not include self-insured group health plans that are exempt from state regulation under ERISA.

Incorporating these new sections into ERISA is significant because for the first time a comprehensive structure of benefit mandates was added to ERISA requirements. Although HIPAA had added a few provisions to ERISA and the IRC that echoed similar language in the PHS Act, notably the limitations on pre-existing condition exclusions,[431] those had been the exception rather than the rule. Traditionally, ERISA did not dictate to employers what benefits and protections had to be contained in employer health plans. A good example of this is the Mental Health Parity and Addiction Equity Act of 2008, which provides: **IF** the employer offers any mental health benefits, then those benefits must meet the requirement of full parity with physical health benefits generally.

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[430] ACA § 1251 (42 U.S.C. § 18011), as modified by ACA § 10103 and Reconciliation Act § 2301. The specific federal provisions that apply to grandfathered plans depend on whether the plan is an individual or group plan, and whether it is insured or self-insured. Through administrative guidance, CMS has also allowed insurers, if permitted by state law, to continue renewing certain non-grandfathered insurance policies that were ACA-compliant when issued

required other plans to provide comparable value in order to meet MV requirements by designing its calculator to measure the extent to which the plan covers such categories as prescription drugs, maternity, mental health, and hospital and physician services. But what if an ALE decides not to try to provide MV, and instead to offer the least expensive plan that will allow employees to satisfy

The following discussion of the significant benefit standards added to ERISA by the ACA is based largely on a compliance checklist prepared by the USDOL.[447] For the most up-to-date USDOL guidance, see EBS https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans This guidance also includes information about other significant legislation such as COBRA, HIPAA, the Genetic Information Nondiscrimination Act

, it is the responsibility of the employer-sponsored group health plan to ensure that the plans it offers to employees meet all requirements. However, state insurance departments approve and regulate the group insurance policies that employers offer to their employees, and would include enforcement relating to these reforms.

1. *Grandfathered*

3. *Mental Health Parity (29 CFR § 2590.712)*

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits financial requirements (such as copayments and deductibles) and treatment limitations (such as visit limits) that are more restrictive for mental health or substance use disorder benefits than the predominant requirements or limitations applied to medical/surgical benefits.[450] The regulations also requiring -quanti -authorization requirements that discourage claims. An earlier law, the Mental Health Parity Act of 1996 (MHPA), already required parity for aggregate lifetime and annual dollar limits.

MHPAEA does not apply to plans that do not offer any mental health or substance disorder benefits. However, all non-grandfathered individual and small group health insurance policies required to include such benefits as part of the EHB package, and large group policies are required to include them under the laws of most states.

4. *Dependent Coverage of Children Under Age 26 (29 CFR § 2590.715-2714)*

Applicable only to plans that provide coverage for dependent children. A child who is under age 26 must be eligible for coverage as long as the relationship between the child and the participant would generally entitle the child to coverage under the terms of the plan. Thus, plans cannot deny or restrict dependent coverage for a child who is under age 26 based on factors such as residency, absence of financial dependency, student status, employment or marital status. The terms of the plan cannot vary based on age, except for children who are age 26 or older. This provision applies to both grandfathered and non-grandfathered plans. Note that if an ALE (50 or more FTE

5. *Rescission Provisions (29 CFR § 2590.715-2712(a)(2))*

Coverage may only be rescinded after it is in force if the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

6. *Prohibition on Lifetime and Annual Dollar Limits on EHB (29 CFR § 2590.715-2711(a)(1))*

A group health plan may not establish any annual or lifetime limits on the dollar amount of benefits -
grandfathered plans. USDOL and Treasury have issued guidance and FAQs on how this prohibition impacts Health Reimbursement Arrangements. For purposes of requirements that apply only to essential benefits, large group insurers and self-insured employers must define

450 -

-employee benchmark plans, supplemented as necessary to meet minimum coverage standards for all ten categories.[451]

7. Limits on Cost Sharing (PHS Act § 2707(b))

All group health plans (including self-
sharing, which require the plan to have a Maximum Out-Of-Pocket expense (MOOP) that does not
-

the MOOP to apply to services that are provided out-of-network or to services that are not covered EHBs, but plans are not prohibited from counting such expenses.[452]

8. Prohibition on Pre-existing Condition Exclusions (29 CFR § 2590.701-2)

GLOSSARY

1. COLLECTIVE BARGAINING AGREEMENT means an agreement between an employer and a labor union that regulates the terms and conditions of employment. *See Black s Law Dictionary.*

2. CONTRIBUTIONS means premiums, contributions or any other sums collected to pay health and welfare benefits whether paid by an employer or an employee.

3. EMPLOYEE means a person who works for salary or wages, under the control and direction of an employer. *See* 29 U.S.C. § 1002(6).

4. EMPLOYEE ORGANIZATION means a labor union or other organization representing employees concerning employment benefits. *See* 29 U.S.C. § 1002(4).

5. EMPLOYEE WELFARE BENEFIT PLAN means a plan, fund or program established or maintained to provide health care or other employment benefits to employees. *See* 29 U.S.C. § 1002(1).

6. EMPLOYER means a person who employs or hires other persons and who controls their performance and pays their salaries or wages. *See* 29 U.S.C. § 1002(5).

7. INSURANCE SERVICE ORGANIZATION means a type of medical service corporation or other entity assuming any risk of loss for benefits to be paid and qualified to conduct business in a state.

8. LABOR ORGANIZATION means an organization described in 29 U.S.C. § 1002(5) in which employees participate for the purposes described in that provision. *See* 29 U.S.C. §§ 151 through 186.

9. MULTIEMPLOYER PLAN means a plan maintained pursuant to collective bargaining agreements between one or more employee organizations and more than one employer and to which more than one employer is required to contribute. *See* 29 U.S.C. § 1002(37)(a); 29 CFR § 2510.3-37.

10. MULTIPLE EMPLOYER TRUST (MET) is a generic term used to market several types of health and welfare plans which may or may not be: (a) subject to ERISA; or (b) insured or self-funded.

11. MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) means a plan, established by two or more employers to offer health and welfare benefits to their employees, but does not include arrangements established pursuant to bona fide collectively bargained agreements or a rural electric cooperative. *See* 29 U.S.C. § 1002(40)(a).

APPENDICES

Appendix 1 – Consumer Alert

CONSUMERS BEWARE—ILLEGAL "ERISA" AND "UNION PLAN" SCAMS

If it seems too good to be true, it probably is. Nationwide, the health insurance marketplace is facing tougher times. The cost of health insurance is rising. Criminals, seeking to make a profit by selling fraudulent health insurance, cl

Deal with reputable agents. If the person trying to sell you the coverage says he or she doesn't need a license because the coverage isn't insurance or is exempt from regulation, watch out.

Appendix 2 – Agent Alert

AGENTS BEWARE—ILLEGAL "ERISA" AND "UNION PLAN" SCAMS

[optional final paragraph]

Anyone with information about an entity offering health coverage without a state license should contact [state insurance department contact information].

Appendix 3 – Regulatory Alert to Stop-Loss Carriers and Third Party Administrators

You are asked to immediately review your internal controls and business practices to ensure that your company does not become an unwitting supporter of unlicensed (illegal) health insurance nt effort to strengthen its internal controls in this area is warranted by

hen
appropriate internal controls may lead to substantial liability. Your company may be subject to

equivalent to Section 4 of the Nonadmitted Insurance Model Act].

The department asks you to establish or strengthen internal controls designed to ensure that:

Unlicensed MEWAs

Your company will not issue or purchase a stop-loss policy or undertake to administer unlicensed - the employees of two or more employers unless all covered employers are under common ownership [or the plan is licensed in this state as a multiple employer welfare arrangement]. These plans are insurers under the laws of this state and are transacting the business of insurance without a license. They commonly, and wrongly, claim to be exempt from state insurance law under the federal Employee Retirement Income Security Act of 1974

Note: States that have MEWA-specific licensing laws should add the language in brackets or make other modifications to this paragraph consistent with their laws.

Unlicensed Professional Employer Organizations ("PEOs") Health Plans

Your company will not issue or purchase a stop-loss policy or undertake to administer an -
company based in this state or offering coverage to client employers in this state. These firms com -
PEO. These self-funded health plans are Multiple Employer Welfare Arrangements under ERISA rather than single employer plans. state law, a business is a direct employer under ERISA only if the facts and circumstances of the case demonstrate that the As long as the participating workers are employed by the various client employers, the health plan covers multiple employers. That makes the plan a MEWA, even if the PEO is also an indirect employer or co-employer. As indicated above, MEWAs that are not fully insured are subject to state regulation as insurers, and state insurance laws applying to PEOs are not preempted by ERISA. Your company should -
company that is an unlicensed insurer under the laws of this state.

Note: Some states have statutes allowing PEOs or employee leasing firms to self-fund health benefits or obtain a license allowing them to self-fund health benefits. Other states have laws - -funding. If

