ASSOCIATION HEALTH PLANS
ERISA COMPLIANCE ASSISTANCE

A new Department of Labor rule expands the ability of employers, including sole proprietors and self-employed workers, to participate in Association Health Plans. For many employers, employees, and their families, these employee benefit plans will offer greater flexibility and more affordable benefits. Like other workplace health plans, these plans are subject to important state and federal consumer protection rules and requirements. To meet their responsibilities, plan sponsors and employers need to understand some basic rules for managing and operating group health plans and other employee welfare benefit plans, particularly those set out in the Employee Retirement Income Security Act (ERISA). ERISA sets standards of conduct for those who manage group health plans (including Association Health Plans) and their assets. The Department of Labor can help employers understand their responsibilities under ERISA.

What is an Association Health Plan?

An Association Health Plan (AHP) is a specific type of ERISA-covered group health plan that is sponsored by a group or association of employers, instead of a single employer, to provide health coverage to the employees of the AHP's employer members. Under ERISA, an AHP is both a group health plan and a multiple employer welfare arrangement (MEWA).

The Department's new rule, published on June 21, 2018, allows more employer groups and associations to form AHPs, and allows AHPs to offer coverage to some or all employers in a state, city, county, or a multi-state metro area, or to businesses in a common trade, industry, line of business, or profession in any area, including nationwide. In addition, working owners without other employees (including sole proprietors) can join AHPs to receive health coverage for themselves and their families.

The new rule also includes important safeguards, including consumer protections that generally apply to large employer health plans and healthcare nondiscrimination protections. For example, AHPs may not charge higher premiums or deny coverage to people because of pre-existing conditions or cancel coverage because an employee or covered family member becomes ill.

The new rule does *not* affect previously existing AHPs, which were allowed under prior Departmental guidance. Such plans can continue to operate under the same rules as before or they can elect to follow the new rules if they want to expand within a geographic area, regardless of industry, or to cover working owners. New plans can also form and elect to follow either the old rules or the new rules.

What ERISA provisions apply to AHPs?

AHPs are employee welfare benefit plans under ERISA. In general, an employee welfare benefit plan covered by ERISA is subject to reporting and disclosure requirements, claims procedure rules, and fiduciary rules. In addition, AHPs and other covered group health plans must comply with health care continuation coverage provisions under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the health care protections provided in Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and other group health plan laws.

Disclosure Rules. Plan administrators must furnish plan information to participants and beneficiaries. Some information must be distributed automatically and other information must be provided upon request. Three of the most important disclosures are the Summary Plan Description, Summary of Material Modifications, and the Summary of Benefits and Coverage.

The **Summary Plan Description** is a plain language summary of the plan and explanation of the plan's rules. It must be comprehensive enough to inform participants of their rights and responsibilities under the plan. AHPs must provide it to each participant within 90 days of the individual becoming covered under the plan, and within 30 days after a written request.

AHPs must also furnish a **Summary of Material Modification** to inform participants any time there is a material change to the AHP or the information required to be in the summary plan description.

A **Summary of Benefits and Coverage** is a disclosure that uses a uniform template to give AHP participants a clear, plain-language summary of the key features of a plan, such as covered benefits, cost-sharing provisions, and coverage limitations. Plan administrators must provide a Summary of Benefits and Coverage as part of any written application materials, upon special enrollment, when coverage is renewed, and within seven business days of receiving a request.

More information on AHP general disclosure obligations under ERISA can be found at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/reporting-and-disclosure-guide-for-employee-benefit-plans.pdf.

Reporting Rules. AHPs, whether fully insured or self-insured, generally must file both a **Form 5500** and a **Form M-1** with the Department. The Form 5500 is an annual report containing information about the plan, its finances, and its operation. AHPs and other MEWAs must also file Form M-1s to register and report certain compliance information before operating in a new state, and annually thereafter. Both the Form 5500 and the Form M-1 are available at https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing.

Anyone considering joining an AHP can visit the Department's webpage and use our electronic Form M-1 database (askebsa.dol.gov/epds) to determine whether the AHP has appropriately registered with the Department. To search the database at https://www.askebsa.dol.gov/epds/, it helps to know the name of the AHP, the Employer Identification Number of the AHP sponsor, and the state(s) in which the AHP operates. Since all AHPs must file the Form M-1, a failure to register or to file a complete, accurate, and timely Form M-1 is a red flag. If you learn of such a filing failure, please notify the Department's Employee Benefits Security Administration (EBSA) immediately and exercise extreme caution before enrolling. Contact information for EBSA is at the bottom of this publication.

Benefit Claims Administration. Group health plans must establish and maintain a claims procedure that participants and beneficiaries can use to apply for and receive the plan's promised benefits. The Department has issued rules setting minimum timing and content standards for benefit claims procedures and benefit determinations for ERISA plans (including insured and self-insured plans). More information on benefit claims administration can be found at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/group-health-and-disability-plans-benefit-claims-procedure-regulation.pdf and https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf (pg. 122-29).

COBRA Continuation Coverage Provisions. COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and the dependent children when group health coverage would otherwise have been lost due to specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare benefits, and a child's loss of dependent status under the plan. Those who are eligible may be required to pay for COBRA continuation coverage and are generally entitled to coverage for a limited period of time (from 18 months to 36 months), depending on certain circumstances. COBRA does not apply to employers with fewer than 20 employees. The Department anticipates future guidance on the application of COBRA to AHPs that provide coverage to member employers with fewer than 20 employees. More information on COBRA can be found at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf.

Consumer Health Care Protections under ERISA. ERISA Part 7 includes various consumer protection provisions, including HIPAA, the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act, among others. More information on ERISA's consumer health care protections can be found at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf.

Fiduciary Rules. ERISA establishes standards and rules governing the conduct of individuals and companies responsible for running the plans, including AHPs. For example, ERISA requires that plan assets be held in a trust by one or more trustees or by an insurance company as part of an insurance contract. AHPs must also have a written document that describes the benefit structure and guides day-to-day operations of the plan. Among other things, this document must provide for one or more named fiduciaries to control and administer the AHP. The named fiduciary may either be named in the plan document or identified as a plan fiduciary pursuant to a procedure specified in the plan document by the group or association of employers that sponsor the AHP. A person may also become a fiduciary of an AHP if the person has any discretionary authority or responsibility in the administration of the plan, exercises any discretion in administering and managing such plan or exercises any authority or control over the plan's assets. In general, the employers that are members of the AHP have a fiduciary duty to monitor the AHP and get periodic reports on the fiduciaries' management and administration of the AHP.

Under ERISA, fiduciaries must discharge their duties solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan. In discharging their duties, fiduciaries must act prudently and in accordance with ERISA and the documents governing the plan. The fiduciary duty to act prudently extends to the AHP's hiring of service providers, such as third-party administrators, insurers, and pharmacy benefit managers. When selecting a service provider, the responsible plan fiduciary must engage in an objective process designed to elicit information necessary to assess the qualifications of the provider, the quality of services offered, and the reasonableness of the fees charged in light of the services provided. In addition, such processes should be designed to avoid self-dealing, conflicts of interest, or other improper influences.

ERISA also prohibits certain transactions involving plans and related parties called "parties-in-interest." Parties-in-interest include, for example, the AHP fiduciaries and related entities (e.g. affiliates of the plan fiduciaries) and the employer members of the AHP. An AHP fiduciary that hires one of the association's member employers to provide services to the AHP would be engaging in a prohibited transaction. Similarly, if a trustee of an AHP or another fiduciary hired an affiliated company to provide services to the AHP, that too would be a prohibited transaction.

Are exemptions available for an AHP from any of ERISA's prohibited transaction provisions?

Yes. ERISA includes a number of exemptions (called "statutory exemptions") that allow AHPs to conduct necessary transactions that would otherwise be prohibited. The Labor Department may also grant additional "administrative" exemptions. "Administrative" exemptions can cover transactions with one specific plan or an entire class of plans. More information on the procedure for applying for an administrative exemption is available at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/exemptions/class/pte-procedures.

One statutory exemption that is particularly important for AHPs allows AHPs to pay individuals or companies who provide services to the AHP but only if the services are necessary to operate the plan, the contract or arrangement under which the services are provided is reasonable, and the compensation for those services is reasonable.

This "service provider" exemption does not cover a fiduciary hiring an affiliate or related person or company to provide services to the AHP — called self-dealing or a "conflict of interest" prohibited transaction. There is a separate statutory exemption for this "conflict of interest" transaction but, in addition to the conditions required by the "service provider" exemption, the affiliate (or related person or company) can be paid only for its direct expenses (not normal fees) incurred when providing services. Fiduciaries of AHPs can apply to the Department for an administrative exemption if they want to hire affiliates or related persons or companies and charge normal fees, but the application would have to prove the arrangement was in the interest of and protective of the plan and its participants and beneficiaries.

Does the Department of Labor have any voluntary correction programs for employers or associations who make mistakes in operating an AHP?

Yes. The Department of Labor's Voluntary Fiduciary Correction Program (VFCP) encourages fiduciaries to comply with ERISA by voluntarily self-correcting certain violations. The program covers 19 common transactions including failure to promptly remit participant contributions, payment of duplicate, excessive, or unnecessary compensation, and improper payment of expenses by the plan. Particularly important for AHPs is the ability to correct failures by member employers to promptly send participant contributions to the AHP. The VFCP describes how to correct certain, covered violations. In addition, the Department gives applicants immediate relief from paying excise taxes for late contributions under a class exemption. The Department also has a Delinquent Filer Voluntary Compliance Program under which AHPs and other employee benefit plans can fix failures to file a Form 5500 on time.

For an overview of both voluntary correction programs, visit https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/correction-programs.

In addition to these correction programs, EBSA has an active compliance assistance effort where the Department works with all types of plans, including AHPs, to help them identify and fix mistakes. For more information on our compliance assistance resources, go to: https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

Does ERISA contain any special MEWA enforcement provisions that apply to AHPs?

The Department may issue a cease-and-desist order when it appears that a MEWA's conduct:

- is fraudulent,
- creates an immediate danger to the public safety or welfare, or
- is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

The Department may also issue a summary seizure order if it appears that a MEWA is in a financially hazardous condition. Persons marketing and/or maintaining AHPs may also face criminal penalties if they make false statements in connection with the sale or marketing of the MEWA. For more comprehensive information on the MEWA provisions applicable to AHPs, visit https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

Do the States have any authority over AHPs?

Yes. ERISA expressly provides both the Department and State insurance regulators joint authority over AHPs. In addition, States can regulate health insurance issuers and the health 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 insurance department for more information on that state's insurance laws.

When can AHPs be established under the new rule?

As stated above, the new rule does not affect previously existing AHPs that complied with the Department's guidance on AHPs. Such plans can continue to operate as before, or elect to take advantage of the options under the new rule, including expanding within a geographic area, regardless of industry, or covering self-employed workers. New plans can also form and elect to follow either the old guidance or the new rule.

Below are important dates for AHPs to be established under the new rule:

- All associations (new or existing) may establish a fully-insured AHP starting on September 1, 2018;

- Existing associations that sponsored a self-insured AHP on or before the date the new rule was published may expand within the context of the new AHP rule starting on January 1, 2019;

- All other associations (new or existing) may establish a self-funded AHP starting on April 1, 2019.

Resources

The U.S. Department of Labor's EBSA offers more information online and through various publications. Some of these resources aim to help employers comply with ERISA and others to help employees understand their rights under the law. To order publications or to request assistance from a benefits advisor, contact EBSA at askebsa.dol.gov or toll free at 1-866-444-3272.